PACIFIC PAIN MANAGEMENT

Dear _____,

This letter is to confirm your appointment with Pacific Pain Management. Please bring the following items to your upcoming appointment:

1. Completed Pain History Questionnaire
2. Valid photo identification (government issued)
3. Current insurance card(s) and/or all claim information

To better serve our patients, we reserve the right to reschedule your appointment if you do not have your paperwork completed, arrive at your appointment after your assigned check in time, or are missing any necessary documents. Thank you for scheduling with Pacific Pain Management, we look forward to meeting you.

6542 SE Lake Rd.
Suite 101
Milwaukie, OR 97222

Appt. Date: _____

Check In Time: _____

18040 SW Lower Boones Ferry Rd.
Suite 207
Tigard, OR 97224

Appt. Date: _____

Check In Time: _____

If you need to reschedule your appointment for any reason, please notify our office at least 24 hours prior to your scheduled check in time. Failure to comply with the Cancellation Policy outlined in our Financial Policy may result in a cancellation fee, and repeated missed appointments will result in possible termination from our facility. Thank you.

PACIFIC PAIN MANAGEMENT

Directions to Pacific Pain Management Milwaukie:

From I-205 take Exit 13 toward 82nd Ave. Follow the signs to OR-224W. Merge onto OR-224W. Travel 0.9 miles and turn right at the stop light onto Lake Road. Our office is located on the left in the Lake Road Medical complex across the street from Unified Grocers and across OR-224 from Alder Creek Middle School.

Directions to Pacific Pain Management Bridgeport:

From I-5, take Exit 290 for Lake Oswego/Durham. Travel west towards Bridgeport Village away from Lake Oswego onto Lower Boones Ferry Road. Travel 0.2 miles and take a left at the large intersection onto SW Lower Boones Ferry Road. Our office is located on the left in the Providence Building next to Claim Jumper restaurant.

Website: www.pacificpainpdx.com

PACIFIC PAIN MANAGEMENT

COMPREHENSIVE PAIN MANAGEMENT QUESTIONNAIRE

Your Name:_____ DOB: _____Appointment Date:_____

Who is your referring physician? _____

Who is your primary care physician? _____

Right or left hand dominant? _____

Where is the worst area of pain? _____

_____

_____

Does your pain radiate? If yes, where? _____

_____

_____

Please list any other areas of pain:_____

_____

Details of your pain:

How did your current episode begin? Suddenly _____ Gradually _____

When did your current pain episode begin? _____

_____

Describe how the injury occurred: _____

_____

_____

Have you ever had a similar pain? _____

_____

_____

What does your pain feel like?

( ) Throbbing	( ) Cramping	( ) Dull
( ) Shooting	( ) Hot-Burning	( ) Numb
( ) Stabbing	( ) Aching	( ) Tingling
( ) Sharp	( ) Tiring-Exhausting	( ) Other _____

How does your pain change over time?

Check the word which best describes the pattern of your pain.

