

PENINSULA PAIN CARE
Initial Pain Management Questionnaire

Name _____ Date _____
Address _____
City, State & _____
Zip _____
Home Phone () _____
Business Phone () _____
Cell Phone () _____
Date of Birth _____ Age _____

Referring Doctor name, phone number and address:

Please provide the name, phone number and address of your pharmacy:

Have you had any MRIs or other diagnostic testing?

No Yes (*Please indicate facility, date, type of testing and Phone number*).

Facility Name:

Phone Number:

Type of Test:

Date of Test:

Please fill out the attached forms as completely as possible.

Office Staff Only

Appt Date: _____ Time: _____

Spoke with: _____ Initial: _____

Please tell us in one sentence why you are here (e.g. "My back hurts.")

What brings on your pain or makes it worse? (Check all that apply).

- sitting standing walking bending forward bending backwards
 lying down on back sleeping coughing/straining cold weather
 touch nothing

What makes your pain better? (Check all that apply).

- ice heat physical therapy massage exercise medications
 sleep other

How bad is the pain (please circle):

0	1	2	3	4	5	6	7	8	9	10	
No Pain											Worst Pain Imaginable

How is your mood:

0	1	2	3	4	5	6	7	8	9	10	
Excellent											Terrible

How well do you function:

0	1	2	3	4	5	6	7	8	9	10	
Able to do everything											Unable to Function

Which words describe the pain (please circle)?

- Throbbing Aching Sharp Dull Shooting Tingling
Burning Numbness Hot Cold Continuous Intermittent

How long have you had the pain?

Was there any event which caused the pain to occur?

If the pain is intermittent, how long do the episodes last?

Are you ever pain free? Yes No

How does the pain limit your activities?

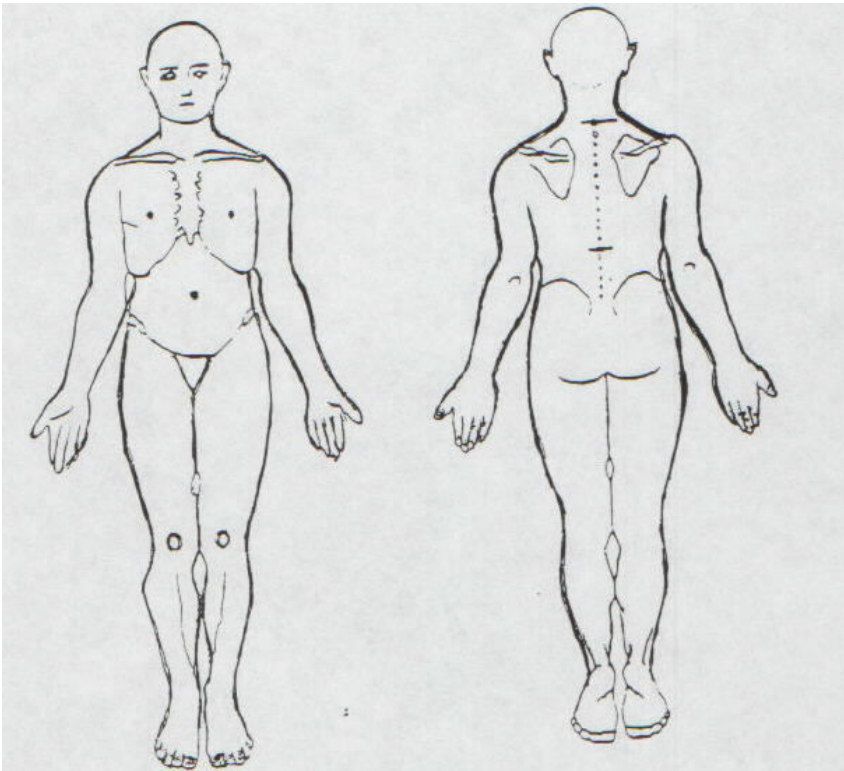
How does the pain affect your sleep?

What is your usual occupation?

Are you currently working? Yes No

If No, when did you last work?

Please show us where you feel your pain:



What therapies have you used to relieve the pain; which have worked:

What medications have you tried; have they worked:

What allergies do you have?

What medications do you take?

Medication	Dose	Prescribing physician

Please list all surgeries you have had.

Surgeries/Operations

Dates

Please list any serious illnesses you have had.

Illnesses/Hospitalizations

Dates

Please list your Family History. (e.g. Cancer, Heart Attack, Stroke.)

Description	Date
_____	_____
_____	_____
_____	_____

Has anyone in your family ever had any problems with addiction or substance abuse?

Yes No

If yes please explain:

Please provide your Social History.

Do you consume Alcohol, if yes how often?

Do you use Tobacco products, if yes how often?

Do you drink caffeine, if yes how often?

What is your level of education? _____

Do you have any children, if yes how old are they?

Please check any of the following problems that you may have had.

<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Rash
<input type="checkbox"/> Sweats	<input type="checkbox"/> History of heart attack	<input type="checkbox"/> Mole Changes
<input type="checkbox"/> Fatigue	<input type="checkbox"/> "Skipped beats"	<input type="checkbox"/> Skin Ulcerations
<input type="checkbox"/> Chills	<input type="checkbox"/> Shortness of breath walking	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Stroke	<input type="checkbox"/> Shortness of breath at night	<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Seizures	<input type="checkbox"/> Swelling of the ankles	<input type="checkbox"/> Pituitary or adrenal disease
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Headache	<input type="checkbox"/> Constipation	<input type="checkbox"/> Gout
<input type="checkbox"/> Poor vision	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Bloody noses
<input type="checkbox"/> Double vision	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Easy bruising
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Difficulty hearing	<input type="checkbox"/> Bleeding disorder
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Cough	<input type="checkbox"/> Black or tarry stools	<input type="checkbox"/> Depression
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Burning on urination	<input type="checkbox"/> Breast masses
<input type="checkbox"/> Lymph node swelling	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Chest surgery
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Fibromyalgia

Have you ever had any problems with addiction or substance abuse? Yes No

If yes, please explain:

Please add any comments, which you feel, would be helpful in treating your condition.

I confirm that I am not a hazard to myself or others. (Please initial)_____

Your Signature

PENINSULA PAIN CARE

Brandon Nguyen, D.O.

Medical Director

Diplomate of the American Board of Anesthesiology

NOTICE: PATIENT PRIVACY **Date:** November 5, 2007

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION

We may require your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your healthcare, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact **Dr. Nguyen** at 650/ 493-7246.

Signature

Date

Witness

**PLEASE LIST THOSE INDIVIDUALS WITH THEIR RELATIONSHIP TO YOU WITH WHOM WE
MAY COMMUNICATE.**

Name Relationship

Name Relationship

2450 El Camino Real Suite 100 b, Palo Alto, CA 94306 Tel: 650/ 493-PAIN (7246) Fax: 650/ 493-7248
www.peninsulapaincare.com