PAIN MANAGEMENT PHYSICIANS
OF SOUTH FLORIDA

ANDREW J. GOLDBERG, M.D.

INITIAL CONSULTATION FORM

Date:_____

Please read these sheets carefully and answer all questions to be the best of your ability. This will assist us in better treating your pain. Thank you for your time and cooperation.

Name: _____ Email: _____

LAST FIRST

Age:_____ Height:_____ Weight:_____

Referring Physician(s):_____

Other Physicians seen for this problem:_____

Allergies or adverse reactions to MEDICATIONS (pill or injection):_____

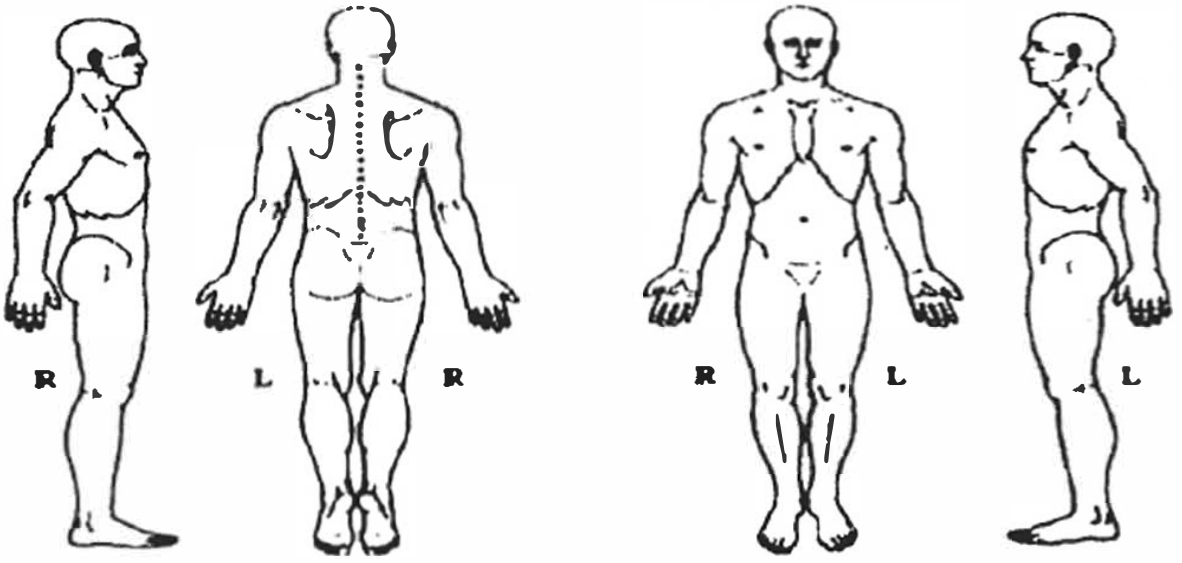
_____

Other allergies: _____

How long have you had this pain:_____

Please rate your pain on a scale from 0 (no pain) to 10 (worst pain): _____

Please shade in the areas on the diagrams where your pain is located.



8880 Royal Palm Blvd. Suite 103. Coral Springs, Fl 33065 Ph: 954-975-8233 Fax:954-974-2335

Please circle the appropriate words that best describe your pain.

ACHING	DULL	SHOOTING	CONSTANT
BURNING	TIGHT	TINGLING	RADIATING
CRAMPING	BRIEF	COLDNESS	SHARP
SORENESS	STABBING	NUMBING	

YES	NO	QUESTIONS
		If you are being seen today for LOWER BACK AND/OR LEG PAIN...
Y	N	Do you have tingling or pins/needles of the legs?
Y	N	Do you have numbness of the legs?
Y	N	Do you have weakness of the legs?
Y	N	Does sneezing make your primary pain worse?
Y	N	Does coughing make your primary pain worse?

Which of the following four activities aggravates your lower back/leg pain the worst? Bending over; Getting up from bed/sitting; immediately walking; prolonged walking; sitting.

Y	N	Do you have tingling or pins/needles of the arms?
Y	N	Do you have numbness of the arms?
Y	N	Do you have weakness of the arms?
Y	N	Does sneezing make your primary pain worse?
Y	N	Does coughing make your primary pain worse?

Which of the following activities increases your pain the most? Right neck rotation, left neck rotation, lying down, looking up, looking down.

