DHEC CHECK ☐ RUDS CHECK☐

Spine and Pain Care

PLEASE PRINT AND ANSWER ALL QUESTIONS. IF NO ANSWER IS PROVIDED OR ANSWER IS NOT LEGIBLE THIS MAY DELAY YOUR APPOINTMENT TIME. THIS FORM COULD BE DOWNLOADED FROM **373pain.com**

Name: _____ Date: _____

Did you remember to bring your medication bottles? If not, you may be turned away from your appointment.

NAME OF YOUR **FAMILY DOCTOR**:_____YOUR **PSYCHIATRIST**:_____

1. **Do you have any new areas of pain? (check to answer and fill in the blank)**
   - ☐ no, I still hurt most in my _____
   - ☐ yes, I have new pain (list areas): _____

2. **Circle the number indicating your pain *today*:**

   (none) 1 2 3 4 5 6 7 8 9 10 (severe)

3. **What best describes your pain today and since your last visit (circle all that apply):**

   Dull Sharp Aching Knifelike Stabbing Throbbing Weakness Giving out Shooting Burning

   When has this pain been worse? (circle all that apply):

   In the: Morning Daytime Evening Night Another time (describe) _____

   When you: Lift things Bend Lie down Sit Stand Drive Walk Change positions

4. **When you were last here, what advice did you receive?** (check to answer and fill in the blank)
   - ☐ medication/prescriptions
   - ☐ injection or another procedure
   - ☐ other _____

   Are you returning after x-ray, CT or MRI scan? ☐No ☐Yes

   What percentage of your pain has been relieved by this treatment?

   0% 10 20 30 40 50 60 70 80 90 100% better

   What do you think would make your treatment more effective? (if nothing, answer N/A) _____

5. **Since your last visit (check and fill in the blank to answer):**

   Have you been prescribed any **Pain Killers** or has any **existing** prescription of yours changed?
   ☐ no ☐ yes (please list any changes)___

   Did you discover any new allergies?
   ☐ no ☐ yes (please describe):_____

   Have you borrowed or shared any **pain** meds?
   ☐ no ☐ yes (please describe):_____

   Did you run out of pain medication?
   ☐ no ☐ yes (please describe):_____

   Are you taking any illegal or street drugs?
   ☐ no ☐ yes: specify:_____

   Have you experienced any significant health events or changes we need to be aware of?
   ☐ no ☐ yes (please describe) _____

Please update the information above and the following:

What pharmacy should we send prescriptions to (include address)?_____

Has your insurance changed? ☐ no ☐ yes (describe any changes) _____

Your new mailing address? _____ NEW Telephone #: _____

Signature:_____ Date: _____

Thank you for helping ensure top quality care based on the most up-to-date information! *Wish to see the doctor faster?*

*Download this form at **373pain.com**, print it, and fill it out **before** your next appointment.* *Updated 5-6-2012*

VITALS BP:	PULSE:	WT:	OTHER: