TOTAL PAIN CARE, LLC
1001 14th Street
Meridian, MS. 39301
Phone (601) 482-9224
Fax (601) 482-9223
newpatient@totalpaincare.org

Please arrive 20 minutes before your scheduled appointment time.

YOU MUST COMPLETE AND BRING YOUR NEW PATIENT QUESTIONNAIRE TO YOUR APPOINTMENT. IF THIS IS NOT COMPLETED PRIOR TO YOUR APPOINTMENT, WE CANNOT GUARANTEE YOU WILL BE SEEN.

Bring your insurance cards and photo ID.

Be prepared to pay any co-pays that may be due at the time of the appointment.

Bring your daily medications or bring a list including name, dosage amount and how often you take your medication.

You can expect this first appointment to last approximately one and a half hours.

*PLEASE CALL OUR OFFICE AS SOON AS POSSIBLE IF YOU ARE UNABLE TO KEEP YOUR NEW PATIENT APPOINTMENT. THERE ARE OTHER PATIENTS WAITING ON AN APPOINTMENT. THANK YOU!

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Your Name: _____ Age: _____ Date: _____

Referring Doctor: _____ your Primary Physician: _____

Other Specialists:	What for:	Where:	Last Visit:
_____	_____	_____	_____

Have you seen a surgeon just for your Pain complaint? Surgeon's name? _____

Have you ever seen another Pain specialist? _____

HISTORY OF CHIEF COMPLAINT

Your specific pain complaint? _____

Does your pain radiate?_____ If yes, where to and how often? _____

If neck/back/arm/leg pain, rank high to low of worst discomfort: _____

When did it start?_____ Pain constant or comes and goes? _____

When did the pain worsen? _____ , _____

Onset gradual or abrupt? _____Trauma or accident? _____

What diagnoses have you been given? _____

Any studies that have been done

MRI-Cervical (neck) ☐ Thoracic (mid back) ☐ Lumabar (low back) ☐ Knee ☐

Hip ☐ EMG Nerve study ☐ Myelogram ☐ CT/CAT scan ☐ Discogram ☐

Blood Labs(genetic testing) ☐ Bone Scan Osteoporosis bone density ☐ X-rays ☐

If Genetic testing has been done you may provide your report for our review.

Related Effects?

Y N Have you had any bowel/bladder problems? What? _____

Y N Do you use any *Blood Thinners*? What and why? _____

Y N Have you ever had Cancer? What/When? _____

Y N Are you now or ever been involved with an attorney/lawsuit about your pain?

Y N Is your pain complaint related to workers compensation?

Where is your pain located? (check)

- ☐ low back
- ☐ mid back
- ☐ upper back
- ☐ neck
- ☐ chest
- ☐ abdomen
- ☐ groin
- ☐ left buttock
- ☐ right buttock
- ☐ left thigh
- ☐ right thigh
- ☐ left calf
- ☐ right calf
- ☐ left ankle or foot
- ☐ right ankle or foot
- ☐ left shoulder
- ☐ right shoulder
- ☐ left arm
- ☐ right arm
- ☐ left hand or wrist
- ☐ right hand or wrist
- ☐ head
- ☐ face
- ☐ other _____
- _____
- _____

Please list three goals you would like for us to help you reach.

1. _____
2. _____
3. _____

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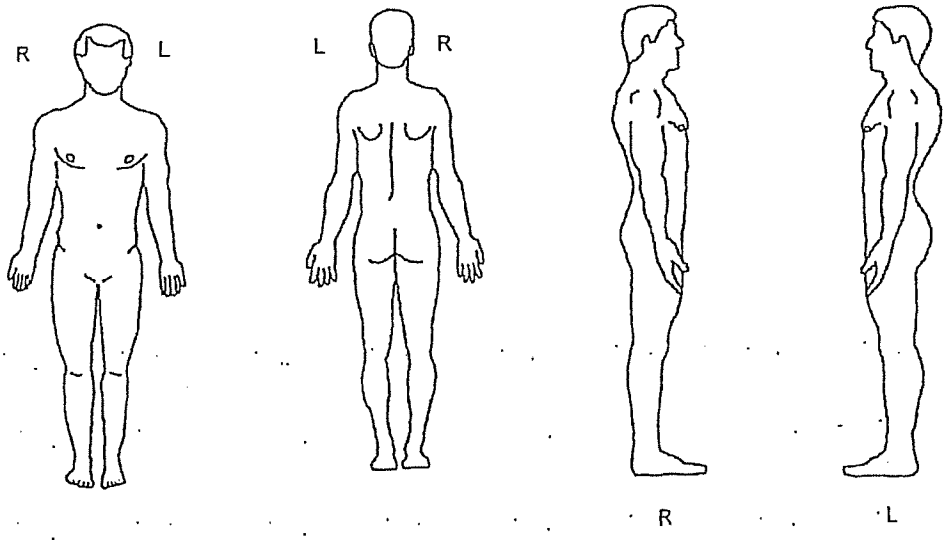
Name:_____ Age: _____ Date: _____

