

NEW PATIENT HISTORY/ASSESSMENT FORM**(This form must be completed prior to the appointment date)**

Name: _____ Male _____ Female _____

Date of Visit: _____ Date of Birth _____ Age _____

Referring Physician _____ MR # _____

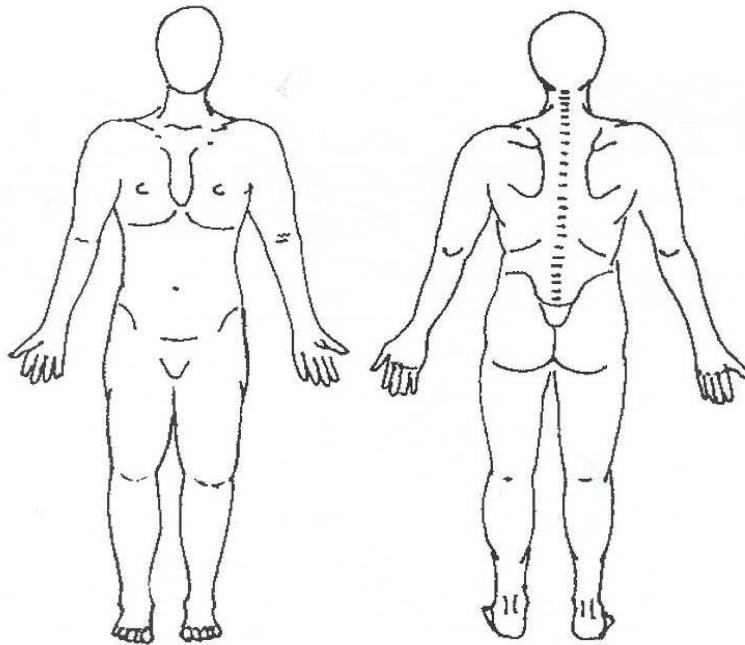
PRESENT ILLNESS

When did your pain start? _____

Under what circumstances did your pain begin? (Please select the appropriate indicator listed below)

<input type="checkbox"/> At work, but NOT an accident	<input type="checkbox"/> Accident at work
<input type="checkbox"/> Following surgery	<input type="checkbox"/> Motor vehicle accident
<input type="checkbox"/> Following illness	<input type="checkbox"/> Accident at home
<input type="checkbox"/> Pain began with no known cause	<input type="checkbox"/> Other _____

Where is the location of your pain? _____

Please shade the painful areas on the diagram below*xxx for most severe pain**ooo for less severe pain***** for tingling*

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NUMERIC PAIN SCALE

Please circle the number that best describes the amount of pain you feel right now.

No pain 0 1 2 3 4 5 6 7 8 9 10

*worst
pain
Imaginable*

What is the highest number that your pain goes to? _____

What is the lowest number that your pain goes to? _____

What pain level is a realistic goal for you? _____

What best describes your pain (please circle all that apply)?

Burning stabbing shooting aching dull electrical deep vague sharp constant intermittent daily

Do you have any numbness? _____ Yes _____ No If yes, where? _____

Do you have any weakness: _____ Yes _____ No If yes, where? _____

What makes your pain worse? (please circle all that apply)

exercise	bending forward	bending backwards	walking
climbing stairs	lifting	sitting	standing
work	driving	cough/sneeze	sexual activity
cold	heat	light touch	stressful situations

other: (describe): _____

What relieves your pain? (please circle all that apply)

lying down	sitting	standing	walking
physical therapy	exercise	ice	heat
medications	bath/shower	meditation	relaxation

Other (describe): _____

Have you ever been treated at another pain management center or program? _____ Yes _____ No

If yes, where? _____ When? _____

What did they do? _____

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MEDICATIONS

List all medications that you are taking now. (Include over the counter, herbal, vitamin, and other supplemental medications)

Name of medication	Dose (mg or # of pills)	How often? (# times per day)	What is this medication for?	Date started	Prescribing Doctor

