

Please print this form and complete it before your appointment. Thank you!

Milwaukee Pain Treatment Services
5400 N. 118th Ct., Milwaukee, WI 53225
Phone 414-257-4673 Fax 414-257-4688

Interview Form

Name: _____ **Age:** _____ **Today's Date:** _____

Where is your pain located? (also specify whether pain on left, right or both sides of body)

When did your pain begin? (indicate the date or year)

How long have you had pain? (indicate the number of days, weeks, months, or years)

What did *you* think caused your pain in the beginning?

What sort of things make your pain worse? (examples: sitting, bending forward, standing, walking, coughing, exercise, cold, etc.)

What makes your pain better? (examples: rest, heat, massage, medications, etc.)

Does your pain radiate anywhere? If so, where? (specify to which side of body)

How would you describe your pain? (examples: dull, sharp, aching, burning, throbbing,

shocking, cramping, hard to pinpoint, etc.)

What percent of the day do you have pain? _____ %

Rate your pain now on a scale of 1-10 (10 being the worst) _____

How does pain interfere with your life?

What sort of expectations do you have for the treatment of your pain?

List your medical problems(examples: high blood pressure, diabetes, arthritis, depression, heart problems, etc.)

List your past surgeries with the dates performed (indicate the side of body if applicable).

List your history of injuries.

List your allergies and negative reactions to medications.

List the medications and doses you are currently taking.

List the prior treatments you have received for your pain.

List your *family* history of medical illness (examples: lower back pain, cancer, depression).

List the type of X-rays (such as plain X-ray, CT scan, MRI scan) and the place and year they were taken (specify the office, hospital or clinic).

List any other tests done (such as emg, labs) and the place and year they were performed.

Indicate the name of your family doctor with address and phone number.

Indicate the name of any specialists you have seen for your pain.

Indicate the name of your pharmacy with phone number.

List your occupational history over the past 5 years. Indicate the type of job you currently hold.

List your hobbies and interests.

Please read ALL QUESTIONS and place a checkmark only if your answer is yes. Questions with no checkmark indicate your answer is no.

_____ Do you have a fever?

_____ Do you have night sweats?

_____ Do you have chills?

_____ Have you lost more than 5% of your weight in the last month?

_____ Have you gained more than 5% of your weight in the last month?

_____ Have you lost interest in your favorite activities?

_____ Are you frequently tearful?

- _____ Are you depressed most of the day?
- _____ Has your appetite decreased?
- _____ Do you have trouble falling asleep?
- _____ Are you excessively sleepy during the day or working hours?
- _____ Do you tire out easily?
- _____ Do you feel worthless or guilty?
- _____ Are you having difficulty concentrating or making decision?
- _____ Have you thought of harming yourself?
- _____ Have you thought of suicide?
- _____ Do you drink alcohol?
- _____ Do you use alcohol to help treat your pain?
- _____ Have you been convicted of drunk driving?
- _____ Do you use any illicit drugs?
- _____ Do you have a personal history of alcohol or drug abuse?
- _____ Do you have a family history of alcohol or drug abuse?
- _____ Do you smoke tobacco?
- _____ Have you been a victim of domestic abuse or child abuse?
- _____ Have you had a recent loss or serious illness of a loved one?
- _____ Have you had trouble with your boss or other coworkers?
- _____ Were you injured at work?
- _____ Have you recently lost your job?
- _____ Are you having major financial difficulties?
- _____ Do you have marital problems or difficulties with your significant other?
- _____ Have you ever been in trouble with the law?
- _____ Do you have any litigation pending?
- _____ Do you have cancer?
- _____ Do you have diabetes?
- _____ Do you have headaches?
- _____ Have you ever had a seizure?
- _____ Have you ever had a stroke?
- _____ Have you ever had a head injury?
- _____ Do you have numbness in your upper extremities?
- _____ Do you have weakness in your upper extremities?
- _____ Do you have numbness in your lower extremities?
- _____ Do you have weakness in your lower extremities?
- _____ Do you have pain in your neck?
- _____ Do you have pain in your shoulders?
- _____ Do you have elbow pain?
- _____ Do you have arm pain?
- _____ Do you have wrist pain?
- _____ Do you have hand pain?
- _____ Do you have mid-back pain?
- _____ Do you have lower back pain?
- _____ Do you have hip pain?
- _____ Do you have knee pain?
- _____ Do you have ankle pain?

- _____ Do you have foot pain?
- _____ Do you have problems with your sinuses?
- _____ Do you have eye trouble?
- _____ Do you have glaucoma?
- _____ Do you have ear problems?
- _____ Do you have trouble swallowing?
- _____ Do you have trouble breathing?
- _____ Do you have a cough?
- _____ Do you have pneumonia?
- _____ Have you had TB (tuberculosis)?
- _____ Do you have chest pain?
- _____ Do you have skipped heart beats?
- _____ Have you ever had a heart attack?
- _____ Do you have a heart condition?
- _____ Do your legs swell?
- _____ Do you have constipation?
- _____ Do you have diarrhea?
- _____ Are you having trouble controlling your bowels?
- _____ Do you have abdominal pain?
- _____ Have you had a history of liver disease?
- _____ Have you noticed any bleeding?
- _____ Do you have a bleeding disorder?
- _____ Do you take any blood thinners?
- _____ Have you ever had a blood clot?
- _____ Do you have burning in the urine?
- _____ Are you having trouble controlling your urine flow?
- _____ Do you have any problems urinating?
- _____ Have you had a history of kidney disease?
- _____ Do you have any groin pain?

- _____ Males: Do you have a prostate problem?
- _____ Males: Are you experiencing impotency?
- _____ Males: Do you have pain in your genitals?

- _____ Females: Are you pregnant?
- _____ Females: Are you trying to get pregnant?
- _____ Females: Have you missed your period?
- _____ Females: Do you have irregular periods?
- _____ Females: Do you have pelvic pain?
- _____ Females: Does pain increase with your periods?

Where do you feel pain?
Circle the area or mark with an X.

