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IPA
INTEGRATED PAIN ASSOCIATES

Dr. Benjamin Lowry
Dr. Brian Goentzel

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Office: (254) 400-2225 Fax: (254) 227-5670

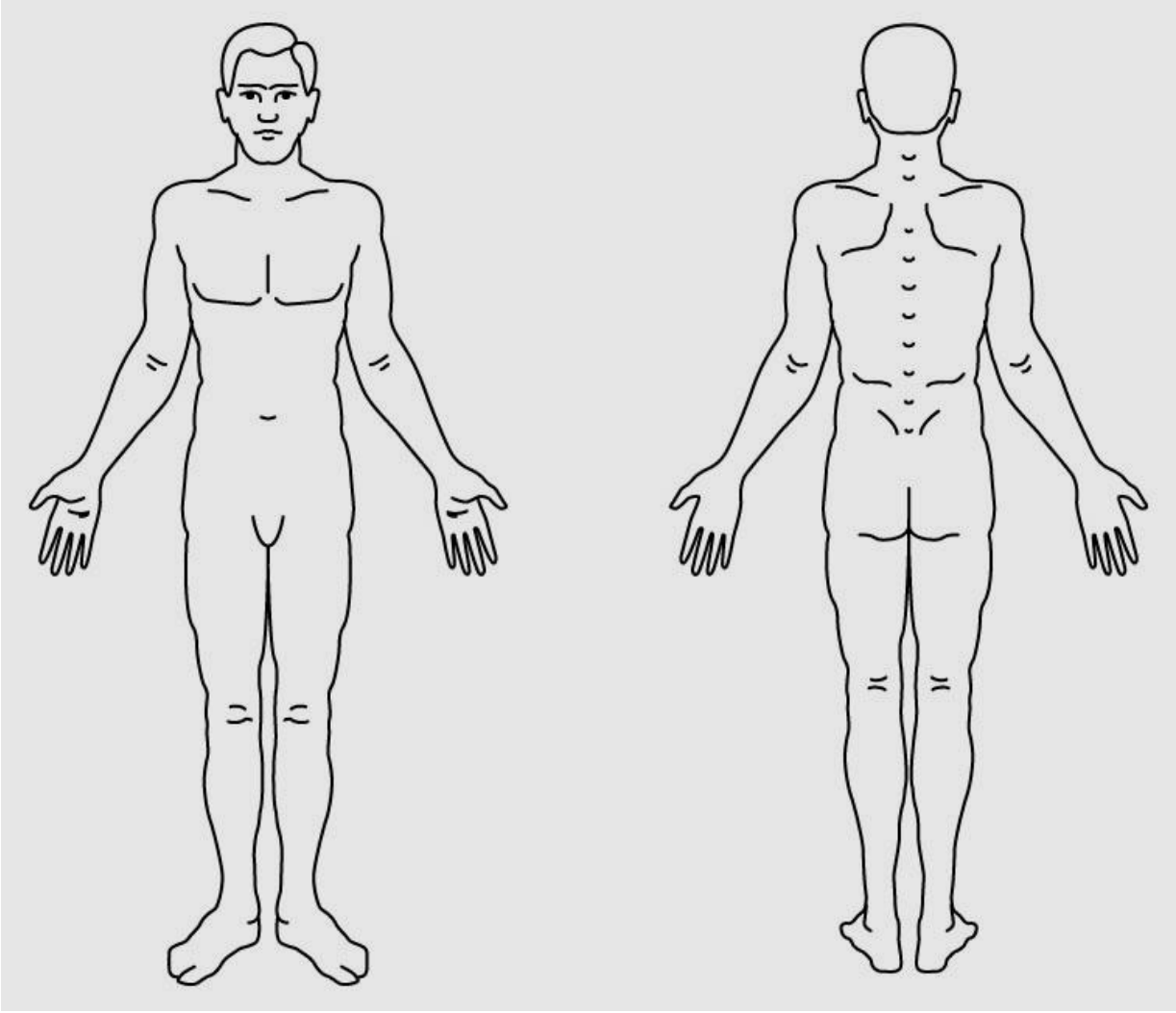
PAIN MANAGEMENT SPECIALISTS

PAIN ASSESSMENT QUESTIONNAIRE

Please take a few minutes to fill out this medical intake to facilitate your appointment today.

Reason for your visit today: _____

Please use the diagram below to describe the location of your pain.



Please check all that apply to describe your pain

◯ Aching ◯ Constant ◯ Numbing ◯ Burning ◯ Sharp ◯ Stinging ◯ Stabbing ◯ Tingling

◯ Dull ◯ Cramping ◯ Radiating ◯ Hot to Touch ◯ Other: _____

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When did you first have this pain? _____

Is the pain constant? ◯ YES ◯ NO How long does the pain last? _____

Please select the appropriate choice to describe the amount of your daily average pain on a scale of 0-10.

