Southwest Medical®
Part of OptumCare®

Pain Management

Ross Seibel, MD
Bryan Werner, MD
Javier Garduno, MD
Deanna Duch, APRN
Vanessa Antolin, APRN
Kathy Rabago, PA-C

Welcome to Southwest Medical's pain management program.

We at Southwest Medical want to provide the best patient experience within the pain management program. In order to meet this goal, we have provided you with paperwork that needs to be completed prior to your initial visit. Without this completed paperwork, we may have to reschedule your appointment. Your completed paperwork is what allows us to spend the entire first appointment to conduct a thorough evaluation.

At Southwest Medical's pain management program, we recognize that chronic pain is a complex problem involving many factors. Affecting millions of patients each year, chronic pain has become a leading cause of disability and general deterioration in quality of life. While a form of tissue injury or destruction is typically imagined when considering pain (i.e. a broken bone or arthritis), chronic pain often encompasses a multitude of other factors which may be refractory or elusive to typical medication management and diagnostic imaging (i.e. x-rays, CT, or MRI scans).

Chronic pain is often best managed with a multidisciplinary approach with emphasis on continuity of care. Primary care providers will often coordinate such care with appropriate specialty providers (i.e. surgeons, pain management specialists, neurologists, rheumatologist, nursing, physical/occupational therapists, and mental health professionals). Each of these specialty providers can provide both different perspectives on sources for various painful conditions and unique diagnostic and therapeutic treatment modalities. For a sub-group of patients, more invasive/interventional pain management modalities may be indicated.

Your referring provider felt that you may be a candidate for such interventional pain management treatment.

Interventional pain management modalities are useful for both diagnostic and therapeutic purposes:

Diagnostic injections typically involve injecting local anesthetic (numbing medication) at particular nerves or joints. They are brief in their duration of pain relief (i.e. 4-8 hours), but can often help identify particular painful regions. For some, these particular painful regions may be treated with further interventional therapies or surgical interventions.

Therapeutic injections are often an extension of a diagnostic injection (discussed above). Ideally, through changes in the medication injected or particular technique, they can provide longer lasting relief. Therapeutic injections can be a useful additional therapy for both acute and chronic pain conditions.

It is important to recognize that chronic pain often involves changes to the body that cannot be "fixed". While certain interventions/injections or surgical procedures can provide extended relief for some conditions, not everyone has such amenable conditions. Your healthcare providers will continually assess your particular presentation to ensure you receive the most appropriate, evidenced-based treatment.

We look forward to seeing you.
Southwest Medical, pain management program

Southwest Medical®
Part of OptumCare®

Pain Management
Interventional Diagnostics and Therapeutics
4750 W. Oakey Blvd., 3rd Floor, Las Vegas, NV 89201
P: 702-877-5199 • F: 702-366-9064

Date:

Thank you for arranging to visit one of our providers at Southwest Medical pain management program. Your appointment information is as follows:

Date:	
Time:	** Please arrive 15 minutes prior to appointment time**
Location:	4750 W. Oakey Blvd., 3rd Floor Las Vegas, NV 89102 PH: 702-877-5199 FAX: 702-366-9064

In order to assist you in the most efficient manner and increase the amount of time spent with your provider, please ensure the following:

- **Complete the enclosed questionnaire prior to your arrival – we will be happy to reschedule your appointment to ensure you have time to complete it in full.**
- Plan enough time to arrive and check in 15 minutes prior to your scheduled appointment time and provide us with your completed paperwork this is essential to completing your evaluation – appointment may be rescheduled for late arrivals.
- Bring copies of available films and reports of any imaging studies (i.e. x-rays, CT, or MRI)
- Bring copies of prior treatments (if not already forwarded to Pain Management Program)
- Bring insurance information/card and identification
- Appropriate co-payment will be collected at time of service
- **Please note**: Most injections are not performed at the office or on the day of initial evaluation. If your provider feels a particular injection may be beneficial, it will be scheduled at the office, but on another day at an outpatient surgery center.

We are here to answer any questions you may have prior to your appointment, please feel free to contact our office at 702-877-5199.

Thank you for your help to ensure a good experience, we look forward to seeing you.

Southwest Medical®
Part of OptumCare®

Pain Management
Interventional Diagnostics and Therapeutics
4750 W. Oakey Blvd., 3rd Floor, Las Vegas, NV 89201
P: 702-877-5199 • F: 702-366-9064

Southwest Medical®
Part of OptumCare®

Pain Management
Interventional Diagnostics and Therapeutics
4750 W. Oakey Blvd., 3rd Floor, Las Vegas, NV 89201
P: 702-877-5199 • F: 702-366-9064

Thank you for arranging to visit one of our providers at Southwest Medical. In order to assist you in the timeliest manner, we ask that you complete this questionnaire before coming to your appointment. The information provided within this form will provide your physician a better understanding of your concerns and subsequently more time to discuss details and treatment plans. Please be as thorough as possible as this information will become part of your medical record.

When you arrive for your first visit, please make sure we receive this completed form as well as any other medical records, X-rays, CT, or MRI pertaining to your condition.

NAME: _____
LAST FIRST MIDDLE MAIDEN

ADDRESS: _____
STREET

_____
CITY STATE ZIP CODE

PHONE *(HOME):* _____ PHONE *(WORK OR OTHER):* _____

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____
STREET

_____
CITY STATE ZIP CODE

PHONE: _____

REFERRING PHYSICIAN: _____

ADDRESS: _____
STREET

_____
CITY STATE ZIP CODE

PHONE: _____

PRIMARY INSURANCE COMPANY: _____

MEMBER OF SUSCRIBER NUMBER: _____ GROUP NUMBER: _____

PHONE NUMBER: 1/800 _____

ATTORNEY'S NAME: (IF APPLICABLE) _____ PHONE: _____

ADDRESS: _____
STREET

_____
CITY STATE ZIP CODE

ABOUT YOUR PAIN

What is the Primary reason for your visit or questions for your doctor today?

Where is your pain located? (also, please draw on diagram on the next page)

How long have you had your painful condition?

Did your pain begin after a specific injury/event? *(if yes, please describe the event below.)*

Briefly describe how your pain started:

Describe the character of your present pain:

- ❑ Aching ❑ Dull ❑ Shooting ❑ Pressure ❑ Burning
- ❑ Throbbing ❑ Sharp ❑ Stabbing ❑ Cramping ❑ Electrical
- ❑ Stiffness ❑ Deep ❑ Pulsing ❑ Hot ❑ Cold
- ❑ Other (Please Describe)

Describe the timing of your pain:

- ❑ constant ❑ intermittent
- ❑ Other (please describe)

Does your pain radiate from one place to another? (i.e. back to legs, neck to arms)

What makes your pain worse?

If you have back or neck pain, which movement makes your pain worse?

- ❑ Bending forward *(i.e. touching your toes)* ❑ Bending backward *(i.e. arching your back)*
- ❑ Rotating/Twisting ❑ Leaning to one side
- ❑ Other *(please explain)*

What do you do to ease or relieve your pain?

If you have headaches, how may days per month have they occurred over the last three months?

Do you experience any of the following?

- ❑ Numbness ❑ Weakness ❑ Temperature changes ❑ Bladder problems
- ❑ Tingling ❑ Balance problems ❑ Sweating changes ❑ Bowel problems
- ❑ Spasms ❑ Walking problems ❑ Hair/nail growth changes
- ❑ Limited motion ❑ Clumsiness ❑ Color changes

Please explain *(i.e. location, frequency)*

Please circle the number that best describes your baseline or constant level of pain over the past few days.

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										WORST POSSIBLE PAIN

Please rate your worst pain.

