In Touch Adult Health NP PC
Specializing in Pain Management

Debbra L Hadden MSN, ANP-C
Deborah L Dzielski MSN, ANP-C

New Patient Paperwork

Today's Date _____

Your Name _____ Date of Birth _____

Email _____ Phone _____

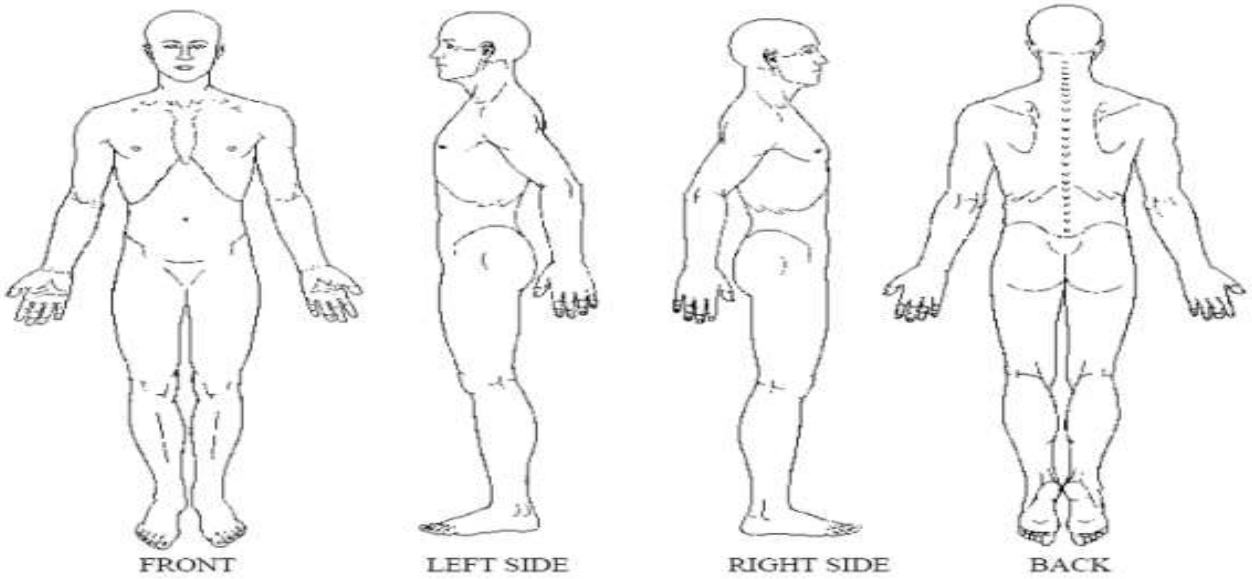
Emergency Contact Name/Relationship _____

Who is your Primary Care Provider (PCP)? _____

Were you referred to our clinic by another physician? Name _____

Onset of Symptoms and Reason for Visit Today

Use the diagram below to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms: **"N"**umbness **"P"**ins and Needles **"A"**ching **"S"**tabbing **"B"**urning



What is your current pain level **right now**? _____ What is your **worst** level of pain level? _____

Where is your worst area of pain located? _____

Does the pain radiate? If yes, where? _____

Please list additional areas of pain _____

When did this pain begin? _____

What caused your current pain or injury? _____

Was the pain or injury due to a motor vehicle accident or personal injury? ❑ Yes ❑ No

How did your current pain episode begin? ❑ Gradually ❑ Suddenly

Since your pain began, has your pain ❑ Increased ❑ Decreased ❑ Stayed the Same

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

When is your pain at its worst? ❑ Mornings ❑ During the Day ❑ Evenings ❑ Middle of Night

Check all that describe your pain **TODAY** -

❑ Aching	❑ Hot/Burning	❑ Shooting	❑ Stabbing/Sharp	❑ Tiring/Exhausting
❑ Cramping	❑ Numb	❑ Spasming	❑ Throbbing	
❑ Dull	❑ Shock-like	❑ Squeezing	❑ Tingling/Pins and Needles	

Diagnostic Tests & Imaging - Mark all of the following tests you have had that are related to your current pain:

❑ MRI of the _____ Date: _____ Facility: _____

❑ X-ray of the _____ Date: _____ Facility: _____

❑ CT scan of the _____ Date: _____ Facility: _____

❑ EMG/NCV study _____ Date: _____ Facility: _____

❑ Other _____

❑ **I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS**

Pain Treatment History - Mark all of the following pain treatments you have undergone **PRIOR** to today's visit:

Treatment	No Relief	Moderate Relief	Excellent Relief
❑ Biofeedback	❑	❑	❑
❑ Bracing	❑	❑	❑
❑ Chiropractic	❑	❑	❑
❑ Decompression Therapy	❑	❑	❑
❑ Epidural Steroid Injection	❑	❑	❑
❑ Home Exercise Program	❑	❑	❑
❑ Medial Branch Blocks or Facet Injections	❑	❑	❑
❑ Medications, please check which ones below -			
❑ Topical Cream	❑	❑	❑
❑ Anti-inflammatories	❑	❑	❑
❑ Muscle Relaxants	❑	❑	❑
❑ Nerve Pain Medications	❑	❑	❑
❑ Physical Therapy, how many sessions _____	❑	❑	❑
❑ Radiofrequency Ablation	❑	❑	❑
❑ Rest	❑	❑	❑
❑ Spine Surgery	❑	❑	❑
❑ Spinal Column Stimulator ❑ Trial ❑ Permanent	❑	❑	❑
❑ TENS Unit	❑	❑	❑
❑ Trigger Point Injections	❑	❑	❑
❑ Other Treatments: _____			

❑ **I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS**

Other Physicians you have seen to treat your pain

❑ Acupuncturist ❑ Neurosurgeon ❑ Orthopedic Surgeon ❑ Pain Physician ❑ Physical Therapist
❑ Primary Care Provider ❑ Psychiatrist/Psychologist ❑ Rheumatologist ❑ Neurologist
❑ Other_____

Factors that Affect your Pain

	Increases Pain	Decreases Pain	No Change
❑ Bending Backward	❑	❑	❑
❑ Bending Forward	❑	❑	❑
❑ Changes in Weather	❑	❑	❑
❑ Climbing Stairs	❑	❑	❑
❑ Coughing/Sneezing	❑	❑	❑
❑ Driving	❑	❑	❑
❑ Lifting Objects	❑	❑	❑
❑ Looking Forward	❑	❑	❑
❑ Looking Downward	❑	❑	❑
❑ Looking Side to Side	❑	❑	❑
❑ Rising from a Seated Position	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Walking	❑	❑	❑

What other factors worsen or affect your pain that is not listed above? _____

_____

Current Medications

Are taking a **prescribed blood-thinner or aspirin**, if so, which one? _____

Name/phone number of the doctor that prescribes your blood thinner _____

Please list **ALL** medications you are currently taking. Attach an additional sheet if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Activity

How many days a week do you exercise? _____ Type of Exercise: ❑ Bicycle ❑ Cardio ❑ Strength

❑ Swimming ❑ Walking ❑ Other _____

Have you had two or more falls in the past year? ❑ Yes ❑ No

Allergies - Please list all allergies that you have:

Medication Name that I'm Allergic to:	The Allergic Reaction I have is:
1)_____	_____
2)_____	_____
3)_____	_____
4) _____	_____
5) _____	_____

Are you allergic to any of the following?

Iodine ❑ Yes ❑ No
Tape ❑ Yes ❑ No
Latex ❑ Yes ❑ No Do you require special rescue measures for your latex allergy? ❑ Yes ❑ No

❑ No Known Allergies

Family History - Mark all appropriate diagnoses as they pertain to your **BIOLOGICAL family members only**.

Anxiety/Depression	❑	High Blood Pressure	❑
Arthritis	❑	Kidney Problems	❑
Cancer	❑	Liver Problems	❑
Diabetes	❑	Rheumatoid Arthritis	❑
Headaches	❑	Seizures	❑
Heart Disease/Stroke	❑	Substance Abuse	❑

❑ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY ❑ I AM ADOPTED (No Medical History Available)

Past Surgical History - Please indicate all surgical procedures you have had done in the past, including the date

Abdominal Surgery:
❑ Gallbladder removal _____
❑ Appendectomy _____

Female Surgeries
❑ Caesarean section _____
❑ Hysterectomy _____
❑ Laparoscopy _____
❑ Ovarian _____

