COMPREHENSIVE CENTERS
FOR PAIN MANAGEMENT

PATIENT INFORMATION FORM

Please complete with blue or black ink only.
Please complete and bring with you to your appointment.

Name:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Work Phone:_____Cell Phone:_____

Age:_____ Date of Birth:_____ Sex: ○ Male ○ Female Height: _____Weight:_____

Physician Information:

Family: _____
Address:_____
City: _____State: _____ Zip: _____
Referring: _____
Address: _____State: _____Zip: _____

Present Problem:

Briefly list the main reasons for your visit today: _____

How did your pain problem first start (describe): _____

Please describe what your pain is like**:** ☐**Sharp** ☐**Shooting** ☐**Burning** ☐**Pressure** ☐**Throbbing** ☐**Cramping** ☐**Achy** ☐**Constant** ☐**Stabbing** ☐**Gnawing** ☐**Tender** ☐**Comes and goes**

How long have you had this pain?_____

At any given time, think of your pain intensity as falling somewhere on a scale from 0 to 10.
Please rate your pain on the following diagrams**: 0=No pain 10=Very severe pain**

Current Level of Pain

0 1 2 3 4 5 6 7 8 9 10

Average Level of Pain

0 1 2 3 4 5 6 7 8 9 10

When is your pain the worst? (Check one**):** ☐**Morning** ☐**Afternoon** ☐**Evening** ☐**Night** ☐**Varies** ☐**All the time**

Are you awakened at night by your pain? ☐**No** ☐**Yes**

What improves your pain? : _____

What worsens your pain? : _____

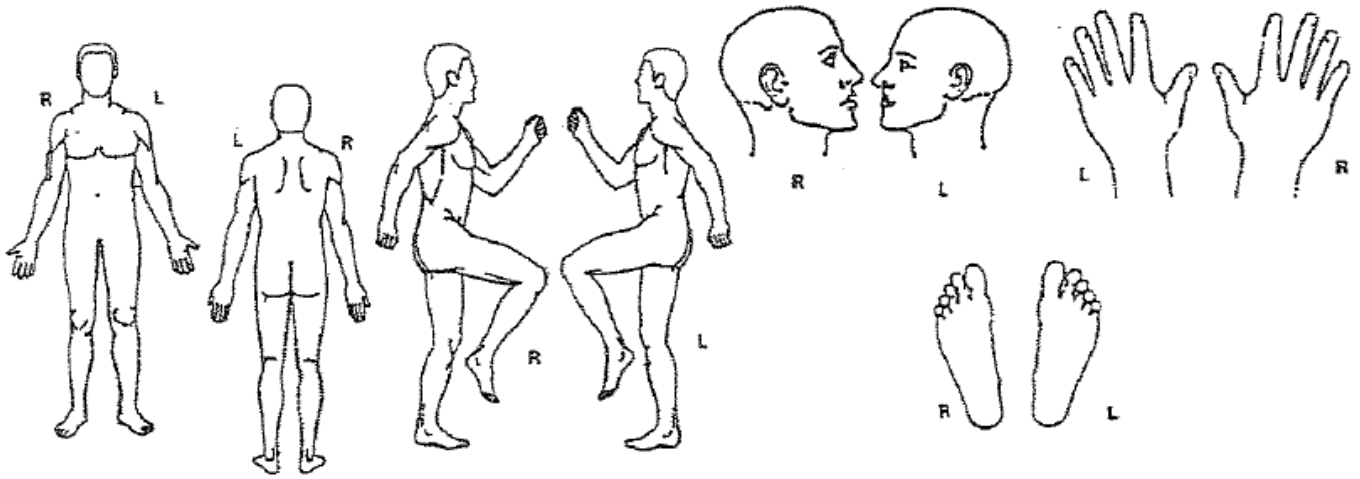
Patient Name:_____

Previous Treatment for Pain:

Which of the treatments listed below have you participated in to relieve your pain?

Treatment (check if you had treatment)		Helpful Yes	Helpful No	Date and Where
Nerve Block	☐	☐	☐	
TENS Unit	☐	☐	☐	
Occupational/Physical Therapy	☐	☐	☐	
Biofeedback	☐	☐	☐	
Hypnosis	☐	☐	☐	
Counseling	☐	☐	☐	
Chiropractor	☐	☐	☐	
Acupuncture/Dry Needle	☐	☐	☐	
Others (Please Note Treatments)				

Please shade in the areas where you feel pain and the degree of pain you are feeling on the drawings below. Please use the following examples: **minimal pain-light shading** **severe pain-dark shading**



Which of the tests below have you had to evaluate your pain problems?

