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NEW PATIENT EVALUATION FORM

INITIAL PATIENT DATA BASE In order to help us provide the best possible care for you at Great Lakes Pain Specialists we ask for your cooperation in providing the following information. Please bring this form with you to your first appointment.

GENERAL INFORMATION

Patient Name _____ Date _____

Height _____ ft. _____ in. Weight _____ Age _____ Birthdate _____

Blood Pressure _____ Heart Rate _____ Tempature _____

Referred By _____ Family Physician _____

Date of onset pain _____ Cause of pain _____

Was this injury ___ at work ___ auto accident ___other _____

Is there legal action related to your injury? ___ yes ___ no

If yes, please explain. _____

_____

On a scale from 1 to 10 your pain at it's worst _____, at it's best _____, at the moment _____.

0 no hurt

1-2 hurts a little

3-4 hurts a little more

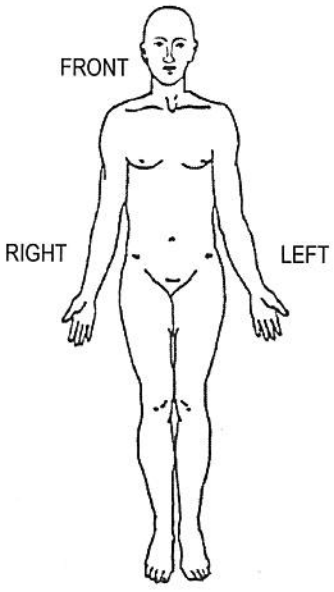
5-6 hurts more

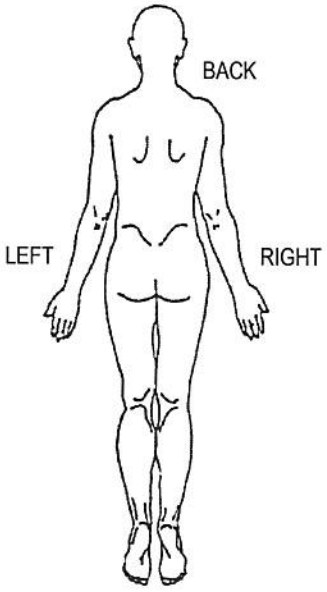
7-8 hurts a lot

9-10 hurts worst

LOCATION OF YOUR PAIN

On the picture color in all your areas of pain.





Associated with (check all that apply)

_____ Fever/Chills
_____ Loss of Control of Bladder
_____ Loss of Control of Bowel
_____ Night Pain
_____ Numbness
_____ Unexplained Weight Loss
How many pounds? _____
_____ Weakness

What area causes most of your pain? _____

_____

_____

_____

Patient Name_____ Birthdate _____

COMPLETE THIS SECTION ONLY IF YOU WERE INVOLVED IN AN AUTOMOBILE ACCIDENT

Were you wearing a seat belt? ___ yes ___ no

Were you the driver? ___ yes ___ no

Were you the passenger? ___ yes ___ no

Did you lose consciousness? ___ yes ___ no

If yes, for how long? _____

Briefly describe the accident. _____

_____

_____

_____

How much damage was done to your vehicle? $ _____

How long after the accident did the pain begin? _____

Have you experience pain in the same area previous to this accident? ___yes ___ no

If yes, please explain. _____

_____

COMPLETE THIS SECTION IF YOU WERE INVOLVED IN A WORK INJURY

Describe injury _____

_____

_____

How long after the incident did your pain occur? _____

_____

When did you first seek medical attention? _____

_____

Have you had pain in the same area prior to your work injury? ___ yes ___no

If yes, please explain. _____

_____

Is your work injury through your current employer? ___ yes ___ no

If it is not through your current employer please list the name of the employer that it is through along with a phone number.

Employer's Name _____

Employer's Phone _____

SYMPTOMS

The questions below refer only to the area of pain that you are coming to our clinic for at this time.

