Irvine Spine and Pain Care

15825 Laguna Canyon Rd #105, Irvine CA 92618 Ph: 949.527.1826

Aspire Pain Medical Center

Patient's Name: _____ Date: _____

We are looking forward to providing you with the best care to manage your needs. Please take the time to complete the following questionnaire as accurately and completely as possible. We rely on this information for your personalized care. If you have any questions about any of the following sections, please call our front desk at (714) 622-5057 or (949) 527-1826.

Initial Pain Management Questionnaire

Today's Date: _____ Your best contact phone #:_____

Name: (First, Middle, Last):_____

Date of Birth: _____ Social Security #: _____ Gender : ☐ Male ☐ Female

Address: _____

City _____ State _____ Zip _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ I refuse to answer this question

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Insurance information:

Name of insurance: _____ Insurance phone number _____

Policy #: _____Group ID: _____

Effective date: _____ Co-pay: _____ Deductible: _____

Your Preferred Pharmacy: Name: _____
Address:_____ Phone: (____) _____

City _____ State ____

Emergency Contact: Name: _____ Phone #: _____

How Did You Hear About Us?

_____

Your Referring Physician: (First and last name): _____
Phone: _____

Patient's Name: _____ Date: _____

Please tell us in one sentence why you are here? (ie. Lower back pain.)

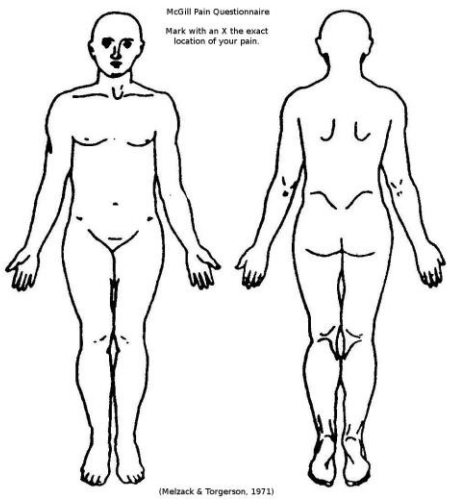
_____

_____

_____

Patient's Name: _____

Please draw in your pain on the following diagram:



How do you rate the intensity of your pain? (0=no pain & 10=worse pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

About how long ago did your pain start?

_____

How did your pain begin? (Accident, Fall, Gradually, Suddenly, etc.)

_____

How frequent is your pain? ☐ Constant or ☐ Intermittent (comes and goes)

Which words describe your pain?

☐ Throbbing ☐ Aching ☐ Sharp ☐ Shooting ☐Dull ☐Tingling ☐ Burning ☐ Pins & Needles

☐ Hot ☐ Cold ☐ Gnawing ☐ Squeezing ☐ Spasming/Cramping ☐ Tender (Sensitive to touch)

Patient's Name: _____ Date: _____

Which activities are you not able to perform due to your pain?

_____

Which activities make your pain worse? (ie. Sitting, standing, walking, etc.)

_____

Which activities make your pain better?

_____

How does your pain affect your sleeping? ☐ I sleep well ☐ I have difficulty falling asleep ☐ I have difficulty maintaining my sleep.

What type of doctors have you seen for the above condition?

☐ physical therapy ☐ chiropractor ☐ acupuncture ☐ neurology ☐ rheumatology ☐ addiction

☐ orthopedic ☐ podiatry ☐ spine surgeon _____ ☐ pain management ☐ other_____

Have you had imaging/diagnostic studies for this condition? (i.e. X-ray, MRI, CT, EMG, sleep, etc.) If so, please provide the following information:

Type of test/study: _____Date: _____
Facility name and phone number where test was performed: _____

What have you done so far for your pain?	Helped	Did not Help
☐ Surgery	☐	☐
☐ Physical Therapy	☐	☐
☐ Acupuncture	☐	☐
☐ Chiropractic treatment	☐	☐
☐ Biofeedback therapy	☐	☐
☐ Massage	☐	☐
☐ Trigger point injections	☐	☐
☐ Epidural Injections	☐	☐
☐ Other injections	☐	☐

☐Other _____

Patient's Name: _____ Date: _____

Do you have allergies to any medication? ☐ No ☐ Yes

If yes, please list medication and the type of reaction:

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

What medications have you tried in the past for your pain?