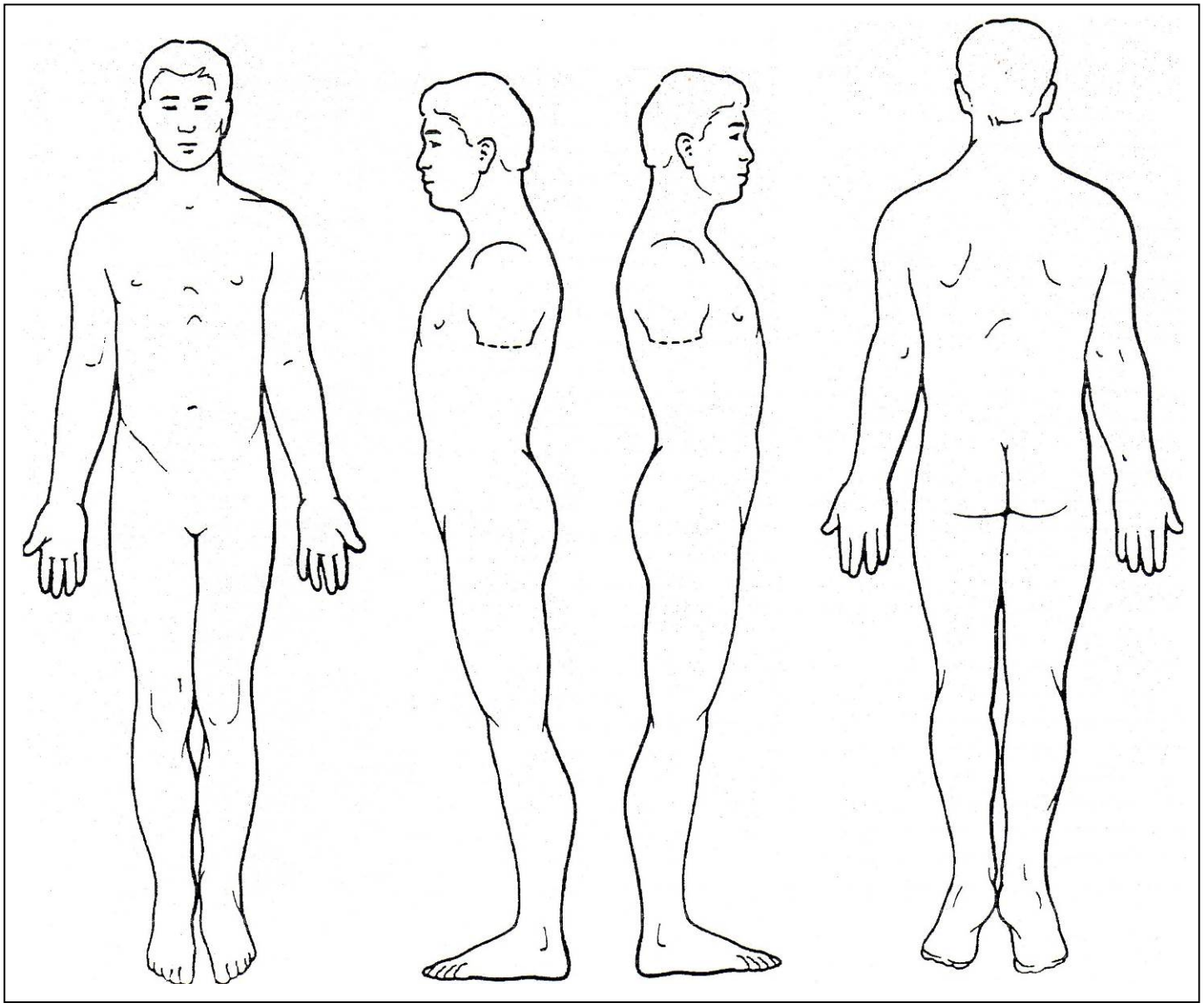
0	1	2	3	4	5	6	7	8	9	10
NO PAIN										WORST POSSIBLE PAIN

On the average over the past few days, how many times did your worst pain occur?

1-2 3-4 5-6 7-8 More than 8

Mark on the drawing below the exact spot where your pain is located. Use a solid black dot (●). If the pain starts at that spot and radiates elsewhere (i.e. travels to another part of your body), draw a line from the spot where the pain starts and where it ends. If it is a whole area that is painful, shade that area.

Next to the places on the drawing where you showed pain, put an "E" if the pain is external (on the outside surface). If the pain is internal (inside the body) mark it with an "I". If the pain is both internal and external, mark it with an EI".



