Carolyn Davis, MSN, FNP-BC
Jennifer McLane, ANP-BC
Christopher Bradley, PA-C
Pain Management Specialists

NEW PATIENT INFORMATION RECORD

Failure to complete this entire form PRIOR to your appointment may result in rescheduling. This information is kept confidential and will be available to your health care team.

PLEASE BRING THIS COMPLETED FORM WITH YOU ON YOUR NEXT VISIT

Today's Date:_____/_____/_____

Last Name:_____ First:_____ MI:_____

Date of Birth:_____/_____/_____ Social Security #:_____ Sex:_____ Age:_____

Home Phone: _____ _____ Mobile Phone:_ _____

Address:_____ City:_____ State:_____ Zip:_____

E-mail :_____ _____

Marital Status:_____ Spouse's Name:_____

Referring Physician: _____ Telephone: _____

Primary Care Physician: _____ Telephone: _____

PATIENT EMPLOYER INFORMATION

____Full-Time ____Part-Time _____Unemployed_____Student _____Retired ____Legally Disabled

Employer's Name:_____ Work Phone: ( )_____

EMERGENCY CONTACT

Name:_____ Relationship:_____ Phone: _____

AUTO/WORK RELATED INJURY DISCLOSURE

Are services you are being treated for today related to an ***automobile accident*** **or** ***work related*** injury**?**

_____ YES _____ NO

Patient Signature* _____ Date: _____

By signing above, you agree to be responsible for all charges your insurance denies as being related to an open worker's compensation or motor vehicle accident claim

PHARMACY INFORMATION

Name of Pharmacy_____ Phone_____

PRIOR TREATMENT

Below are different medical specialties. Indicate if you have seen any of these specialists for your pain condition:

Cardiologist_____
Chiropractor_____
Endocrinologist_____
Family Practice_____
Internal Medicine_____
Neurologist_____
Neurosurgeon _____
Orthopedic Surgeon (Bones) _____
Pain Specialist_____
Psychiatrist/Psychologist_____
Rheumatologist_____
Physical Therapy_____
Other_____
Number of E.R visits for pain this year?_____

HISTORY OF PRESENT ILLNESS

Over the past 48 hours, have you taken any **pain medication**? ( ) yes ( ) no

If so, what have you taken?_____
_____

What part(s) of your body hurt? _____
_____

On the following scale, rate your pain **right now:** (circle one)

PAIN SCALE: 0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

Symptoms have continued for (**circle one**): 1-5 years 5-10 years 10-15 years 15 +

The timing of your pain is: (please check those that apply to you)

Continuous_____
Intermittent_____
Non-specific_____
Worse in the mornings_____
Worse at night_____

HISTORY OF PRESENT ILLNESS

Pain is described as: (please check those that apply to you)

Dull _____	Stabbing_____	Pressure_____
Aching _____	Weakness_____	Shooting_____
Throbbing _____	Stiffness_____	Spasm_____
Sharp _____	Cramping_____	Squeezing_____
Burning _____	Hot _____	Stinging_____
Numbness _____	Cold_____	Tenderness_____
Tingling _____	Pinching_____	Grinding_____

The pain is associated with: (please check those that apply to you)

Decreased function_____	Change in appetite_____	Numbness_____
Anger_____	Fatigue_____	Poor sleep_____
Anxiety_____	Headache_____	Weight gain
Blurred vision_____	_	Depression_____

Pain is aggravated by: (please check those that apply to you)

Walking_____	Shopping/Yard Work_____	Lifting_____
Bending_____	Household chores_____	Lying down_____
Sitting_____	Weather changes_____	Movement_____
Work_____	Cold_____	Nothing_____
Physical Therapy _____	Everything_____	Sitting to standing_____

Pain is improved with: (please check those that apply to you)

Bed-rest_____	Psychotherapy_____	Lying down_____
Traction_____	TENS Unit_____	Nothing_____
Chiropractic's_____	Back brace_____	OTC medication_____
Exercise_____	Heat_____	Position change_____
Massage_____	Ice_____	Sitting_____
Rest_____	Aquatic Therapy_____	Standing_____
Medication_____	Injections_____	Walking_____
Physical Therapy_____	Relaxation_____	Stretching_____

On the following scale, rate your pain level **<u>WITH</u>** ***current pain medication***-if any

PAIN SCALE: 0 1 2 3 4 5 6 7 8 9 10

No Pain Extreme Pain

On the following scale, rate your pain level **<u>WITHOUT</u>** ***current pain medication***-if any

PAIN SCALE: 0 1 2 3 4 5 6 7 8 9 10

No Pain Extreme Pain

HISTORY OF PRESENT ILLNESS

- Have you had an **MRI** done before? ( ) yes ( ) no
- Where was the **MRI** completed at?_____
  _____
- Have you been to the Emergency Room in the past 3 months? ( ) yes ( ) no
  If so what for/how many visits: _____

Check off the following medications that you have EVER taken before:

Morphine_____	Exalago _____	OxyContin_____
Hydrocodone_____	Butrans patch _____	Dilaudid_____
Oxycodone (Percocet) _____	Fentanyl patch _____	Suboxone_____
Opana (Oxymorphone) _____	Nucynta_____	Tramadol_____

Previous Treatment includes:

Trigger Point Injections_____
Epidural Injections_____
Surgery_____
Chiropractic Adjustments_____

Please list any previous pain clinics that you have been treated at:

Facility Name:	**Doctors Name:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS

- Please list all your current medications below (include over-the-counterdrugs)

*****If you have a list, please hand to the nurse to copy (not front desk). Do not write meds down again!!***

Name & Strength	Prescribing Doctor
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- List all things that you are **ALLERGIC** or have **BAD REACTIONS** to:

Allergic to:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

SURGERIES

- List all **MAJOR Surgeries** which you have had in the past:

Name of Surgery	Hospital/Facility and Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Please list any **MAJOR medical history** regarding family members:

Family Member:	**Medical History:**
_____	_____
_____	_____
_____	_____
_____	_____

Do you have children? ( ) yes ( ) no

Number of Children: _____ Living with you:_____

- Do you drink alcohol? ( )yes ( ) no
- Do you ever have suicidal thoughts? ( ) yes ( )no
- Marital Status? ( ) Married ( )Single ( )Divorced ( )Widowed
- Work Status? ( )Full Time ( )Part Time ( )Unemployed ( )Retired ( )Disability
- Do you use recreational or illegal substances? ( )yes ( ) no
- Do you smoke tobacco? ( )yes ( ) no
- Have you ever been treated for addiction? ( ) yes ( )no

MEDICAL HISTORY

Cardiovascular:	**YES**		**NO**
Heart Attack	_____		_____
Stroke/TIA	_____		_____
High Blood Pressure	_____		_____
Chest pain/angina	_____		_____
Irregular heart beat	_____		_____
Gastrointestinal:			
Ulcers/gastritis	_____		_____
Frequent Constipation	_____		_____
Frequent Diarrhea	_____		_____
Hearburn/indigestion	_____		_____
Nausea	_____		_____
Incontinence of Stool	_____		_____
Hematologic			
Immune Disease	_____		_____
Hemophilia	_____		_____
Taking blood thinner	_____		_____
Frequent Nose bleeds	_____		_____
Bleeding problems	_____		_____
Genitourinary:			
Kidney problems	_____		_____
Kidney stones	_____		_____
Problems Urinating	_____		_____
Sexual problems	_____		_____
Musculoskeletal			
Fibromyalgia	_____		_____
Arthritis	_____		_____
Syndrome	_____		_____
Skin color/temp changes	_____		_____
Constitutional			
Frequent fevers	_____		_____
Recent Weight Loss	_____	lbs.	_____
Recent Weight Gain	_____	lbs.	_____
Frequent nights sweat	_____		_____
Allerigic/Immunologic:			
Wheezing	_____		_____
Itching	_____		_____

Respiratory	**YES**	**NO**
Asthma	_____	_____
Smoking Now	_____	_____
# packs per day	_____	
Snoring	_____	_____
Chronic cough	_____	_____
Shortness of Breath	_____	_____
Neurological		
Seizures/epilepsy	_____	_____
Numbness	_____	_____
Weakness	_____	_____
Headaches	_____	_____
Dizziness	_____	_____
Restless Legs	_____	_____
Endocrine		
Thyroid Problems	_____	_____
Diabetes	_____	_____
On Insulin?	_____	_____
Liver problems	_____	_____
Hepatitis	_____	_____
Emotional/Psychiatric		
Depression	_____	_____
Anxiety/panic	_____	_____
Irritability	_____	_____
Suicidal thoughts	_____	_____
Ophthalmologic:		
Blurred Vision	_____	_____
Eye discharge	_____	_____
Ears, Nose, Throat:		
Hearing Loss	_____	
Bleeding Gums	_____	_____
Problems Swallowing	_____	_____
Integumentary:		
Rash/Hives	_____	_____
Blistering of skin	_____	_____
Skin Cancer	_____	_____