

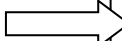
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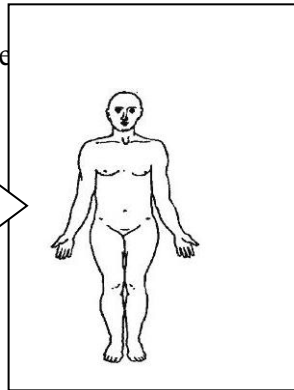
Pain Management Specialist

Date: _____ **Name:** _____

1. What is your pain level today? _____ 0 is no pain, 10 is the worst imaginable

2. What parts of your body are painful? _____

_____ (also mark on this diagram) 



3. Are you experiencing any side-effects from your medications? Yes () No ()

If yes: then explain: _____

4. Which benefits have the occurred because of treatment in this clinic? **Please circle**

Walking better Sleeping better Able to work Increased function Better mood

Improves quality of life Lowers pain score I'm making progress

5. Have you been experiencing anxiety Yes () No () or depression Yes () No ()

6. Have you been able to take your medications **only as prescribed**? Yes () N ()

If no then explain: _____

7. Since your last visit to this clinic, have you received pain medications from **any other source?** **Failure to disclose will result in termination**

If yes then explain: _____

Dr. shopping is a serious offense which will be investigated by the DEA
Please remember to keep your medications safe and secure. Lost or

stolen medications/prescriptions will not be replaced. Also, you must

attend an appointment to receive medications-they are not called in.

Schedule your appointment well in advance. There is a \$35 for no shows

or same day cancellations-it disrupts the schedule