COMPREHENSIVE
Pain Management Center
Defining Excellence in Pain Management

Annu H. Navani, M.D., Q.M.E.
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www.cpainmc.com

Patient: ____ **Date:** ______________________________

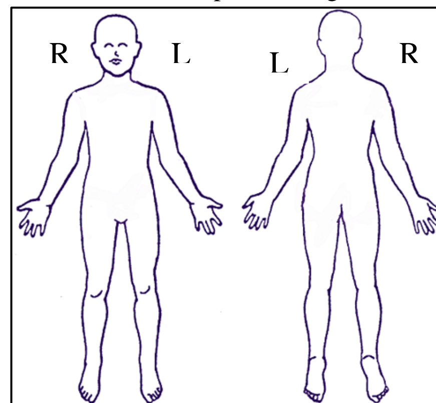
Referral: How did you hear about us? ❑ Physician/Practice Name: ______________________________
❑ Internet (Please specify): ________________________ ❑ Other: ______________________________
What are your pain concerns today? ____

HISTORY OF PRESENT ILLNESS
How long have you noticed your pain? _____ Days _____ Weeks _____ Months _____Years
Was there any injury/event that caused your pain? ❑ Yes ❑ No (Please describe your pain below):

____

Where is your pain located?
❑ Neck/Mid Back/Low Back ❑ Buttock/Hip/ Legs
❑ Shoulder/Elbow/ Hand ❑ Foot/Ankle
❑ Other

Where is the Pain?
(Indicate location of pain in diagram below):



Rate your usual pain (CIRCLE NUMBER BELOW THAT BEST APPLIES):
No Pain 0 1 2 3 4 5 6 7 8 9 10 *The Worst Pain Imaginable*

Describe your pain (Check all that apply):
❑ Burning ❑ Sharp-Shooting ❑ Tingling ❑ Numbness
❑ Pinprick ❑ Stabbing ❑ Deep-pressure ❑ Tightness
❑ Spasms ❑ Other: ____________________________________
What makes the pain worse?

____

What makes the pain better? ____

Which of the following have been affected because of your pain? (Check all that apply):
❑ Household Chores ❑ Office Work ❑ Driving ❑ Walking/Running ❑ Sports ❑ Concentration
❑ Depression ❑ Anxiety ❑ Mood ❑ Appetite ❑ Sleep ❑ Relationships

Past Treatment:
Which of the following treatments/ evaluations have you tried for your pain? (Check all that apply):
❑ MRI ❑ X-Ray ❑ CT ❑ EMG ❑ Bone Scan ❑ Blood/Laboratory ❑ Epidurals
❑ Physical Therapy ❑ TENS ❑ Heating Pad ❑ Ice ❑ Injections ❑ Exercise ❑ Steroids
❑ Surgery ❑ Massage ❑ Medications ❑ Acupuncture ❑ Hypnotherapy

CURRENT MEDICATIONS:

Name of Medication	Strength (e.g. mg, mcg)	Frequency (e.g. once a day)	Number of Pills Taken At One Time	Prescribing Physician

Patient Name: ____ DOB: ____________________

Name of Medication	Strength (e.g. mg, mcg)	Frequency (e.g. once a day)	Number of Pills Taken At One Time	Prescribing Physician

What Pharmacy do you use (Name, Address, Phone Number)? ___________________________________

PAST MEDICAL HISTORY (Check all that apply):
❑ Brain ❑ Heart ❑ Lungs ❑ Liver ❑ Kidneys ❑ Diabetes ❑ Bleeding/Anemia ❑ Depression/ Bipolar ❑ Psychiatric ❑ Arthritis ❑ Fibromyalgia ❑ Headaches ❑ Suicide ideation/ attempts ❑ Alcohol/ Drug Problems ❑ State/ SS Disability ❑ Other: __________________________

ALLERGIES (Please also list reactions):____

PAST SURGICAL HISTORY (List all surgeries below or write N/A):

Surgery Type	Date of Surgery (Mo/Yr)	Surgeon

HOSPITALIZATION (List all hospital visits below or write N/A):

Reason for Most Recent Hospitalization or ER visit?	Date of Admission (Mo/Yr)	Name of Hospital

