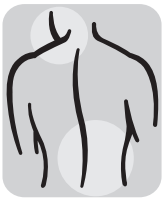

PIEDMONT
Interventional
PAIN CARE, PA

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Pain Medicine Specialist
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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?

- ❑ Injury at work
- ❑ Injury, not at work
- ❑ Treatment caused (e.g., radiation, surgery, etc.)
- ❑ Other: _____
- ❑ Motor vehicle accident
- ❑ Illness
- ❑ Undetermined

Progression of Pain

❑ Slow/Gradual ❑ Rapid/Sudden

Pain Rating

Current Pain Level:	0	1	2	3	4	5	6	7	8	9	10
Maximum Pain Level:	0	1	2	3	4	5	6	7	8	9	10
Minimum Pain Level:	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)

- ❑ Constantly (100% of the time)
- ❑ Nearly constantly (60% to 95% of the time)
- ❑ Intermittently (30% to 60% of the time)
- ❑ 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:

- ❑ Going to work
- ❑ Performing household chores
- ❑ Doing yard work or shopping
- ❑ Socializing with friends
- ❑ Participating in recreation
- ❑ Having sexual relations
- ❑ Exercise
- ❑ Sitting
- ❑ Standing
- ❑ 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	❑	❑	❑
Standing	❑	❑	❑
Sitting	❑	❑	❑
Walking	❑	❑	❑
Exercise	❑	❑	❑
Medications	❑	❑	❑
Relaxation	❑	❑	❑
Coughing/Sneezing	❑	❑	❑
Urination	❑	❑	❑
Bowel movement	❑	❑	❑

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
❑ Bed rest	_____	❑	❑	❑
❑ Traction	_____	❑	❑	❑
❑ Surgery	_____	❑	❑	❑
❑ Nerve block or other injections	_____	❑	❑	❑
❑ TENS	_____	❑	❑	❑
❑ Physical Therapy	_____	❑	❑	❑
❑ Exercise	_____	❑	❑	❑
❑ Heat	_____	❑	❑	❑
❑ Ice	_____	❑	❑	❑
❑ Biofeedback	_____	❑	❑	❑
❑ Psychotherapy	_____	❑	❑	❑
❑ Chiropractic	_____	❑	❑	❑
❑ Other	_____	❑	❑	❑

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

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

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

SOCIAL HISTORY

Marital Status

- ❑ Divorced
- ❑ Engaged
- ❑ Married living w/spouse
- ❑ Remarried
- ❑ Separated
- ❑ Single
- ❑ Spouse Deceased
- ❑ Significant other Deceased

Living Arrangements

- ❑ Living alone
- ❑ Living with friends
- ❑ Living with children
- ❑ Living with spouse/partner
- ❑ Living with spouse/partner and children
- ❑ Living with other

Employment

Your current or former occupation: _____

_____

Current employment status (please check all that apply):

- ❑ Employed full-time
- ❑ Employed part-time
- ❑ Student
- ❑ Unemployed or working part time, because of pain
- ❑ Unemployed
- ❑ Retired
- ❑ Homemaker

SOCIAL HISTORY CONTINUED

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

- ❑ 1 - 3 weeks
- ❑ 1 - 3 months
- ❑ 4 - 7 months
- ❑ 8 - 11 months
- ❑ 12 - 18 months
- ❑ 19 - 24 months
- ❑ 25 or more months

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

- ❑ Workers' compensation
- ❑ Personal injury/liability (unrelated to work)
- ❑ Social Security Disability Insurance (SSDI)
- ❑ Other Insurance
- ❑ None

Substance Abuse

Do you have a history of:

Tobacco use?	❑ Yes - Currently	❑ Yes - In the past	❑ Never
Alcoholism?	❑ Yes - Currently	❑ Yes - In the past	❑ Never
Illicit (illegal) drug abuse?	❑ Yes - Currently	❑ Yes - In the past	❑ 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:

- ❑ Do you have a change in appetite? ❑ Decreased ❑ Increased
- ❑ Chills?
- ❑ Decreased energy level?
- ❑ Fatigue?
- ❑ Fever? ❑ Daily ❑ Every few days ❑ High ❑ Low ❑ Recurrent ❑ Weekly
- ❑ Unusual Sweats? ❑ Night Sweats
- ❑ Weight Change? ❑ Gain ❑ Loss

Eyes:

- ❑ Change in Vision?

Respiratory:

- ❑ Shortness of breath?

Cardiovascular:

- ❑ Do you have palpitations (awareness of fast heart)?
- ❑ Do you have chest pain/pressure?

VITAL SIGNS

Height: _____ Weight: _____ lbs.