

Existing Patient Change of Diagnosis  
Brian H. Siegel, M.D.

Referred by \_\_\_\_\_ City \_\_\_\_\_

Family Physician \_\_\_\_\_ City \_\_\_\_\_

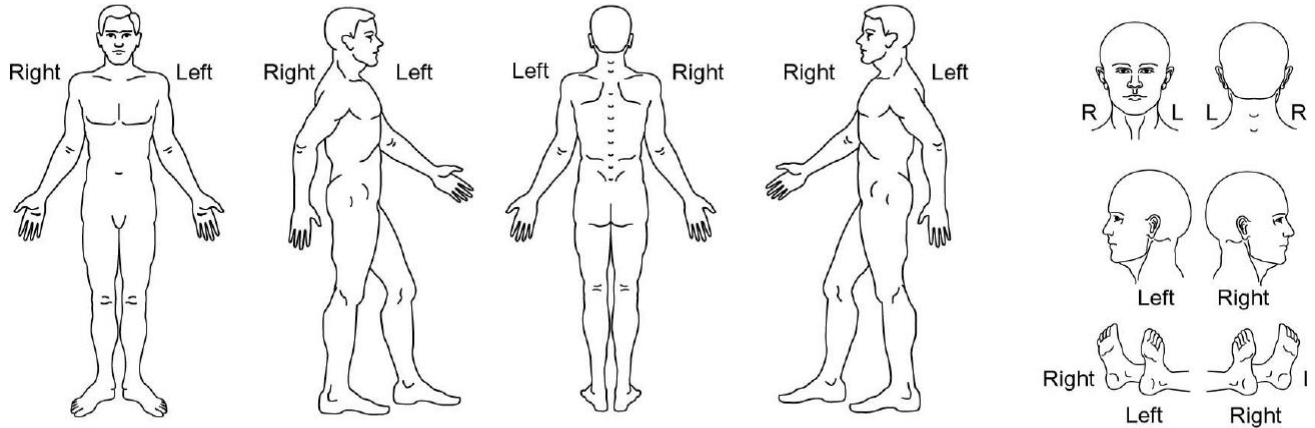
Brief Description of Pain Complaint: \_\_\_\_\_  
\_\_\_\_\_

1. When did your pain start? \_\_\_\_\_

2. How did your pain start? \_\_\_\_\_

3. Rate your pain by **CIRCLING** the number that best describes your pain right now.  
No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine  
**Goal of acceptable level of pain:**  
No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

4. Shade on the diagram your painful areas



5. **CIRCLE** the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable

6. Which of the following best describes the duration of your pain?

<input type="radio"/> Constant	<input type="radio"/> Rhythmic	<input type="radio"/> Intermittent
<input type="radio"/> Brief	<input type="radio"/> Momentary	<input type="radio"/> Transient

**YAMPA VALLEY**  
MEDICAL CENTER

**Pain Management Service**  
940 Central Park Dr., Suite 202  
Steamboat Springs, CO 80487

(Patient Identification)

**7. Does your pain interfere with:**

- Socialization
- Work
- Walking
- Relations with other people
- Enjoyment of life
- Sexuality
- Moods

**8. Is your pain associated with any of the following?**

- Numbness
- Weakness
- Muscle spasm
- Tingling, pins and needles
- Coldness
- Increased sweating
- Skin discoloration

**9. What makes your pain worse?**

- Sitting
- Walking
- Standing
- Physical activity
- Twisting
- Riding in a car
- Lying down

**10. What makes your pain better?** \_\_\_\_\_

**11. Are you undergoing physical therapy and if so where?** \_\_\_\_\_

**12. Check the box if you have had any of the following:**

- X-rays
- Myelogram
- MRI
- Cat Scan
- EMG
- Nerve conduction
- Bone Scan

Where were these studies performed? \_\_\_\_\_

**13. Have you ever had any of the following for pain relief?**

- Trigger Points
- Traction
- Relaxation
- Steroid injections
- Psychotherapy
- Hypnosis
- Acupuncture
- Biofeedback
- Chiropractor
- Heat
- Tens
- Cold Compresses

**14. Do you have any of the following?**

- Headaches
- Vision Problems
- Hearing Problems
- Dizziness
- Difficulty Swallowing
- Chronic Fatigue
- Stomach Pain
- Nausea
- Vomiting
- Constipation
- Diarrhea
- Chest Pain
- Shortness of Breath
- Urinary Problems
- Rashes
- Swollen Joints

**15. How do you sleep?**

- Good
- Fair
- Poor

**Food intake?**

- Good
- Fair
- Poor

**Activity?**

- Good
- Fair
- Poor

**14. List all current medications and their doses:**

---




---



---



---

 <p><b>Pain Management Service</b>  <b>940 Central Park Dr., Suite 202</b>  <b>Steamboat Springs, CO 80487</b></p>	<p>(Patient Identification)</p>
---	---------------------------------