( ) Continuous ( ) Intermittent

How many hours per day do you have pain? _____

When severe pain occurs, how long does it last?_____

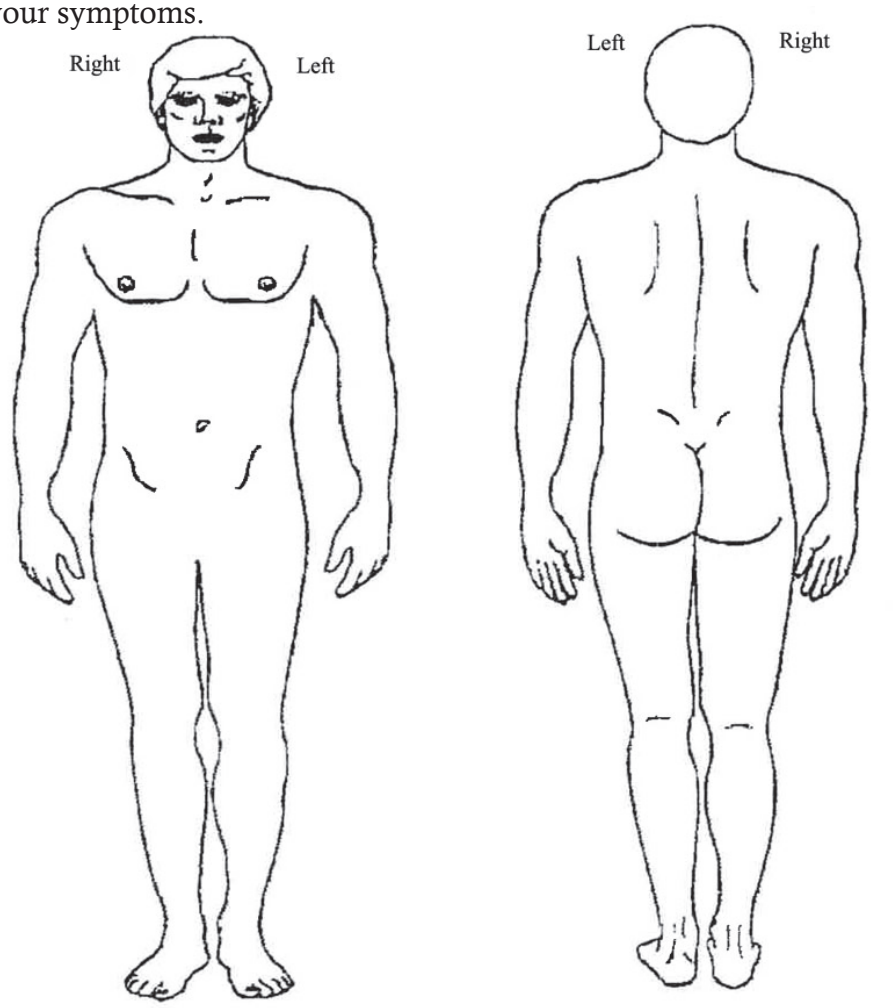
_____

Pacific Pain Management • 6542 SE Lake Rd • Suite 101 • Milwaukie, OR 97222 • **503-654-5636**
Pacific Pain Management • 18040 SW Lower Boones Ferry Road • Suite 207 • Tualatin, OR 97224

Location of pain

Use this diagram to indicate the location and type of pain. Mark the drawing with the following letters that best indicate your symptoms.

"N"=numbness
"S"=stabbing pain
"B"=burning pain
"P"=pins and needles
"A"=aching pain



What is your pain level today?

0=pain free
1=very minor annoyance, occasional minor twinges
2=minor annoyance, occasional strong twinges
3=annoying enough to be distracting
4=can be ignored if you are really involved in your work, but still distracting
5=can't be ignored for more than 30 minutes
6=can't be ignored for any length of time, but you can still work and participate in social activities
7=makes it difficult to concentrate, interferes with sleep, you can still function with effort
8=physical activity severely limited, you can read and converse with effort, nausea and dizziness set in as factors of pain
9=unable to speak, crying out or moaning uncontrollably, near delirium
10=unconscious, pain makes you pass out

Please rate your pain using the scale provided above.

_____ Which number (0-10) describes your pain **right now**?
_____ Which number (0-10) is your worst pain?
_____ Which number (0-10) is your least pain?
_____ Which number (0-10) describes your average pain over the past week?

Mark the effect of each of the following on your pain:

	Decreases my pain	Increases my pain	No change
Sitting	_____	_____	_____
Standing	_____	_____	_____
Rising from sitting	_____	_____	_____
Bending forward	_____	_____	_____
Bending backward	_____	_____	_____
Walking	_____	_____	_____
Climbing stairs	_____	_____	_____
Lying on your back	_____	_____	_____
Lying on your stomach	_____	_____	_____
Driving	_____	_____	_____
Coughing/sneezing	_____	_____	_____
Lifting objects	_____	_____	_____

Please mark all of the following treatments you have used for pain relief:

	Decreases my pain	Increases my pain	No Change
Acupuncture	_____	_____	_____
Biofeedback	_____	_____	_____
Brace Support	_____	_____	_____
Chiropractic	_____	_____	_____
Hot or cold packs	_____	_____	_____
Injection therapy	_____	_____	_____
Massage Therapy	_____	_____	_____
Medications	_____	_____	_____
Osteopathic	_____	_____	_____
Physical therapy	_____	_____	_____
Psychological counseling	_____	_____	_____
Surgery	_____	_____	_____
TENS unit	_____	_____	_____
Traction	_____	_____	_____

Are there other details of your pain or medical conditions we should know about?

