Integrated Pain Solutions

FOR ACTIVE LIVING

***PATIENT INFORMATION*** Today's Date: _____

Name: _____ Date of Birth: _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Cell: _____ Home: _____ Work: _____

May we leave a message on voicemail or answering machine: Y _____ N _____

Sex: M _____ F _____ DOB: _____ Age: _____ SS# _____

Email Address: _____Preferred Language: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

American Indian/Alaska Native _____ Asian _____ Black/African American _____ White _____

Native Hawaiian/Other Pacific Islander _____ Decline to answer _____

Patient Employer: _____ Occupation: _____

Employment Status: Full Time ___Part Time ___Self Employed ___Not Employed ___ Retired___

Emergency Contact: _____ Phone Number: _____

***INSURANCE INFORMATION***

Primary Insurance: _____Policy Holder: _____ DOB: _____

Policy Number: _____Group Number: _____Relation: _____

Secondary Insurance: _____Policy Holder: _____ DOB: _____

Policy Number: _____Group Number: _____Relation: _____

***BWC***

Is the reason for your visit today the result of a work injury? Y ____ N ____

Claim Number: _____ Date of injury: _____

***PHYSICIAN INFORMATION***

Referring Physician: _____Phone: _____ Fax: _____

Primary Care Physician: _____Phone: _____ Fax: _____

Pharmacy Name: _____Phone: _____

***VITALS* (*office staff to complete)***

BP _____/_____ PULSE _____ RATE _____ HT_____ WT _____

***MEDICATION ALLERGIES***

Please list all allergies to medication or foods:

_____

***MEDICATIONS***

Please list all medications you are taking, including over the counter medications and herbal supplements. Please include dose and frequency.

1. _____ 7. _____
2. _____ 8. _____

3. _____ 9. _____
4. _____ 10. _____

***REASON FOR TODAYS VISIT***

_____

_____

Date condition began: _____

If yes, please describe:

_____

_____

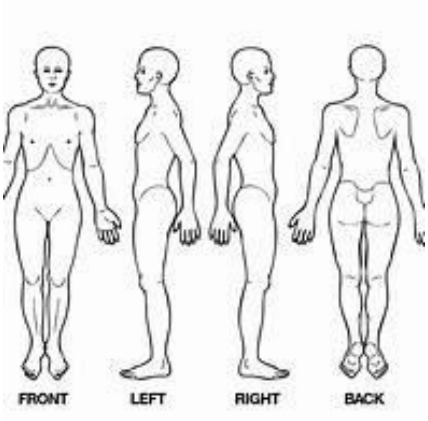
Have you been treated previously for this condition? Y _____ N _____

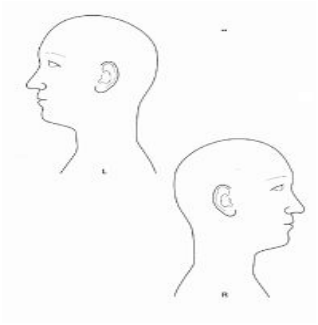
Please list all previous treatments:

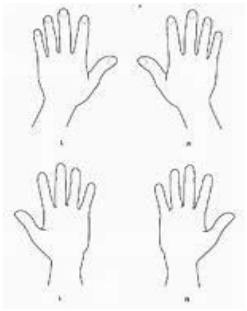
_____

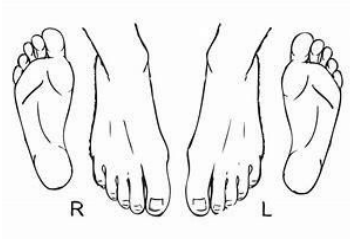
_____

Where is your pain located? (*please shade all areas below, light shading (minimal pain) and dark shading (severe pain)*








***DESCRIBE YOUR PAIN***

Does your pain do one of the following (circle all that apply): *Intermittent* *Constant/continuous* *Aching* *Throbbing* *Gnawing* *Sharp* *Shooting* *Stabbing* *Burning* *Numbness* *Tingling* *Unbearable*

My current pain rating on my medication is (circle):

0 1 2 3 4 5 6 7 8 9 10

*Able to function with most activities with Little to no modification*

*Need to modify daily activities and choose which tasks to complete*

*Severely limited in daily function, only able to accomplish basic ADL's*

What makes your pain better:

_____

_____

What makes your pain worse:

_____

_____

***CONSERVATIVE TREATMENT***

Please check mark all treatments past or present that apply to you: Acupuncture _____, Chiropractic _____, Homeopathy _____, Medication _____, Exercise _____, Biofeedback _____, Injections _____, Surgery _____, Hypnosis _____, Herbal supplements _____Massage_____, Other: _____

Physical Therapy: When? _____How many visits? 1 to 6 visits _____7-12 _____ more than 12_____

Please check any of the following medications (NSAIDS) if you have tried them for your pain:

Ibuprofen (Advil/Motrin) _____ Naproxen (Aleve/Naprosyn) _____ Celebrex _____ Mobic _____

Tylenol _____

How many hours a night do you sleep? _____

Quality of sleep: Difficulty falling asleep _____ Staying asleep _____

Level of sleep: Increase _____ Stayed the same _____ Decreased _____

***IMAGING (most recent)***

Date of exam: _____Test Performed: _____ Facility: _____

Date of exam: _____Test Performed: _____ Facility: _____

***PAST MEDICAL HISTORY***

Please check if you have had any of these conditions now or in the past.

