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INTERVENTIONAL PAIN MANAGEMENT
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THE FOLLOWING MULTI-PAGE QUESTIONNAIRE IS A VERY IMPORTANT TOOL THAT IS USED TO ASSESS YOUR PAIN CONDITION AS WELL AS THE APPROPRIATE TREATMENTS FOR YOUR PROBLEM.

- 1. PLEASE READ AND FILL OUT EVERY SINGLE ITEM IN THIS FORM, INCLUDING THE DEMOGRAPHIC AND FINANCIAL INFORMATION ON THE FIRST THREE PAGES. PLEASE ALSO INCLUDE YOUR SIGNATURE WHERE REQUESTED. FAILURE TO COMPLETE OR SIGN THIS FORM COULD RESULT IN A DELAY IN YOUR APPOINTMENT.**
- 2. PLEASE BRING THE COMPLETED FORM ALONG WITH ANY PERTINENT FILMS, REPORTS, DOCTOR NOTES, ETC. FOR YOUR INITIAL CONSULTATION.**
- 3. AN INFORMED PATIENT MAKES BETTER DECISIONS ABOUT TREATMENT OPTIONS OFFERED BY HIS OR HER PHYSICIAN. THEREFORE, IF YOU HAVE ACCESS TO THE INTERNET, PLEASE VISIT MY WEBSITE'S "TREATMENTS" SECTION AND TAKE A FEW MINUTES BEFORE YOUR APPOINTMENT TO REVIEW THE INFORMATION ON TREATMENTS AVAILABLE FOR YOUR AND OTHER CONDITIONS. www.PainFree.com**

THANK YOU VERY MUCH IN ADVANCE FOR YOUR COOPERATION!!



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GENERAL INFORMATION

Name: _____ Date: _____ Height: _____ Weight: _____
Social Security Number: _____ Date of Birth: _____ Age: _____
Address: Street _____
City _____ State _____ Zip _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Driver's License #: _____ Driver's License State: _____
Employer's Name & Address: _____
Spouse's Name: _____ Spouse's Date of Birth: _____
Spouse's Employer & Work Number: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Person Not Living With You: _____
Emergency Contact's Relation To You: _____ Phone Number: _____

INSURANCE INFORMATION

Primary Insurance Name: _____
Claims Address: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
ID #: _____ Group #: _____
Subscriber Relation To Patient: Self _____ Spouse _____ Child _____ Other _____

Secondary Insurance Name: _____
Claims Address: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
ID #: _____ Group #: _____
Subscriber Relation To Patient: Self _____ Spouse _____ Child _____ Other _____

ACCIDENT / INJURY & LITIGATION INFORMATION

Is Your Condition Due To:

Work Related Injury or Accident (Workers Compensation)? ___ Yes ___ No

Date of Injury/Accident: _____

Case Manager's Name: _____ Phone: _____ Fax: _____

Adjuster's Name: _____ Phone: _____ Fax: _____

WC Insurance Co. Name: _____ Claim Number: _____

Please describe the details of your work related injury or accident (what happened?):

Automobile Accident? ___ Yes ___ No Date of Accident: _____

Name of Auto Insurance Company: _____ Phone: _____

Policy Number: _____

Please describe the details of your auto accident (what happened?):

Other Type of Accident? ___ Yes ___ No Date of Accident: _____

Please describe the details of your injury or accident (what happened?):

Is Litigation (Lawsuit) Pending? ___ Yes ___ No

Attorney's Name: _____ Phone: _____

Attorney's Address: _____

Please describe the current status of your legal case or settlement :

COMPREHENSIVE MEDICAL QUESTIONNAIRE

Referring Physician: _____ Primary Care Physician: _____

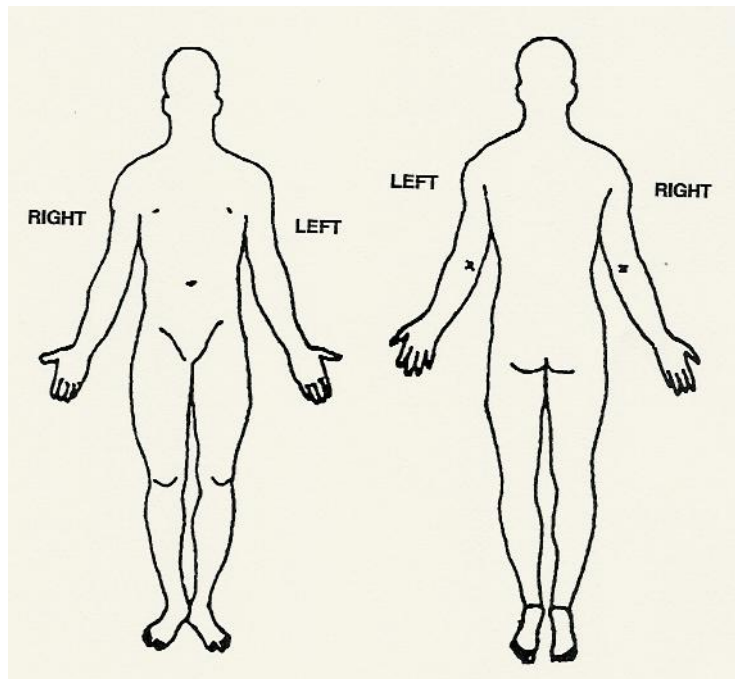
Please list the names of any healthcare professionals who have been involved in the evaluation and / or treatment(s) of your pain condition (please print names):

