ADVANCE SPINE CARE AND PAIN MANAGEMENT
PAIN FREE, LIVE FREE
2555 East Colorado Blvd. #306 Pasadena, CA 91107

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New Patient Pain History Questionnaires

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

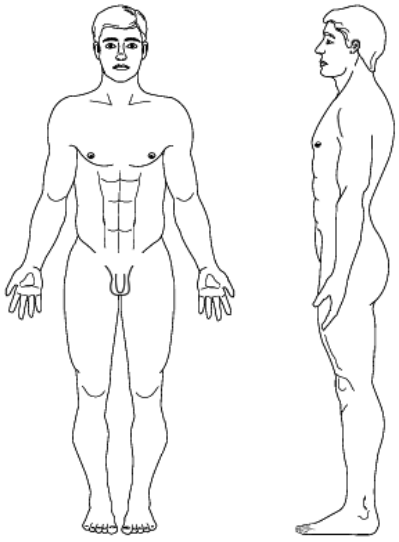
THE REASON(S) FOR THIS CONSULTATION

_____

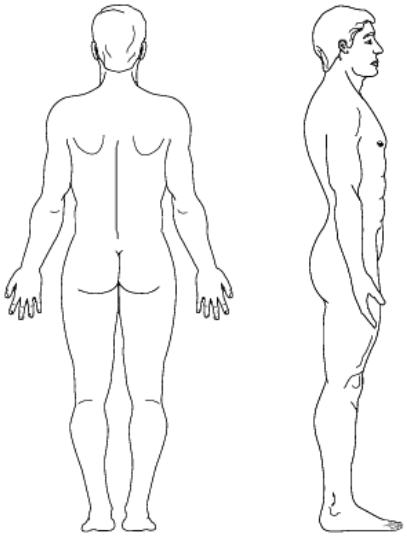
DESCRIPTION OF YOUR SYMPTOMS

1. Location: **How many area(s) do you currently have pain? _____**

If you have more than one pain area, Please mark them with different **symbols (X, ○, or △).**



(Front and Left)



(Back and Right)

2. Quality of Pain (please write down the corresponding number for the description of pain for each pain area**)**

Painful Area	X	○	△
Quality of Pain (Please choose numbers below for different pain area)			

(1) Burning	(5) Cramping	(9) Constant	(13) Tender	(17) Shooting
(2) Dull	(6) Fullness	(10) Crushing	(14) Throbbing	(18) Vague
(3) Pulsating	(7) Radiating	(11) Pressure	(15) Deep aching pain	(19) Other
(4) Stabbing	(8) Stiffness	(12) Sharp	(16) Pressure sensation	

3. Intensity of Pain (Please write the number that correlate to your pain. 0 = no pain, 10 = worst pain imaginable)

Painful Area		X	○	△
Intensity of Pain	Current	_____out of 10	_____out of 10	_____out of 10
	Worst	_____out of 10	_____out of 10	_____out of 10
	Least	_____out of 10	_____out of 10	_____out of 10

4. How long have you had this pain?

Painful Area	X	○	△
Duration of Pain	_____ Days _____ Weeks _____ Months _____ Years	_____ Days _____ Weeks _____ Months _____ Years	_____ Days _____ Weeks _____ Months _____ Years

5. In what time period is your pain WORST?

Painful Area	X	O	△
When is the pain worst?			
Is the pain constant or come-and-go?			

6. What makes your pain WORST?

Painful Area	X	O	△
What positions make pain worst?			
What activities make the pain worst?			
Anything else makes the pain worst?			

7. What RELIEVES your pain?

Painful Area	X	O	△
What positions relieve the pain?			
What activities relieve the pain?			
Anything else relieves the pain?			

Please check of the following treatments you have had including the dates and results if possible

Treatment	When	By Whom	Did this help you with your pain?	
			Yes	No
Nerve Blocks				
Physical Therapy				
Acupuncture				
Chiropractic				
Surgery				

Does the pain travel to other parts of your body? ☐ Yes ☐ No

If yes, where _____

How did the pain start?

