Modern Pain Consultants

Interventional Pain & Spine Specialist

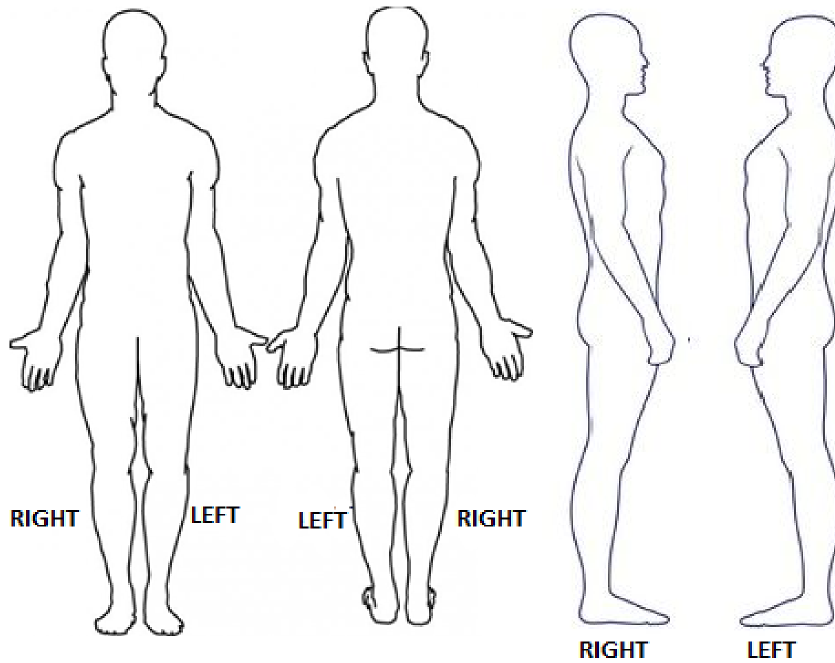
Gary L. Koehn, M.D., Ph.D
Farooq A. Khan, M.D.

Name:____Age:______

Referring Physician:__________________Primary Physician:__________________

Chief Complaint:____

Please shade the painful area(s) on the diagram below to indicate where you pain occurs:



History of Present Illness

A. Location: ____________________ B. Duration: ____________________

C. Severity ____________________ D. Characterize (sharp, throbbing, ect)

____

E. Context (brought on by...) ________________________________

____

F. What makes it better? ________________________________

____

What makes it worse?

____

G. Intermittent/Consistent ____________________

H. Affect on Sleep ____________________

Have you ever been tested or told you have sleep apnea? ☐ Yes ☐ No

I. Other related Symptoms: ____________________

Are you planning on getting pregnant or currently nursing? ☐ Yes ☐ No

Date of last menstrual period: __________ Are you on birth control ☐ Yes ☐ No

J. Have you had any diagnostic tests related to your pain problem? List exam,date, and facility.

____

Have you been seen by another pain specialist? ☐ Yes ☐ No

Physicians name: ____________________ City: ____________________

Please check off any treatment you had done by this pain specialist:

☐ Joint injection ☐ Spine Injections ☐ Ablation

☐ Nerve Blocks ☐ Spinal Cord Stimulator

☐ Pain Pump ☐ Other? ____________________

When did you have this done? Month: Year:

Was this treatment helpful? ☐ Yes ☐ No Explain:

Do you participate in regular exercise? ☐ Yes ☐ No How often?

Is it helpful? ____________________

Have you or are you currently participating in physical therapy? ☐ Yes ☐ No

When: How long: Is it helpful?

Have you seen a spine surgeon? ☐ Yes ☐ No

Please list providers name: City:

Previous Surgeries: ____________________

Are you currently under the care of a psychiatrist? ☐ Yes ☐ No

Please list the name: City:

K. What does your pain prevent you from doing? ______________________________

____

L. Family/Social History

Current occupation: ______________________ ☐ Full Time ☐ Part Time

Marital Status:

Do any family members have chronic pain?

Do you smoke? ☐ Yes ☐ No How often? Duration:

Alcohol use: ☐ Yes ☐ No How often?

Street Drug Use: (type, frequency, and quantity)

____

Have you ever suffered from addiction to pain medication, street drugs, or alcohol?

☐ Yes ☐ No

Have you suffered from verbal, physical, or sexual abuse? ☐ Yes ☐ No

Diet: (include restrictions) ______________________________

Allergies: ______________________________________

History of Pain Medication

List all pain medications you have tried in the past or are currently taking	Currently taking?	Did you have any side effects?	List side effects	Helps A lot	Helps Some	Did not help

Current Medications

List any over the counter meds, vitamins, & supplements.

Name of Medication	Dosage	Frequency	How Long have you been taking this medication?	Helps A lot	Helps Some	Has not helped

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