

# Lanier Interventional Pain Center

**John L. Givogre, M.D.**

Board Certified in Pain Medicine and Anesthesiology

2335 Limestone Overlook  
Gainesville, GA 30501

Phone 770.297.0356  
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## PATIENT REGISTRATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street City State Zip

Phone: \_\_\_\_\_  
Home Cell Work

DOB: \_\_\_\_\_ Social Security \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Insured Party: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date: \_\_\_\_\_

**- PLEASE GIVE INSURANCE CARDS TO FRONT DESK PERSONNEL FOR COPYING PURPOSES -**

Secondary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Insured Party: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

Policy # \_\_\_\_\_ Group #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

I hereby authorize payment directly to the physician for any professional services rendered to my dependent or myself. I understand that I am financially responsible for any charges not paid by my insurance company, unless my insurance plan is one that contracts directly with the physician and they determine that I am not responsible. Regulations pertaining to medical assignment of benefits apply. In the event it becomes necessary to collect the amount due on my account by legal litigation, the handling fees, service charges, or court cost will be paid by the guarantor. In order to prevent the application of the above, fees should be paid timely upon completion of rendered services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Lanier Interventional Pain Center

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## Authorization for Use and/or Disclosure of Protected Health Information

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security \_\_\_\_\_

### Section A: Use or Disclosure of Health Information

By signing this form, I authorize the exchange, use, and/or disclosure of my individually identifiable health information maintained by \_\_\_\_\_

Fax: \_\_\_\_\_ Phone: \_\_\_\_\_ Contact: \_\_\_\_\_

Mail/Send records to \_\_\_\_\_

### Section B: Scope and Use of Disclosure

I understand that this authorization may include, if applicable:

- Information pertaining to the identification of, diagnosis, prognosis, or treatment for alcohol or drug abuse.
- Information concerning the testing for HIV (Human Immune Virus) and/or treatment for AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.
- Privileged communications between me and a psychiatrist, psychologist, licensed clinical social worker, licensed marriage and family counselor, or licensed professional counselor or between them concerning my communications with any of them.

Information that may be used or disclosed based on this authorization is as follows:

- Specific health information about me as directed in the preceding section, also including the following: Last two office notes, lab reports, hospital/ER reports, medical records, x-ray reports, drug screens, procedure notes, operative notes, MRI results, bone/dexa scan results.
- All health information and medical records created by the above Doctor/Facility.
- All health information about me as directed above excluding the following: \_\_\_\_\_  
\_\_\_\_\_

Section C: Purpose The purpose for this disclosure is (check only one):

- Specifically, the following: \_\_\_\_\_
- The consumer does not elect to disclose the purpose. Note: This box may not be checked if the information to be disclosed pertains to alcohol or drug abuse.

Section D: Expiration This content will expire without revocation twelve months from the date of signing or in the event written notification is received.

Patient/Consumer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Lanier Interventional Pain Center

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## Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Health Care Information

1. I understand that as part of my health care, Lanier Interventional Pain Center originates records and maintains health information about me describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this health care information may be used or disclosed by LIPC for treatment, payment, and health care operations. For example, my health information serves as

- a basis for planning my care and treatment
- a means of communication among many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third party payor can verify that services billed were actually provided
- a tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.

2. I acknowledge that if I desire I can be provided with Lanier Interventional Pain Center's notice of privacy practices that provides a more complete description of information uses and disclosures. I understand that LIPC reserves the right to change its notice of privacy practices and prior to implementation will mail a copy of any revised notice to the address I have provided.

3. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and that LIPC is not required to agree to the restrictions requested but if it does, it is bound by such restrictions.

4. I understand that I may revoke this consent in writing, except to the extent that LIPC has already taken action in reliance thereon.

5. By signing this form, I consent to Lanier Interventional Pain Center's use and disclosure of my health information for treatment, payment, and health care operations. I give consent to LIPC to obtain copies of my medical records for treatment and health care operations.

