New Patient History

Date: _____ Name: _____

Address: _____ City: _____ State: _____

Referring Physician: _____ Phone: _____

Primary Physician: _____ Phone: _____

Background Information:

Age: _____ Male/Female Right/Left Handed Married/Single/Widowed/Divorced

Number of children: _____ Ages: _____

Who do you live with? _____

Do you live in an apartment/house/condo?

How many steps upwards/downwards to enter? _____ How many levels? _____

On what level is the main bathroom? _____

Are you able to dress/use toilet/bath and groom yourself? _____

If not, why and who helps? _____

Are you able to cook/clean/shop/manage your own finances? _____

If not why and who helps? _____

How much schooling have you completed? _____

What type of work do you do? _____

How many hours/week? _____

How would you rate your job satisfaction? Very satisfying Satisfying Not Satisfying

If you don't work, why? _____

When was the last time you worked? _____

Are you receiving any of the following? Please circle

Workers compensation No fault auto Long term disability Social Security Unemployment

Retirement/Pension Other _____

Have you ever been a victim of verbal/physical/sexual abuse? _____

Date:_____Name:_____

For what problem are you here today? _____

_____

_____

_____

When and how did pain/problem start? _____

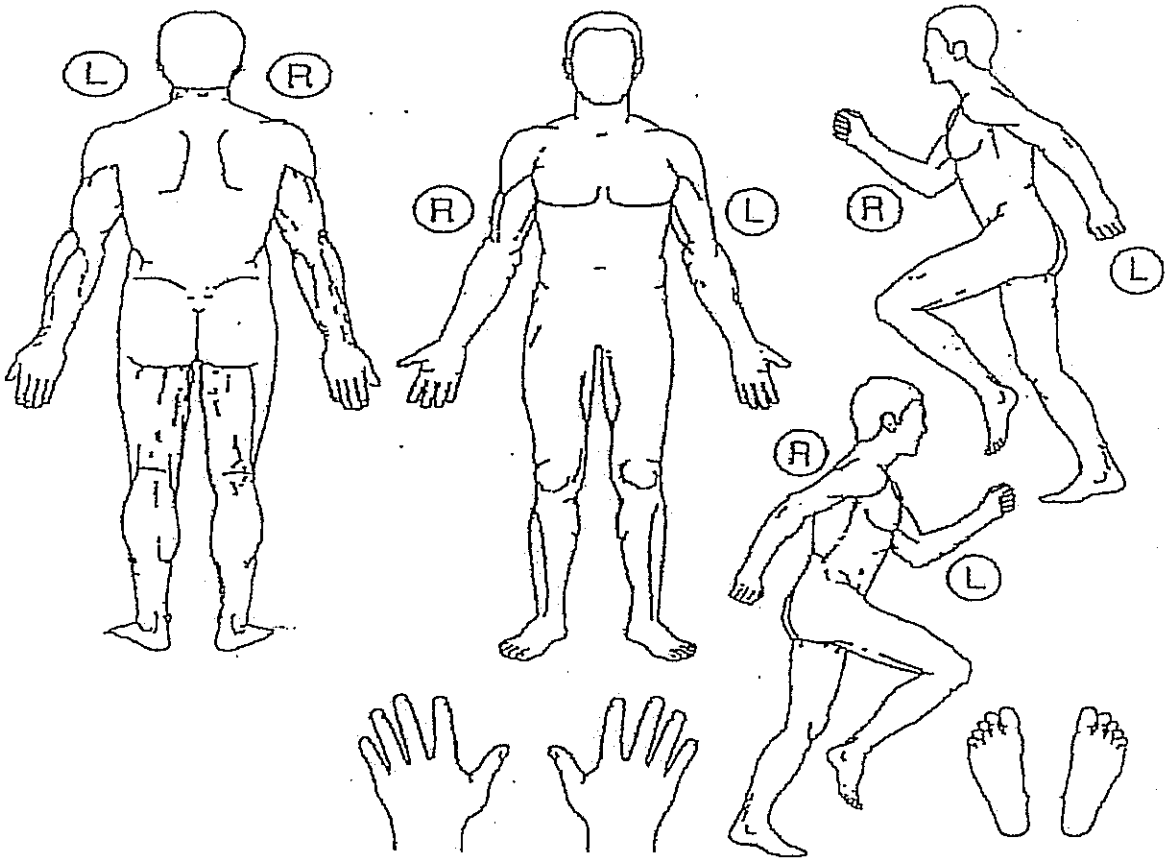
_____

_____

Is your pain from a work injury? Yes No Is your pain from an auto accident? Yes No

Is there a lawsuit due to this injury? Yes No

Draw pain pattern here:



Place an X on the line below that describes your average daily pain:

No Pain 0____1____2____3____4____5____6____7____8____9____10____Worse Pain

What numeric value do you give as your worst pain on the 0-10 scale above? _____

Date:_____Name:_____

Circle the words that describe your pain:

throbbing shooting stabbing sharp cramping gnawing hot-burning aching heavy tender

dull splitting sickening distressing punishing-cruel electric

What makes it better? _____

_____

What makes it worse? _____

_____

Testing: Have you had any of the tests below to evaluate this problem?