Orthopedic Surgeon: _____	Physiatrist / Rehabilitation Specialist: _____
Spine Surgeon: _____	Chiropractor: _____
Neurologist: _____	Acupuncturist: _____
Neurosurgeon: _____	Pain Medicine Specialist: _____
Rheumatologist: _____	Other: _____

PAIN HISTORY

1. **PLEASE DESCRIBE YOUR PAIN PROBLEM** Where is your pain? Where does the pain spread or radiate? (Example – “Low back pain that radiates down the back of my left leg to the heel”):

Please use the diagram below to demonstrate where your pain is located by shading the areas that are painful.



FRONT VIEW

REAR VIEW

2. **WHEN** did your pain begin? (Please be as specific as possible - for example: "4 months ago")

3. **HOW** did your pain begin? (Please check one and describe below)

	<u>Date of Accident / Illness</u>
<input type="checkbox"/> Pain Just Started By Itself	_____
<input type="checkbox"/> Injury or Accident At Work	_____
<input type="checkbox"/> Injury or Accident At Home	_____
<input type="checkbox"/> Motor Vehicle Accident	_____
<input type="checkbox"/> Following Surgery	_____
<input type="checkbox"/> Following Illness	_____
<input type="checkbox"/> Other Reason (specify): _____	_____

4. **WHO** do you think is at fault for your pain? (please check one)

No One Is At Fault
 I Am At Fault
 Employer
 Other (please explain): _____

5. **WHAT DOES YOUR PAIN FEEL LIKE?** Please circle any of the words below which describes the character of your pain:

1	2	3	4
Sharp	Dull	Annoying	Penetrating
Burning	Aching	Miserable	Piercing
Electricity	Sore	Intense	Tight
Shooting	Hurting	Unbearable	Numb
Stabbing	Heavy	Troublesome	Squeezing
Lancinating	Tender	None	Cool
Tingling	Tiring		Cold
Throbbing	Sickening		Nauseating
Pounding	Terrifying		Agonizing
Cramping	Punishing		Dreadful
Crushing	Blinding		Torturing
Pulling			

6. **HOW DOES YOUR PAIN CHANGE WITH TIME?** Please circle any of the words below that describe the pattern of you pain:

1	2	3
Continuous	Rhythmic	Brief
Steady	Periodic	Momentary
Constant	Intermittent	Transient

7. Which activities or body positions (e.g. walking, bending, etc.) bring on or WORSEN your pain?

Which activities or body positions (e.g. sitting, lying down, etc.) seem to IMPROVE your pain?

8. Which symptoms are associated with your pain (check all that apply):

- Weakness of arm(s) - Left / Right / Both
- Weakness of leg(s) - Left / Right / Both
- Numbness of arm(s)- Left / Right / Both
- Numbness of leg(s) - Left / Right / Both
- Loss of bladder or bowel control
- Tenderness of affected area
- Cool, pale skin
- Discolored or mottled skin
- Impotence
- Decreased sex drive
- Depression
- Other: _____
- Headaches
- Pain with only light touch
- Weight gain (How many lbs. past 6 mos? _____)
- Weight loss (How many lbs. past 6 mos? _____)
- Difficulty sleeping
- Pain awakens you at night
- Fever

9. Please help us to rate your pain on a numerical scale:

(0= No Pain At All 10= The Worst Pain Imaginable)

Today	0 1 2 3 4 5 6 7 8 9 10
On good days:	0 1 2 3 4 5 6 7 8 9 10
On bad days:	0 1 2 3 4 5 6 7 8 9 10
Average past week	0 1 2 3 4 5 6 7 8 9 10
Average past month	0 1 2 3 4 5 6 7 8 9 10

