New Patient Information

Name: _____ DOB: _____

PRIOR PAIN PROCEDURES:

Have you previously had any pain procedures, blocks, or injections? YES NO

If YES please specify: _____

_____

Why are you seeking treatment? _____

_____

Have you seen another pain doctor? Who? _____

PAIN DURATION: How long have you had your current pain? _____years _____months

ONSET OF PAIN: How did your current pain start? _____ undetermined

_____ motor vehicle accident _____ injury at work _____ illness, non-injury

TIMING OF PAIN: How often do you have your pain? (please check one)

_____ constantly (100 % of the time) _____ intermittently (30-60% of the time)

_____ nearly constantly (60-95% of the time) _____ occasionally (less than 30% of the time)

PAIN QUALITY: How would you describe the pain? _____ burning _____ numbness

_____ pressing _____ cramping _____shooting _____pins & needles _____aching

_____ sharp _____ throbbing _____other _____

Name: _____ DOB: _____

RELIEVING AND AGGRAVATING FACTORS:

How do the following affect your pain? Please check one for each item

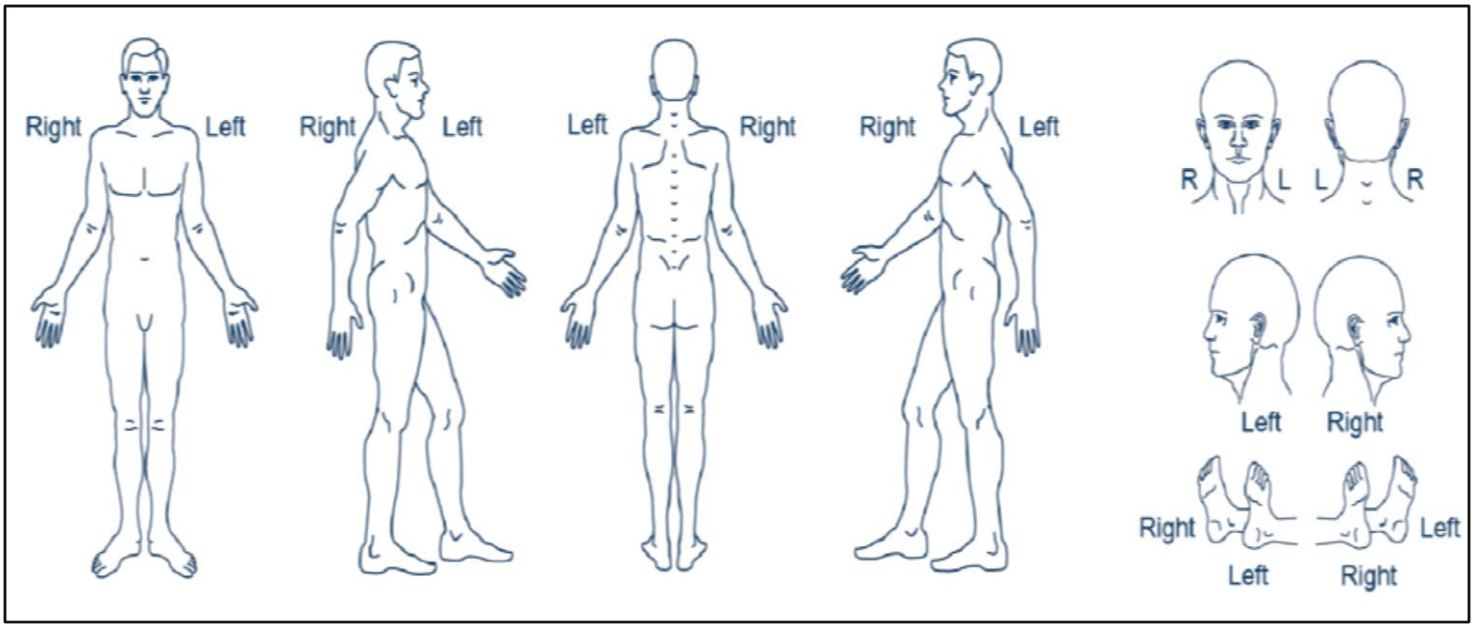
	INCREASED	NO CHANGE	DECREASED
Lying down			
Standing			
Sitting			
Walking			
Medications			
Relaxation			
Coughing/Sneezing			

How long can you walk before having to stop due to pain? _____ minutes _____ hours

How long can you sit before having to get up? _____ minutes _____ hours

How long can you stand before you have to sit down? _____ minutes _____ hours

Place an "X" on your area of pain on the diagram below



Name: _____ DOB: _____

YOUR PRIOR MEDICAL HISTORY:

Infectious Disease YES NO Describe: _____

	YES	NO		YES	NO
Alcoholism			*Heart Attack*		
Anemia			*Heart Disease*		
Anxiety			*Heart Murmur*		
Arthritis			*Hemorrhage*		
Asthma			*Hepatitis*		
Back Pain			*HIV*		
Bleed Easily			*Hyperlipidemia*		
Blood Clots			*Hypertension (HTN)*		
Coronary Disease			*IBS/Irritable Bowel*		
Cancer/Tumor			*Insomnia*		
Carotid Stenosis			*Kidney Disease*		
Carpal Tunnel Syndrome			*Liver Disease*		
COPD/Emphysema			*Lung Disease*		
Crohn's Disease			*Mitral Valve Regurg*		
CVA/Stroke			*Narcotic Addiction*		
Depression			*Nicotine Addiction*		
Diabetes			*Pancreatitis*		
Diverticulitis			*Plantar Fasciitis*		
Edema			*Pneumonia*		
Endometriosis			*PVD/Vascular Disease*		
Epilepsy/Seizures			*Scoliosis*		
Fibromyalgia			*Shingles*		
Fracture			*Sleep Apnea*		
Gallbladder problems			*Thyroid Disease*		
Gastro-intestinal disease			*Ulcer*		
Glaucoma			*UTI*		
Gout			*Yellow Jaundice*		
Headaches					
Other					

Name: _____ DOB: _____

PAIN TREATMENTS:

Check all of the treatments you have tried and then indicate the amount of relief if any

	DATE	No Relief	Moderate Relief	Excellent Relief
Traction				
Acupuncture				
TENS Unit				
Physical Therapy				
Heat Treatment				
Chiropractic				
Exercise				

PSYCHOLOGICAL TREATMENT:

Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? If yes, when? _____

_____

Have you ever considered suicide? _____

EDUCATION: Your highest education level:_____

EMPLOYMENT: Current employment status (please check all that apply):

____Full time ____Part time ____Unemployed _____Unemployed due to pain

_____Homemaker _____Retired _____Student

If you are currently unemployed, indicate how long you have been off work:

_____1-3 weeks _____4-7 months _____12-18 months _____25 or more months

_____1-3 months _____8-11 months _____9-24 months

LEGAL ISSUES: Indicate any of the following you have filed related to your pain:

_____ Workers' Compensation _____ Social Security Disability (SSDI)

_____ Personal Injury/liability (unrelated to work) _____ Other _____ None

Name: _____ DOB: _____

SURGERIES:

Date	Hospital	Type of Operation

MEDICATIONS:

Medication	Dose	Frequency

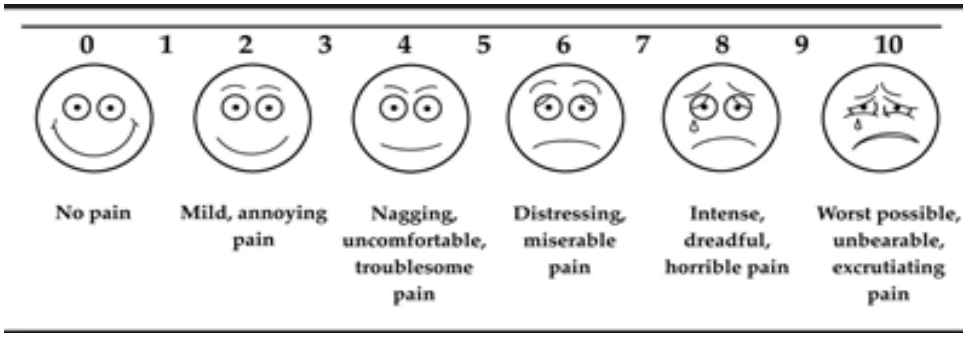
ALLERGIES:

Are you allergic to dye? YES NO

Other allergies:

Name: _____DOB: _____DOS:_____

MILD MODERATE SEVERE



*PLEASE USE CORRESPONDING DIAGRAM ABOVE TO ANSWER QUESTIONS BELOW

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual **ACTIVITY:**

0-------1-------2------3------4------5------6------7------8------9------10

Does not interfere completely interferes

2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your **SLEEP:**

0-------1-------2------3------4------5------6------7------8------9------10

Does not interfere completely interferes

3. Circle the one number that describes how, during the past 24 hours, pain has affected you **MOOD:**

0-------1-------2------3------4------5------6------7------8------9------10

Does not interfere completely interferes

4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your **STRESS:**

0-------1-------2------3------4------5------6------7------8------9------10

Does not interfere completely interferes