FAMILY HISTORY (Check all that apply):
❑ Stroke ❑ Seizure ❑ Heart ❑ Lungs ❑ Liver ❑ Kidney/ Bladder ❑Cancer ❑ Migraines ❑ Diabetes ❑ High Blood Pressure ❑ Thyroid □ Bleeding/ Anemia ❑ Stomach/ Bowel ❑ Fibromyalgia ❑ Gout ❑ Arthritis ❑ Suicide ideation/ attempts ❑ Depression/Bipolar ❑ Mental Disorders
❑ Alcohol/ Drug Problems ❑ State/ SS Disability ❑ Other: __________________________

SOCIAL HISTORY:
What is your highest level of education? ____
Are you employed? ❑ Full Time ❑ Part Time ❑ Unemployed ❑ Disability ❑ Retired
Employer: __________________________________ Job Title: _______________________________________
Relationship Status: Are you: ❑ Single? ❑ Married? ❑ Separated? ❑ Divorced? ❑ Widowed?
Do you have children? ❑ Yes- How many? ___________ ❑ No
Who do you live with? ____
Smoking Status: Are you a: ❑ Current Smoker? How many packs a day? ____________ ❑ Former Smoker? How many years since you smoked? ________ ❑ Never smoker?
Do you drink alcohol? ❑ Yes- How many glasses per day? ____________ ❑ No
Do you use recreational drugs? ❑ Yes- Please elaborate: ____________ ❑ No
Have you ever abused drugs or alcohol in the past? ❑ Yes ❑ No
Have you ever been treated at a drug or alcohol rehabilitation center?

OFFICE USE ONLY: Ht: ________ Wt: _______ BP: _______ HR: ________

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PATIENT INFORMATION SHEET

Please fill out this information sheet carefully by filling in the blanks, circling the right answer or checking off the correct box. Please try to answer all of the questions. You may use the back side of any page to explain your answer or to give more information. This form will become part of your medical record.

NAME:	AGE:	SEX: *Male Female*
I am: *Left handed Right handed Ambidextrous*	My marital status is: *Married Single Divorced Separated Widowed*	
Employer at time of injury:	Date Hired:	Full Time / Part Time
Job title when injured:		
Job Description:		
List any other jobs or income source at the time of your work injury:		
Current work status: *Not working Regular work Modified work Part time Full time Same employer Different employer*		
List all the date(s) of all work injuries and the parts of your body that were injured each time:		
List any similar problems, illnesses or injuries at any time in your life prior to the work injury:		
Describe specifically how your work injury(s) occurred:		
Describe your current problems and areas of pain:		
What worsens or increases your problem or pain?		
What lessens or decreases your problem or pain?		
Any problems with bowel movements or with urination? *Yes No*	Do you have trouble sleeping? *Yes No*	
If zero (0) is no pain and ten (10) is the worst pain imaginable, how would you rate your pain:		
During the day time, how much time do you spend lying down or resting?		
Describe what you do in an average day:		
Please list all of your CURRENT MEDICATIONS: (Include dosages and how often you take them)		
Please list all ALLERGIES you have to medications:		

Patient Name: ____ DOB: ___________________

Circle all past & current MEDICAL PROBLEMS: DIABETES HIGH BLOOD PRESSURE HEART-LUNG THYROID DISEASE SEIZURES NEUROLOGIC PROBLEMS KIDNEY-BLADDER BROKEN BONES CANCER STOMACH PROBLEMS BOWEL PROBLEMS SKIN PROBLEMS STROKE PSYCHOLGICAL PROBLEMS NERVOUSNESS DEPRESSION-ANXIETY GOUT HEREDITARY DISEASE HEARING LOSS SUICIDE ATTEMPT ANEMIA PAST WORK INJURIES SPORTS INJURIES AUTO ACCIDENTS	Please list any other problems not already mentioned:
List dates for all injuries, auto accidents, hospitalizations and surgeries:	
Circle any of the following which have occurred in family members: DIABETES MENTAL DISORDERS NECK OR BACK PROBLEMS DISABILITY ARTHRITIS SEVERE INJURIES ALCOHOL OR DRUG PROBLEMS	
How would you characterize your childhood?	
How far did you get in school?	Have you ever served in the military? *Yes No*
Have you ever been arrested or convicted of a crime? *Yes No*	
How many times have you been married?	If married now, for how long?
What is the job title of your spouse or companion?	
If you have children, please list their ages: (Circle the ones living with you)	
Who do you live with now?	
List your hobbies & recreational activities before your work injury. (Circle those you can no longer do)	
Have you ever had an alcohol or drug problem? *Yes No*	How much alcohol do you use now?
How much tobacco is used in an average day?	Current recreational drug use: *Yes No*
Salary before work injury:	Present Income (List sources & amounts)
Do you have an attorney? *Yes No*	Who?
Please list previous employers, job titles and length of employment at each place (Start with the most recent job)	
What do you see in the future for yourself and what do you hope to be doing in one year?	