Check the boxes that best describe what your pain feels like. ___ aching ___ burning ___ cramping ___ deep

___ heaviness ___ numb ___ pressure ___ stabbing ___ sharp ___ shooting ___ tender ___ tingling ___ throbbing

Which word(s) best describe the pattern of pain? ___ continuous ___comes and goes

What makes your pain worse? ___ bending ___ coughing ___ driving ___ lifting ___lying down ___ sitting

___ sneezing ___ standing ___ twisting ___walking ___ other, explain _____

What makes your pain better? ___ bending ___ ice or heat ___ lying down ___ medication ___rest

___ sitting other, specify _____

Does your pain interfere with any of the following? (check all that apply) ___ daily activities ___ sleep ___ work

Does your pain make you... (check all that apply) ___ angry ___ depressed ___ helplessness/hopeless ___ frustrated

Patient Name_____ Birthdate _____

Please check any previous treatments for current pain. ___ biofeedback ___ chiropractor visits ___ counseling

___herbal remedies ___ hypnosis ___ injections ___ medications, list _____

_____

___ physical or occupational therapy ___ tens unit ___ work hardening

List any tests for your pain. ___ blood tests ___ bone scan ___ct scan ___emg ___mri ___ myelogram ___ x-ray

Please bring current imaging studies to your appointment.

PAST MEDICAL HISTORY

Please check all that apply.

___ aneurysm	___ diabetes	___ high cholesterol	___ reflux	___ thyroid
___ asthma	___ fibromyalgia	___ hiv or aids	___ respiratory	___ ulcer
___ bleeding disorder	___ heart attack	___ liver	___ rheumatic fever	___ other, please list
___ cancer	___ heart disease	___ kidney disease	___ seizure disorder	_____
___ circulation problem	___ hepatitis	___ murmur	___ stroke	_____
___ defibrillator	___ high blood pressure	___ pacemaker	___ sleep apnea	_____

PAST SURGICAL HISTORY

List all previous surgeries.

Date	Procedure
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Name_____ Birthdate _____

FAMILY HISTORY

Does any of your blood relatives have had any of the following...

DISEASE	RELATIONSHIP TO YOU
Alcoholism	_____
Asthma	_____
Bleeding Disorder	_____
Cancer	_____
Chemical Dependency	_____
Diabetes	_____
Heart Disease, Stroke	_____
High Blood Pressure	_____
Kidney Disease	_____
Neurologic Condition	_____
Other, please list	_____

SOCIAL HISTORY

Educational Background _____

Marital Status ___ divorced ___ married ___ separated ___ single

If you are married, how is your marriage? ___ average ___ fair ___ good ___ poor

How many children do you have? _____

Do you smoke? ___ yes ___ no If yes, number per day. _____ How many years have you smoked? _____

Do you drink alcohol? ___ occasionally ___often ___ never ___ rarely

Do you use recreational drugs? ___ occasionally ___often ___ never ___ rarely

Do you exercise? ___ occasionally ___often ___ never ___ rarely

Patient Name_____ Birthdate _____

WORK HISTORY

Do you work? ___ yes ___ no

If yes, where _____

Occupation _____

How long have you worked at your present job? _____

Do you like your job? ___ yes ___ no

Do you have problems at work? ___ yes ___ no

Do you get along with your co-workers? ___ yes ___ no

Are you on worker's compensation? ___ yes ___ no

Is your employer contesting? ___ yes ___ no

Do you have an attorney? ___ yes ___ no

If yes, attorney's name. _____

When did you last work? _____

Are you currently working? ___ yes ___ no

Do you have work restrictions? ___ yes ___no

Would you return to work with restrictions? ___ yes ___ no

Have you missed work because of your pain? ___ yes ___ no

Do you want to go back to work? ___ yes ___ no

Do you want permanent disability? ___ yes ___ no

PSYCHOSOCIAL HISTORY

Do you have a history of alcohol abuse? ___ yes ___ no

Do you have family members with a history of alcohol abuse? ___ yes ___ no

Do you have a history of drug abuse? ___ yes ___ no

Do you have any immediate family members with a history of drug abuse? ___ yes ___ no

