PAIN DIAGNOSTICS AND INTERVENTIONAL CARE

● Phone: 412-221-7640 ● Internet: www.DavidProvenzanoMD.com ● Fax: 412-490-9850

301 Ohio River Boulevard, Suite 203
Edgeworth Medical Commons
Sewickley, PA 15143

INITIAL PAIN ASSESSMENT FORM

Patient Name: _____ **Date of Birth:** _____ **Age:** _____
Gender: ☐ Male ☐ Female **Social Security Number:** _____
Address: _____ **Home Phone:** _____
_____ **Alternative Phone:** _____
Email address: _____
Would you like to receive copies of our newsletters? ☐ Yes ☐ No
Person to contact in case of an emergency: _____
Relationship: _____ **Phone:** _____

EMPLOYMENT INFORMATION:

Place of Employment: _____
Address: _____
Phone: _____ **Occupation:** _____

INSURANCE INFORMATION:

Subscriber: _____ **Insurance Company:** _____
Address: _____ **Policy #:** _____
_____ **Group #:** _____
Insurance Phone #: _____ **Relationship of patient to subscriber:** _____
DOB of Subscriber: _____
Subscriber: _____ **Insurance Company:** _____
Address: _____ **Policy #:** _____
_____ **Group #:** _____
Insurance Phone #: _____ **Relationship of patient to subscriber:** _____
DOB of Subscriber: _____
Is this a work-related injury: Yes No If yes, date of the injury: _____
Case worker or contact name: _____
Phone: _____
_____
Is this a motor vehicle-related accident: Yes No If yes, date of accident: _____
Car Insurance: _____ **Policy #:** _____
Name of Insured: _____

LEGAL ISSUES:

Are you currently involved in a lawsuit because of your current pain? Yes No
If yes, what is the name of your attorney: _____
Address: _____
_____
Phone: _____

SOCIAL HISTORY:

Marital Status: □ **Single** □ **Married** □ **Separated** □ **Divorce** □ **Widow(er)**

Do you feel free from apparent physical or emotional abuse in your home? □ **YES** □**NO**
If no, would you like to speak to a member from our Social Service Dept.? □ **YES** □**NO**

Type	**Present Use	Amount		**Past Use	Amount
Alcohol					
Cigarettes					
Cigars					
Chew/Snuff					
Marijuana					
Cocaine					
Heroin					
Other					

WORK:

Occupation: _____

Status: □ **Working FT** **Same Duties** □ **Reduced Duties** □
□ **Working PT** **Same Duties** □ **Reduced Duties** □
□ **Not working due to pain**
□ **Not working due to other non-pain related reasons**
□ **Unemployed, seeking employment**
□ **Unemployed, not seeking employment**
□ **Retired** □ **Homemaker** □ **Student**
□ **Other:** _____

KNOWLEDGE ASSESSMENT:

Your Primary Language: _____ **Secondary Language:** _____

1. **Do you prefer to learn by:**
   □ **Reading** □ **Classroom** □ **Demonstration** □ **Video** □ **Repetition** □ **Other**
2. **Do you have any learning difficulties?** □ **Yes** □ **No**
3. **Current living arrangements (check all that apply):**
   □ **House** □ **Apartment** □ **Assisted Living** □ **Personal Care Home/Nursing Home**
   □ **Lives Alone** □ **Lives with relative/friend:** _____ □ **Stairs**
4. **Your highest level of education achieved:**
   □ **College graduate** □ **High School Graduate** □ **Other:** _____
5. **Check below any impairments that pertains to you:**
   □ **Hearing** □ **Wears a Hearing Aide** □ **Visual** □ **Wears Corrective Lens**
   □ **Mobility** □ **Requires use of cane, crutches, walker** □ **Speech**
   □ **Emotional** □ **Other**_____

HISTORY OF PRESENT ILLNESS:

What is the problem that you are being seen for today? _____

_____

Location: _____

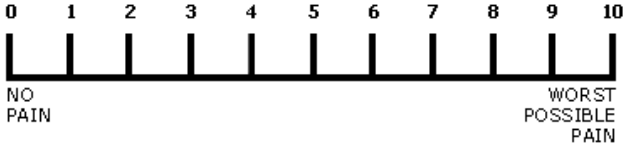
Where is your PRIMARY pain? (consider it to be primary if it is 50% or more of your pain)