( ) Weakness in the legs or arms? If yes, where?_____

( ) Bladder incontinence?	( ) Bowel incontinence?	( ) Fever?
( ) Chills?	( ) Night sweats?	( ) Frequent falls?
( ) Difficulty writing?	( ) Genital numbness?	( ) Other? _____

Treatment for your pain:

Please mark physicians/specialists you have seen **only for pain relief for the current problem.**

( ) Acupuncturist	( ) General Physician	( ) Orthopedic Surgeon
( ) Anesthesiologist	( ) Hypnotist	( ) Pain Clinic
( ) Chiropractor	( ) Internist	( ) Physical Therapist
( ) Dentist	( ) Naturopathic Doctor	( ) Plastic Surgeon
( ) ENT Physician	( ) Neurologist	( ) Podiatrist
( ) Endocrinologist	( ) Neurosurgeon	( ) Psychiatrist/Psychologist
( ) Faith Healer	( ) Ophthalmologist	( ) Rheumatologist

( ) Other : _____

Which pain clinics and/or physical therapists have you been to in the past? _____

_____

Goals/Limitations

What are your treatment goals? _____

_____

_____

What three activities are limited by your pain?

1._____

2._____

3._____

Have you had a recent MRI/CT of current painful area? ( ) Yes ( ) No

If yes, please list the date and facility of the MRI/CT _____

_____

Have you ever had an EMG or nerve conduction study? ( ) Yes ( ) No

Location on body and what side? _____ When? _____

What was the purpose? _____

Medications: Dosages/Frequency Per Day

Medication Dose Frequency Per Day

_____

_____

_____

_____

_____

_____

_____

Do you take blood thinners (Coumadin, Plavix)? ( ) Yes ( ) No

Do you have a pacemaker or defibrillator? ( ) Yes ( ) No

Allergies & Reactions

_____

_____

_____

_____

Past surgical history—Mark all that apply and include approximate date of surgery:

( ) Hysterectomy _____ ( ) Appendectomy_____

( ) Tonsillectomy_____ ( ) Tubal ligation_____

( ) Sinus_____ ( ) Fracture repair_____

( ) Hip replacement_____ ( ) Knee replacement_____

( ) Rotator cuff_____ ( ) Knee scope_____

( ) Foot_____ ( ) Carpal tunnel_____

( ) Gallbladder_____ ( ) Hernia repair_____

( ) Cervical laminectomy_____ ( ) Lumbar laminectomy_____

( ) Cervical fusion_____ ( ) Lumbar fusion_____

( ) Wisdom teeth_____ ( ) Thyroid_____

( ) Prostate_____ ( ) Cesarean section_____

( ) Mastectomy_____ ( ) Breast biopsy_____

( ) Other_____

_____

_____

Past medical history—Have you had any of these conditions? (Mark all that apply):

( ) Headaches	( ) Heart disease	( ) Increased cholesterol
( ) Diabetes (Type 1 or 2)	( ) High blood pressure	( ) Kidney problems
( ) Arthritis	( ) Rheumatoid arthritis	( ) Osteoporosis
( ) Liver problems	( ) Fibromyalgia	( ) Hepatitis
( ) Cancer	( ) Mitral valve prolapse	( ) Cirrhosis
( ) Emphysema/COPD	( ) Asthma	( ) Irritable bowel syndrome
( ) Seizures	( ) Stroke	( ) TIA
( ) Bursitis	( ) Carpal tunnel	

( ) Other medical problems_____

Have you had any hospital stays other than for surgery? ( ) Yes ( )No

Family history: Please indicate which family members have the following medical problems

Disease	**Which family member(s)?**
Headaches	_____
Heart disease	_____
Stroke	_____
Diabetes	_____
High blood pressure	_____
Increased cholesterol	_____
Arthritis	_____
Rheumatoid arthritis	_____
Kidney problems	_____
Liver problems	_____
Seizures	_____
Osteoporosis	_____
Cancer	_____
Fibromyalgia	_____
Other medical problems	_____
Pain conditions	_____

Social history

Married/Living with significant other_____ Divorced_____ Widowed_____ Single_____

Are you currently employed?_____ If so, what kind of work do you do? _____

How many children do you have? _____ What are their ages?_____

Do any children live at home? _____

Do you ever drink alcohol? ( ) Yes ( ) No If yes, how often do you drink?_____

Were you a heavy drinker? ( ) Yes ( ) No If yes, when did you quit?_____

Are you currently a smoker? ( ) Yes ( ) No If no, are you a former smoker? ( ) Yes ( ) No

Tobacco or Chew? _____ How much?_____

Did you or do you use any street drugs? ( ) Yes ( ) No If yes, when did you quit?_____

Have you ever **OVER** used narcotics or prescription medications?_____

Have you ever used narcotic or prescription medication for conditions other than pain or what they are intended for?_____

Do you currently or have you recently experienced any of the following?

