NEW PATIENT FORM

Patient: ________________________________

Date: ________________________________

Referred by ____________________________________________

What is / are your main pain area(s)? ____________________________

What do you hope to improve or accomplish by coming to a pain clinic? (Goals) ____________________________________________

When did the pain start? ____________________________________________

Did an accident or trauma precede the beginning of the pain? Yes____ No____ Describe ____________________________________________

___________________________________________________________

Do you have any numbness in your arms, hands, legs or feet? Yes____ No____ If Yes, where? ____________________________

Do you have any weakness in your arms, hands, legs or feet? Yes____ No____ If Yes, where? ____________________________

Do you lose control of your bowel or bladder? Yes____ No____ If Yes, which? ____________________________

Circle the number below to indicate the level or intensity of your pain: ( 0 = no pain 10 = "worst pain I've ever had"")

Usually

0 1 2 3 4 5 6 7 8 9 10

Right now:

0 1 2 3 4 5 6 7 8 9 10

List any specific activities or things that INCREASE your pain:

__________________________________________________________________________________________

List any specific activities or things that DECREASE your pain:

__________________________________________________________________________________________

Does your pain interfere with your ability to sleep? Yes____ No____

What activities does your pain prevent you from doing?

Housework yard work dressing yourself shopping walking traveling working enjoying activities

Other activities ____________________________________________

Please circle each of the following words that apply to your pain:

Throbbing Shooting Stabbing Sharp Cramping Gnawing Hot-burning Aching Heavy

Tender Splitting Tiring-exhausting Sickening Fearful Punishing-cruel

Have you seen any other healthcare provider(s) for your pain?

<table>
<thead>
<tr>
<th>Name</th>
<th>Type Provider</th>
<th>Treatment</th>
<th>Date(s)</th>
<th>Helpful?</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
FAMILY HISTORY

Are there any pain problems that run in your family? ______________________________________

SOCIAL HISTORY


Children: Ages _____________________________________________ Living at home with you? Yes _____ No _____

Use of alcohol: Never _____ Rarely _____ Moderate: _____ Daily: _____

Use of tobacco: Never: _____ Previously, but quit: _____ Current packs per day: _____

Have you ever had a problem with dependency or abuse of prescription or non-prescription drugs? Yes _____ No _____

Occupation ______________________________________________ Hours per day ______________________

Retired: Yes _____ No _____ Disabled: Yes _____ No _____ If yes, since when? ______________________

Are you involved in any litigation, workers compensation claim or disability claim? Yes _____ No _____

REVIEW OF SYSTEMS:

<table>
<thead>
<tr>
<th>CONSTITUTIONAL SYMPTOMS</th>
<th>GENITOURINARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good general health lately</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Recent weight change</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Fever</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Yes _____ No _____</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EYES</th>
<th>GENITOURINARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye disease or injury</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Wear glasses/contact lenses</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Blurred vision</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>Yes _____ No _____</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EAR/NOSE/MOUTH/THROAT</th>
<th>GENITOURINARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing loss or ringing</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Earaches or drainage</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Chronic sinus problem or rhinitis</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Nose bleeds</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Mouth sores</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Bleeding gums</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Sore throat or voice change</td>
<td>Yes _____ No _____</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CARDIOVASCULAR</th>
<th>MUSCULOSKELETAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart trouble</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Chest pain or angina pectoris</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Palpitations</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Exposure to TB?</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Swelling of feet, ankles or hands</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Murmurs</td>
<td>Yes _____ No _____</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESPIRATORY</th>
<th>MUSCULOSKELETAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic or frequent coughs</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Spitting up blood</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Asthma or Wheezing</td>
<td>Yes _____ No _____</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>GASTROINTESTINAL</th>
<th>MUSCULOSKELETAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of appetite</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Nausea or vomiting</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Frequent diarrhea</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Painful bowel movements or constipation</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Rectal bleeding or blood in stool</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Peptic ulcer(stomach or duodenal)</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Pancreatitis</td>
<td>Yes _____ No _____</td>
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<table>
<thead>
<tr>
<th>INTEGUMENTARY (skin, breast)</th>
<th>MUSCULOSKELETAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rash or itching</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Change in skin color</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Change in hair or nails</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Change in temperature of extremities</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Varicose veins</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Breast pain</td>
<td>Yes _____ No _____</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>NEUROLOGICAL</th>
<th>MUSCULOSKELETAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent or recurring headaches</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Light headed or dizzy</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Convulsions or seizures</td>
<td>Yes _____ No _____</td>
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<tr>
<td>Numbness or tingling sensations</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Tremors</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Paralysis</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Stroke</td>
<td>Yes _____ No _____</td>
</tr>
<tr>
<td>Head injury</td>
<td>Yes _____ No _____</td>
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</tbody>
</table>
What medications or therapies (such as heat, TENS unit, Biofeedback, Ultrasound, etc.) have you tried for your pain?

<table>
<thead>
<tr>
<th>Medication/Therapy</th>
<th>? Helpful</th>
<th>Side effects if any</th>
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<tbody>
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Have you had any of the following done concerning your pain area?

- **X-rays**
  - Yes____ No_____ if Yes, When __________ Where________________________

- **CT-scan**
  - Yes____ No_____ if Yes, When __________ Where________________________

- **MRI scan**
  - Yes____ No_____ if Yes, When __________ Where________________________

- **Discography**
  - Yes____ No_____ if Yes, When __________ Where________________________

**PAST MEDICAL HISTORY: Including mental health problems**

Please list current medical problems (diabetes, high blood pressure, etc.):

<table>
<thead>
<tr>
<th>Medical Problem</th>
<th>Details</th>
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Please list previous surgeries:

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Date</th>
<th>Details</th>
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</table>

What medications are you taking regularly?

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>How often</th>
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Do you have allergies to any medications?  YES _____  NO _____ If Yes, please write below

<table>
<thead>
<tr>
<th>Medication</th>
<th>Type of reaction</th>
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<tr>
<td>PSYCHIATRIC</td>
<td>HEMOTOLOGIC/LYMPHATIC</td>
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<td>-------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Memory loss or confusion</td>
<td>Bleeding or bruising tendency</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Anemia</td>
</tr>
<tr>
<td>Depression</td>
<td>Phlebitis</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Past transfusion</td>
</tr>
<tr>
<td></td>
<td>Enlarged glands</td>
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<thead>
<tr>
<th>ENDOCRINE</th>
<th>ALLERGIC/IMMUNOLOGIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glandular or hormone problem</td>
<td>History of skin reaction or other adverse reaction to:</td>
</tr>
<tr>
<td>Thyroid disease</td>
<td>Penicillin or other antibiotics</td>
</tr>
<tr>
<td>Diabetes (insulin or Non insulin) circle one</td>
<td>Morphine, Demerol or other narcotics</td>
</tr>
<tr>
<td>Excessive thirst or urination</td>
<td>Novocain or other anesthetics</td>
</tr>
<tr>
<td>Heat or cold intolerance</td>
<td>Aspirin or other pain remedies</td>
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<tr>
<td>Skin becoming dryer</td>
<td>Tetanus antitoxin or other serums</td>
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<tr>
<td>Change in hat or glove size</td>
<td>Iodine or other antiseptic</td>
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**PHYSICAL EXAMINATION:**

**GENERAL**

**SKIN**

**HEENT**

**LUNGS**

**HEART**

**ABDOMEN**

**EXTREMITIES**

**SPINE**

**NEUROLOGICAL**

**CLINICAL IMPRESSION:**

**PLAN:**