

Pain Management  
Initial Consultation

<b>Patient Name:</b>
<b>DOB:</b>
<b>MR#:</b>

<b>Allergies</b>	<b>Med. Reactions/Allergies</b> <input type="checkbox"/> NKA <input type="checkbox"/> NKDA <input type="checkbox"/> NKA to tape <input type="checkbox"/> NKA to latex <input type="checkbox"/> NKA to IV contrast <input type="checkbox"/> NKA foods								
	<b>Substance</b>		<b>Reaction</b>		<b>Substance</b>		<b>Reaction</b>		
<b>Medications</b>	<b>Anticoagulant Medications:</b> (Coumadin, Warfarin, Low Molecular weight Heparin, Lovenox, Fragmin, Innohep) <input type="checkbox"/> Other <input type="checkbox"/> None								
	<b>Antiplatelet Medications:</b> (Plavix, Platel, Ticlid) <input type="checkbox"/> Other <input type="checkbox"/> None								
	<b>Medication:</b> (List all current medications including over the counter medications and herbs with doses/schedule)								
	<hr/> <hr/> <hr/> <hr/>								
<b>Medical History</b>	<b>Have you ever Had:</b>								
	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>	
			Aids/HIV Positive			Emphysema/Bronchitis			Osteoporosis
			Anemia			Epilepsy			Psychiatric/Emotional Problems
			Anxiety/Depression			Gall Bladder Disease			Sickle Cell Trait or Disease
			Arthritis			Glaucoma			Ulcers/Gastroesophageal Reflux
			Asthma			Heart Disease			Stroke
			Bleeding Disorders			Hepatitis/Liver Disease			Thyroid Disease/Other Gland Problems
			Cancer/Lymphoma Leukemia			High Blood Pressure			Tuberculosis/recent infection History of MRSA (Staph) infection
			Depression			High Cholesterol			Blood Clots/Bleeding Disorders
		Diabetes			Kidney Disease			Hospitalization	
					Migraines/Headaches			Other: _____	
<b>Surgical History</b>	List type of Surgery & Year Performed: <input type="checkbox"/> None				<b>Hospital Admissions</b>	List Non-Surgical Hospitalization and Reason for them: <input type="checkbox"/> None			
	1.					1.			
	2.					2.			
	3.					3.			
	4.					4.			
	5.					5.			
	6.					6.			
	7.					7.			
	8.					8.			
	9.					9.			