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THE EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your personal physician.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze or sleep
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

Please fill in your answers:

Situation	Chance of Dozing or Sleeping
Sitting and reading	____
Watching TV	____
Sitting inactive in a public place	____
Being a passenger in a motor vehicle for an hour or more	____
Lying down in the afternoon	____
Sitting and talking to someone	____
Sitting quietly after lunch (no alcohol)	____
Stopped for a few minutes in traffic while driving	____
Total score (add the scores up)	____

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PHQ-9 – Scoring Tally Sheet

Patient Name ____________________________ **Date** ____________________

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully and check your response.

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little or no pleasure in doing things				
b. Feeling down, depressed or hopeless				
c. Trouble falling asleep, stay asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure or feeling that you have yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed; or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
TOTALS				

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult At All	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

FOR CPAINMC STAFF USE ONLY:

TOTAL: __________

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QUESTIONS CONCERNING ACTIVITIES OF DAILY LIVING (ADL)

Name: ______________________________________ **Date:** ______________

Please fill out this form based on how you are currently feeling. Please fill out this form carefully and mark only one box for each question.

1. **How well can you perform personal self-care activities including washing, dressing, using the bathroom, etc.?**
   - ☐ I can look after myself normally without having extra discomfort.
   - ☐ I can look after myself normally but have extra discomfort.
   - ☐ It is uncomfortable to look after myself and I am slow and careful.
   - ☐ I need some help but I manage most of my personal self-care.
   - ☐ I need help every day in most aspects of my person self-care.
   - ☐ I do not get dressed, I wash with difficulty and I stay in bed or lay down most of the day.

2. **How well can you lift and carry?**
   - ☐ I can lift and carry heavy objects without having extra discomfort.
   - ☐ I can lift and carry heavy objects but I get extra discomfort.
   - ☐ I can lift and carry heavy objects only if they are conveniently positioned.
   - ☐ I can only lift and carry light to medium objects if they are conveniently positioned.
   - ☐ I can only lift very light objects.
   - ☐ I cannot lift or carry anything at all.

3. **How well can you walk?**
   - ☐ I am able to walk the same distance I could before my injury.
   - ☐ My injury and discomfort prevents me from walking more than 1 mile.
   - ☐ My injury and discomfort prevents me from walking more than 1/2 mile.
   - ☐ My injury and discomfort prevents me from walking more than 1/4 mile.
   - ☐ Because of my injury and discomfort I walk only a limited distance or use a cane or walker.
   - ☐ Because of my injury and discomfort I am in bed most of the time or use a wheelchair.

4. **What is the most strenuous level of activity that you can do for at least 2 minutes?**
   - ☐ Very heavy activity
   - ☐ Heavy activity
   - ☐ Moderate activity
   - ☐ Light activity
   - ☐ Very light activity
   - ☐ Extremely light to no activity

Patient Name: ____ DOB: _______________

5. **How well can you climb a flight of stairs?**
   - ☐ No difficulty (and you can easily perform the activity)
   - ☐ Some difficulty (but you can still perform the activity well enough)
   - ☐ A lot of difficulty (but you can still do the activity)
   - ☐ Unable (you cannot do this activity or someone else helps you with it)

6. **How well can you sit for 30 minutes?**
   - ☐ No difficulty (and you can easily perform the activity)
   - ☐ Some difficulty (but you can still perform the activity well enough)
   - ☐ A lot of difficulty (but you can still do the activity)
   - ☐ Unable (you cannot do this activity)

