Advanced Pain Treatment Center
INNOVATIVE HELP FOR MANAGING YOUR PAIN

Pragya B. Gupta M.D., F.R.C.S. (Edin), D.A.B.P.M.
Lawrence Zeff MD
Email: pbgupta@aptcmd.com
Website: www.aptcmd.com
Brandi Roland, APRN

Name:_____ **DOB:**_____, **Sex:**_____ **Date:**

PEG ASSESSMENTS:

1. What number best describes your pain on **average in the past week with treatment (intervention or pain meds):**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere --mild----------I I----------moderate--------I I----severe------- pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere mild----------I I----------moderate--------I i--------severe------- completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity (such as ability to do your household work, activities of daily living, e.g., taking care of yourself etc.)?

0 1 2 3 4 5 6 7 8 9 10

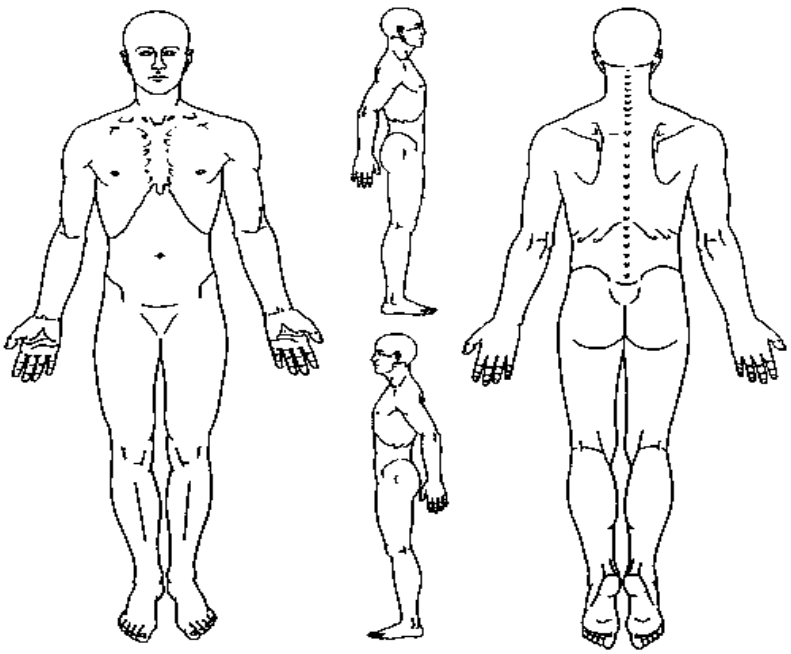
Does not interfere mild----------I I----------moderate--------I I-------severe------- completely interferes

PEG **AVERAGE SCORE:**

PHQ – 2

Over the past two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**

Score: If the score is > 3 then have the patient fill out PHQ – 9.



Please shade in the location of your pain and put an X on the area that hurts the most and also for abnormal sensation mark as directed in the diagram below.

For Pins and needle mark XXXXX
For aching and cramping \\\\\\
For stabbing ZZZZZ
For Numbness mark ++++++
For Burning mark BBBBBBB
Other OOOOO

THANK YOU!

OVER FOR THE REVIEW OF SYSTEM QUESTIONNAIRE

APTC – F/U ROS------PLEASE CIRCLE APPROPRIATE RESPONSE

NAME:_____ DOB:_____ DATE: _____

☐ PLEASE CHECK IF NO CHANGE SINCE THE LAST VISIT: General:

RECENT WEIGHT LOSS OF MORE THAN 10 POUNDS				YES	NO			
RECENT WEIGHT GAIN OF MORE THAN 10 POUNDS				YES	NO			
FEVER	YES	NO						
CHILLS	YES	NO						
NIGHT SWEATS	YES	NO						
RESPIRATORY:				SKIN:				
CHRONIC COUGH	YES	NO		OPEN SORE	YES	NO		
ASTHMA / WHEEZING	YES	NO		NEW MOLE	YES	NO		
COPD/ EMPHYSEMA	YES	NO		POOR HEALING	YES	NO		
PNEUMONIA	YES	NO		SKIN INFECTION	YES	NO		
RECENT RESPIRATORY INFECTION	YES	NO		BONE/ JOINTS				
CARDIOVASCULAR:				SHOULDER PAIN	YES	NO		
CHEST PAIN	YES	NO		WRIST OR HAND PAIN:	YES	NO		
SHORTNESS OF BREATH	YES	NO		HIP PAIN	YES	NO		
HIGH BLOOD PRESSURE	YES	NO		KNEE PAIN	YES	NO		
HEART DISEASE	YES	NO		LUPUS	YES	NO		
SWELLING OF ANKLE/LEG	YES	NO		MUSCLE WEAKNESS	YES	NO		
ABNORMAL HEART RHYTHM	YES	NO		FIBROMYALGIA	YES	NO		
HISTORY OF HEART ATTACK	YES	NO		DERMATOMYOSITIS	YES	NO		
BLOOD CLOT IN LEGS OR LUNGS	YES	NO		NEUROLOGICAL:				
VARICOSE VEINS	YES	NO		HEADACHE	YES	NO		
ENDOCRINE:				TINGLING NUMBNESS	YES	NO		
EXCESSIVE THIRST	YES	NO		BURNING SENSATION	YES	NO		
HEAT OR COLD INTOLERANCE	YES	NO		WEAKNESS	YES	NO		
EXCESSIVE URINATION	YES	NO		TREMORS	YES	NO		
THYROID PROBLEM	YES	NO		GAIT DISTURBANCE	YES	NO		
DIABETES	YES	NO		STROKE	YES	NO		
OSTEOPOROSIS	YES	NO		EPILEPSY/ SEIZURE	YES	NO		
ADRENAL GLAND PROBLEM	YES	NO		IN-COORDINATION	YES	NO		
GASTROINTESTINAL:				INVOLUNTARY MOVEMENTS	YES	NO		
GERD-REFLUX	YES	NO		DIZZINESS	YES	NO		
HEARTBURN	YES	NO		SPASTICITY	YES	NO		
ABDOMINAL PAIN	YES	NO		MENTAL HEALTH:				
NAUSEA & OR VOMITING	YES	NO		DEPRESSION	YES	NO		
DIARRHEA	YES	NO		INSOMNIA /SLEEP DISTURBANCE	YES	NO		
BOWEL INCONTINENCE	YES	NO		ANXIETY	YES	NO		
GENITOURINARY:				FEELING OF HOPELESSNESS	YES	NO		
RECENT URINARY TRACT INFECTION	YES	NO		ORGAN REMOVAL OR TRANSPLANT				
BLADDER INCONTINENCE	YES	NO		REMOVAL OF SPLEEN	YES	NO		
KIDNEY FAILURE	YES	NO		REMOVAL OF KIDNEY	YES	NO		
HEMATOLOGY:				ORGAN TRANSPLANT:	YES	NO		
LYMPH NODE SWELLING	YES	NO		WHICH ORGAN & WHEN;				
ANEMIA	YES	NO						
ARE YOU ON BLOOD THINNER?	YES	NO						
BLEEDING TENDENCY	YES	NO						

Thanks

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Name: _____ DOB:_____ Sex:_____ Date: _____

Please answer each question as honestly as possible. Keep in mind that we are only asking about the past 30 days. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can. THIS IS NOT A LIE DETECTOR. This is confidential information and protected under HIPPA law.

Please answer the questions using the following scale:	**NEVER**	**SELDOM**	**SOMETIMES**	**OFTEN**	**VERY OFTEN**
Score	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	O	O	O	O	O
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	O	O	O	O	O
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the emergency room, friends, Street sources)	O	O	O	O	O
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	O	O	O	O	O
5. In the past 30 days, how often have you seriously thought about hurting yourself?	O	O	O	O	O
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	O	O	O	O	O
7. In the past 30 days, how often have you been in an argument?	O	O	O	O	O

Edgewood Office
Phone 859.331.4159 • Fax 859.331.4163
162 Barnwood Dr. • Edgewood, KY 41017

Mason Office
Phone 513.492.9317 • Fax 513.492.9325
6406 Thornberry Ct. • Unit 220A • Mason, OH 45040

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Score	0	1	2	3	4
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	O	O	O	O	O
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	O	O	O	O	O
10. In the past 30 days, how often have you been worried about how you're handling your medications?	O	O	O	O	O
11. In the past 30 days, how often have others been worried about how you're handling your medications?	O	O	O	O	O
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	O	O	O	O	O
13. In the past 30 days, how often have you gotten angry with people?	O	O	O	O	O
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	O	O	O	O	O
15. In the past 30 days how often have you borrowed pain medication from someone else?	O	O	O	O	O
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	O	O	O	O	O
17. In the past 30 days how often have you had to visit the Emergency Room?	O	O	O	O	

THANK YOU: SCORE:

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