_____

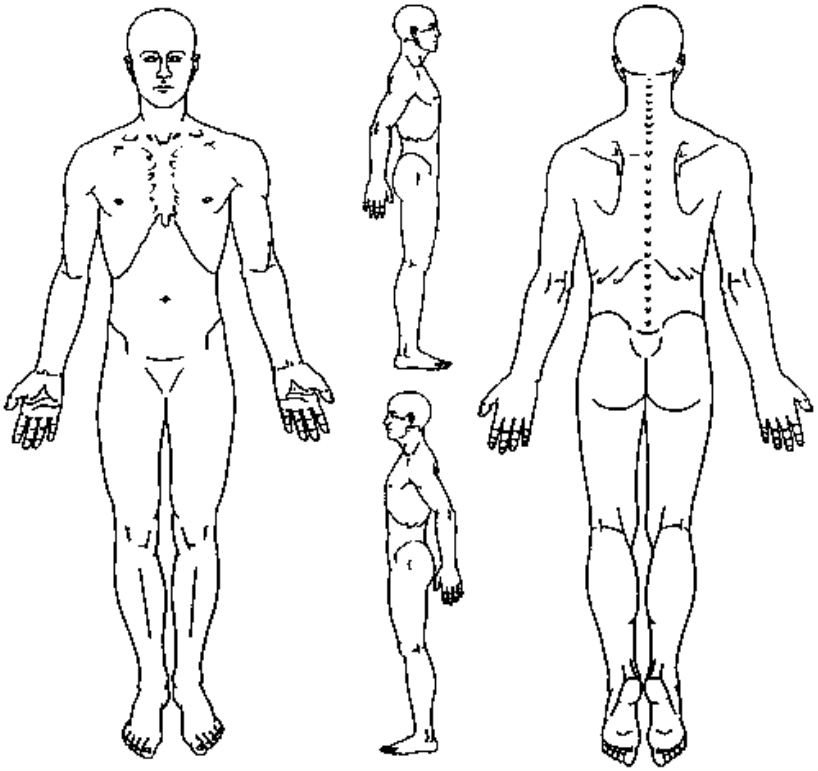
Please list the amount of time that you have been suffering from this condition in days, weeks, months or years: _____

RATING OF PAIN:

Rate your pain level TODAY on a 0-10 Scale? (O no pain, 10 worst imaginable)



PAIN DIAGRAM: **On the diagram below, please indicate where you are experiencing pain or other symptoms, right now.**



A = ACHES

P = PINS AND NEEDLES

B = BURNING

S = STABBING

N = NUMBNESS

O = OTHER

CURRENT OR PREVIOUSLY TRIED TREATMENTS: PLEASE LIST ALL PREVIOUS PAIN TREATMENT MODALITIES YOU HAVE TRIED FOR THIS OR SIMILAR CONDITIONS:

A. **Medications:**
(Including dose and frequency, if known. Do not include current medications.)

_____

_____

_____

_____

B. **Physical/Occupational therapy, Chiropractic care:**

_____

_____

C. **Injections/Procedures:**

_____

_____

D. **Other:**

_____

_____

NUTRITIONAL SCREENING TOOL:

Height: _____ **Weight:** _____ **Current Diet:** _____

How do you rate your appetite? □ **Excellent** □ **Good** □ **Fair** □ **Poor**

Questions	Yes	No
1. Are there times when you have been unable to obtain food/eat for more than 4 consecutive days?		
2. Have you without wanting to, lost 10 lbs. in the past 6 months?		
3. Have you without wanting to, gained 10 lbs. in the past 6 months?		
4. Does any of the medications that you are currently taking cause you to experience nausea, vomiting, stomach pains, or heart burn?		
5. Does any of the medications that you are currently taking cause you to experience constipation or diarrhea?		

FAMILY HISTORY: Has anyone in your family ever had:

Medical Condition	Father	Mother	Grandparent	Siblings
Cancer				
Diabetes				
Heart Problems				
Circulatory Problems				
High Blood Pressure				
Stroke				
Other				
CHECK HERE IF NO SIGNIFICANT FAMILY MEDICAL HISTORY: □				

PERSONAL HEALTH HISTORY:

Check each of the health conditions you have now or have had in the past. Please enter the approximate date of onset next to each item marked. Items not checked are considered not to be applicable to you.

