



Advanced Pain Medicine

www.advancedpainmedicine.com

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Clinic Locations:

MAIN OFFICE
7000 Stonewood Drive
Wexford, PA 15090

1000 Higbee Dr. Suite D207
Bethel Park, PA 15102

One Hospital Way
Butler, PA 16001

545 Rugh Street
Greensburg, PA 15601

2566 Haymaker Rd
Monroeville, PA 15146

1009 Beaver Grade Rd
Moon Twp, PA 15108

356 Freeport St.
New Kensington, PA 15068

500 Lewis Run Road
West Mifflin, PA 15122

333 State Street
Erie, PA 16507

500 Market Street
West Bridgewater, PA 15009

3000 Mon Health Medical Park Dr.
Morgantown, WV 26505

2915 Wilmington Road
New Castle, PA 16105

100 Trich Dr
Washington, PA 15301

675 N. Broad St Ext. Suite 3
Grove City, PA 16127

How does our process work?

When a patient first visits, us a comprehensive examination is conducted, and their medical history is thoroughly reviewed. This allows our specialists to accurately diagnose or confirm the patient's specific condition. Subsequently, the physician specialists and clinical staff collaborate to develop a personalized treatment plan that aligns with the patient's needs and goals.

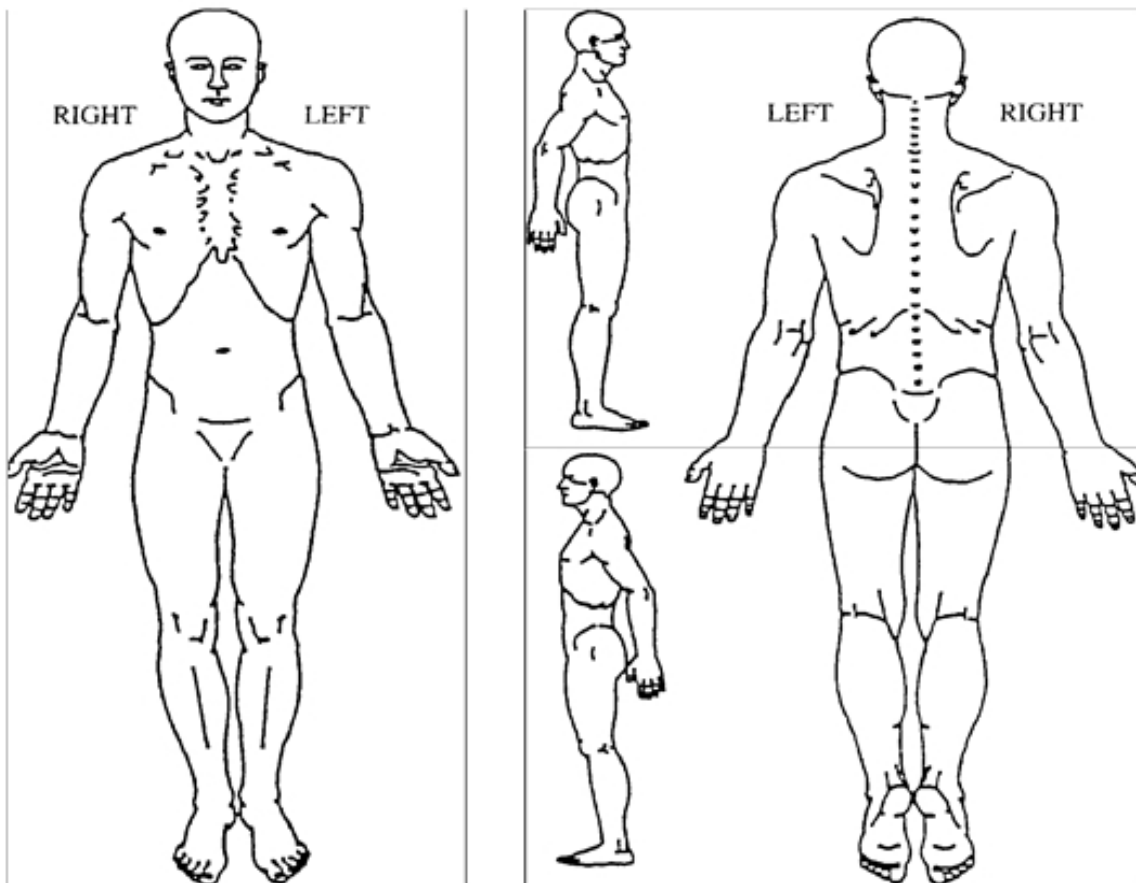
In our clinic, we provide a range of pain management procedures tailored to meet the specific needs of each patient. The treatment plan may commence with a series of epidural steroid injections, then according to the degree of your pain relief, may proceed with nerve blocks and diagnostic procedures in order to identify the point of origin of the patient's pain. These treatments are part of a comprehensive plan developed by our healthcare team to ensure effective pain management and improve the patient's quality of life. A customized pain medication regimen is included in the plan to address the individual's specific needs. Throughout the treatment, monitoring the patient's body's response is crucial for diagnosing the underlying cause of pain. Therefore, it is essential to adhere to the plan, even if the patient perceives the procedures as ineffective.

