PREMIER PAIN SOLUTIONS

# NEW PATIENT HISTORY FORM

**(This form must be completed prior to being seen)**

Name: _____DOB: _____ Date:_____

Referring Physician _____Primary Physician_____

## PRIMARY COMPLAINT

When did your pain start?

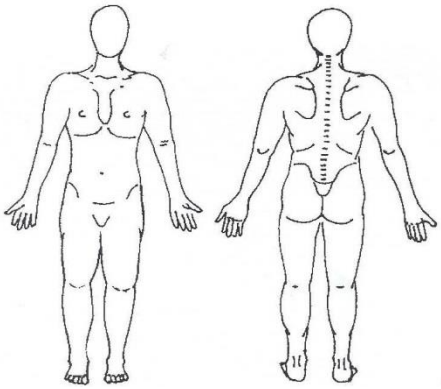
_____

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

_____ At work, but NOT an accident
_____ Following surgery
_____ Following illness
_____ Pain began with no known cause
_____ Accident at work
_____ Motor vehicle accident
_____ Accident at home
_____ Other

**Where is the location of your pain?**

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



## 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? _____

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

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

Other?_____

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 | cold | stress |
| climbing stairs | lifting | sitting | standing | heat | |
| work | driving | cough/sneeze | sexual activity | light touch | |

other: *(Please 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?_____

## MEDICATIONS

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

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

_____
_____
_____

**List all medications that you are taking <u>now</u>. *(Include over the counter, herbal, vitamins, and other supplemental medications)***

| Medication | Dose (mg) | How often? (# times/day) | What is this medication for? | Date started | Prescribing Doctor |
|---|---|---|---|---|---|
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## ALLERGIES

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

_____

_____

## MEDICAL HISTORY

(please check all that apply)

| Cardiovascular | Respiratory | Gastrointestinal | Endocrine | Hematologic |
|---|---|---|---|---|
| ___Chest Pain | ____Asthma | ____Acid Reflux/GERD | ____Obesity | ____Bleeding disorders |
| ___Heart Attack | ____Emphysema | ____Ulcers | ____Hypothyroid | ____Anemia |
| ___Heart Disease | ____Chronic Bronchitis | ____Polyps | ____Hyperthyroid | |
| ___Heart Rhythm Disturbances | | ____Easy bruising | ____Frequent Pneumonia | ____Hepatitis A, B, C |
| ___Diabetes | ____Anticoagulation | ____Arterial Insufficiency | ____Positive TB Test | ____Pancreatitis |
| ___Insulin | ____Venous Insufficiency | ____Bowel problems | ____Frequent Colds/Sore Throat | |
| ___High Blood Pressure | ____Low Blood Pressure | ____Blood thinners | ____Blood clots | ____Abnormal Chest x-ray |
| ___Colitis | ____Hiatal Hernia | ____Embolism | ____Gallbladder problems | ____Crohn's Disease |
| ___Irritable Bowel Syndrome | | ____Liver Disease | ____Special Diet | ____Other |

| Neurological | Psychological | Genitourinary | Musculoskeletal |
|---|---|---|---|

____Memory problems
____Seizures
____Stroke
____Movement Disorder
____Muscular Dystrophy
____Neuropathy
____Migraine
____Epilepsy
____Headaches

____Nervous Breakdown
____Depression
____Anxiety
____Panic Disorder
____Psychosis
____Alcohol or drug abuse
____ Other

____Sexual Dysfunction
____ Sexually Transmitted Disease
____Prostate Disease
____Kidney Problems
____Chronic Infection
____Bladder Problems

____Fibromyalgia
____Rheumatoid Arthritis
____Osteoarthritis
____Osteoporosis
____Back Problems
____Neck Problems

| Cancer | Miscellaneous | General | Allergic/Immunological |
|---|---|---|---|

Site _____
Diagnosis Date _____

Chemotherapy _____
Radiation _____
Other _____

____Glaucoma
____Cataracts

____Visual Problems
____Hearing Loss
____Chronic Skin Disorder
____Pregnancy
_____Date of last period

____Medical Equipment
____Cane
____Walker
____Wheel Chair
____Hospital Bed
____Oxygen at ___ LPM

____Autoimmune disorder
____Lupus, Sjogren's
____Raynaud's Syndrome
____Immune deficiency
____HIV

## SURGICAL HISTORY

*(Please list all surgeries)*

| DATE | SURGERY | DOCTOR |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## FAMILY MEDICAL HISTORY

Please check what applies

- Back Problems
- Migraines
- Heart Attack
- Cancer
- Diabetes
- Seizures
- Depression
- Stroke
- Anxiety
- Hypertension

Has family experienced any problems resulting in similar conditions or chronic pain? ____Yes ____No

## SOCIAL HISTORY

Smoking habits: _____ packs per day for _____ years
Alcohol intake: _____ Amount & Frequency_____

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## 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 exercise or recreational activities do you enjoy?
_____

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

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:
_____

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?
_____

## MEDICAL TESTING

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

| | **Date (approximate)** | **Result (if known)** |
|---|---|---|
| _____ X-ray | _____ | _____ |
| _____ CT Scan | _____ | _____ |
| _____ Myelogram | _____ | _____ |
| _____ MRI | _____ | _____ |
| _____ Discogram | _____ | _____ |
| _____ Bone Scan | _____ | _____ |
| _____ EMG | _____ | _____ |

## 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 & not intending pain-related litigation/lawsuit
_____Currently in pain related litigation/lawsuit
_____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)
_____

## 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 incontinence infections 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

## PAIN MANAGEMENT GOALS & EXPECTATIONS

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

_____ A diagnosis (to help find the cause of pain)
_____ A cure
_____ Help in coping with the pain
_____ No expectations
_____ A reduction in pain
_____ Do not know what to expect

## PAST TREATMENTS

*(Please select the treatments you have received for your pain problem, and what was the 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 | | | | | | |