Institute for Pain Relief

Patient Information Form

Patient Name:_____

Height:_____ Weight:_____ Referring Doctor:_____

If your visit is due to an accident, continue below. If not, please sign below and continue to the next page.

Type of Accident: Auto Workers Comp

Other (please specify):_____

Date of Injury:_____ Phone:_____

Attorney's Name:_____ Fax:_____

Case Manager:_____

Address:_____

Accident Insurance Information:_____

Primary Insurance Company:_____ ID/Claim Number:_____

Phone:_____ Fax:_____

Address:_____

Secondary Insurance Company (if applicable):_____

ID/Claim Number:_____ Phone:_____

Address:_____ Fax:_____

I hereby authorize my insurance benefits to be paid directly to the physician and acknowledge that I am financially responsible for any unpaid balances. I also authorize release to appropriate insurance companies and attorneys of medical information related to the services described.

SIGNATURE:_____ DATE:_____

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120 Carnie Blvd, Ste. 4
Voorhees, NJ 08043

1000 Atlantic Ave.
Camden, NJ 081

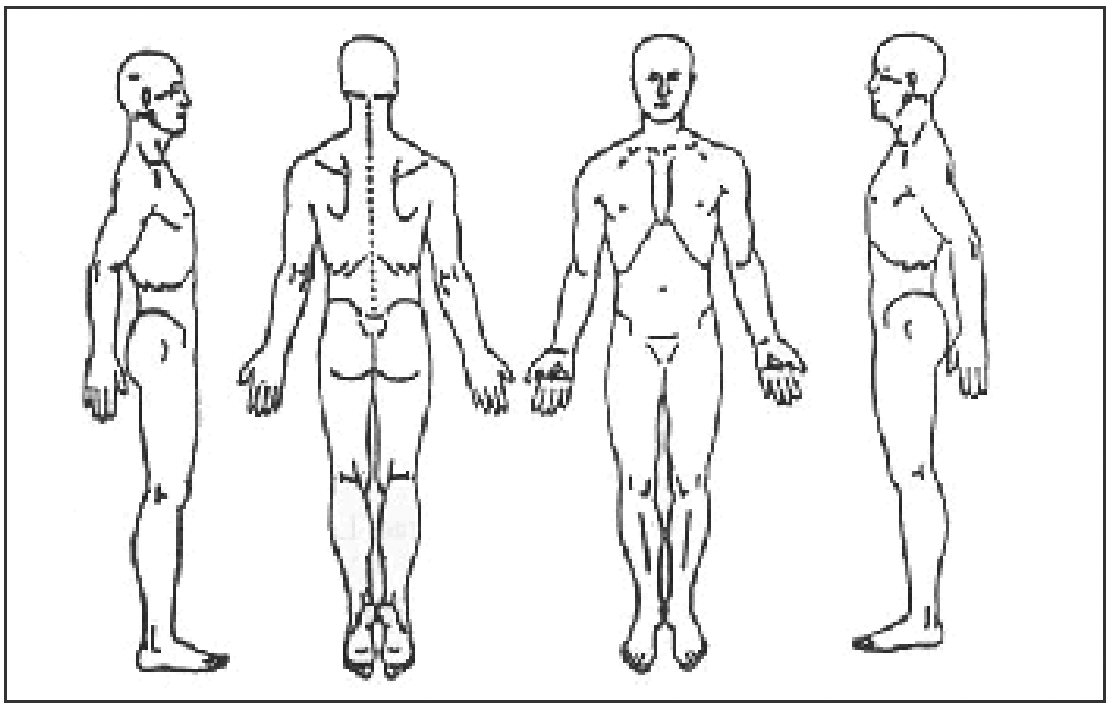
318 White Horse Pike
Haddon Heights, NJ

378 S. White Horse Pike
West Berlin, NJ 08091

Pain History

Use the diagram and symbols to indicate where your pain is.

Ache: AAA Burning: XXX Numbness: OOO Pins/Needles: …. Stabbing: ////



When did you symptoms begin? _____

Did they begin gradually or suddenly?_____

What were you doing? Bending Twisting Pushing/Pulling Lifting Fall Accident

Other: _____

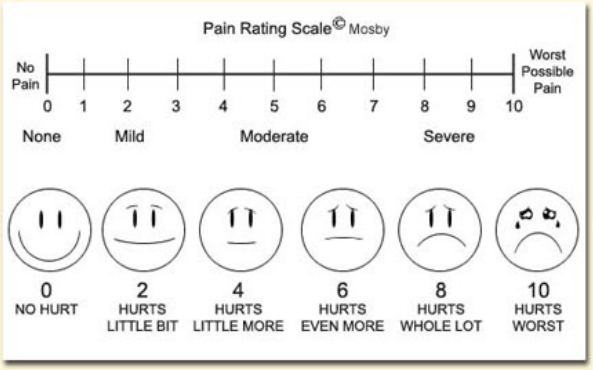
Are your symptoms getting better or worse? _____

Did you have these symptoms before? _____

If your pain is due to an injury, briefly describe the events that led to the injury.

Where were you (town and street)?_____
Passenger or driver? _____ What were you driving?
Date and time of day: _____ Weather:
Who else was involved? _____
Were you seat belted? _____ Did the airbags deploy? _____
Type of vehicle and related damage:_____
How fast were you traveling? _____
What do you remember before and after the accident?_____

On a scale of 0 – 10, how bad is your pain?



What does your pain feel like?

Sharp Dull Aching Stabbing Crushing Burning Throbbing

Other:_____

Is your pain constant or intermittent?_____

What associated symptoms do you have?

Numbness Tingling Weakness Fevers Chills Falls Bowel bladder changes

Other: _____

Please circle the activities that make your pain worse and <u>underline</u> those that make you pain better.

Coughing/Sneezing	Sitting
Bending Forward	Overhead Reaching
Straining	Lifting
Bending Backward	Squatting
Standing	Pushing/Pulling
Lying on Back	Kneeling
Walking Lying on Stomach	Driving

Other:_____

Previous Treatments:

Indicate if you had any of the following treatments and the amount and duration of pain relief.

Treatment When Relief (Y / N)

Acupuncture_____

Physical Therapy_____

Chiropractic (with whom)_____

Psychotherapy_____

TENS unit _____

Medications _____

Injections (Nerve blocks)_____

Surgery _____

Previous tests and treating physicians:

Physicians:_____

X-ray:_____

CAT Scan: _____

MRI:_____

EMG/Nerve Conduction Study:_____

Bone Scan:_____

Myelogram:_____

Discogram:_____

Past History

Please list your medical problems:_____

_____

_____

Please list all hospitalizations: **Reason**

_____ _____

_____ _____

_____ _____

Please list past surgeries: **When**

_____ _____

_____ _____

Please list any allergies to medications or contrast material:

_____

_____

_____

Please list all your medications with dosage:

_____

_____

Please list any accident history: **When**

_____ _____

_____ _____

Please list any psychiatric illnesses:

_____

_____

Please list medical problems in family members:

Relationship Disease

_____

_____

Social History:

Marital Status: Single Married Divorced Separated Widowed

Number of Children:_____ Number of persons living in household:_____

What is your occupation?_____

How many hours do you work a week?_____

Do you:

Smoke Cigarettes _____Yes ____No How Much?_____ Packs / day

Alcoholic Beverages _____ Yes ____No How Much?_____ Drinks/day

Recreational Drugs _____Yes ____No What Kind _____ How Much?_____

Highest grade level completed: (circle one) 1 2 3 4 5 6 7 8 9 10 11 12 College Other

Are you in any **litigation** concerning your pain condition? _____Yes _____No

If yes, please explain.

_____

How often have you had to go to the Emergency Room concerning pain in the last year?

_____

Are you **disabled** and receiving benefits? _____Yes _____No

Have you applied for disability? _____Yes _____No

Are you working currently? _____Yes _____No

Occupation_____

If Unemployed, for how long? _____ Is this due to Pain? _____Yes ____No

Is your Pain due to a **work-related** injury? If yes please explain. _____

_____

What is your **goal** for your treatment?

_____

Pain level goal (What number do you like your pain to be from 0-10)

_____

Other goal (please specify)

_____

Psychological History

How do you feel? Please circle all that apply. Sad Depressed Happy

Other:_____.

If you feel depressed, how much is Pain responsible for your depression? _____%

Have you ever had thoughts of committing suicide? _____Yes _____No

If yes, please describe.

_____

_____

REVIEW OF SYSTEM: Please circle any of the following symptoms you are experiencing.

General:	Fever	Weight Loss	Weight Gain	Night Sweats	Chills	Dizziness
Skin:	Bruises	Itching	Rash			
Hair:	Hair loss	Excessive hair growth				
Eyes:	Vision changes		Discharge	Burning	Redness	
Ears:	Pain	Discharge	Hearing loss			
Mouth:	Soreness	Toothache	Sores on lips or gums			
Neck:	Swelling	Stiffness	Restricted movement			
Nose:	Discharge Bleeding					
Throat:	Hoarseness		Soreness	Itching	Voice change	
Breasts:	Swelling		Lumps	Pain	Tenderness	
Chest:	Pain	Coughing	Shortness of breath		Wheezing	
Heart:	Fluttering	Skipping	Pounding			
Stomach:	Nausea	Vomiting	Diarrhea		Constipation	
Urinary:	Blood in urine		Frequent Urination		Burning while urinating	
Bowel:	Loss of control					
Bladder:	Loss of control		Hesitancy		Frequency	
Psychiatry:	Depression	Anxiety	Suicidal ideas	Memory loss	Insomnia	
Muscle:	Soreness	Fractures	Sprain	Swelling	Stiffness	
CNS:	Seizures	Weakness	Numbness	Tingling	Falls	Dizziness
Head:	Headaches	Dizziness	Loss of consciousness		Trauma	
Sexual:	Impotency	Difficulty with erection		Loss of interest		
Glands:	Swollen lymph glands					

Reviewed:

Physician: _____ **Date:** _____