RMH Pain Management

1310 N Main St.
Rushville, IN 46173
Phone: (765) 932-7600
Fax: (765)932-7609

Please ***READ*** the information below and follow the steps to receive your Pain Management appointment:

- Please fill out the following paperwork in this entirety.
- Return your completed packet to the office or place the paperwork in the pre-stamped, pre-addressed envelope and mail it to the office.
- Expect a call from a member of our staff in 5-7 days from mailing your packet. If you do not receive a call from us in that time, please call (765) 932-7600 to confirm we have received your packet. **Appointments will not be made until we have received your completed packet.** Thank you!

We look forward to seeing you at Rush Memorial Hospital Pain Management.

General Information Sheet

Office Hours:

Office hours will alternate on the following, repeating schedule:
Week 1 - Wed, Thur and Fri - 8am-5pm
Week 2 - Wed, Thur and Fri - 8am-5pm
Week 3 - Wed, Thur and Fri - 8am-5pm
Week 4 - Mon, Wed, Thur and Fri - 8am-5pm
Week 5 - Wed, Thur and Fri - 8am-5pm

Appointment Expectations:

- Please give a 24- hour notice for cancellations.
- If you do not show for an appointment 3 or more times, you may be discharged from the practice.
- Treatment for your condition will be determined by the doctor on a case by case basis. In some cases, there is structural damage that cannot be reversed by these treatments.
- In such cases where the patients have failed all other treatment modalities, the goal is to reduce the pain and improve the quality of life.
- When you arrive, a nurse will take a very thorough history. You will then be examined by the physician after he has reviewed your test results and history. He then will discuss his findings with you and recommend an individualized treatment plan.

  We will make every attempt to be on time however some patients have very complex pain pathologies and require more time. Every patient, including you, will be given the time necessary to understand their pain, treatment methods, and long-term goals.

Primary Care Provider:_____
Diagnosis (if applicable):_____

RUSH MEMORIAL HOSPITAL

Pain Management New Patient Packet

Birthplace: _____

Name: _____ Birthdate: ____/____/____ Age: _____
LAST FIRST M.I. MAIDEN

Address: _____ Sex: ❒ Female ❒ Male
STREET APARTMENT #

_____ Telephone: Home (_____)_____ Work (_____)_____
CITY STATE ZIP

MARITAL STATUS: ❒ Never Married ❒ Married ❒ Divorced ❒ Separated ❒ Widowed

Spouse / Significant Other: ❒ Alive / Age ___ ❒ Deceased / Age ___ ❒ Major Illness _____

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked on average per week _____

Referred here by: (check one) ❒ Self ❒ Family ❒ Friend ❒ Doctor ❒ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Do you have an orthopedic surgeon? ❒ Yes ❒ No If yes, Name: _____

Describe briefly your present symptoms: _____

_____

_____

_____

Date symptoms began (approximate): _____

_____

Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later)

_____

_____

_____

Please list the names of other practitioners you have seen for this problem:

_____

_____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Yourself	Condition	Relative Name / Relationship	Yourself	Condition	Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.
Date of last mammogram: ___/___/___ Date of last eye exam: ___/___/___ Date of last chest x-ray: ___/___/___
Date of last Tuberculosis Test ___/___/___ Date of last bone densitometry: ___/___/___

Constitutional

❒ Recent weight gain

Amount _____

❒ Recent weight loss

Amount _____

❒ Fatigue
❒ Weakness
❒ Fever

Eyes

❒ Pain
❒ Redness
❒ Loss of vision
❒ Double of blurred vision
❒ Dryness
❒ Feels like something in eye
❒ Itching eyes

Ears – Nose – Mouth – Throat

❒ Ringing in ears
❒ Loss of hearing
❒ Nosebleeds
❒ Loss of smell
❒ Dryness in nose
❒ Runny nose
❒ Sore tongue
❒ Bleeding gums
❒ Sores in mouth
❒ Loss of taste
❒ Dryness of mouth
❒ Frequent sore throats
❒ Hoarsness
❒ Difficulty in swallowing

Cardiovascular

❒ Pain in chest
❒ Irregular heart beat
❒ Sudden changes in heart beat
❒ High blood pressure
❒ Heart murmurs

Respiratory

❒ Shortness of breath
❒ Difficulty in breathing at night
❒ Swollen legs or feet
❒ Cough
❒ Coughing of blood
❒ Wheezing (asthma)