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<b>Social History</b>	Presently Employed <input type="checkbox"/> Yes <input type="checkbox"/> No      Occupation or Previous Occupation: _____	
	Tobacco use: <input type="checkbox"/> Yes <input type="checkbox"/> No    ___Packs/Day___ No. of Years    Marital Status: _____ Children <input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol Use: <input type="checkbox"/> Yes <input type="checkbox"/> No    How Often (amount/type): _____      Street Drugs: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Review of Systems</b>	<b>Skin:</b> <input type="checkbox"/> <b>No significant History</b> <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Acne <input type="checkbox"/> Other: _____	<b>Hematologic:</b> <input type="checkbox"/> <b>No significant History</b> <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Easy Bleeding <input type="checkbox"/> Clots <input type="checkbox"/> Anemia
	<b>HEENT:</b> <input type="checkbox"/> <b>No significant History</b> <input type="checkbox"/> Tinnitus <input type="checkbox"/> Dysphasia <input type="checkbox"/> Glasses/Contact Lenses <input type="checkbox"/> Visual Disturbances <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Hair Piece/Weave <input type="checkbox"/> Discharge <input type="checkbox"/> Dentures <input type="checkbox"/> Other: _____	
<b>Review of Systems</b>	<b>Neurologic:</b> <input type="checkbox"/> <b>No significant History</b> <input type="checkbox"/> Headaches <input type="checkbox"/> Memory Loss <input type="checkbox"/> Back/Neck Pain <input type="checkbox"/> Dizziness <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Numbness <input type="checkbox"/> Paralysis <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Seizures <input type="checkbox"/> Other: _____	
	<b>Cardiovascular:</b> <input type="checkbox"/> <b>No significant History</b> <input type="checkbox"/> Chest Pain <input type="checkbox"/> HTN <input type="checkbox"/> AICD <input type="checkbox"/> MI <input type="checkbox"/> Palpitations <input type="checkbox"/> Angina <input type="checkbox"/> Syncope <input type="checkbox"/> Pacemaker <input type="checkbox"/> Other: _____	
<b>Review of Systems</b>	<b>Gastrointestinal:</b> <input type="checkbox"/> <b>No significant History</b> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Reflux <input type="checkbox"/> Jaundice <input type="checkbox"/> Change of Appetite <input type="checkbox"/> Change in Bowel Habits <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Weight Change <input type="checkbox"/> Other: _____	
	<b>Urinary:</b> <input type="checkbox"/> <b>No significant History</b> <input type="checkbox"/> Dysuria <input type="checkbox"/> Polyuria <input type="checkbox"/> Renal Failure <input type="checkbox"/> Frequency/Hesitancy <input type="checkbox"/> Hematuria <input type="checkbox"/> Other: _____	<b>OB/GYN:</b> <input type="checkbox"/> <b>No significant History</b> <input type="checkbox"/> Dysmenorrheal <input type="checkbox"/> Possibility of Pregnancy <input type="checkbox"/> Cancer <input type="checkbox"/> Other: _____
<b>Review of Systems</b>	<b>Endocrine:</b> <input type="checkbox"/> <b>No significant History</b> <input type="checkbox"/> Heat or Cold Intolerance <input type="checkbox"/> Polyuria <input type="checkbox"/> Renal Failure <input type="checkbox"/> Frequency/Hesitancy <input type="checkbox"/> Hematuria <input type="checkbox"/> Other: _____	<b>Immunological:</b> <input type="checkbox"/> <b>No significant History</b> <input type="checkbox"/> Scleroderma <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus
	<b>Pulmonary:</b> <input type="checkbox"/> <b>No significant History</b> <input type="checkbox"/> Pneumonia <input type="checkbox"/> Orthopnea <input type="checkbox"/> SOB <input type="checkbox"/> TB <input type="checkbox"/> Asthma <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Cough <input type="checkbox"/> DOE <input type="checkbox"/> Emphysema	
<b>Review of Systems</b>	<b>Musculoskeletal:</b> <input type="checkbox"/> <b>No significant History</b> <input type="checkbox"/> Pain <input type="checkbox"/> DVT <input type="checkbox"/> Arthritis <input type="checkbox"/> Swelling	<b>Body Piercing:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    Where: _____ <b>Prosthesis:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    Where: _____
	<b>PLEASE CHECK THE BOX IF ANYONE IN YOUR FAMILY HAS THE FOLLOWING AND LIST WHICH FAMILY MEMBER.</b>	
<b>Family History</b>	Yes No <input type="checkbox"/> <input type="checkbox"/> Birth Defects: _____ <input type="checkbox"/> <input type="checkbox"/> Breast Disease: _____ <input type="checkbox"/> <input type="checkbox"/> Cancer(Breast,Ovarian,Colon): _____ <input type="checkbox"/> <input type="checkbox"/> Diabetes: _____ <input type="checkbox"/> <input type="checkbox"/> Heart Attack before age 50: _____ <input type="checkbox"/> <input type="checkbox"/> Heart Disease: _____	Yes No <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure: _____ <input type="checkbox"/> <input type="checkbox"/> High Cholesterol: _____ <input type="checkbox"/> <input type="checkbox"/> Osteoporosis: _____ <input type="checkbox"/> <input type="checkbox"/> Stroke: _____ <input type="checkbox"/> <input type="checkbox"/> Bleeding Disorders: _____ <input type="checkbox"/> <input type="checkbox"/> Other: _____

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**Pain History**

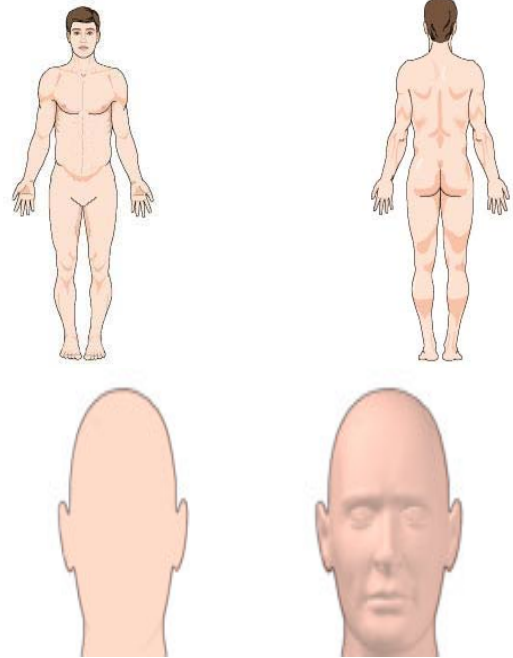
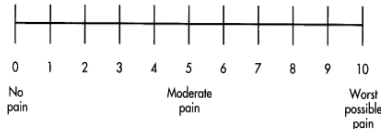
**Location of Pain or Other Symptoms:**