Have you ever been treated for depression? ___ yes ___ no

If yes, when? _____

Have you ever been treated for emotional/behavioral disorder? ___ yes ___ no

Do you have a history of suicidal attempts? ___ yes ___ no

Patient Name_____ Birthdate _____

MEDICATION HISTORY

DRUG ALLERGIES/INTOLERANCE Pharmacy's Phone Number _____

What medications are you allergic to? _____

What mediations do you not tolerate due to side effects?_____

Please list any other allergies that may be pertinent such as latex, ivp dye, etc. _____

_____

Please list the pain mediations your are now taking (include any nonprescription mediations such as tylenol, bengay, etc.).

NAME	**MG'S**	**HOW TAKING?** (example one tablet twice daily)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you taken any medications in the past for your current pain problem even if they didn't work? ___ yes ___ no

If yes, please list (be sure to include any nonprescription medications such as tylenol, bengay, etc.)

NAME	**WHY STOPPED?**
_____	_____
_____	_____
_____	_____

Pharmacy's Name _____ Pharmacy's Phone Number _____

Do you currently take any medications for other health conditions? ___ yes ___ no

If yes, please list (be sure to include eye drops, topical drugs and nonprescription drugs such as vitamins or herbs)

NAME	**MG'S**	**HOW TAKING?** (example one tablet twice daily)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently taking any blood thinning medications? ___ yes ___ no

I, the undersigned, have completed this form to the best of my knowledge. The information that I have provided is true and accurate to the best of my knowledge. I understand that this information is used in the care and treatment plan while under the care of all physicians and staff of Great Lakes Pain Specialists.

Patient/Guardian Signature _____ Date _____

Physician Signature _____ Date _____

Patient Name_____ Birthdate _____

Review the following list and check any that apply to you.

ALLERGIC/IMMUNOLOGIC

___ Environmental Allergies

___ Food Allergies

CARDIOVASCULAR

___ Ankle Swelling

___ Chest Pain

___ Palpitations

___ Shortness of Breath

CONSTITUTIONAL

___ Chills

___ Fatigue

___ Fever

___ Insomnia

___ Weight Gain Amount _____

___ Weight Loss Amount _____

E & ENT

EYES

___ Abnormal Vision

___ Dryness

___ Pain

EARS

___ Dizziness

___ Hearing Loss

___ Tinnitus (ringing in ears)

___ Vertigo (spinning sensation)

NOSE

___ Decreased Smell

___ Epistaxis (nose bleeds)

___ Facial Pain

___ Nasal Congestion

THROAT

___ Dysphagia (difficulty in swallowing)

___ Sore Throat

ENDOCRINOLOGY

___ Diaphoresis (sweating)

___ Intolerance to Cold

___ Intolerance to Heat

GASTROINTESTINAL

___ Abdominal Pain

___ Bloody Stool

___ Constipation

___ Diarrhea

___ Dysphagia (difficulty swallowing)

___ Fecal Incontinence

___ Heartburn

___ Nausea

___ Vomiting

GENITOURINARY

___ Dysuria (pain with urination)

___ Erectile Dysfunction

___ Hematuria (blood in urine)

___ Incontinence

___ Loss of Sexual Drive

___ Urgency

HEMATOLOGIC/LYMPHATIC

___ Easy Bleeding

___ Easy Bruising

___ Lymphadenopathy (swollen glands)

MUSKULOSKELETAL

___ Joint Pain

___ Low Back Pain

___ Mid Back Pain

___ Neck Pain

NEURO/PSYCHIATRIC

___ Anxiety

___ Depression

___ Fainting

___ Headache

___ Incoordination (clumsiness)

___ Memory Loss

___ Numbness

___ Seizures

___ Weakness

RESPIRATORY

___ Chest Pain

___ Cough

___ Hemoptysis (bloody sputum)

___ Shortness of Breath

___ Snoring

___ Sputum

___ Wheezing

VASCULAR

___ Pain or Cramping in Legs