

Garden State Pain Control Center, PA

PERSONAL DATA:

Name: _____ Age: _____ Ht: _____ Wt: _____

Referring Provider: _____ If MVA Name of Lawyer and Date Of Accident: _____

CHIEF COMPLAINT: (What is the reason for your visit?) _____
_____**HISTORY OF PRESENT PROBLEM:** When did your symptoms begin? _____ Work Injury Auto Accident
Spontaneous Onset Other__ Briefly describe: _____

Ever had such symptoms in the past? Yes No Explain: _____

Past treatments: Physical Therapy Chiropractic Nerve block Epidural injection Biofeedback
Surgery Other: _____ Briefly describe response: _____

Past tests: Labs X-rays MRI EMG Other: _____

Since the onset of your problem, have your symptoms changed? Yes No If so, how? _____
_____Are your symptoms: Constant Sharp Stabbing Burning Throbbing Intermittent Dull
Shooting Aching Other _____

Do you experience: Numbness Tingling Weakness Other: _____

What increases your pain?: Walking Lifting Lying Twisting Sitting Bending Standing
Reaching Other: _____What decreases your pain? Heat Rest Reclining Sitting Walking Ice Activity Standing
Other: _____

Does pain interfere with? Work Daily Activities Social Life Hobbies Relationships

Where would you rate your pain? (mark an "x" on the line)

No pain _____ Worst Imaginable Pain

Medical History

Current Medications	Dosage	Times per Day	Condition Being Treated

VITAMINS/SUPPLEMENTS _____**Patient Initials:** _____

ALLERGIES? (Medication, food/other) _____

MEDICAL HISTORY: Please check all that apply.

Stroke Heart Attack High blood pressure COPD/asthma Blood clots
Coronary artery disease Peripheral vascular disease/circulation problems
Diabetes Kidney disease Hepatitis Thyroid disease Cancer
Coagulation disorder Gastritis/ulcers/reflux Psychiatric treatments HIV/AIDS
Other: _____

PAST SURGERIES OR HOSPITALIZATIONS (and year): _____

SOCIAL HISTORY:

Occupation: _____ Full time Part time Retired Not working

Marital Status: **S** **M** **D** **W** Sep # of Children: _____

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

Tobacco use: No Yes _____ Pack per day _____ Years

Alcohol use: No Yes _____ drinks per week

FAMILY HISTORY- (Please circle yes or no)

Diabetes	Y	N	Cancer	Y	N
High blood pressure	Y	N	Lupus	Y	N
Heart disease	Y	N	Rheumatoid Arthritis	Y	N
Stroke	Y	N	Fibromyalgia	Y	N

AT THE PRESENT TIME ARE YOU EXPERIENCING PROBLEMS WITH?

General: weight loss weight gain appetite changes fever chills night sweats fatigue hard to perform usual activities sleep disturbance

Eyes: vision discharge pain glaucoma double vision tearing blind spots

Ears, Nose, Throat: hearing swallowing nasal congestion hoarseness bleeding dentures

Cardiovascular: chest pain fainting leg swelling irregular heart beats cramping limb discoloration
mitral valve prolapse low blood pressure

Respiratory: shortness of breath cough wheezing/asthma blood in sputum bronchitis

Gastrointestinal: ulcers diarrhea constipation heartburn reflux bloating poor appetite
difficulty swallowing nausea vomiting

Urination: frequent urgent painful change in color decreased stream bloody yeast infection
dribbling incontinence decreased sex drive infrequent urination

Skin: plaques texture or color change lesions rashes dryness itching hair loss nail changes

Endocrine: heat/cold intolerance nervousness lethargy hypoglycemia menopause

Hematological: easy bruising anemia bleeding lymph node enlargement transfusions **Psychiatric:**
depression mania anxiety hallucinations delusions

Neurological: seizures problems w/ balance headache weakness tremor memory paralysis
incoordination numbness tingling speech problems

Musculoskeletal: pain spasm cramps joint swelling redness stiffness muscle loss

Patient Signature: _____

Date: _____