Do you take any blood thinning medication? _____ What? _____
(This is not an inclusive list but examples of some anticoagulants : Coumadin, Plavix, Ticlid, or others)

List all other pain medications that you have tried in the past and why you stopped: _____

ALLERGIES

Please list any known drug, food, or environmental allergies and indicate what the adverse effect/reaction is:

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MEDICAL HISTORY

(please check all that apply)

Cardiovascular	Respiratory	Gastrointestinal	Endocrine	Hematologic
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- | | | | | |
|--|---|---|---------------------------------------|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Acid Reflux/GERD | <input type="checkbox"/> Obesity | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Polyps | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Easy bruising |
| <input type="checkbox"/> Heart Rhythm Disturbances | <input type="checkbox"/> Frequent Pneumonia | <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anticoagulation
(blood thinners) |
| <input type="checkbox"/> Arterial Insufficiency | <input type="checkbox"/> Frequent Colds/Sore Throat | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Insulin | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Venous Insufficiency | <input type="checkbox"/> Positive TB Test | <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Other | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Abnormal Chest x-ray | <input type="checkbox"/> Colitis | | |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Other | <input type="checkbox"/> Hiatal Hernia | | |
| <input type="checkbox"/> Embolism | | <input type="checkbox"/> Gallbladder problems | | |
| <input type="checkbox"/> Other | | <input type="checkbox"/> Irritable Bowel Syndrome | | |
| | | <input type="checkbox"/> Crohn's Disease | | |
| | | <input type="checkbox"/> Special Diet | | |
| | | <input type="checkbox"/> Liver Disease | | |

Neurological	Psychological	Genitourinary	Musculoskeletal
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- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Depression | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Movement Disorder | <input type="checkbox"/> Panic Disorder | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Psychosis | <input type="checkbox"/> Chronic Infection | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Alcohol or drug abuse | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Neck Problems |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Other | | |
| <input type="checkbox"/> Epilepsy | | | |
| <input type="checkbox"/> Headaches | | | |

Cancer	Miscellaneous	General	Allergic/Immunological
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- | | | | |
|----------------------|--|--|--|
| Site _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Medical Equipment | <input type="checkbox"/> Autoimmune disorder |
| Diagnosis Date _____ | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Cane | <input type="checkbox"/> Lupus, Sjogren's |
| Chemotherapy _____ | <input type="checkbox"/> Visual Problems | <input type="checkbox"/> Walker | <input type="checkbox"/> Raynaud's Syndrome |
| Radiation _____ | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Wheel Chair | <input type="checkbox"/> Immune deficiency |
| Other _____ | <input type="checkbox"/> Chronic Skin Disorder | <input type="checkbox"/> Hospital Bed | <input type="checkbox"/> HIV |
| | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Oxygen at ___ lpm | |
| | <input type="checkbox"/> Date of last period | | |

SURGICAL HISTORY

(Please list all surgeries)

DATE	SURGERY	DOCTOR

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FAMILY MEDICAL HISTORY

	Age	Any disease/Conditions Past/Present	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Has family experienced any problems resulting in similar conditions or chronic pain? ___Yes ___No

Please explain: _____

PSYCHOSOCIAL HISTORY

Highest level of education _____ Are you going to school now? _____

Are you able to care for yourself _____ if not, who helps you? _____

Have you fallen lately? Y N When? _____ Do you use any assistive device at home (walker, cane, etc.)? _____

What is your marital status? _____ How many people live in your household? _____

What is your culture/ethnic background? _____

How do you like to learn? By Video? ___ Handouts? ___ Explanation? ___ Demonstration? _____.