**Constitutional:** Have you had unexplained weight loss of more than 10 pounds? ___Y OR ___N

Have you had any fevers within that last few days? ___Y OR ___N

**Cardiovascular: ___**High Blood Pressure **___**Cholesterol ___Angina (chest pain or pressure)

**___** Heart Attack ___Congestive Heart Failure ___Cardiac Surgery ___Irregular Heart Beat

**Pulmonary: ___**Bronchitis ___Emphysema ___COPD ___Shortness of Breath ___Sleep Apnea ___Asthma ___Cough

**Liver/Genitourinary: ___**Ulcers ___Hepatitis ___Pancreatitis ___Urinary Tract Infections ___Bladder Problems ___Kidney Problems ___Kidney Stones ___Other Liver Problems

**Endocrine: ___**Diabetes ___Thyroid Disease ___Hormone Issues(explain) _____

**Gastrointestinal: ___**Acid Reflux ___Stomach Ulcers

**Nervous System: ___**Seizures ___Stroke ___Head Injury ___Paralysis ___Peripheral Neuropathy

**Musculoskeletal: ___**Neck/Back Problems ___Arthritis ___Artificial Joints

**Psychiatric: ___**Depression ___Anxiety ___Bipolar ___Panic Disorder ___Posttraumatic Stress Disorder (PTSD) ___Other

**Other: ___**Cancer ___HIV ___STD ___Tuberculosis ___Claustrophobia

***PAST SURGICAL HISTORY***

Year _____ Surgery Name: _____

Year _____ Surgery Name: _____

Year _____ Surgery Name: _____

Any problems with Anesthesia? (nausea/vomiting/other): _____

***FAMILY HISTORY***

For each of the following family members: List their age, age of death, and if they passed away due to the following conditions: Diabetes, Hypertension, Heart Disease, Cancer, Kidney Problems, Lung Problems, Depression, Allergies, and Arthritis

Mother: _____

Father: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Children: _____

Siblings: _____

***SOCIAL HISTORY***

Have you ever been sexually and/or physically abused? Y or N

Do you currently feel threatened in your environment? Y or N

Have you ever seriously considered or attempted suicide? Y or N

Do you have a suicide plan at the moment? Y or N
Do you have any children? Y or N
If yes, how old are they? _____

Do you smoke? Y or N
If yes, ___ ½ pack to 1 pack a day ___1 or more packs per day
If you are a former smoker when did you quit? _____

Do you drink alcohol? Y or N
If yes, ___Less than 6 drinks per week ___7-12 drinks per week ___Over 24 drinks per week
___Binge drinker ___Drink to decrease your pain?

Have you or a physician ever thought you had a abuse problem with any medications? _____
If yes, please explain: _____
In the past 10 years have you tried any street drugs? Y or N
(please check) ___Marijuana ___Cocaine ___Heroin ___Meth ___Other: _____

***WORK HISTORY***

Current Occupation: _____
Job Description: _____
Are you: ___Employed full time ___Employed part time ___Unemployed due to pain ___Unemployed for "other" reason ___Retired due to pain ___Retired ___In school or training ___Full time disability ___Temporary disability ___Homemaker
If you are NOT working currently:
Do you think you will be able to return to the same sort of job that you were doing before your pain?
Y or N
Are you considering a change of employment or retraining program?
Y or N
Overall, on a scale of 0-10, how close are you to returning to work? (10 means back to full time, 0 means not even close to working at any job) _____

***CURRENTLY EXPERIENCING CONDITIONS/SYMPTOMS***

___Fever ___Chills ___Chest Pain ___Heart Murmur ___Irregular Heart Rate ___Blood Clots ___Unusual Bruising___ Rashes ___ Hair Loss ___Temperature Changes ___Discoloration ____Weight Loss ___Joint Swelling ___Joint Pain ___Weakness ___Numbness/Tingling ___Migraines ___Depression ___Sudden Loss of Bladder Control ___Sudden Loss of Bowel Control ___Excessive Bleeding ___Shortness of Breath ___Difficulty Swallowing ___Difficulty Sleeping ___Anxiety ___Other Mental Illness: _____

_____ _____
PATIENT SIGNATURE DATE

_____ _____

GUARDIAN SIGNATURE IF UNDER 18 DATE