7. **How well can you sit for 2 hours?**
   - ☐ No difficulty (and you can easily perform the activity)
   - ☐ Some difficulty (but you can still perform the activity well enough)
   - ☐ A lot of difficulty (but you can still do the activity)
   - ☐ Unable (you cannot do this activity)

8. **How well can you stand or walk 30 minutes to an hour?**
   - ☐ No difficulty (and you can easily perform the activity)
   - ☐ Some difficulty (but you can still perform the activity well enough)
   - ☐ A lot of difficulty (but you can still do the activity)
   - ☐ Unable (you cannot do this activity)

9. **How well can you stand or walk for 2 hours?**
   - ☐ No difficulty (and you can easily perform the activity)
   - ☐ Some difficulty (but you can still perform the activity well enough)
   - ☐ A lot of difficulty (but you can still do the activity)
   - ☐ Unable (you cannot do this activity)

10. **How well can you reach and grasp something off a shelf at eye level?**
    - ☐ No difficulty (and you can easily perform the activity)
    - ☐ Some difficulty (but you can still perform the activity well enough)
    - ☐ A lot of difficulty (but you can still do the activity)
    - ☐ Unable (you cannot do this activity or someone else helps you with it)

11. **How well can you reach and grasp something off a shelf overhead?**
    - ☐ No difficulty (and you can easily perform the activity)
    - ☐ Some difficulty (but you can still perform the activity well enough)
    - ☐ A lot of difficulty (but you can still do the activity)
    - ☐ Unable (you cannot do this activity or someone else helps you with it)

12. **Do you have any difficulty with pushing and pulling activities?**
    - ☐ No difficulty (and you can easily perform the activity)
    - ☐ Some difficulty (but you can still perform the activity well enough)
    - ☐ A lot of difficulty (but you can still do the activity)

- ☐ Unable (you cannot do this activity or someone else helps you with it)

13. Do you have any difficulty with gripping, grasping, holding and manipulating objects with your hands?

- ☐ No difficulty (and you can easily perform the activity)
- ☐ Some difficulty (but you can still perform the activity well enough)
- ☐ A lot of difficulty (but you can still do the activity)
- ☐ Unable (you cannot do this activity or someone else helps you with it)

14. Do you have any difficulty with repetitive motions such as typing on a computer?

- ☐ No difficulty (and you can easily perform the activity)
- ☐ Some difficulty (but you can still perform the activity well enough)
- ☐ A lot of difficulty (but you can still do the activity)
- ☐ Unable (you cannot do this activity or someone else helps you with it)

15. Do you have any difficulty with forceful activities with your arms and hands?

- ☐ No difficulty (and you can easily perform the activity)
- ☐ Some difficulty (but you can still perform the activity well enough)
- ☐ A lot of difficulty (but you can still do the activity)
- ☐ Unable (you cannot do this activity or someone else helps you with it)

16. Do you have any difficulty with kneeling, bending or squatting?

- ☐ No difficulty (and you can easily perform the activity)
- ☐ Some difficulty (but you can still perform the activity well enough)
- ☐ A lot of difficulty (but you can still do the activity)
- ☐ Unable (you cannot do this activity or someone else helps you with it)

17. Do you have any difficulty sleeping?

- ☐ I have no trouble sleeping because of my injury and discomfort.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless) since my injury.
- ☐ My sleep is mildly disturbed (1-2 hours sleepless) since my injury.
- ☐ My sleep is moderately disturbed (2-3 hours sleepless) since my injury.
- ☐ My sleep is greatly disturbed (3-5 hours sleepless) since my injury.
- ☐ My sleep is completely disturbed (5-7 hours sleepless) since my injury.

18. In regards to sexual activity since and because of your injury?

- ☐ It is not a problem and there has not been a change because of my injury.
- ☐ It is a little less frequent because of my injury.
- ☐ It is much less frequent because of my injury.
- ☐ No sexual functioning because of my injury.

19. In regards to your pain <u>at the moment</u>?

- ☐ I have no pain at the moment.
- ☐ My pain is mild at the moment.
- ☐ My pain is moderate at the moment.
- ☐ My pain is severe at the moment.

