

Total Pain Care LLC

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www.totalpaincare.org

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? _____

Onset gradual or abrupt? _____ Trauma or accident? _____

What diagnoses have you been given? _____

Where is your pain located? (check)

- | | | |
|--|--|--|
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Left Thigh | <input type="checkbox"/> Right Arm |
| <input type="checkbox"/> Mid Back | <input type="checkbox"/> Right Thigh | <input type="checkbox"/> Left Hand or Wrist |
| <input type="checkbox"/> Upper Back | <input type="checkbox"/> Left Calf | <input type="checkbox"/> Right Hand or Wrist |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Right Calf | <input type="checkbox"/> Head |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Left Ankle or Foot | <input type="checkbox"/> Face |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Right Ankle or Foot | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Groin | <input type="checkbox"/> Left Shoulder | _____ |
| <input type="checkbox"/> Left Buttock | <input type="checkbox"/> Right Shoulder | _____ |
| <input type="checkbox"/> Right Buttock | <input type="checkbox"/> Left Arm | |

Indicate all that describe your pain (check)

- | | | |
|---------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Dull Aching | <input type="checkbox"/> Sharp | <input type="checkbox"/> Crawling |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Burning | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Warmth |
| <input type="checkbox"/> Spasms | <input type="checkbox"/> Weakness | <input type="checkbox"/> Coldness |
| <input type="checkbox"/> Intermittent | <input type="checkbox"/> Numb | <input type="checkbox"/> Discoloration |
| <input type="checkbox"/> Constant | <input type="checkbox"/> Pins/Needles | <input type="checkbox"/> Cracking/Popping |

Indicate any that worsen your pain (check)

- | | | |
|-----------------------------------|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Extending | <input type="checkbox"/> Bowel Movement |
| <input type="checkbox"/> Sneeze | <input type="checkbox"/> Lying | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Walking | <input type="checkbox"/> Emotions |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Driving | <input type="checkbox"/> Cold |
| <input type="checkbox"/> Rising | <input type="checkbox"/> Exercise | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Stairs | <input type="checkbox"/> Weather Changes |
| | <input type="checkbox"/> Sexual Activity | |

Any other symptoms or observations: _____

Indicate any that relieve your pain (check)

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Relaxation |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Exercise | <input type="checkbox"/> Accupuncture |
| <input type="checkbox"/> Lying | <input type="checkbox"/> Heat | <input type="checkbox"/> Injections |
| <input type="checkbox"/> Change Position | <input type="checkbox"/> Ice | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Massage | |

Indicate any studies that have been done (check)

- | | | |
|--|--|--|
| <input type="checkbox"/> MRI - Cervical (Neck) | <input type="checkbox"/> EMG Nerve Study | <input type="checkbox"/> Bone Scan |
| <input type="checkbox"/> Thoracic (Mid Back) | <input type="checkbox"/> Myelogram | <input type="checkbox"/> Osteoporosis Bone Density |
| <input type="checkbox"/> Lumbar (Low Back) | <input type="checkbox"/> CT/CAT Scan | <input type="checkbox"/> Plain X Rays |
| <input type="checkbox"/> Knee | <input type="checkbox"/> Discogram | <input type="checkbox"/> Surgical Evaluation |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Blood Labs | |

Check any treatments that have been prescribed.

Indicate if treatment was effective: Yes / No

- | | | |
|---|----------------------------|----------------------------|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| <input type="checkbox"/> TENS Unit | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| <input type="checkbox"/> Rest | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| <input type="checkbox"/> Time Off Work | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| <input type="checkbox"/> Injections | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Y | <input type="checkbox"/> N |

What kind? _____

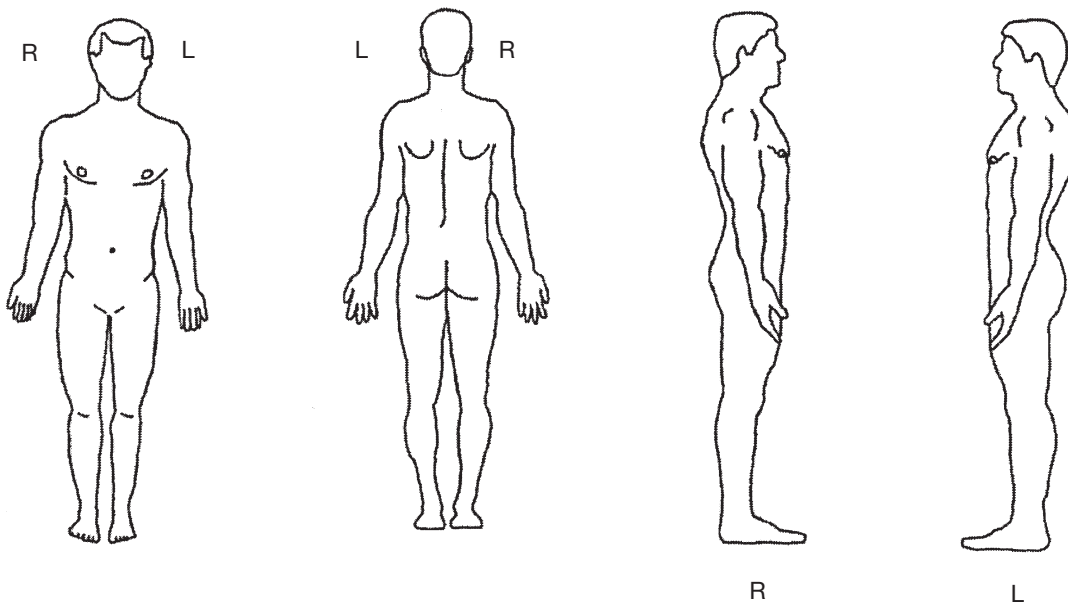
Rx most effective? _____ Also helps? _____

Related Effects? Check Yes / No

- Y N Have you had any numbness/loss of sensation: Where? _____
- Y N Have you had any true weakness? (not giving to pain) Where? _____
- Y N Have you had any bowel/bladder problems? What? _____
- Y N Does time of day effect your pain? How/When? _____
- 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/suit about your pain? _____

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.



You will be asked about drug allergies and a list of all medications with doses. Please have a list ready.

List Drug Allergies

List Pain Medicines:

List only *Current* Medical Non Surgical Problems:

List all Past *Surgeries*:

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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How often have you felt a need for higher doses of medication to treat your pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. How often have you felt impatient with your doctors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. How often have you felt that things are just too overwhelming that you can't handle them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. How often is there tension in the home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. How often have you counted pain pills to see how many are remaining?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. How often have you been concerned that people will judge you for taking pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. How often do you feel bored?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. How often have you taken more pain medication than you were supposed to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. How often have you worried about being left alone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. How often have you felt a craving for medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. How often have others expressed concern over your use of medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. How often have others told you that you had a bad temper?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. How often have you felt consumed by the need to get pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. How often have you run out of pain medication early?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. How often have others kept you from getting what you deserve?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. How often, in your lifetime, have you had legal problems or been arrested?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. How often have you attended an AA or NA meeting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. How often have you been in an argument that was so out of control that someone got hurt?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. How often have you been sexually abused?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. How often have others suggested that you have a drug or alcohol problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. How often have you had to borrow pain medications from your family or friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. How often have you been treated for an alcohol or drug problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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 _____