What exercise or recreational activities do you enjoy? _____

How often do you exercise or do the above activities? _____

Do you identify with any particular faith? _____ If so, which one? _____

Are you under financial stress? _____ If so, how? _____

Do you feel safe in your home? ___Yes___No If not, why? _____

Have there been any other stressful life experiences recently? ___Yes___No If so, explain: _____

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PSYCHOSOCIAL HISTORY (Continued)

Have you ever had thoughts of suicide or harming yourself? Yes No If yes, did you seek help? Yes No

Have you ever had thoughts of harming someone else? Yes No If yes, who? _____

Have you been under the care of a mental health professional? Yes No If yes, who? _____

Have you received treatment for alcohol or substance (legal/illegal) abuse? Yes No If yes, when? _____

Does anyone in your household have substance abuse (legal/illegal) issues? Yes No If yes, who? _____

Are you, or have you ever been, involved with any of the following? (Please select appropriate choices)

<u>Current Use</u>	<u>Past Use</u>	<u>Item</u>	<u>Comments (how much and how many years?)</u>
		Tobacco Use	_____
		Drink alcohol	_____
		Caffeine-containing beverages	_____
		Marijuana use	_____
		Cocaine	_____
		Methamphetamine	_____
		Heroin	_____
		Other illicit/street Drug use	_____

Have you ever felt the need to cut down on your drinking/drug use? Yes No

Have you ever felt annoyed by people complaining about your drinking/drug use? Yes No

Have you ever felt guilty about your drinking/drug use? Yes No

Do you ever drink/take a pill as an eye-opener in the morning to relieve the shakes? Yes No

Do you drink alcohol to decrease or relieve pain? Yes No

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VOCATIONAL/WORK HISTORY

(Select the best description for you)

- Homemaker (full time) by choice
- Retired, not due to pain
- Working part time

- Not working due to pain
- Not working due to other reasons
- Working full time

- Retired due to pain
- On leave from work

What is your current occupation (if working)? _____

What is your current place of employment (if working)? _____

Current job description, duties, tasks: _____

Has your job changed because of your painful conditions? Yes No How? _____

Are you out of work because of an injury at work? Yes No When was the injury? _____

Are you receiving workers compensation? Yes No

Have you ever been in the military? Yes No

Are you receiving Social Security Disability? Yes No

MEDICAL TESTING

(Select the medical tests below that have been done to evaluate your pain)

	Date (approximate)	Result (if known)
<input type="checkbox"/> X-ray	_____	_____
<input type="checkbox"/> CT Scan	_____	_____
<input type="checkbox"/> Myelogram	_____	_____
<input type="checkbox"/> MRI	_____	_____
<input type="checkbox"/> EMG	_____	_____
<input type="checkbox"/> Discogram	_____	_____
<input type="checkbox"/> Bone Scan	_____	_____
<input type="checkbox"/> EKG	_____	_____
<input type="checkbox"/> Other	_____	_____

****Please bring your films to the initial doctor visit****

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PAST TREATMENTS

(Please select the treatments you have received for your pain problem, and what was the result?)

RESULT:

Indicate Pain Therapies	Tried	Not Tried	Improved	No change	Worse	Comments
Drug Detoxification						
Epidural steroid injections						
Facet joint injections						
Trigger point injections						
Nerve (lumbar sympathetic, stellate ganglion, etc.) blocks						
Spinal cord stimulation						
Medication pump						
Radiation therapy						
Physical therapy						
Exercise						
Manipulations/Mobilizations						
Traction Exercise/Aerobic conditioning						
Passive (heat, ice, gentle massage, ultrasound)						
Aqua/water/pool therapy						
Trigger point therapy/deep tissue massage/acupressure						
Occupational therapy						
Acupuncture						
Chiropractic						
Prosthetics/Orthotics (e.g. braces, supports, etc)						
Electric stimulation (TENS)						
Biofeedback/relaxation						
Yoga						
Hypnosis						
Other						

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OTHER ACTIVITIES

How much sleep do you average each night? _____ hours

How much do you sleep/nap during the day? _____ hours _____ minutes

Is your sleep disturbed at night: _____ Yes _____ No If yes, please select all that applies to you

- pain
- anxiety/tension/can't relax
- preoccupying thoughts
- twitching, jumpy or restless feeling in legs or elsewhere
- urination
- no reason

_____ other (specify): _____

How often do you have a bowel movement? _____ When was your last one? _____

List any bowel medications you may be on: _____

Have there been changes/problems in your sexual function? _____ Yes _____ No

What? _____

Why do you think? _____

MISCELLANEOUS

Are you, or have you ever been, involved with any of the following?

