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INTERVENTIONAL PAIN MANAGEMENT

KEVIN T. TOLIVER, M.D.

ESTABLISHED 1947

**INITIAL PATIENT QUESTIONNAIRE
WILLIAM L. TONTZ, JR. M.D.**

Date: _____

Job Description

Name: _____ Age: _____ Right/Left Handed

Height: _____ feet _____ inches Weight: _____ lbs.

Employer at the time of injury: _____

How long have you worked for this employer? _____

Job Title: _____

Number of hours per day? _____ How many days per week? _____

Basic work duties at the time of injury: _____

Estimate the amount of weight you lift at any one time during your workday: _____

Did you work somewhere else at the same time you worked for this employer? _____ If yes, what were your duties?

List places of employment for the last 10 years:

1) Employer _____ Position _____ How Long? _____

2) Employer _____ Position _____ How Long? _____

3) Employer _____ Position _____ How Long? _____

History of Injury

Specific date of injury: _____

If there is no specific date of injury, when did you first begin to have problems? _____

Tell in your own words what happened: _____

Did you continue to work? _____

When did you report this injury? _____ To Whom? _____

When did you first receive treatment? _____

Where did you receive treatment? _____

Did you have: ___ X-rays ___ Medication ___ Injections ___ Therapy

List all physicians seen:

1) Dr. _____ Date seen: _____

Treatment given: ___ X-Rays ___ Medication ___ MRI ___ Injections

___ Splints ___ Physical therapy ___ times per week for ___ weeks

Did any treatment help? ___ If yes, what helped? _____

What were you told was the problem? _____

2) Dr. _____ Date seen: _____

Treatment given: ___ X-Rays ___ Medication ___ MRI ___ Injections

___ Splints ___ Physical therapy ___ times per week for ___ weeks

Did any treatment help? ___ If yes, what helped? _____

What were you told was the problem? _____

Did you return to work? ___ If yes, when? _____

Are you working for the same employer? ___ Who is your present Employer? _____

What are your new duties? _____

If you did not return to work when were you released, why? _____

List all dates you did **not** work:

From _____ To _____

List all dates you performed **light** duty:

From _____ To _____

When did you return to regular duty? _____

Since this injury, have you had any other injuries? _____

If yes, what body parts were injured? _____

Date of Injury: _____

Was this work related? _____ If yes, describe all treatment and where you received this treatment: _____

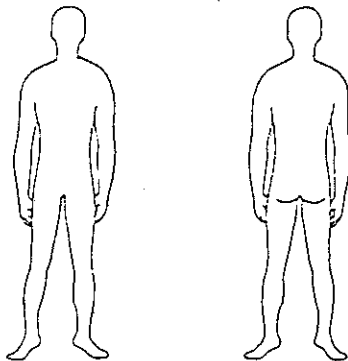
Present Complaints

Are you presently having pain? _____ If yes, list all areas where you are having pain.

1) _____ 3) _____

2) _____ 4) _____

Please mark on the diagram where your pain is located.



Is the pain present all the time? _____

What activities cause pain? _____

What relieves your pain? _____

Does your pain radiate or travel? _____

Do you have numbness? _____ ; tingling? _____

Do you have swelling? _____ ;stiffness? _____

If you have a back problem, do you have loss of bowel or bladder control since the injury? _____

On a scale of 1-10, with 10 being the worst, what is your pain now? _____

Past Medical History

Have you had any previous work related injuries? _____ If yes, describe in detail _____

Have you had any injuries to the body parts involved in this claim in the past? If yes, were these work related? _____

When did this occur? _____ If work related, did you receive a disability rating _____ If yes, what was the rating _____

Medical History

Circle any and all conditions listed below that you have received treatment for in the past?

Diabetes Heart murmur High blood pressure Asthma Ulcers

Lung problems Kidney problems Tumors/Cancer Arthritis

List any allergies to medications: _____

List previous surgeries and dates: _____

List present medications: _____

Family History (If significant to the present injury)

Social History

Do you smoke? _____ How much per day? _____ How long? _____

Do you drink? _____ How much per day? _____ How long? _____

For Women Only

Do you think that you might currently be pregnant? _____ If yes, when is your estimated date of delivery? _____

A.D.L.

In order to assess your limitations with activities of daily living please answer the following.

Activity

Sleep Disturbance _____ Yes _____ No

Travel

a) Riding _____ Yes _____ No

b) Driving _____ Yes _____ No

c) Flying _____ Yes _____ No

Sexual Function

a) Orgasm _____ Yes _____ No

b) Ejaculation _____ Yes _____ No

c) Lubrication _____ Yes _____ No

d) Erection _____ Yes _____ No

Nonspecialized Hand Activities

a) Grasping _____ Yes _____ No

b) Lifting _____ Yes _____ No

Sensory Function

a) Hearing _____ Yes _____ No

b) Seeing _____ Yes _____ No

c) Sensation (feeling) _____ Yes _____ No

d) Tasting _____ Yes _____ No

e) Smelling _____ Yes _____ No

Physical Activity

a) Standing _____ Yes _____ No

b) Sitting _____ Yes _____ No

c) Reclining _____ Yes _____ No

d) Walking _____ Yes _____ No

e) Climbing Stairs _____ Yes _____ No

Communication

- a) Writing _____ Yes _____ No
- b) Typing _____ Yes _____ No
- c) Seeing _____ Yes _____ No
- d) Hearing _____ Yes _____ No
- e) Speaking _____ Yes _____ No

Thank you for your time in completing this questionnaire

TRANS/FORM