INDICATE YOUR PAIN ON THIS DIAGRAM Show where you hurt by marking on the diagram. Use dots for numbness ::::: Use slash marks for pain \\\\ Add any detail you like.



BRIEF PAIN INVENTORY

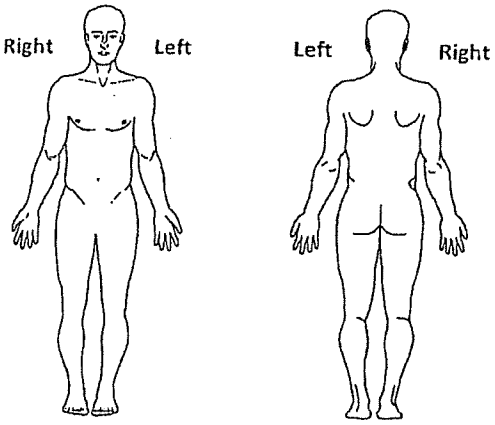
Date_____/_____/_____ Time:_____

Name:_____ _____ _____
Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the last week.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the last week.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can

7) What treatments or medications are you receiving for your pain?

_____

_____

8) In the last week, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.

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

No relief — Complete relief

9) Circle the one number that describes how, during the past week, pain has interfered with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

D. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

Pain Severity Score_____

Pain Interference Score _____

OSWESTRY DISABILITY QUESTIONNAIRE

Please circle the number that most closely represents your ***present*** condition. Please answer all items.

Pain Intensity

_0__ I have no pain at the moment
_1__ The pain is very mild at the moment
_2__ The pain is moderate currently
_3__ The pain is fairly severe currently
_4__ The pain is very severe currently
_5__ The pain is the worst imaginable currently

Personal Care (Washing, Dressing, etc...)

_0__ I can look after myself without extra pain
_1__ I can look after myself with extra pain
_2__ It is painful to look after myself, I am slow and careful.
_3__ I need some help but can manage most myself
_4__ I need help every day in most aspects
_5__ I do not get dressed; wash with difficulty and stay in bed.

Lifting

_0__ I can lift heavy weights without extra pain
_1__ I can lift heavy weights but it gives me extra pain
_2__ Pain prevents me lifting heavy weights off the floor but I can manage them otherwise
_3__ Pain prevents me from lifting heavy weights but I can manage light or medium weights
_4__ I can only lift very light weights
_5__ I cannot lift or carry anything

Walking

_0__ Pain does not prevent me walking any distance
_1__ Pain prevents me walking more than 1 mile
_2__ Pain prevents me walking more than ½ mile
_3__ Pain prevents me walking more than ¼ mile
_4__ I can only walk using a stick or crutch
_5__ I am in bed most of the time

Sitting

_0__ I can sit in any chair as long as I want
_1__ I can only sit in my favorite chair as long as I like
_2__ Pain prevents me sitting more than 1 hour
_3__ Pain prevents me sitting more than 30 minutes
_4__ Pain prevents me sitting more than 10 minutes
_5__ Pain prevents me from sitting at all

Standing

_0__ I can stand as long as I want without extra pain
_1__ I can stand as long as I want with some extra pain
_2__ Pain prevents me standing more than 1 hour
_3__ Pain prevents me standing more than 30 minutes
_4__ Pain prevents me standing more than 10 minutes
_5__ Pain prevents me standing at all

