KIUMARS ARFAI, M.D.
Dedicated to a Multidisciplinary Approach to Pain Management
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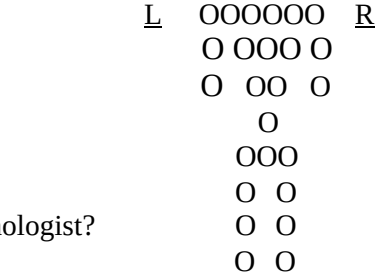
Name _____ Date _____
Age _____ Job Description _____

Please answer the following questions to the best of your ability:

1. Where is your pain? _____
2. How and when did your pain start? _____
3. Did you have similar pain problems before your current one? Please Explain:
_____
4. Please describe your pain: □ Constant □ intermittent □ Dull
□ Throbbing □ Sharp □ Stabbing □ Shooting □ Burning
Indicate with an "x" your level of pain 0_____10
Numbness □ Yes □ No If yes where: _____
Weakness □ Yes □ No If yes where: _____
5. What aggravates your pain? _____
6. What relieves your pain? _____
7. Have you had any of the following tests done? □ MRI □ CT scan
□ X-Ray □ EMG □ Bone Scan □ Other: _____
8. Have you had any treatment(s) for your pain? □ Medications □ Epidural Injections □ Nerve Blocks □ Physical Therapy □ TENS Unit □ Acupuncture
9. Did your previous treatments help? □ Yes □No
10. Do you sleep well at night? □ Yes □ No ____Interrupted ___Uninterrupted
11. Are you frustrated with the pain?
□ Yes □ No
12. Are you depressed?
□ Yes □ No
13. How is the stress in your life?
□ Average □ Above □ Below
14. Do you have suicidal thoughts?
□ Yes □ No If yes, state last time: _____
15. Have you ever attempted suicide?
□ Yes □ No
16. Do you now see or have you seen a psychiatrist/psychologist?
□ Yes □ No If so, why? _____
17. Are you married?
□ Yes □ No Number of children? _____
18. Do you smoke cigarettes?
□ Yes □ No How many cigarettes per day? _____
19. Do you drink alcohol?
□ Yes □ No How many drinks per day? _____



20. Do you now use or have you ever-used illicit drugs?
□ Yes □ No If yes, which drugs? _____

21. Do you have any problems with any of the following: □ Heart □ Lungs
□ Stomach/Ulcer □ Kidneys □ Diabetes □ High Blood Pressure □ Liver
□ Stroke □ Cholesterol □ Thyroid □ Other: _____

Review of Systems (please circle all that apply):

Weight Loss	Weight Gain	Fever	Chills	Rash
Itching	Blurred Vision	Headache	Neck Pain	Cough
Shortness of Breath	Chest Pain	Pain On Urination	Pelvic Pain	Nausea
Vomiting	Constipation	Blood In Stools	Dark Tarry Stools	Tender Muscles
Stiff Joints	Swollen Joints	Back Pain	Numbness Arms/Hands	Numbness Legs/Feet
Weakness Arms/Hands	Dizziness	Loss of Balance	Depression	Anxiety
Poor Sleep		Other:		

22. List all previous surgeries and give approximate dates: _____
_____
23. List all your current medications and dosages: _____
_____
_____

24. List all other medications tried previously for your pain: _____
_____

25. List all medications to which you are allergic: _____
26. Are you presently working? □ Yes □ No
27. Are you receiving disability benefits? □ Yes □ No
28. Workers' Compensation? □ Yes □ No
29. Are you currently involved in any legal action or proceeding? □ Yes □ No

Additional Comments:
_____
_____
_____

PLEASE DO NOT WRITE BELOW THIS LINE

History:
_____
_____
_____
_____

VS: HT: _____ WT: _____ BP: _____ P: _____ Temp: _____ R: _____