Gastrointestinal

❒ Nausea
❒ Vomiting of blood or coffee ground material
❒ Stomach pain relieved by food or milk
❒ Jaundice
❒ Increasing constipation
❒ Persistent diarrhea
❒ Blood in stools
❒ Black stools
❒ Heartburn

Genitourinary

❒ Difficult urination
❒ Pain or burning in urination
❒ Blood in urine
❒ Cloudy, "smoky" urine
❒ Pus in urine
❒ Discharge from penis / vagina
❒ Getting up at night to pass urine
❒ Vaginal dryness
❒ Rash / ulcers
❒ Sexual difficulties
❒ Prostate trouble

For Women Only:

Age when periods began: _____
Periods regular? ❒ Yes ❒ No
How many days apart?
Date of last period? _____ / _____ / _____
Date of last pap? _____ / _____ / _____
Bleeding after menopause? ❒ Yes ❒ No
Number of pregnancies? _____
Number of miscarriages? _____

Musculoskeletal

❒ Morning stiffness

Lasting how long?

_____ Minutes _____ Hours

❒ Joint pain
❒ Muscle weakness
❒ Muscle tenderness
❒ Joint swelling

List joints affected in the last 6 months:

_____
_____
_____
_____

Integumentary (skin and / or breast)

❒ Easy bruising
❒ Redness
❒ Rash
❒ Hives
❒ Sun sensitive (sun allergy)
❒ Tightness
❒ Hair loss
❒ Hair loss
❒ Color changes of hands or feet in the cold

Neurological System

❒ Headaches
❒ Dizziness
❒ Fainting
❒ Muscle spasm
❒ Loss of consciousness
❒ Sensitivity or pain of hands and / or feet
❒ Memory loss
❒ Night sweats

Psychiatric

❒ Excessive worries
❒ Anxiety
❒ Easily losing temper
❒ Depression
❒ Agitation
❒ Difficulty falling asleep
❒ Difficulty staying asleep

Endocrine

❒ Excessive thirst

Hematologic / Lymphatic

❒ Swollen glands
❒ Tender glands
❒ Anemia
❒ Bleeding tendency
❒ Transfusion / when

_____

Allergic / Immunologic

❒ Frequent sneezing

Patient's Name: _____ Date: _____ Physician's Initials _____

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups / glasses per day? _____

Do you smoke? ❒ Yes ❒ No ❒ Past – How long ago? _____

Do you drink alcohol? ❒ Yes ❒ No – Number per week _____

Has anyone ever told you to cut down on your drinking?

❒ Yes ❒ No

Do you use drugs for reasons that are not medical? ❒ Yes ❒ No

If yes, please list: _____

_____

Do you exercise regularly? ❒ Yes ❒ No

Type: _____

Amount per week: _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ❒ Yes ❒ No

Do you wake up feeling rested? ❒ Yes ❒ No

PAST MEDICAL HISTORY

Do you or have you ever had (check if "yes")

❒ Cancer	❒ Heart Problems	❒ Asthma
❒ Goiter	❒ Leukemia	❒ Stroke
❒ Cataracts	❒ Diabetes	❒ Epilepsy
❒ Nervous breakdown	❒ Stomach ulcers	❒ Jaundice
❒ Bad headaches	❒ Rheumatic fever	❒ Colitis
❒ Kidney disease	❒ Pneumonia	❒ Psoriasis
❒ Anemia	❒ High blood pressure	❒ HIV / AIDS
❒ Emphysema	❒ Glaucoma	❒ Tuberculosis

Other significant illness (please list): _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.): _____

_____

_____

PREVIOUS OPERATIONS

Type	*Year*	*Reason*
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❒ No ❒ Yes Describe: _____

Any other serious injuries? ❒ No ❒ Yes Describe: _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings: _____ Number living: _____ Number deceased: _____

Number of children: _____ Number living: _____ Number deceased: _____ List ages of each: _____

Health of children: _____

_____

Do you know of any blood relative who has or had: (check and give relationship)

❒ Cancer _____ ❒ Heart disease _____ ❒ Rheumatic fever _____ ❒ Tuberculosis _____

❒ Leukemia _____ ❒ High blood pressure _____ ❒ Epilepsy _____ ❒ Diabetes _____

❒ Stroke _____ ❒ Bleeding tendency _____ ❒ Asthma _____ ❒ Goiter _____

❒ Colitis _____ ❒ Alcoholism _____ ❒ Psoriasis _____

Patient's Name: _____ Date: _____ Physician's Initials: _____

MEDICATIONS

Drug allergies: ❒ No ❒ Yes To what? _____

_____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check : Helped? A Lot	Some	Not At All
1.			❒	❒	❒
2.			❒	❒	❒
3.			❒	❒	❒
4.			❒	❒	❒
5.			❒	❒	❒
6.			❒	❒	❒
7.			❒	❒	❒
8.			❒	❒	❒
9.			❒	❒	❒
10.			❒	❒	❒
11.			❒	❒	❒
12.			❒	❒	❒
13.			❒	❒	❒
14.			❒	❒	❒
15.			❒	❒	❒
16.			❒	❒	❒
17.			❒	❒	❒
18.			❒	❒	❒
19.			❒	❒	❒
20.			❒	❒	❒

PAST MEDICATIONS – Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, ***how long*** you were taking the medication, the ***results*** of taking the medication and list any ***reactions*** you may have had. Record your comments in the space provided below.

Drug names / Dosage	Length of time	Please check: Helped? A Lot	Some	Not At All	Reactions
Pain Relievers					
Acetaminophen		❒	❒	❒	
Codeine (Vicodin, Tylenol 3)		❒	❒	❒	
Propoxyphene (Darvon ./ Darvocet)		❒	❒	❒	
Other:		❒	❒	❒	
Other:		❒	❒	❒	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		❒	❒	❒	
Gold shots (Myochrysine or Solganol)		❒	❒	❒	
Hydroxychloroquine (Plaquenil)		❒	❒	❒	
Penicillamine (Cuprimine or Depen)		❒	❒	❒	
Methotrexate (Rheumatrex)		❒	❒	❒	
Azathioprine (Imuran)		❒	❒	❒	
Sulfasalazine (Azulfidine)		❒	❒	❒	
Quinacrine (Atabrine)		❒	❒	❒	
Cyclophosphamide (Cytoxan)		❒	❒	❒	
Cyclosporine A (Sandimmune or Neoral)		❒	❒	❒	
Etanercept (Enbrel)		❒	❒	❒	
Infliximab (Remicade)		❒	❒	❒	
Prosorba Column		❒	❒	❒	
Other:		❒	❒	❒	

Non-Steroidal Anti-inflammatory Drugs (NSAIDs)

Circle any you have taken in the past

Ansaid (flurbiprofen)	Arthrotec (diclofenac + misoprostil)	Aspirin (including coated aspirin)	Celebrex (celecoxib)	Clinoril (sulindac)
Daypro (oxaprozin)	Disalcid (salsalate)	Dolobid (diflunisal)	Feldene (piroxicam)	Indocin (indomethacin)
Lodine (etodolac)	Meclomen (meclofenamate)	Motrin/Rufen (ibuprofen)	Nalfon (fenoprofen)	Naprosyn (naproxen)
Oruvail (ketoprofen)	Tolectin (tolmetin)	Trilisate (choline magnesium trisalicylate)	Vioxx (rofecoxib)	Voltaren (diclofenac)

Drug names / Dosage	Length of time	Please check: Helped? A Lot	Some	Not At All	Reactions
Osteoporosis Medications					
Estrogen (Premarin, etc.)		❒	❒	❒	
Alendronate (Fosamax)		❒	❒	❒	
Etidronate (Didronel)		❒	❒	❒	
Raloxifene (Evista)		❒	❒	❒	
Fluoride		❒	❒	❒	
Calcitonin injection or nasal (Miacalcin, Calcimar)		❒	❒	❒	
Risedronate (Actonel)		❒	❒	❒	
Other:		❒	❒	❒	
Other:		❒	❒	❒	
Gout Medications					
Probenecid		❒	❒	❒	
Colchicine		❒	❒	❒	
Allopurinol (Zyloprim / Lopurin)		❒	❒	❒	
Other:		❒	❒	❒	
Other:		❒	❒	❒	
Others					
Tamoxifen (Nolvadex)		❒	❒	❒	
Tilidronate (Skelid)		❒	❒	❒	
Cortisone / Prednisone		❒	❒	❒	
Hyalgan / Synvisc injections		❒	❒	❒	
Herbel or Nutritional Supplements		❒	❒	❒	
Please list supplements:					

Have you participated in any clinical trials for new medications? ❒ Yes ❒ No

If yes, please list: _____

_____

_____

_____

Patient's Name: _____ Date: _____ Physician's Initials: _____

ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ❒ Yes ❒ No If yes, how many? _____