◯ 0 (no pain) ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10(worst pain)

Please rate your pain without pain medication on a scale from 0 to 10

◯ 0 (no pain) ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10(worst pain)

Is your pain the result of an ☐ accident ☐ illness ☐ unsure ☐ N/A

If yes, please describe:_____

If accident, is there litigation involved? ☐ YES ☐ NO If yes, please provide your case worker and contact information: _____ Contact number: _____

Have your tried Physical Therapy? ◯ YES ◯ NO When? _____ For how long? _____

Did this help? ◯ YES ◯ NO

Have you been treated by a Pain Specialist in the past? ◯ YES ◯ NO

When? _____By who?_____

Previous Treatments

Treatment	Area of body	Date	Relief ?		If yes, how much
Epidural Injections			Yes	No	
Joint Injections			Yes	No	
Muscle Injections			Yes	No	
Nerve Blocks			Yes	No	
Radiofrequency Ablations			Yes	No	
Stimulator Trial			Yes	No	
Stimulator Implant			Yes	No	
Botox			Yes	No	
Chiropractic Care			Yes	No	

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MEDICAL HISTORY QUESTIONNAIRE

Dear New Pain Management Patient,
Welcome to INTEGRATED PAIN ASSOCIATES. Please take a few moments to carefully and completely fill out the following questions regarding your pain history and medical history. Accurate completion of this form is important, so please ask the receptionist or the nurse if you have any questions. When choices are given, mark the answer that is most correct. At INTEGRATED PAIN ASSOCIATES, your time is important to us. We greatly appreciate your arriving on time and will always do our best to stay on schedule. Occasionally, we do get behind schedule because of emergencies or because prior patients have required more time for their appointment than we had anticipated. In the event that this happens, please be assured that you will be seen as soon as possible and always in the order which you were scheduled.

Your Medical History
Are you currently experiencing any of the following issues below?

Yes	No	Issue	Yes	No	Issue
Yes	No	Chills	Yes	No	Hallucinations
Yes	No	Night sweats	Yes	No	Pain with urination
Yes	No	Fever	Yes	No	Difficulty controlling urine
Yes	No	Visual changes	Yes	No	Erectile dysfunction
Yes	No	Constipation	Yes	No	Swelling
Yes	No	Nausea	Yes	No	Stiffness
Yes	No	Vomiting	Yes	No	Joint pain
Yes	No	Decrease in sex drive	Yes	No	Loss of body hair
Yes	No	Chest pains	Yes	No	Memory loss
Yes	No	Headaches	Yes	No	Numbness
Yes	No	Shortness of breath	Yes	No	Bleeding disorder
Yes	No	Sores	Yes	No	Rash

Have you ever been diagnosed with the following condition?

☐ AIDS ☐ Asthma ☐ Cancer ☐ Diabetes ☐ Emphysema ☐ Epilepsy ☐ Fibromyalgia ☐ Stroke
☐ HIV Positive ☐ Heart Disease ☐ Hepatitis (A, B, C ,D) ☐ High Blood Pressure ☐ Kidney Disease
☐ Lupus ☐ Migraines ☐ Osteoarthritis ☐ Peripheral Vascular Disease ☐ Shingles ☐ Arthritis

Are you currently pregnant? ◯ YES ◯ NO If yes, how far along? _____

Sleep Behavior

Have you ever been evaluated for sleep apnea with a sleep study? ◯ YES ◯ NO

Were you diagnosed with sleep apnea? ◯ YES ◯ NO

If yes, are you currently using a CPAP machine or BiPAP machine? ◯ YES ◯ NO

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Surgical History

Do you currently have an implanted ICD, Pacemaker, defibrillator or any surgical steel? ◯ YES ◯ NO

If yes, please provide a copy for our staff to update your medical record.

Please list prior surgeries or procedures you have completed in the past 5 years.

Date	Surgery/procedure	Physician

Please list the diagnostic tests you have received. Please include the approximate date and location in which the testing was performed in the past 5 years.

Diagnostic test	Area of body	Date	Location
X-RAY			
X-RAY			
X-RAY			
MRI SCAN			
MRI SCAN			
MRI SCAN			
CT SCAN			
CT SCAN			
CT SCAN			
EMG			
EMG			

Psychological History

Have you ever been diagnosed with or received treatment/evaluation for any of the following diagnosis/problems?

☐ Alzheimer's ☐ Anxiety ☐ Bipolar Disease ☐ Dementia ☐ Depression
☐ Multiple Personality Disorder ☐ Schizophrenia ☐ Other: _____

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Social History

Do you have a history of Drug use, addiction or abuse? ☐ YES ☐ NO
If yes, explain_____

Have you ever used any drugs that are illegal in Texas? (Cocaine, marijuana, ect)?
☐ YES, in the past ☐ NO, never If in the past, when? _____

Have you ever been treated for addiction or alcoholism?
☐ YES, in the past ☐ NO, never If in the past, when? _____

Do you have a history of alcohol abuse or addiction? ☐ YES ☐ NO

Do you currently drink alcohol? ☐ YES ☐ NO

If yes what kind, how much and how often?

Do you use tobacco? ☐ YES ☐ NO ☐ Smokeless ☐ tobacco ☐ Cigar ☐ Cigarettes ☐ Dip

If you smoke cigarettes, how many packs per day?
☐ Less than ☐ 1 ☐ 1 ☐ 2 ☐ 3 ☐ More than 3 packs

Have you ever had an issue with prescription medications (misuse, abuse, addiction, ect)?
☐ YES, in the past ☐ NO, never If in the past, when? _____

Lifestyle

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed Separated

Current living situation
☐ Alone ☐ Spouse ☐ With Family ☐ Friend ☐ Long Term/ Assisted Living Facility

Employment Status
☐ Currently Employed ☐ Retired ☐ Disabled ☐ Unemployed
If currently working what type of work: _____
☐ Full time ☐ Part time

Weight Questionnaire
Have you had a recent weight ☐ loss ☐ Gain? ☐ No ☐ Yes
If yes, how much? _____ Time frame? _____

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Current Medications

Please list ALL pain related medications that you are currently taking or provide our office with a current list.

Name of Medication	Strength	How often

Integrated Pain Associates would like to access your pharmacy records and drug formulary information through a third party database. This service provides IPA with accurate information from other prescribing physicians and will allow our system to check which medications are on your drug formulary.

I authorize Integrated Pain Associates access to my prescription history through my pharmacy or access through certain third party databases.

Patient Signature: _____ Date: _____

Medication Allergies and Side Effects

Please list ALL medication allergies or side effects that you have experienced.

Name of Medication	Reaction /Side Effect

Are you allergic to Latex? ☐ YES ☐ NO

Are you allergic to Iodine? ☐ YES ☐ NO

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Pain Medication History
Please mark all medications that you have tried in the past.

Opioid Medications	Duration of Use	Relief?		If no, please explain
Baclofen		Yes	No	
Buspar		Yes	No	
Butrans Patch		Yes	No	
Celebrex		Yes	No	
Codeine		Yes	No	
Cymbalta		Yes	No	
Diclofenac		Yes	No	
Dilaudid		Yes	No	
Embeda		Yes	No	
Fentanyl Patches		Yes	No	
Flector Patch		Yes	No	
Flexeril		Yes	No	
Gabapentin		Yes	No	
Hydrocodone		Yes	No	
Imitrex		Yes	No	
Keppra		Yes	No	
Lyrica		Yes	No	
Maxalt		Yes	No	
Methadone		Yes	No	
Mobic		Yes	No	
Morphine		Yes	No	
Motrin		Yes	No	
Naproxen		Yes	No	
Nucynta		Yes	No	
Opana		Yes	No	
Oxycontin		Yes	No	
Oxycodone		Yes	No	
Robaxin		Yes	No	
Soma		Yes	No	
Tramadol		Yes	No	
Tylenol		Yes	No	
Zanaflex		Yes	No	
Zohydro		Yes	No	
Other:		Yes	No	
Other:		Yes	No	
Other:		Yes	No	

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Family History
Do any of your family members have a history of or are currently suffering from any of the following medical conditions.

Medical Condition	Suffering?		Who?	Side of the family?	
Addiction/substance abuse	Yes	No		Paternal	Maternal
Alcoholism	Yes	No		Paternal	Maternal
Anxiety	Yes	No		Paternal	Maternal
Arthritis	Yes	No		Paternal	Maternal
Cancer	Yes	No		Paternal	Maternal
Chronic Pain	Yes	No		Paternal	Maternal
Depression	Yes	No		Paternal	Maternal
Diabetes	Yes	No		Paternal	Maternal
Heart Disease	Yes	No		Paternal	Maternal
Hypertension	Yes	No		Paternal	Maternal
Stroke	Yes	No		Paternal	Maternal
Mental Illness	Yes	No		Paternal	Maternal
Other:	Yes	No		Paternal	Maternal

Treatment Goals

We are dedicated to helping you improve your quality of life. Please list your personal pain goals that you would like to achieve.

Examples: Biking, Dancing, Hiking, ect

_____

_____

_____.

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Opioid Risk Tool (ORT)

MARK EACH BOX THAT APPLIES	FEMALE	MALE
FAMILY HISTORY OF SUBSTANCE ABUSE		
ALCOHOL	☐ 1	☐ 3
ILLEGAL DRUGS	☐ 2	☐ 3
PRESCRIPTIONS DRUGS	☐ 4	☐ 4
PERSONAL HISTORY OF SUBSTANCE ABUSE		
ALCOHOL	☐ 1	☐ 3
ILLEGAL DRUGS	☐ 2	☐ 3
PRESCRIPTIONS DRUGS	☐ 4	☐ 4
AGE BETWEEN 16 AND 45 YEARS	☐ 1	☐ 1
HISTORY OF PREADOLESCENT SEXUAL ABUSE	☐ 3	☐ 0
PYSCHOLOGICAL DISEASE		
ADD, OCD, BIPOLAR, SCHIZOPHRENIA	☐ 2	☐ 2
DEPRESSION	☐ 1	☐ 1
SCORING TOTALS		

SCORING (RISK)

0-3= LOW 4-7=MODERATE ≥8=HIGH