



**PIEDMONT**  
*Interventional*  
**PAIN CARE, PA**

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## 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: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: \_\_\_\_ Age: \_\_\_\_  
Home Telephone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
E-mail (optional) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  
**Referring Physician:** \_\_\_\_\_ **Telephone:** ( ) \_\_\_\_\_  
**Primary Care Physician:** \_\_\_\_\_ **Telephone:** ( ) \_\_\_\_\_

### PRIMARY INSURANCE

Insurance Company: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_  
Policy Holder's DOB: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Benefits #: ( ) \_\_\_\_\_  
Policy Holder's Employer: \_\_\_\_\_

### SECONDARY INSURANCE

Insurance Company: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_  
Policy Holder's DOB: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Benefits #: ( ) \_\_\_\_\_  
Policy Holder's Employer: \_\_\_\_\_

### PATIENT EMPLOYER INFORMATION

Full-Time     Part-Time     Unemployed     Student     Retired     Legally Disabled  
Employer's Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Telephone: ( ) \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

## COMPREHENSIVE PAIN QUESTIONNAIRE

Complete this form before your first appointment at PIEDMONT INTERVENTIONAL PAIN CARE. Your careful answers will help us to understand your pain problem and design the best treatment program for you.

### CHARACTERISTICS OF PAIN (Chief Complaint)

What is the main problem for which you are seeking treatment at Piedmont Interventional Pain Care for pain relief? \_\_\_\_\_

\_\_\_\_\_

## HISTORY OF PRESENT ILLNESS

### Pain Location

Please describe the location(s) of your pain: \_\_\_\_\_

\_\_\_\_\_

### Onset of Pain (Cause)

How did your current pain start?

- |  |   |
|--|---|
| <input type="checkbox"/> Injury at work                                    | <input type="checkbox"/> Motor vehicle accident |
| <input type="checkbox"/> Injury, not at work                               | <input type="checkbox"/> Illness                |
| <input type="checkbox"/> Treatment caused (e.g., radiation, surgery, etc.) | <input type="checkbox"/> Undetermined           |
| <input type="checkbox"/> Other: _____                                      |   |

### Progression of Pain

- Slow/Gradual       Rapid/Sudden

### Pain Rating

<b>Current Pain Level:</b>	0	1	2	3	4	5	6	7	8	9	10
<b>Maximum Pain Level:</b>	0	1	2	3	4	5	6	7	8	9	10
<b>Minimum Pain Level:</b>	0	1	2	3	4	5	6	7	8	9	10

### Pain Duration

How long have you had your current pain problem(s)? \_\_\_\_\_ weeks      \_\_\_\_\_ months      \_\_\_\_\_ years

### Frequency/Timing of Pain

How often do you have your pain? (please check one)

- |   |   |
|---|---|
| <input type="checkbox"/> Constantly (100% of the time)              | <input type="checkbox"/> Intermittently (30% to 60% of the time)  |
| <input type="checkbox"/> Nearly constantly (60% to 95% of the time) | <input type="checkbox"/> Occasionally (less than 30% of the time) |

In general, during the past month, when has your pain been the worst? (please check one)

- Morning       Afternoon       Evening       Night       No typical pattern

### Activities and Your Pain

Place a check mark next to the activities that you have avoided or limited during the past month because of pain:

- |  |  |
|--|--|
| <input type="checkbox"/> Going to work               | <input type="checkbox"/> Having sexual relations |
| <input type="checkbox"/> Performing household chores | <input type="checkbox"/> Exercise                |
| <input type="checkbox"/> Doing yard work or shopping | <input type="checkbox"/> Sitting                 |
| <input type="checkbox"/> Socializing with friends    | <input type="checkbox"/> Standing                |
| <input type="checkbox"/> Participating in recreation | <input type="checkbox"/> Walking                 |

**Associated Symptoms**

- "Pins and Needles"    Numbness    Tingling    Weakness

**Pain Quality**

How would you describe the pain?