- ☐ My pain is the worst imaginable at the moment.

20. In regards to your pain <u>most of the time</u>?
- ☐ I have no pain most of the time.
- ☐ My pain is mild most of the time.
- ☐ My pain is moderate most of the time.
- ☐ My pain is severe most of the time.
- ☐ My pain is the worst imaginable most of the time.

21. How much do your injury and/or pain interfere with your ability to travel?
- ☐ None
- ☐ Some or a little of the time
- ☐ A lot or most of the time
- ☐ All of the time – I can't travel

22. How much do your injury and/or pain interfere with your ability to engage in social activities?
- ☐ None
- ☐ Some or a little of the time
- ☐ A lot or most of the time
- ☐ All of the time – I can't engage in social activities

23. How much do your injury and/or pain interfere with your ability to engage in recreational activities?
- ☐ None
- ☐ Some or a little of the time
- ☐ A lot or most of the time
- ☐ All of the time – I can't engage in recreational activities

24. How much do your injury and/or pain interfere with concentrating or thinking?
- ☐ None
- ☐ Some or a little of the time
- ☐ A lot or most of the time
- ☐ All of the time – I can't concentrate or think very clearly

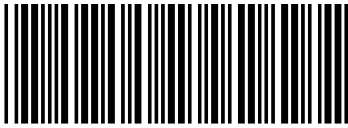
25. How much has your injury and/or pain caused emotional distress with depression or anxiety?
- ☐ None (no depression or anxiety from the injury or discomfort)
- ☐ Some or a little of the time (mild depression or anxiety from the injury or discomfort)
- ☐ A lot or most of the time (moderate depression or anxiety from the injury or discomfort)
- ☐ All of the time (severe depression or anxiety from the injury or discomfort)

Patient Name: ____ DOB: ________________

Work & Functional Capacity Activity Estimation Summary

Please complete based on your estimate of your capacity at the current time. This is a measure of how long you are able to tolerate these activities, not how long your occupation requires you to do them.

ACTIVITY (Hours per Day)	NEVER 0 hours	SOME <1 hour	OCCASIONALLY 1-3 hours	FREQUENTLY 3-6 hours	CONSTANTLY 6-8 hours+
Repetitive neck motions					
Static neck posturing					
Bending / Twisting (waist)					
Squatting & kneeling					
Sitting					
Standing					
Walking					
Climbing stairs					
Climbing ladders					
Walking over uneven ground					
Working at heights					
Working around moving machinery					
Repetitive use of upper extremity (right)					
Repetitive use of upper extremity (left)					
Grasping / Gripping (right hand)					
Grasping / Gripping (left hand)					
Forceful use of upper extremity (right)					
Forceful use of upper extremity (left)					
Fine manipulation (right hand)					
Fine manipulation (left hand)					
Pushing & pulling (right) – in pounds					
Pushing & pulling (left) – in pounds					
Reaching (at shoulder level)					
Reaching (above shoulder level)					
Lifting / Carrying – in pounds					



STATE OF CALIFORNIA Division of Workers' Compensation Disability Evaluation Unit

DEU Use Only

EMPLOYEE'S DISABILITY QUESTIONNAIRE

This form will aid the doctor in determining your permanent impairment or disability. Please complete this form and give it to the physician who will be performing the evaluation. The doctor will include this form with his or her report and submit it to the Disability Evaluation Unit, with a copy to you and your claims administrator.

Employee

First Name ______ MI ______

Last Name ______

SSN (Numbers Only) ______

Street Address 1/PO Box (Please leave blank spaces between numbers, names or words) ______

Street Address 2/PO Box (Please leave blank spaces between numbers, names or words) ______

International Address (Please leave blank spaces between numbers, names or words) ______

City ______ State ______ Zip Code ______

Date of Birth ______ MM/DD/YYYY

Date of Injury ______ MM/DD/YYYY

Employer ______

Nature of Employers Business ______

Claim Number 1 ______

Claim Number 2 ______________________________

Claim Number 3 ______________________________

Claim Number 4 ______________________________

Claim Number 5 ______________________________

PLEASE ANSWER THE FOLLOWING QUESTIONS FULLY:
How was your evaluating doctor selected? (check one)

☐ From a list of doctors provided by the State of California, Division of Workers' Compensation.

