Date: _____

Patient Information

Name _____ SSN _____ Gender _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Date of Birth _____ Marital Status _____ E-Mail _____

Guarantor Information (If the patient is not the guarantor, please complete this section)

Name _____ SSN _____ Gender _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Date of Birth _____ Marital Status _____ E-Mail _____

Guarantor Relationship _____

PRIMARY INSURANCE

Insurance Company Name _____ Insurance Co Phone _____

Policy Holder Name _____ Date of Birth _____

ID/Subscriber Number _____ Group Name/Acct# _____

SECONDARY INSURANCE

Insurance Company Name _____ Insurance Co Phone _____

Policy Holder Name _____ Date of Birth _____

ID/Subscriber Number _____ Group Name/Acct# _____

How did you hear about us? _____

Name of Referring Physician, Patient, source, etc. _____

_____ _____

I certify that the above information is accurate and I understand that I am responsible for payment of all charges to American Pain and Wellness regardless of quoted insurance benefits and eligibility.

Date

American Pain and Wellness

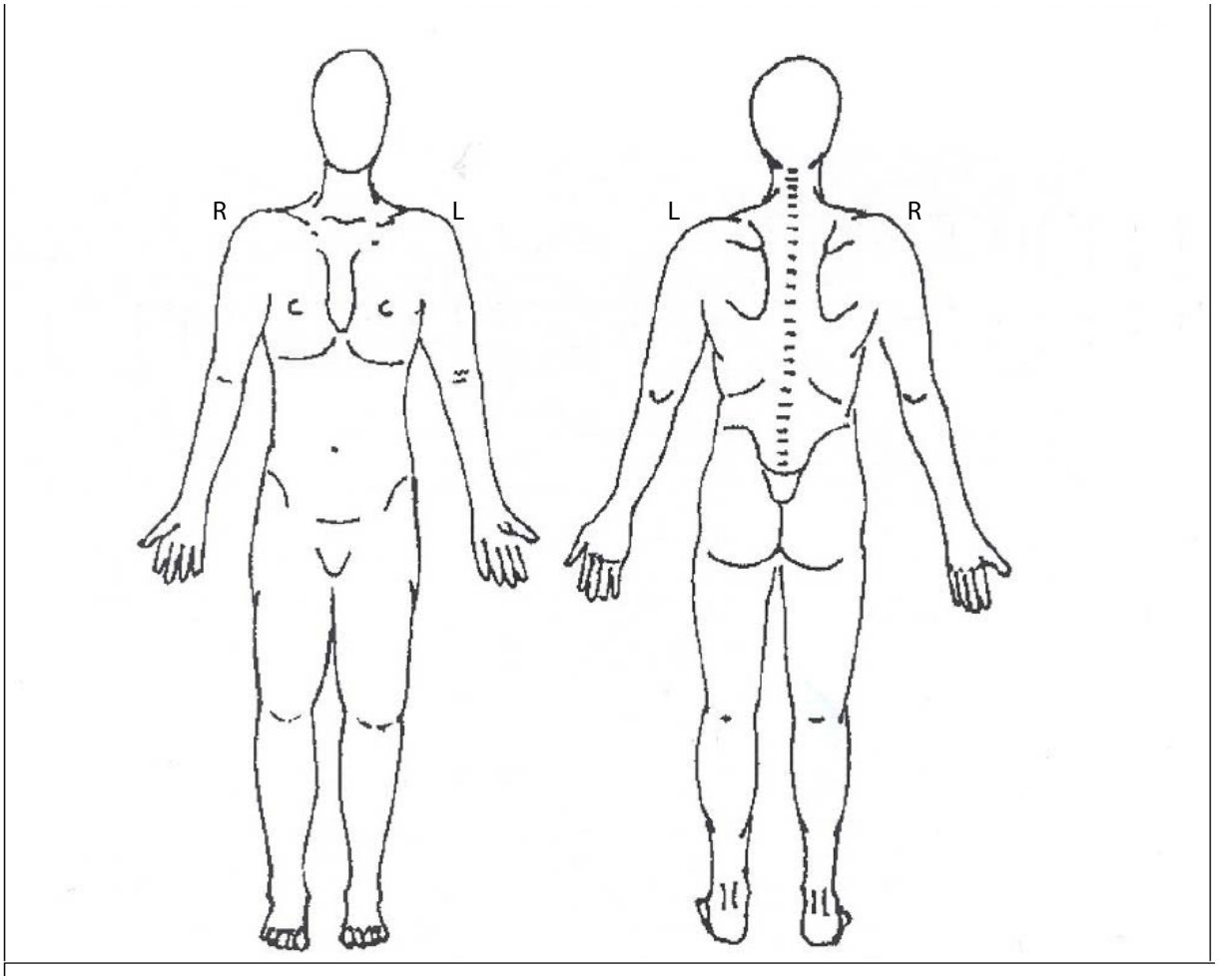
Patient Pain Profile

Date: _____ Name: _____ DOB: _____ Age: _____

Primary MD: _____ Referring MD: _____

Please mark the MAJOR areas of Pain you are experiencing.

A= ACHE P= PINS & NEEDLES B= BURNING S= STABBING N= NUMBNESS O= OTHER



Thinking back over the last 30 days, rate your pain at its lowest, highest and most consistent by circling the numbers below.
(You may do this when you print your forms or come in for your appointment)

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

Height _____ Weight _____ What is the date your pain began? _____

How did the pain begin? Work Accident ☐ Following Surgery ☐ Incident at home ☐ No Specific Event ☐

Motor Vehicle Accident ☐ Following Illness ☐

Onset of Pain: Sudden ☐ Gradual ☐ Is the pain constant ☐ Intermittent? ☐

Describe the injury. Specify the position of your body at the time of injury. (Twisting, turning, leaning, reaching)

_____

_____

Do you have any of the following? Please check all that apply on a REGUALR basis.

Loss of Bowel ☐ Loss of Bladder ☐ Leg Weakness ☐ Fevers/Chills ☐

My pain is increased by only: Check ONLY the descriptors which usually worsen your pain.

Sitting ☐ Standing ☐ Bending Backwards ☐ Bending Forwards ☐ Walking Up Steps ☐

Walking Down Steps ☐ Sneezing ☐ Coughing ☐ Stress ☐ Straining ☐

Sleeping on Stomach ☐ Weather Changes ☐ Sexual Activity ☐ Other _____

My pain is improved by: ONLY check the descriptors which usually relieve your pain.

Sitting ☐ Relaxing ☐ Leaning Forward ☐ Lying on back ☐ Hot packs ☐ Cold Packs ☐

Medications ☐ Sleeping ☐ Lying on Side ☐ Fetal Position ☐ Other: _____

Have you had any diagnostic studies for your pain: X-Ray, CT/MRI, EMG, Discogram? Where (name of facility)?

_____

_____

Please note if you have had any of the additional treatments listed below?

TREATMENT	Did it work?
Physical Therapy	
Ultrasound	
TENS	
Hydro Therapy	
Traction	
Chiropractic	
Acupuncture	

Please note if you have had any of the spinal injections below

Injection	Location on the body	Date	Physician	Did it help?
Epidural				
Caudal				
Facet				
Medical Branch Block				
Trigger Point				
Sympathetic Block				

Please list any **SPINE surgeries** you have had?

Spinal Level	Type: Fusion, Disectomy, Laminectomy, etc,.	Date	Surgeon

Please list all past Surgeries & Dates:

_____

_____

_____

Past Medical History

Do you have any of the medical following conditions?

Cardiac: Arrhythmia ☐ Heart Attack ☐ Blocked Arteries ☐ High Blood Pressure ☐ High Cholesterol ☐

Other: _____

Pulmonary: Asthma ☐ Emphysema ☐ Bronchitis ☐ Sleep Apnea ☐ Smoker ☐

Other: _____

GI: Ulcers ☐ Reflux ☐ Diverticulitis ☐ Gall Stones ☐ Liver Disease ☐ Irritable Bowel ☐
Inflammatory Bowel ☐ Crohn's/Ulcerative Colitis ☐

Other: _____

GU: Kidney Disease ☐ Kidney Stones ☐ Endometriosis ☐ Fibroids ☐ Prostate Problems ☐

Other: _____

Endocrine: Diabetes ☐ Thyroid Disease ☐ Adrenal Disease ☐

Other: _____

Rheumatological: Osteoarthritis ☐ Ankylosing Spondylitis ☐ Rheumatoid Arthritis ☐
Polymyalgia Rheumatica ☐ Fibromyalgia ☐ Systemic Lupus ☐ Erthromitosis ☐

Other: _____

Hematological: Anemia ☐ Low Platelets ☐ Bleeding Disorder ☐

Other: _____

Neurological: Seizures ☐ Multiple Sclerosis ☐ Parkinson's ☐ Tremors ☐ Stroke ☐ Neuropathy ☐

Other: _____

Psychological: Anxiety ☐ Depression ☐ Excessive Alcohol Use ☐ Substance Abuse ☐

Other: _____

What medications have you taken for **pain** in the past?	Dosage	How many times a day?	Did it help?	List any side effects

List all current medications	Dosage	How many times a day?	Does it help?	List any side effects

Check any of the medications you are taking:

Aspirin ☐ Ticlid ☐ Plavix ☐ Warafin/Coumadin ☐ Aggrenox ☐

Herapin ☐ Levenox ☐ Fragmin ☐

Are you taking any **vitamin supplements**? Yes ☐ No ☐ If so, what? _____

Are you interested in learning about our recommended vitamin & nutritional programs? Yes ☐ No ☐

Please list any Medication, Anesthesia, Tape/Soap and/or Latex/Contrast Material **allergies**. _____

_____

_____

Social History

	How often per week?	How many years?	Have you quit? if so, when?
Smoking			
Alcohol			
Illegal Substances			

Check one that applies:

Employment Status: Full Time ☐ Part Time ☐ Temporary ☐ Disabled ☐ Retired ☐ Homemaker ☐ Student ☐

Does your occupation require you to bend in an awkward position? If so, please explain.

_____

_____

Does anyone in your family suffer from chronic pain?

Parent ☐ Sibling ☐ Spouse ☐ Child ☐ Grandparent ☐

Review of System: Check those that apply on a REGULAR basis

General: Weight Loss ☐ Weight Gain ☐ Fever ☐ Chills ☐ Insomnia ☐

HEENT: Eye Problems ☐ Ear Problems ☐ Nose Problems ☐ Throat Problems ☐

Cardiac: Chest Pain ☐ Fainting Spells ☐ **Pulmonary:** Shortness of Breath ☐ Cough ☐ Bloody Sputum ☐

GI: Blood in stool ☐ Constipation ☐ Diarrhea ☐ Loss of Bowel ☐

GU: Difficulty Urinating ☐ Loss of Urine ☐ Bloody Urine ☐

Musculoskeletal: Joint Pain ☐ Muscular Pain ☐ Osteoporosis ☐

Neurological: Seizures ☐ Tremors ☐ Weakness ☐ **Psychiatric:** Depression ☐ Anxiety ☐

What do you expect from this consultation? _____

Print Form