SPM
SOUTHWEST PAIN MANAGEMENT
Relief begins here.

Name: ____ **Date of Birth:** ____________________ **Today's Date:** ____________

Reason for Today's Visit (Mark ALL that apply)

☐Neck Pain ☐Leg Pain
☐Low Back Pain ☐Shoulder Pain
☐Mid Back Pain ☐Arm Pain
☐Facial Pain ☐Other: _______________________

My CHIEF PAIN COMPLAINT is: (Mark only ONE)

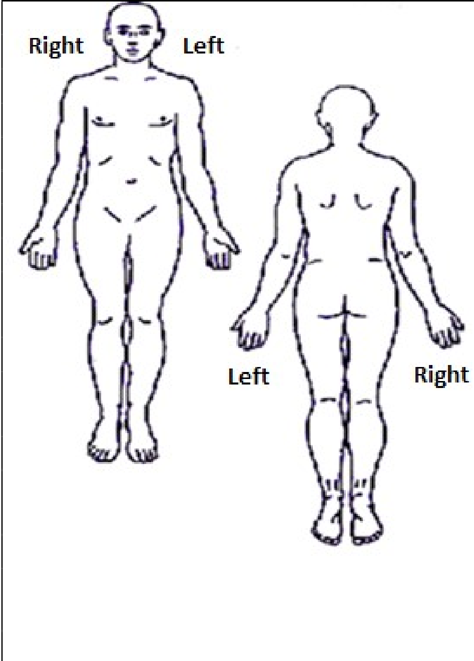
☐headache ☐neck pain ☐left arm pain
☐facial pain ☐mid-back pain ☐right arm pain
☐chest wall pain ☐low-back pain ☐left leg pain
☐abdominal pain ☐buttock pain ☐right leg pain
☐groin pain ☐tailbone pain ☐other: ____________

My ADDITIONAL pain complaint(s) is (are): (Mark ALL that apply)

☐headache ☐neck pain ☐left arm pain
☐facial pain ☐mid-back pain ☐right arm pain
☐chest wall pain ☐low-back pain ☐left leg pain
☐abdominal pain ☐buttock pain ☐right leg pain
☐groin pain ☐tailbone pain ☐other: ____________

Your pain right now: ____/10 ☐constant
Your average pain: ____/10 ☐fluctuating, rarely present

Indicate where your pain is located:



1. Use the following letters to describe your pain.
Ache = A
Burning = B
Cramping = C
Dull = D
Numbness = N
Pins/Needles = P
Stabbing = S
Throbbing = T
Muscle spasm = M

2. Draw arrows where the pain radiates.

What makes your pain worse?

My MEDICAL HISTORY:

Mark all that apply.	☐HTN	☐Asthma	☐Arthritis
	☐Hyperlipidemia	☐Anxiety	☐Heart Disease
	☐Diabetes	☐Depression	☐Other/Please List:

Current PAIN Medications

Medication Name	Dose	Frequency	Prescriber/Provider

Are your pain medications helping? ☐Yes ☐No
-Improved Pain Relief: _______% (0-100%)
-Functional Improvement: _______% (0-100%)
-Improved Quality of Life: _______% (0-100%)
-Are there any side effects? ☐Yes ☐No
-If 'Yes', which?

Have you had pain injections? ☐Yes☐No
If 'Yes', which?

If you have had an injection, how much relief did it provide?
_______% (0-100%) ☐ N/A (I did not have a recent injection)

Have you tried other treatments for your pain? ☐Yes ☐No
-Physical therapy: ☐Helpful ☐Not Helpful ☐N/A
-Chiropractic: ☐Helpful ☐Not Helpful ☐N/A
-Massage/Acupuncture: ☐Helpful ☐Not Helpful ☐N/A
-TENS Therapy: ☐Helpful ☐Not Helpful ☐N/A
-Bracing/Orthotics: ☐Helpful ☐Not Helpful ☐N/A
-Other: __________________ ☐Helpful ☐Not Helpful ☐N/A

Have you had any testing/images? ☐Yes ☐No
If 'Yes', which?

Do you have any DRUG ALLERGIES? ☐Yes ☐No
If 'Yes', Please list:

Do you currently use any form of TOBACCO? ☐Yes☐No
If 'Yes', How many packs per day?

Do you currently drink ALCOHOL? ☐Yes☐No
If 'Yes', How much? How often?

Do you currently or do you have a history of illicit drug use?
☐Yes ☐No If 'Yes', Please explain?

Have you had any SURGERIES? ☐Yes ☐No
If 'Yes', please list:

FAMILY HISTORY

Mother: age___ ☐Alive ☐Deceased, Health Issues ☐Yes ☐No
Father: age___ ☐Alive ☐Deceased, Health Issues ☐Yes ☐No
Sibling: age___ ☐Alive ☐Deceased, Health Issues ☐Yes ☐No
Sibling: age___ ☐Alive ☐Deceased, Health Issues ☐Yes ☐No

Patient Signature:____ Date:_____________________________________