Pain & Spine INSTITUTE

Patient Information

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Mobile Phone #: _____

Email: _____ Marital Status: _____

Employer Name: _____ Work Phone: _____

Primary Care Physician: _____ PCP Phone #: _____

Referring Physician: _____ Referring Phone #: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Insurance Information

Primary Insurance: _____ Subscriber Name: _____

Subscriber ID: _____ Subscriber DOB: _____ Group Number: _____

If Applicable

Secondary Insurance: _____ Subscriber Name: _____

Subscriber ID: _____ Subscriber DOB: _____ Group Number: _____

If Applicable

☐ **Workers Compensation Insurance** ☐ **Motor-Vehicle Accident Insurance** ☐ **Personal Injury** (check one)

Insurance Name: _____ Insurance Phone #: _____

Insurance Address: _____ City: _____ State: _____ Zip Code: _____

Employer at time of Injury: _____ Date of Injury: _____ Claim #: _____

Adjustor's Name: _____ Adjustor's Phone #: _____ Email: _____

Attorney's Name: _____ Attorney's Phone #: _____ Email: _____

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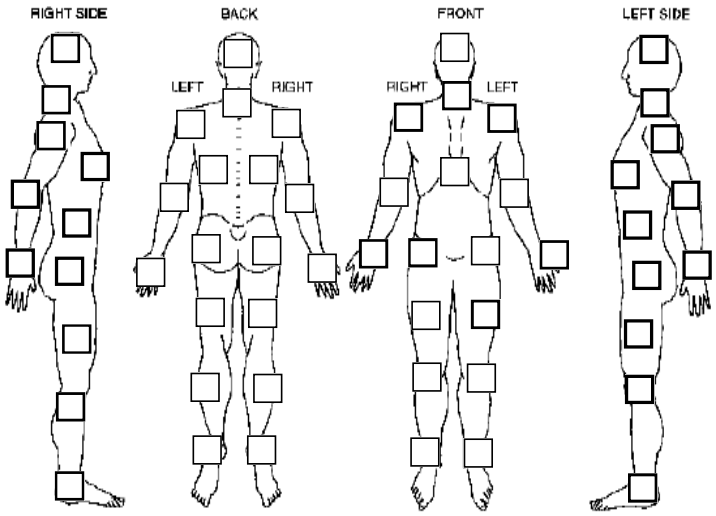
Patient Name:_____ Height:_____ Weight:_____

Mark the Areas of Pain



Check The Words That Best Describes Your Pain

☐Dull	☐Numb	☐Aching
☐Tingling	☐Sharp	☐Cramping
☐Shooting	☐Electric	☐Stabbing
☐Pulling	☐Burning	☐Throbbing
☐Radiating	☐Tearing	☐Pounding
☐Unbearable	☐Other:_____	

Pain Score (check your pain score below)

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain Moderate Pain Severe Pain

History of Present Illness

Are you Experiencing any Weakness? ☐Yes ☐No **What is the frequency of your pain?** ☐Constant ☐Intermittent

Are you experiencing any Loss of Bowel/Bladder Control? ☐Yes ☐No **Are you, or could you be pregnant?** ☐Yes ☐No

How Long has the pain been present?_____ **How Did the Injury or Pain Occur?**_____

_____

_____

Has your pain affected your daily activities or relationships with family or friends? ☐Yes ☐No

If Yes, please explain:_____

Is there anything that worsens the pain?

☐Bending	☐Coughing	☐Daily Activities	☐Neck Movement	☐Twisting	☐ Kneeling
☐Lifting	☐Lying Down	☐House Work	☐Prolonged Positions	☐Sitting	☐Standing
☐Sneezing	☐Stretching	☐Getting Dressed	☐Weather Changes	☐Walking	☐Stairs

☐Other:_____

Is there anything that makes the pain better?

☐Rest	☐Bending Forward	☐Bending Backward	☐Twisting	☐Massage	☐Heat	☐Ice
☐Walking	☐Switching Positions	☐Muscle Relaxant	☐Medication	☐Narcotics	☐Stretching	☐Laying

Does your Pain radiate? ☐Yes ☐No If Yes: ☐Right Arm ☐Left Arm ☐Right Leg ☐Left Leg ☐Orbit

☐Buttocks ☐Shoulder Blades ☐Other:_____

Have you missed work due to your condition? ☐Yes ☐No If so, what date?_____

Are you currently on work restrictions? ☐Yes ☐No If yes, explain:_____

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Patient Name:_____

Allergies:

☐ Penicillin ☐ Sulfa ☐ IV Dye/Contrast ☐Topical Iodine ☐Shellfish ☐Latex ☐None ☐Other:_____

Current Medications:

Medication	Dosage	Instructions

Are there any updates to your Medical History since your last visit (please list):_____

_____

_____

Have you had any of the following Imaging/tests to evaluate your pain since your last visit? (check all that apply)

☐MRI ☐X-Ray ☐CAT Scan ☐Bone Scan ☐EMG/Nerve Conduction ☐Vascular Studies

☐Ultrasound ☐FCE ☐Ultrasound ☐None ☐Other:_____

Please list when the test was preformed, facility, and area tested:_____

_____

_____

Review of Systems

General (Constitutional)

Chills ☐Yes ☐No
Fatigue ☐Yes ☐No
Fever ☐Yes ☐No
Night Sweats ☐Yes ☐No
Weight Change ☐Yes ☐No

Neurologic

Dizziness ☐Yes ☐No
Headache ☐Yes ☐No
Seizures ☐Yes ☐No

Musculoskeletal

Back Pain ☐Yes ☐No
Joint Stiffness ☐Yes ☐No
Limb Pain ☐Yes ☐No

Hematology

Bleeding ☐Yes ☐No
Bruising ☐Yes ☐No
Anemia ☐Yes ☐No

My signature confirms that the answers in this packet are accurate and stated to the best of my ability.

Patient Signature:_____ Date:_____
Guardian Signature (if under 18):_____ Date:_____