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Patient Registration Information

Demographics:

Date: _____
Name (Last, First, MI): _____
Home Address: _____ City: _____ State: _____ Zip Code: _____
DOB: _____ SSN: _____
Home #: _____ Cell Phone #: _____ Work #: _____ Preferred Contact #: _____
Height: _____ Weight: _____

Marital Status:

- Married
- Single
- Separated
- Widowed
- Divorced

Referring Physician: _____

Preferred Pharmacy (name and address): _____
Pharmacy Tel #: _____

Primary Care Physician (name, phone number): _____
Referring Physician (name, phone number): _____
If not referred by a physician, how did you hear about us? _____

Employment Status:

- Employed
- Unemployed
- Retired
- Disabled

Occupation (if currently or previously employed): _____

Living Arrangement:

- Alone
- With Others, who: _____

Emergency Contact: _____
Relationship to Patient: _____ Phone: _____
Address: _____

Purpose of Visit: _____

Insurance Information:

Primary Insurance: _____
ID #: _____ Group #: _____
Policyholder's Name (if different than patient): _____
Policyholder's Tel #: _____ Policyholder's SSN: _____ Policyholder's DOB: _____
Address: _____
Secondary Insurance: _____
ID #: _____ Group #: _____

Policyholder's Name (if different than patient): _____
 Policyholder's Tel #: _____ Policyholder's SSN: _____ Policyholder's DOB: _____
 Address: _____

Is your pain the result of a work-related injury? • Yes • No If yes, Date of Injury: _____
 Is your pain the result of a motor vehicle accident? • Yes • No If yes, Date of Accident: _____

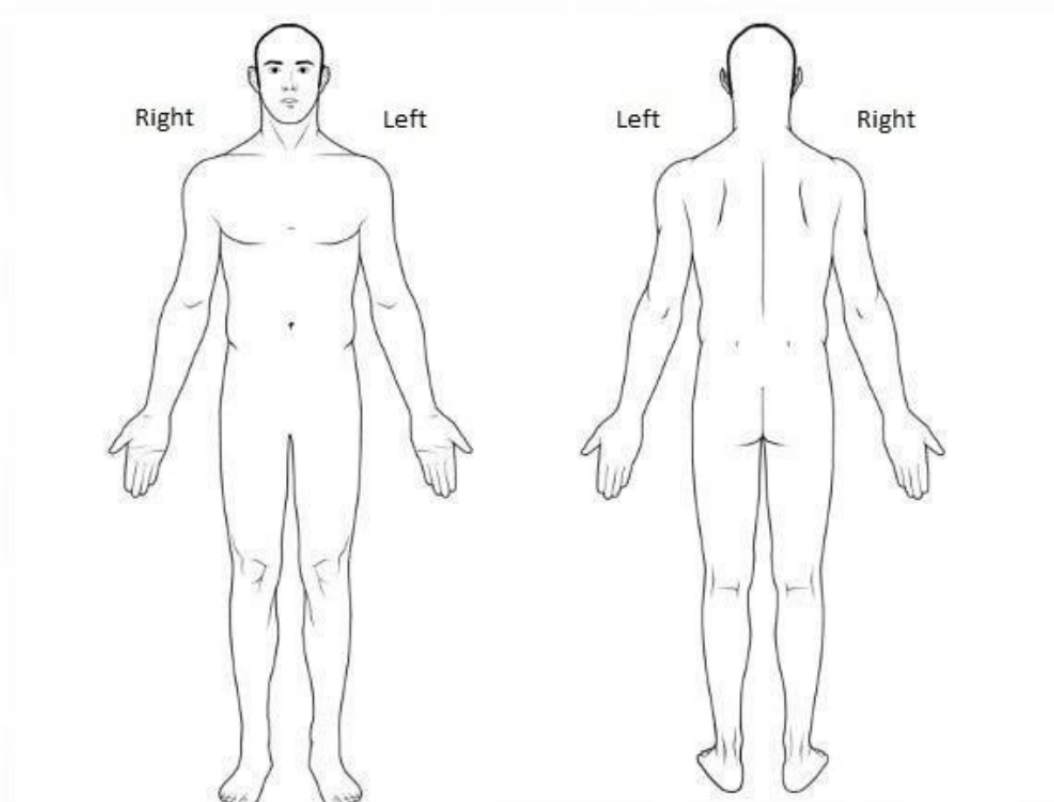
Pain Description:

Location of worst pain: _____
 Date when pain first noticed (month and year): _____
 Was there any event that triggered this pain? _____
 Do you have pain anywhere else in your body? _____

Check the words that best describe your pain:

- Constant
- Cramping
- Dull
- Stabbing
- Throbbing
- Radiating (spreads out from a central area)
- On/off
- Burning
- Sharp
- Shooting

Please shade in all areas of pain in the image below:



Do you have any of the following symptoms?

Weakness Yes No If yes, where? _____
 Numbness Yes No If yes, where? _____

Tingling Yes No If yes, where? _____

Over the past month, please rate your pain on a scale from 0 (no pain) to 10 (most severe pain):

Worst day: _____ Best day: _____ Average day: _____

What makes your pain worse (check all that apply)?

Standing Sitting Lying down Walking Prolonged positions Stress
 Activities: _____ Other: _____

What makes your pain better (check all that apply)?

Standing Sitting Lying down Walking Frequent position changes Rest
 Activities: _____ Other: _____

Has pain affected your: Sleep Yes No How many hours do you sleep at night? _____

Daily Activities Yes No List: _____

Please list major stressors in your life: _____

What are your goals of treatment (e.g. resume work/hobbies, avoid surgery, etc.)? _____

Diagnostic Tests:

Diagnostic Test	Part(s) of body	Date(s)	Location(s)
X-ray			
MRI scan			
CT scan			
EMG/Nerve conduction study			

Pain Treatment History:

Treatment	Details (e.g., body part treated or name of treatment)	Date(s)
Surgery		
Injections		
Physical Therapy		
Chiropractor		
TENS Unit		
Psychological Counseling		

Current Pain Medications: please indicate pain medications that you are **currently** taking:

Medication	Dosage/Frequency

Pain Medication History: please indicate pain medications that you have taken in the **past**:

Medication Reason for discontinuing	Reason for discontinuing

Review of Systems: Indicate if you are currently experiencing any of the following:

General

- Weight gain
- Weight loss
- Fever
- Fatigue

Skin

- Rash
- Itching

Endocrine

- Cold intolerance
- Heat intolerance

Hematologic

- Abnormal bleeding

HEENT

- Headache
- Blurred vision
- Nasal congestion
- Sore throat

Respiratory

- Cough
- Shortness of breath
- Snoring

Cardiovascular

- Chest pain
- Irregular heart beat

Gastrointestinal

- Blood in stool
- Constipation
- Diarrhea
- Nausea/Vomiting

Musculoskeletal

- Joint swelling
- Joint redness
- Joint stiffness
- Extremity swelling

Genitourinary

- Flank pain
- Incontinence
- Painful urination
- Blood in urine

Neurologic

- Numbness/tingling
- Weakness
- Seizures
- Fainting

Dizziness

- Psychiatric
- Anxiety
- Depression
- Mood changes
- Suicidal thoughts

Patient History, Medications and Allergies:

PLEASE NOTE: you may skip this section if you already provided this information on the online patient intake forms

Past Medical History (please list all current/prior diagnoses): _____

Past Surgical History (please list all prior surgeries not related to your current pain): _____

Family History (please list any health issues in your parents and/or siblings): _____

Substance Use:

Alcohol Current: Yes No Drinks per week: _____ Past: Yes No Quit date: _____

Tobacco Current: Yes No Packs per day: _____ How many years: _____

Past: Yes No Quit date: _____ How many years: _____

Marijuana Current: Yes No Past: Yes No

Other Recreational Drugs Type(s): _____

Current: Yes No Past: Yes No

Do you have a history of alcohol or prescription drug abuse? Yes No

If yes, please describe:
