

**NORTHWEST
SUBURBAN
PAIN CENTER**

Name of Pain Physician **Dr.Ahsan Dr.Bukhalo**
Appointment Date _____ / _____ / _____

Telephone (847)255-0900
FAX (847)255-4344

PATIENT INFORMATION- PLEASE PRINT

Who referred you? _____ **Primary care physician** _____

Your name _____ **Sex** _____ **Date of Birth:** ____/____/____
Last First MI

Home phone number () _____ - _____ **Work phone number** () _____ - _____

Home address _____

City _____ **State** _____ **Zip Code** _____

Please describe your current status by checking the appropriate category:

____ Working full-time ____ Working part-time
____ Retired ____ Unable to work due to painful condition
____ Semi Retired

My previous or current employment is: _____

Do you live alone? ____ Yes ____ No If 'No', with whom do you live with? _____

What is your marital status? ____ Single ____ Married ____ Widowed ____ Divorced ____ Other

Have you had any of the following tests done within the last 3 years?

____ X-Rays ____ EMG ____ CT Scan ____ MRI ____ Bone Scan

Other diagnostic tests/procedures _____

Please describe the location of your pain: _____

When did the pain first seem to be a problem? (Check appropriate category with the date pain started if possible)

____ On-the-job injury date ____/____/____ ____ Car accident date ____/____/____

____ Related to cancer date ____/____/____ ____ No exact date time when pain first began

Please use this section to provide other information on your pain including circumstances of accident if work related. It is also helpful to know what you feel makes the pain better or worse.

PATIENT INFORMATION - PAIN ASSESSMENT

- Please indicate on the line below, the level of pain that you feel **TODAY**. Your average pain score can be anywhere between the two extremes shown on the line. Circle the number score which most closely matches how your pain feels **today**.

No pain _____ Pain feels as bad as it can be. ("10" is considered hospitalization type of pain)
0 1 2 3 4 5 6 7 8 9 10

- Please indicate on the line below the average pain level you have felt in the past week. Your average pain score can be anywhere between the same two (2) extremes.

No pain _____ Pain feels as bad as it can be. ("10" is considered hospitalization type of pain)
0 1 2 3 4 5 6 7 8 9 10

WHERE IS YOUR PAIN?

Please look carefully at the pain distribution diagram which follows this questionnaire. Use the diagram to help us understand more about the pain you have been experiencing. **Mark on the diagram where your pain is.**

HEALTH HISTORY & FAMILY HISTORY

Do you have any medical problems the doctor should know about? _____ NO _____ YES

If your answer is 'YES', please list conditions you have been diagnosed or treated for in the past.

Have you had any surgeries or operations? _____ NO _____ YES

If your answer is "YES", please list all surgeries or operations performed and dates when they were performed.

Please check any of the following conditions that are part of your **family's medical history**.

Depression Neck/Back problems Neck/Back surgeries or operations
 Chronic Pain Fibromyalgia Migraine Headaches
 Heart Disease Cancer Arthritis or joint replacement surgery

Is there any other family history you feel we should be aware of? (If yes, please explain).

What time do you go to bed? _____ How many hours of sleep do you get per night? _____

How would you rate your sleeping pattern now? _____ Poor _____ Fair _____ Good _____ Very good

How would you rate your appetite now? _____ Poor _____ Fair _____ Good _____ Very good

