PATIENT INFORMATION FORM

PATIENT INFORMATION

Today's Date	
Last Name	First Name Middle Initial
Street Address City, State Zip Code	
Home Phone #	( ) Cell Phone # ( ) Work# ( )
Email Address	
Occupation	
Birth Date	mm/dd/yyyy / / Gender □ Male □ Female
Over 18 years of age?	□ YES □ NO (Ages 17 and under require parent/guardian consent)
Treating Physician	Phone #
Emergency Contact	
How did you hear about us?	□ Friend ____________________ □ Internet:________________ Other: __________ □ Mail/Advertisement: Source __________________ □ Sign/Location □ Open House

PAIN HISTORY

1. Please describe the pain/problem that you are currently seeking relief from and how it originated

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2. When did your pain first start and what was the cause? Please be as specific as possible.

Date: Cause: ____

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MEDICAL HISTORY

- □ Cancer
  - □ *No chemotherapy in the past 30 days*
- □ Currently being checked for cancer
- □ Weight loss in the past 6 months
- □ Night sweats/fevers in the past 6 months
- □ Currently taking blood thinner medication
- □ Received a steriod shot in the last 7 days
- □ Currently receiving injections (If yes explain: ________________________________)
- □ Taking medications that may increase my sensitivity to light
- □ Antibiotics recently
- □ Epilespy
- □ Diabetes
- □ Pacemaker/implanted devices
- □ Currently pregnant
- □ **None of the above**

TREATMENT HISTORY

1. On a scale of 1-10 (10 being the worst) what is your pain level today? ____________________
2. Reducing your level of pain is what priority in your life:
   - □ Highest
   - □ Moderate
   - □ Lowest
3. Has any other medical specialist evaluated this condition?

   □ No □ Yes Please list:

Name of specialist	Specialty (if known)	Date of assessment/Treatment Received

4. Have you received any surgeries or medical procedures to this area:

   □ NO □ YES

   If yes explain: *(Include date, type of procedure, and result)*

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MEDICATIONS

What medications are you currently taking for pain?

Drug Name	Dosage	How often?	Date started	Is it Effective?
				□ Yes □ No
				□ Yes □ No
				□ Yes □ No

Other Medicatons:

Drug Name	Dosage	Condition/Reason

Opiate History: Opiate (narcotic) medications include:

Codeine, Morphine, Hydromorphone (Dilaudid), Oxycodone (Percocet, Endocet, Tramadol (Tramacet), and Fentanyl patch, or *** Vicoden (*Must be 24 hours since last dose)**

Please ask if you are not sure if your medication is an opiate.

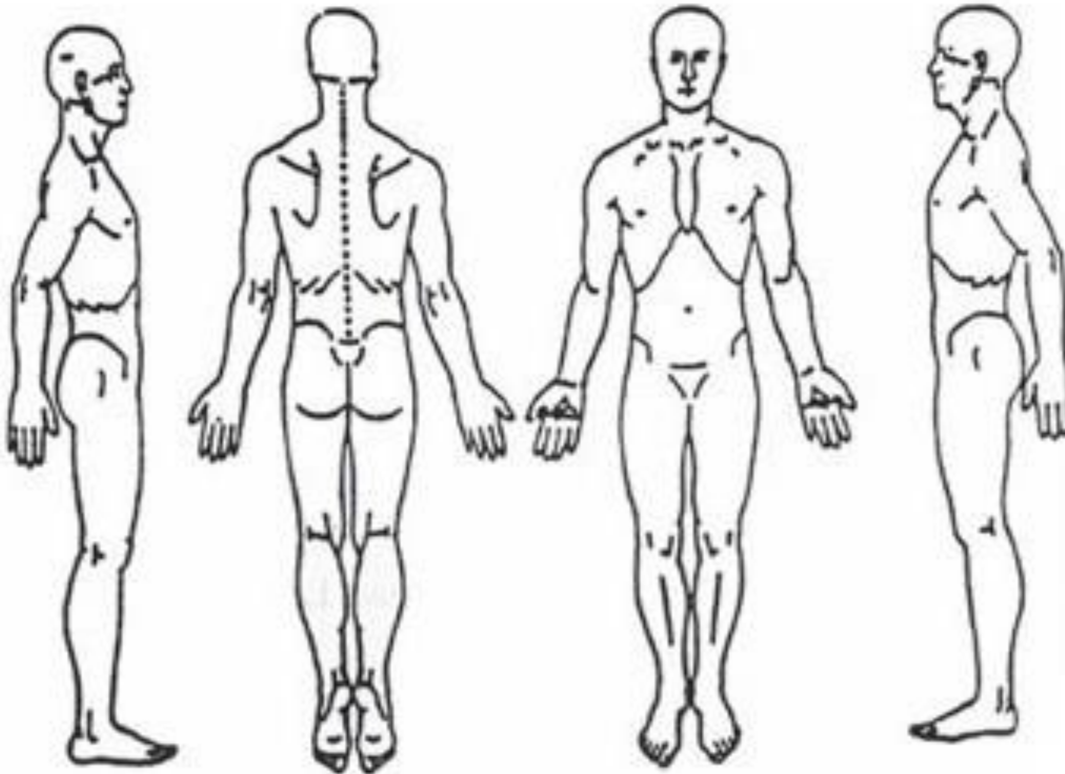
Currently taking an OPIATE based medication:

□ Yes:

Perscription Name: ______________________ Dosage: __________________

□ No

PAIN DIAGRAM: Please shade where you are currently experiencing pain/other symptoms:



Comments:

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I certify that the information that I have given here is complete, true, and accurate to the best of my knowledge.

Print Name ______________________________

Signature ______________________________ Date __________

Dr. Signature ______________________________ Date __________