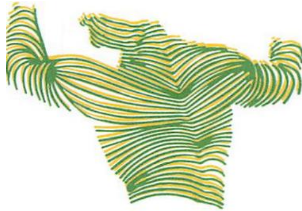

MJ HABER MD LLC

Non-Surgical Pain Specialists

Non-Surgical Orthopedic Pain Medicine
Pain Medicine & Sports Medicine

Did you have clinical interest in Opiods? ◯ Yes ◯ No

FOR OFFICE USE ONLY	
DOS:	
PCP:	
Referring:	
Insurance:	

Name: ______________________________

Date of Birth: ______________

☐ Male ☐ Female

☐ Right handed ☐ Left handed ☐ Ambidextrous

Chief Complaint: ______________________________

PAIN CHARACTERISTICS:

Describe your pain: ☐ Aching ☐ Burning ☐ Cramp-like ☐ Dull ☐ Tingling
☐ Sharp ☐ Shooting ☐ Stabbing ☐ Numbness ☐ Other

SHADE and NUMBER the areas of your top 3 complaints. Draw an arrow to where the pain radiates.

R L

L R

R

L

Under what circumstances did your pain begin?

[ ]Accident at work
[ ]At work (no accident)
[ ]Accident at home
[ ]Motor Vehicle accident
[ ]Following illness
[ ]Other:
[ ]Following surgery
[ ]Unknown reason
[ ]Reacreation

What makes your pain worse? *Check off your top 3*

[ ]During Exercise
[ ]After exercise
[ ]Sitting
[ ]Standing
[ ]Walking
[ ]Work
[ ]Stress
[ ]Sex
[ ]Sneezing
[ ]Bending forward
[ ]Bending backward
[ ]Touching skin
[ ]Morning
[ ]Night
[ ]Lying on the back
[ ]Lying on Left side
[ ]Lying on Right side
[ ]Other

What reduces your pain? *Check off your top 3*

[ ]Lying down
[ ]Standing
[ ]Exercise
[ ]Walking
[ ]Other: ____________
[ ]Sitting
[ ]Advil-type pills
[ ]Aspirin
[ ]Pain pills
[ ]Injections
[ ]Marijuana
[ ]Alcohol
[ ]CBA

List any clinicians (doctors, nurse practitioners, physicians, physical therapists, etc.)
with whom you have worked on this issue in the last 2 years.

1 ____________ 2 ____________
3 ____________ 4 ____________

Have you visited the emergency room in the last year from your pain? [ ] Yes [ ] No

a. Pain body location ____________
b. Number of visits ____________

How many times have you been to the emergency room for varied pain problems over the last year? ________

PAIN POTENCY AND AFFECT

Read through the 11 descriptions on the left-hand side. Select the TWO boxes that best describes how you have felt over the last 7 DAYS

a. Place a **"L"** in the circle that correlates with the description that best describes your **lowest pain.**

b. Place a **"W"** in the circle that correlates with the description that best describes your **worst pain**.

i. **ONLY CHECK TWO BOXES**

ii. **ONE FOR LEAST PAIN "L" AND ONE FOR WORST PAIN "W"**

	Description	
-	Pain free	◯
	Minor annoyance	◯
-	Annoying and distracting	◯
	Can be ignored if you are busy with activities	◯
-	Cannot be ignored	◯
	25% activity reduced, can work, & socialize	◯
-	Challenging to work and concentrate	◯
	Unable to concentrate with the pain	◯
-	Cannot; common tasks-drive, shop, cook, transport	◯
	Cannot; personal tasks-toilet hygiene, eat, dress -need assist transfers positions	◯
-	Cannot move, induces lose consciousness	◯

OSWESTRY QUESTIONNAIRE

Select the box at each section that most closely describes how you are feeling over the last 2 to 3 days.

1 **Pain Intensity**

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

2 **Personal Care**

0. I do not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increases the pain, but I manage not to change my way of doing it.
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

3 **Lifting**

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on the table.
4. Pain prevents me lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

4 **Walking**

0. I have no pain on walking.
1. I have some pain on walking, but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

5 **Sitting**

0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately .

6 **Standing**

0. I can stand as long as I want without extra pain.
1. I have some pain on standing, but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

OSWESTRY QUESTIONNAIRE cont.

7 **Sleeping**

0. My sleep is never disturbed by pain.
1. I get pain in bed, but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

8 **Sex Life**

0. My sex life is normal and causes me no extra pain.
1. My sex life is normal, but causes some extra pain.
2. My sex life is nearly normal, but is very painful.
3. My sex life is severely restricted by pain.
4. My sex life is nearly absent because of pain.
5. Pain prevents any sex life at all.

9 **Social Life**

0. My social life is normal and gives me no pain.
1. My social life is normal, but it increase the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests. e.g., dancing. etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

10 **Traveling**

0. I get no pain when traveling.
1. I get some pain when traveling, but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling, but it does not compel me to seek alternate modes of travel.
3. I get extra pain while traveling which compels me to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

REVIEW OF SYSTEMS

During the **Last Week,**

Only check off if condition is present:

GENERAL

- Fever >100.5
- Insomnia/Sleep Problems
- Always Tired, Fatigued
- Weight Loss -Unintentional >15 lbs/Month

MUSCULOSKELETAL

- Muscle Cramps
- Muscle Pain
- Back Pain
- Hip Pain
- Knee Pain
- Foot and Ankle Pain
- Neck Pain
- Shoulder Pain
- Elbow Pain
- Hand Wrist Pain

GU

- Prominent Consistent Urine Loss -Need Depends/Diapers
- Painful Urination
- Blood in Urine

GI

- Frequent Nausea
- Heartburn
- Consistent Constipation
- Repeated Vomiting
- Black Tarry Stools
- Bright Red Blood per Rectal

REVIEW OF SYSTEMS cont.

CARDIOVASCULAR

- Chest Pain
- Taking Anticoagulant Medications
- Deep Vein Thrombosis
- High Blood Pressure
- Breathless Lying on Back
- New Heart Murmur

NEUROLOGY

- Seizures (witnessed)
- No Feeling in Groin
- Headache
- Both Legs Give Away with Fall
- Fall to Ground Repeatedly Daily

PSYCHIATRIC/PSYCHOLOGIC

- Depression
- Anxiety
- Much Confusion
- Much Memory Loss
- Plan Harm Self
- Plan Harm Other

RESPIRATORY

- Sleep Apnea
- Wheezing
- Prominent Persistent Cough
- Painful Breathing

HEENT

- Allergies (seasonal)
- Dizziness, Balanced Challenge
- Vertigo, World Appears Spinning
- No Longer Have Taste/Smell

MEDICATION QUESTIONNAIRE

Medications: (*Please list all current medications or chec the applicable box below*).

☐ I brought a copy of my medication list (*Please provide the list to the front desk reception*).

☐ I am not currently taking any medications.

Medication Name	Dosage	# of times dosage taken per day

Previous Medications Tried - *Check mark all medications that apply below*

Opioids

- ☐ Tramadol
- ☐ Codeine
- ☐ Nucynta
- ☐ Dilaudid
- ☐ Oxycodone
- ☐ Suberone
- ☐ Percocet
- ☐ Methadone
- ☐ Morphine
- ☐ Buprenorphine
- ☐ Hydrocodone
- ☐ Oxymorphone
- ☐ Meloxicam
- ☐ Hydromorphone

NSAIDs/Tylenol

- ☐ Tylenol
- ☐ Aspirin
- ☐ Naproxen
- ☐ Voltaren gel
- ☐ Indocin
- ☐ Celecoxib
- ☐ Ibuprofen

Muscle Relaxant

- ☐ Soma Casisprodol
- ☐ Flexeril Cyclobenzaprine
- ☐ Baclofen
- ☐ Zanaflex/Tizanidine
- ☐ Robaxin Methocarbamol
- ☐ Skelaxin Metaxolone
- ☐ Valium (Diazepam)

