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Diplomate of the American Board of Pain Medicine
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PALOMAR SPINE &PAIN

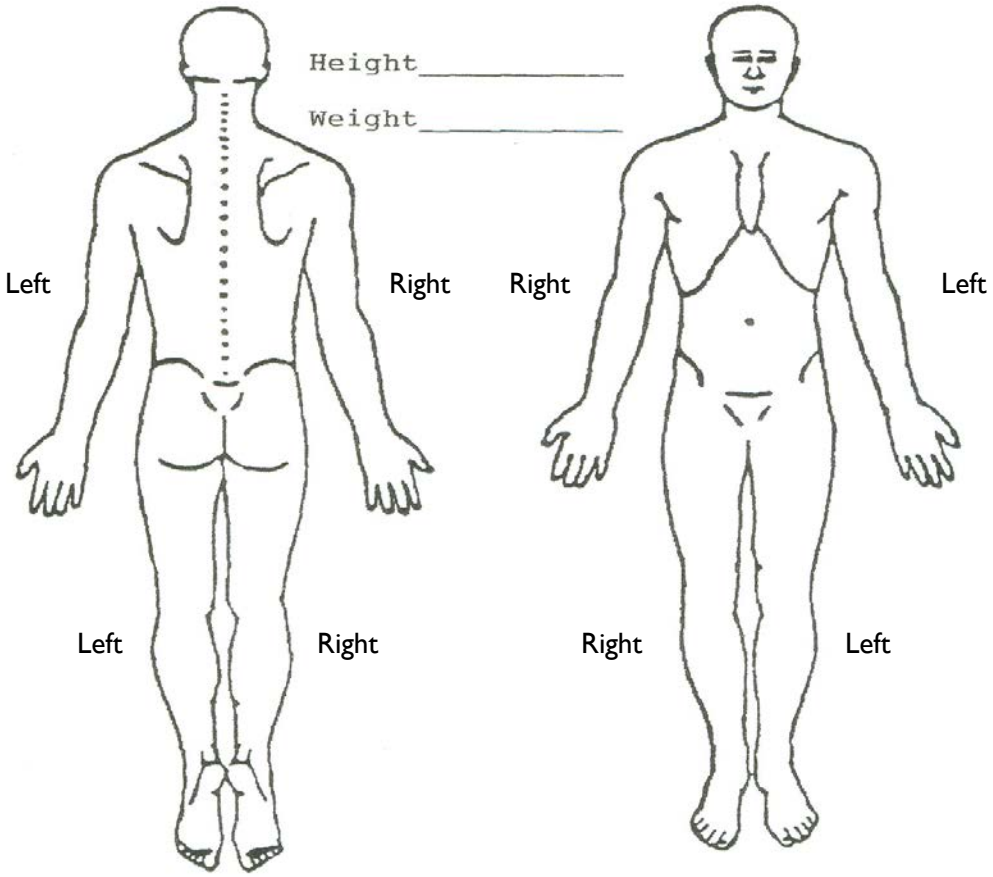
Name: _____ Date: _____

CHRONIC PAIN EVALUATION

Please help us understand your pain by completing this drawing:

A) Use the pictures below to show the origin of your pain. (mark with a solid dot)

B) Does the pain travel or radiate anywhere? (mark with a broken line)



Please list your areas of pain from most painful to least painful:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Please help us understand your pain by answering the following questions:

1) When did your pain start? _____

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2) Is your pain aggravated by work? [ ] yes [ ] no
If so, how? _____

3) Have you had any other injuries in the past that were **not** work-related? If yes, please describe:

_____

_____

4) Have you received a medical discharge from the Armed Forces? [ ] yes [ ] no

5) **Please rate your pain level on the scale below:**

0 = no pain 10 = worst pain

Now:	0	1	2	3	4	5	6	7	8	9	10
Average:	0	1	2	3	4	5	6	7	8	9	10
Most Intense:	0	1	2	3	4	5	6	7	8	9	10

6) My pain is **worse** when I (please "X" all that apply):

[ ] Cough or sneeze
[ ] Sit
[ ] Bend my neck
[ ] Walk
[ ] Push
[ ] Stand
[ ] Breathe In
[ ] Bend my low back
[ ] Turn my head
[ ] Lift
[ ] Pull
[ ] Other: _____

7) What makes your pain **better**? _____

8) Do you have **weakness**? [ ] yes [ ] no
Where? _____

9) Do you have areas of **numbness** or **tingling**? [ ] yes [ ] no
Where? _____

10) Do you have difficulty controlling your bowels or bladder? [ ] yes [ ] no

11) Have you had any of the following procedures done to treat your pain? (Please "X" all that apply):

[ ] physical therapy
[ ] psychological counseling
[ ] epidural steroid injections
[ ] facet joint injections
[ ] trigger point injections
[ ] chiropractic therapy
[ ] anti-inflammatory medication
[ ] joint injection(s)
[ ] TENS (transcutaneous electrical nerve stimulation)
[ ] bed rest
[ ] ice
[ ] heat
[ ] nerve blocks
[ ] acupuncture
[ ] surgery
[ ] traction
[ ] steroids

12) Have any of the above-listed procedures decreased your pain?
[ ] yes [ ] no

13) List all medications you have used in the past to treat your pain.

_____

_____

14) List all diagnostic tests you have had and specify which body part was tested:
[ ] MRI _____ [ ] Bone Scan _____
[ ] X-ray _____ [ ] CT scan _____
[ ] Myelogram _____ [ ] Discogram _____
[ ] EMG/nerve conduction studies _____
[ ] Other _____

15) Have you had any of the following medical illnesses?

[ ] Depression	[ ] Peptic Ulcer Disease	[ ] Gastritis
[ ] Anxiety	[ ] Diabetes	[ ] Shingles
[ ] Pulmonary Embolus	[ ] Pancreatitis	[ ] Syphilis
[ ] Major Blood Vessel	[ ] Thyroid Disease	[ ] Lupus
[ ] Congestive Heart Failure	[ ] Kidney Disease	[ ] Asthma
[ ] Bleeding Tendency	[ ] Emphysema	[ ] Peripheral Vascular Disease
[ ] Abnormal Heart Rhythm	[ ] Heart Attack	[ ] High Cholesterol
[ ] High Blood Pressure	[ ] Liver Disease	[ ] Parkinson's Disease
[ ] Interstitial Cystitis.	[ ] Hepatitis	[ ] Restless Leg Syndrome
[ ] Chronic Bronchitis	[ ] Tuberculosis	[ ] Psoriasis
[ ] Rheumatoid Arthritis	[ ] Osteoarthritis	[ ] Migraine Headaches
[ ] Stroke	[ ] Chicken Pox	[ ] Tension Headache
[ ] Kidney Stones	[ ] Multiple Sclerosis	[ ] Carpal Tunnel Syndrome–[ ]right [ ]left
[ ] Other Nervous System Diseases	[ ] Osteoporosis	[ ] Deep Venous Thrombosis
[ ] Urinary Tract Infections	[ ] Meningitis	[ ] Endometriosis
[ ] Seizures/Epilepsy	[ ] Gout	[ ] Sleep Apnea
[ ] Cancer. What type?_____	[ ] Radiation	[ ] Chemotherapy
[ ] Whiplash	[ ] Concussion	[ ] Peripheral Neuropathy

16) Have you had any major illnesses that required hospitalization? [ ] yes [ ] no
Describe: _____
_____

17) Have you had chronic exposure to any toxins? _____

18) List all surgeries you have had in the past: _____
_____
_____

19) List all medications you are currently taking, including nonprescription medications – continue on the back of this page if necessary.
_____
_____

20) List all drugs to which you are allergic: _____

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_____

21) List all drugs to which you have had a bad reaction: _____

_____

22) Have you ever used prescribed controlled drugs before? _____

23) Have you ever been to a pain doctor before? _____

24) Do you have a past history of chemical/substance abuse, including alcohol, illicit and/or illicit drugs? _____

REVIEW OF SYSTEMS

25) Please list any problems that you **NOW HAVE** with the following body systems:

Ear/Nose/Throat: ( ) Denied _____
Eyes: ( ) Denied _____
Lungs: ( ) Denied _____
Liver: ( ) Denied _____
G-I Tract (Stomach, Intestines, Bowels, Etc.): ( ) Denied _____
Kidney/Bladder: ( ) Denied _____
[Women] Reproductive System: ( ) Denied _____
Skin: ( ) Denied _____
Neurological: ( ) Denied _____
Heart/Circulation: ( ) Denied _____
Psychological: ( ) Denied _____

FAMILY HISTORY:

26) Has anyone in your family experienced similar pain? [ ] yes [ ] no

SOCIAL HISTORY:

27) What is your marital status?
[ ] single [ ] married [ ] divorced [ ] separated [ ] widowed

28) Do you have children? [ ] yes [ ] no How many? _____
Ages: _____

29) Do you smoke? [ ] yes [ ] no How many packs per day? ____ How many years? ____

30) Do you drink alcohol on a regular basis? [ ] yes [ ] no
If yes, how many drinks per day of what type? _____
31) Do you use any street drugs? [ ] yes [ ] no
32) What is your highest level of education? _____