I request the following restrictions to the use or disclosure of my health information:

- Restrictions accepted       Restrictions denied

\_\_\_\_\_  
Signature/Title      Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Representative      Date: \_\_\_\_\_

\_\_\_\_\_  
Witness      Date: \_\_\_\_\_

# Lanier Interventional Pain Center

## Biopsychosocial Trauma Inventory Pain and Disability Questionnaire Pre-Screening

Patient's Name: \_\_\_\_\_ ID: \_\_\_\_\_ Date: \_\_\_\_\_

1. Are you now or have you in the past been treated for (A) depression, (B) anxiety, (C) other emotional problems (specify) \_\_\_\_\_ (D) drug or alcohol problems. \*Please circle the appropriate letter.

2. Do you currently have suicidal plans Yes \_\_\_\_\_ No \_\_\_\_\_

Since becoming ill or injured. \*Circle either T for true or F for false.

- |  |     |  |     |
|--|-----|--|-----|
| 1. I feel depressed most of the time.                                    | T F | 25. I wonder if I will be able to fully comply with my doctor's orders.          | T F |
| 2. Pain prevents me from sleeping well.                                  | T F | 26. I find I break into sweats easily.   | T F |
| 3. I suffer with pain much of the time.                                  | T F | 27. I have thoughts of ending my life.   | T F |
| 4. I often have pressure or pains in my chest.                           | T F | 28. I have urges to beat, injure, or harm someone.                               | T F |
| 5. I become angry and frustrated much more easily.                       | T F | 29. I have panic attacks.  | T F |
| 6. I have trouble remembering things.                                    | T F | 30. I have difficulty making decisions.  | T F |
| 7. My family and friends have begun to lose patience with me.            | T F | 31. I feel confused much of the time.  | T F |
| 8. I am seldom happy any more.   | T F | 32. I have urges to break or smash things.                                       | T F |
| 9. I have frequent headaches.  | T F | 33. I am easily annoyed or irritated.  | T F |
| 10. Minor things worry or aggravate me more than before.                 | T F | 34. I often feel tired or weak all over.   | T F |
| 11. I feel nervous much of the time.                                     | T F | 35. I sleep a great deal during the day.   | T F |
| 12. I find I often need medicine to help with the pain.                  | T F | 36. My appetite has changed significantly.                                       | T F |
| 13. I fear that I may be re-injured.                                     | T F | 37. I sometimes have delusions / hallucinations.                                 | T F |
| 14. My overall level of stress has increased.                            | T F | 38. I feel useless or helpless.  | T F |
| 15. I have lost much of my interest in work and social activities.       | T F | 39. I sometimes worry that I will not be given enough pain medication.           | T F |
| 16. I regret not having been more concerned about my health in the past. | T F | 40. I find it difficult to think about much else other than my condition.        | T F |
| 17. I feel my family and friends do not care for me.                     | T F | 41. There are times when I want to talk to someone about my condition.           | T F |
| 18. At times I have found myself thinking "I would be better off dead".  | T F | 42. I am often bothered by my muscle spasms or cramps.                           | T F |
| 19. I often worry about becoming addicted to drugs.                      | T F | 43. I have numbness in parts of my body.   | T F |
| 20. I worry about supporting myself or my family.                        | T F | 44. I frequently have bad dreams about my condition.                             | T F |
| 21. I have lost hope of recovering.                                      | T F | 45. I have periods when I have blacked out or felt faint for no apparent reason. | T F |
| 22. I have worried about being harmed by my doctor or treatment.         | T F | 46. I feel these questions are important to my treatment.                        | T F |
| 23. I find it difficult to concentrate.                                  | T F |  |     |
| 24. I have stomach problems and nausea.                                  | T F |  |     |

\_\_\_\_\_ Raw score

# Lanier Interventional Pain Center

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## Informed Consent for Female Patients

The diagnosis and treatment of pain often involves using various medications and x-ray procedures. Be advised that many medicines used in the treatment of pain have not been adequately studied for their effects on pregnant women and/or a developing fetus. Therefore, you are responsible for taking any medications or undergoing diagnostic procedures, as well as the use of adequate measures to prevent pregnancy during such time.

If you are currently pregnant or if you become pregnant while enrolled in a pain treatment program at Lanier Interventional Pain Center, you **must** take immediate steps to inform the physicians so that appropriate treatment adjustments can be made. Additionally, some x-rays and scans are not considered safe for women who are pregnant. Therefore, if any possibility exists that you are pregnant, you must inform us of this prior to diagnostic testing.

