



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? : _____

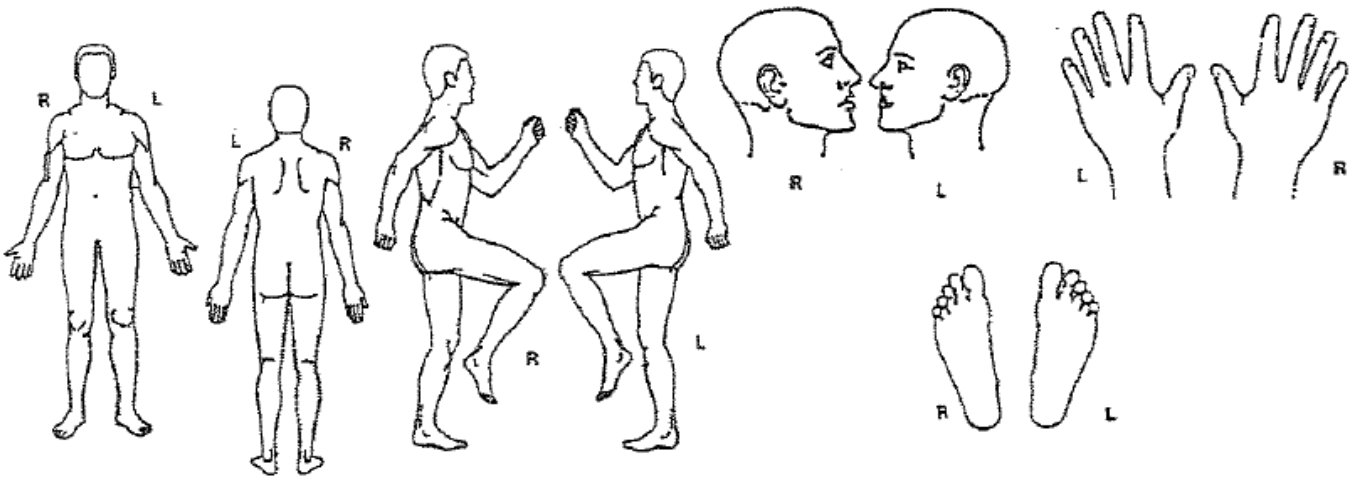
Patient Name: _____

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:		Headaches	
Radiation/Chemotherapy:		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	
			Where? _____		
Respiratory		None	Skin		None
	Shortness of Breath			Rashes, Where? _____	
	Coughing up Blood			Skin ulcer, Where? _____	
	Rapid Breathing			Open Cuts/ Sores/ Buries	
Gastrointestinal		None	Psychological		None
	Heartburn			Anxiety, Depression	
	Nausea		(Circle the ones that apply)	Bipolar Disorder	
	Abdominal pain			Insomnia	
	Constipation				
	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: _____