Key Procedures Include:

- ⇒ **Epidural Steroid Injections** used to provide pain relief from inflammation and pain of the spine
- ⇒ **Facet Nerve Blocks** diagnostic procedures that help locate the source of spine pain
- ⇒ **Rhizotomy** involves lesioning of the nerve roots to reduce pain after successful nerve blocks
- ⇒ **Kyphoplasty** procedure to alleviate pain from vertebral compression fractures by stabilizing the bone
- ⇒ **Spinal Cord Stimulator** device implanted near the spine to send electrical signals that mask pain signals to the brain
- ⇒ **Intrathecal Pain Pump** pumps that deliver pain medication directly to the spinal cord to manage chronic pain
- ⇒ **Intrasept Procedure** minimally invasive procedure to treat chronic spinal pain by targeting the nerve that innervates the disc and bone

Name: _____

1. What is the main complaint for which you are seeking treatment at Advanced Pain Medicine?
2. On the diagram, shade in the areas where you feel pain. Put an "X" on the area that hurts the most.



3. How long have you had the pain problem you are currently experiencing (in months and years)?
4. What caused your current pain?
5. Describe the characteristics of your pain (circle each that describes your pain).

Piercing

Stabbing

Shooting

Burning

Grinding

Throbbing

Cramping

Aching

Stinging

Squeezing

Numbing

Itching

Tingling

None

Past Medical History

Have you had any of the following health problems? (please circle all that apply)

Neurologic Disorder	Obstructive Sleep Apnea	Muscle Disease
Seizures or Epilepsy	Asthma or Wheezing	Arthritis
Transient Ischemic Attack/Stroke	Chronic Cough	Blood Disorder/Anemia
High Blood Pressure	Stomach Ulcer	Blood Clots: Pulmonary/DVT
Heart Attack	Liver Disease/Hepatitis/Cirrhosis	Cancer
Heart Rhythm Disorder	Diabetes or High Blood Sugar	Depression/Anxiety
Valvular Heart Disease	Thyroid Disease	Mania
Lung Disease	Kidney Disease/Kidney Stones	Suicidal Tendency

Review of Symptoms

Please circle the symptoms listed below that you have experienced in the past few months.

CONSTITUTIONAL: Fever Chills Weight Change Change in appetite

CARDIOVASCULAR: Chest Pain Palpitations Irregular Heart Beat Difficulty breathing when lying down

RESPIRATORY: Shortness of Breath Cough Wheezing

GASTROINTESTINAL: Nausea Vomiting Abdominal Pain Change in bowel habits Black Stools

GENITOURINARY: Frequent urination Urinary incontinence Painful urination

MUSCULOSKELETAL: Muscle Pain Joint Pain Muscle Weakness

SKIN: Rashes Bruising easily Ulcers Itching

NEUROLOGICAL: Headaches Dizziness Seizures Numbness Tingling Weakness

PSYCHIATRIC: Anxiety Depression Difficulty sleeping

HEMATOLOGIC/LYMPHATIC: Bleeding tendency Frequent infections

Explain any above circled items here:

Social History

1. Current or previous occupation: _____

2. Present employment status:

Full Time Unemployed Leave of Absence Student

Part Time Retired Homemaker

If you are working full- or part-time, when did you return to work? (Date): _____

3. What was your last day of work (if not currently working)? _____

4. Substance intake per day: (Please indicate how often you use or consume the following)

a. Caffeine (coffee, tea, cola, etc.) _____

b. Nicotine (Cigarettes, cigar, pipe, smokeless tobacco, etc) _____

5. Your present use of alcoholic beverages is (choose one):

None

Occasionally (less than 1 drink per week)

Daily

Rarely (less than one drink per month) Regularly (drink 2-3 times per week)

6. Have you ever used any of the following drugs? Choose all that apply.

PLEASE INDICATE WHEN LAST USED in the space provided.

- Marijuana _____ Cocaine _____ Other Street Drugs _____
 Amphetamines _____ Heroin _____ None of these

7. Marital Status (choose one):

- Single Divorced Widowed
 Married Separated Remarried

8. Number of children: _____

9. Present living situation:

- Alone With Children With friend
 With Spouse With Parents With other family members

10. Education (check the highest grade/degree completed):

- Less than 8th grade Some high school Some college Advanced degree
 Completed 8th grade High school graduate College graduate

Family Medical History

1. Please list any chronic pain conditions that are present in your family:

2. Is there any family history of anesthesia problems? Yes No

Signature of Patient: _____ **Date Completed:** _____

If form has been completed by someone other than the patient, please print and sign name below:

Name: _____

Signature: _____

Relationship to Patient: _____

Signature of Reviewer: _____ M.D. / PA-C