Disability:

- Not receiving or seeking disability
- Not receiving but seeking or planning to seek disability
- Receiving disability

Litigation/lawsuit(s):

- No (and not intending) pain-related litigation/lawsuit
- Currently in pain related litigation/lawsuit or pain-related legal involvements
- Past litigation/lawsuit or legal involvements related to pain condition

Motor Vehicle Accidents:

- Pain not related to motor vehicle accident
- Pain related to motor vehicle accident and settlement pending
- Pain related to motor vehicle accident but no settlement pending or necessary

Do you have any other litigation or lawsuits ongoing, pending, planned, or under consideration?

_____ Yes _____ No (If so, please explain) _____

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REVIEW OF SYSTEMS

(Please circle any of the listed symptoms that are current problems for you)

- Constitutional:** fever chills weight loss or gain fatigue
- Eyes:** double vision blurry vision need for glasses injury or surgery
- Ear, Nose, Throat:** sinusitis hearing loss ringing in ears sores voice change swelling
- Cardiovascular:** palpitations leg swelling heart attack chest pain high blood pressure
- Respiratory:** shortness of breath asthma cough spitting up blood wheezing
- Gastrointestinal:** loss of appetite nausea vomiting blood in stools
- Genitourinary:** frequent or painful urination incontinenceinfections irregular menses
- Musculoskeletal:** Joint pain or stiffness weakness injury or surgery swelling spasm
- Skin/Breast:** rashes ulcers nail changes breast pain or lump or discharge
- Neurological:** stroke or TIA headaches dizziness seizures loss of balance
- Psychological:** memory loss depression insomnia anxiety nervousness
- Endocrine:** diabetes thyroid problems excessive thirst or urination
- Hematologic:** bleeding or bruising tendency phlebitis DVT blood clots transfusion
- Infection:** Hepatitis A B C HIV/AIDS MRSA VRE
- Other:** _____

PAIN MANAGEMENT GOALS & EXPECTATIONS

What do you expect from our pain program? *(select the ONE best answer)*

- | | |
|---|---|
| <input type="checkbox"/> A diagnosis (to help find the cause of pain) | <input type="checkbox"/> A cure |
| <input type="checkbox"/> Help in coping with the pain | <input type="checkbox"/> No expectations |
| <input type="checkbox"/> A reduction in pain | <input type="checkbox"/> Do not know what to expect |

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Thank You, the nurse will complete the rest.

Please do not write below this line.

PHYSICAL EXAMINATION

Pulse _____ Resp _____ BP _____ Temp _____ Height _____ Weight _____ (actual)

Are you right _____ or left _____ handed?

Patient Signature _____ Clinical Staff Signature: _____

(Signature verifies information is correct)

Date: _____

EVALUATION & PLAN

Prescriptions: _____

Authorization Submitted

Return to Clinic _____

Procedure Ordered with Procedure Protocol: _____

Referral: _____

Therapy: (PT, OT, etc.) _____

Other: (labs, x-ray, MRI) _____

Schedule Patient with: _____ Physician _____ Physician Assistant _____ Advanced Registered Nurse Practitioner

PA/ARNP signature: _____

Physician signature: _____

&/,1.&\$/ DISCHARGE

Education (list topic) _____ Written information given to patient/family _____ Yes _____ No

Patient verbalizes understanding of education _____ Yes _____ No

Patient or Family signature: _____
 (signature verifies understanding of discharge instructions)

DischargLQJ &OLQFDO 6WDII Vignature: _____

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