By signing below, I understand the above warnings and agree to inform my physician of any possible pregnancy. I fully understand that some medications used to treat pain are not proven safe for women who are pregnant or to a developing baby. I also understand that I must inform my physician if there is a possibility that I am pregnant (or if I am currently pregnant) prior to undergoing any tests or procedures.

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Patient's Signature

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Date

# Lanier Interventional Pain Center

## History and Physical Examination

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ T \_\_\_\_\_ Wt \_\_\_\_\_

Intake completed by \_\_\_\_\_ M.D.

Chief Complaint and Primary Reason for New Patient Visit: \_\_\_\_\_

### Serious Childhood Illnesses (Answer YES or NO)

\_\_\_\_\_ Chicken Pox      \_\_\_\_\_ Mumps      \_\_\_\_\_ Measles      \_\_\_\_\_ Diphtheria  
\_\_\_\_\_ Whooping Cough      \_\_\_\_\_ Scarlet/Rheumatic Fever      \_\_\_\_\_ Mononucleosis      \_\_\_\_\_ Other

### Past Surgical History (Operations)

1. \_\_\_\_\_ Date \_\_\_\_\_ Facility \_\_\_\_\_  
2. \_\_\_\_\_ Date \_\_\_\_\_ Facility \_\_\_\_\_  
3. \_\_\_\_\_ Date \_\_\_\_\_ Facility \_\_\_\_\_  
4. \_\_\_\_\_ Date \_\_\_\_\_ Facility \_\_\_\_\_  
5. \_\_\_\_\_ Date \_\_\_\_\_ Facility \_\_\_\_\_  
6. \_\_\_\_\_ Date \_\_\_\_\_ Facility \_\_\_\_\_  
7. \_\_\_\_\_ Date \_\_\_\_\_ Facility \_\_\_\_\_  
8. \_\_\_\_\_ Date \_\_\_\_\_ Facility \_\_\_\_\_

Have you had transfusions? Yes \_\_\_ No \_\_\_ When? \_\_\_\_\_

### Serious Accidents Requiring Medical Care:

1. \_\_\_\_\_ Date \_\_\_\_\_ Place \_\_\_\_\_  
2. \_\_\_\_\_ Date \_\_\_\_\_ Place \_\_\_\_\_  
3. \_\_\_\_\_ Date \_\_\_\_\_ Place \_\_\_\_\_  
4. \_\_\_\_\_ Date \_\_\_\_\_ Place \_\_\_\_\_

### Past Medical History (Medical Illnesses as an Adult)

1. \_\_\_\_\_ Date \_\_\_\_\_  
2. \_\_\_\_\_ Date \_\_\_\_\_  
3. \_\_\_\_\_ Date \_\_\_\_\_  
4. \_\_\_\_\_ Date \_\_\_\_\_  
5. \_\_\_\_\_ Date \_\_\_\_\_  
6. \_\_\_\_\_ Date \_\_\_\_\_  
7. \_\_\_\_\_ Date \_\_\_\_\_  
8. \_\_\_\_\_ Date \_\_\_\_\_

Do you have any chronic infectious diseases Yes \_\_\_ No \_\_\_

\_\_\_\_\_

History and Physical Examination #2

Patient Name \_\_\_\_\_

Any emotional or mental illness? Yes \_\_\_\_\_ No \_\_\_\_\_

List all medications or supplements that you are taking. (Include vitamins and aspirin.)

Name or Type of Medicine	Dose	How often you take
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____
14. _____	_____	_____
15. _____	_____	_____

Allergies to Medications: Please list and describe adverse effects.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

Allergies to Food or Other Substances: Please list and describe adverse effects.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

Family History:

	Health Status			Age	Cause of Death
	Good	Poor	Deceased		
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Brothers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

History and Physical Examination #3

Patient Name \_\_\_\_\_

	Health Status			Age	Cause of Death
	Good	Poor	Deceased		
Sisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Do any blood relatives have the following?