10. How does pain affect your lifestyle? (What can you no longer do because of your pain condition?)

11. Which TREATMENTS have been used for your pain? (Check all that apply)

	<u>Helpful?</u>	<u>WHEN did you receive this treatment?</u>
<input type="checkbox"/> Pain Killers	Yes__ No__	_____
<input type="checkbox"/> Anti-Inflammatory Meds	Yes__ No__	_____
<input type="checkbox"/> Muscle Relaxants	Yes__ No__	_____
<input type="checkbox"/> Bedrest	Yes__ No__	_____
<input type="checkbox"/> Physical Therapy	Yes__ No__	_____
<input type="checkbox"/> Exercise	Yes__ No__	_____
<input type="checkbox"/> TENS (electrical stim)	Yes__ No__	_____

PRIOR TREATMENTS (continued):

	<u>Helpful?</u>	<u>WHEN did you receive this treatment?</u>
<input type="checkbox"/> Chiropractic Therapy	Yes__ No__	_____
<input type="checkbox"/> Traction	Yes__ No__	_____
<input type="checkbox"/> Cortisone Injections	Yes__ No__	_____
<input type="checkbox"/> Epidural Injections	Yes__ No__	_____
<input type="checkbox"/> Other Nerve Blocks	Yes__ No__	_____
<input type="checkbox"/> Surgery	Yes__ No__	_____
<input type="checkbox"/> Psychotherapy	Yes__ No__	_____
<input type="checkbox"/> Biofeedback	Yes__ No__	_____
<input type="checkbox"/> Other _____		_____

Please list any medication(s) that you have taken *in the past* for your condition which has/have **NOT** helped to reduce or relieve your pain: _____

PAST MEDICAL & SURGICAL HISTORY:

12. Have you ever been diagnosed with or treated for any of the following health problems?
(Please check and circle all items that apply)

- | | |
|---|--|
| <input type="checkbox"/> Angina / Chest Pain | <input type="checkbox"/> Hepatitis (Circle Type: A / B / C) |
| <input type="checkbox"/> Angioplasty or Stent for blocked artery | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Anxiety, Depression, or Panic Disorder | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Arrhythmia/Atrial Fibrillation /Cardiac Arrest | <input type="checkbox"/> Implantable Defibrillator |
| <input type="checkbox"/> Arthritis (Type?: Osteo / Rheumatoid) | <input type="checkbox"/> Kidney Failure / Dialysis |
| <input type="checkbox"/> Asthma / Wheezing | <input type="checkbox"/> Liver Disease / Cirrhosis |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Neuropathy (Type? _____) |
| <input type="checkbox"/> Bleeding Disorder (Hemophilia, ITP, etc.) | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Cancer (Type _____) | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Paralysis (Describe _____) |
| <input type="checkbox"/> Congestive Heart Failure (year? _____) | <input type="checkbox"/> Previous Suicide Attempt |
| <input type="checkbox"/> Deep Venous Thrombosis (Blood Clot Leg) | <input type="checkbox"/> Pulmonary Embolism (blood clot to the lung) |
| <input type="checkbox"/> Diabetes (__ Type I __ Type II) | <input type="checkbox"/> Seizure or Epilepsy |
| <input type="checkbox"/> Drug or Alcohol Abuse / Addiction | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Emphysema, Chronic Bronchitis, or COPD | <input type="checkbox"/> Stomach or Duodenal Ulcer (Year _____) |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Stroke or TIA |
| <input type="checkbox"/> Headache (Migraine, Cluster, or Tension ?) | <input type="checkbox"/> Thyroid Disease (Under or Overactive?) |
| <input type="checkbox"/> Heart Attack (year? _____) | |

13. Please list any operation(s) you have had in the past:

<u>Year</u>	<u>Type of Operation</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES:

14. Please list your **ALLERGIES TO MEDICATIONS or OTHER DRUGS:**

<u>Name of Medication</u>	<u>Type or Reaction Experienced</u>
_____	_____
_____	_____

15. Are you allergic to Iodine Contrast Dye (e.g. IVP Dye)? Yes No

If you answered yes, what type of reaction did you have? _____

16. Are you allergic to Aspirin or Anti-Inflammatory Medications (e.g. Ibuprofen)? Yes No

If you answered yes, what type of reaction did you have? _____

CURRENT MEDICATIONS:

17. Please list the medications which you currently take strictly **FOR PAIN**:

<u>Name of Pain Medication</u>	<u>Dosage and Number of pills per day</u>
_____	_____
_____	_____
_____	_____
_____	_____

18. Please list the medications which you currently take **FOR OTHER MEDICAL CONDITIONS**:

<u>Name of Medication</u>	<u>Name of Medication</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

19. Do you take Aspirin? Yes No If you answered yes, when was your last dose? _____

20. Do you take Coumadin, Plavix, Pletal, Aggrenox, or Ticlid? Yes No

If you answered yes, when was your last dose? _____

If you answered yes, will the prescribing physician allow you to discontinue this blood thinner medication for any length of time? Yes** No

** Please note that you **MUST** have permission from the physician who prescribes or manages the blood thinner in order to stop this medication.