- Burning    Cutting    Sharp    Throbbing    Other: \_\_\_\_\_  
 Cramping    Dull, aching    Pressure    Shooting

**Relieving and Aggravating Factors**

How do the following affect your pain? (please check one for each item)

	Decrease	No Change	Increase
Lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relaxation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Attempted Treatments**

Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right.

Treatment	Date (approx)	No Relief	Moderate Relief	Excellent Relief
<input type="checkbox"/> Bed rest	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Traction	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Surgery	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nerve block or other injections	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> TENS	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical Therapy	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Exercise	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heat	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ice	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Biofeedback	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Psychotherapy	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chiropractic	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Effect on Sleep**

- No effect    Pain makes it difficult to fall asleep    Pain makes it difficult to stay asleep

**Effect on Bowel and Bladder Control**

- No effect    Loss of bladder control    Loss of bowel control

**Assisting Device**

Devices used to assist ambulation

- Cane    Walker    Wheelchair    None

**MEDICATIONS**

Please list all of your current medications below:

Name of Drug	Strength	# of times taken per day	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Over The Counter \_\_\_\_\_

**\*If your list of medications exceeds these lines, attach a written list.**

**PAST MEDICAL HISTORY**

**Medical**

Have you had any of the following health problems? (please check all that apply)

- Angina or chest pain     Chronic cough     Kidney disease     Seizure or epilepsy
- Arthritis     Diabetes or high blood sugar     Liver disease     Thyroid disease
- Asthma or wheezing     Heart attack     Peptic Ulcer     TIA or stroke
- Bleeding problem     High blood pressure     Reflux (GERD)
- Cancer: please specify what type: \_\_\_\_\_

**NOTE: If you checked yes to any of the above problems, please give an explanation:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES**

Do you have any drug allergies that you are aware of?  Yes  No

List all items (medicines and non medicines) that you are **ALLERGIC** to and the type of reaction it causes:

ITEM	REACTION	ITEM	REACTION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had a reaction to intravenous contrast dye or iodine?  Yes  No

Are you allergic to any shellfish?  Yes  No

## SURGICAL HISTORY

List all major surgeries that you have had in the past:

Name of Surgery	Where Performed	When	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any problems with anesthesia related to any surgery?  Yes  No If yes, specify: \_\_\_\_\_

Have you ever had surgery to relieve your current pain condition?  Yes  No

Have you been told you may need surgery for your current pain problem?  Yes  No

## GENERAL FAMILY ILLNESS

Please check any health problems that are known to run in your family and place the relationship in the blank:

M = Mother F = Father Grandmother = GM Grandfather = GF S = Siblings C = Children

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Angina or chest pain ____               | <input type="checkbox"/> Chronic cough ____                | <input type="checkbox"/> Kidney disease ____ | <input type="checkbox"/> Seizure or epilepsy ____ |
| <input type="checkbox"/> Arthritis ____                          | <input type="checkbox"/> Diabetes or high blood sugar ____ | <input type="checkbox"/> Liver disease ____  | <input type="checkbox"/> Thyroid disease ____     |
| <input type="checkbox"/> Asthma or wheezing ____                 | <input type="checkbox"/> Heart attack ____                 | <input type="checkbox"/> Peptic Ulcer ____   | <input type="checkbox"/> TIA or stroke ____       |
| <input type="checkbox"/> Bleeding problem ____                   | <input type="checkbox"/> High blood pressure ____          | <input type="checkbox"/> Reflux (GERD) ____  |   |
| <input type="checkbox"/> Cancer: please specify what type: _____ |  |  |   |
| <input type="checkbox"/> Other: please specify: _____            |  |  |   |

## SOCIAL HISTORY

### Marital Status

- |  |                                    |   |
|--|------------------------------------|---|
| <input type="checkbox"/> Divorced                | <input type="checkbox"/> Remarried | <input type="checkbox"/> Spouse Deceased            |
| <input type="checkbox"/> Engaged                 | <input type="checkbox"/> Separated | <input type="checkbox"/> Significant other Deceased |
| <input type="checkbox"/> Married living w/spouse | <input type="checkbox"/> Single    |   |

