

KIUMARS ARFAI, M.D.*Dedicated to a Multidisciplinary Approach to Pain Management***www.painvisit.com**

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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 OO
12. Are you depressed?
 Yes No OO
 II
13. How is the stress in your life? L OOOOOO R
 Average Above Below O OOO O
14. Do you have suicidal thoughts? O OO O
 Yes No If yes, state last time: _____ O
15. Have you ever attempted suicide? OOO
 Yes No O O
16. Do you now see or have you seen a psychiatrist/psychologist? O O
 Yes No If so, why? _____ O O
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: _____