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-<u>all the time</u>, Episodic-<u>comes and goes</u>***
- ***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?* _____**
  _____

Medical Doctor Name/Location: _____

Height :(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 date	**Medication name/strength/frequency**	**Start date**	**Medication name/strength/frequency**

PREVIOUS MEDICATIONS (TRIED FOR THIS PAIN PROBLEM)

Stop date	**Medication name/strength/frequency**	**Stop date**	**Medication name/strength/frequency**

Have you tried the following treatment for your Pain problem?

TREATMENT TRIED	**Date Tried**	**DID IT HELP??**		***COMMENTS***
		YES ☑	**NO ☑**	
*Chiropractic care				
*Physical Therapy				
*TENS unit (electrical Stim device)				
*Acupuncture				
*Massage Therapy				
*Water (Pool) Therapy				
*Biofeedback				
*Injections/ Nerve Blocks/ Epidurals				
*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

History of:	☑	**Diarrhea**	
Headaches		**Irritable Bowel Syndrome (IBS)**	
Cluster headaches		**Hemorrhoids**	
Migraines		**Diverticulosis**	
Stroke		**Colon Polyps**	
Head Injury / Coma		**Kidney or Bladder infections**	
Peripheral Neuropathy		**Urinary Frequency**	
Shingles		**Blood in Urine**	
Seizures		**Kidney Stones**	
Depression		**Prostatitis (BPH)** ***enlarged prostate***	
Anxiety		**Prostate Cancer**	
Suicide thoughts		**Night time Urination**	
Pneumonia		**Kidney Failure/ Dialysis**	
Bronchitis		**Skin Cancers**	
Asthma		**Psoriasis or eczema**	
Emphysema/COPD		**Rash**	
Tuberculosis		**Bruises *currently* on arms or legs**	
High blood pressure		**Current wound/burn/laceration**	
Congestive Heart Failure		**Osteoarthritis**	
Angina (chest Pain)		**Rheumatoid Arthritis**	
Heart Attack		**Osteoporosis**	
Coronary Artery disease		**Fibromyalgia**	
Angioplasty/		**Gout**	
Diet please check the following		**Unsteady walk, history of falls**	
REGULAR DIET		**Use a cane, walker or wheelchair**	
DIABETIC DIET		**Thyroid problems**	
LOW Sodium/Low Fat diet		**Diabetes**	
GOOD Appetite		**Long term steroid therapy**	
FAIR Appetite		**Anemia**	
POOR Appetite		**Free bleeder (bleed easily)**	
Hepatitis		**Blood Clots (legs or lungs)**	
Pancreatitis		**Sickle Cell Anemia**	
Abdominal (Stomach) Pain		**Bruise easily**	
Ulcers		**Previous blood transfusion**	
Stomach or bowel bleeding		**Hearing impaired**	
Acid Reflux		**Dentures, caps, crowns, missing or bad teeth? (may circle)**	
Hiatal hernia (stomach)		**Last Menstrual period**	
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*
How much? □ ½ PPD □ 1 PPD □ 2PPD Other: _____
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