

Emerald Coast Pain Services New Patient Form

Please read carefully and answer all questions. Use the back of the paper if necessary.

1. Name: Last:_____ First:_____ MI:_____
2. Age:_____ Height:_____ Weight:_____ Male/Female_____
3. Address:_____ Phone:_____
4. DOB:___/___/___ Social Security #:_____ Marital Status:_____
5. Insurance Information: (Primary Insurance)_____
Name of insured:_____ DOB_____ Relationship_____
Policy Number:_____ Group Number: _____
Insurance Information: (Secondary Insurance)_____
Name of insured:_____ DOB_____ Relationship_____
Policy Number:_____ Group Number: _____
6. Who referred you?_____
7. Where is your worst pain?_____
8. When did you first start having pain?_____
9. How did this pain occur?_____
10. Have you had this pain before? Yes / No When?_____
Please explain:_____
11. If your pain was caused by an accident, please give the date of the accident:_____
Describe the accident:_____
12. Please describe your pain: Sharp / Dull / Knots / Burning / Throbbing / Electric Shocks / Tingling / Aching /
Constant / Intermittent / Other:_____
13. Is your pain: Constant or Intermittent?
14. Do you have areas of pins and needles sensation? Yes / No. Where?_____
Do You have areas of Numbness? Yes / No. Where? _____
Do you have Weakness? Yes / No. Where? _____
15. Do you have any of the following symptoms? Swelling / Stiffness / Bruising / Locking or Catching / Popping /
Giving Way / Difficulty Walking / Foot Drop / Limitation of Motion / Paralysis / Loss of Bladder Control/ Loss
of Bowel Control
Explain_____
16. Has your pain become worse recently? Yes / No When did it get worse?_____
Why do you think it became worse?_____

17. Circle what makes your pain worse: Sitting / Standing / Walking / Sneezing / Coughing / Running / Exercise / Lifting / Twisting / Stairs / Lying in bed / Bending / Squatting / Kneeling / Rising from a chair / Other: _____

18. Circle what makes your pain better: Rest / Heat / Cold / Elevation / Brace / Bandage / Exercise / Therapy / Medication / Other: _____

19. What treatments have you had for your pain? Physical therapy / Chiropractic / TENS unit / Massage / Brace / Cane / Crutch / Nerve blocks / Epidural / Pain clinic / Psychiatry / Surgery / Other: _____

20. Names of prior pain management physicians, locations, dates, and treatments:

21. For your pain issue, do you have any recent: MRI's / CT scans / Lab work / Nerve conduction studies / Specialist referrals? Provide dates: _____

22. If Headaches are a major issue for you the answer the following: Are your Headaches bilateral or one-sided? Describe-your-headache

Do you have: vision loss / hearing abnormalities / unusual sensations? How often do you get these headaches? _____

What prior treatments have you had? _____

23. Have you been diagnosed with any of the following: Carpal Tunnel Syndrome / Restless Leg Syndrome / Fibromyalgia / Myofascial Pain / Migraines / Menstrual Disorders / Endometriosis / Cluster Headaches / Rheumatoid Arthritis / Osteo-Arthritis / Lupus / Chronic Fatigue Syndrome / When were you diagnosed and what treatments have been done? _____

24. Do you get adequate sleep? Yes / No Why not? _____ How many hours? _____

25. Have you ever been diagnosed with: Depression / Bipolar / Manic / Psychosis / Addictive Disorder? Explain _____

26. **PAST MEDICAL HISTORY:** Circle any of the following illnesses you have had: Hypertension / Heart disease / Emphysema / Depression / Anxiety / Epilepsy or Seizure / Diabetes / Cancer / Arthritis / Stroke / Hepatitis / Kidney Disease / Thyroid Issues / Anemia / Leukemia / Lupus / Goiter / Lung Disease / Asthma / Bunion / COPD / Pneumonia / Tuberculosis / Migraine / Alcoholism / Colitis / Polio / Blood Clots / Bleeding Problems / Problem with Anesthesia / HIV/AIDS / Stomach Ulcers / Other: _____