Heart Surgery
❑ Valve replacement _____
❑ Aneurysm repair _____
❑ Stent placement _____

Joint Surgery
❑ Shoulder _____
❑ Hip _____
❑ Knee _____

Spine / Back Surgery
❑ Discectomy (levels) _____
❑ Laminectomy _____
❑ Spinal fusion (levels) _____

Other Common Surgeries
❑ Hemorrhoid surgery _____
❑ Hernia repair _____
❑ Thyroidectomy _____
❑ Tonsillectomy _____
❑ Vascular surgery _____

Please list any other surgeries and dates (attach an additional sheet if necessary):

_____
_____
_____

❑ **I HAVE NOT HAD ANY SURGICAL PROCEDURES DONE**

Past Medical History /Problem List - Mark all conditions/diseases that you have been DIAGNOSED with:

Cardiovascular / Hematologic
- ❑ Anemia/Bleeding Disorders
- ❑ Coronary Artery Disease
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ Hypertension
- ❑ High Cholesterol
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker/Defibrillator
- ❑ Poor Circulation
- ❑ Stroke

Gastrointestinal
- ❑ Bowel Incontinence
- ❑ Acid Reflux (GERD)
- ❑ Gastrointestinal Bleeding
- ❑ Constipation

General Medical
- ❑ Cancer – Type _____
- ❑ Diabetes – Type _____
- ❑ HIV / AIDS

Genitourinary/Nephrology
- ❑ Bladder/Kidney Infection(s)
- ❑ Dialysis
- ❑ Kidney Stones
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Urinary Incontinence

Hepatic list active inactive unsure

Hepatitis ❑ A ❑ B ❑ C

❑ active ❑inactive ❑unsure

Head/Eyes/Ears/Nose/Throat
- ❑ Glaucoma
- ❑ Headaches
- ❑ Head Injury
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Migraines

Musculoskeletal
- ❑ Amputation/ Phantom Limb Pain
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Fibromyalgia
- ❑ Joint Injury
- ❑ Osteoarthritis/Osteoporosis
- ❑ Rheumatoid Arthritis
- ❑ Vertebral Compression Fracture

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema / COPD
- ❑ Tuberculosis
- ❑ Valley Fever

Neuropsychological
- ❑ Alzheimer Disease
- ❑ Anxiety/Depression
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Epilepsy
- ❑ Multiple Sclerosis
- ❑ Paralysis
- ❑ Peripheral Neuropathy
- ❑ Schizophrenia
- ❑ CRPS/Reflex Sympathetic Dystrophy

Other Diagnosed Conditions:

_____

_____

_____

_____

_____

❑ **I HAVE NO SIGNIFICANT MEDICAL HISTORY**

Social History

Alcohol Use: ❑ Current Alcoholism ❑ History of Alcoholism ❑ Never Drinks Alcohol ❑ Social Alcohol Use

Smoker or Tobacco Use: ❑ Current User ❑ Former User ❑ Never

Marijuana Use: ❑ Current User ❑ Former User ❑ Never ❑ Medical Marijuana Card Holder

Drug Use:

❑ I Deny Any Illegal Drug Use

❑ I am Currently Using Illegal Drugs, list: _____

❑ I am Currently Using Someone Else's Prescription Medications, list _____

❑ I Formerly Used Illegal Drugs (not currently using); list _____

❑ I Have **Abused** Narcotic or Prescription Medications, list _____

Global Pain Scale Please answer all questions

INSTRUCTIONS: For each question, please indicate your response by circling a number from 0 to 10

YOUR PAIN:	**0 = No Pain**										**10 = Extreme Pain**
During the *past week,* the **best** my pain has been is	0	1	2	3	4	5	6	7	8	9	10
During the *past week*, the **worst** my pain has been is	0	1	2	3	4	5	6	7	8	9	10
During the *past week*, my **average** pain has been	0	1	2	3	4	5	6	7	8	9	10
During the *past 3 months*, my **average** pain has been	0	1	2	3	4	5	6	7	8	9	10

YOUR FEELINGS: During the past week I have felt:	**0 = Strongly Disagree**										**10 = Strongly Agree**
Afraid.....	0	1	2	3	4	5	6	7	8	9	10
Depressed	0	1	2	3	4	5	6	7	8	9	10
Tired	0	1	2	3	4	5	6	7	8	9	10
Anxious	0	1	2	3	4	5	6	7	8	9	10
Stressed.....	0	1	2	3	4	5	6	7	8	9	10

