PATIENT INFORMATION

Last Name	First Name	Middle Initial	Nickname
Date of Birth	Social Security Number		Gender Male Female

Marital Status (Circle one) Married Single Divorced Life Partner Separated Widowed Other Language other than English

Race (Optional) (Circle one) Black–Non Hispanic American Indian Hispanic Asian/Pacific Islander White–Non Hispanic Other

Home Address	Apt #	City	State	Zip Code

Home Phone	Work Phone	Other Phone (Type: _Cell _Pager _Fax)
Email Address	Employer	Occupation

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician	Referring Physician

How did you hear about us?

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient (If self, skip to Emergency Contact) _Spouse _Parent _Other

Last Name	First Name	Middle Initial
Date of Birth	Social Security Number	

Home Address	Apt #	City	State	Zip Code

Home Phone	Work Phone	Other Phone (Type: _Cell _Pager _Fax)

EMERGENCY CONTACT INFORMATION/AUTHORIZED HIPAA CONTACT

Last Name	First Name	Relationship to Patient

Home Address	Apt #	City	State	Zip Code

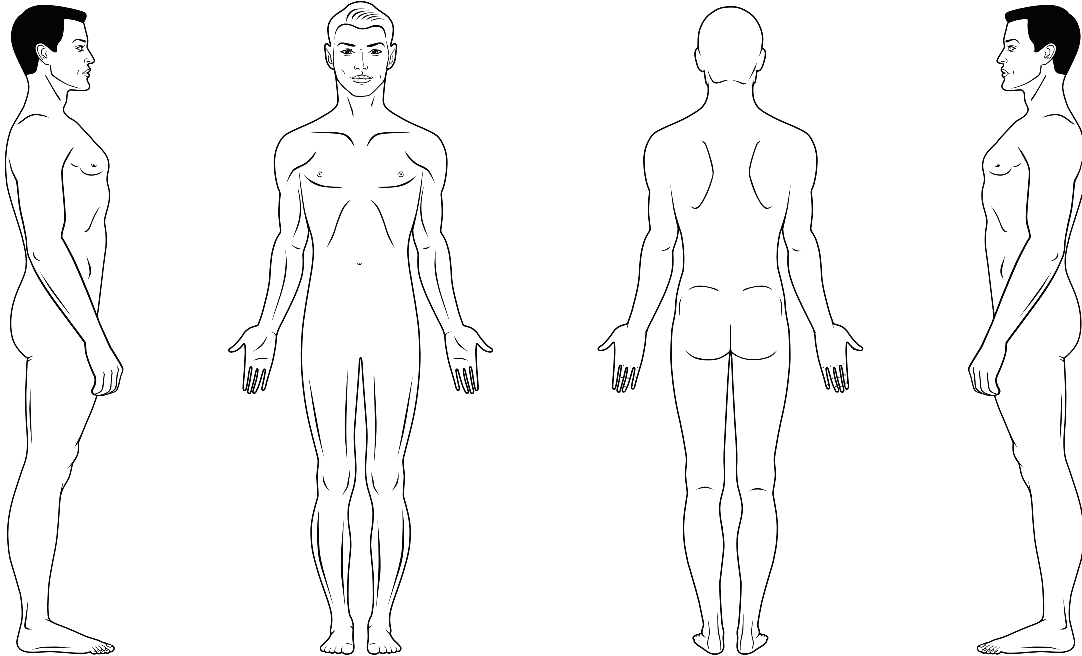
Home Phone	Work Phone	Other Phone (Type: _Cell _Pager _Fax)

INSURANCE INFORMATION

Primary Insurance	ID Number	Group Number	Telephone Number
Secondary Insurance	ID Number	Group Number	Telephone Number
Insured Member	Social Security Number	Date of Birth	ID Number

Patient Name: ______________________

MARK ON THE PICTURE WHERE YOU ARE HAVING PAIN.
ALSO MARK (X) FOR NUMBNESS, (T) FOR TINGLING, (B) FOR BURNING.



Pain:

When did the pain begin? ____

How did it start?

❑ Work Accident ❑ Following Surgery ❑ No Trauma ❑ Gradual Onset
❑ Home Accident ❑ Other Accident or Injury ❑ Auto Accident ❑ Unknown

Duration of Pain:

❑ 1-4 weeks ❑ 1-3 months ❑ 3-6 months ❑ Less than 1 year ❑ More than 1 year ❑ Many years

How often does the pain occur?

❑ Continuously ❑ Constantly (76-100% of the day) ❑ Frequently (51-75% of the day) ❑ Occasional (26-50%of the day)
❑ Intermittently (0-25% of the day) ❑ Less than daily ❑ Monthly

Select one or more items below to describe the nature of your pain:

❑ Throbbing ❑ Shooting ❑ Sharp ❑ Cramping ❑ Hot/Burning ❑ Aching ❑ Stabbing ❑ Tingling ❑ Numbing ❑ Dull-ache

How do the following factors affect your pain?

