PACIFIC
PAIN & WELLNESS GROUP

23000 Crenshaw Blvd. #100
Torrance, CA 90505
Tel. (424) 625-6600 Fax: (424)250-9397
www.pacificpaingroup.com

Please fill out this form in its entirety before your appointment.
Note: You are able to enter your answers directly onto this form.

Patient Information

Name: _____ **Date of Birth:** _____

Age:_____ **Social Security Number**:_____
Sex: ☐Male ☐Female **Email:** _____

Which doctor will you be seeing
☐Dr. Ananth ☐Dr. Chen

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Address: _____
Home Phone: _____**Cell Phone**: _____

Ethnicity: _____

Emergency Contact Name: _____
Phone, and Relationship: _____
Who were you referred to our clinic by: _____

Current Physician:
PCP: _____ Surgeon: _____ Prior Pain Physician: _____

*******For all New Pain Patients*******

I understand if I cancel my appointment after the 48 hour cancellation policy or no show/miss my appointment my card will be charged the full amount of the appointment. ☐ **Yes** ☐ **No**
Type or initial name: _____

Is your pain the result of a Motor Vehicle Accident or Personal Injury: (legal term describing injury sustained to your person by negligence of another) ☐ Yes ☐ No - If yes, you will be asked to complete a separate form

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Pharmacy Information
Name of Preferred Pharmacy: _____

Pharmacy Address: _____
Pharmacy Cross Streets:_____ & _____
Pharmacy City: _____

Pharmacy Phone: _____ Pharmacy Fax:_____

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NAME: _____

Medical Information

Chief Complaint: _____ **When did it start**: _____

Are you a smoker: ☐Yes ☐No

History of Present Illness

Pain is: ☐Improving ☐Worsening ☐Stable ☐Constant ☐Intermittent

How did the pain start: ☐Car accident ☐Work injury
☐Sports injury ☐Old age ☐Other-explain: _____

What worsens the pain:
☐Standing ☐Sitting ☐Lying down ☐Walking ☐Twisting
☐Reaching ☐Weather ☐Coughing ☐Sneezing ☐Leaning forward
☐Driving ☐Heat ☐Cold ☐Leaning backward
☐Fatigue ☐Alcohol ☐Other: _____

What reduces the pain:
☐Standing ☐Sitting ☐Lying down ☐Walking ☐Twisting
☐Driving ☐Reaching ☐Heat ☐Cold ☐Leaning forward
☐Stretching ☐Exercise ☐Leaning backward ☐Other _____

Is there new or different:
☐Weakness (not pain related) ☐Loss of feeling ☐Bowel/bladder incontinence/accidents

Do you have reduced sleep: ☐Yes ☐No
Does your pain make you feel: ☐Depressed ☐Angry ☐Anxious

Prior therapies, injections, treatments:
☐Physical therapy ☐MRI ☐CT scan ☐EMG ☐X-Ray
☐Discogram ☐Epidural ☐Narcotics ☐Acupuncture ☐Surgery
☐Other _____

Past Medical History:
☐Diabetes ☐Heart Disease ☐Blood pressure ☐Cancer
☐Asthma ☐Emphysema ☐Liver disease ☐Kidney disease
☐Stroke ☐Depression ☐Anxiety ☐Thyroid disease
☐Ulcers ☐Other _____

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Past Surgical History:

☐Appendix ☐Gall bladder ☐CABG/Angioplasty ☐Hysterectomy
☐Hernia repair ☐Tonsillectomy ☐Neck surgery ☐Back Surgery
☐Other surgery Click here to enter text.

