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Patient: _____

Appointment Date and Time: _____

Office Location: _____

Thank you for choosing InterveneMD. Our mission is to uphold high principles while providing safe, compassionate, high quality, cost-effective interventional pain management techniques for the diagnosis and treatment of pain and related disorders. We believe in educating you about your pain so that you can become an active participant in our treatment.

Included in this packet you will find directions to our office and our general office policies. You will also find a medical history and insurance form. Filling this form out completely prior to your visit will enable our physicians to spend more time answering your questions and discussing your treatment plan. Please bring this completed questionnaire with you to your initial appointment.

Please also bring your insurance card, a photo ID, and any recent office notes from you referring doctor (including any Xray or MRI reports).

If you are taking blood thinning medication, please let us know. If possible, contact the prescribing physician to see if you can safely stop these medications prior to any injections we may give.

We will do everything we can to accommodate your request to have an injection at this first visit. But, please remember that our first priority is to ensure that we have an adequate assessment of your pain, given you the opportunity to ask questions, and explained any procedures to your satisfaction.

If you have any questions, please feel free to call our office at 843-216-4844. We look forward to meeting you.

Pre Visit Questionnaire

Full Name: _____ DOB: _____

Location of your Pain: _____

Who referred you to us: _____

Primary Care Physician: _____

HISTORY OF PRESENT ILLNESS

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain imaginable

Pain level today: _____ Worst pain: _____ Least pain: _____ Usual pain: _____

When and how did your pain start? _____

What activities increase your pain?

- Coughing and Sneezing Sitting Standing Lying Down Bending
- Rest Walking, how far? _____ Physical Activity
- Sexual Activity Posture Time of Day or Night

Other, please describe: _____

What relieves your pain? _____

Have you had any of the following for your pain?

Chiropractor Physical Therapy: # times per week _____ when was your last visit? _____

Massage: # times per week _____ when was your last visit? _____

Interventional Procedures (Injections like epidural, facet joint, SI joint, trigger point, etc). If so, please list them below:

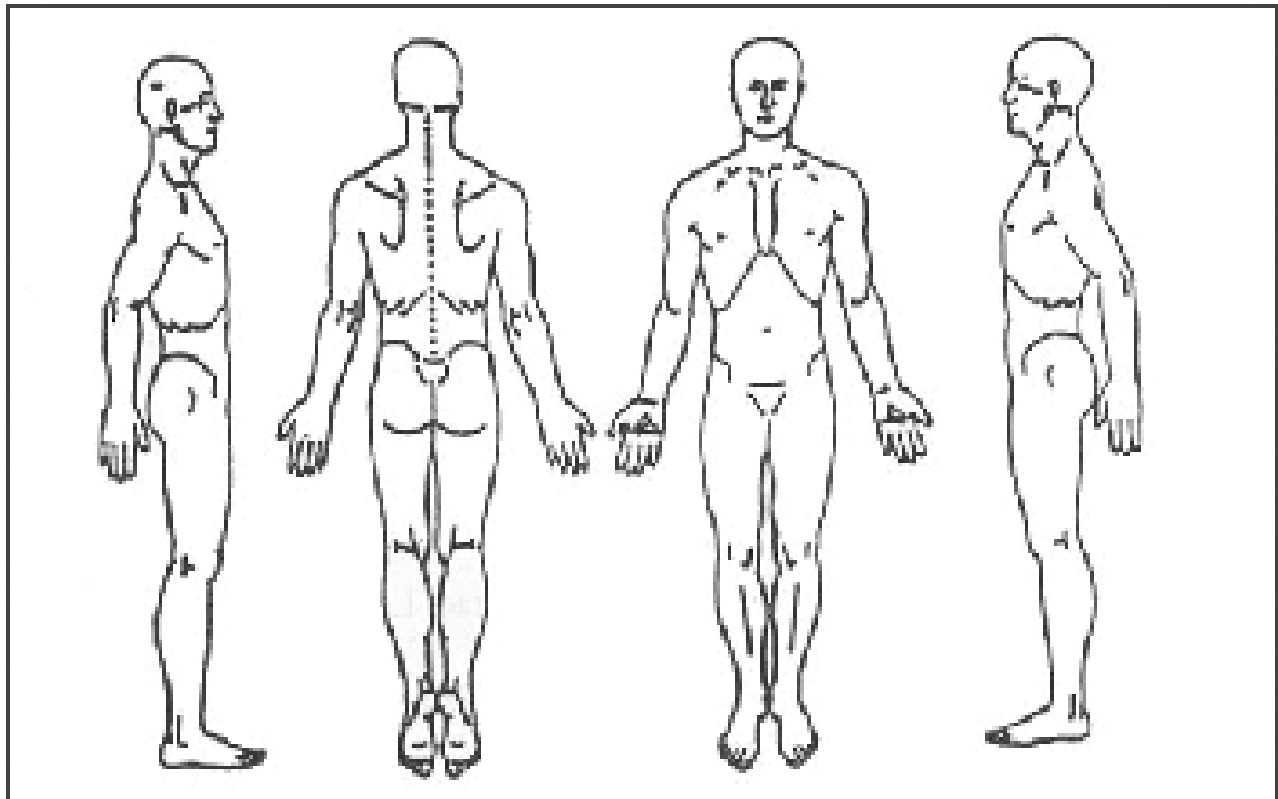
LAST?	RELIEF?	HOW LONG RELIEVED?
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Patient Name _____ Date of Birth _____