Test	Y	N	Date	Where were tests done?
X-Rays				
CT Scan				
MRI				
EMG				
Myelogram				
Other (please indicate type of test)				

Patient Name: _____

Medical History:

Check All that Apply

Cancer	None	**Neurological**	None
What Type: Radiation/Chemotherapy:		Headaches	
		TIA (Mini Stroke)	
Skin	None	Multiple Sclerosis	
Skin ulcer, Where:		Stroke/Paralysis	
Psoriasis		**Psychological**	None
Rash, Where:		Depression/Anxiety	
Head/Ears/Eyes/Nose/Throat	None	Eating Disorder	
Cataract		Bipolar	
Glaucoma		Alcoholism, (Type):	
Sinus Infection or Sinus problems		Drug Abuse, (Type):	
Respiratory	None	**Hematologic**	
Asthma		Blood Clot, Where:	
Sleep Apnea		Anemia, Type:	
If yes, do you use a C-pap machine		**Endocrine**	None
Emphysema/COPD		Thyroid Disease	
Pneumonia		Diabetes, Type:	
Cardiac	None	**Infectious Disease**	None
Heart Failure		Hepatitis, Type:	
Abnormal Heart Rhythm/Heart Palpitation/A Fib		MRSA	
High Blood Pressure		Herpes Zoster	
Gastrointestinal	None	Rheumatic Fever	
Stomach/Duodenal ulcer		**Rheumatology**	None
Cirrhosis		Rheumatoid Arthritis	
Gallstones		Gout	
Pancreatic Disease		Lupus	
Esophagus Disease		Fibromyalgia	
Crohn's or Colitis		Additional Notes:	
Diverticulitis			
Acid Reflux/GERD			
Genitourinary	None		
Kidney Infection			
Kidney Stones			
Kidney Failure			
Dialysis			
Prostate Problems			
Musculoskeletal	None		
Osteoporosis			
Degenerative Arthritis			

Patient Name:_____

Past Surgeries:

Please list all surgeries:

List of Surgeries	Date	List of Surgeries	Date

Are you allergic to any medications? ☐ Yes ☐ No If Yes, which medications? _____

_____

Have you ever had difficulties with spinal epidural or anesthetics? ☐ Yes ☐ No

Current Medications:

List current medications, prescriptions, and over-the-counter products, including herbs, vitamins, and supplements:

Medication	Strength	Frequency	Medication	Strength	Frequency

List any medications you have previously taken for your pain:

Medication/Dosage	Frequency	Why did you discontinue?

Patient Name:_____

Family History:

Check All That Apply

	Mother	Father	Sisters	Brothers	Grandmother	Grandfather
Cancer (Type)						
Heart Disease						
Lung Disease						
Diabetes						
Kidney Disease						

Mother: Living or Deceased, Cause: _____
(CIRCLE ONE)

FATHER: Living or Deceased, Cause: _____
(CIRCLE ONE)

Social History:

Military Status: Veteran: _____ Currently Serving:_____

Marital Status: Married_____ Single: _____ Widowed: _____ Divorced: _____

Alcohol: Type: _____Amount per day: _____

Tobacco (Circle one) Smoke: _____per day **Chew**: _____times per day

Employment Status: Full-Time:____ Part-Time: ____ Unemployed: ____ Student: _____ Retired: ____ Disabled:_____

Occupation: _____

What does your work involve? _____

Who lives at home with you? _____

Drug Use: □ None □ Prescribed □ Marijuana-frequency_____ □ Cocaine-frequency_____

□ Other: _____

Diet: Normal (No restrictions): _____ Other:_____

Caffeine Intake: Coffee _____ Tea: _____ Soda: _____
(# cups per day) (# cups per day) (#cups per day)

Exercise: None Or Type: _____ How many times a week: _____

Activities/ Hobbies: List: _____

_____

Patient Name:_____

Review of Systems:

In the **PAST 4 WEEKS** have you noticed any of the following symptoms? **Please check all that apply.**

General	None	Genitourinary	None
Weight Change		Problems/Pain with passing urine	
Appetite Change		Urine Leakage	
(Circle the ones that apply) Fever, Chills, Sweats		Menstruate Problems	
(Circle the ones that apply) Dizziness, Fainting		Possibly Pregnant	
Head/Eyes/Ears/Nose/Throat	**None**	Prostate Problems	
Vision Change		**Musculoskeletal**	**None**
Hearing Change		Joint pain	
Dry Mouth		Joint Swelling	
Trouble Swallowing		Stiff Muscles	
Mouth Sores		Painful Muscles	
Cardiac	**None**	**Neurological**	**None**
Chest Pain		Headache	
Swollen Ankle		Weakness	
Rapid Heart Rate		(Circle the ones that apply) Numbness/Tingling	
Respiratory	**None**	Where? _____	
Shortness of Breath		**Skin**	**None**
Coughing up Blood		Rashes, Where? _____	
Rapid Breathing		Skin ulcer, Where?_____	
Gastrointestinal	**None**	Open Cuts/ Sores/ Buries	
Heartburn		**Psychological**	**None**
Nausea		(Circle the ones that apply) Anxiety, Depression	
Abdominal pain		Bipolar Disorder	
Constipation		Insomnia	
Diarrhea		**Endocrine**	**None**
Bleeding from Rectum		Thyroid Problems	
Black Bowel Movements		Excessive Sweating	
Additional Note:		**Allergy**	**None**
		(Circle the ones that apply) Latex, Seasonal	
		Hematologic	**None**
		Varicose Vein	
		Blood Colt	

Patient Name:_____

Patient Plan of Care/Goals:

(To be completed with the providers and pain management staff at the time of the first appointment)

It is important you take an active role in a plan to control your pain. Please communicate with our pain management staff, your pain management goals, including any educational needs.

1. Restore or improve functioning by reducing pain whenever possible:_____
2. Develop self-help and maintenance skills for managing pain and its related problems:_____
3. Increase knowledge of chronic pain management:_____
4. What do you expect from the pain management clinic? _____

_____

_____

_____

Completed By:_____Date:_____

Reviewed By:_____Date:_____