ABOUT YOUR FUNCTION

How far do you travel to visit this clinic? _____ Miles *(approx)* _____ Driving time *(minutes)*

How do you usually commute to this clinic? *(i.e. drive car, bus, etc.)*

_____

Please list aspects of your life you can not perform normally because of your pain.

_____

_____

_____

How long *(in minutes or hours)* can you continuously:
_____ Sit _____ Stand _____ Walk

How would you describe your emotional health?

- ❑ Happy/Cheerful ❑ Anxious ❑ Worried ❑ Optimistic
- ❑ Depressed ❑ Panicked ❑ Compulsive ❑ Desperate
- ❑ Angry ❑ Hopeless ❑ Frustrated ❑ Suicidal
- ❑ Other *(please describe)* _____

YOUR THOUGHTS ABOUT YOUR PAIN

What do you feel is the cause of your pain?

_____

_____

Do you feel there is something representing a continual threat to your health that has not been addressed or treated? *(if so, what do feel this is?)*

_____

_____

How would you describe the impact your pain has had on your life?

- ❑ Annoying ❑ Limiting ❑ Devastating
- ❑ Very annoying ❑ Very limiting
- ❑ Other *(please describe)* _____

What do you feel is the appropriate treatment for your condition?

_____

_____

What are your goals for treatment or change in your life?

_____

_____

PREVIOUS EVALUATIONS

Please list other healthcare providers you have seen for this problem *(past or present)*

Please indicate any previous diagnostic tests done to evaluate your condition?

	Dates	Results
❑ Plain x-rays		
❑ CT scan (CAT scan)		
❑ MRI		
❑ EMG/Nerve conduction studies		
❑ Functional Capacity evaluation (FCE)		
❑ EEG (electroencephalogram)		
❑ Other		

Please list any surgeries you have had related to your pain:

Date	Surgery	Surgeon	Reason for surgery	Results

Additional comments about previous evaluations?

PREVIOUS THERAPIES

Please indicate your experience with the following therapies?

NO	YES	TREATMENT	IMPROVED	NO CHANGE	WORSE	COMMENT
❑	❑	Physical therapy				
❑	❑	Occupational therapy				
❑	❑	Aquatic/Pool therapy				
❑	❑	Passive modalities(heat, ice, ultrasound, massage)				
❑	❑	mobilizations				
❑	❑	Traction				
❑	❑	Exercises/aerobic conditioning				
❑	❑	TENS unit				
❑	❑	Orthotics (i.e. corrective foot/shoe inserts				
❑	❑	Prosthesis (braces, supports, etc)				
❑	❑	Chiropractic				
❑	❑	Deep tissue massage				
❑	❑	Psychological counseling (for pain management)				
❑	❑	Drug detoxification				
❑	❑	Acupuncture				
❑	❑	Bed rest				
❑	❑	Biofeedback or relaxation therapy				
❑	❑	Radiation treatment				
❑	❑	Interventional Therapies:(Performed by…)				
❑	❑	Trigger point injections				
❑	❑	Epidural steroid injections				
❑	❑	Facet joint injections				
❑	❑	Medial branch blocks (lumbar, cervical)				
❑	❑	Selective nerve blocks				
❑	❑	Spinal cord stimulation				
❑	❑	Intrathecal delivery system (pump)				

Please indicate other therapies not included on the above list as well as your experience:

_____

_____

_____

_____

_____

Please circle the number of times you had to visit the following providers for your pain in the last 6 months:

Emergency Room	1	2-3	4-6	7-10	More than 10
Primary Care Physician or Specialist	1	2-3	4-6	7-10	More than 10
Alternative provider *(chiropractor, homeopath, naturopath, acupuncturist)*	1	2-3	4-6	7-10	More than 10

ALLERGIES

Please list medication allergies: *(include reaction)* _____

_____

_____

PREVIOUS MEDICATIONS

Please indicate which medications you have used in the past *(include side effects and whether still taking):*

