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? _____

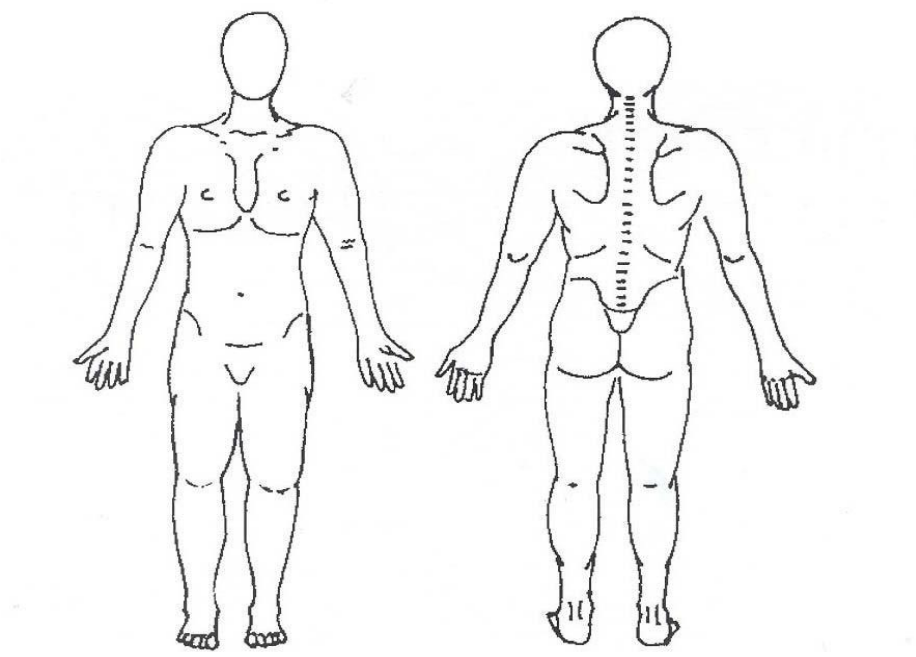
Under what circumstances did your pain begin? (Please select the appropriate indicator listed below)

_____ 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*



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Pain Care Center

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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 <u>now</u>. ***(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
___ Chest Pain	__ Asthma	__Acid Reflux/GERD	__ Obesity	___ Bleeding disorders
__Heart Attack	__ Emphysema	__Ulcers	___ Hypothyroid	___ Anemia
__Heart Disease	__ Chronic Bronchitis	__Polyps	___ Hyperthyroid	___Easy bruising
__Heart Rhythm Disturbances	___ Frequent Pneumonia	__Hepatitis A, B, C	___ Diabetes	___ Anticoagulation
__Arterial Insufficiency	___ Frequent Colds/Sore Throat	___ Pancreatitis	___ Insulin	(blood thinners)
___Venous Insufficiency	___ Positive TB Test	__ Bowel problems	___ Other	___ Blood clots
__High Blood Pressure	__Abnormal Chest x-ray	__ Colitis		
___ Low Blood Pressure	___ Other	__ Hiatal Hernia		
___ Embolism		__ Gallbladder problems		
__Other		__ Irritable Bowel Syndrome		
		___ Crohn's Disease		
		___ Special Diet		
		___Liver Disease		

Neurological	Psychological	Genitourinary	Musculoskeletal
__Memory problems	___ Nervous Breakdown	__Sexual Dysfunction	___ Fibromyalgia
__Seizures	___ Depression	__Sexually Transmitted Disease	___ Rheumatoid Arthritis
__Stroke	__Anxiety	__Prostate Disease	__Osteoarthritis
__ Movement Disorder	__Panic Disorder	__Kidney Problems	___ Osteoporosis
__ Muscular Dystrophy	__Psychosis	___ Chronic Infection	___ Back Problems
__Neuropathy	__Alcohol or drug abuse	__Bladder Problems	___ Neck Problems
__Migraine	__Other		
__Epilepsy			
__Headaches			

Cancer	Miscellaneous	General	Allergic/Immunological
Site _____	__Glaucoma	___ Medical Equipment	__Autoimmune disorder
Diagnosis Date _____	___ Cataracts	___ Cane	__Lupus, Sjogren's
Chemotherapy _____	__ Visual Problems	___ Walker	__Raynaud's Syndrome
Radiation _____	__Hearing Loss	___ Wheel Chair	__Immune deficiency
Other _____	___ Chronic Skin Disorder	___ Hospital Bed	__HIV
	___ Pregnancy	___ Oxygen at ___ lpm	
	__ 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)

Current Use	***Past Use***	***Item***	***Comments (how much and how many years?)***
		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)
_____ X-ray	_____	_____
_____ CT Scan	_____	_____
_____ Myelogram	_____	_____
_____ MRI	_____	_____
_____ EMG	_____	_____
_____ Discogram	_____	_____
_____ Bone Scan	_____	_____
_____ EKG	_____	_____
_____ 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)* _____

_____

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

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)*

_____ A diagnosis (to help find the cause of pain)

_____ Help in coping with the pain

_____ A reduction in pain

_____ A cure

_____ No expectations

_____ 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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