Antidepressants

- ☐ Elavamil (Amitriptyline)
- ☐ Pamelor (Nortriptyline)
- ☐ Cymbalta (Duloxetine)
- ☐ Effexor (Venlafaxine)
- ☐ Paxil (Paroxetine)
- ☐ Prozac (Fluoxetine)
- ☐ Savella(Milnacipran)
- ☐ Zoloft(Sertraline)

Others

- ☐ Neurontin(Gabapentin)
- ☐ Tegretol(Carbamazepine)
- ☐ Imitrex(Sumatriptan)
- ☐ Xanax(Alprazolam)
- ☐ Ativan(Lorazepam)
- ☐ Lyrica (Pregabalin)
- ☐ Topamax(Topiramate)
- ☐ Mexilitine
- ☐ Klonapin(Clonazepam)

ALLERGY QUESTIONNAIRE

Allergies (*Please list all knowing allergies or check applicable box below*).

☐ I brought a copy of my allergy list (*Please provide the list to the front desk reception*).

☐ I have no known drug allergies.

Medication Name	Please describe allergic reactions, severity & symptoms

Topical Allergies *(Please list all knowing topical allergies or check applicable box below).*

☐ I have no known topical allergies.

Topical Allergens	Please describe allergic reactions, severity & symptoms

☐ Metal ☐ Iodine ☐ Latex ☐ Tape

Food Allergies *(Please list all knowing food allergies).*

☐ I have no known food allergies.

Food	Please describe allergic reactions, severity & symptoms

SURGICAL HISTORY

SPINE	Levels	Date
☐ Discectomy		
☐ Laminectomy		
☐ Spinal Fusion		
☐ Spinal Cord Stimulator		
☐ Other		

HEART	Date
☐ Valve Replacement	
☐ Aneurysm Repair	
☐ Stent Placement	
☐ Vascular Surgery	
☐ Other	

JOINT	Type	Left/Right	Date
☐ Ankle/foot			
☐ Knee			
☐ Hip			
☐ Shoulder			
☐ Wrist/Hand			
☐ Other			

FEMALE SURGERIES	Date
☐ Cesarean Section	
☐ Hysterectomy	
☐ Laparoscopy	
☐ Ovarian	
☐ Other	

ABDOMINAL	Date
☐ Gallbladder	
☐ Appendectomy	
☐ Gastric Bypass	
☐ Other:	

OTHER SURGERIES	Date
☐ Thyroidectomy	
☐ Hemorrhoid surgery	
☐ Hernia Repair	

LIFESTYLE QUESTIONS

EXERCISE

Do you exercise? ☐ Yes ☐ No If so, how many days per week? ☐ 1-2 ☐ 3-4 ☐ 5-7

What type of exercise do you enjoy? ________________

How much time do you exercise on the days you do exercise? ☐ 15-30min ☐ 30-60min ☐ >60min

Involved in any sports or hobbies? ☐ Yes ☐ No If so, please list: ________________

SLEEP

How many hours do you sleep on average each night? ☐ <5 ☐ 6 ☐ 7 ☐ 8 ☐ >8

Do you wake feeling refreshed? ☐ Yes ☐ No Do you snore? ☐ Yes ☐ No

Do you ever had a sleep study? ☐ Yes ☐ Date of exam: ________________

Diagnosis: ☐ Obstructive Sleep Apnea (OSA) ☐ Central Sleep Apnea (CSA)

☐ Normal Study ☐ Other

STRESS

Do you have a lot of stress in your life currently? ☐ Yes ☐ No

If so, what is the usual source of the stress?

☐ Pain ☐ Financial ☐ Family ☐ Other: ________________

☐ Work ☐ Recreation limitation ☐ Social

What is your typical daily stress level? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Are you easily upset or irritated? ☐ Yes ☐ No

Are you constantly keyed up or jittery? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Mark the following conditions/diseases that you currently have or have been treated for in the past.

