MATHEW LEFKOWITZ, MD
Pain management

NEW PATIENT FORM

Name: _____ Height / Weight: _____/_____

Age: _____ Date of Birth: _____/_____/_____ Male / Female Right Handed / Left Handed

Tel #: _____ Occupation: _____ (Unemployed / Retired)

Where is your pain?

Head Neck Shoulder Mid Back Upper Back Low Back Hip Knee Foot

Chest Arm Hand Wrist Groin Buttock Thigh Leg Ankle Other_____

Where is the **one** most painful area? _____

Circle your pain level (0 = no pain, 10 = worst pain imaginable): 0 1 2 3 4 5 6 7 8 9 10

How long have you had this pain? (Please enter a #) _____Years _____Months _____Weeks

Have you been to **Physical Therapy** for this issue? Yes / No If **YES**, when? _____

Have you had any **MRIs** or **X-Rays** for this issue? Yes / No If **YES**, where? _____

Is your pain from a **Work-Related** injury? Yes / No If **YES**, when? _____

Is your pain from a **Car Accident**? Yes / No If **YES**, when? _____

Review of Systems: (Please circle any symptom that applies to you)

Sharp	Electrical	Weight loss	Shortness of breath
Aching	Tingling	Rash	Heartburn
Stabbing	Clicking	Headache	Abdominal pain
Burning	Headaches	Vision disturbance	Nausea
Shooting	Pins/Needles	Swollen lymphnodes	Vomiting
Throbbing	Spasms/Tightening	Chest pain	Diarrhea
Numbness	Fever	Ankle/leg swelling	Bloody stools

Your Doctors:

Referring Doctor: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

Other Specialists: _____ Phone: _____

Other Specialists: _____ Phone: _____

Your Pharmacy:

Name: _____ Phone: _____

Address: _____

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Other Illnesses: (Please circle all that apply) N/A

Anemia	Fibromyalgia	Kidney disease	Rheumatoid Arthritis
Asthma	Gout	Lupus	Seizure disorder
Bronchitis	Heart Disease	Mental illness	Stomach ulcer
Cancer _____	HIV/AIDS	Osteoarthritis	Stroke
Depression	High blood pressure	Osteoporosis	Substance abuse
Diabetes	High cholesterol	Parkinson's disease	Thyroid disease
Emphysema/COPD	Insomnia	Prostate disease	Other_____

Past Operations:

Have you had an operation? Yes / No (Please list all past operations) Year:

_____ _____

_____ _____

_____ _____

Current Medications:

Do you take any medications? Yes / No (Please list all current medications and dosages)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you taking a Blood Thinner? Yes / No

Allergies / Drug Reactions: (Write "NONE" if applicable)

_____

Smoking Status:

Non-smoker	1-3 cigarettes per day	1-2 packs per day
Previous smoker	Up to 1 pack per day	2 or more packs per day

I certify that the information given is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made.

I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits; and,

I authorize payment of medical benefits for myself to Dr. Mathew Lefkowitz; and,

I authorize the release of any and all information necessary to process this claim.

X_____

Signature Date