_____

How has the pain symptoms progress?

_____

Is your pain caused by injury? ☐ Yes ☐ No Work-related? ☐ Yes ☐ No

If yes, please explain. (Include the date of injury)

_____

Is your case in litigation? ☐ Yes ☐ No Are you ☐ **Right or** ☐ **Left** hand-dominated? (Please choose one)

Do you have the following symptoms <u>RECENTLY?</u> (Please check all that apply)

Weight loss	Weight loss despite no appetite	Frequent fatigue	Fever	Bowel dysfunction	Bladder dysfunction
Change appetite	Weight gain despite no appetite	Gait difficulty	Sleep disturbance	Night sweat	Muscle weakness

MEDICAL HISTORY

Past Medical History (Please check all that apply**)**

Heart attack	Stroke	Asthma	Arthritis	Seizure
Bronchitis	Ulcer	Emphysema	Diabetes	Fainting/Dizziness
Cancer	Urinary	Prostate problem	Headaches	Hepatitis
Kidney problems	High blood pressure	Gastrointestinal problem		
Others				
Any of these conditions?	Hepatitis B	Hepatitis C	HIV/AIDS	
Please answer **yes** or **no**				

Are you currently under treatment by other health care practitioners? ☐ Yes ☐ No | Please explain if **Yes**_____

Psychological History

Do you have any history of depression, anxiety, bipolar? ☐ Yes ☐ No | Please explain if **Yes** _____

Have you ever had suicidal thoughts or suicidal attempts? ☐ Yes ☐ No | Please explain if **Yes**_____

Are you currently under treatment by a psychiatrist or psychologist? ☐ Yes ☐ No | Please explain if **Yes**_____

Past Surgical History

Surgery	**Date**

Family History (Please check all that apply**)**

	Chronic Pain	Alcohol Abuse	Drug Abuse	Others Significant Medical Conditions
Father				
Mother				

Social History (Please check all that apply**)**

	Yes	No	Occasional	Regular	How Much and How Long
Smoking					
Coffee					
Alcohol					
Drugs					

	Employed	Self-employed	Unemployment	If Retired, what's your previous occupation?
Occupation (please describe)				

Marital Status	Single	Married	Divorce	Widowed
Who do you live with?				

MEDICATION

Known Allergies: Are you allergic to any of the following?

			Details	Reaction
Medications	Yes	No		
IV Contrast	Yes	No		
Food	Yes	No		
Latex	Yes	No		

Current Medication (non-pain medications)

Non-Pain Medication	Dose	How often do you take it?

Please list the PAIN medications that you have tried for your pain in the past and their effectiveness

Pain Medication	Dose	How often do you take?	Is it effective? Yes / No?

ALL STUDIES: Please mark any of the following tests you have had to investigate your pain

	Description	Ordered by	Date
X-ray			
EMG/NCT			
Myelogram			
CT Scan			
MRI			

REVIEW OF SYSTEMS

Constitutional (Please check all that apply)

Fevers	Chills	Sweats	Fatigue	Appetite loss	Weight loss

Eye (Please check all that apply)

Vision loss	Light sensitivity	Double vision	Discharge	Blurred vision	Eye pain

ENMT (Please check all that apply)

Earache	Ear discharge	Ringing in the ears	Decreased hearing	Frequent colds	Difficulty swallowing
Nasal congestion	Nosebleeds	Bleeding gums	Hoarseness	Sore throat	

Cardiovascular (Please check all that apply)

Irregular heart beats	Leg cramps with exertion	Swelling of hands or feet	Fatigue	Shortness of breath with exertion	Difficulty breathing at night
Lightheadedness	Discoloration of lips or nails	Recent weight gain	Palpitation	Difficulty breathing while lying down	Chest pain or discomfort

Respiratory (Please check all that apply)

Cough	Wheezing	Chest discomfort	Shortness of breath	Excessive snoring	Coughing up blood
Excessive sputum	Sleep disturbances due to breathing				

Gastrointestinal (Please check all that apply)

