Patient Information Form Pain Management Center at Phoebe

Please complete the following form, so that we may facilitate your visit

•	Occupation:or (circle) Retired, Disabled Homemaker, Full time student
•	Where is your pain?
•	Date began:
•	What caused this pain to begin?
•	Are you seeking Disability?
•	Do you have legal representation, a lawyer to help you?
•	Describe your pain: (circle) burning, shooting, aching, throbbing, tingling and or numbness. Other:
•	Pain is: (circle) Mild, Moderate, Moderate to Severe, Severe
•	Pain is: (circle) Constant-all the time, Episodic-comes and goes
•	If tingling or numbness where?
•	What are your goals of pain management? (Circle) reduce or control pain, Increase activity, increase sleep, Return to work, Increase social activities Other:
•	What makes your pain worse?
•	What helps your pain makes it better?
Medio	cal Doctor Name/Location:
Heigh	ht :(how tall you are?) Weight:

ALLERGIES (WHAT TYPE OF ALLERGY) ALLERGIES (allergic too) ALLERGIC REATION (rash, nausea etc) PREVIOUS SURGERIES (ALL SURGERIES) Year | Type of Surgery Year | Type of Surgery **CURRENT MEDICATIONS** Start Medication Start Medication name/strength/frequency name/strength/frequency date date

PREVIOUS MEDICATIONS (TRIED FOR THIS PAIN PROBLEM)

Stop date	Medication name/strength/frequency	Stop date	Medication name/strength/frequency
32000			

Have you tried the following treatment for your Pain problem?

	<u>Date</u>	DID IT HELP??		HELP??	
TREATMENT TRIED	Tried	YES		NO 🗹	COMMENTS
*Chiropractic care					
*Physical Therapy					
*TENS unit (electrical Stim device)					
*Acupuncture					
*Massage Therapy					
*Water (Pool) Therapy					
*Biofeedback					
*Injections/ Nerve Blocks/					
<u>Epidurals</u>					
*Radiofrequency of nerves					
*Dorsal Column Stimulator trial					

PREVIOUS Diagnostic Studies

Date	Type of Study	Date	Type of Study (may list)
	X-rays of		
	MRI of		
	CT Scan of		
	Myelogram of		
	Dexa Scan (Bone Density study)		
	Nuclear Bone Scan		
	Nerve Conduction Study of		
	Electromyogram (EMG) of		
	Discogram of		
	Spinal Tap		

PLEASE Check all that apply

Diarrhea Diarrhea Irritable Bowel Syndrome (IBS)	PLEASE Check all that app		D: 1				
Cluster headaches Migraines Diverticulosis Stroke Colon Polyps Head Injury / Coma Peripheral Neuropathy Shingles Seizures Blood in Urine Seizures Blood in Urine Seizures Depression Prostatitis (BPH) enlarged prostate Anxiety Prostate Cancer Suicide thoughts Night time Urination Pneumonia Bronchitis Skin Cancers Asthma Psoriasis or ezema Emphysema/COPD Rash Tuberculosis Bruises currently on arms or legs High blood pressure Current wound/burn/laceration Congestive Heart Failure Angina (chest Pain) Rheumatoid Arthritis Heart Attack Osteoporosis Coronary Artery disease Angioplasty/ Diet please check the following REGULAR DIET Use a cane, walker or wheelchair DIABETIC DIET LOW Sodium/Low Fat diet GOOD Appetite FalR Appetite Free bleeder (bleed easily) Heartis Bruise easily Ulcers Previous blood transfusion Sickle Cell Anemia Bruise easily Ulcers Stomach or bowel bleeding Hearing impaired Acid Reflux Dentures, caps, crowns, missing or bad teeth? (may circle) Hiatal hernia (stomach) Last Menstrual period		⊻					
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	Constipation		Last Mammogram				

Substance use: If you would rather, you may wait and discuss these issues with the Nurse. Do you use tobacco? □ Yes □ No **□ Smoke **□ Dip **□ Chew □ ½ PPD □ 1 PPD □ 2PPD Other: _____ How much? How many years? Do you use Alcohol? □ Yes □ No Amount/frequency: _____ History of Alcohol abuse? □ Yes □ No Quit/When: _____ Do you use Street Drugs? □ Yes □ No Type/frequency: _____ History of Drug abuse? □ Yes □ No Type/last use: Comments or additional information you would like to share