Advanced Pain Centers, S.C.
Pre-Visit Questionnaire (Non-Pain)

Full Name: ______________________________ D.O.B. _____________ Date: ______________

Date of Service: ________________________ Height: _____________ Weight: _____________

I. **Chief Complaint** (Describe your symptoms): ____________________________________

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II. **History of Present Illness:**

1. When did the symptoms start: Date: _____________ Unknown ☐

2. What was the cause of the symptoms?

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3. Describe your symptoms:

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4. What increases your symptoms?

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5. What decreases your symptoms

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6. Sleep History:

a. What time do you go to bed? ____

b. How many hours does it take you to fall asleep? __________________________

c. How many times do you wake up at night, and why? ______________________

d. How many hours of sleep do you get per night? ___________________________

e. How many hours of sleep do you require to feel rested? ____________________

f. Have you taken sleep medications or natural supplements to help you fall asleep?

☐ Yes ☐No If yes, please list: ________________________________

____

g. Do you use alcohol to go to sleep? ☐ Yes ☐No

Patient Name: ___________________________________ Date of Birth: _________________

7. Who is your primary care/general doctor? When were they last seen?
Name: _______________________ Phone: ______________ Last seen: ___________

8. Other providers seen:

Name	Specialty	Treatment Provided	Did it help

9. Could you be pregnant? ☐Yes ☐No

III. Past History

1. Allergies: ☐No Know Allergies
☐Latex ☐IVP Dye ☐Iodine ☐Shellfish ☐Sulfa ☐Penicillin
☐Other (please list): ____

2. Medications For PTSD:
Please list all medications you are currently taking for PTSD
(Use reverse if more space needed)

Medication	Dose	Frequency	Date Started	Prescribing Doctor

3. Other Medications:
Please list all other medications you are currently taking (prescription and non-prescription, including aspirin, Tylenol, fish oil, etc. Be sure to include any blood thinners you are taking – plavix, coumadin, etc.) (Use reverse if more space needed)

Medication	Dose	Frequency	Date Started	Prescribing Doctor

4. Previous Medications/Natural Supplements

	Effective?
	☐Yes ☐No
	☐Yes ☐No
	☐Yes ☐No
	☐Yes ☐No
	☐Yes ☐No

Patient Name: ________________________________ Date of Birth: ________________

5. Previous Hospitalizations without surgery ☐Yes ☐No
(include year and physician's name)

____
____
____

6. Past Surgical History (include year and physician's name)
Have you ever had surgery on your neck? ☐Yes ☐No

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____
____
____
____

7. Psychiatric Hospitalizations: ☐Yes ☐No

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____
____

8. Hospitalization due to suicide attempt: ☐Yes ☐No

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____
____

IV. Other History Questions:

1. Family Medical History ☐No Problems
(Answers should be mom, dad, brother, sister, aunt, uncle, etc.)

☐Arthritis _______________	☐High Blood Pressure _______	☐ Cancer:
☐Fibromyalgia ___________	☐Heart Attack ______________	Location ________________
☐Lupus __________________	☐Heart Disease _____________	Relationship ______________
☐Multiple Sclerosis ________	☐Diabetes __________________	Location ________________
☐Epilepsy ________________	☐Bronchial Asthma __________	Relationship ______________
☐Depression ______________	☐Bleeding Disorder __________	Location________________
☐Schizophrenia ___________	☐Hepatitis __________________	Relationship ______________
☐Alcoholism ______________	☐Thyroid Disorders __________	Location ________________
☐Addictive Behavior _______	☐Rehab Center ______________	Relationship ______________
☐Suicidal Ideation ________	☐Suicide Attempt ____________	Location ________________
☐PTSD __________________	☐ HIV ____________________	Relationship ______________

2. Social History

A. Smoking:

Do you smoke now? ☐Yes ☐No If yes, when did you start? ________________

☐Cigarettes # per day? ___________
☐Cigars # per day? ___________
☐Pipe # per day? ___________

Have you ever? ☐Yes ☐No Explain ______________________________________

Patient Name: ___________________________________ Date of Birth: _________________

B. Alcohol:

Do you drink alcohol? ☐Yes ☐No How much? __________________________

Have you ever had a problem with alcohol? ☐Yes ☐No ☐Cirrhosis of Liver

Explain? ____

____

C. Caffeinated Drinks:

Do you consume drinks with caffeine? ☐Yes ☐No

☐ Coffee ☐ Tea ☐ Iced Tea ☐ Colas

D. Illicit Drugs:

Do you use any street drugs? ☐Yes ☐No Explain _________________________

Do you use marijuana? ☐Yes ☐No

E. Marital Status:

☐Married ☐Single ☐Divorced ☐Widowed No. of children: ______________

F. Criminal History:

Have you ever been convicted of a crime? ☐Yes ☐No

If yes, what was the nature of the offense leading to conviction?

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____

How recent was such offense? _______________________________________

G. Work History:

1. 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: ____

Hours you spend standing: ________ sitting: ________ walking: ________

bending: ________ computer work: ________

Do you lift? ☐Yes ☐No How much weight? _____ Repetitions per day? _____

2. Currently not at work: ☐Unemployed ☐Retired ☐Disability

☐Other Specify: ____

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V. Review of Systems:

1. Constitutional Symptoms:

☐Weight Loss ___________ lbs during ____________________

☐Weight Gain ___________ lbs during ____________________

☐Trying to lose weight ☐Recurrent Fever

☐General Weakness ☐Fatigue ☐Chills ☐Insomnia

☐Hypersomnolence (over sleeping)

Patient Name: ___________________________________ Date of Birth: _________________