27. **SURGERY HISTORY:** Please list ALL previous surgeries and the dates performed:

28. **FAMILY HISTORY:** Relationship / Present Age or Age at Death / Medical Illnesses/Problems

Father _____

Mother _____

Brother/Sister _____

Brother/Sister _____

Brother/Sister _____

29. **ALLERGIES:** List medicines and types of reactions (nausea, itching, rash, hives, wheezing, palpitations)

30. Are you presently taking **COUMADIN, PLAVIX** or any other blood thinners? Yes / No If yes, why do you take blood thinners? _____

31. **MEDICATIONS:** Medication / Date Started / Dosage / Times per Day / Purpose of Medication / Doctor

32. **SOCIAL HISTORY:** Circle your marital status: Married / Single / Divorced / Widowed

33. Race: White / Black / Asian / Native American / Brown or Mixed / Other: _____
Ethnicity: Hispanic or Latino / Not Hispanic

34. Education Level: Some High School / High School Graduate / Associate Level / Bachelor Degree / Master's / Doctorate / Other _____

35. Number of Children: _____ Religion: _____

36. Number of people who live in your household: _____

37. What is or was your occupation? _____

38. Circle your current employment status: Working Full-Time / Working Part-Time / On Sick Leave / Disabled / Retired / Other _____

39. Do you smoke? Yes / No If yes, # of packs/day _____

40. Do you drink alcohol? Yes / No If yes, average number of drinks/day _____, drinks/week _____

41. Have you ever been treated for alcohol or drug abuse? Yes / No If yes, explain _____

42. Have you ever been discharged from a pain practice? Yes / No If yes, why? _____

43. **ROS:** Please circle any of the following medical problems you have had:

HEENT: blurred vision / double vision / vision loss / dryness / wear glasses or contacts / trouble swallowing / hoarseness / hearing loss / nosebleeds /

Cardio: chest pain / irregular heartbeat / palpitations / anesthesia problems /

Respiratory: shortness of breath / chronic cough / wheezing /

Abdominal: heartburn / ulcers / nausea & vomiting / blood in stool / jaundice /

Renal: painful urination / blood in urine / difficult urination /

Musculoskeletal: morning stiffness lasting longer than 3 hours / joint pain / back pain / gout /

Skin/Breast: frequent rashes / skin ulcers / psoriasis / lumps /

Neurological: headaches / dizziness / seizures /

Psychiatric: depression / anxiety / sleep disorder /

Endocrine: heat intolerance / cold intolerance / excessive thirst /

Hematologic/Lymphatic: blood clots / easy bleeding / easy bruising / swollen glands /

Immunologic: hay fever / HIV exposure / persistent infections /

Other: loss of appetite / weight loss /

44. Is your injury workman's comp related? Yes / No Automobile insurance related? Yes / No

45. Is there litigation pending with your injury? Yes / No If so, who is your lawyer? _____
Do you want us to share information with your lawyer if he contacts us? Yes / No Your initials, if Yes _____

We're glad that you have chosen Emerald Coast Pain Services for your treatment. The practice of pain management includes the usage of medications and some minor procedures or surgeries. There are risks included with any treatment and we want you to be aware of this. Risks from procedures include bleeding, infection, tissue damage, nerve damage and risk of life or limb. These risks are very small, usually less than 1%, but you need to be made aware of them. There are also risks with an medications, which include allergic reactions, psychological changes, worsening of symptoms or even life threatening reactions. Again, these reactions are usually rare. During this visit, we will outline a treatment plan that may include medications, injections, referrals, etc. to help you get better and we expect you to progress along with that plan in a timely manner. Failure to follow the treatment plan may result in dismissal from the practice. Nothing in medicine is absolute and not all treatments work in all patients! We want you to be informed and if at any time you desire additional information about your medications or procedures, please ask and make sure your questions are answered.

I, _____ have read and understand the above.

Name _____ Date _____/_____/20____