Dr. Michael H. Verdolin Board Certified Specialist in Pain Management
7051 Alvarado Rd #101, La Mesa, CA 91942

NEW PATIENT QUESTIONNAIRE

INSTRUCTIONS: YOU CAN TYPE ON THIS FORM. SIMPLY PRESS PRINT FOR A HARDCOPY OR EMAIL TO SUBMIT

Patients Name _____ Marital Status ☐ ☐ ☐ ☐ Age _____
M S D W

Social Security # _____ Driver's License # _____ Birthdate _____ Home phone _____

Home Address _____
City State Zip Code

Patients Employer _____ Work Phone _____

Address _____
City State Zip Code

Occupation _____ How were you referred to us? _____

Nearest friend or relative not living with you, in case of emergency:

Name _____ Relationship _____ Phone Number _____

INSURANCE
Name of Insurance _____ Employer's Name _____

Insured's Name _____ Insured's Date of Birth _____ Relationship _____

Insured's Social Security # _____

Group # _____ Certificate # _____ Insurance Phone Number _____

SECONDARY
Name of Insurance _____ Employer's Name _____

Insured's Name _____ Insured's Date of Birth _____ Relationship _____

Insured's Social Security # _____

Group # _____ Certificate # _____ Insurance Phone Number _____

WORKER'S COMP. INFORMATION
Employer Name _____ Date of Injury _____ Claim # _____

Insurance Company _____

Claim Address _____
City State Zip Code

Adjusters Name _____ Phone Number _____

ATTORNEY INFORMATION (LIEN)
Attorney's Name _____ Phone # _____

Address _____
City State Zip Code

ASSIGNMENT & RELEASE
I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO VERDOLIN PAIN SPECIALISTS, INC (DR. MICHAEL H VERDOLIN, MD). I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES.

Signature _____ Date _____

Dr. Michael H. Verdolin Board Certified Specialist in Pain Management
7051 Alvarado Rd #101, La Mesa, CA 91942

Please tell us in one sentence why you are here _____

What brings on your pain or makes it worse? (e.g. walking, coughing)_____

_____

What makes your pain better? _____

Please rate your pain on the following scale, Zero is NO PAIN, while 10 is WORST IMAGINABLE:

0 ● 1 ● 2 ● 3 ○ 4 ○ 5 ○ 6 ○ 7 ● 8 ● 9 ● 10 ●

No Pain — Worst Pain

Please rate how disabled you are, Zero is ABLE TO DO EVERYTHING, while 10 is TOTALLY DISABLED :

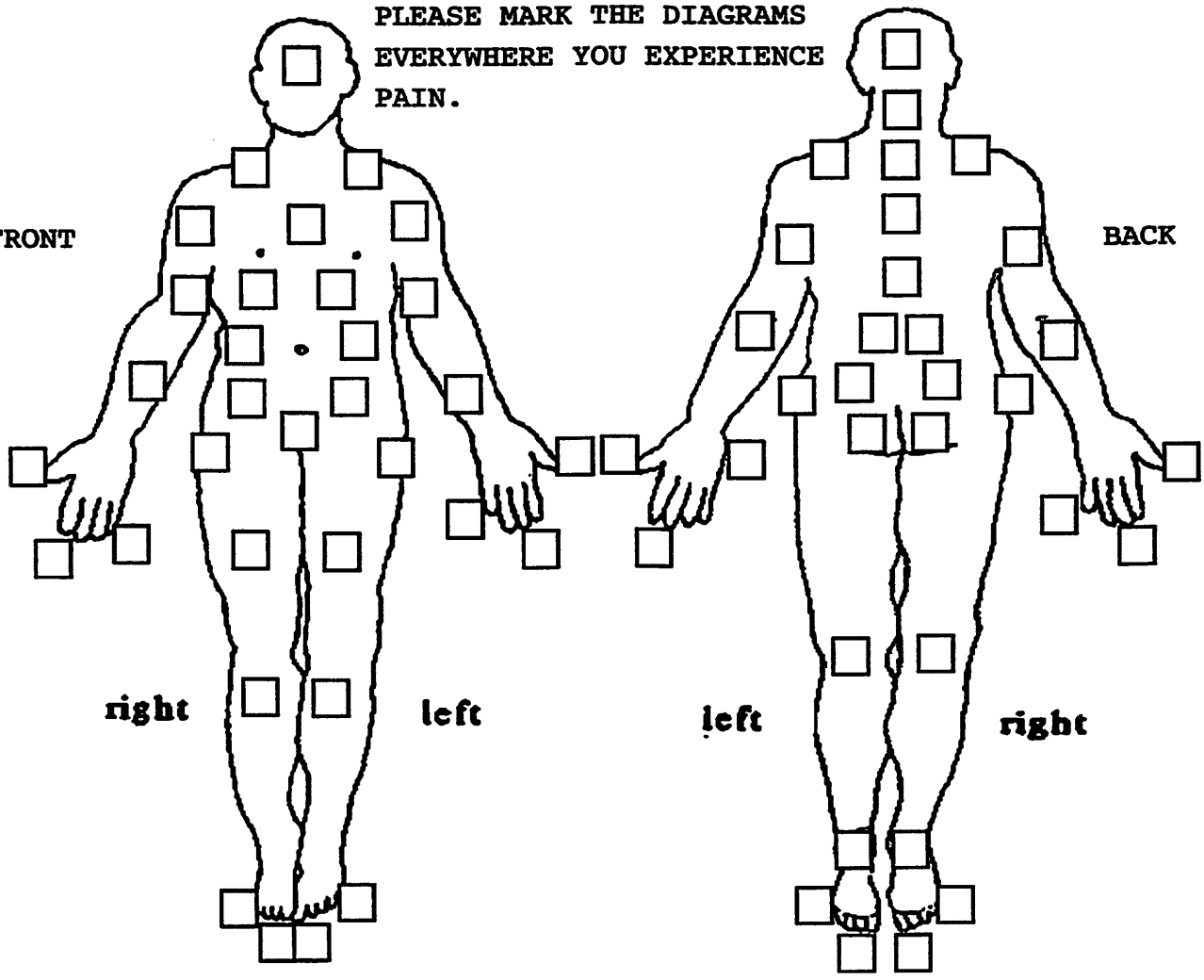
0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