☐ Other (explain) ______________________________

What is the name of the doctor who will be doing the evaluation? ______________________________

When is your examination scheduled? ______________________________

What were your job duties at the time of your injury?

What is the disability resulting from your injury?

How does this injury affect you in your work?

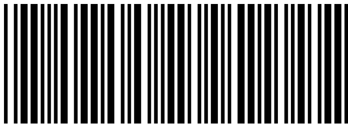
Have you ever had a disability as a result of another injury or illness? ______________________________

If so, when? ______________________________

Please describe the disability?

Date ______________________________
MM/DD/YYYY

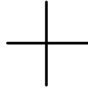
Signature ______________________________

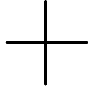


State of California
Division of Workers' Compensation
Disability Evaluation Unit

DEU Use Only

REQUEST FOR SUMMARY RATING DETERMINATION of Qualified Medical Evaluator's Report





INSTRUCTIONS TO THE CLAIMS ADMINISTRATOR:

1. Use this form if employee is unrepresented and has not filed an application for adjudication.
2. Complete this form and forward it along with a complete copy of all medical reports and medical records concerning this case to the physician scheduled to evaluate the existence and extent of permanent impairment or disability.
3. Send the EMPLOYEE'S DISABILITY QUESTIONNAIRE, DEU FORM 100 to the employee in time for the medical evaluation.
4. **This form must be served on the employee prior to the evaluation. Be sure to complete the proof of service.**

INSTRUCTIONS TO THE PHYSICIAN:

1. If the employee is unrepresented, review and comment upon the Employee's Disability Questionnaire, (DEU Form 100), in your report. (If the employee does not have a completed Form 100 at the time of the appointment, please provide the form to the employee.)
2. Submit your completed medical evaluation and, if the employee is unrepresented, the DEU Form 100, to the Disability Evaluation Unit district office listed below. **PLEASE USE THIS FORM AS A COVER SHEET FOR SUBMISSION TO THE DISABILITY EVALUATION UNIT.**
3. Serve a copy of your report and the Form 100 upon the claims administrator and the employee.

Date of first medical report indicating the existence of permanent impairment or disability: ____________________
MM/DD/YYYY

Last date for which temporary disability indemnity was paid: ____________________
MM/DD/YYYY

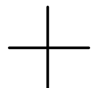
Submit To: Disability Evaluation Unit

____
Address/PO Box (Please leave blank spaces between numbers, names or words)

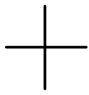
____________________________________ CA ____ ____________
City State Zip Code

____
Physician

Exam Date ____________________
MM/DD/YYYY



Claims Administrator



Company Name

Street Address1/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claim Number 1

Claim Number 2

Claim Number 3

Claim Number 4

Claim Number 5

Phone No.

Adjustor

Employer

Employee

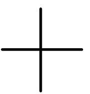
First Name MI

Last Name

Street Address 1/PO Box (Please leave blank spaces between numbers, names or words)

Street Address 2/PO Box (Please leave blank spaces between numbers, names or words)

International Address (Please leave blank spaces between numbers, names or words)



City ______________________________ State ______ Zip Code ______________

Date of Injury ______________________ Date of Birth ______________________

MM/DD/YYYY MM/DD/YYYY

SSN (Numbers Only) ______________________________

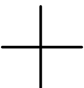
Case No (if any) ______________________________

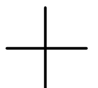
OCCUPATION ____

(Please attach job description or job analysis, if available)

WEEKLY GROSS EARNINGS ____________________

(Attach a wage statement/DLSR 5020 if earnings are less than maximum. Include the value of additional advantages provided such as meals, lodging, etc. If earnings are irregular or for less than 30 hours per week, include a detailed description of all earnings of the employee from all sources, including other employers, for one year prior to the date of injury. Benefits will be calculated at MAXIMUM RATE unless a complete and detailed statement of earnings is attached.)





PROOF OF SERVICE BY MAIL

On ________________________, I served a copy of this Request for Summary Rating Determination on

Name of Employee____

Address ____

City________________________State __________________ Zip___________________

by placing a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

____
Signature