Problem	Relation
<input type="checkbox"/> Migraine	_____
<input type="checkbox"/> Epilepsy	_____
<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Glaucoma	_____
<input type="checkbox"/> Hearing Loss	_____
<input type="checkbox"/> Rheumatic Fever	_____
<input type="checkbox"/> Heart Murmur	_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Emphysema	_____
<input type="checkbox"/> Lung Disease	_____
<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Stomach Ulcers	_____
<input type="checkbox"/> Gallstones	_____
<input type="checkbox"/> Kidney Stones	_____
<input type="checkbox"/> Nephritis	_____
<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Thyroid Disease	_____
<input type="checkbox"/> Overweight	_____
<input type="checkbox"/> Infectious Disease	_____
<input type="checkbox"/> Allergies	_____
<input type="checkbox"/> Anemia	_____
<input type="checkbox"/> Gout	_____
<input type="checkbox"/> Bleeding Tendency	_____
<input type="checkbox"/> Mental Illness	_____
<input type="checkbox"/> Other: _____	_____

History and Physical Examination #4

Patient Name \_\_\_\_\_

Social History:

	<u>Position</u>	<u>Nature or Description of Work</u>	<u># of Years</u>
<u>Present Occupation:</u>	_____	_____	_____

Previous Occupations: 1. \_\_\_\_\_  
 2. \_\_\_\_\_

Any Exposure to Toxic or Dangerous Materials?

Yes	No	<u>Substance</u>	<u>When</u>	<u>Name of Type</u>	<u>Physical Symptoms</u>	<u>Others Affected?</u>
<input type="checkbox"/>	<input type="checkbox"/>	Insulation	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Fumes	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Metals	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chemicals	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Plastics	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Solvents	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dyes	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Animals	_____	_____	_____	_____
		Other:	_____	_____	_____	_____

Foreign Travel (past 10 years):

1. \_\_\_\_\_ Year \_\_\_\_\_
2. \_\_\_\_\_ Year \_\_\_\_\_
3. \_\_\_\_\_ Year \_\_\_\_\_
4. \_\_\_\_\_ Year \_\_\_\_\_

HIV Risk Factors? \_\_\_\_\_

Pets: Cats \_\_\_\_\_ Dogs \_\_\_\_\_ Other \_\_\_\_\_

Social History:

Single \_\_\_\_\_ Divorced \_\_\_\_\_ When? \_\_\_\_\_ How many times? \_\_\_\_\_ Widowed \_\_\_\_\_ When? \_\_\_\_\_  
 Married \_\_\_\_\_ How many times? \_\_\_\_\_ Children: Boys \_\_\_\_\_ Girls \_\_\_\_\_

Social Habits:

Yes	No	<u>Started</u>	<u>Stopped</u>	<u>Amount</u>
<input type="checkbox"/>	<input type="checkbox"/>	Cigarettes	_____	Packs per day _____
<input type="checkbox"/>	<input type="checkbox"/>	Coffee	_____	Cups per day _____
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	_____	Liquor/day _____ beer/day _____ wine/day _____
<input type="checkbox"/>	<input type="checkbox"/>	Other Drugs	_____	_____

Meals: Regular? Yes \_\_\_\_\_ No \_\_\_\_\_ Meals per day: \_\_\_\_\_ Snacks per day: \_\_\_\_\_

Emotional Stress – At work \_\_\_\_\_  
 Family \_\_\_\_\_  
 Other \_\_\_\_\_

History and Physical Examination #5

Patient's Name \_\_\_\_\_

Exercise: None \_\_\_\_\_

Regular Exercise – Type? \_\_\_\_\_ # times/week \_\_\_\_\_

Irregular Exercise – Type? \_\_\_\_\_ # times/week \_\_\_\_\_

Sleep: Regular? Yes \_\_\_\_\_ No \_\_\_\_\_ Hours per night \_\_\_\_\_ Do you snore? Yes \_\_\_\_\_ No \_\_\_\_\_

Other relevant information that may have a bearing on your lifestyle and health, in your own words:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Review of Systems:

Yes	No	Problem	Date Began	Yes	No	Problem	Date Began
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Seizures	_____	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	_____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	_____	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nausea	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dizzy, balance problems	_____	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting blood	_____
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	_____	<input type="checkbox"/>	<input type="checkbox"/>	Bloody or black stools	_____
<input type="checkbox"/>	<input type="checkbox"/>	Wear glasses, contacts	_____	<input type="checkbox"/>	<input type="checkbox"/>	Frequent diarrhea	_____
<input type="checkbox"/>	<input type="checkbox"/>	Vision worse	_____	<input type="checkbox"/>	<input type="checkbox"/>	Frequent constipation	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eye pain	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or jaundice	_____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent earaches	_____	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis of liver	_____
<input type="checkbox"/>	<input type="checkbox"/>	Decreased hearing	_____	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sinus pains	_____	<input type="checkbox"/>	<input type="checkbox"/>	Pain on urination	_____
<input type="checkbox"/>	<input type="checkbox"/>	Often stuffy nose, sneezing	_____	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	_____
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty/sore swallowing	_____				
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	_____	<input type="checkbox"/>	<input type="checkbox"/>	Rapid gain in weight	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain at rest	_____	<input type="checkbox"/>	<input type="checkbox"/>	Rapid loss of weight	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain exercising	_____	<input type="checkbox"/>	<input type="checkbox"/>	Constant loss of feeling	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart "races"	_____			somewhere on body	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart "skips beats"	_____	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	_____	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sleeping	_____
<input type="checkbox"/>	<input type="checkbox"/>	Short of breath:	_____	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite	_____
<input type="checkbox"/>	<input type="checkbox"/>	...at night	_____	<input type="checkbox"/>	<input type="checkbox"/>	Pain in joints	_____
<input type="checkbox"/>	<input type="checkbox"/>	...at rest	_____	<input type="checkbox"/>	<input type="checkbox"/>	Pain in muscles	_____
<input type="checkbox"/>	<input type="checkbox"/>	...exercising	_____	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of joints	_____
<input type="checkbox"/>	<input type="checkbox"/>	Swelling feet/ankles	_____	<input type="checkbox"/>	<input type="checkbox"/>	Weakness in arms	_____
<input type="checkbox"/>	<input type="checkbox"/>		_____	<input type="checkbox"/>	<input type="checkbox"/>	Weakness in legs	_____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent cough	_____				
<input type="checkbox"/>	<input type="checkbox"/>	Cough up blood	_____				
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	_____				
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	_____				
<input type="checkbox"/>	<input type="checkbox"/>	Pleurisy	_____				
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or wheezing	_____				
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	_____				

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Patient's Full Name \_\_\_\_\_ ID # \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Date \_\_\_\_\_

General Pain Questionnaire #1 Please answer the following questions to the best of your ability.

1. Where is your pain located? \_\_\_\_\_
2. Since your pain first began has it gotten worse, better, or remained the same? \_\_\_\_\_
3. Does your pain travel anywhere? Yes \_\_\_ No \_\_\_ If yes, where? \_\_\_\_\_
4. Which statement best describes your pain?  
\_\_\_ Always present, always the same intensity.  
\_\_\_ Always present, but intensity changes.  
\_\_\_ Usually present, but have short periods without pain.  
\_\_\_ Occasionally present – have pain once to several times per day.  
\_\_\_ Occasionally present for brief periods, a few seconds to minutes.
5. When did you first see a doctor for your pain? \_\_\_\_\_
6. What doctors have you seen for your pain? \_\_\_\_\_
7. Have you had any of the following for your pain?  
X-ray \_\_\_ Myelogram \_\_\_ EMG \_\_\_ CT scan \_\_\_ MRI \_\_\_ Bone scan \_\_\_ Other \_\_\_\_\_
8. Have you had surgery for your pain? Yes \_\_\_ No \_\_\_ If yes, please describe \_\_\_\_\_  
\_\_\_\_\_
9. Have you had nerve blocks (injections) for your pain? Yes \_\_\_ No \_\_\_ Were they helpful? Yes \_\_\_ No \_\_\_  
Helpful for a short time \_\_\_\_\_
10. Have you had any of the following for your pain? Biofeedback \_\_\_ TENS \_\_\_ Chiropractic \_\_\_  
Heat therapy \_\_\_ Bed rest \_\_\_ Traction \_\_\_ Relaxation therapy \_\_\_ Corset \_\_\_ Ultrasound \_\_\_\_\_
11. Were any of these therapies helpful? Yes \_\_\_ No \_\_\_ If yes, please list which ones were useful \_\_\_\_\_  
\_\_\_\_\_
12. If you have taken medication for your pain, please list the ones that were useful. \_\_\_\_\_  
\_\_\_\_\_  
Please list the ones that were not useful \_\_\_\_\_  
\_\_\_\_\_
13. Do any of the following make your pain feel worse? Relaxation \_\_\_ Sitting \_\_\_ Standing \_\_\_  
Lying down \_\_\_ Walking \_\_\_ Physical Activity \_\_\_ Sexual Activity \_\_\_ Other \_\_\_\_\_
14. Do any of the following make your pain feel better? Relaxation \_\_\_ Sitting \_\_\_ Standing \_\_\_ Lying  
Down \_\_\_ Walking \_\_\_ Physical Activity \_\_\_ Sexual Activity \_\_\_ Other \_\_\_\_\_
15. Does pain interrupt your sleep? Yes \_\_\_ No \_\_\_ Do you have a difficult time getting comfortable in bed?  
Yes \_\_\_ No \_\_\_ Do you have a hard time going to sleep? Yes \_\_\_ No \_\_\_