X-Ray MRI CAT Scan Bone Scan EMG EEG Blood Drawn

What medications have you tried and which were effective or ineffective?

_____

_____

_____

_____

Therapies: Circle those that apply

Physical Therapy- Date of last visit _____ Occupational Therapy-Date of last visit _____

Massage Therapy Accupuncture Psychological Support

Other Therapies: _____

Procedures: Circle those that apply

Nerve blocks- Date of last _____ Steroid Injection/Epidural-Date of last _____

Surgery- Date of last _____ Other _____

What worked best? _____

What did not help? _____

Date:_____Name:_____

Past Medical History: Circle those that apply

High blood pressure high cholesterol heart attack congestive heart failure stroke

Peripheral vascular disease diabetes thyroid problems liver problems

anemia cancer Hepatitis HIV asthma COPD TB acid reflux

gut ulcers kidney problems cataracts glaucoma migraine seizure

multiple sclerosis hearing problems arthritis scoliosis depression/anxiety

Other: _____

Surgical History: Please list all surgeries you have had

_____

_____

_____

Family History:

Who else in your family has experienced this problem or chronic pain? Please circle

Father Mother Siblings Children If yes, what part of the body? _____

Has any family member suffered from spine problems? Please circle

Father Mother Siblings Children If yes, did they require surgery? _____

Allergies: please list _____

Current Medications: please list _____

_____

_____

Social History:

Do you smoke? Yes/no How much per day?_____ How many years? _____

When did you stop? _____

How much alcohol do you drink per day? _____ How many days/week? _____

When did you stop? _____

Do you use any marijuana/cocaine/crack/heroin? How often? _____ Last use? _____

When did you stop? _____

Have you had a substance abuse problem? Yes/no When did you stop? _____

Do you exercise? _____

Date:_____Name:_____

Review of Systems: Have you experienced any of the symptoms below recently? Please circle

Fever	unexplained weight loss	fatigue		Constitutional
Blurred vision	double vision	seeing spots		Eyes
Ear Pain	ringing in ears	nose bleeds	difficulty swallowing	ENT
Swollen arms/legs	chest pain	palpitations		Cardiovascular
Shortness of breath	cough	asthma		Respiratory
Loss of bowel control	constipation	decreased appetite	difficulty swallowing	GI
Loss of bladder control	loss of urine with cough/sneeze/straining			GU
Frequent urination				
Joint swelling	stiffness	muscle spasms		Msk
Rash	Hair loss on arms/legs	itching		Derm
Headache	Numbness/tingling of arms/legs	Loss of balance/coordination		Neuro
Feelings of anger	depression/anxiety	personality change		Psych
Excessive thirst	excessive sweating	weight gain/loss		Endo
Easy bruising	bleeding disorder	swollen glands		Heme
Chronic infections	hepatitis	HIV/AIDS		ALL/Imuno

Name:
Chart/Acct #:
Date:

SOAPP

The following are questions given to all patients who are being considered for opioids for their pain. Please answer each question as honestly as possible. Your answers alone will not determine your treatment.

Please answer the questions below using the following scale:

0=Never, 1=Seldom, 2=Sometimes, 3= Often, 4=Very Often

1.	How often do you have mood swings?	0 1 2 3 4
2.	How often do you smoke a cigarette within an hour of waking up?	0 1 2 3 4
3.	How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
4.	How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
5.	How often have others suggested that you have a problem with alcohol or drugs?	0 1 2 3 4
6.	How often have you attended an AA or NA meeting?	0 1 2 3 4
7.	How often have you taken medication other than the way it was prescribed?	0 1 2 3 4
8.	How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
9.	How often have your medications been lost or stolen?	0 1 2 3 4
10.	How often have others expressed concern over your use of medication?	0 1 2 3 4
11.	How often have you felt a craving for medication?	0 1 2 3 4
12.	How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
13.	How often have you used illegal drugs (for example, marijuana, cocaine, heroin, etc) in the past five years?	0 1 2 3 4
14.	How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

PCS

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feeling that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
I worry all the time about whether the pain will end	0	1	2	3	4
I feel I can't go on	0	1	2	3	4
It's terrible and I think it's never going to get any better	0	1	2	3	4
It's awful and I feel that it overwhelms me	0	1	2	3	4
I feel I can't stand it anymore	0	1	2	3	4
I become afraid that the pain will get worse	0	1	2	3	4
I keep thinking of other painful events	0	1	2	3	4
I anxiously want the pain to go away	0	1	2	3	4
I can't seem to keep it out of my mind	0	1	2	3	4
I keep thinking about how much it hurts	0	1	2	3	4
I keep thinking about how badly I want the pain to stop	0	1	2	3	4
There's nothing I can do to reduce the intensity of the pain	0	1	2	3	4
I wonder whether something serious may happen	0	1	2	3	4