Portland Ketamine Clinic
Dr. Enrique Abreu
503.207.4992

Chronic Pain Patient Questionnaire

LAST NAME : _____FIRST NAME_____MI_____

AGE : _____DOB:_____

PHONE : _____Secondary Phone : _____

EMAIL : _____

ADDRESS:_____

_____

HEALTH CARE PROFESSIONAL YOU WERE REFERRED BY:_____

CURRENT MEDICATIONS:

_____ _____

_____ _____

_____ _____

ALLERGIES (Medications and/or Food):

_____

_____

CURRENT AND PREVIOUS PSYCHIATRIC DIAGNOSIS :

_____ _____

_____ _____

PREVIOUS SURGERIES:_____

PAST MEDICAL HISTORY:_____

ARE YOU CURRENTLY PREGNANT, BREAST FEEDING OR PLAN ON BECOMING PREGNANT IN THE NEAR FUTURE:_____

HOW LONG HAVE YOU HAD CHRONIC PAIN:_____

WHAT WAS THE INITIAL CAUSE OF YOUR PAIN:_____
_____

HAS IT PROGRESSED:_____

HOW DO YOU DESCRIBE YOUR PAIN:_____
_____

WHAT OTHER SYMPTOMS DO YOU HAVE (BURNING, SWELLING, SKIN CHANGES,LACK OF SWEATING, PAIN WITH LIGHT TOUCH) :
_____

_____

HAVE YOU HAD INTERVENTIONAL BLOCKS OR OTHER PROCEDURES, DID THEY HELP:_____

_____

WHAT PARTS OF YOUR BODY ARE AFFECTED:_____

WHAT MEDICATIONS HAVE HELPED YOU IN THE PAST:_____

_____

NAME ADDRESS & PHONE PRIMARY CARE DOCTOR :
_____

HAVE YOU HAD BRAIN SURGERY, TUMORS, OR BLOOD VESSEL MALFORMATIONS IN THE PAST:_____

DO YOU HAVE HIGH BLOOD PRESSURE:_____

WHAT MEDICINES DO YOU TAKE FOR BLOOD PRESSURE:_____

_____

HAVE YOU EVER HAD OR CURRENTLY HAVE SEIZURES:_____

WHAT MEDICATIONS DO YOU TAKE FOR SEIZURES:_____
_____

ARE YOU CURRENTLY TAKING NARCOTIC (OPIATE) PAIN MEDICATIONS, WHICH ONES:_____

ARE YOU CURRENTLY TAKING BENZODIAZEPINES OR MOOD STABILIZERS, WHICH ONES:_____

ARE YOU CURRENTLY TAKING MAOI INHIBITORS (SELEGILINE, ISOCARBOXAZID, PHENELZINE, TRANCYCLOPROMINE):_____

PLEASE RETURN THIS COMPLETED FORM BY EMAIL:

info@portlandketamineclinic.com

or

FAX 503-961-8959