PAIN DRAWING

Please fill this out carefully. Mark the area on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation of pain and include all affected areas.

Numbness - **N** Burning - **B** Aching - **A** Pins & Needles - **P** Stabbing - **S**



FAMILY HISTORY

Do any of these problems run in your family? (mom, dad, brother, sister, aunt, uncle)

- No Problems
- Arthritis High Blood Pressure HIV Lupus Fibromyalgia Heart Attack
- Heart Disease Multiple Sclerosis Diabetes Epilepsy Asthma
- Depression Bleeding Disorder Schizophrenia Hepatitis
- Alcoholism Thyroid Disorders Chronic Pain
- Cancer, please specify what kind and in which relative: _____

Patient Name _____ Date of Birth _____

SOCIAL HISTORY

Smoking Yes Never Former Smoker - when did you quit? _____

How many cigarettes per day _____ Cigars per day _____ Pipe _____

Do you drink alcohol? No Yes -how much? _____

Have you ever had a problem with alcohol? No Yes - explain _____

Do you consume drinks with caffeine? No Yes

Do you use any street drugs? No Yes - explain _____

Marital Status: Single Married Divorced Widowed # of Children _____

Have you ever been convicted of a crime? No Yes - what was the date and nature of the offense leading to conviction? _____

WORK HISTORY

Currently at Work: Employed . Full Time . Part Time . Self Employed

Occupation: _____ What shift do you work? _____

How many hours/day? _____ How many hours/week? _____

Describe job duties: _____

How many hours at work do you: Stand - # hours _____ Sit - # of hours _____

Walk - # of hours _____ Bend - # of hours _____ Computer work - # of hours _____

Do you lift at work? No Yes - how much weight? _____ lbs., how many times per day? _____

Currently Not At Work: Unemployed Retired Disability

Other, explain _____

Last date of employment: _____

Litigation History

Open Case Work Related Personal Injury Auto Accident

Claim # _____ Date of Injury: _____

Name of Adjuster/Case Worker: _____

Working with an Attorney, please tell us who _____

Patient Name _____ Date of Birth _____

SLEEP HISTORY

What time do you go to bed? _____ How long does it take you to fall asleep? _____

How many times do you wake up at night? _____

How many hours of sleep do you get per night? _____

How many hours of sleep would you like to get per night? _____

Have you taken sleep medications or natural supplements to help you fall asleep? Yes No

If yes, please list: _____

Does your pain wake you up at night? Yes No

FUNCTIONAL HISTORY

Do you require assistance: Driving Walking Standing Climbing Stairs

Lifting Cooking Bathing Using the Toilet Dressing Shopping

Household Chores Outdoor Yard Work

PAST MEDICAL HISTORY

Please check all conditions that you have been diagnosed with:

Heart Attack Stroke Blood Clots Diabetes Liver Disease

Asthma Thyroid Disease Kidney Disease Depression Alcohol/Drug Abuse

Ulcers Seizures

ALLERGIES No Known Allergies

Latex Allergy IVP Dye Allergy Iodine Allergy Shellfish Allergy Sulfa Allergy

Penicillin Other - explain _____

PAST SURGICAL HISTORY - Please list surgeries and the year they were done

Patient Name _____ Date of Birth _____

MEDICATIONS

List all medications you currently take (prescription & non prescription). Use reverse side of this paper if necessary.

Medication	Dose	Frequency	Date Started	Prescribing Doctor
1) _____				
2) _____				
3) _____				
4) _____				
5) _____				
6) _____				
7) _____				
8) _____				
9) _____				

List all medications you have previously taken for your pain problem

EFFECTIVE?