Sleeping

_0__ My sleep is never disturbed by pain
_1__ My sleep is occasionally disturbed by pain
_2__ I sleep less than 6 hours because of my pain
_3__ I sleep less than 4 hours because of my pain
_4__ I sleep less than 2 hours because of my pain
_5__ Pain prevents me from sleeping at all

Social Life

_0__ My social life is normal and gives me no extra pain
_1__ My social life is normal but increases my pain
_2__ Pain has no significant effect on my social life apart from limiting my more energetic interests
_3__ Pain has restricted my social life and I do not go out as often
_4__ Pain has restricted my social life to my home
_5__ I have no social life because of my pain

Traveling

_0__ I can travel anywhere without pain
_1__ I can travel anywhere with extra pain
_2__ Pain is bad but I manage journeys of 2 hours
_3__ Pain restricts me to journeys less than 1 hour
_4__ Pain restricts me to journeys less than 20 minutes
_5__ Pain prevents me from traveling except for treatment

Employment and Homemaking

_0__ My normal job activities do not cause pain
_1__ My normal job activities increase my pain, but I can still perform what needs to be done
_2__ I can perform most of my job activities, but pain prevents me from physically rigorous ones
_3__ Pain prevents me from doing anything but light duties
_4__ Pain prevents me from doing even light duties
_5__ Pain prevents me from doing any job activities

Clinic use only below this line

Osw raw score _____

Times 2 = % score _____

Time of this Osw _____
(0, 1, 3, 6, 12 months)

Patient Name_____

DOB _____

SOAPP-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	☐	☐	☐	☐	☐
2. How often have you felt a need for higher doses of medication to treat your pain?	☐	☐	☐	☐	☐
3. How often have you felt impatient with your doctors?	☐	☐	☐	☐	☐
4. How often have you felt that things are just too overwhelming that you can't handle them?	☐	☐	☐	☐	☐
5. How often is there tension in the home?	☐	☐	☐	☐	☐
6. How often have you counted pain pills to see how many are remaining?	☐	☐	☐	☐	☐
7. How often have you been concerned that people will judge you for taking pain medication?	☐	☐	☐	☐	☐
8. How often do you feel bored?	☐	☐	☐	☐	☐
9. How often have you taken more pain medication than you were supposed to?	☐	☐	☐	☐	☐
10. How often have you worried about being left alone?	☐	☐	☐	☐	☐
11. How often have you felt a craving for medication?	☐	☐	☐	☐	☐
12. How often have others expressed concern over your use of medication?	☐	☐	☐	☐	☐

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	☐	☐	☐	☐	☐
14. How often have others told you that you had a bad temper?	☐	☐	☐	☐	☐
15. How often have you felt consumed by the need to get pain medication?	☐	☐	☐	☐	☐
16. How often have you run out of pain medication early?	☐	☐	☐	☐	☐
17. How often have others kept you from getting what you deserve?	☐	☐	☐	☐	☐
18. How often, in your lifetime, have you had legal problems or been arrested?	☐	☐	☐	☐	☐
19. How often have you attended an AA or NA meeting?	☐	☐	☐	☐	☐
20. How often have you been in an argument that was so out of control that someone got hurt?	☐	☐	☐	☐	☐
21. How often have you been sexually abused?	☐	☐	☐	☐	☐
22. How often have others suggested that you have a drug or alcohol problem?	☐	☐	☐	☐	☐
23. How often have you had to borrow pain medications from your family or friends?	☐	☐	☐	☐	☐
24. How often have you been treated for an alcohol or drug problem?	☐	☐	☐	☐	☐

Please note it is a felony to give false information to obtain narcotic medications.

I verify that the above information to be true and accurate.

Name _____ Signature _____

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Patient Name _____

Birth Date _____

Patient ID _____

Any Physician, staff, employee or representative of Total Pain Care, LLC has my permission to discuss my account and medical conditions, which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment.

_____ _____

Name/Relationship Phone Number

_____ _____

Name/ Relationship Phone Number

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to our HIPAA Compliance Officer or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals, it may be subject to redisclosure by the individual(s).

Patient Signature _____ Date _____