

HEMET PAIN & WELLNESS INSTITUTE • ARUL DORAISWAMY, M.D., APC

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Name:

Date of Birth:

Date of Service:

Are you experiencing any of the following symptoms?

Yes / No

- Fever, chills
- Wt. loss gain >10lbs
- Blurry vision
- Decreased hearing
- Sore throat
- Chest pain or palpitations
- Allergies? To what? _____

Yes/No

- Shortness of breath
- Weakness in arms legs
- Numbness in arms legs
- Problems walking or recent falls
- Stomach pain or nausea
- Bowel or bladder incontinence

Yes/No

- Constipation
- High blood sugars
- Easy bruising
- Swollen glands
- Depression
- Anxiety
- New rash or lesion

Allergic to: Iodine or IV contrast Latex I am not allergic to Iodine, IV contrast, or Latex

Please check if you have tried any of the following?

Yes / No

- Physical therapy
- Pool therapy
- TENS therapy
- Acupuncture
- Opiate analgesics

Yes / No

- Chiropractic manipulation
- back or neck surgery
- Injections (Epidurals, facet blocks, joint injections, etc.)
- Pain management counseling or psychiatric therapy
- Non-opiate analgesics

Where is your worst pain? On the diagram to the right, shade in the areas(s) that are painful.

- Lower Back Mid-back Neck Shoulder Hip Knee
Other: _____

Quality of pain: Aching Throbbing Shooting Burning
 Uncomfortable Dull Radiating Sharp Cramping

Timing of pain: Constant Intermittent

Average pain level:

- 1 2 3 4 5 6 7 8 9 10

Average pain level when TAKING opioid pain medications:

- 1 2 3 4 5 6 7 8 9 10 N/A

Average pain level when NOT TAKING opioids:

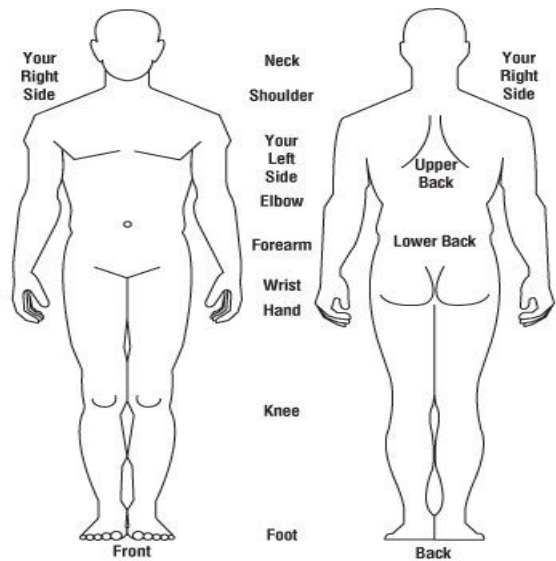
- 1 2 3 4 5 6 7 8 9 10

Activity level when TAKING opioids (1 = bedridden, 10 = unlimited):

- 1 2 3 4 5 6 7 8 9 10 N/A

Activity level when NOT TAKING opioids (1 = bedridden, 10 = unlimited):

- 1 2 3 4 5 6 7 8 9 10



What makes your pain better: Rest Ice pack Heat Medication Exercise stretching

What makes your pain worse: Sitting Bending Standing Lying down Lifting Walking

Are you having trouble sleeping due to pain?

- Yes No

Do opioid pain medications improve the quality of your sleep?

- Yes No N/A

Do you Smoke?

- Yes No

Are you using illegal street drugs?

- Yes No

Are you currently working?

- Yes No

Are you on blood thinners? Yes No

If yes, which blood thinners are you taking? COUMADIN PLAVIX PRADAXA XARELTO

AGGRENOX CILOSTAZOL TICLID EFFIENT BRILINTA APIXABAN/ELIQUIS OTHER _____

What pain medications are you taking? _____

Email Address: _____ **Best Contact Number:** _____ **Has your insurance changed?** Yes No

Patient's Signature: _____ **Date:** _____