

GLOBAL PAIN CARE
New Patient Form

Date: _____

Name: _____

Date of Birth: _____

Chief Complaint (PLEASE CHOOSE ONLY ONE):

- | | | |
|--|--|---|
| <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Mid-Back Pain | <input type="checkbox"/> Hand Pain | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Groin Pain |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Foot Pain |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Generalized Pain |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Upper back pain | |

Describe your pain (select ALL that apply):

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Pinching |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Pressure |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Stinging/Numbness |
| <input type="checkbox"/> Throbbing | |

What makes your pain feel worse:

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Physical Activity | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Movement | <input type="checkbox"/> Cold Weather |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Lying down |
| <input type="checkbox"/> Bending | |
| <input type="checkbox"/> Position change | |

What makes your pain feel better:

- | | |
|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Medications | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Rest | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Stretching |
| <input type="checkbox"/> Ice | |

Rate your pain 0-10 (0=no pain, 10=worst pain) circle ONE:

Level of pain at its worst: 1 2 3 4 5 6 7 8 9 10

Level of pain at its best: 1 2 3 4 5 6 7 8 9 10

Level of pain on average: 1 2 3 4 5 6 7 8 9 10

Does the pain radiate to any part of your body?

(For example: low back pain shoots down to my legs)

Have you had an MRI, X-Ray or CT scan? Yes No

If yes, where was the imaging done? _____

Physicians visited in the last year?

What pain medications have you tried in the past?

How long have you had the pain? _____

Have you had spinal surgeries in the past? Yes No

What kind of spinal surgery? _____

Did you improve from your spine surgery procedure? Yes No

Which of the following do you experience more pain, if any (please circle):

- More back pain than leg pain
- More leg pain than back pain
- Even amount of pain in back and leg

Which of the following do you experience more pain, if any (please circle):

- More neck pain than arm pain
- More arm pain than neck pain
- Even amount of pain in arm and neck

What other methods of pain treatment have been used in the past?

What other methods of pain treatment have been used in the past:

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Mid-Back Pain | <input type="checkbox"/> Hand Pain | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Groin Pain |

Allergies to medication: _____

Past Medical History

No medical history

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Ovarian Cyst |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer | <input type="checkbox"/> Blood Clots in Legs |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Lupus | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Kidney Failure |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Scleroderma | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Endometriosis | _____ |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Liver Disease | _____ |
| <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Gastric Reflux | |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Osteoarthritis | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Ankylosing Spondylitis | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> COPD/Emphysema | |

Surgical History:

No known surgical history

1. _____
(Month/year) (Procedure)
2. _____
(Month/year) (Procedure)
3. _____
(Month/year) (Procedure)
4. _____
(Month/year) (Procedure)
5. _____
(Month/year) (Procedure)

6. _____
(Month/year) (Procedure)
7. _____
(Month/year) (Procedure)
8. _____
(Month/year) (Procedure)
9. _____
(Month/year) (Procedure)
10. _____
(Month/year) (Procedure)

Social History:

Are you currently working? Yes No

Company _____ Occupation _____

Marital Status? Single Married Divorced Widowed

Who do you live with? _____

What do you live in? House Apartment Mobile Home
 Condo/Townhome

Are you a cigarette smoker? Yes No
If yes, how much do you smoke a day? _____

Any drugs or substance abuse? Yes No
If yes, what's the name of the drug? _____
When last used? _____

Family History:

Mother Alive Deceased
Father Alive Deceased
Siblings Alive Deceased
Children Alive Deceased

How many Brothers? _____	Healthy?	Yes	No
How many Sisters? _____	Healthy?	Yes	No
How many Sons? _____	Healthy?	Yes	No
How many Daughters? _____	Healthy?	Yes	No