General/Infection Diseases

- [ ] Cancer
- [ ] Tuberculosis
- [ ] Lyme Disease
- [ ] MRSA
- [ ] HIV/AIDS

Head/Eyes/Ears/Nose/Throat

- [ ] Headache
- [ ] Migraine
- [ ] Head Injury
- [ ] Glaucoma

Musculoskeletal

- [ ] Carpal Tunnel Syndrome
- [ ] Chronic Low Back Pain
- [ ] Chronic Neck Pain
- [ ] Chronic Joint Pain
- [ ] Fibromyalgia
- [ ] Osteoporosis
- [ ] Osteoarthritis
- [ ] Rheumatoid Arthritis

Respiratory

- [ ] Asthma
- [ ] Bronchitis
- [ ] Emphysema/COPD
- [ ] Obstructive Sleep Apnea
- [ ] Seasonal Allergies

Genitourinary/Nephrology

- [ ] Bladder Infection(s)
- [ ] Dialysis
- [ ] Kidney Infection (s)
- [ ] Kidney Stones
- [ ] Urinary Incontinence
- [ ] Prostate Issues

Gastrointestinal

- [ ] Bowel Incontinence
- [ ] GERD (Acid Reflux)
- [ ] Gastrointestinal Bleeding
- [ ] Constipation
- [ ] Ulcer
- [ ] Gallbladder Disease
- [ ] Fatty Liver
- [ ] Liver Disease

Endocrine

- [ ] Diabetes; Type: ________
- [ ] Hyperthyroid
- [ ] Hypothyroid
- [ ] Vitamin D Deficiency
- [ ] Low Testosterone
- [ ] Menstrual Disorder
- [ ] Post Menopause

Cardiovascular/Hematologic

- [ ] Anemia
- [ ] Bleeding Disorder
- [ ] Heart Attack
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Valve Disorder
- [ ] Murmur
- [ ] Phlebitis
- [ ] Poor Circulation
- [ ] Stroke
- [ ] Coronary Artery Disease
- [ ] Blood Clot
- [ ] Peripheral Vascular Disease
- [ ] Congestive Heart Failure

Neuro-Psychosocial

- [ ] Alcohol abuse
- [ ] Prescription Drug Abuse
- [ ] Alzheimers Disease
- [ ] Depression
- [ ] Anxiety
- [ ] Bipolar Disorder
- [ ] Schizophrenia
- [ ] Seizures
- [ ] Multiple Sclerosis
- [ ] Paralysis
- [ ] Peripheral Neuropathy
- [ ] Reflex Sympathetic Dystrophy
- [ ] Restless Leg Syndrome

Other chronic medical conditions that you are treated for or medical conditions you were hospitalized (overnight stay).

____

____

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: ______

Highest level of education: ☐ Grammar School ☐ High School ☐ College ☐ Post-Graduate

Are you working? ☐ Yes ☐ No ☐ Retired If yes, Employer ______

Job Description: ______ If Retired, what type of work did you do? ______

Are you on Disability? ☐ Yes ☐ No If so, why and since when? ______

Are you capable of becoming pregnant? ☐ Yes ☐ No If so, are you currently pregnant? ☐ Yes ☐ No

Alcohol Use

☐ None

☐ Occasssional ☐ Drinks per Day: ______

Drug Use

☐ History of drug abuse ______

☐ Current drug abuse ______

Tobacco Use

☐ Never smoke

☐ Former smoker; Quit ______

☐ Current smoker; Cigarettes per day ______

FAMILY HISTORY

Check the box for any of the following conditions that is present to your immediate blood family members:
(Parents, Siblings, Son, Daughter)

☐ Cancer
☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure
☐ Stroke
☐ Epilepsy
☐ Mental Illness
☐ Asthma
☐ Hay Fever/Hives
☐ Anemia
☐ Kidney Disease
☐ Liver Disease
☐ Gallbladder Disease
☐ Ulcer
☐ Tuberculosis
☐ Goiter
☐ Arthritis
☐ Heart Murmur
☐ Cataracts

Is there any other information that you would like to add? ______

______

______