MITRA
Pain Management
your friend against pain

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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 #: _____

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

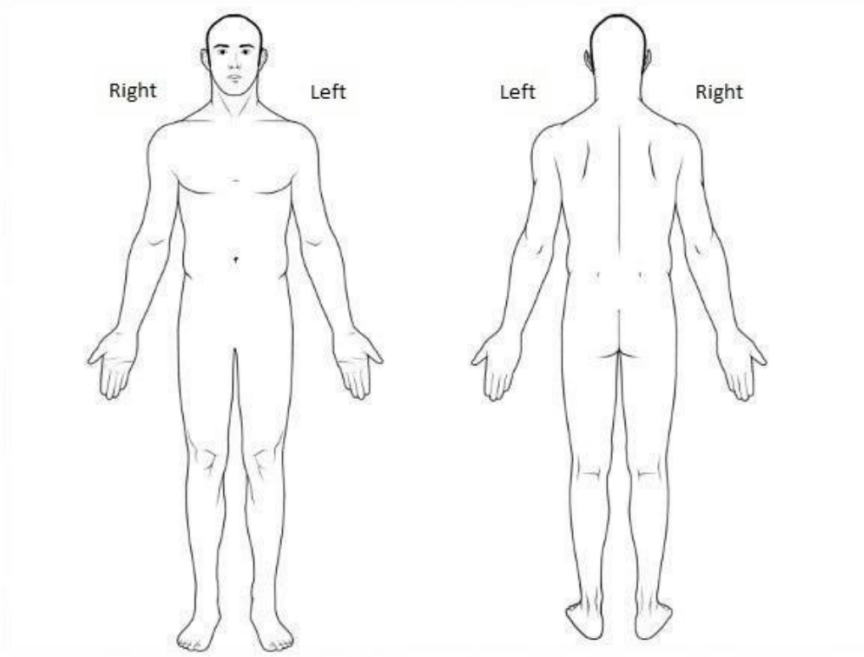
Is your pain the result of a work-related injury? • Yes • No If yes, Date of Injury: _____
Is your pain the result of a motor vehicle accident? • Yes • No If yes, Date of Accident: _____

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

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



Do you have

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: _____

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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

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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:
_____

Allergies (including type of reaction): _____
_____

Medications (other than pain medications):