

INTERVENTIONAL PAIN CONSULTANTS, LLC

PATIENT INFORMATION

NAME: _____ MARITAL STATUS: _____ DOB: _____
ADDRESS: _____ SS#: _____
CITY: _____ STATE: _____ HOME PHONE: _____
ZIP CODE: _____ ALTERNATE PHONE: _____
EMPLOYER: _____ OCCUPATION: _____
ADDRESS: _____ WORK #: _____
CITY: _____ STATE: _____ ZIP CODE: _____
REFERRING/ PRIMARY DOCTOR: _____ PHONE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
EMERGENCY CONTACT: _____ PHONE NUMBER: _____

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN SELF)

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____
CITY: _____ STATE: _____ SS#: _____
ZIP CODE: _____ HOME PHONE #: _____
EMPLOYER: _____ OCCUPATION: _____
ADDRESS: _____ WORK #: _____
CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE INFORMATION

NAME OF INSURED: _____
DOB: _____ SS#: _____ EMPLOYER: _____
PRIMARY INSURANCE: _____ ACCOUNT NUMBER: _____
SECONDARY INSURANCE: _____ ACCOUNT NUMBER: _____

WORKMANS' COMPENSATION INJURY

INJURED ON JOB? YES NO
DATE OF INJURY: _____
INDUSTRIAL CLAIM #: _____
BILLING ADDRESS: _____

CASE WORKER: _____
PHONE: _____
FAX: _____

OTHER INJURY:

DATE OF ACCIDENT: _____
WAS AUTO INVOLVED? YES NO
LIABILITY? YES NO
ATTORNEY: _____
LIABLE PARTY: _____
ADDRESS: _____

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____

HEALTH HISTORY



Patient Name: _____ **Date:** ____/____/____

Primary Care Physician & Clinic: _____ **Phone:** () _____

Previous Pain Management Physicians: _____ **Date Last Treated:** ____/____/____

Other doctors treating this condition: _____ **Phone:** () _____

Therapists treating you for this condition: _____ **Phone:** () _____

Date of initial onset for this condition: _____ **If reoccurrence, date of current aggravation:** _____

Describe how the injury occurred: _____

When did your problem begin? Immediately after a specific incident Multiple incidents Gradually developed

No specific incident - Please list the "incident/s": _____

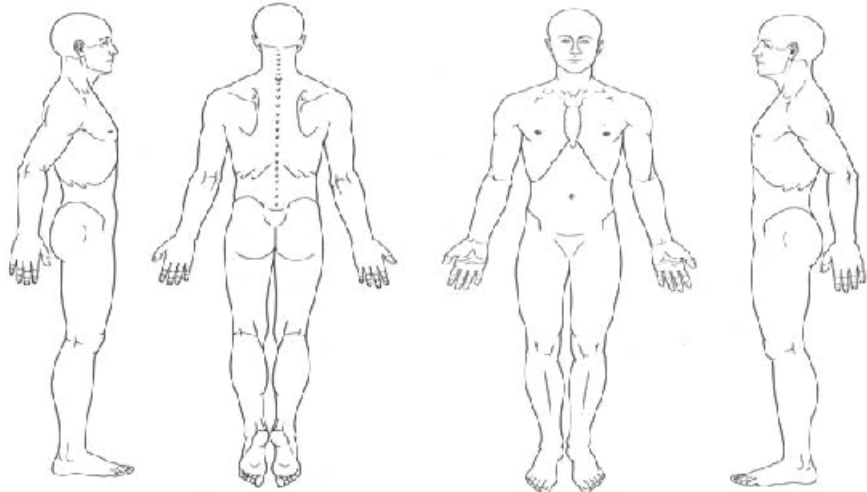
Pain Diagram: Use symbols below to mark the figures.

Description:

- XXX = Aching
- /// = Numbness
- >>> = Stabbing
- ### = Burning
- 000 = Pins/Needles
- TTT = Throbbing

Frequency (overall):

- Constant (76-100%)
- Frequent (51-75%)
- Occasional (26-50%)
- Intermittent (25% or less)



Rate Intensity as Follows (This Section):

- | | | |
|------------------------------|------------------------------------|---|
| 0 None | 4 Moderate, bothers during | 8 Intense, preoccupied, seeks |
| 1 Maybe | work/activities | relief instead of activity |
| 2 Mild, forgotten w/activity | 6 Limiting, prevents full activity | 10 Severe—on bed rest, stops all activity |

Complaint (I.e. Neck Pain, Low Back Pain, etc)	Place "X" for average pain, "O" worst pain, "□" pain now	Is it getting		
		Better	Worse	No Change
1. _____	0....1....2....3....4....5....6....7....8....9....10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	0....1....2....3....4....5....6....7....8....9....10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	0....1....2....3....4....5....6....7....8....9....10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. _____	0....1....2....3....4....5....6....7....8....9....10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your general stress level: No stress Minimal stress Moderate stress Greatly stressed

Physical activity at work: Sitting more than 50% of day Light manual labor Manual labor Heavy manual labor

General physical activity: No regular exercise program Light exercise program Strenuous exercise program

Please describe any other physical/emotional/hormonal medical concerns that you are considering seeking care for, currently receiving care for, or in the past have sought care for:

Patient signature _____ Date _____

HEALTH HISTORY



Physician Notes

11. What time of the day are your symptoms worse?

- (1) Morning
- (2) Afternoon
- (3) Evening
- (4) During Sleep
- (5) None of the above (constant pain)

12. What makes your pain better?

- (1) Rest
- (2) Ice or Heat (Please circle one)
- (3) Prescription medications
- (4) Interventional Injections
- (5) Other: _____

13. What makes your pain worse?

- (1) Activity (work, repetitive motions, etc.)
- (2) Ice or Heat (Please circle one)
- (3) Sitting
- (4) Standing
- (5) Laying
- (6) Other: _____

14. Does your pain wake you at night?

- (1) Yes
- (2) No

15. Do you experience any weakness in the area of your pain or other body regions?

16. Do you experience any change in sensation in the area of your pain?

17. Do you experience any radiation of your pain into other areas of your body?



Review of Systems Worksheet

Patient Name: _____ Date: _____

Please check all that apply to you:

1. General

- No problems
- Fever or chills
- Unexplained hair loss (alopecia)

2. Eyes

- No problems
- Vision problems (blurred vision, loss of vision)
- Eye pain

3. Ears/Nose/Mouth/Throat

- No problems
- Dizziness
- Dental problems
- Swollen glands in neck
- Sore throat/pain when swallowing
- Mouth sores

4. Cardiovascular

- No problems
- Chest pain (sharp, crushing, or heaviness)
- Heart racing (palpitations)
- Sudden shortness of breath at night or lying down
- Leg pain in calf or thigh of leg
- Aching/Burning in legs
- Fainting spells
- Swelling of legs (Edema)

5. Respiratory

- No problems
- Shortness of breath
- Night sweats
- Cough/coughing up blood

6. Gastrointestinal

- No problems
- Decreased appetite
- Nausea/Vomiting
- Constipation
- Increased appetite
- Stomach pain
- Diarrhea

7. Genitourinary

Men and Women:

- No problems
- Pain when passing water (urination)
- Passing water more than usual (day and/or night)
- Pain during sex
- Sores (vagina, penis, rectum)
- Blood in urine
- Bladder Infection/other infections
- Changes in sex drive (libido)

Women:

- Irregular periods (menstruation)
- Increased or too little bleeding during periods (menstruation)
- Three or more yeast infections in a year
- Painful periods (menstruation)
- Discharge from vagina

Men:

- Discharge from penis (drip)
- Swelling in balls (scrotum)

8. Musculoskeletal

- No problems
- Joint pain
- Numbness, tingling, or weakness in arms or legs
- Limited motion of arms or legs
- Swelling/Redness If so, where _____
- Pain in calf or thigh