Cardiovascular
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Pacemaker/ Defibrilator Implant
- ☐ Heart valve disease/surgery
- ☐ Irregular heart beat
- ☐ Heart Failure
- ☐ Peripheral vascular disease
- ☐ Aneurysm
- ☐ Previous bypass/stent
- ☐ Other:_____

Pulmonary
- ☐ Asthma
- ☐ COPD
- ☐ Lung Cancer
- ☐ Pulmonary hypertension
- ☐ Sleep apnea
- ☐ Tuberculosis
- ☐ Other:_____

Endocrine
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Diabetes, diet controlled
- ☐ Diabetes, on medications
- ☐ Diabetes, on insulin
- ☐ Other: _____

Neurological
- ☐ Stroke
- ☐ TIA/ "Mini Stroke"
- ☐ Seizure
- ☐ Headaches
- ☐ Tremor
- ☐ Weakness
- ☐ Multiple sclerosis
- ☐ Spinal cord injury
- ☐ Other:_____

Psychosocial
- ☐ Depression/Mania
- ☐ Anxiety
- ☐ Suicidal thoughts/attempts
- ☐ Seeing a psychiatrist
- ☐ Previous overdose
- ☐ Other:_____

Genintourinal
- ☐ Prostate cancer
- ☐ Sexually transmitted disease
- ☐ Kidney disease/dialysis
- ☐ Frequent urination
- ☐ Loss of bladder control
- ☐ Other:_____

Musculoskeletal
- ☐ Degenerative arthritis
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Frequent Falls
- ☐ Date of last fall: _____
- ☐ Joint surgery
- ☐ Neck pain
- ☐ Back pain
- ☐ Upper extremity pain
- ☐ Lower extremity pain
- ☐ Fibromyalgia
- ☐ Use of cane/walker
- ☐ Work injury☐
- ☐ Other:_____
- ☐ Females > age 60: Date of last bone density scan: _____ If none, do you want a Prescription for one? _____

Head/Neck
- ☐ Eye problems
- ☐ Congestion
- ☐ Nosebleeds
- ☐ Sore throat/Hoarseness
- ☐ Other: _____

Hematology/Lymph
- ☐ Anemia
- ☐ Abnormal bleeding
- ☐ Easy bruising
- ☐ Prior blood transfusion
- ☐ Swelling in groin/armpit
- ☐ Other: _____

Gastrointestinal
- ☐ Colitis
- ☐ Pancreatitis
- ☐ Irritable bowel syndrome
- ☐ Inflammatory bowel syndrome
- ☐ Reflux (GERD)/indigestion
- ☐ Ulcer
- ☐ Liver disease
- ☐ Nausea/vomiting
- ☐ Diarrhea/constipation
- ☐ Change in appetite
- ☐ Difficulty swallowing
- ☐ Black/bloody stools
- ☐ Loss of bowel control
- ☐ Other: _____

Skin
- ☐ Open Sore
- ☐ Change in mole
- ☐ Rash
- ☐ Other: _____

Other
- ☐ HIV/AIDS
- ☐ Transplant surgery
- ☐ Recurrent infections
- ☐ Cancer_____
- ☐ Other:

_____

_____

SURGICAL HISTORY: (PLEASE ALL SURGERIES YOU HAVE HAD WITH APPROXIMATE DATES):

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

Name of Physician who referred you to Pain Diagnostics and Interventional Care:

Name: _____ **Phone:** _____
Address: _____ **Specialty:** _____
_____ **Date Last Seen:** _____

Name of Your Primary Care Physician:

Name: _____ **Phone:** _____
Address: _____ **Specialty:** _____
_____ **Date Last Seen:** _____

Name of any Other Physicians whom you see regarding your current health to include PAIN TREATMENT (PLEASE INCLUDE NAMES OF ANY PHYSICAL THERAPY OR CHIROPRACTORS USED):

Name: _____ **Phone:** _____
Address: _____ **Specialty:** _____
_____ **Date Last Seen:** _____

Name: _____ **Phone:** _____
Address: _____ **Specialty:** _____
_____ **Date Last Seen:** _____

Name of Your Pharmacy:

Name/Location: _____ **Phone:** _____

Do you have a Living Will or designated Durable Power of Attorney to help with medical decision-making if you are unable to do so? Yes___ No___
Name of Responsible Person/Relationship to you: _____
Their phone Number: _____ **Location of Document:** _____
If you don't have one, do you want information on Living Will/Power of Attorney? Yes_____ No_____

Patient Authorization Form
Consent for Phone Contact

In an effort to give you the best possible patient care, it is often necessary to leave a message at your home regarding test results or more often, an upcoming appointment. Please read the following and check all that apply.

- ☐ **I prefer all discussions and/or confirmation of appointments be given only to me. If I am unavailable you may leave a message for me to call you back.**
- ☐ **You may leave test results or confirm appointments with *any* member of my family.**
- ☐ **You may leave test results, confirm appointments and discuss my care with a specific person(s):** _____
- ☐ **You may leave test results, confirm appointments, and leave messages on my voice mail.**

_____ _____ _____
Signature of Patient Date Time