On Diagram indicate pain location

**Circle type of Pain/Symptom**

- Pressure
- Burning
- Achy
- Stabbing
- Numbness
- Pins & Needles

**Pain Intensity:**



Location of Pain: \_\_\_\_\_

Other Related Symptoms: \_\_\_\_\_

What Makes Pain Better/Worse: \_\_\_\_\_

Pain History, (When, How did your pain begin, has it changes): \_\_\_\_\_

Procedures and Medication tried in the Past: \_\_\_\_\_

Previous Pain Doctor: \_\_\_\_\_

What are your goals: \_\_\_\_\_


What would you do if your pain decreased: \_\_\_\_\_

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**PAIN MANAGEMENT INITIAL  
CONSULTATION**

<b>Physical Examination</b>	BP _____ P _____ T _____ Height _____ Weight _____
	GA: <input type="checkbox"/> WD/WN SKIN: <input type="checkbox"/> No lesions <input type="checkbox"/> No Bruises
	HEENT: <input type="checkbox"/> NC/AT CHEST: <input type="checkbox"/> Clear COR: <input type="checkbox"/> RRR S <sub>1</sub> S <sub>2</sub>
	ABDOMEN: <input type="checkbox"/> S/NT + BS EXT: <input type="checkbox"/> No C/C/E
	NEURO: <input type="checkbox"/> A & O
	SENSORY MOTOR
	LUMBAR: FLEX EXT ROT CERVICAL FLEX EXT ROT
	DTR:
	SLR: L  R FABER: L R
	CERVICAL TENDERNESS C- RLM SPASM C- R L M
LUMBROSACRAL TENDERNESS C- RLM SPASM C- R L M	
SIJ TROCHANTERIC SCIATIC NOTCH	
<b>Imaging</b>	MRI/CT:
	EMG/NOV:
	XRAYs:
<b>Assessment Plan</b>	Assessment:

**Dr. Bruce H. Levin**  
**Interventional Pain Management**  
**Board & Subspecialty Board Certified**

1. I consent Dr. Bruce Levin, MD or another doctor he may designate to perform upon me the following operation, procedure and/or medical treatment with or without Fluroscopic, Ultrasound, CT, or MRI guidance:

Cervical Thoracic Lumbar Facet injections of steroid and local anesthetic  
Levels:

Cervical Thoracic Lumbar Transforaminal epidural injections of steroid and local anesthetic.  
Levels:

Other:

2. The information listed below has been explained to me about the operation, procedure and/or medical treatment.

The nature and extent of the operation, procedure and/or treatment.

- Other types of treatment I could choose and what may happen if I do not have treatment.
- Possible complications include, but are not limited to:

Death, infection, headache, drug or other allergic or adverse reactions to steroids or local anesthetic effects, respiratory arrest, heart attack, abscess, collapsed lung, organ perforation, stroke, seizure, paralysis, weakness, nerve damage, new or increased pain or worsening of symptoms, bleeding, blood clot, blood vessel damage, occlusion or dissection, disability, exacerbation of other medical conditions, spinal cord injury, total spinal, vegetative state, fetal damage or death if pregnant.

The information was provided to me in terms that I understand. I am aware that the practice of medicine is not an exact science. I agree that no guarantee of results, success or cure has been given to me.

If, in the opinion of my doctor, any conditions are found in the course of the treatment which require additional or different treatment than those listed above, I allow my doctor to perform such procedures.

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3. If I am prescribed an opioid or other medication, I understand it is my obligation to take them as directed. I understand that all treating physicians are to be made aware that I am receiving these medications and that I will not receive these medications from another physician. I

understand that I will be required to undergo random urine drug screens. It is my understanding that failure of these points will result in my discharge from the practice.

4. I understand that my doctors or others may need to administer conscious sedation injections and/or nerve blocks. If so, the possible complications of the type of planned anesthesia have been explained to me.

5. I consent to the taking and publication of any videographic or photographic reports in the course of treatment for inclusion in my medical record for treatment, education or other purposes.

6. I consent to the release of my Social Security number to the manufacturer of any surgical implants.

7. I understand that I can change my mind any time before this procedure and withdraw my consent in whole or in part by indicating on this form.

8. I understand that my doctor and those doctors that care for me in a hospital or outpatient facility may not be employees of agent of that facility. I will receive a separate bill for their services.

9. I certify that I read this consent form or it has been read to me. I understand the information in this form, and all of my questions were answered to my satisfaction.

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Signature of Patient/Authorized Representative and Relationship

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Witness to Signature

\_\_\_\_\_  
Second Witness (if verbal consent)

I have explained the nature of the above treatment as well as reasonably anticipated risks, complications, and alternative to such treatment.

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Signature of Physician

I certify that I have had the above referenced procedures at the levels noted and have received and understood all postoperative instructions given to me.

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Signature of Patient/Authorized Representative and Relationship