QUESTIONS FOR ALL PATIENTS:

Y	N	Have you had physical therapy for this problem?
Y	N	Have you had chiropractic therapy for this problem?
Y	N	Have you tried the following drugs; circle answer: Celebrex, Naproxen, Motrin, Advil, Lodine, Voltaren, Mobic (meloxicam)?
Y	N	Have you tried the following three drugs; circle answer: Cymbalta (duloxetine), Neurontin (gabapentin), Lyrice (pregablin)?
Y	N	Have you tried Prednisone or oral steroids for this problem?
Y	N	Have you received any injections for this problem?
Y	N	Have you tried acupuncture for this problem?

Please mention to your Doctor any other treatment you may have had for this problem.

Have you ever had any of the following studies done?

Yes/No	MRI When: _____	Report included:	☐
Yes/No	X-ray When: _____	Report included:	☐
Yes/No	CT When: _____	Report included:	☐
Yes/No	EMG/Nerve Conduction Study When: _____	Report included:	☐

Results: _____

_____

Past Medical History

YES	NO	QUESTIONS
Y	N	**Are you having any non-intentional weight loss?**
Y	N	**Are you having chills or fever?**
Y	N	**Do you suffer from bowel retention?**
Y	N	**Do you suffer from bladder retention or incontinence?**
Y	N	**Do you suffer from dizziness?**
Y	N	**Do you suffer from headaches?**
Y	N	**If yes to headaches - Migraines?**
Y	N	**Have you been treated for high blood pressure?**
Y	N	**Have you had a heart attack?**
Y	N	**Do you get chest pain?**
Y	N	**Has a stent been put into your heart?**
Y	N	**Have you had open heart surgery or a valve placed into your heart?**
Y	N	**Have you suffered from heart failure?**
Y	N	**Do you have a pacemaker?**
Y	N	**Are you on a blood thinner, such as Coumadin, Plavix, Aggrenox, pradaxa?**
Y	N	**Have you been treated for asthma?**
Y	N	**Have you been treated for Emphysema?**
Y	N	**Have you been treated for sleep apnea?**
Y	N	**Do you have any current wheezing?**
Y	N	**Have you been treated for hepatitis or liver disease?**
Y	N	**Are you treated for reflux, heartburn or ulcer?**
Y	N	**Have you ever had rectal bleeding?**
Y	N	**Have you ever suffered from kidney stones?**

Y N **Do you have any kidney function problems?**
Y N **Do you have burning when you urinate?**
Y N **Have you ever received dialysis?**

Y N **Have you been treated for Diabetes?**
Y N **If yes to diabetes, do you take Insulin?**
Y N **Are you being treated for low functioning thyroid function?**

Y N **Do you bruise easily?**
Y N **Have you been treated for cancer?**

Y N **Have you been treated by a Rheumatologist?**

Y N **Have you been treated for depression?**
Y N **Have you been treated for anxiety?**
Y N **Have you ever been hospitalized for depression or anxiety?**

Y N **Have you ever suffered a seizure?**
Y N **Have you ever suffered a stroke?**
Y N **Have you ever suffered a mini-stroke or TIA?**

Y N **Have you been treated for skin cancer?**
Y N **Do you suffer from psoriasis or other long term skin conditions?**

Y N **Does sneezing make your primary pain worse?**

LIST ALL PAST SURGERIES: _____

_____

_____

_____

_____

Patient or family history of problems with anesthesia _____

_____

Current Medications (Please list all medications including the dosage (mg) and all vitamins and herbal supplements.)

_____

_____

_____

Social History:

Yes/No	Do you work now? If yes, where _____ # hrs/day _____
Yes/No	Are you retired?
Yes/No	Are you on disability?
Yes/No	Are you married? If yes, how long? _____
Yes/No	Are you divorced?
Yes/No	Are you widowed?
	How many children do you have? _____ Do they live close by? _____
Yes/No	Do you smoke? _____ If yes, how many packs/day? _____
Yes/No	Do you drink? _____ If yes, how may drinks/week? _____

What do you do to keep busy, for fun? _____

_____

Goals if the pain could be reduced? _____

_____

Family History:

☐ Non-contributory for the patient's pain condition

☐ Other: _____

The above information I have given is complete and accurate to the best of my knowledge:

Patient Signature: _____ **Date:** _____

Assisting Staff: _____ **Date:** _____

I have reviewed the above information with the nurse and patient.

Physician Signature: _____