



College Park Family Care Center, P.A.

Pain Management

BACK PAIN - NEW PATIENT INFORMATION

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

Patient Name: _____ Date of Birth: _____

REFERRING DOCTOR: _____

PRIMARY DOCTOR: _____

DURATION: How long have you had the pain (weeks, months, years)? _____

FREQUENCY: How many days a week do you have pain? _____

ONSET: Did the pain or injury start ___suddenly or ___gradually?

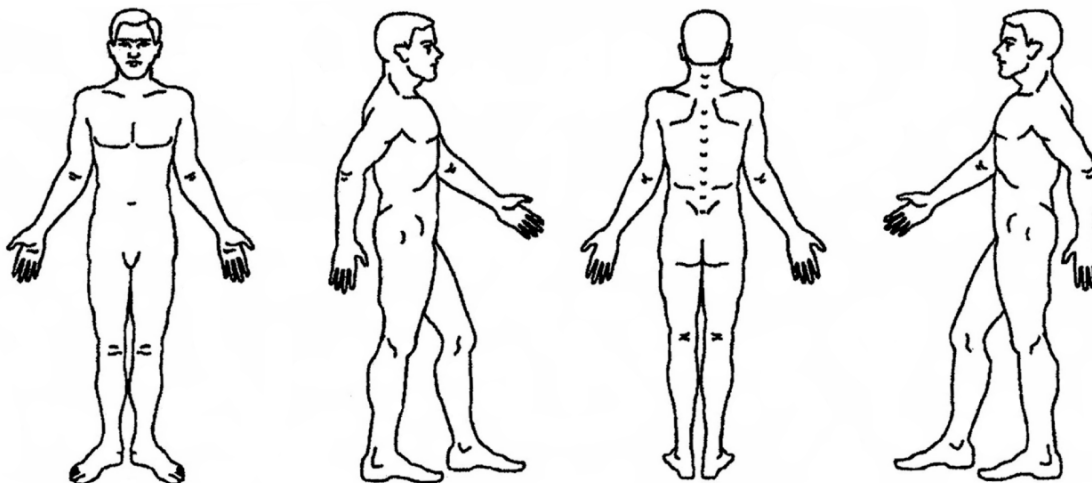
MODIFYING FACTORS: Was there an accident or incident that first caused the pain? ___NO
___YES, please describe: _____

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**? (Sneezing, coughing, walking, sitting too long, carrying something heavy in one arm, crossing your legs, sleeping, etc.)

ASSOCIATED SIGNS/SYMPTOMS: Does the pain every travel down your legs? ___NO ___YES

If yes, which pain is worse: ___Back pain is worse ___Leg pain is worse ___Both are equal

Do you have pain or a funny sensation that travels down your leg(s)? ___NO ___YES

If yes, which side? ___Left ___Right

How far down the leg does the pain go?

___To the knee, but NEVER below the knee on the ___Left ___Right

___To the calf, but NEVER into the feet or toes on the ___Left ___Right

___To the ankle, but NEVER to the feet or toes on the ___Left ___Right

___All the way to the feet and toes on the ___Left ___Right

If the pain goes to the toes, which toe(s) are most affected?

___The big toe, with or without the toe next to it on the ___Left ___Right

___The little toe, with or without the toe next to it on the ___Left ___Right

___All toes equally on the ___Left ___Right

1. List other Doctors who have treated you for this problem:

2. List tests that have been performed (i.e. MRI, CAT scan, myelogram, etc.):

3. Circle any treatments you have tried before to treat your pain:

Physical Therapy Chiropractor Massage Therapy Ice Heat TENS Unit Other

4. Have you previously had any injections/epidurals for your pain?

5. Have you been treated by other pain specialists/clinics in the past?

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT OTHER SYMPTOMS YOU MAY HAVE (REVIEW SYSTEM)

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

Do you have FREQUENT lower leg cramping or pain when walking that goes away if you stop and rest? ___NO ___YES, details_____

Do you cough up bloody sputum? ___NO ___YES, details_____

Have you had any complete loss of bowel control (NOT diarrhea or constipation)?
___NO ___YES, details_____

Have you had any complete loss of bladder control (NOT loss of urine while coughing, sneezing or straining)? ___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 your blood clotting or do you have low platelets?
___NO ___YES, details_____

In the past few months have you experienced any of the following symptoms or complaints?

Night sweats	___NO ___YES	New rashes or blisters	___NO ___YES
Chest pain	___NO ___YES	Red swollen joints	___NO ___YES
Difficulty breathing	___NO ___YES	Numbness	___NO ___YES
Persistent cough	___NO ___YES	Weakness	___NO ___YES
Constipation	___NO ___YES	Recurrent infections	___NO ___YES
Diarrhea	___NO ___YES	Nausea	___NO ___YES

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PAST MEDICAL HISTORY

Please list your past or present medical conditions:

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Bleeding ulcers |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart disease or heart attack | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Other Medical Problems |
| <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Hepatitis | _____ |
| <input type="checkbox"/> AIDS or HIV | _____ |
| <input type="checkbox"/> Cancer (if yes, what type) | _____ |
| _____ | _____ |
| <input type="checkbox"/> Gout | _____ |
| <input type="checkbox"/> Rheumatoid arthritis | _____ |

Please list any BACK OR NECK SURGERIES you have had:

- | | | | |
|----------|------------|----------|------------|
| 1. _____ | Date _____ | 3. _____ | Date _____ |
| 2. _____ | Date _____ | 4. _____ | Date _____ |

Please list any BACK OR NECK 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:

<u>Medicine</u>	<u>Dose</u>	<u>How many times daily</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take any of the following?

- | | | |
|---------------------|-----------------------------|------------------------------|
| Aspirin | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| Plavix | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| Warfarin (coumadin) | <input type="checkbox"/> NO | <input type="checkbox"/> 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? _____

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 care, 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