### Living Arrangements

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Living alone        | <input type="checkbox"/> Living with children       | <input type="checkbox"/> Living with spouse/partner and children |
| <input type="checkbox"/> Living with friends | <input type="checkbox"/> Living with spouse/partner | <input type="checkbox"/> Living with other                       |

### Employment

Your current or former occupation: \_\_\_\_\_

Current employment status (please check all that apply):

- |   |                                     |
|---|-------------------------------------|
| <input type="checkbox"/> Employed full-time                               | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> Employed part-time                               | <input type="checkbox"/> Retired    |
| <input type="checkbox"/> Student  | <input type="checkbox"/> Homemaker  |
| <input type="checkbox"/> Unemployed or working part time, because of pain |                                     |

## SOCIAL HISTORY CONTINUED

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

- |  |  |
|--|--|
| <input type="checkbox"/> 1 - 3 weeks   | <input type="checkbox"/> 12 - 18 months    |
| <input type="checkbox"/> 1 - 3 months  | <input type="checkbox"/> 19 - 24 months    |
| <input type="checkbox"/> 4 - 7 months  | <input type="checkbox"/> 25 or more months |
| <input type="checkbox"/> 8 - 11 months |  |

Please indicate any of the following claims you have related to your pain problem:

- |  |  |
|--|--|
| <input type="checkbox"/> Workers' compensation                         | <input type="checkbox"/> Other Insurance |
| <input type="checkbox"/> Personal injury/liability (unrelated to work) | <input type="checkbox"/> None            |
| <input type="checkbox"/> Social Security Disability Insurance (SSDI)   |  |

### Substance Abuse

Do you have a history of:

- |                               |  |  |                                |
|-------------------------------|--|--|--------------------------------|
| Tobacco use?                  | <input type="checkbox"/> Yes - Currently | <input type="checkbox"/> Yes - In the past | <input type="checkbox"/> Never |
| Alcoholism?                   | <input type="checkbox"/> Yes - Currently | <input type="checkbox"/> Yes - In the past | <input type="checkbox"/> Never |
| Illicit (illegal) drug abuse? | <input type="checkbox"/> Yes - Currently | <input type="checkbox"/> Yes - In the past | <input type="checkbox"/> Never |

Have you ever been in a detoxification program for drug abuse?  Yes  No

### Psychological Treatment

Have you ever had psychiatric, psychological, or social work evaluation or treatments for any problem, including your current pain?  Yes  No

If yes, when? \_\_\_\_\_

Have you ever considered suicide?  Yes  No

## REVIEW OF SYSTEMS

Please check all items you feel are applicable to you.

General:

- |  |                                       |   |                               |                              |                                    |                                 |
|--|---------------------------------------|---|-------------------------------|------------------------------|------------------------------------|---------------------------------|
| <input type="checkbox"/> Do you have a change in appetite? | <input type="checkbox"/> Decreased    | <input type="checkbox"/> Increased      |                               |                              |                                    |                                 |
| <input type="checkbox"/> Chills?                           |                                       |   |                               |                              |                                    |                                 |
| <input type="checkbox"/> Decreased energy level?           |                                       |   |                               |                              |                                    |                                 |
| <input type="checkbox"/> Fatigue?                          |                                       |   |                               |                              |                                    |                                 |
| <input type="checkbox"/> Fever?                            | <input type="checkbox"/> Daily        | <input type="checkbox"/> Every few days | <input type="checkbox"/> High | <input type="checkbox"/> Low | <input type="checkbox"/> Recurrent | <input type="checkbox"/> Weekly |
| <input type="checkbox"/> Unusual Sweats?                   | <input type="checkbox"/> Night Sweats |   |                               |                              |                                    |                                 |
| <input type="checkbox"/> Weight Change?                    | <input type="checkbox"/> Gain         | <input type="checkbox"/> Loss           |                               |                              |                                    |                                 |

Eyes:

Change in Vision?

Respiratory:

Shortness of breath?

Cardiovascular:

- |  |
|--|
| <input type="checkbox"/> Do you have palpitations (awareness of fast heart)? |
| <input type="checkbox"/> Do you have chest pain/pressure?                    |

## VITAL SIGNS

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs.