VIRGINIA KETAMINE THERAPY

Mark W. Newman, DO

223 Bulifants Blvd., Suite C

Williamsburg, VA 23188

Phone: 757.258.2561 Fax: 757.258.5936

Name:_____ Date:_____ DOB:_____
Consultation Requested By:_____
Specialty of Referring Physician:_____ Phone #:_____
Primary Care Physician:_____ Phone #:_____

1. Use the following rating scales to indicate how severe your pain is at its worst and as it usually is.

Circle the appropriate number.

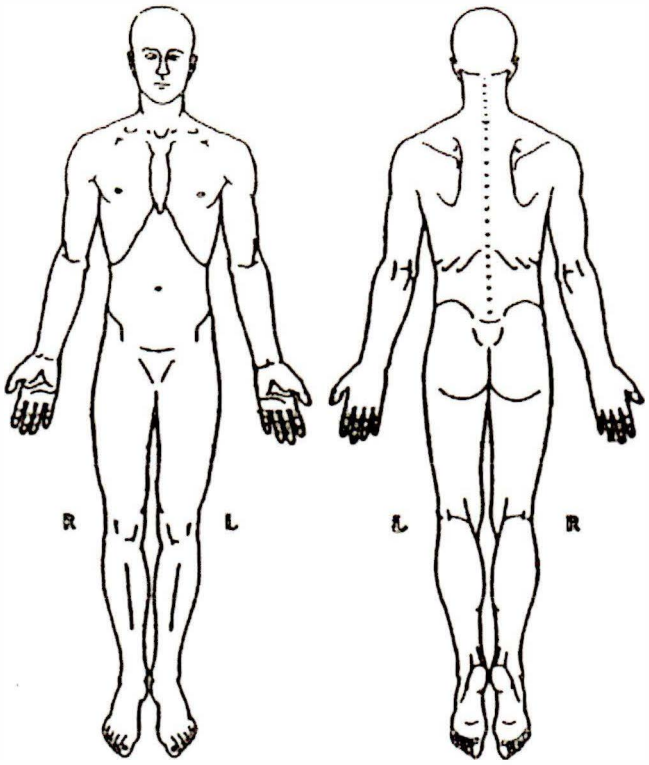
Your pain at its worst:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Your pain as it usually is:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

2. Please shade in the area of your pain.



3. Please rate your current level of activity:

No Activity 0 1 2 3 4 5 6 7 8 9 10 Very Active

4. Complete the following:

	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Burning				

5. Does your pain travel anywhere? [ ] No [ ] Yes If yes, where?_____

6. Which statement best describes your pain?

[ ] Always present, always the same intensity.
[ ] Always present, intensity varies.
[ ] Usually present, but have short periods without pain.
[ ] Often present, occasionally present, have pain once to several times/day, lasting a few minutes to an hour.
[ ] Occasionally present for brief periods, a few seconds to a few minutes.
[ ] Rarely present, have pain every few days or weeks.

7. What time of day is your pain worst?

[ ] Morning or arising
[ ] Later in the morning
[ ] Afternoon
[ ] Evening
[ ] Bedtime
[ ] Night (during usual sleeping hours)
[ ] Pain is always the same
[ ] Pain varies, but is not worse at any particular time

8. Do any of the following make your pain feel worse?

[ ] Coughing, Sneezing
[ ] Sitting
[ ] Standing
[ ] Lying Down
[ ] Walking
[ ] Physical Activity
[ ] Sexual Activity
[ ] Other (describe)_____

9. Do any of the following make your pain feel better?

[ ] Relaxation
[ ] Sitting
[ ] Standing
[ ] Lying Down
[ ] Walking
[ ] Medicines
[ ] Heat
[ ] Sexual Activity
[ ] Alcoholic Drinks
[ ] Other (describe)_____
[ ] Nothing makes it feel better

10. Does pain interrupt your sleep? (Check one)

[ ] Not at all

[ ] Once per night [ ] Three times per night

[ ] Twice per night [ ] More than three times per night

11. When did you first notice the pain? Month_____ Day_____ Year_____

12. Under what circumstances did pain begin? (Check one)

[ ] Accident at work

[ ] Accident at home

[ ] At work, but not an accident

[ ] Pain just began, no reason

[ ] Motor vehicle accident

[ ] Following surgery

[ ] Following illness

[ ] Other (describe)_____

13. If pain began at work, please list

Place of employment when pain began_____

Date of injury: Month_____ Day_____ Year_____

How long had you been employed there? Years_____ Months_____

Type of work:_____

14. If injury resulted from a motor vehicle accident, were you:

[ ] Driving an automobile or truck [ ] Motorcycle passenger

[ ] Passenger in automobile or truck [ ] Pedestrian

[ ] Driving a motorcycle

Please describe details:_____

_____

15. Have you had nerve blocks (injections) for pain relief? [ ] No [ ] Yes

If yes:

Name of doctor:_____

Did they relieve the pain? [ ] No [ ] Yes

If yes, how long did relief last?

[ ] Less than one day

[ ] A few days

[ ] A few weeks

[ ] More than one month

16. Have you had any of the following for pain relief? If yes, did it relieve your pain?

Hypnosis	[ ] No	[ ] Yes	[ ] Relief
BioFeed Back	[ ] No	[ ] Yes	[ ] Relief
Tens (Electrical Stimulation)	[ ] No	[ ] Yes	[ ] Relief
Acupuncture	[ ] No	[ ] Yes	[ ] Relief
Chiropractic Treatment	[ ] No	[ ] Yes	[ ] Relief
Heat Therapy	[ ] No	[ ] Yes	[ ] Relief
Physical Therapy	[ ] No	[ ] Yes	[ ] Relief
Bed Rest	[ ] No	[ ] Yes	[ ] Relief
Traction	[ ] No	[ ] Yes	[ ] Relief
Osteopathic Treatment	[ ] No	[ ] Yes	[ ] Relief
Psychotherapy	[ ] No	[ ] Yes	[ ] Relief
Other (describe)_____	[ ] No	[ ] Yes	[ ] Relief

17. Please use the following scale to rate your ability to cope with your pain.
Circle the appropriate number.

Unable to Cope 0 1 2 3 4 5 6 7 8 9 10 Cope Very Well

18. Do you feel you are helpless to change your present condition?

Always Helpless 0 1 2 3 4 5 6 7 8 9 10 Never Helpless

19. Do you feel your present condition is Hopeless?

Very Hopeless 0 1 2 3 4 5 6 7 8 9 10 Never Hopeless

20. Have you ever had psychological or psychiatric treatment? [ ] No [ ] Yes

21. Have you ever been physically or sexually abused? [ ] No [ ] Yes

22. CURRENT MEDICATIONS:

A. Medications **for pain** (please bring the bottles with you to your appointments):

Medication Name	Dosage	Times/Day

B. Mediations **for all other conditions**:

Medication Name	Dosage	Times/Day

C. Do you have any questions about drug side effects, dependency, or addiction?

[ ] No [ ] Yes

23. **ALLERGIES**: List all medical allergies:

_____

_____

_____

24. Have you **had surgery for your pain**?

Operation	Hospital	Date	Surgeon

25. Have you **had any other surgery for other reasons** (i.e. tonsillectomy, appendectomy, etc.)?

Operation	Hospital	Date	Surgeon

Social History

26. Are you: [ ] Married [ ] Never Married [ ] Divorced [ ] Widowed

27. Do you live:

[ ] Alone [ ] With spouse [ ] With Children [ ] With Relatives [ ] With Friend, Roommate

28. If you are married or have a spouse equivalent, please use the following rating scales to describe your relationship with your spouse:

Relationship before pain began:

Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

Relationship now:

Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

29. Do you have any children? [ ] No [ ] Yes If yes, how many? _____

30. What is the highest level of education you have completed?

[ ] Some High School [ ] High School Diploma/GED [ ] Some College

[ ] Associates Degree [ ] Bachelor's Degree

[ ] Graduate/Professional [ ] Technical Degree

31. Do you drink alcohol? [ ] No [ ] Yes If yes, how much? _____
Have you ever cut down on drinking? [ ] No [ ] Yes
Or ever felt annoyed by criticisms about drinking? [ ] No [ ] Yes
Or had guilty feelings about drinking? [ ] No [ ] Yes
Or taken an "eye opener" in the morning? [ ] No [ ] Yes