YOUR CLINICAL OUTCOMES: During the past week:	**0 = Strongly Disagree**										**10 = Strongly Agree**
I had trouble sleeping	0	1	2	3	4	5	6	7	8	9	10
I had trouble feeling comfortable 0	1	2	3	4	5	6	7	8	9	10	
I was less independent	0	1	2	3	4	5	6	7	8	9	10
I was unable to work (or perform normal tasks).....	0	1	2	3	4	5	6	7	8	9	10
I needed to take more medication.....0	1	2	3	4	5	6	7	8	9	10	

YOUR ACTIVITIES: During the past week I was NOT able to:	**0 = Strongly Disagree**										**10 = Strongly Agree**
Go to the store	0	1	2	3	4	5	6	7	8	9	10
Do chores in my home.....	0	1	2	3	4	5	6	7	8	9	10
Enjoy my friends and family	0	1	2	3	4	5	6	7	8	9	10
Exercise (including walking).....	0	1	2	3	4	5	6	7	8	9	10
Participate in my favorite hobbies.....	0	1	2	3	4	5	6	7	8	9	10

Review of Systems - Mark all of the following symptoms that you **CURRENTLY** suffer from:

Cardiovascular/Respiratory:
- ❑ Chest Pain
- ❑ Cough
- ❑ Difficulty Breathing
- ❑ Fainting
- ❑ High Blood Pressure
- ❑ Swelling in the Feet

Constitutional:
- ❑ Chills
- ❑ Difficulty Sleeping
- ❑ Fatigue
- ❑ Fevers
- ❑ Night Sweats

Ears/Nose/Throat/Neck:
- ❑ Difficulty Hearing
- ❑ Earaches
- ❑ Hay fever/Allergies
- ❑ Nosebleeds
- ❑ Recurrent Sore Throats
- ❑ Ringing in the Ears
- ❑ Sinus Problems

Eyes: ❑ Recent Visual Changes

Gastrointestinal:
- ❑ Constipation
- ❑ Dark and Tarry Stools
- ❑ Diarrhea
- ❑ Nausea/Vomiting

Genitourinary/Nephrology:
- ❑ Blood in Urine
- ❑ Involuntary Urination
- ❑ Loss of Bowel Control
- ❑ Painful Urination
- ❑ Pelvic Pressure

Musculoskeletal:
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Neck Pain

Neurological:
- ❑ Dizziness
- ❑ Headaches
- ❑ Instability When Walking
- ❑ Numbness/Tingling
- ❑ Weakness

Psychiatric:
- ❑ Anxiety/Stress
- ❑ Depressed Mood
- ❑ Suicidal Thoughts
- ❑ Suicidal Planning

		OFFICE USE ONLY	
	Mark Each that Applies	item Score If **Female**	Item Score if **Male**
Family History of Substance Abuse:			
Alcohol	❑	1	3
Illegal Drugs	❑	2	3
Prescription Drugs	❑	4	4
Personal History of Substance Abuse:			
Alcohol	❑	3	3
Illegal Drugs	❑	4	4
Prescription Drugs	❑	5	5
Your Age (Mark box if 16-45)	❑	1	1
Personal History of Preadolescent Sexual Abuse:	❑	3	0
Personal History of Psychological Disease:			
Attention Deficit Disorder, *OR* Obsessive Compulsive Disorder, *OR* Bipolar, *OR* Schizophrenia	❑	2	2
Depression	❑	1	1
❑ **None of the above apply to me**	**TOTAL**		

Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true. I authorize In Touch Adult Health and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. In the event that I am asked to provide a urine, oral swab and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine, oral swab and/or blood sample as requested. I have the right to refuse specific tests, but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I give my consent for In Touch Adult Health to retrieve and review my medication history. I understand that this will become part of my medical record.

Signed:_____ Date: _____

Patient or Guardian or Patient Representative

Printed Name: _____

1408 Sweethome Road Suite 12
Amherst, NY 14228
phone 716-458-1100
fax 716-458-1101
www.intouchpainmanagement.com