Pain Management
10600 Mastin St.
Overland Park, KS 66212
(913) 469-6447

NEW PATIENT INFORMATION

Please help us to help you by answering the following questions as accurately as possible

Patient name____ Date of birth _______________

Who is your primary care doctor?____

What problem (pain or injury) did your doctor refer you for? ________________________

____

Duration: How long have you had the pain or injury (weeks, months, years)? _______________

Frequency: How many days a week do you have pain? __________________________________

Onset: Did the pain or injury start ___suddenly or ___ gradually?

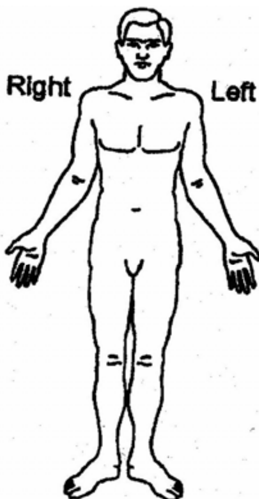
Modifying Factors: Was there an accident or incident that first caused the injury? ____ No
____Yes, please describe____
____

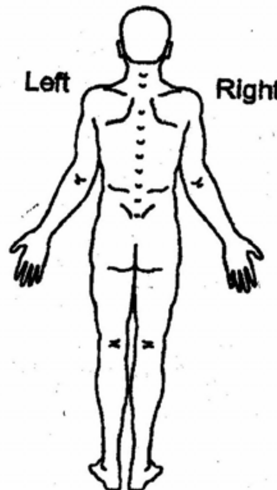
Timing: Is the pain or injury ___constant or does it ____come and go?

Quality: How would you describe the pain __burning __ stabbing __aching
____Other, please describe____

Severity: Please rate your pain with "0"=no pain and "10"=pain requiring immediate ER visit
How severe is the pain at its **best** (circle one)? 0 1 2 3 4 5 6 7 8 9 10
How severe is the pain at its **worst** (circle one)? 0 1 2 3 4 5 6 7 8 9 10
At what level of pain do you need to take medication (circle one)? 0 1 2 3 4 5 6 7 8 9 10

Location: Where is your pain located (please mark the area(s) of your pain with an "X" below)





Modifying factors:
What (if anything) makes the pain **better**? ____
What (if anything) makes the pain **worse**? ____

Associated sign/symptoms: Do you have any other symptoms related to your pain or injury that you want us to know about? ___No ___Yes, details ______________________________
____

<u>Please answer the following questions about other symptoms you may have (Systems review)</u>

Do you have fevers on a regular basis (temperature of 101 degrees or more on a thermometer)?
___No ___Yes, details ____
Have you had any unintentional weight loss greater than 15 pounds? ___No ___Yes
Details____

Does your pain or injury cause you to feel sad or depressed on a regular basis? ___No ___Yes
Details____

Do you have problems with you blood clotting or have low platelets? ___No ___Yes
Details____

<u>Please answer the following questions about your past medical history:</u>
Please list your past or present medical conditions

___Diabetes
___High blood pressure
___High cholesterol
___Stroke
___Heart disease or heart attack
___Aneurysm
___Tuberculosis
___Hepatitis
___AIDS or HIV
___Cancer (if yes, what type)
____
___Gout
___Rheumatoid Arthritis

___ Kidney disease
___ Bleeding ulcers
___Uvenitis
___Glaucoma
Other Medical Problems
____
____
____
____
____
____
____
____

Please list any ORTHOPEDIC SURGERIES you have had
1. ____________________ Date ____________ 3. ____________________ Date ____________
2. ____________________ Date ____________ 4. ____________________ Date ____________

Please list any JOINT OR SPINAL INJECTIONS you have had
1. ____________________ Date ____________ 3. ____________________ Date ____________
2. ____________________ Date ____________ 4. ____________________ Date ____________

Please list any OTHER SURGERIES you have had

1. ____________________ Date ___________ 4. ____________________ Date ___________
2. ____________________ Date ___________ 5. ____________________ Date ___________
3. ____________________ Date ___________ 6. ____________________ Date ___________

Are you allergic to any medications? ____No ____ Yes, please list ____________________
____

Please list ALL of the medications you currently take

Medicine	Dose	How many time daily

Do you take any of the following?

Aspirin	______No	______Yes
Plavix	______No	______Yes
Warfarin (coumadin)	______No	______Yes

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR SOCIAL HISTORY

Do you currently smoke? _____ No ______ Yes
If so, how many packs per day? _______________
For how many years? ___________

If you don't currently smoke, did you smoke in the past? ______ No ______ Yes
If yes, how long ago did you quit? ______________
Before you quit, how many packs per day did you smoke? _____________
Before you quit, how many years did you smoke? ______________

Do you CURRENTLY drink alcohol? ______ No ______ Yes
If yes, how many days per week? _______________
How many drinks do you have when you drink? _______________

Do you CURRENTLY use any of the following recreational drugs?

Marijuana	______No	______Yes
Cocaine	______No	______Yes
Speed or amphetamines	______No	______Yes
Heroin/opium/morphine	______No	______Yes
Designer drugs	______No	______Yes

Other____

Have you EVER used any of the following recreational drugs?

Marijuana ______No ______Yes, last time used ____________________
Cocaine ______No ______Yes, last time used ____________________
Speed or amphetamines ______No ______Yes, last time used ____________________
Heroin/opium/morphine ______No ______Yes, last time used ____________________
Designer drugs ______No ______Yes, last time used ____________________
Other____ last time used ____________________

Are you CURRENTLY ______Married ______Single ______Divorced

How many children do you have? __________________
What are their ages?______________________________

Do you CURRENTLY work? ______No ______ Yes, where? __________________________

What do you do? ____
For how long? ____

If you currently work, how would you describe your job satisfaction?

_____I love my job.
_____I like my job most of the time.
_____I go to work because I have to.
_____I usually dislike my job.
_____I hate my job.

If you don't currently work, how long have you been out of work? _______________

Is this related to you back pain or injury? _____No _____Yes

Are you presently receiving DISABILITY benefits? _____No _____Yes

Have you EVER filed a claim under worker's compensation? _____No _____Yes

Are you currently involved in ANY litigation due to your pain or injury? ____No ____Yes

Have you EVER been a victim of any of the following?

Emotional abuse _____No _____Yes, how long ago ____________________
Physical abuse _____No _____Yes, how long ago ____________________
Sexual abuse _____No _____Yes, how long ago ____________________

I understand that for my doctor to provide me with the best possible acre, I must provide complete and accurate information about my medical history. I certify the information I have provided is true and correct.

____ _____/_____/_____
Patient Signature Date