32. Please check the most appropriate answer:
_____ Current every day smoker
_____ Current some day smoker
_____ Former smoker
_____ Have never smoked
If you smoke, would you like to talk to the doctor about quitting? [ ] No [ ] Yes

33. Do you have any prior history of drug abuse? [ ] No [ ] Yes

Family History

34. Does your family have a history of significant medical problems?

Relationship to you

[ ] Diabetes _____
[ ] Hypertension _____
[ ] Heart Disease _____
[ ] Strokes _____
[ ] Cancer _____
[ ] Other (please specify) _____

Work History

35. What is your occupation?_____
Specifically, what are your duties?_____

36. Do you work: [ ] Full Time [ ] Part Time [ ] Don't Work [ ] Self Employed
If unemployed, last date worked:_____

37. Did you find your job satisfying? [ ] No [ ] Yes

38. Did you find your job financially satisfying? [ ] No [ ] Yes

39. Did you stop working because of your pain? [ ] No [ ] Yes

40. Have you received financial compensation related to your pain? [ ] No [ ] Yes
If yes, was payment a lump sum? [ ] No [ ] Yes

41. Are you receiving continued financial support related to your pain? [ ] No [ ] Yes
If yes, who is providing payments?_____

42. If you are receiving financial compensation, do you feel it is satisfactory? [ ] No [ ] Yes

Review of Symptoms

What medical problems do you think you have currently?

General:

[ ] Fatigue
[ ] Fever
[ ] Chills
[ ] Change in weight
[ ] Trouble sleeping
[ ] Depression
[ ] Nervousness
[ ] Panic Attacks

Allergies:

[ ] Food
[ ] Pollens
[ ] Other:_____

Head and Neck:

[ ] Headache or Neck Pain
[ ] Visual Problems
[ ] Nose Problems
[ ] Mouth Sores
[ ] Hearing Problems
[ ] Sinus Problems

Lungs:

[ ] Shortness of Breath
[ ] Pneumonia
[ ] Cough
[ ] Pleurisy
[ ] Coughing up Blood
[ ] Wheezing or Asthma

Kidneys and Bladder:

[ ] Frequent Infections
[ ] Frequent Urination
[ ] Painful Urination
[ ] Leakage of Urine
[ ] Trouble Starting
[ ] Blood in Urine
[ ] Dark Urine

Blood:

[ ] Bleeding Disorder
[ ] Blood Clots or Inflamed Veins
[ ] Enlarged Lymph Node(s)

Brain and Nerves:

[ ] Numbness or Tingling
[ ] Loss of Consciousness
[ ] Difficulty Thinking or Concentrating
[ ] Difficulty with Memory
[ ] Incoordination
[ ] Weakness or Paralysis
[ ] Muscle Wasting
[ ] Problem Walking
[ ] Vertigo or Dizziness

Endocrine:

[ ] Excessive Thirst
[ ] Increased Perspiration
[ ] Heat or Cold Intolerance
[ ] Radiation Exposure

Heart:

[ ] Chest Pain
[ ] Shortness of Breath while while laying down
[ ] Shortness of Breath upon exertion

Musculoskeletal:

[ ] Leg Cramps
[ ] Swelling of Ankles
[ ] Muscle Aches
[ ] Back Pain
[ ] Joint Pain

Skin and Hair:

[ ] Skin Ulcers, Sores
[ ] Growth or Lumps
[ ] Rash
[ ] Loss of Hair
[ ] Bruising
[ ] Hands turning blue or white

Stomach and Bowel:

[ ] Constipation
[ ] Problems swallowing
[ ] Change in Appetite
[ ] Abdominal Pain
[ ] Nausea or Vomiting
[ ] Vomiting Blood
[ ] Black Stool or Blood in Stool
[ ] Jaundice (Yellowing)
[ ] Diarrhea
[ ] Heart Burn
[ ] Food Intolerance:_____
_____

[ ] Other:_____
_____

[ ] None to report