Medication	Helped	Did not help
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐

What MEDICATIONS do you currently take?

Medication	Dose	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please let us know if you take any of the following "Blood Thinners":

☐ Aspirin ☐ Coumadin/Warfarin ☐Plavix ☐ Aggrenox ☐ Lovenox ☐ Pradaxa

☐ Other blood thinner: _____

PLEASE LIST ALL OF THE SURGERIES you have had in the past:

Surgery	Date (month/year)
_____	_____
_____	_____
_____	_____

Patient's Name: _____ Date: _____

Do you have any serious illness or medical conditions that we should know about? If so, please list: (ie. Diabetes, Hypertension, Hepatitis, etc.)

_____

_____

SOCIAL HISTORY: marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ N/A

Children: Do you have any children? ☐ Yes ☐ No

If so, what year/years were they born? _____

Do you smoke? ☐ Cigarettes ____ ppd ☐ Cigars ☐ Marijuana, license expiration date: _____

*If applicable, please provide a copy of your medical marijuana license to us.

Do you drink alcohol? ☐ No ☐ Yes If yes, how often? ☐ Daily ☐ occasionally ☐ rarely

Drug use history: Have you ever had any problem with addiction or substance abuse? ☐ Yes ☐ No

If yes, please explain:

Education: What is your highest level of education? _____

Employment: Do you work? ☐Yes ☐No If yes, what do you do? _____

How many hours per week? _____ If no, when was the last time you worked? _____What did you do? _____

Pregnancy: Are you or can you be pregnant? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY:

Please list any diseases which have affected your parents , siblings or any close relatives?

_____

Has anyone in your family ever had any complications from surgery or anesthesia? ☐ No ☐ Yes

If yes, please explain : _____

Patient's Name: _____

REVIEW OF SYSTEMS: Have you experienced any of the following symptoms during the last 7 days?

Constitutional: ☐ Fever☐ Chills☐ Night sweats ☐ Fatigue☐ Unexplained weight loss

Head/Eyes/Ears/Nose/Throat: ☐ Visual change or difficulty with vision ☐ Snoring ☐ Hoarseness ☐ Difficulty swallowing ☐ Nose Bleeds ☐ Difficulty hearing or ringing in the ears

Cardiovascular: ☐ History of chest pain or heart attack☐ Swelling in the ankles or feet

Respiratory:☐ Wheezing ☐ Shortness of breath ☐ Cough ☐ Blood in sputum ☐Bronchitis

Gastrointestinal: ☐ Nausea☐ Vomiting ☐ Constipation☐ Diarrhea☐ Black or tarry stools

Genitourinary: ☐ Frequency ☐ History of Jaundice ☐ Difficulty urinating ☐ Blood in urine ☐ Kidney stones ☐Painful Urination ☐ Urinary incontinence

Musculoskeletal: ☐ Back pain☐ Neck Pain☐ Joint swelling☐ Joint pain/Stiffness ☐ Muscle spasm

Neurological: ☐ Difficulty walking ☐ Stroke ☐ Numbness ☐ Tingling ☐ Seizure ☐ loss of consciousness ☐ Weakness ☐Bowel incontinence

Hematological/Lymphatic : ☐ Bleeding Disorder ☐ Node Swelling ☐ Easy Bruising

Psychiatric: ☐ Insomnia ☐Bipolar ☐ Depression ☐ Suicidal Thoughts☐ Anxiety☐ Stressed

Endocrine: ☐ Thyroid Disorder ☐ Diabetes ☐ Adrenal Insufficiency ☐Hypogonadism ☐Menopause

☐ Low testosterone ☐ Grave's disease

Skin: ☐ Rash ☐ Mole changes ☐ Skin Ulcerations

**I certify that the above information is accurate, complete and true. I authorize the care providers at Irvine Spine and Pain Care, Aspire Pain Medical Center, and Orange County Surgery Center to treat my condition as necessary. I agree to actively participate in my care to optimize its effectiveness. I give my consent for the care providers at Aspire Pain Medical Center, Irvine Spine and Pain Care, and Orange County Surgery Center, as well as all affiliated physicians, nursing staff, assistants, and facilities to retrieve and review my medical records. I understand that this will become part of my medical records.

SIGNATURE _____

PRINT NAME _____

DATE _____