22. Do you take any herbal medications? Yes No If yes, list: _____

Do you take Vitamin E? Yes No

SOCIAL HISTORY

23. What is your current marital status? (please check one)

	<u>How Long?</u>
<input type="checkbox"/> Single- Never Married	N / A
<input type="checkbox"/> Married	_____ years
<input type="checkbox"/> Divorced	_____ years
<input type="checkbox"/> Widowed	_____ years
<input type="checkbox"/> Separated	_____ years

24. With whom do you live? (Check all that apply)

<input type="checkbox"/> I Live Alone	<input type="checkbox"/> With My Parents
<input type="checkbox"/> With Spouse	<input type="checkbox"/> With In-Laws
<input type="checkbox"/> With Children (ages? _____)	<input type="checkbox"/> With Other Relatives
<input type="checkbox"/> With Brothers or Sisters	<input type="checkbox"/> With Others (Significant Other, Roommate, etc.)

25. How far did you get in school? (Please check one)

<input type="checkbox"/> Less than 8 th grade	<input type="checkbox"/> Completed College
<input type="checkbox"/> Completed 8 th grade	<input type="checkbox"/> Technical or Business School
<input type="checkbox"/> Completed High School	<input type="checkbox"/> Advanced Degree (Type _____)
<input type="checkbox"/> Some College (_____ years)	

26. Do you currently smoke cigarettes? Yes No

If yes, how many packs do you smoke during an average day? _____ packs /day

If yes, for how many years have you smoked? _____ years

If no and you are a former smoker, when did you quit for good? _____

27. Do you drink alcoholic beverages? Yes No

If yes, how often? What is your drink of choice (i.e. beer, wine, gin, vodka, etc.)

<input type="checkbox"/> Never	<input type="checkbox"/> Daily or More Often
<input type="checkbox"/> Less Than Once A Week	<input type="checkbox"/> Several Times A Week
<input type="checkbox"/> About Once A Week	<input type="checkbox"/> I am a heavy drinker

How many drinks do you have each time you consume alcohol? _____

28. Have you ever been diagnosed with or treated for drug or alcohol abuse? Yes No

If yes, when? _____ Please describe _____

WORK HISTORY

29. What is your employment status? (please check one)

<input type="checkbox"/> Retired	<input type="checkbox"/> Able to work but currently unemployed
<input type="checkbox"/> Homemaker	<input type="checkbox"/> Not working, on Workers' Comp. leave from my job since _____
<input type="checkbox"/> Student	<input type="checkbox"/> Not working, on Disability since (date) _____
<input type="checkbox"/> Working Part Time	<input type="checkbox"/> Working Full Time (_____ Light Duty)

30. What is (was) your occupation or job title? (please describe)

31. Which of the following are regular requirements of your job? (check all that apply to you)

- Heavy Lifting (over 30 pounds)
- Light Lifting (15 - 30 pounds)
- Frequent Stooping, Bending, Twisting
- Standing For Long Periods of Time (over one hour at a time)
- Sitting For Long Periods of Time (over one hour at a time)
- Computer Work
- Other Physical Requirements (describe): _____

32. How much work have you missed as a result of your pain problem? (check one)

- None
- I have missed _____ days of work due to my pain problem
- I have missed _____ weeks of work due to my pain problem
- I have missed _____ months of work due to my pain problem
- Not applicable to my situation
- Other: _____

33. Please use the following space to address any other issues related to your pain condition not already covered in this questionnaire. Your comments and concerns are welcome:

WHICH DIAGNOSTIC STUDIES HAVE BEEN DONE TO EVALUATE YOUR PAIN PROBLEM?:
(Please check all that apply)

- | | |
|---|-------------------------|
| <input type="checkbox"/> Blood Tests | <u>Ordered by Whom?</u> |
| <input type="checkbox"/> X-Rays | _____ |
| <input type="checkbox"/> MRI Scan | _____ |
| <input type="checkbox"/> CT Scan | _____ |
| <input type="checkbox"/> EMG / Nerve Conduction Studies | _____ |
| <input type="checkbox"/> Bone Scan | _____ |
| <input type="checkbox"/> Other? _____ | _____ |

I certify that I have answered all of the above questions truthfully and to the best of my ability.

Patient Signature

Date