How many people in household? _____ Relationship and age of each: _____

Who does most of the housework? _____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best described your situation; *Most of the time, I function...*

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

Because of health problems, do you have difficulty:
(Please check the appropriate response for each question)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	❒	❒	❒
Walking?	❒	❒	❒
Climbing stairs?	❒	❒	❒
Descending stairs?	❒	❒	❒
Sitting down?	❒	❒	❒
Getting up from chair?	❒	❒	❒
Touching your feet while seated?	❒	❒	❒
Reaching behind your back?	❒	❒	❒
Reaching behind your head?	❒	❒	❒
Dressing yourself?	❒	❒	❒
Going to sleep?	❒	❒	❒
Staying asleep due to pain?	❒	❒	❒
Obtaining restful sleep?	❒	❒	❒
Bathing?	❒	❒	❒
Eating?	❒	❒	❒
Working?	❒	❒	❒
Getting along with family members?	❒	❒	❒
In your sexual relationship?	❒	❒	❒
Engaging in leisure time activities?	❒	❒	❒
With morning stiffness?	❒	❒	❒
Do you use a cane, crutches, a walker or wheelchair? (circle one)	❒	❒	❒

What is the hardest thing for you to do? _____

Are you receiving disability? ❒ Yes ❒ No

Are you applying for disability? ❒ Yes ❒ No

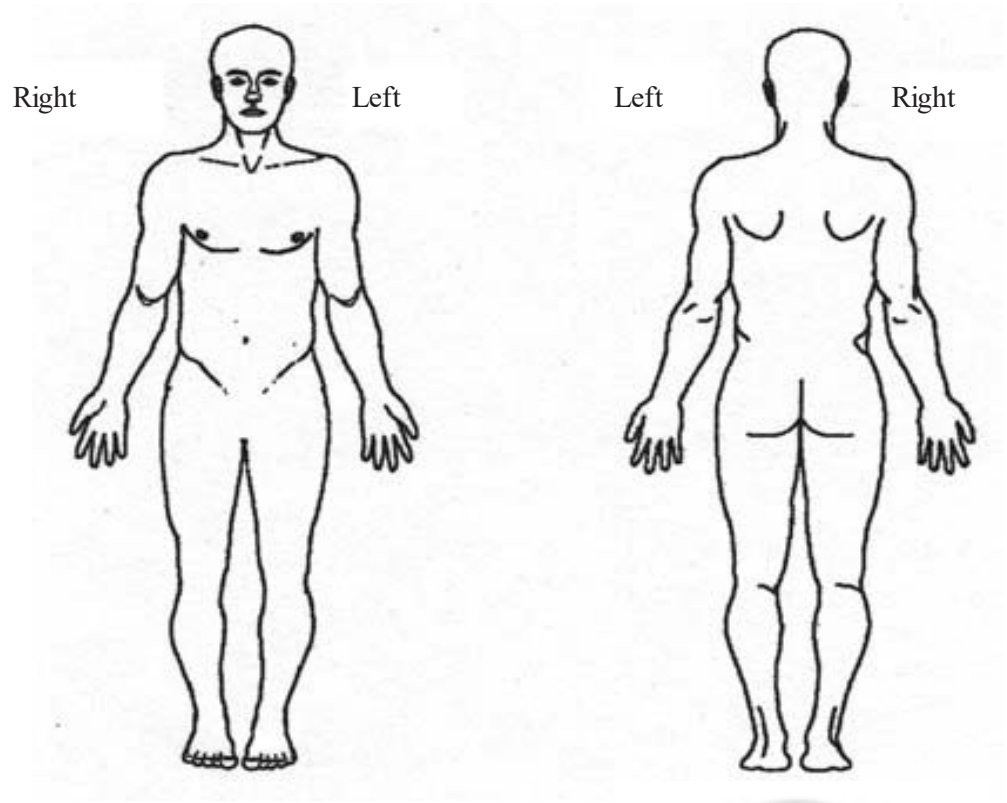
Do you have a medically related lawsuit pending? ❒ Yes ❒ No