- 1) _____ Yes No
- 2) _____ Yes No
- 3) _____ Yes No
- 4) _____ Yes No
- 5) _____ Yes No

REVIEW OF SYSTEMS

Constitutional Symptoms No Problems

Weight loss _____ lbs, during the past _____

Weight gain _____ lbs, during the past _____

Recurrent fever General weakness Fatigue Chills

Insomnia Excessive sleeping

Ear/Eyes/Nose/Throat . No Problems

Hearing loss Ringing in Ears Blurred Vision Difficulty Swallowing Hoarseness

Patient Name _____ Date of Birth _____

Neurological No Problems

- Incontinence of urine or stool Frequent or recurrent headaches Fainting
- Blackouts Stroke Gait difficulties Paralysis Frequent Falls
- Tremors Neuropathy Weakness, where? _____
- Seizures Epilepsy Polio Dizzy Spells Vertigo
- Ataxia Paresthesia Confusion Problems with concentration
- Hyperesthesia Speech Disorder Problems with thinking or thought process
- Problems with memory

Psychiatric No Problems

- Suicidal thoughts Depressed Anxious Shaky Agitated
- Obsessive Compulsive Disorder Post Traumatic Stress Disorder
- Sexual Abuse History Domestic Violence Previous Suicide Attempts
- Panic Episode Paranoia Hallucinations Crying Spells
- Mood Swings Nervousness

Have you had any previous hospitalizations for psychiatric care or treatment? Yes No

History of substance abuse or rehab? Yes No

Hematologic No Problems

- Blood Transfusion Bleeding Disorders (Hemophilia) Anemia
- Easy Bruising IV Drug Use Enlarged Lymph Nodes

Musculoskeletal No Problems

- Muscle Cramps Stiff Joints Swelling of Joints Generalized Arthritis
- Rheumatoid Arthritis Fibromyalgia Syndrome Osteoporosis
- Neck Pain Upper Back Pain Low Back Pain Heel spur Joint Pain
- Hardware Deformity Limited Range of Motion
- Gout Difficulty with Walking Pain in Feet Cold Upper Extremity R L
- Cold Lower Extremity R L

Patient Name _____ Date of Birth _____

Cardiac No Problems

- Heart Disease Swelling of Feet High Blood Pressure Chest Pain
- Heart Murmur Heart Failure Stents Shortness of Breath with Walking
- Pacemaker Shortness of Breath When Lying Flat Palpitations
- Rheumatic Fever

Peripheral Vascular No Problems

- Thrombophlebitis Poor Circulation
- Blood Clots Varicose Veins Vascular Surgery

Infectious Disease No Problems

- Hepatitis A B C
- HIV Herpes Shingles Tuberculosis

Gastrointestinal No Problems

- Irritable Bowel Syndrome Crohn's Disease (Ulcerative Colitis)
- Constipation Diarrhea Chronic Laxative Use
- Eating Disorder Heartburn Jaundice Blood in Stool

Urinary No Problems

- Kidney infections Blood in Urine Difficulty with Urination Painful Urination

Endocrine No Problems

- Diabetes Use Insulin Goiter Excessive Sweating Infertility
- Thyroid Disorder Excessive Thirst Excessive Eating Decreased Sex Drive

Respiratory No Problems

- Cough Wheezing Asthma Bronchitis
- Emphysema Pneumonia Sleep Apnea CPAP at Night

Other No Problems

- Cancer – Specify _____
- Rashes, Scars

Patient Name _____ Date of Birth _____

SCHOOL HISTORY

Circle your highest completed level of education:

Post Graduate (PhD/Masters/Professional) College High School Elementary

Do you have any difficulty

Reading Writing Speaking Understanding English

RADIOLOGICAL TESTS

Which of the following tests have been performed? Mark only applicable tests and dates if known.

Regular X-rays of _____

CT scan of _____

Myelogram of _____

MRI of _____

Discogram of _____

Bone Scan of _____

Nerve Conduction Study of _____

Other, specify _____

Patient Name _____ Date of Birth _____

TREATMENT GOALS

What do you expect to accomplish at interveneMD? (Please check all that apply)

- Ability to return to work Complete pain relief Partial pain relief
- Decreased medication use Increase in activity Better mood or behavior
- Other, please explain _____

When do you expect these changes in your pain to occur?

- Overnight A couple of weeks One month Six months
- Other, please explain _____

Treatment Expectation

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10
 No pain Worst pain imaginable

If you are currently not working, what pain score is needed to get you back to work? _____

If your pain is currently limiting leisure activities or hobbies, what pain score is needed to get you back into these activities? _____

THANK YOU!

Thank you for completing this rather lengthy questionnaire. We realize it can be exhausting to fill out this information. Please know that your answers will be most useful in helping us to understand you and your pain, as well as how different you are from other people who have similar types of problems. If there is anything else you think we should know at this time, please feel free to use the lines below.

Any additional information, comments or questions:
