Chronic Pain   New Injury   PI   WC

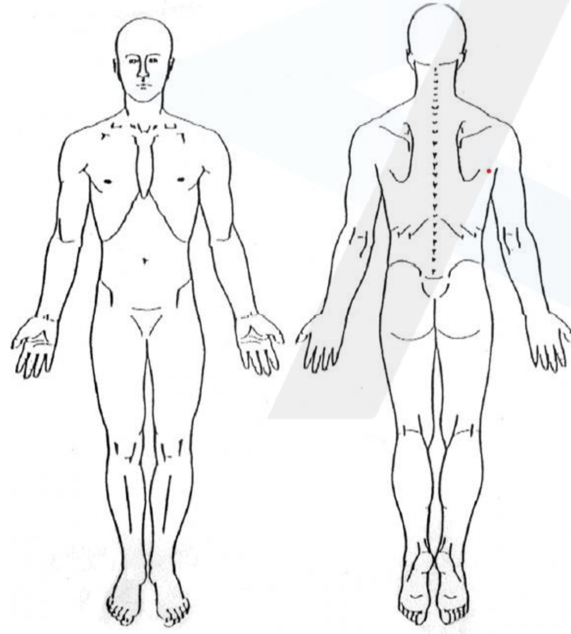
Name: Date of Birth: Today's Date:

What Brought you to Arizona Pain Relief?

(Click Any Problematic Areas)

Check all that Apply	
✓	**Symptom**
	Headaches
	Neck Pain
	Arm Pain/ Numbness
	Lower Back Pain
	Leg Pain/ Numbness
	Knee Pain
	Shoulder Pain
	Hip Pain
	Ankle/Foot Pain
	Elbow Pain
	Upper Back Pain
	Mid Back Pain
	Hand/Wrist Pain

R	L



	Cause	Onset	Palliative	Provocative	Quality	Radiation	Severity	Percentage	Time
Main Concerns	**Was there an injury or trauma?**	**How long have you had this pain?**	**What helps? What have you tried?**	**What makes it worse?**	**How would you describe the pain?**	**Does the pain radiate?**	**Severity now & at worst**	**What percent of the day are you in pain?**	**Is the pain worse at a particular time of day?**
1.	Auto Work Repeat Motion Fall Sports Inj	____ Day(s) Weeks(s) Months(s) Year(s)	Ice Heat Medication Stretching PT Chiro Exercise Other:	Movement Lifting Sitting Standing Bending Twisting Other:	Dull Aching Sharp Burning Tingling Numbing Other:	________ To ________	Now: _____/10 Worst: _____/10	____% of the hours awake	Morning Afternoon Night
2.	Auto Work Repeat Motion Fall Sports Inj	____ Day(s) Weeks(s) Months(s) Year(s)	Ice Heat Medication Stretching PT Chiro Exercise Other:	Movement Lifting Sitting Standing Bending Twisting Other:	Dull Aching Sharp Burning Tingling Numbing Other:	________ To ________	Now: _____/10 Worst: _____/10	____% of the hours awake	Morning Afternoon Night
3.	Auto Work Repeat Motion Fall Sports Inj	____ Day(s) Weeks(s) Months(s) Year(s)	Ice Heat Medication Stretching PT Chiro Exercise Other:	Movement Lifting Sitting Standing Bending Twisting Other:	Dull Aching Sharp Burning Tingling Numbing Other:	________ To ________	Now: _____/10 Worst: _____/10	____% of the hours awake	Morning Afternoon Night

Revised Oswestry Pain Disability Questionnaire

Please Read:

This questionnaire has been designed to give your doctor/therapist information as to how your pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the **one** box that best describes your condition today.

We realize you may feel that two of the statements in any one section can relate to you, but please just mark the box which most closely describes your current condition.

Section 1 – Pain Intensity

- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad, but I manage without having to take pain medication.
- ☐ Pain medication provides me complete relief from pain.
- ☐ Pain medication provides me moderate relief from pain.
- ☐ Pain medication provides me little relief from pain.
- ☐ Main predication has no effect on the pain.

Section 2 – Personal Care (Washing, Dressing, etc.)

- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally, but it increases my pain.
- ☐ It is painful to take care of myself and I am slow and careful.
- ☐ I need help, but I can manage most of my personal care.
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights, but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g., on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than a ½ mile.
- ☐ Pain prevents me walking more than a ¼ mile.
- ☐ I can only walk using crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me from sitting for more than a ½ hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing

- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but increases my pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than a ½ hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using pain medication.
- ☐ Even when I take pain medication, I sleep less than 6 hours.
- ☐ Even when I take pain medication, I sleep less than 4 hours.
- ☐ Even when I take pain medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (i.e., sports, dancing, etc.).
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

Section 9-Traveling

I can travel anywhere without increased pain.
I can travel anywhere but it increases my pain.
Pain restricts travel over 2 hours.
Pain restricts travel over 1 hour.
Pain restricts my travel to short necessary journeys under a ½ hour.
Pain prevents all travel except visits to the doctor therapist or hospital

Section 10 – Employment/Homemaking

- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (i.e., lifting, vacuuming).
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any homemaking/ job duties.

Total Score __________

Medical History			
☐ Arthritis	☐ Anemia	☐ Sleep Apnea; CPAP- Yes/No	☐ Seizure Disorder
☐ Falls/Balance Issues	☐ Sickle Cell Disease	☐ Hyper/Hypo Thyroid	☐ Bleeding or Clotting Disorder
☐ Asthma	☐ Heartburn/GERD	☐ Anxiety/Depression	☐ Non-healing wounds
☐ COPD/Emphysema	☐ Ulcer	☐ Dementia	☐ Diabetes Type 1 Type 2
☐ Stroke	☐ Trouble Swallowing	☐ Bowel Disorder	☐ Migraine Headaches
☐ Tuberculosis	☐ Covid – 19	☐ Liver Disorder	☐ Cancer
☐ Congestive Heart Failure	☐ Vision Disorder	☐ Kidney Disorder	☐ Atrial Fibrillation
☐ Heart Attack	☐ High Cholesterol	☐ Pacemaker or AICD	☐ High/Low Blood Pressure
☐ AIDS Herpes STDS MRSA VRE C-Diff			
☐ Other Medical Conditions:			

Do you use: Glasses Contact Lenses Hearing Aids Dentures

Do you use: Cane Walker Wheelchair Scooter Service Animal

Social History: Current Smoker:_____packs per day If Previous Smoker: Year Quit________ Alcohol:_____drinks per week

Illicit Drugs:

Previous Surgeries	Year
Do you or a family member experience problems with **anesthesia/sedation/analgesia?** Yes No **Describe:**	

Family Medical History	
Relation	**Major Medical Problems and/or Cause ofDeath**

Allergies	
Name	**Reaction/Symptom**

If you are unsure of which medications you are taking, including the does, please provide a list on your next visit

Medications (Including Non-Prescription Such as Herbs, Supplements and Over the Counter)							
Drug: Please list Anti-Coagulants (blood thinners) first	**Purpose:** Why do you take the medication?	**Dose:** Mg, mcg units	**Frequency:** Daily, as needed	**Drug:**	**Purpose:**	**Dose:**	**Frequency:**

Review of Systems Check if Experienced in the last 1-2 months	
☐ Fevers	☐ Muscle Aches
☐ Night Sweats	☐ Joint Pain/Swelling
☐ Fatigue	☐ Headaches
☐ Congestion	☐ Dizziness
☐ Sneezing	☐ Numbness
☐ Itchy/Rashes	☐ Balance Issues/Falls
☐ Earache or Ear Infection	☐ Tingling
☐ Sore Throat	☐ Fainting
☐ Difficulty Swallowing	☐ Unintentional Weight Loss/Gain
☐ Wheezing	☐ Pain in Legs When Walking
☐ Cough	☐ Bowel or Bladder Incontinence
☐ Shortness of Breath	☐ Nausea/Vomiting
☐ Chest Pain	☐ Diarrhea
☐ Racing Heartbeats	☐ Other:

Previous Imaging: X-ray MRI CT Scan

Most Recent Year Taken: _______________

Occupation: ___________________

Hours Spent Sitting: _________

Hours Spent Standing: _________

Hobbies/Recreational Activities: (*How does your pain affect these?*)

____

____

____

What are your long-term goals related to function and activities?

____

____

Previous Traumas/Auto Accidents:

Trauma/Accident Date:	Hospitalized? Y/N	If Hospitalized: Where?	Injury Description:	Related Issues:

Staff Notes:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the Arizona Pain Relief staff to perform the necessary services I may need.

Patient Signature:	**Date:**
Signature of Parent or Guardian:	**Date:**
Signature of Provider:	**Date:**

Congratulations! You have completed your portion of the new patient paperwork packet!