Current Medication List

Medication Name	Dose	Frequency

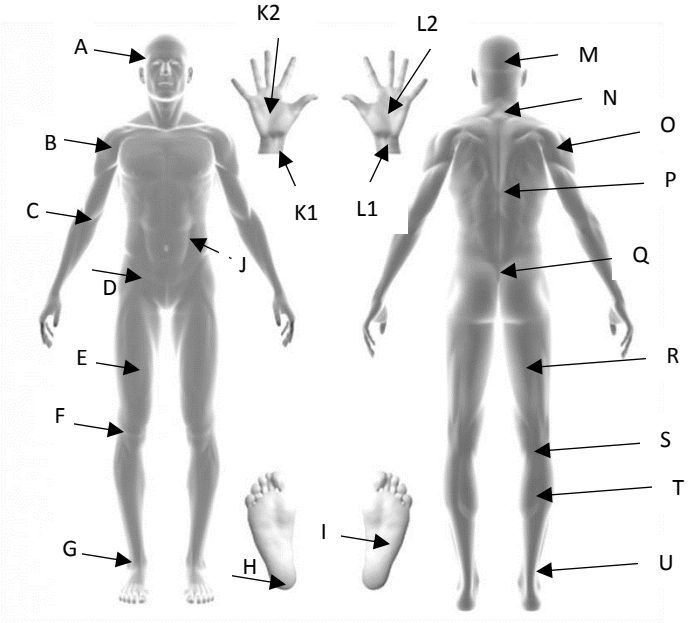
Prior Pain Medication: _____

Over the counter Medication: ☐Aspirin ☐Mortin ☐Advil ☐Aleve ☐Other

Allergies (both medication and non-medication/and IV dye allergy: _____

Current Symptoms

Where is your pain: _____



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Describe the circumstances around the onset of your pain: _____

How often is your pain: ☐Occasional ☐Frequent ☐Constant

Does the pain radiate: ☐Yes ☐No **Where:**_____

Do you have numbness: ☐Yes ☐No **Where:**_____

Check the number that best describes your pain on average:

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (worst)

Do you experience any of the following:

☐Weakness ☐Muscle Spasms ☐Stiffness ☐Limping ☐Numbness
☐Tingling ☐Headaches

Does your pain feel:

☐Aching ☐Burning ☐Throbbing ☐Shooting ☐Other _____

How long can you do the following until the pain interferes:

Sit _____ Minutes
Stand _____ Minutes
Walk _____ Minutes

Have you avoided strenuous lifting, carrying, pushing, pulling, stooping, and bending because of your injury: ☐Yes ☐No

Family History

Do you have a family history of

☐Spine conditions ☐Heart disease ☐Rheumatic conditions ☐Cancer

How many children do you have **How many Siblings do you have**

____ Boys _____ Girls _____ Brothers _____ Sisters

Have you suffered from or are currently suffering from

☐Depression/Anxiety ☐PTSD ☐Alcohol/Drug abuse ☐Childhood emotional/physical abuse
☐Fever/weight loss ☐Sweats ☐Swelling/rash ☐Abdominal pain
☐Shortness of breath ☐Paralysis ☐Headaches ☐Easy bruising/bleeding

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Current Opioid Misuse Measure (COMM)®

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	☐	☐	☐	☐	☐
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	☐	☐	☐	☐	☐
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	☐	☐	☐	☐	☐
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	☐	☐	☐	☐	☐
5. In the past 30 days, how often have you seriously thought about hurting yourself?	☐	☐	☐	☐	☐
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	☐	☐	☐	☐	☐

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Please answer the questions using the following scale:	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
	0	1	2	3	4
7. In the past 30 days, how often have you been in an argument?	☐	☐	☐	☐	☐
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	☐	☐	☐	☐	☐
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	☐	☐	☐	☐	☐
10. In the past 30 days, how often have you been worried about how you're handling your medications?	☐	☐	☐	☐	☐
11. In the past 30 days, how often have others been worried about how you're handling your medications?	☐	☐	☐	☐	☐
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	☐	☐	☐	☐	☐
13. In the past 30 days, how often have you gotten angry with people?	☐	☐	☐	☐	☐
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	☐	☐	☐	☐	☐
15. In the past 30 days, how often have you borrowed pain medication from someone else?	☐	☐	☐	☐	☐
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	☐	☐	☐	☐	☐
17. In the past 30 days, how often have you had to visit the Emergency Room?	☐	☐	☐	☐	☐

To score the COMM, simply add the rating of all the questions. A score of 9 or higher is considered a positive

Sum of Questions	COMM Indication
> or = 9	**+**
< 9	**-**

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