2. Neurological ☐No Problems

☐Incontinence of urine or stool ☐Frequent or Recurrent Headaches ☐Fainting
☐Blackouts ☐Stroke ☐Gait Difficulties ☐Paralysis ☐Frequent Falls
☐Tremors ☐Neuropathy ☐Weakness ☐Seizures ☐Epilepsy ☐Polio
☐Dizzy Spells ☐Vertigo ☐Problems with concentration ☐Lupus ☐Alzheimer's
☐Problems with thinking or thought process ☐Pain with light touch to skin
☐Problems with memory ☐Confusion ☐Multiple Sclerosis ☐Head Injury

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3. Hematologic ☐No Problems

☐Blood Transfusion ☐Bleeding Disorder (Hemophilia)
☐Anemia (Iron deficiency, Pernicious, Sickel cell) ☐Easy Bruising
☐IV Drug Use ☐Enlarged Lymph Nodes

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4. Infectious Disease ☐No Problems

☐Hepatitis ☐Type A ☐Type B ☐Type C
☐HIV ☐Herpes ☐Shingles ☐TB (Tuberculosis)

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5. Psychiatric ☐No Problems

☐Suicidal Thoughts ☐Suicide Attempt If yes, when was last attempt? _____________
☐Schizophrenia ☐Alcohol/Drug Abuse ☐Crying Spells ☐Mood Swings
☐Suicide attempt requiring hospitalization ☐Depressed ☐Anxious ☐Shaky
☐Agitated ☐Obsessive Compulsive Disorder ☐Nervousness
☐Post Traumatic Stress Disorder ☐Sexual Abuse History ☐Domestic Violence
☐Panic Episode ☐Paranoia ☐Hallucinations
☐Admission to detox center (if yes, what for?) ☐Alcohol ☐Opioids ☐Other
Specify ____

Have you had any previous hospitalizations for psychiatric care or treatment
☐Yes ☐No Specify ____

History of substance abuse or rehab ☐Yes ☐ No

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6. NSAIDS/Anti-Inflammatory ☐None

List name, frequency, dosage (i.e. advil, Ibuprofen, Celebrex, etc.)

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7. Blood Thinners ☐None

List name, frequency, dosage (i.e. Coumadin, Aspirin, Excedrin, Vitamin E, Plavix, Xeralto, garlic, fish oil, etc.)

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____

Patient Name: ___________________________________ Date of Birth: _________________

8. Musculoskeletal ☐No Problems

☐Muscle Cramps ☐Stiff Joints ____
☐Swelling of Joints ☐Generalized Arthritis ☐Rheumatoid Arthritis
☐Fibromyalgia Syndrome ☐Osteoporosis ☐Neck Pain ☐Upper Back Pain
☐Middle Back Pain ☐Lower Back Pain ☐Heel Spur(s) # __________
☐Joint Pain ☐Hardware ☐Deformity ☐Limited Range of Motion
☐Abnormal sound when moving joint ☐Gout ☐Difficulty with walking
☐Pain in feet ☐Pain with light touch of skin Specify ________________________
☐Cold Upper Extremity(ies) ☐R ☐L
☐Cold Lower Extremity(ies) ☐R ☐L
☐Painful light touch to skin ☐Post surgical pain ☐Other, specify ______________

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9. Cardiac ☐No Problems

☐Heart Trouble ☐Swelling of Feet ☐High Blood Pressure ☐Chest Pain
☐Heart Murmur ☐Heart Failure ☐Stents ☐Shortness of breath with walking
☐Arterial Graft ☐Pacemaker ☐Heart Disease ☐Edema ☐Palpitations
☐PND (Paroxysmal Nocturnal Dyspnea) ☐Blue Extremities ☐Rheumatic Fever
☐Heart Attack or other Cardiac Condition Specify ____________________________

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10. Peripheral-Vascular ☐No Problems

☐Thrombophlebitis (Inflamed Veins)
☐Poor circulation in arms ☐R ☐L
☐Blood clots in arms ☐R ☐L
☐Varicose Veins ☐R ☐L
☐Poor circulation in legs ☐R ☐L
☐Blood clots in legs ☐R ☐L
☐Vascular Surgery ☐R ☐L
☐Other ____

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11. Gastrointestinal ☐No Problems

☐IBS (Irritable Bowel Syndrome) ☐Crohn's/Ulcerative Cholitis ☐Constipation
☐Diarrhea ☐Chronic use of laxatives ☐Jaundice (Yellow Eyes)
☐Eating Disorder (Anorexia, Bulemia, etc) ☐Heartburn ☐Melena (Dark Stool)
☐Frequent Bowel Movements ☐Change in Bowel Habits ☐Clay Color Stool
☐Hemorrhoids ☐Rectal Discharge

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12. Endocrine ☐No Problems

☐Diabetes If yes, do you take insulin ☐Yes ☐No
☐Hot/Cold Tolerance ☐Excessive Sweating ☐Polydipsia (Increased Thirst)
☐Polyphagia (Increased Hunger) ☐Infertility ☐Thyroid Disorder

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13. Respiratory ☐No Problems

☐Cough ☐Sputum ☐Hemoptysis (Coughing up blood) ☐Wheezing
☐Asthma ☐Emphysema ☐Bronchitis ☐Pneumonia ☐Pleurisy ☐Sleep Apnea
☐CPAP at night ☐COPD ☐Self-Employed

Patient Name: ___________________________________ Date of Birth: _________________

14. Other ☐No Problems

☐Cancer Specify ____

☐Rashes/Scars ____

Treatment Goal(s):

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Certification:

I certify that I have answered truthfully all the questions, and have not knowingly withheld any information concerning any of the above problems, either past or resent.

Patient Signature: ____________________________________ Date: ____________

Parent Signature if Minor: ____

Transcriber: ____

Reviewing Provider(s): ____