Vomiting	Indigestion	Heartburn	Nausea	Change in appetite	Constipation
Excessive gas	Abdominal pain	Abdominal bloating	Hemorrhoids	Diarrhea	Bloody stools
Black or tarry stools	Change in bowel habits				

Musculoskeletal (Please check all that apply)

Joint pain	Back or neck pain	Muscle cramps	Muscle weakness	Muscle aches	Joint stiffness or swelling
Loss of strength					

Skin (Please check all that apply)

Suspicious lesions	Night sweats	Dryness	Itching	Rash	Changes in color of skin
Flushing	Poor wound healing	Excessive perspiration	Change in hair or nail		

Neurologic (Please check all that apply)

Headaches	Poor balance	Seizures	Excessive daytime sleeping	Difficulty with concentration	Sensation of room spinning
Tremors	Weakness or blackouts	Faints or blackouts	Visual disturbances	Difficulty with speaking	Disturbances in coordination
Tingling	Memory loss				

Psychiatric (Please check all that apply)

Anxiety	Nervousness	Depression	Memory change	Thoughts of suicide or violence	Frightening versions or sounds

Endocrine (Please check all that apply)

Weight change	Heat or cold intolerance	Excessive thirst or hunger	Excessive sweating or urination		

Hematologic-lymphatic (Please check all that apply)

Bleeding	Fevers	Skin discoloration	Abnormal bruising	Enlarged lymph nodes	

Allergic-immunologic (Please check all that apply)

Seasonal allergies	Hives or rash	HIV exposure	Persistent infections		

Genitourinary (Please check all that apply)

Frequent urination	Blood in urine	Burning or pain on urinary	Urinary urgency	Foul urinary discharge	Trouble starting urinary stream
Inability to empty bladder	Flank pain	Testicular pain or masses	Genital rashes or sores	Inability to control bladder	Missed periods
Unusual urinary color	Pelvic pain	Excessively heavy periods			

Patient Signature: _____ **Date: _____**

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Patient Registration Form

Patient Personal Information

Name (Last / First / MI) — Date of Birth (MM / DD / YY)

Social Security Number (required) — Gender **M** **F**

California Driver's License (required) — Race (circle) White / Black / Hispanic / Asian / Other

Marital Status (circle) Married / Single / Divorced / Widowed / Separated / Minor Child

Contact Information

Home Address

City — State — Zip Code

Home Phone — Cell Phone

Email

Emergency Contact — Phone — Relationship

Work Information

Status (circle) Employed / Un-Employed / Retired / Full-Time Student / Part-Time Student

Employer — Work Phone

Employer Address

City — State — Zip Code

Health Insurance Information

Primary Insurance — Phone — Co-pay — Deductible

Insured Name — DOB — Relationship to Patient Self Spouse Other

Policy ID# — Group# — Plan#

Effective Date — Expiration

Billing Address

Secondary Insurance — Phone — Co-pay — Deductible

Insured Name — DOB — Relationship to Patient Self Spouse Other

Policy ID# — Group# — Plan#

Effective Date — Expiration

Billing Address

Referral Information

How did you find us Referred by ☐ Primary Care Physician ☐ Specialist ☐ Chiropractor ☐ Attorney

Self-referred from ☐ Friends and Family Members ☐ Internet Search Engine (google, yahoo, etc) ☐ Social Media Page

Referring Physician Phone Fax

Address

Primary Care Physician Phone Fax

Address

Is this a work-related injury or personal injury? ☐ Yes ☐ No
If yes, please answer the following questions:

Workers Compensation (W/C) / Personal Injury (PI) Information

Employer (at time of injury) Occupation

Employment Address

Insurance Company Policy #

Claim/File# Date of Accident

W/C Adjuster Phone Fax

PI Adjuster Phone Fax

Referring Physician Phone Fax

Address

Primary Care Physician Phone Fax

Address

Attorney Information

☐ Workers Compensation Attorney

☐ Personal Injury Attorney

Attorney Name Phone Fax

Address

Signature Patient /Guardian **Date**