PATIENT INFORMATION: **DATE:**

Name: ______________________________________ Sex: _________ Age: _________
Date of Birth: _______________________ Social Security #: _________________________
Cell Phone: _________________________ Home Phone: ___________________________
Address: ____
City: _____________________________ State: ______ Zip Code ______________
Email Address: ____
Occupation: ____
Emergency Contact: _________________________ Phone #: _______________________
Referring Physician: ____
Primary Care Physician: ____

OTHER INFORMATION:

Is this a ***workman's compensation injury*** case? ☐ No ☐ Yes

Is this a ***personal injury*** case? ☐ No ☐ Yes (fill out this portion of form)

Accident Date: _____________________ Police Report? ☐ No ☐ Yes

Were you the ☐ driver or ☐ passenger?

Body Parts Injured in Accident: ____
____
____

Your Insurance:
Company Name: _________________________________ Claim #: ___________________
Adjuster: ____________________________ Phone: ______________________

Other Individual's Insurance:
Company Name: _________________________________ Claim #: ___________________
Adjuster: ____________________________ Phone: ______________________

Attorney Information:
Firm Name: ______________________________________
Attorney Name: __________________________________ Phone: ___________________

Pain & Healing INSTITUTE

CURRENT PAIN:

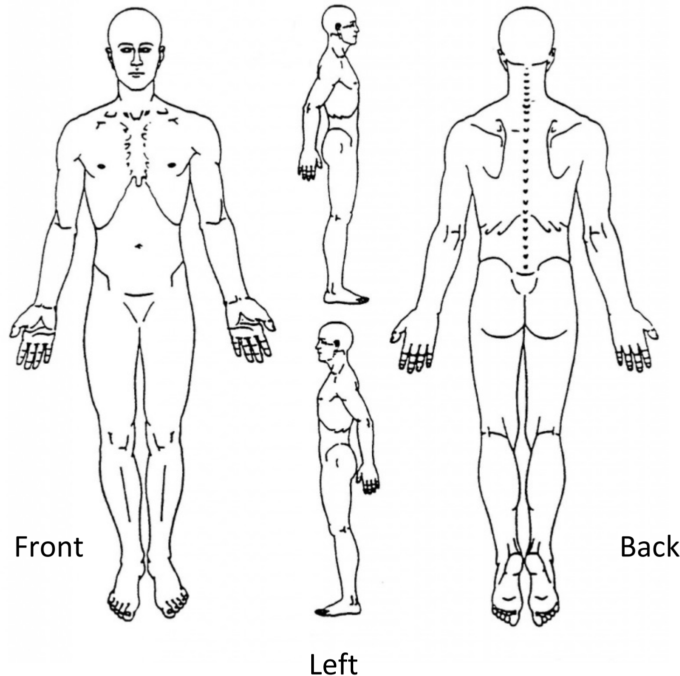
Throbbing ☐ Shooting ☐ Aching ☐ Stabbing ☐ Sharp ☐ Tender ☐

Mark a number below to indicate your **usual** pain intensity daily:

0	1	2	3	4	5	6	7	8	9	10

No Pain Mild Pain Moderate Pain Severe Pain Worst Pain Imaginable

Please shade in areas of pain:



What makes the pain ***WORSE***? ____
____

What makes the pain ***BETTER***? ____
____

When did your pain start? ____
Describe the pain in your own words: ____
____

PREVIOUS TREATMENTS:

Nerve Blocks ☐ Chiropractor ☐ Psychotherapy ☐ Acupuncture ☐ Biofeedback ☐
Physical Therapy ☐ Other ☐ (List): ____

SOCIAL HISTORY:

Smoking: Yes ☐ No ☐ Quit ☐ Packs per day: ______ Number of years: ______
Alcohol Use: None ☐ Occasional ☐ Daily ☐ How much per week: _____________
Recreational Drugs: No ☐ Yes ☐: ____

Pain & Healing INSTITUTE

MEDICAL PROBLEMS:

Please list any medical conditions you have

List	Beginning Date	List	Beginning Date

SURGICAL HISTORY:

Please list any surgical procedures you have had

Year	Describe	Hospital	Doctor

ALLERGIES: ☐ No Known Allergies

Medicine	Reaction	Medicine	Reaction

CURRENT MEDICATIONS:

List all medications you are currently taking for medical and problems including prescribed, over-the-counter, herbs, and vitamins. Do not bring your medicines to the clinic unless you have a question to discuss with the physicians. Please use an additional sheet of paper if more room is needed.

Medication Name	Dose	Schedule	Prescribing Doctor

PAIN EVALUTATION
GENERAL

PATIENT I.D.

REVIEW OF SYSTEMS:

Please check if you have or had any of the following:

General
- ☐ Weight Change
- ☐ Poor or changed appetite
- ☐ Severe fatigue / low energy
- ☐ Recent fevers
- ☐ Recent Antibiotics

Hematological
- ☐ Anemia
- ☐ Easy bruising
- ☐ Bleeding disorder
- ☐ Taking blood thinners
- ☐ Blood Transfusion
- ☐ Cancer

Skin
- ☐ Rash
- ☐ Nail changes
- ☐ Bumps / nodules

Head and Neck
- ☐ Headaches
- ☐ Visual changes
- ☐ Mouth problems
- ☐ Neck pain
- ☐ TMJ problems

Cardiac
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Heart murmurs
- ☐ High or low blood pressure
- ☐ Circulation problems
- ☐ Ankle swelling

Pulmonary
- ☐ Shortness of breath
- ☐ Cough
- ☐ Asthma or bronchitis
- ☐ Lung disease
- ☐ Sleep apnea
- ☐ Snoring

Endocrine
- ☐ Diabetes
- ☐ Thyroid problems

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea or vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ History of ulcers
- ☐ Reflux
- ☐ Heartburn

Genitourinary
- ☐ Frequent or hesitant urination
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Sexual dysfunction

Musculoskeletal
- ☐ Arthritis –
  Type:______________
- ☐ Osteoporosis
- ☐ Muscle pain
- ☐ Muscle wasting
- ☐ Fractures

Neurologic
- ☐ Numbness
- ☐ Weakness
- ☐ Falling
- ☐ Stroke
- ☐ Seizures
- ☐ Memory Loss
- ☐ Loss of balance

Infectious Diseases
(check all that apply)
- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Rheumatic fever
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Other:
  ____
- ☐ HIV
- ☐ AIDS
- ☐ Herpes (Oral)
- ☐ Herpes (Genital)
- ☐ Shingles
- ☐ Post-herpatic neuralgia

Gynecologic
- ☐ Pregnant
- ☐ Post Menstrual Period
  Date: ___________________