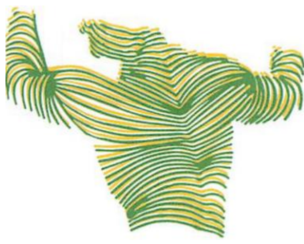


MJ HABER MD LLC

Non-Surgical Pain Specialists

FOR OFFICE USE ONLY	
DOS:	
PCP:	
Referring:	
Insurance:	
Pill Count:	
B/P:	
How did you hear about NSPS?	

Are opiods one of your clinical interests?

☐ Yes ☐ No

Name: ______________________

Date of Birth: ____________

☐ Male ☐ Female ☐ Right handed ☐ Left handed

Number 1-3 Your Top Three -- PAIN COMPLAINTS

☐ Low Back ☐ Upper Back ☐ Neck ☐ Shoulder ☐ Other: ____________

☐ Hip ☐ Knee ☐ Foot/Ankle ☐ Hand/Wrist ☐ Other: ____________

PAIN CHARACTERISTICS:

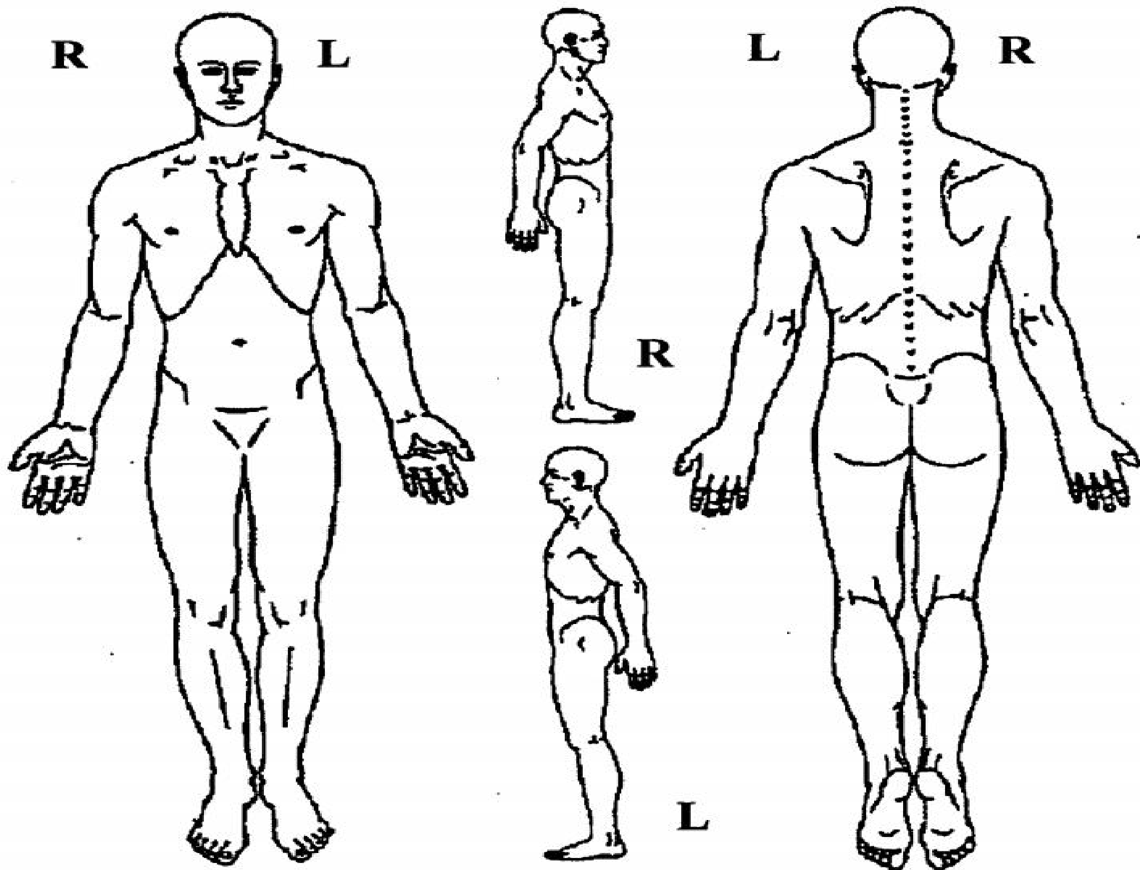
☐ Aching ☐ Burning ☐ Cramp-like ☐ Dull ☐ Tingling

☐ Sharp ☐ Shooting ☐ Stabbing ☐ Numbness ☐ Other ________

BODY SYMPTOM CHART

NUMBER(1-3) & SHADE the areas of your top 3 complaints.

