GILBERT NEUROLOGY

Name:_____ Age:_____
Date of Birth: _____

I am being considered for a:_____ Spinal Cord Stimulator _____ Pain Pump/Intrathecal Pump
Who is your pain physician?_____
Specify the origin of the pain (e.g., lower back, right leg, etc):_____
_____

Does the pain radiate or spread to other areas of your body (YES/NO)
If yes, please specify:_____
When did the pain begin? _____
What was the cause? (Injury, joint degeneration, accident, surgery, etc.)
_____
Is the pain due to a work-related injury? _____
Do you take medication for the pain (YES/NO)
If so, what medications_____
Side effects from the medications_____

- On a scale from 0 (no pain) to 10 (severe pain), indicate your daily pain level WITH medication:_____
- On a scale from 0 (no pain) to 10 (Severe Pain), indicate your daily pain level WITHOUT medication:_____

Does anything give you relief other than medication (e.g. sitting down, laying down, walking, etc.)? _____

PSYCHOSOCIAL HISTORY
Did you graduate from high school (YES/NO)
If not, what grade were you in when you dropped out?_____
Why did you drop out? _____
Did you receive a GED (YES/NO)
Any history of learning disabilities (YES/NO) If yes, which ones?_____
Were you ever in special education classes (YES/NO)
If yes, which grades were you in special education?_____
Did you ever repeat a grade (YES/NO) If yes, which ones? _____
Did you receive a college degree (YES/NO)
If yes, did you receive an Associates, Bachelors, Master's or Doctorate (Circle all that apply)
What was your major? _____

MARITAL STATUS

Are you married, widowed, single, divorced, separated (Circle)
How long have you been married, widowed or divorced? _____
How many times have you been married? _____
Do you have children (YES/NO) If yes, how many? _____

OCCUPATIONAL HISTORY

Are you currently employed (YES/NO)
If yes, where do you work? _____
What is your work title and job duties? _____
Do you work full-time or part-time? _____

If you don't work, when did you last work? _____
Why did you stop working? _____
Have you applied for disability? (YES/NO)
If yes, is your claim granted, pending, denied?_____

PSYCHIATRIC HISTORY

Have you ever received inpatient care for any psychiatric problems (e.g. depression, suicide attempts, or thoughts, etc.) (YES/NO) If yes, how many times?_____
Where and when were you hospitalized? _____
Why were you hospitalized? _____

Have you been diagnosed with a psychiatric disorder (YES/NO)
If so, what diagnosis/diagnoses? _____
When were you diagnosed? _____
Who diagnosed you? _____

Are you currently receiving or have you received any therapy/counseling (YES/NO)
If so, when did your treatment begin and end? _____

Are you currently or have you been under the care of a psychiatrist (YES/NO)
If so, when did your treatment begin and end? _____

Are you currently being treated with medication for emotional or psychiatric problems (YES/NO)
If so, please specify the medication(s), dosages, and when you began taking each medication:
_____
_____

Do you have a history of depression (YES/NO)
Do you have a history of attempted suicide (YES/NO)
Have you ever experienced auditory or visual hallucinations (hearing things or seeing things that are not there) (YES/NO)

Have you ever been physically abused (YES/NO) If yes, when? _____
Have you ever been sexually assaulted or molested (YES/NO) If yes, when? _____
_____

Have you used illegal drugs (YES/NO) If yes, when was the last time you used any drug? _____
_____
What drugs have you used? _____

Have you been treated (outpatient or inpatient) for drug addiction or alcoholism? (YES/NO)
_____

If you drink alcohol, how much do you consume on average per week? _____

NEUROLOGICAL/MEDICAL HISTORY
Have you ever sustained a head trauma where you lost consciousness (YES/NO)
If yes, how long were you unconscious? _____
When did this occur and what happened? _____
_____
Did you receive medical attention (YES/NO)
If yes, what type? (brain surgery, etc.)_ _____
Did you sustain any orthopedic injuries (YES/NO)
Do you have diabetes (YES/NO)
If yes, Type I or Type II (circle one)? When were you diagnosed? _____
Do you have sleep apnea (YES/NO)
If yes, do you use a CPAP device? When were you diagnosed? _____
Do you have problems with sleep (YES/NO)
If yes, is your pain causing you to lose sleep (YES/NO)
Do you wear glasses (YES/NO)
Do you have problems with sense of smell (YES/NO)
Do you have problems with sense of taste (YES/NO)