

NEW PATIENT REGISTRATION INFORMATION

**PATIENT INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adress: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_\_\_ Sex: 🞏 F 🞏 M DOB: \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: 🞏 Divorced 🞏 Married 🞏 Single 🞏 Partner 🞏 Widow/Widower 🞏 Separated

Race: 🞏 American Indian/Alaska Native 🞏 Asian 🞏 Black/African American 🞏 White 🞏Native Hawaiian/Pacific Islander

 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Decline to Specify

Ethnicity: 🞏 Hispanic/Latino 🞏 Not Hispanic/Latino 🞏Decline to Specify

Patient Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER INFORMATION**

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAIN HISTORY**

When did your pain begin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe how your pain began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PEG Scale Assessing Pain Intensity and Interference (Pain, Enjoyment, General Activity)

1. What number best describes your pain on average in the past week?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

Does not 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

Does not 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

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 Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Where is your pain located? Please mark all areas of pain. Circle most severe areas:



 Please rate your pain WITH medication:

 0 1 2 3 4 5 6 7 8 9 10

 Please rate your pain WITHOUT medication:

 0 1 2 3 4 5 6 7 8 9 10

 Describe your pain?

 🞏 Aching 🞏 Burning

 🞏 Dull 🞏 Numb/Tingling

 🞏 Sharp 🞏 Shooting

 🞏 Stabbing 🞏 Throbbing

Does your pain travel from your spine into your arms or legs? What makes your pain better?

 🞏 Yes 🞏 No 🞏 Nothing 🞏 Position Change

If the pain travels to your arm, how far down does it go? 🞏 Activity 🞏 Rest

 🞏 Shoulder 🞏 Elbow 🞏 Wrist/Hand 🞏 Heat/Ice 🞏 Sitting

 What side? 🞏 Right 🞏 Left 🞏 Both 🞏 Lying Down 🞏 Standing

If the pain travels to your leg, how far down does it go? 🞏 Prescription Medication 🞏 TENS

 🞏 Hip/buttocks 🞏 Knee 🞏 Ankle/Foot 🞏 Over-the-Counter Medication

 What side? 🞏 Right 🞏 Left 🞏 Both

Describe the timing of your pain? What makes your pain worse?

 🞏 Continuous 🞏 Intermittent 🞏 Bending 🞏 Movement 🞏 Touch

 🞏 Cold 🞏 Nothing 🞏 Walking

Have you been treated by another Pain Management Provider? 🞏 Everything 🞏 Position Change 🞏 Working

 🞏 Yes 🞏 No 🞏 Lifting 🞏 Sitting 🞏 Weight Bearing

 If yes: Name of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Lying Down 🞏 Standing

 Date of Last Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any procedures you have tried to treat your pain:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a | Name of Treatment | Date of last visit? | Number of visits |  |  | Name of Procedure | Date of last Procedure? | Percentage of pain relief |
|  | Acupuncture |  |  |  |  | Botox |  |  |
|  | Biofeedback |  |  |  |  | Lumbar Epidural Injection |  |  |
|  | Chiropractic Care |  |  |  |  | Cervical Epidural Injection |  |  |
|  | Massage Therapy |  |  |  |  | Lumbar Medial Branch Block/Facet Injection |  |  |
|  | Physical Therapy |  |  |  |  | Cervical Medial Branch Block/Facet Injection |  |  |
|  | Psychotherapy |  |  |  |  | Lumbar Radiofrequency Ablation |  |  |
|  | TENS |  |  |  |  | Cervical Radiofrequency Ablation |  |  |
|  |  |  |  |  |  | Sacroiliac (SI) Joint Injection |  |  |
|  |  |  |  |  |  | Joint Injection with Steroid |  |  |
|  |  |  |  |  |  | Pain Pump Trial |  |  |
|  |  |  |  |  |  | Spinal Cord Stimulator Trial |  |  |

