UNIVERSITY PAIN MANAGEMENT CENTER
PATIENT INFORMATION

Patient: _____ M F Age:_____
Last Name First Name Middle Initial

Please Circle One
DOB: _____ SSN: _____ Single Married Divorced Widow (er)

Address: _____ Apt_____

City:_____ State:_____ Zip Code: _____

Home Ph #:_____ Cell Ph #:_____ Work Ph#:_____

Patient Employer: _____ Occupation: _____

INSURANCE

Please Circle One
HMO * PPO * POS * EPO * Medical * Medicare Part B * Auto * Worker's Compensation

1) Primary Carrier:_____ ID#:_____ Group:_____

Phone Number:_____ Adjuster: _____ DOI:_____

Name of Guarantor:_____ Relationship: Self Spouse Parent

Guarantor SSN:_____ Guarantor DOB:_____

2) Secondary Carrier: _____ ID#:_____ Group:_____

Name of Guarantor:_____ Relationship: Self Spouse Parent

REFERRAL

Primary Care Physician (PCP): _____ Phone#:_____

How did you learn of our practice? _____

EMERGENCY CONTACT

Name: _____ Phone#:_____

_____ _____
Signature of Patient or Legal Representative Date this form was filled out

UNIVERSITY PAIN MANAGEMENT CENTER

Patient Name: _____ Referring Physician:_____ Date:_____
CC: What problem brings you to University Pain Management Center? _____
_____
_____
Is this an **Automobile Accident?** _____ **If yes,** what date did this happen? _____
H&P: Age:_____ When (roughly what date) did your present pain start? _____
What were you doing when the pain started? _____
_____
Please Circle what best describes the pain: Sharp Stabbing Dull Aching Pressure Burning Other: _____
On a scale of 1 (mild) to 10 (severe) what is your pain level? _____ Please circle the word(s) that best describe when you have the pain: Always Most of the time Several times a day Seldom Morning Daytime Evening Night
Other:_____ Where is the pain primarily located?_____
Does the pain spread to other parts of the body? _____ If so, where?_____
What makes the pain better?_____ What makes the pain worse? _____
Does the Pain limit you from working or doing normal housework? _____ Do you sleep well? _____
Sleeping hours per night?_____ Do you exercise or do stretching exercises? _____
Have you been seen by a psychologist/psychiatrist regarding your pain condition? _____
Are you currently involved in a law suit? _____ If yes, name of attorney: _____
Review of symptoms: Eye: □normal □abnormal If abnormal please state why _____
ENT: □normal □abnormal If abnormal please state why _____
Respiratory: □normal □abnormal If abnormal please state why _____
Cardiovascular: □normal □abnormal If abnormal please state why _____
Endocrine: □normal □abnormal If abnormal please state why _____
Gastrointestinal: □normal □abnormal If abnormal please state why _____
Genitourloigical: □normal □abnormal If abnormal please state why _____
Hematological/Lymphatics: □normal □abnormal If abnormal please state why _____
Skin: □normal □abnormal If abnormal please state why _____
Neurophysical: □normal □abnormal If abnormal please state why _____

Past medical history: Please list all medications that you are currently taking and the doses: _____
_____
_____

Please check if you have any of the following conditions: □Diabetes □High Blood Pressure □Heart Disease
□Lung Disease □Kidney Disease □Liver Disease □Stomach Ulcers or Hiatal Hernia □Bleeding Disorder
□Mental Illness □Stroke □Any other medical conditions: _____
Have you ever been hospitalized? _____ If so, for what? _____
Please list all surgeries with dates:_____
_____

Family History: Please list any medical illness and the ages of the following family members
Father: _____
Mother: _____
Siblings: _____
Social History: Do you smoke? _____ If yes, what do you smoke and how many per day? _____
How long have you been smoking? _____ Alcohol: Do you drink alcoholic beverages? _____
If yes, what type and number of beverages per week?_____
Do you drink to help your pain? _____
Allergies: Do you have any allergies? _____ If yes, please list them and the reaction you have: _____
_____Previo
us Physicians and Tests: Name all the doctors whom you have seen to treat your pain: _____
_____

What tests have you undergone to evaluate your pain (please state approximate date and result):
Xrays:_____ EMG (Electromyelogram): _____
CT Scan:_____ Blood Test: _____
MRI:_____ Other Tests not listed: _____
Myelogram:_____ _____

Using the symbols below, mark the areas on your body where you feel the described sensations. Draw arrows to show if the pain spreads.

Aching
# # #

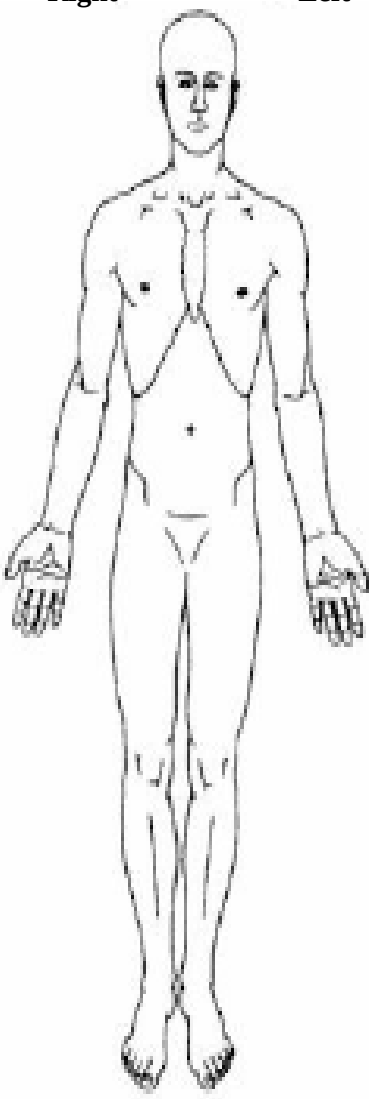
Numbness
= = =

Pins & Needles
> > >

Stabbing
/ / /

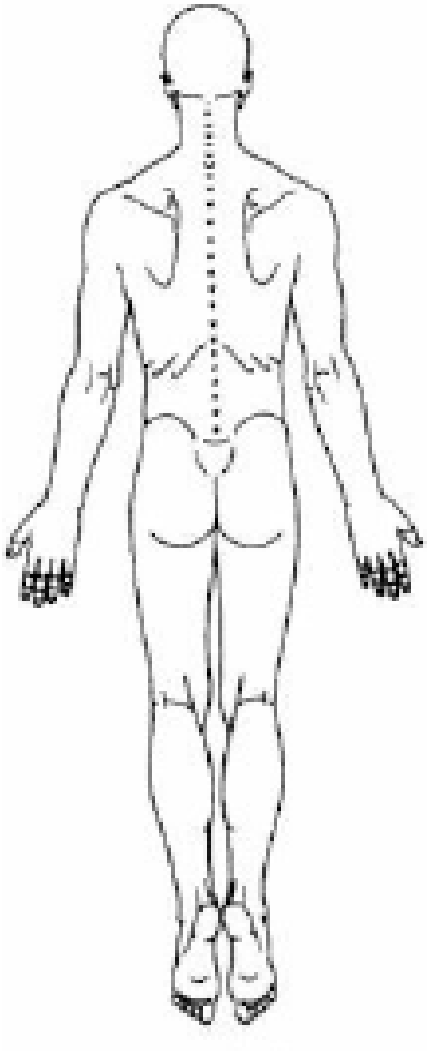
Other
● ● ●

Right **Left**



Front

Left **Right**



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