General

( ) Recent illness ( ) Insomnia ( ) Low sex drive ( ) Fatigue
( ) Weakness ( ) Unintended weight loss ( ) Other_____

Eyes

( ) Eye pain ( ) Vision changes ( ) Light sensitivity ( ) Other_____

Ears, Nose, Throat, Neck

( ) Ringing in ears ( ) Hearing loss ( ) Earache ( ) Nose bleed
( ) Sinus congestion ( ) Dental problem ( ) Sore throat ( ) Other_____

Cardiovascular

( ) Chest pain/pressure ( ) Irregular heartbeats ( ) Swelling of feet
( ) Other_____

Respiratory

( ) Wheezing ( ) Chest congestion ( ) Cough ( ) Shortness of breath/dyspnea
( ) Other_____

Digestive

( ) Abdominal pain ( ) Nausea ( ) Vomiting ( ) Constipation
( ) Diarrhea ( ) Heartburn ( ) Upset stomach ( ) Other_____

Urinary/Kidneys

( ) Pain while urinating ( ) Urinary retention/hesitancy or feeling of incomplete emptying

Musculoskeletal

( ) Neck pain ( ) Back pain ( ) Muscle weakness ( ) Joint pain
( ) Arm pain ( ) Leg pain ( ) Other_____

Dermatologic/Skin

( ) Bruises easily ( ) Sores ( ) Itchy ( ) Rash
( ) Other_____

Neurologic

( ) Headache ( ) Dizziness ( ) Fainting ( ) Excessive sleepiness
( ) Seizure ( ) Disturbances of thinking ( ) Other_____

Psychiatric

( ) Alcohol abuse ( ) Drug abuse ( ) Anxiety ( ) Bipolar
( ) Depression ( ) Stress ( ) Suicide attempts

Reproductive System:

Could you be pregnant? ( ) Yes ( ) No
Would you like a test to be sure you are not pregnant before you have a procedure? ( )Yes ( ) No

PACIFIC PAIN MANAGEMENT

Patient Demographics

PATIENT INFORMATION	
Full Patient Name:	Sex: M F Date of Birth:
Street Address:	Social Security #: Marital Status:
City: State: Zip:	Employer:
Home Phone:	Occupation:
Cell Phone:	Work Phone:
Race: Are you of Hispanic or Latino decent? ( ) Yes ( ) No ( ) Decline to answer. Language:	
Referring Provider:	Primary Care Provider:
SPOUSE OR RESPONSIBLE PARTY IF PATIENT IS A MINOR	
Full Name:	Sex: M F Date of Birth:
Street Address:	Social Security #:
City: State: Zip:	Employer:
Home Phone:	Cell Phone:
Is the above stated person responsible for the bill? ( ) Yes ( ) No	
PRIMARY INSURANCE	**SECONDARY INSURANCE**
Name of Insurance:	Name of Insurance:
Address:	Address:
City: State: Zip:	City: State: Zip:
Member ID: Group ID:	Member ID: Group ID:
Policy Holder: Birth Date:	Policy Holder: Birth Date:
WORKMANS COMP INFORMATION	**MOTOR VEHICLE INFORMATION**
Name of Insurance:	Name of Insurance:
Claim #: Date of Injury:	Claim #: Date of Injury:
Employer at time of Injury:	State Where Accident Occurred:
Adjuster Name:	Adjuster Name:
Adjuster's Phone:	Adjuster's Phone:
Is the above documented claim in litigation? ( ) Yes- if yes, please answer the question below ( ) No	
Attorney:	Attorney's Phone:

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I authorize all insurance benefits, unless previously paid by myself, to be paid directly to this physician/facility and l so authorize the physician/facility to release any information required in the processing of the insurance claim. I authorize the physician/facility to release and request any medical information pertinent to the patient's care to/from the patient's referring provider, primary care provider, pharmacy and any provider he/she may refer the patient to for additional treatment.

Patient/Responsible Party Signature _____ Relationship to Patient _____ Date _____