Able to do everything — Unable to Function

Which words BEST describe your pain (PLEASE CHECK ALL THAT APPLY)?

Throbbing	☐	Aching	☐	Sharp	☐	Dull	☐	Shooting	☐	Tingling	☐
Burning	☐	Numbness	☐	Hot	☐	Cold	☐	Continuous	☐	Intermittent	☐

PLEASE MARK THE DIAGRAMS EVERYWHERE YOU EXPERIENCE PAIN.



Dr. Michael H. Verdolin Board Certified Specialist in Pain Management
7051 Alvarado Rd #101, La Mesa, CA 91942

How does the pain limit your activities? _____

In the boxes below please tell us if your pain limits the following activities and tell us your goals of treatment.

☐	Ability to work	How many hours per day do you work?
☐	Ability to sleep	Hours of sleep night?
☐	Recreation activities	Sleep is best described as:
☐	Relationship with family	Emotionally I am frequently:
☐	Relationship with friends	What are your expectations in the treatment of your pain?
☐	Concentration	

Please indicate if you have tried any of these treatments and if they were effective.

	Treatment	Yes	No
☐	Surgery	◯	◯
☐	Physical Therapy	◯	◯
☐	Chiropracter	◯	◯
☐	Acupuncture	◯	◯
☐	Massage	◯	◯
☐	Biofeedback	◯	◯
☐	Psychological counseling	◯	◯
☐	Steroid Injections	◯	◯
☐	Nerve Blocks	◯	◯

The Pain began on (date):

Onset of Pain was: ◯Sudden ◯Gradual

My Pain is: ◯Improving ◯Worsening ◯Unchanged

	Yes	No
Were you in an accident?	◯	◯
Were you injured at work?	◯	◯
Is legal action pending?	◯	◯
Are you currently working?	◯	◯

Please tell us about ALL medications and if they help your pain

Name of Drug, Herb, or Supplement	Strength or dosage	How many tablets at a time?	Per Day?	Total number of tablets per day	How long have you been taking it	Does it help?

List blood thinners you may be taking:

☐	Coumadin/Warfarin
☐	Ticlid/Plavix
☐	Lovenox/Enoxaparin
☐	Ginko, Garlic, Vitamin E
☐	325 mg (Full strength) Aspirin
☐	I certify to the best of my knowledge I am NOT on any blood-thinning medication or herb.

☐ I have NO DRUG ALLERGIES

☐ I am ALLERGIC to IODINE,SHELLFISH,CONTRAST DYE

☐ I have other drug allergies:

Please list physicians you have seen for your pain problem.

Doctor's Name	Practice Name	Date last seen

Dr. Michael H. Verdolin Board Certified Specialist in Pain Management
7051 Alvarado Rd #101, La Mesa, CA 91942

Please list all surgery you have had	Date

Please indicate if you have any of the following medical conditions.

☐	Stroke	☐	Heart attack	☐	Cancer	☐	Kidney Stones
☐	Dizziness	☐	Heart failure	☐	HIV/AIDS	☐	Smoking
☐	Blurry Vision	☐	Palpitations	☐	Muscle disease	☐	Asthma
☐	Hearing loss	☐	Irregular heart beat	☐	Broken bones	☐	Bronchitis
☐	Seizures	☐	High blood pressure	☐	Fibromyalgia	☐	Ulcer
☐	Headaches	☐	Chest pain	☐	Diabetes	☐	Blood in stool
☐	Memory loss	☐	Shortness of breath	☐	Thyroid disease	☐	Depression
☐	Numbness	☐	Murmurs	☐	Emphysema	☐	Easy bruising

Reset - Erase all input and start over

Pain Consultants of San Diego

Oswestry Disability Questionnaire **Name:**_____ **Date:**_____

This questionnaire has been designed to give us information as to how your pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly describes your problem.**

Section 1: Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but can manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- ☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights
- ☐ I cannot lift or carry anything

Section 4: Walking*

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than 1/2 mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5: Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6: Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minut
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7: Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9: Social Life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10: Traveling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to receive treatment