YES TRIED	NOT TRIED	NAME	STILL TAKING		IF STOPPED, WHY? SIDE EFFECTS	NOT EFFECTIVE
		PAIN KILLERS				
❑	❑	Fentanyl Transmucosal (*Actiq*)				
❑	❑	Fentanyl Transdermal (*Duragesic*)				
❑	❑	Tylenol with codeine				
❑	❑	Hydrocodone (*Vicodin, Lortab, Norco*)				
❑	❑	Hydromorphone (*Dilaudid*)				
❑	❑	Methadone (*Dolophine, Methadose*)				
❑	❑	Morphine				
❑	❑	*MS-Contin*				
❑	❑	*Avinza*				
❑	❑	*Kadian*				
❑	❑	MSIR				
❑	❑	Meperidine (*Demerol*)				
❑	❑	Oxycodone				
❑	❑	*Oxycontin*				
❑	❑	Percocet				
❑	❑	Propoxyphene (*Darvon, Darvocet*)				
❑	❑	Butorphanol (*Stadol*)				
❑	❑	Buprenorphine (*Buprenex, Subutex*)				
❑	❑	Oxymorphone (*Opana*)				
❑	❑	Tramadol (*Ultram, Ultracet*)				
		ANTINEUROPATHICS				
❑	❑	Carbamazepine (*Tegretol*)				
❑	❑	Gabapentin (*Neurontin*)				
❑	❑	Pregabalin (*Lyrica*)				
❑	❑	Lamottrigine (*Lamictal*)				
❑	❑	Oxycarbazepine (*Trileptal*)				
❑	❑	Tiagabine (*Gabatril*)				
❑	❑	Tipiramate (*Topamax*)				
❑	❑	Zonisamide (*Zonegram*)				
❑	❑	Lidocaine Transdermal (*Lidoderm* Patch)				
		MUSCLE RELAXANTS				
❑	❑	Baclofen (*Lioresal*)				
❑	❑	Carisoprodol (*Soma*)				
❑	❑	Clonazepam (*Klonopin*)				
❑	❑	Cyclopenzaprine (*Flexeral*)				
❑	❑	Diazepam (*Valium*)				
❑	❑	Metaxolone (*Skelaxin*)				
❑	❑	Methocarbamol (*Robaxin*)				
❑	❑	Tizanidine (*Zanaflex*)				
		ANTI-INFLAMMATORIES				
❑	❑	Celecoxid (*Celebrex*)				
❑	❑	Ibuprofin (*Motrin, Advil*)				
❑	❑	Meloxicam (*Mobic*)				
❑	❑	Diclofenac (*Voltaren*)				
❑	❑	Nabumetoned (*Relafen*)				
❑	❑	Piroxecam (*Feldene*)				
❑	❑	Naproxen (*Naprosyn, Aleve*)				
❑	❑	Roficoxib (Vioxx)				
❑	❑	Valdecoxib (Bextra)				

PREVIOUS MEDICATIONS (CONTINUED)

Please indicate which medications you have used in the past *(include side effects and whether still taking):*

YES TRIED	NOT TRIED	NAME	STILL TAKING		IF STOPPED, WHY? SIDE EFFECTS	NOT EFFECTIVE
		ANTI-DEPRESSANTS				
❑	❑	Amitriptyline (*Elavil*)				
❑	❑	Buproprion (*Wellbutrin*)				
❑	❑	Citalopram (*Celexa*)				
❑	❑	Desipramine (*Norpramine*)				
❑	❑	Escitalopram (*Lexapro*)				
❑	❑	Fluoxetine (*Prozac*)				
❑	❑	Imipramine (*Trofranil*)				
❑	❑	Mirtazepine (*Remeron*)				
❑	❑	Nefazedone (*Serzone*)				
❑	❑	Nortriptyline (*Pamelor*)				
❑	❑	Sertraline (*Zoloft*)				
❑	❑	Trazedone (*Deseryl*)				
❑	❑	Venlafaxine (*Effexor*)				
❑	❑	Duloxetine (*Cymbalta*)				
		ANTI-ANXIETY				
❑	❑	Alprazolam (*Xanax*)				
❑	❑	Chlodiazepoxide (*Librium*)				
❑	❑	Lithium (*Eskalith*)				
❑	❑	Olazepine (*Zyprexa*)				
❑	❑	Phenelzine (*Nardil*)				
❑	❑	Respiridone (*Risperdal*)				
		SLEEP				
❑	❑	Temazepam (*Restoril*)				
❑	❑	Triazolam (*Halcion*)				
❑	❑	Zaleplon (*Sonata*)				
❑	❑	Zolpidem (*Ambien*)				
❑	❑	Trazedone (*Deseryl*)				