	Worse	Better	No Effect
Standing	❑	❑	❑
Walking	❑	❑	❑
Sneezing	❑	❑	❑
Coughing	❑	❑	❑
Weather	❑	❑	❑
Lifting	❑	❑	❑
Lying Down	❑	❑	❑
Sitting	❑	❑	❑

Current Pain Score ______________ (0-10, 10 being the worst pain)

Best Pain Score ______________

Worst Pain Score ______________

Patient Name: ____________________

Check the treatments you have had for pain:

- ❑ Acupuncture ❑ Physical Therapy ❑ Trigger Points ❑ Massage ❑ Exercise ❑ TENS Unit
- ❑ Chiropractor ❑ Brace ❑ Surgery ❑ Facet Blocks ❑ Radiofrequency neurotomy
- ❑ Epidural ❑ Nerve Blocks ❑ Biofeedback ❑ Other ____________________

Imaging Studies/Tests Done:

❑ MRI ❑ CT Scan ❑ X-rays ❑ EMG/NCV Results of Test ____________________

PAST MEDICAL HISTORY (Circle all that apply)

Constitutional
Obesity Weight Loss Weight Gain Cancer

Musculoskeletal
Arthritis Fibromyalgia Muscle spasms

Neurological
Headache Seizures Migraines Stroke

Psychiatric
Depression Substance Abuse Anxiety
Bipolar Schizophrenia

Cardiovascular
Angina Heart Attack Heart Stent
Pacemaker High Blood Pressure (Hypertension)

Respiratory
Asthma Emphysema Chronic Bronchitis
Lung Cancer Obstructive Sleep Apnea COPD

Gastrointestinal
Reflux Hepatitis Ulcer
Irritable Bowel Syndrome Heartburn
Cirrhosis Diverticulitis Colon Cancer

Genitourinary
Impotence Kidney Stones Incontinence

Endocrine Hematologic Allergy/Immunologic
Diabetes Hypothyroidism Hyperthyroidism
HIV Hyperlipidemia (Elevated Cholesterol)
Leukemia Lymphoma Multiple Myeloma

Rheumatologic
Lupus Sjogrens Scleroderma
Polymyalgia Rheumatica Rheumatoid Arthritis.

REVIEW OF SYSTEMS (Circle all that apply)

Constitutional
Chills Fever Fatigue

Musculoskeletal
Numbness Weakness

Neurological
Confusion Dizziness Light Sensitivity
Loss of Consciousness

Psychiatric
Suicidal Thoughts Difficulty Sleeping

Cardiovascular
Chest Pain Palpitations

Respiratory
Cough Shortness of Breath

Gastrointestinal
Diarrhea Constipation Abdominal Pain
Bloating Nausea Vomiting

Genitourinary
Decreased Libido Urinary Frequency

Endocrine Hematologic Allergy/Immunologic
Easy Bruising Ringing In Ears

Surgical History (Check all that apply)

- ❑ Appendectomy ❑ Tonsillectomy/Adenoids ❑ Gallbladder Surgery ❑ Coronary Bypass ❑ Hernia Repair ❑ Tubal Ligation
- ❑ Mastectomy ❑ Hysterectomy ❑ Breast Biopsy ❑ Prostate ❑ Vasectomy ❑ Knee Replacement
- ❑ Hip Replacement ❑ Knee Surgery ❑ Shoulder Surgery ❑ Cataracts ❑ Colon ❑ Liver Surgery

Lumbar Spinal Surgery/ Back Surgery: ____________________
Cervical Spinal Surgery/ Neck Surgery: ____________________
Other: ____________________

Patient Name: ____________________

Women: Are you pregnant? ❑ YES ❑ NO ❑ NOT SURE PATIENT'S INITIALS __________

Social History:

Do you smoke?	❑ YES	❑ NO	How much per day? ________	How many years? ________
Do you drink alcohol?	❑ YES	❑ NO	How much per day? ________	How many years? ________
Do you use illicit drugs?	❑ YES	❑ No	How much per day? ________	How many years? ________

Family History:

CONDITIONS	DIABETES	HEART	ANXIETY	KIDNEY	CANCER	DEPRESSION	BACK	OTHER
MOTHER	❑	❑	❑	❑	❑	❑	❑	❑
FATHER	❑	❑	❑	❑	❑	❑	❑	❑
BROTHER(S)	❑	❑	❑	❑	❑	❑	❑	❑
SISTER(S)	❑	❑	❑	❑	❑	❑	❑	❑

Allergies:

❑ Latex ❑ IV Contrast ❑ Betadine/Iodine ❑ Shellfish/Seafood

Drug Allergies:

1. ____________________
2. ____________________
3. ____________________

List All Medications You Are Currently Taking:

Medication	Dose	Prescribing Physician	Medication	Dose	Prescribing Physician
1.			9.		
2.			10.		
3.			11.		
4.			12.		
5.			13.		
6.			14.		
7.			15.		
8.			16.		

Are you taking any medications that are blood-thinners? ____________________

Are you taking any medications that are prescription pain relievers? ____________________

Past pain medications tried: ____________________

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I ACKNOWLEDGE THAT I HAVE COMPLETED THIS QUESTIONNAIRE ACCURATELY AND TO THE BEST OF MY KNOWLEDGE

____________________ ____________________

Patient or Legal Guardian Signature Date