Premier Pain Care, P.C.

PATIENT DEMOGRAPHICS

All sections of this Patient Registration must be filled out completely

Is your condition a result of a work injury? YES NO An auto accident? YES NO Date of Injury: _____

PATIENT PERSONAL INFORMATION Marital Status: __Single __ Married __Divorced __Widowed

Social Security # _____-_____-_____ Sex: ___Female ___Male

Name: _____ _____ E-Mail: _____

Street Address:_____ City: _____State:_____ ZIP:_____

Home Phone: _____Work Phone:_____ Cell Phone:_____

Date of Birth: ____/____/_____ Driver's License Number:_____DL State: _____

Employer / Name of School:_____ Full Time ____ Part Time ____

Spouse's Name: _____ Spouse's Work Phone:_____

Emergency Contact: _____ Phone Number: _____

PATIENTS INSURANCE/ RESPONSIBLE PARTY INFORMATION

Worker's Comp *Insurance Company:*_____

PRIMARY Insurance Company's Name: _____

Insurance Address: _____ City:_____ State:____ZIP:_____

Name of Insured/Responsible Party: _____Insured Date of Birth:___/____/ _____

Relation to Patient:_____ Insured Social Security #:_____

Insurance ID Number: _____ Group Number: _____

Medicare Number: _____ Medicaid Number: _____

SECONDARY Insurance Company's Name:_____

Insurance Address:_____City:_____State:_____ZIP:_____

Insurance ID Number:_____ Group Number:_____

PATIENTS REFERRAL INFORMATION

Referred by:_____ Other Physicians who care for you:_____

_____

Pharmacy: _____ *Phone Number:* _____

*Address:*_____ *City:*_____ *State:*_____

All sections of this Patient Registration must be filled out completely

PAST MEDICAL HISTORY:

Please check any problems below that you have had in the past or are currently experiencing:

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis / Joint pain
- ☐ Asthma
- ☐ Blood transfusions
- ☐ Bowel Trouble
- ☐ Breast Cancer
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Fracture
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ Hepatitis / Jaundice
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Infections
- ☐ Kidney Stones
- ☐ Mood Disorders
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Tuberculosis - TB
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ OTHER:_____
- ☐ NO PAST MEDICAL HISTORY

PAST SURGICAL HISTORY:

Please list previous surgeries you have had including the date:

☐ **NO PAST SURGICAL HISTORY**

MEDICATIONS:

Please list all medications that you are currently taking:

DRUG NAME, Strength	HOW OFTEN	PHYSICIAN	DRUG NAME, Strength	HOW OFTEN	PHYSICIAN

Please list all 'over-the-counter' drugs, vitamins, and herbal remedies:

Please list all Medications you have already tried for pain relief:

DRUG NAME, Strength	HOW OFTEN	DRUG NAME, Strength	HOW OFTEN

ALLERGIES:

Please list any allergies you have:

TO MEDICATIONS:	TO FOODS:	ENVIRONMENTAL:
☐ NO ALLERGIES		

FAMILY MEDICAL HISTORY;

Check any of the following conditions that immediate FAMILY MEMBERS have:
Please list who…mother, father, grandparents, children, siblings, etc.

- ☐ Arthritis:_____
- ☐ Bleeding Disorders:_____
- ☐ Cancer:_____
- ☐ Diabetes:_____
- ☐ Heart Disease:_____
- ☐ High Blood Pressure:_____
- ☐ Kidney Disease:_____
- ☐ Memory Problems:_____
- ☐ Mental Illness:_____
- ☐ Multiple Sclerosis:_____
- ☐ Parkinson's Disease:_____
- ☐ Seizures:_____
- ☐ Stroke:_____
- ☐ Thyroid Disease:_____

REPRODUCTIVE STATUS: *Please Circle One*

Pre-menopausal Peri-menopausal Post-menopausal

SOCIAL HISTORY:

Marital Status: (*Circle One*) Married Divorced Single Widowed

Do you exercise: (*Circle One*) None 1 to 3 times per week 4 or more times per week

Occupation:_____

Smoking: None Packs per day_____ Number of years_____

Alcohol: None Drinks per day____ Drinks per week_____

Drug Abuse (past or present/ illicit or prescription):_____

Victim of Abuse (past or present): (*Circle One*) None Physical Emotional Sexual

HISTORY:

Pain/Chief Complaint:_____

_____

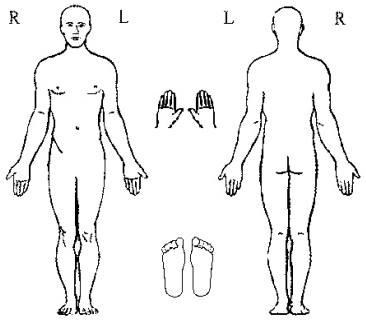
Referring Physician:_____

How long have you had this pain?_____

Do you believe this is the result of a specific event? Explain_____

_____

Where is it located: (*shade diagram, mark worst spot(s) with an* X)



How Would You Describe Your Pain? (*Circle all that apply*)

Aching	Penetrating	Stabbing	Tender	Miserable	Twisting	Tiring
Burning	Pressure	Throbbing	Nagging	Gnawing	Unbearable	Dull
Numb	Sharp	Shooting	Shocking	Tingling		

Other: _____

Has your pain changed in intensity and/or character within the last few weeks?___YES___NO

If yes, describe:_____

_____

Pain Scale:

Over the last week, please rate your…

	None										*Worst*
Worst Pain:	0	1	2	3	4	5	6	7	8	9	10
Least Pain:	0	1	2	3	4	5	6	7	8	9	10
Usually:	0	1	2	3	4	5	6	7	8	9	10
Right Now:	0	1	2	3	4	5	6	7	8	9	10
Acceptable Level:	0	1	2	3	4	5	6	7	8	9	10

How much relief have pain treatments and medicines provided for you *in the past week*?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

No relief *Complete Relief*

What makes the Pain Better? (*Circle all that apply*)

Heat Sitting Walking Resting in Bed Medications

Cold Standing Massage Other: _____

What makes the Pain Worse? (*Circle all that apply*)

Heat Sitting Walking Standing Activity Coughing

Cold Vomiting Being Still Having a BM

Other: _____

PLEASE MARK PROCEDURES YOU HAVE HAD FOR THIS PAIN PROBLEM.
INCLUDE DATES AND RESULTS:

	TREATMENT DATE	PAIN RELIEF Yes	No	RESULTS
	Nerve Block			
	Epidural Steroids			
	Physical Therapy			
	Traction			
	Chiropractor			
	Psychologist			
	Hypnosis, Biofeedback			
	Comprehensive Pain Center			
	TENS Unit			

WHAT DIAGNOSTIC TESTS HAVE YOU HAD?
PLEASE INDICATE WHEN AND WHERE THEY WERE DONE.

TEST	DATE	LOCATION
X-ray		
EMG		
CT Scan		
Myelogram		
Discogram		
MRI Scan		

Review of Systems

PLEASE CIRCLE ALL OF THE FOLLOWING THAT APPLIES TO YOU *NOW*

Constitutional:	Weight gain, weight loss, change in appetite, loss of appetite, night sweats, fever chills, fatigue, body aches
Eyes:	Eye pain, impaired vision, changes in vision, transient visual loss
HENT:	Sinus pain, nose bleeding, neck stiffness, neck pain, neck lumps or masses, hearing loss, ear pain, dental problems, mouth sores, sore throat, hoarseness, difficulty swallowing, snoring
Breasts:	Tenderness, swelling, lumps, nipple discharge
Cardiovascular:	Chest pain, irregular heartbeats, cardiac murmurs, blacking out or fainting, swelling of the feet or ankles, shortness of breath with exertion, shortness of breath at night, cold/blue extremities
Respiratory:	Shortness of breath, wheezing, hoarseness, non-productive cough, productive cough
Gastrointestinal:	Nausea, vomiting, diarrhea, constipation, reflux/heartburn, abdominal pain, jaundice stools, hemorrhoids
Genitourinary:	Frequent urination, irregular menses, possible pregnancy, difficulty urinating, incontinence, sexual dysfunction
Integument:	Rash, itching, new lesions
Neurologic:	Speech difficulties, seizures, falls, head injuries, change in alertness, numbness, loss of consciousness, weakness in limbs, difficulty walking, strokes, muscle twitching, tingling
Musculoskeletal:	Joint pain, joint swelling, muscle pain, limitation of motion, muscular weakness, muscle cramps, back pain, stiffness, back surgery
Endocrine:	loss of hair, cold intolerance, heat intolerance, increased urination decreased sex drive, increased appetite, increased fatigue, increased thirst
Psychiatric:	Anxiety, depression, difficulty sleeping, suicidal thoughts, homicidal thoughts
Heme-Lymph:	Easy bleeding, easy bruising, lymph node enlargement or tenderness, history of blood transfusions, hepatitis, HIV