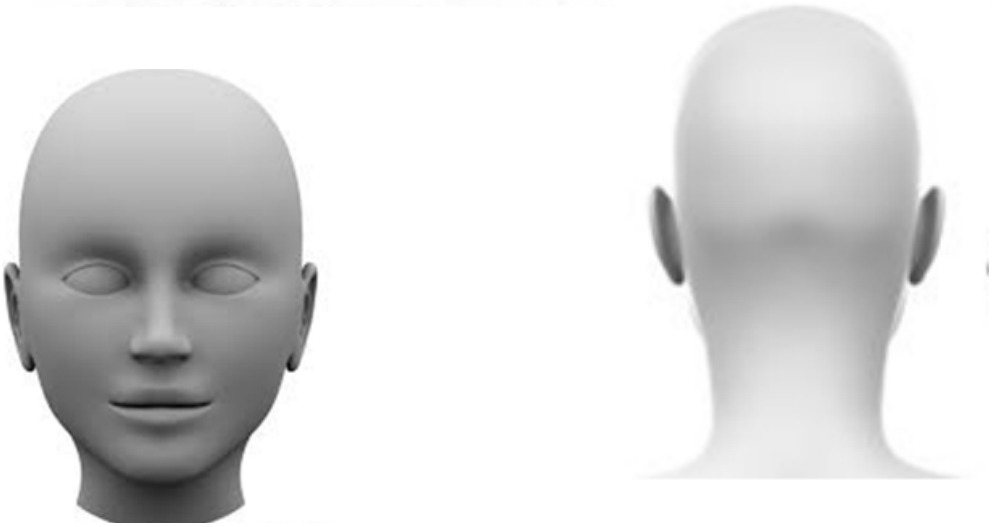
Patient's Name: _____ Date: _____ Physician's Initials: _____

Brief Pain Inventory

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?
   ☐ Yes ☐ No

2) On the diagram, shade in the areas where you feel pain. Put XXX on any areas that you feel aching, /// on any areas you feel sharp pain, OOO on any areas you feel numbness/tingling, and +++ on any areas you feel a burning sensation.





3) Please rate your pain by circling the one number that best describes your pain at its **WORST**.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its **LEAST**.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

6) Please rate your pain by circling the one number that best describes your pain **RIGHT NOW**.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

7) How much relief have pain treatments or medications provided?
Please circle the percentage that shows how much **RELIEF** you have received.

0% 10 20 30 40 50 60 70 80 90 100%

No Pain — Pain as bad as you can imagine

8) Circle the one number that describes how, during the past 24 hours, pain has interfered with:

General activity 0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

Mood 0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

Walking Ability 0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

Normal work 0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

Adult Relations 0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

Sleep 0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

Enjoyment of life 0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

9) What treatments or medications are you receiving for your pain?

_____

_____

_____

_____

_____

In addition to completing the Brief Pain Inventory, to help your doctor better manage your pain, please circle the word(s) that best describe your pain:

aching	throbbing	shooting	exhausting
stabbing	gnawing	pricking	tiring
sharp	tender	burning	penetrating
nagging	numb	miserable	unbearable
dull	radiating	squeezing	cramping
deep			

How long have you had this pain?

_____Days _____Months _____Years

What kinds of things make your pain feel better (for example, heat, medicine, rest)?

_____

_____

_____

What kinds of things make your pain worse (for example, walking, standing, lifting)?

_____

_____

_____

Do you have any other symptoms? Circle all that apply:

nausea	vomiting
constipation	diarrhea
lack of appetite	indigestion
difficulty sleeping	feeling drowsy
nightmares	dizziness
tiredness	itching
urinary problems	sweating
weakness	headaches

Talking About Your Pain

It's important to remember that each person's pain is different. The pain that you experience can't be compared to another person's pain. **ONLY YOU** know how and when you hurt, and how the pain affects your life. It is important to describe what you are feeling to those who are trained to help you. Don't be embarrassed to talk to your doctor, nurse, or pharmacist. They need to know as much as possible about you pain in order to develop the best plan to control it. The questions on this form can help you describe your pain.

Why is Pain Relief So Important?

Proper treatment for pain is not only a matter of comfort. Unrelieved pain can lead to nausea, loss of appetite, loss of sleep, depression, weakness, and other problems. Pain can also affect your life at home and at work. Relieving you pain means that you can continue to do the day-to-day things that are important to you.

Most Pain Can Be Controlled

It is important to know that most pain CAN be improved. Your doctor will work with you to find the treatment that may be best for your pain. The key to effective pain control is to take the **RIGHT AMOUNT** of the **RIGHT MEDICINE** at the **RIGHT TIME**. You should take your pain medicine on a regular schedule as your doctor, nurse, or pharmacist, tells you. Don't wait until the pain becomes severe. Pain is easier to control when it is mild than when it has reached full force.