33) Has pain affected your:

Sleep	[ ] yes	[ ] no
Exercise	[ ] yes	[ ] no
Mood	[ ] yes	[ ] no
Appetite	[ ] yes	[ ] no
Sexual Activity	[ ] yes	[ ] no

OCCUPATIONAL HISTORY:

34) Are you currently employed? [ ] no [ ] full time [ ] part time [ ] homemaker
[ ] retired

35) What is your occupation? _____

36) If you are unemployed or employed part time, is this due to your pain? [ ] yes [ ] no

37) Is there currently any personal injury litigation due to your pain? [ ] yes [ ] no

38) Are you receiving any disability payments due to your pain? [ ] yes [ ] no
If so, what type ("X" all that apply):
[ ] Social Security [ ] State Disability
[ ] Private [ ] Workers Compensation

39) If female, is there any way you could be pregnant? [ ] yes [ ] no

40) Are you currently receiving **chiropractic physical therapy**? [ ] yes [ ] no
If yes, where and how many days per week? _____

41) Are you currently receiving **physical therapy**? [ ] yes [ ] no
If yes, where and how many days per week? _____

42) Have you had any **work-related** injuries in the past? [ ] yes [ ] no

43) Is your current pain due to a **work-related** injury? [ ] yes [ ] no

44) Who is your primary care physician? _____

45) Which doctor referred you to us? _____

46) If you were not referred, how did you hear about us? _____
_____

47) Do you have an Advance Healthcare Directive? [ ] Yes [ ] No
If yes, please provide us with a copy

REVIEW OF SYSTEMS:

GENERAL, CONSTITUTIONAL

Recent weight loss.....[No][Yes]
Fever.....[No][Yes]
Chills.....[No][Yes]

EYES, VISION
Visual Changes.....[No][Yes]

EARS, NOSE, THROAT
Hearing loss.....[No][Yes]

HEART, CARDIOVASCULAR
Chest pain or pressure.....[No][Yes]
Arrythmia or palpitations.....[No][Yes]
Shortness of breath.....[No][Yes]
Peripheral edema.....[No][Yes]
Blood clots.....[No][Yes]
Varicose Veins.....[No][Yes]
Cramping in thighs.....[No][Yes]

RESPIRATORY
Cough.....[No][Yes]
Shortness of breath.....[No][Yes]
Wheezing.....[No][Yes]

GASTROINTESTINAL
Abdominal pain.....[No][Yes]
Heartburn.....[No][Yes]
Bloody stool.....[No][Yes]

GENITOURINARY
Frequent urination.....[No][Yes]
Urgency.....[No][Yes]

MUSCULOSKELETAL
Joint pain or swelling.....[No][Yes]
Restricted motion.....[No][Yes]
Musculoskeletal pain.....[No][Yes]

SKIN & INTEGUMENTARY
Rashes.....[No][Yes]
Sores.....[No][Yes]
Blisters.....[No][Yes]
Growths.....[No][Yes]

NEUROLOGICAL
Numbness or tingling sensations...[No][Yes]
Sensation loss.....[No][Yes]
Burning .....[No][Yes]

PSYCHIATRIC
Nervousness, anxiety.....[No][Yes]
Depression.....[No][Yes]

ENDOCRINE
Heat or cold intolerance.....[No][Yes]
Excessive thirst.....[No][Yes]

HEMATOLOGIC/LYMPHATIC
Abnormal bleeding.....[No][Yes]
Bleeding.....[No][Yes]

ALL/IMMUN:
Allergic reaction.....[No][Yes]
Recurrent infections.....[No][Yes]

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CERTIFICATION

I certify that I have answered truthfully all the questions, and have not knowingly withheld any information concerning any of the above problems, either past or present.

_____	_____
Your Signature	Witness
_____	_____
Date	Date

BECAUSE DR. VELIZ IS A SOLO MEDICAL PRACTITIONER WITH NO OTHER MEDICAL DOCTORS, PHYSICIAN ASSISTANTS OR NURSE PRACTITIONERS, HE CANNOT DO ANY MORE OPIATE OR NARCOTIC MEDICATION MANAGEMENT.

DR. VELIZ WILL MAKE RECOMMENDATIONS FOR YOUR PRIMARY CARE PHYSICIAN TO FILL YOUR OPIATES OR NARCOTICS.

I agree that Dr. Jose Veliz will **not** provide **narcotic medication management** for me. I agree that my narcotic medications will be filled by my primary care physician OR other prescribing specialist not including Dr. Jose Veliz.

_____	_____
Signature of Patient	Date

THANK YOU!

_____	_____
Signature of Reviewing Physician	Date

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