CURRENT MEDICATIONS

Please list ALL of you current medications:

MEDICATION	DOSE	FREQUENCY	DATE STARTED	PRESCRIBING PHYSICIAN

PAST MEDICAL HISTORY

Please indicate any medical problems now or in the past:

HEAD AND NECK
- ❑ Glaucoma
- ❑ Eye/vision problems
- ❑ Hearing balance problems
- ❑ Nose/sinus problems
- ❑ Throat/neck problems
- ❑ Jaw/teeth problems
- ❑ Other:

SKIN
- ❑ Rashes
- ❑ Sores/ulcers
- ❑ Eczema/allergic dermatitis
- ❑ Other:

LUNGS/CHEST
- ❑ Shortness of Breath
- ❑ Cough
- ❑ Chest pain
- ❑ Asthma/emphysema
- ❑ Hay fever/allergies
- ❑ Pneumonia
- ❑ Other:

CARDIOVASCULAR
- ❑ High blood pressure
- ❑ Heart surgery
- ❑ Artificial heart valves
- ❑ Chest pain/angina
- ❑ Heart attack
- ❑ Heart murmur
- ❑ Irregular heart beat
- ❑ Blood clots in legs or arms
- ❑ Mitral valve prolapse
- ❑ Non healing sores
- ❑ Poor circulation
- ❑ Leg or arm swelling
- ❑ Other:

GASTROINTESTINAL
- ❑ Acid reflux
- ❑ Ulcers
- ❑ Difficulty swallowing
- ❑ Diarrhea
- ❑ Constipation
- ❑ Loss of bowel control
- ❑ Red or black stools
- ❑ Nausea or vomiting
- ❑ Stomach upset with medications
- ❑ Irritable bowel syndrome
- ❑ Liver problems/hepatitis
- ❑ Other

GENITOURINARY
- ❑ Kidney stones
- ❑ Urinary tract infections
- ❑ Kidney failure/dialysis
- ❑ Difficulty urinating
- ❑ Loss of bladder control
- ❑ Sexual dysfunction
- ❑ Other:

OB/GYN
- ❑ Pelvic pain
- ❑ First menstrual period at age: ____
- ❑ Last menstrual period at age: ____
- ❑ Menstrual problems
- ❑ Pains associated with menstruation
- ❑ Menopause

NERVOUS SYSTEM
- ❑ Headache
- ❑ Dizziness
- ❑ Seizures
- ❑ Stroke
- ❑ Brain Injury
- ❑ Spinal cord injury
- ❑ Tremor
- ❑ Double vision
- ❑ Loss of consciousness
- ❑ Multiple sclerosis
- ❑ Peripheral neuropath
- ❑ Peripheral nerve injury
- ❑ Other:

SPINE
- ❑ Neck injury or pain
- ❑ Back injury or pain
- ❑ Disc disease
- ❑ Fracture
- ❑ Scoliosis
- ❑ Other:

MUSCLE/BONES/JOINTS
- ❑ Broken bones
- ❑ Arthritis
- ❑ Joint swelling or stiffness
- ❑ Very Flexible (“double –jointed”)
- ❑ Muscle pain
- ❑ Fatigue
- ❑ Morning stiffness
- ❑ Other

PSYCHOLOGICAL
- ❑ Depression
- ❑ Anxiety
- ❑ Panic attacks
- ❑ Bipolar disorder
- ❑ Schizophrenia
- ❑ Suicide attempts
- ❑ Psychiatric hospitalization
- ❑ Psychological counseling
- ❑ Victim of abuse
- ❑ Addiction problems
- ❑ Other:

HEMATOLOGIC/IMMUNOLOGIC
- ❑ Easy Bruising
- ❑ Bleeding Problems
- ❑ Anemia
- ❑ Previous blood transfusion
- ❑ Immunodeficiency
- ❑ Transplant patient
- ❑ Swollen glands
- ❑ Cancer
- ❑ HIV

ENDOCRINE/METABOLIC
- ❑ Diabetes: Insulin vs. Non-insulin
- ❑ Hypothyroid (Low)
- ❑ Hyperthyroid (High)
- ❑ Other:

OTHER

_____
_____
_____
_____
_____
_____

PREVIOUS SURGERIES
OTHER THAN LISTED FOR PAIN,
INCLUDE DATES (MONTH/YEAR)

_____
_____
_____
_____
_____
_____
_____
_____
_____

SLEEP HISTORY

On the worst night during the last two weeks, how badly was your sleep affected by your pain?

- ❑ Not affected at all
- ❑ I didn't lose sleep but needed medication for assistance
- ❑ It prevented me from sleeping more than 4 hours
- ❑ I had only 2-4 hours of sleep
- ❑ I had less than 2 hours sleep

YES	NO	
❑	❑	Have you been told you snore a lot?
❑	❑	Have you been told you gasp for breath at night?
❑	❑	Are you a restless sleeper?
❑	❑	Do you often have problems with restlessness of your legs keeping you awake?

ABOUT YOUR LIFE

What is your present or previous occupation? _____

Do you work: ❑ Full time? ❑ Part time? ❑ Light or limited duty? Explain: _____

_____

_____

How long have/had you been at this job? _____ How much do/did you enjoy your job? _____

Have you been off of work because of your pain in the past? ❑ YES ❑ NO If so, how many times and for how long?

_____

_____

_____

How many hours per day does your job require you to:

- ❑ Sit _____ ❑ Stand _____ ❑ Walk _____
- ❑ Drive _____ ❑ Reach _____ ❑ Bend/Stoop _____
- ❑ Carry, push,pull *(how much?)* _____ ❑ Lift *(how much?)* _____
- ❑ Work at computer *(how long?)*

Please answer these questions if you are not working outside the home.

When did you last work? _____

Why did you stop? _____

How do you spend your day? _____

What is your source of income? _____

Do you plan to: ❑ Return to your old job? ❑ Take a different job? ❑ Not return to work?

❑ Other: _____

Is this a worker's compensations case? If yes, where are you in your case? *(i.e. total temporary disability, permanent and stationary)* _____

_____

ABOUT YOUR LIFE (CONTINUED)

Are you: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Do you have any children? If so, list with ages. _____

Who lives at home with you? _____

Did you have a happy childhood?	❑ YES	❑ NO
Have you ever been physically of sexually abused?	❑ YES	❑ NO
Do you feel threatened in your current environment?	❑ YES	❑ NO
Do you ever seriously consider or attempt suicide?	❑ YES	❑ NO
Do you have a suicide plan at the moment?	❑ YES	❑ NO

Do you currently:

			If yes, how much/how long?	If no, did you in the past?		If yes, how much/how long?
Smoke?	❑ YES	❑ NO	_____	❑ YES	❑ NO	_____
Drink alcohol?	❑ YES	❑ NO	_____	❑ YES	❑ NO	_____
Use other drugs?	❑ YES	❑ NO	_____	❑ YES	❑ NO	_____
Use caffeine?	❑ YES	❑ NO	_____	❑ YES	❑ NO	_____

Do you ever consume alcohol to help with your pain?	❑ YES	❑ NO
Have you or others ever thought you have a problem with your alcohol use?	❑ YES	❑ NO
Have you or your doctors ever thought you had a problem with pain medications?	❑ YES	❑ NO

Thank you for your cooperation. Please sign below. If you are unable to sign, pleas have a parent, guardian, or responsible party sign and indicate the reason you are unable to sign.

_____ _____

Signature Date and Time

Reason patient unable to sign: _____

_____