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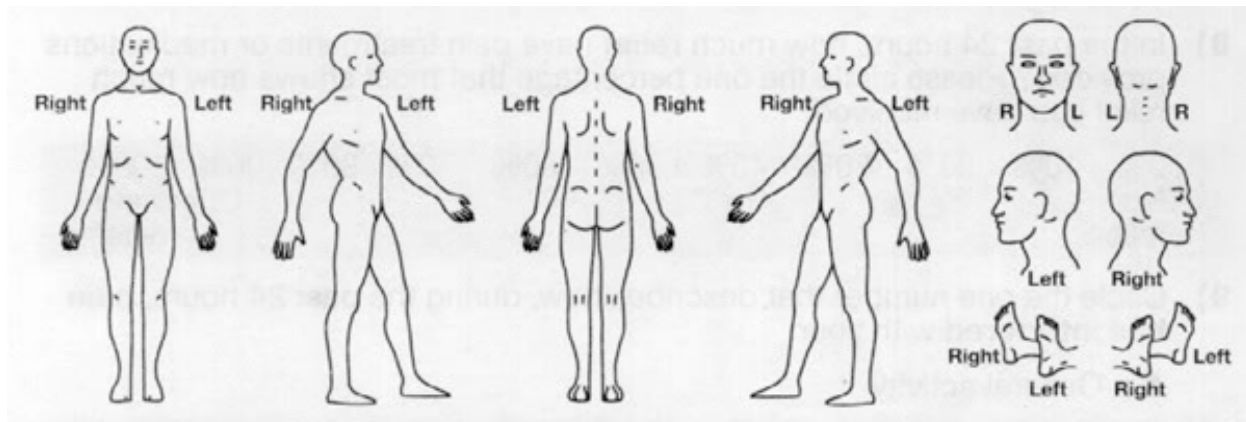
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Patient's Full Name \_\_\_\_\_ ID # \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Date \_\_\_\_\_