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 Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please check mark any medication you have tried to treat your pain | Reason for stopping(check best option) |  | Please check mark any medication you have tried to treat your pain | Reason for stopping(check best option) |
| ✓ | Name of Drug | If not currently taking, last dose? | Not helpful | Side effect/ allergy |  | ✓ | Name of Drug | If not currently taking, last dose? | Not helpful | Side effect/ allergy |
| NSAIDS/Acetaminophen |  | Opioids |
|  | Motrin (Ibuprofen) |  |  |  |  |  | Ultram (Tramadol) |  |  |  |
|  | Naprosyn/Naproxen (Aleve) |  |  |  |  |  | Ultram ER (Tramadol ER) |  |  |  |
|  | Lodine |  |  |  |  |  | Percocet (Oxycodone) |  |  |  |
|  | Relafen |  |  |  |  |  | Oxycontin (Oxycodone ER) |  |  |  |
|  | Indocin |  |  |  |  |  | Xtampza (Oxycodone ER) |  |  |  |
|  | Mobic (Meloxicam) |  |  |  |  |  | Vicodin/Lortab/Norco (Hydrocodone) |  |  |  |
|  | Tylenol (Acetaminophen) |  |  |  |  |
|  | Diclofenac |  |  |  |  |  | Hysingla (Hydrocodone ER) |  |  |  |
| Anti-Anxiety |  |  | Zohydro (Hydrocodone ER) |  |  |  |
|  | Valium (Diazepam) |  |  |  |  |  | Dilaudid (Hydromorphone) |  |  |  |
|  | Xanax (Alprazolam) |  |  |  |  |  | Exalgo (Hydromorphone ER) |  |  |  |
|  | Lorazepam |  |  |  |  |  | Duragesic Patch (Fentanyl Patch) |  |  |  |
|  | Lexapro (Escitalopram) |  |  |  |  |
|  | Cymbalta (Duloxetine) |  |  |  |  |  | Morphine |  |  |  |
| Tricyclic Antidepressant |  |  | MS Contin (Morphine ER) |  |  |  |
|  | Elavil (Amitriptyline) |  |  |  |  |  | Methadone |  |  |  |
|  | Pamelor (Nortriptyline) |  |  |  |  |  | Nucynta |  |  |  |
|  | Doxepin |  |  |  |  |  | Butrans Patch (Buprenorphine) |  |  |  |
|  | Tofranil |  |  |  |  |  | Belbuca (Buprenorphine) |  |  |  |
|  | Desyrel (Trazodone) |  |  |  |  |  | Suboxone |  |  |  |
| Anti-Convulsant |  |  | Levorphanol |  |  |  |
|  | Neurontin (Gabapentin) |  |  |  |  | Migraine |
|  | Lyrica (Pregabalin) |  |  |  |  |  | Imitrex/Sumatriptin |  |  |  |
|  | Topamax (Topiramate) |  |  |  |  |  | Amerge |  |  |  |
|  | Depakote |  |  |  |  |  | Maxalt |  |  |  |
|  | Tegretol |  |  |  |  |  | Relpax |  |  |  |
|  | Dilantin |  |  |  |  |  | Zomig |  |  |  |
|  | Lamictal |  |  |  |  |  | Botox |  |  |  |
|  | Gralise (Gabapentin ER) |  |  |  |  |  | Ajovy |  |  |  |
| Constipation |  |  | Aimovig |  |  |  |
|  | Relistor |  |  |  |  |  | Emagality |  |  |  |
|  | Amitiza |  |  |  |  |  | Nurtec |  |  |  |
|  | Symproic |  |  |  |  | Other |
|  | Movantik |  |  |  |  |  | Pennsaid Cream |  |  |  |
|  | Miralax/Milk of Magnesia |  |  |  |  |  | Ketamine Gel |  |  |  |
|  | Metamucil/Benefiber |  |  |  |  |  | Lidoderm Patch (Lidocaine Patch) |  |  |  |
|  | Colace |  |  |  |  |
|  | Dulcolax/Senokot |  |  |  |  |  | Medical Marijuana |  |  |  |
| Muscle Relaxant |  |  | Flector Patch |  |  |  |
|  | Skelaxin |  |  |  |  |  | Lidoderm Gel (Lidocaine Gel) |  |  |  |
|  | Norflex |  |  |  |  |  | Voltaren Gel (Diclofenac Gel) |  |  |  |
|  | Soma (Carisoprodol) |  |  |  |  | Page 3 of 5 |
|  | Flexeril (Cyclobenzaprine) |  |  |  |  |
|  | Zanaflex (Tizanidine) |  |  |  |  |
|  | Baclofen |  |  |  |  |
| Sleep |  |
|  | Ambien (Zolpidem) |  |  |  |  |
|  | Trazodone |  |  |  |  |
|  | Belsomra |  |  |  |  |
|  | Silenor (Doxepin) |  |  |  |  |
|  | Lunesta (Eszopiclone) |  |  |  |  |



 Patient Name: Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY**

**Current Medication**

Please list ALL medication you are currently taking (prescription Please check if you have any of these conditions now or

over-the-counter herbal supplement, vitamins). Include dose have been diagnosed with them in the past:

and frequency. Attach a separate sheet if needed. Constitutional:

 🞏 Unexplained weight loss of more than 10lbs

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Fever in the last few days

 Cardiovascular:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 High blood pressure 🞏 Chest Pain/Angina

 🞏 Heart attack 🞏 Cardiac Surgery

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Irregular heartbeat 🞏 Pacemaker

 🞏 Defibrillator

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pulmonary:

 🞏 COPD 🞏 Sleep apnea

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Oxygen Use 🞏 Asthma

 Liver/Urinary/Gastrointestinal:

 🞏 Stomach Ulcers 🞏 Acid Reflux

**ALLERGIES**

 🞏 Hepatitis 🞏 Kidney problems

Please list ALL allergies and their reactions. Include any medication, 🞏 Pancreatitis 🞏 Liver Disease

latex, dye, and food allergies. Attach a separate sheet if needed. 🞏 Urinary tract infections

 Endocrine:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Diabetes 🞏 Thyroid disease

 Nervous System:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Seizures 🞏 Stroke

 🞏 Paralysis 🞏 Peripheral neuropathy

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Musculoskeletal:

 🞏 Osteoarthritis 🞏 Artificial joints

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Fibromyalgia 🞏 Rheumatoid Arthritis

 Psychiatric:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Depression 🞏 Bipolar

 🞏 Anxiety 🞏 Post-traumatic stress disorder (PTSD)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other:

 🞏 Cancer (Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) 🞏 Claustrophobia

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 HIV/AIDS 🞏 MRSA

**SURGICAL HISTORY**

Please list ALL surgeries. Attach a separate sheet if needed.

Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any problems with Anesthesia (nausea/vomiting/difficulty waking up/other)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOSPITALIZATION**

Please list ALL hospitalizations. Include any not related to pain as well (pneumonia, heart issues, etc.). Attach a separate sheet if needed.

Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

For each of the following family members, list their year of birth, age of death if applicable, and if they had a history of any of the following conditions: Diabetes, Hypertension, Heart Disease, Cancer, Kidney Problems, Lung Problems, Depression, Allergies, and Arthritis:

Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMAGING**

Please list any imaging (X-ray, MRI, CT, EMG, etc.) done in the last 5 years for your pain. Attach a separate sheet if needed. If time permits, please contact the facility and have the report faxed to the number on the cover letter.

Date of exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

**Alcohol: Other Drugs:**

 Have you had a drink containing alcohol in the past year? 🞏 Yes 🞏 No Have you ever used illegal substances?

 If yes, how often? 🞏 Yes 🞏 No

 🞏 Monthly or less 🞏 2-4x per month If yes, what kind?

 🞏 2-3x per week 🞏 4-7x per week 🞏 Marijuana 🞏 Heroin 🞏Cocaine

 If yes, how many drinks at one time? 🞏 Ecstasy 🞏 LSD 🞏 Meth

 🞏 1-2 🞏 3-4 🞏 5-6 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞏 7-9 🞏 10 or more Last time used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If yes, how often do you binge drink (>5 drinks at once)? Have you ever used prescription medication not prescribed

 🞏 0 🞏 <Monthly 🞏 Monthly to you? 🞏 Yes 🞏 No

 🞏 Weekly 🞏 Daily/Almost Daily If yes, what medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you drink to decrease your pain? 🞏 Yes 🞏 No Last time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you have a Medical Marijuana Card? 🞏 Yes 🞏 No

**Smoking/Tobacco Use:**

 Do you currently smoke cigarettes? 🞏 Yes 🞏 No Do you use other tobacco products? 🞏 Yes 🞏 No

 If yes, do you smoke cigarettes every day? 🞏 Yes 🞏 No If yes, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How many cigarettes per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If you are a former smoke/tobacco user, when did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WORK HISTORY**

Employment Status – please check:

 🞏 Employed Full-time 🞏 Employed Part-time 🞏 Retired 🞏 Retired early due to pain

 🞏 Homemaker 🞏 Unemployed due to pain 🞏 Unemployed for another reason

 🞏 In school/training 🞏 On permanent disability/long-term disability 🞏 On temporary disability/short-term disability

If still working, current position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This type of work is:

 🞏 Sedentary (sit most of day, minimal lifting, < 10lbs) 🞏 Light (stand most of day, lift up to 20 lbs)

 🞏 Medium (stand most of day, lift 20-50 lbs) 🞏 Heavy (stand most of day, lift 50-100 lbs)

If not working due to pain, who took you off work?

 🞏 Self 🞏 Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 0 – 10, how close are you to returning to work (10 = back to full-time, 0 = not even close to working any type of job)?

0 1 2 3 4 5 6 7 8 9 10

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