



Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home# () _____ Work# () _____ Cell# () _____

Date of Birth: ___/___/___ Age: _____ Male Female

Marital Status: S M D W Other SS# _____ - _____ - _____

Spouse/Significant Other: _____ Phone # () _____

Your Employer: _____ Phone # () _____

Referring Physician: _____ Phone # () _____

Primary Physician: _____ Phone # () _____

Pharmacy _____ Phone # () _____

Primary Insurance: _____

Member ID # _____ Group# _____

Cardholder: _____ Phone # () _____

Relationship (if other than patient): _____ Date of Birth: ___/___/___

Your Secondary Insurance: _____

Member ID# _____ Group# _____

Cardholder: _____ Phone # () _____

Relationship (if other than patient): _____ Date of Birth: ___/___/___

Is this a Workman's Comp. Claim? Yes No If Yes, Complete Workmen's Comp. Form

Is this a motor vehicle accident claim? Yes No If Yes, Complete MVA Form

Adjustor's Name: _____ Phone # () _____

Agreement: I understand I am totally responsible for all charges to my account. I understand that this office will file my insurance and that I am responsible for any amount not paid. If this account has to be collected by an attorney, I understand that I will be responsible for the attorney fees also. I authorize release of my medical information to my physicians and insurance carriers. I also authorize payment of benefits directly to my physicians.

PATIENT SIGNATURE _____ DATE _____

I, _____ (please print) give permission for Prima Pain Relief to take an identification photograph to be maintained in my medical records. I understand that this picture will be used in a confidential manner related only to my personal care in the above named office.

PATIENT SIGNATURE _____ DATE _____



New Patient Questionnaire:

Name _____ Age _____ Date _____

Referring Physician _____

Primary Care Physician _____

Occupation _____

Height: _____ Weight: _____

I. Chief Complaint:

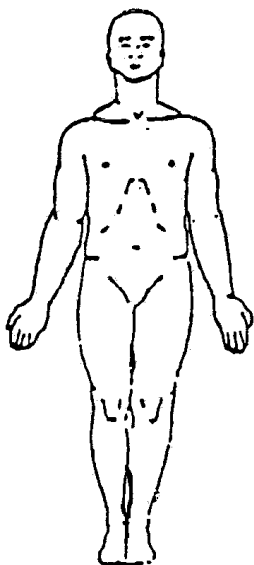
1) Where is your pain located? _____

2) When and how did it begin? _____

3) Does your pain radiate anywhere? _____

4) Please mark the area(s) in the diagrams below where you are having pain:

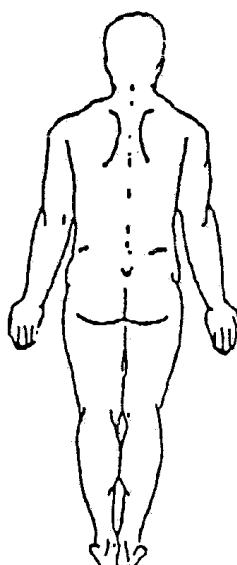
FRONT



RIGHT SIDE



BACK



LEFT SIDE



5) On a scale from 0-10, with 0 being no pain and 10 being the worst pain imaginable, what number describes your pain?

At it's best: _____ At it's worst _____ Right at this moment: _____

6) How often does the pain occur: Continuously Several times a day Intermittent occasionally Less than daily

7) When is your pain worse?
 Morning Afternoon Evening No Usual Pattern All the time

8) How has the pain intensity changed since it began?
 Better Worse No change

9) Select one or more items below to describe your pain:
 Aching Burning Cramping Dull Electric Shock Sharp Shooting
 Stabbing Throbbing Other _____

10) What makes the pain worse?
 Standing Sitting Walking Movement Lying Down Bending Forward
 Arching Backward Coughing/Sneezing Using Bathroom
 Other _____

11) What makes the pain better?
 Standing Sitting Walking Movement Lying Down Bending Forward
 Arching Backward Coughing/Sneezing Using Bathroom
 Other _____

12) What tests have been done and when?
Test: X-ray MRI CT Myelogram EMG Bone Scan Other
Date: _____

13) Do you have any of the following symptoms associated with your pain?
 Numbness / Tingling If yes, where? _____
 Weakness If yes, where? _____
 Bowel/Bladder Incontinence When did it start? _____

14) List the names of other doctors or specialists you have seen for your pain or who have Treated your pain: _____

15) Please check all procedures or modalities you have tried to manage or treat your pain:

Did it help?		Did it help?	
<input type="checkbox"/> Acupuncture _____	<input type="checkbox"/> Massage _____	<input type="checkbox"/> Biofeedback _____	<input type="checkbox"/> Meditation _____
<input type="checkbox"/> Chiropractor _____	<input type="checkbox"/> Nerve Blocks _____	<input type="checkbox"/> Epidural _____	<input type="checkbox"/> Physical Therapy _____
<input type="checkbox"/> Facet Block _____	<input type="checkbox"/> Psychotherapy _____	<input type="checkbox"/> Ice/Heat _____	<input type="checkbox"/> Surgery _____
<input type="checkbox"/> Medications _____	<input type="checkbox"/> TENS _____	<input type="checkbox"/> Other _____	

16) Are you involved in any litigation or lawsuit regarding your pain? Yes No

17) Are you seeking Worker's Compensation as a result of your pain? Yes No

II. Medical Illnesses (check all that apply):

<input type="checkbox"/> Thyroid	<input type="checkbox"/> Lung (asthma, emphysema, COPD)
<input type="checkbox"/> Liver (Hepatitis, cirrhosis)	<input type="checkbox"/> Heart (angina, heart attack, irregular heart beat, pacemaker, heart failure)
<input type="checkbox"/> Psychiatric (depression, anxiety, suicide)	<input type="checkbox"/> Stomach (ulcer, GERD/reflux)
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney (stones, failure, dialysis)
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Neurologic (stroke, seizure, neuropathy)
<input type="checkbox"/> Diabetes (diet, medication, insulin)	

___ Cancer (Type _____)

___ Arthritis (rheumatoid, fibromyalgia)

III. Prior Surgeries:

Type: _____
Date: _____

Type: _____
Date: _____

IV. Medications

Allergies: _____

Do you take any of the following?

Current Non-pain Medications:

___ Aspirin ___ Coumadin
___ Plavix ___ Heparin
___ Aggrenox ___ Pletal
___ Lovenox ___ Ticlid

Current Pain Medicatons:

Previous Pain Medications:

V. Social History (check all that apply):

___ Use tobacco? Amount _____
___ Use alcohol? Amount _____

___ Use illegal drugs? Type _____
___ Been treated for alcohol or drug addiction

VI. Family History (check all that apply):

Cancer ___ Who? _____
Diabetes ___ Who? _____
Heart Disease ___ Who? _____

Hypertension ___ Who? _____
Stroke ___ Who? _____
Alcohol/Drug abuse ___ Who? _____

VII. Review of Systems (circle all that apply):

GEN: Weight changes, fatigue
SKIN: Bruising, rashes
HEAD/EYES: Headache, blurry vision
ENT: Ears ringing, sinusitis, soar throat
RES: Chronic cough, shortness of breath
CV: Chest pain, palpitations
HEM: Anemia, easy bruising/bleeding

GI: Heartburn, nausea, constipation
GU: Blood in urine, painful urination
M.S. Joint pain, arthritis
NEURO: Stroke, seizures, weakness
PS: Depression, anxiety, sleep problems
END: Thyroid problems, diabetes
VASC: Leg cramps, aneurysms

Form Completed By: (circle one) Patient ___ Other
Signature: _____ **Date:** _____