Draw an ARROW to where the pain radiates.



LAST 7 DAYS: PAIN POTENCY

- Read descriptions below.
- Select <u>TWO BOXES</u> that best describes your pain effects over the <u>LAST 7 DAYS.</u>
  Mark <u>BEST</u> and <u>WORST</u> per description below.

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	◯

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 ______
- ☐ ______
- ☐ ______

Under what circumstances did your pain begin?

☐ Accident at work	☐ Motor vehicle accident	☐ Following surgery
☐ At work (no accident)	☐ Following illness	☐ Unknown reason
☐ Accident at home	☐ Reacreation	☐ Other: ______

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

☐ During exercise	☐ Stress	☐ Morning
☐ After exercise	☐ Sex	☐ Night
☐ Sitting	☐ Sneezing	☐ Lying on the back
☐ Standing	☐ Bending forward	☐ Lying on left side
☐ Walking	☐ Bending backward	☐ Lying on right side
☐ Work	☐ Touching skin	☐ Other ______

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

☐ Lying down	☐ Sitting	☐ Injections
☐ Standing	☐ Advil-type pills	☐ Marijuana
☐ Exercise	☐ Aspirin	☐ Alcohol
☐ Walking	☐ Pain pills	☐ CBA
☐ Other: ______		

List any clinicians (doctors, nurse practitioners, physicians, physical therapists, etc.) you have worked on this issue in the LAST 2 YEARS.

	Name of the Physician/Institution		Name of the Physician/Institution
1		5	
2		6	
3		7	
4		8	

Have you visited the emergency room in the last year for your pain? ☐ Yes ☐ No

a. Pain; body location: ______

b. Number of visits: ______

How many times have you been to the following medical resources for your main pain complaints last year?.

	0	2	4	6	8	10	>10
Emergency room							
Physical therapy							
Chiropractic							
Surgical specialist							

	0	2	4	6	8	10	>10
Massage therapy							
Spine Injection							
Trigger Point							
Joint Injection							

OSWESTRY QUESTIONNAIRE

Select **ONE BOX** at **each section** that describes your feelings the **LAST WEEK**

1 PAIN INTENSITY

- ☐ 0. MILD & NOT Consistent
- ☐ 1. MILD & Consistent
- ☐ 2. Moderate & NOT Consistent
- ☐ 3. Moderate & Consistent
- ☐ 4. Severe & NOT Consistent
- ☐ 5. Severe & Consistent

2 PERSONAL CARE: DRESSING & CLEANING SELF

- ☐ 0. WITHOUT Pain
- ☐ 1. MILD Pain- NO Modification Needed
- ☐ 2. MODERATE Pain- NO Modification Needed
- ☐ 3. PROMINENT Pain- Modification Needed
- ☐ 4. PROMINENT Pain- Some Help Needed
- ☐ 5. SEVERE Pain - DEPENDENT On Help

3 LIFTING & PAIN

- ☐ 0. NO PAIN- OK Lift Heavier Weights Off Floor
- ☐ 1. WITH PAIN- OK Lift Heavier Weights Off Floor
- ☐ 2. Limited to Lift Heavier Weights OFF TABLE
- ☐ 3. Limited Lifting to about 24 lbs. (3 gallons) OFF TABLE
- ☐ 4. Limited Lifting to about 8 lbs. (1 gallons) OFF TABLE
- ☐ 5. Limited Lifting to about 4 lbs or less

4 WALKING & PAIN

- ☐ 0. NO PAIN with walking.
- ☐ 1. SOME PAIN, **NOT** Limit Distance.
- ☐ 2. Maximum Walking **1 mile**
- ☐ 3. Maximum Walking **1/2 mile**
- ☐ 4. Maximum Walking **1/4 mile**
- ☐ 5. Walking - Less than **5 Minutes**

5 SITTING & PAIN

- ☐ 0. No Limit With Most Chairs
- ☐ 1. Only Can Sit In Favorite Chair- NO Limit
- ☐ 2. Sitting - Less than 1 hour
- ☐ 3. Sitting - Less than 1/2 hour
- ☐ 4. Sitting - Less than 10 Minutes
- ☐ 5. Avoid All Sitting- Intolerable Pain

6 STANDING & PAIN

- ☐ 0. WITHOUT Pain- NOT Limited
- ☐ 1. WITH Pain- NOT Limited
- ☐ 2. Less than 1 hr.
- ☐ 3. Less than ½ hr.
- ☐ 4. Less than 15 Min
- ☐ 5. Less than 5 Min

7 SLEEPING & PAIN

- ☐ 0. Sleep NOT Disturbed By Pain
- ☐ 1. Pain Present, Sleep Not Reduced
- ☐ 2. Sleep Reduced 25%
- ☐ 3. Sleep Reduced 50%
- ☐ 4. Sleep Reduced 75%
- ☐ 5. Sleep Reduced 90-100%

8 SEX LIFE & PAIN

- ☐ Not Applicable
- ☐ 0. Sex Life Normal Without Extra Pain
- ☐ 1. Sex Life Normal With MILD Pain
- ☐ 2. Moderate Challenge From Pain
- ☐ 3. Severely Restricted By Pain.
- ☐ 4. Nearly Absent By Pain.
- ☐ 5. Pain Prevents Any Sex Life At All.

9 SOCIAL LIFE & PAIN

- ☐ 0. Social Life Normal- NOT affected by pain.
- ☐ 1. Social Life Normal- Some Increased Pain.
- ☐ 2. LIMITS Energetic Interests, (dance, hike, etc)
- ☐ 3. CANNOT Go Out Often
- ☐ 4. STAY HOME
- ☐ 5. Almost NO Social Life Secondary to Pain

10 TRAVELING & PAIN

- ☐ 0. NO Traveling Pain
- ☐ 1. MILD Traveling Pain- NO Modifications Needed
- ☐ 2. MODERATE Pain- Travel Modifications Needed
- ☐ 3. PROMINENT Pain- Alternative Travel Modes Required
- ☐ 4. Pain Restricts Journeys To Under ½ hour
- ☐ 5. Pain Restricts All Travel

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

Illegal Drug Use

- [ ] Cocaine
- [ ] Heroin
- [ ] Methampetamine
- [ ] Marijuana
- [ ] Other

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 or Dependence
- [ ] Prescription Drug Abuse
- [ ] Attention Deficit Hyperactivity Disorder
- [ ] 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).

______

______

______

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)

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

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
- [ ] Alcohol > 6 drinks per day

RESPIRATORY

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

HEENT

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

SOCIAL HISTORY

Are you working? ☐ Yes ☐ No ☐ Retire

Job Description: ____________ (If **RETIRED**, what type of work did you do?) ____________

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

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

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

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

---

ALCOHOL USE HISTORY

1 How often do you drink alcohol?

☐ Never ☐ Monthly or less ☐ 2-4times/month ☐ 2-3 times/week ☐ 4 or more times/week

2 How many alcoholic drinks are consumed on a typical day?

☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 8-9 ☐ 10-11 ☐ 12 or more

3 Frequency to have 6 or more drinks on 1 occasion?

☐ Less than monthly ☐ Monthly ☐ Twice/month ☐ Weekly ☐ Daily

4 Previous history quit alcohol comnsumption second to overuse concerns ☐ **YES** ☐ **NO**

TOBACCO USE HISTORY

= ☐ Never smoked = ☐ Currently Use (_____Smoking ______Oral)

= ☐ Former smoker (#_______Years of use) (# _______Years Ago Quit)

= Present or Past Smoking; Amount Packs Per Day PPD: ☐ 1/4 ☐ 1/2 ☐ 1 ☐ 2 ☐ 3 or more

---

DRUG ABUSE HISTORY

☐ None VS ☐ Last Used (#_____ Weeks, #_____Months, #_____Years)

☐ Present Use; Type: ____________

☐ Past Use; Type: ____________

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? ____________

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	Reaction	Medication Name	Reaction

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

☐ Metal ☐ Iodine ☐ Latex ☐ Tape ☐ I have no known topical allergies.

LIFESTYLE QUESTIONS

HOBBIES AND RECREATION

What do do you do now? ______

What would you add if Pain descreased by 50%? ______

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

Have you ever had a sleep study? ☐ Yes ☐ No 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