PAIN MANAGEMENT INITIAL PATIENT INFORMATION

INITIAL PATIENT VISIT INFORMATION (please fill this form accurately & completely) DATE: _____

HEIGHT:_____ WEIGHT:_____

LAST: _____ FIRST: _____ MI: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE #: ( ) _____ CELL PHONE #: ( ) _____

DOB _____ AGE: _____ SEX _____ SOCIAL SECURITY #: _____-_____-_____

MARITAL STATUS: S M D W REFERRED BY: _____ PHONE #: ( ) _____

EMPLOYER: _____ PHONE #: ( ) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

VISIT REASON: WORKMEN'S COMP: ____ NO-FAULT: ____ SLIP & FALL: ____ IME: _____ PRIVATE INS: _____ OTHER: _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO: _____ PHONE # ( ) _____

ADDRESS: _____

GROUP, PLAN, or POLICY #: _____ CLAIM#: _____

NAME of POLICY HOLDER and RELATION: _____ PHONE #: ( ) _____

SECONDARY INSURANCE CO. (IF APPLICABLE)

INSURANCE CO: _____ PHONE # ( ) _____

ADDRESS: _____

NAME of POLICY HOLDER and RELATION: _____ PHONE #( ) _____

NO-FAULT INSURANCE CASE

INSURANCE COMPANY NAME: _____ DATE OF ACCIDENT: _____

ADDRESS: _____

CLAIM #: _____ ADJUSTER'S NAME: _____

POLICY # _____ POLICY HOLDER'S NAME: _____

PHONE # ( ) _____

WORKER'S COMPENSATION CASE

INSURANCE CARRIER: _____ DATE OF INJURY: _____

ADDRESS: _____

CLAIM #: _____ ADJUSTER'S NAME: _____

PHONE # ( ) _____

WHERE DID INJURY OCCUR? _____

ARE YOU WORKING? _____ FULL-TIME: _____ PART-TIME: _____

IF NO, WHEN DID YOU STOP WORKING? _____

WHEN DID YOU BEGIN TO WORK? _____

ATTORNEY'S INFORMATION

ATTORNEY'S NAME: _____ PHONE # ( ) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

PAIN MANAGEMENT PATIENT HISTORY INITIAL VISIT FORM

PATIENT HISTORY FORM

Name:_____ **Date of Birth:**_____ **Age:** _____ **Date:** _____
SS #_____ **Sex: M** ____ **F**___ **Referred by:**_____

Where on your body is your main pain:

Head | Arm right / left | Hand right / left | Leg right / left

Neck | Chest right / left | Abdomen right / left | Back right / left

How long have you had this pain: months years

Is there another area on your body that you have pain: Yes / No

Describe the quality of the pain: Knife like | Burning | Electric Shock | Throbbing | Dull Ache

Describe the duration of the pain: Constant | Comes & Goes | Always present but gets worse at times.

Describe the intensity of the pain: Mild | Discomforting | Distressing | Horrible | Excruciating

Pick a number for your pain: Least 1 2 3 4 5 6 7 8 9 10 Worst

What makes the pain worse: Sitting | Walking | Damp Weather | Other_____

What makes the pain better: Rest | Hot Shower

What treatments have you received for pain:

Physical Therapy Injections | None | Others (specify) _____

What medications do you take for pain?_____ _____ _____

Do you take Aspirin / Baby Aspirin or Blood Thinning Medications? Yes No

How do you sleep at night? Poor Fair Normal

Have you had to cut down on normal activities because of your pain? Yes No
If yes, how much? Mildly Moderately Severely

Have you had any of these medical conditions (please circle):

Heart problems | Asthma | Kidney problems | Liver problems | Arthritis | Stomach Ulcers
Diabetes | Stroke | High Blood Pressure | Blood disorders | Easy bruising | Psychiatric problems

List the surgeries you have had in the past: _____ _____
_____ _____ _____

List all your medications: _____ _____ _____
_____ _____ _____ _____ _____

Are you allergic to any medications? _____ _____ _____

Do you smoke? Yes / No **If yes how many packs per day do you smoke?** _____

Do you drink alcohol? Yes / No / Socially

Do you use any recreational drugs like marijuana, cocaine, etc? Yes / No

Signature of Patient: _____