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Chronic Pain Management
(MSP, expedited WCB, ICBC and private consultations)

Cortisone injections:
Epidural Steroid Injections (Back or Neck)
Knee or Hip or shoulder joints

Baker's cyst
Trigger points/myofascial
Carpal Tunnel
Tennis elbow
Botox/migraine

NAME_____
LAST FIRST MIDDLE

ADDRESS_____

CITY_____PROVINCE_____POSTAL CODE_____

HOME_____BUSINESS_____CELL_____

DATE OF BIRTH_____AGE_____SEX (circle one) male female other
(DD/MM/YYYY)

HEIGHT_____WEIGHT_____PERSONAL HEALTH NUMBER_____

EXTENDED HEALTHCARE (circle one) Yes No PROVIDER_____

EMAIL ADDRESS: _____

REFFERING DOCTOR_____FAMILY DOCTOR_____

REASON FOR VISIT? _____

ACTIVE ICBC CLAIM (circle one) yes no ACTIVE WCB CLAIM (circle one) yes no

PLEASE LIST ANY PREVIOUS SURGERIES/OPERATIONS.

_____

_____

PLEASE LIST ANY MEDICAL PROBLEMS (I.E. DIABETES, HIGH BLOOD PRESSURE ETC.).

_____

_____

_____

PLEASE LIST ALL MEDICATIONS YOU ARE **NOW** TAKING:

BLOOD THINNERS (PLAVIX / WARFARIN / XARELTO / ETC.)_____

PAIN MEDICATIONS_____

_____

OTHER MEDICATIONS_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? *YES* *NO*

_____

DO YOU HAVE ANY OTHER ALLERGIES (LATEX, ETC.)? *YES* *NO* _____

HISTORY OF PRESENT CONDITION

Pain Location:

Back	Right	Left	Bilateral
Leg	Right	Left	Bilateral
Neck	Right	Left	Bilateral
Shoulder	Right	Left	Bilateral
Arm	Right	Left	Bilateral

When did the pain start? _____

Progression:	Better	Worse	Same

Frequency: Daily or _____ times per week

Severity: _____ out of 10

Associated with: Numbness_____ (where)

Weakness_____ (leg/arm)

ACTIVITIES OF DAILY LIVING

Does your condition affect your daily activities? Yes No

Do you work? Yes No What is your occupation? _____

Does your condition affect your work? Yes No

How does it affect you at work? _____

_____

What kind of leisure activities do you do? (What do you do for fun? Bowling, golfing, gardening, etc.)_____

_____

_____

Does your condition affect your leisure activities? Yes No

How does it affect your leisure activities? _____

_____

_____

Who lives at home with you? _____

Who does the cooking _____, cleaning _____, grocery shopping _____, and yard work _____? Does your condition affect your walking? Yes No

How far can you walk? ____ (blocks)

Do you smoke? Yes No Do you drink alcohol? Yes No

If yes, how often? Rarely _____Socially _____Daily_____

Street Drugs? Yes No If yes what: _____