**General Pain Questionnaire #2** Please answer the following questions to the best of your ability.

1. Under what circumstances did your pain begin? Accident at work \_\_\_\_\_ Accident at home \_\_\_\_\_  
At work, but not an accident \_\_\_\_\_ Pain just began, no reason \_\_\_\_\_ Motor vehicle accident \_\_\_\_\_  
Following surgery \_\_\_\_\_ Following an illness \_\_\_\_\_ Other \_\_\_\_\_
2. If pain was caused by an accident, please describe what happened \_\_\_\_\_  
\_\_\_\_\_
3. How often do you take part in social activities? Never \_\_\_\_\_ Infrequently \_\_\_\_\_ Regularly \_\_\_\_\_
4. Does pain prevent you from taking part in activities? Yes \_\_\_\_\_ No \_\_\_\_\_ Do you normally enjoy social activities? Yes \_\_\_\_\_ No \_\_\_\_\_
5. How often do you take part in recreational activities? Never \_\_\_\_\_ Infrequently \_\_\_\_\_ Regularly \_\_\_\_\_
6. Does pain prevent you from taking part in these activities? Yes \_\_\_\_\_ No \_\_\_\_\_
7. Please rate on a scale of 1-10 your ability to cope with your pain (0=totally unable to cope, and 10= coping very well) \_\_\_\_\_
8. Do you feel helpless with your pain? Yes, all the time \_\_\_\_\_ Sometimes \_\_\_\_\_ Infrequently \_\_\_\_\_ Never \_\_\_\_\_
9. Do you feel your present pain condition is hopeless? Yes \_\_\_\_\_ No \_\_\_\_\_
10. Please rate your relationship with your family and spouse: excellent and supportive \_\_\_\_\_ good but could use improvement \_\_\_\_\_ frequently stressful \_\_\_\_\_ poor with very little support \_\_\_\_\_
11. Are you employed now? Yes, full time \_\_\_\_\_ Yes, full time with restrictions \_\_\_\_\_ Yes, part-time \_\_\_\_\_  
Yes, part-time with restrictions \_\_\_\_\_ On sick leave \_\_\_\_\_ No, but not because of pain \_\_\_\_\_ No, unable to work because of pain \_\_\_\_\_
12. What is your occupation? \_\_\_\_\_
13. What is the highest level of school that you completed? \_\_\_\_\_
14. Do you find your job satisfying? Yes \_\_\_\_\_ No \_\_\_\_\_. If your job gives you hassles because of your pain problem? Yes \_\_\_\_\_ No \_\_\_\_\_ If you are off work now due to a job injury, do you think he will ever be able to go back to that job again? Yes \_\_\_\_\_ No \_\_\_\_\_
15. Do you think your work was too heavy for you? Yes \_\_\_\_\_ No \_\_\_\_\_
16. Have you received financial compensation for your pain? Yes \_\_\_\_\_ No \_\_\_\_\_
17. Do you have a lawyer? Yes \_\_\_\_\_ No \_\_\_\_\_
18. Have you ever had emotional problems? Yes \_\_\_\_\_ No \_\_\_\_\_
19. Do you live with: spouse \_\_\_\_\_ children \_\_\_\_\_ other relative \_\_\_\_\_. Do any other relatives have serious health problems? Yes \_\_\_\_\_ No \_\_\_\_\_

Please indicate on the diagram where your pain occurs by shading the painful areas.



Please rate your pain on a scale of 0-10  
 0 = no pain and 10=the worst pain in the world.  
 Your pain at its worst \_\_\_\_\_  
 Your pain at its least severe \_\_\_\_\_  
 Your pain at the present time \_\_\_\_\_

**What does your pain feel like?**

Some of the words below describe your present pain. Circle ONLY those words that best describe it. Leave out any category that is not suitable. Use only a single word in each appropriate category - the one that applies best.

- |   |  |  |   |
|---|--|--|---|
| 1<br>Flickering<br>Quivering<br>Pulsing<br>Throbbing<br>Beating<br>Pounding | 2<br>Jumping<br>Flashing<br>Shooting                       | 3<br>Pricking<br>Boring<br>Drilling<br>Stabbing<br>Lancinating | 4<br>Sharp<br>Cutting<br>Lacerating                                 |
| 5<br>Pinching<br>Pressing<br>Gnawing<br>Cramping<br>Crushing                | 6<br>Tugging<br>Pulling<br>Wrenching                       | 7<br>Hot<br>Burning<br>Scalding<br>Searing                     | 8<br>Tingling<br>Itchy<br>Smarting<br>Stinging                      |
| 9<br>Dull<br>Sore<br>Hurting<br>Aching<br>Heavy                             | 10<br>Tender<br>Taut<br>Rasping<br>Splitting               | 11<br>Tiring<br>Exhausting                                     | 12<br>Sickening<br>Suffocating                                      |
| 13<br>Fearful<br>Frightful<br>Terrifying                                    | 14<br>Punishing<br>Grueling<br>Cruel<br>Vicious<br>Killing | 15<br>Wretched<br>Blinding                                     | 16<br>Annoying<br>Troublesome<br>Miserable<br>Intense<br>Unbearable |
| 17<br>Spreading<br>Radiating<br>Penetrating<br>Piercing                     | 18<br>Tight<br>Numb<br>Drawing<br>Squeezing<br>Tearing     | 19<br>Cool<br>Cold<br>Freezing                                 | 20<br>Nagging<br>Nauseating<br>Agonizing<br>Dreadful<br>Torturing   |