

# Oklahoma Interventional Pain Management Questionnaire

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**Is this injury related to a Motor Vehicle Accident?** Yes No If yes, Date of Accident: \_\_\_\_\_ Date pain began: \_\_\_\_\_

**Is this a Worker's Comp injury?** Yes No If yes, Date of Injury: \_\_\_\_\_ Date pain began: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

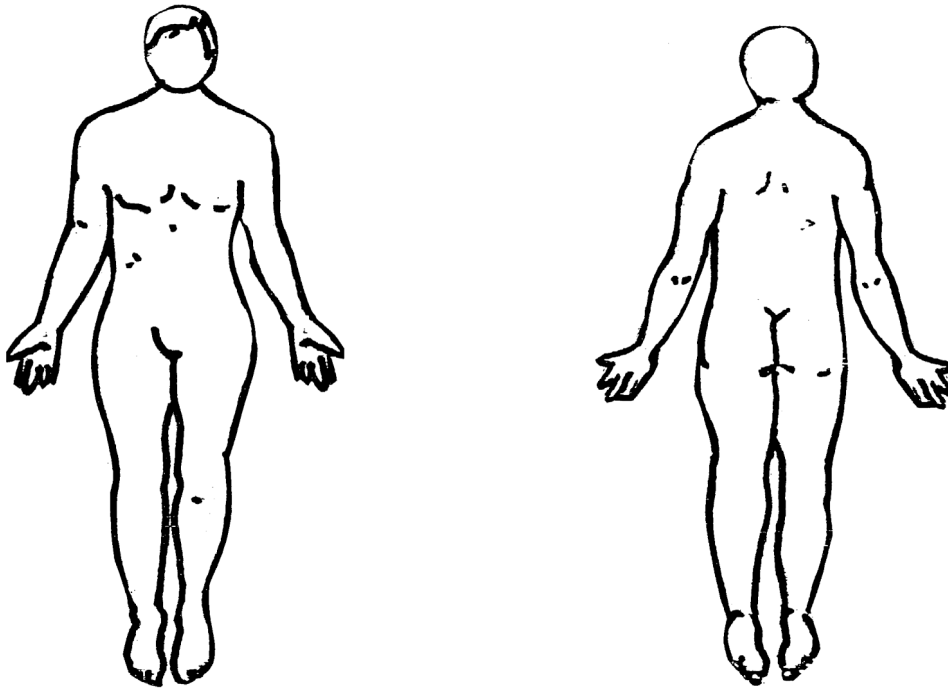
Are you currently working? \_\_\_\_\_ If no, last date worked? \_\_\_\_\_

Current Work Restrictions: \_\_\_\_\_

List all previous Workers' Comp Injuries \_\_\_\_\_

Date Pain Began: \_\_\_\_\_ Describe Event/Onset: \_\_\_\_\_

On the diagram shade in the area(s) where your pain is located:



If you have both back and leg pain what percent is Back \_\_\_\_\_ % Leg \_\_\_\_\_ %

**On a scale from 0 (no pain) to 10 (excruciating) rate your pain:**

At its WORST: \_\_\_\_\_ At its LEAST: \_\_\_\_\_ At its USUAL: \_\_\_\_\_ TODAY: \_\_\_\_\_

**Circle all that apply:**

Burning \_ Weakness \_ Aching \_ Tingling \_ Throbbing \_ Coldness \_ Sharp \_ Skin Discoloration \_ Dull \_ Muscle Spasms \_ Shooting Muscle \_ Tightness \_ Numbness \_ Increased Swelling \_ Bowel and/or Bladder problems \_ Other: \_\_\_\_\_

**Circle any form of treatment received for pain:**

Injections/Blocks When? \_\_\_\_\_ Where: \_\_\_\_\_ Physical/Occupational Therapy \_  
Chiropractor/Manipulation Acupuncture \_ Hypnosis \_ TENS Unit \_ Psychotherapy/Psychiatric Therapy

**Check any tests perform for evaluation of pain:**

<input type="checkbox"/> Lumbar MRI	Where? _____	Date (if known) _____
<input type="checkbox"/> Cervical MRI	Where? _____	Date (if known) _____
<input type="checkbox"/> CT Scan	Where? _____	Date (if known) _____
<input type="checkbox"/> Myelogram	Where? _____	Date (if known) _____
<input type="checkbox"/> X-Rays	Where? _____	Date (if known) _____
<input type="checkbox"/> Bone Scan	Where? _____	Date (if known) _____
<input type="checkbox"/> EMG	Where? _____	Date (if known) _____
<input type="checkbox"/> Discogram	Where? _____	Date (if known) _____

**List ALL current medications: (continue on back if needed or attach list)**

\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES TO MEDICATIONS:** \_\_\_\_\_

**Medical History - Circle all that apply**

Arthritis	Bone Disease	Anxiety	High Blood Pressure
Glaucoma/cataracts	Muscular Disorder	Epilepsy or Seizure	High Cholesterol
Hepatitis	Blood Transfusion	Muscular Disorder	Any Type of Infection
Kidney Disease	Bone Disease	Jaundice	Describe: _____
Blood Disease/Anemia	Paralysis	Diabetes	_____
Heart Attack/CAD/CHF	GI/Stomach Disorder	Thyroid Disease	COPD/Emphysema
Positive HIV/AIDS Test	Psychiatric or Mental Disorder	Heart Murmur	Cancer Type: _____
Anticoagulant Therapy	Depression	Abnormal EKG	Asthma
Asthma	Abnormal Bleeding Tendencies	Fracture of Neck/Back	

**Family Medical History:** \_\_\_\_\_

**Past Surgical History**

Surgery: _____	Year: _____
Surgery: _____	Year: _____
Surgery: _____	Year: _____
Surgery: _____	Year: _____
Surgery: _____	Year: _____

**Social History – Check all that apply**

Drink Alcohol: (Circle One) Occasionally Frequently Daily  
 Use street drugs or have a history of substance addiction/abuse  
 Use Tobacco \_\_\_\_ Pack per day

Are you pregnant or trying to become pregnant? Yes No

Marital Status: (Circle) Married Single Divorced Widowed Number of Children: \_\_\_\_

Level of Education: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Currently Working? Yes No

Are you disabled? No Yes Permanent Restrictions? \_\_\_\_\_ % of Disability \_\_\_\_\_

**Circle any of the following symptoms you currently have:**

Paralysis	Irregular Heartbeat	Blood in Urine
Fever	Wheezing	Shortness of Breath
Coughing	Muscle Aches	Diarrhea/Constipation
Numbness	Sore Throat	Unexpected Weight Loss
Fatigue	Heartburn	Weakness
Vomiting	Headaches	Urinary Pain/Discomfort
Other _____	Chest Pain	Skin rashes