Patient Information

Title ☐ Dr. ☐ Ms. ☐ Mrs. ☐ Mr.

First Name _____

Middle Name_____

Last Name _____

DOB _____/_____/_____ Sex M F

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Separated ☐ Partnered

Social Security Number _____-_____-_____

Referring Provider _____

Home Address _____

Apt / Suite_____

City_____ Zip _____

Home Phone _____

Cell Phone _____

Work Phone _____

Preferred Contact Phone

☐ Home ☐ Cell ☐ Work

Email _____

*We use your email for communication only. We do not sell to 3rd party vendors. *

Contacts

Employer

Employment Status

☐ Full Time ☐ Unemployed ☐ Self - Employed

☐ Retired ☐ Active Military ☐ Disabled

☐ Full Time Student ☐ Part Time Student

If Employed, Name of employer_____

_____

Address _____

Occupation _____

Emergency Contact Details

Name _____

Relation _____

Phone Number _____

Address _____

Spouse/Parent/ Legal Guardian

Name _____

Relation _____

Phone Number _____

Address _____

Other Information

Preferred Language _____

Race ☐ African American ☐ Hispanic/Latino

☐ White/Caucasian ☐ Other _____

Physicians

*Please list **ALL** specialty physicians that currently treat you as well as your Primary Care Physician (PCP).

Type	**Name**
PCP	_____
_____	_____
_____	_____
_____	_____
_____	_____

Billing Info

Do you currently have insurance?

☐ Yes ☐ No

Will you be a self-pay patient?

☐ Yes ☐ No

University Center for Pain Management
UCPM of knoxville
reclaim relief & function
Practice: (865) 305-8684
Fax: (865) 305-4025
www.ucpmk.com

Name_____ DOB: _____

History of Present Illness

What is the location of your pain?

☐ Neck ☐ Mid Back ☐ Low-Back

Other Area _____

What is the date of injury or onset of pain?

_____/_____/_____

Duration

Tell us how long you have had the pain.

____ # Days ___ # Weeks ___# Months ___# Years

Onset

What were you doing when the pain started?

_____

_____

Frequency of Pain

How often does your pain occour?

☐ Constant ☐ Intermittent ☐ Rare

Quality

What does the pain feel like?

☐ Aching ☐ Cramping ☐ Dull

☐ Hot-Burning ☐ Numbing ☐ Pins and Needles

☐ Pressure Like ☐ Sharp ☐ Shooting

☐ Stabbing ☐ Throbbing ☐ Tingling

History of Present Illness (Continued)

Radiation

Does your pain radiate anywhere else?

_____

_____

Pain Score (0=No Pain , 10=Pain so bad you can not even speak)

Severity of pain at its worst?

0----1----2----3----4-----5-----6----7----8----9----10

Severity of pain at its best?

0----1----2----3----4-----5-----6----7----8----9----10

Severity of average pain?

0----1----2----3----4-----5-----6----7----8----9----10

Severity of pain right now?

0----1----2----3----4-----5-----6----7----8----9----10

Worsening Factors

What makes the pain worse? _____

_____

_____

Relieving Factors

What makes the pain better? _____

_____

_____

History of Present Illness (Continued)

Do you have a history of vertigo or dizziness?

☐ Yes ☐ No

History of falls? ☐ Yes ☐ No

History of Fibromyalgia? _____

Use of supporting devices?

☐None ☐ Cane ☐ Crutches ☐ Walker

Other_____

Functional Assessment

*Previous level of activity*_____

Walk: *How far can you walk before having to stop because of pain?*

☐ 10 feet ☐ 20 feet ☐ 30 feet ☐ 50 feet

☐ 100 feet ☐ 300 feet ☐ More

Focus: *How long can you concentrate on a task before being distracted by your pain?*

☐ 5 mins ☐ 10 mins ☐ 15 mins ☐ 30 mins

☐ 45 mins ☐ 60 mins

Sit: *How long can you sit before having to change positions because of pain?*

☐ 5 mins ☐ 10 mins ☐ 15 mins ☐ 30 mins

☐ 45 mins ☐ 60 mins

Stand: *How long can you stand before having to change positions because of pain?*

☐ 5 mins ☐ 10 mins ☐ 15 mins ☐ 30 mins

☐ 45 mins ☐ 60 mins

What are your functional goals for the next six months? _____

Name_____ DOB: _____

Tests

Have you had any of the following tests to help figure out the causes of your pain? ☐ Yes ☐ No

___ MRI ___ CT-Scan ___ Nerve Conduction Study

___ Xray ___ Other

Body Part, When, Where?

_____

_____

_____

___ **Other** _____

Type of Test _____

Body Part? _____

When? _____ Where? _____

Treatments

Have you ever had physical therapy to treat you pain?

☐ Yes ☐ No If Yes, list what area/location of pain was treated?

_____

_____

Have you ever taken medications for your pain?

☐ Yes ☐ No If Yes, list what medications you have tried.

_____

_____

_____

Treatments (Continued)

Have you ever had **injections/procedure** to treat your pain?

☐ Yes ☐ No If Yes, please describe the type of injection and area it was treating.

_____

_____

_____

_____

_____

Did the prior treatments help you?

☐ No ☐ Yes

When was the prior treatment started?

_____

Comments: _____

_____

Allergies

☐ No Known Drug Allergies

☐ Betadine ☐ Iodine ☐ Latex ☐ Contrast

Please list other allergies to medications below

Other _____Reaction_____

Other _____Reaction_____

Other _____Reaction _____

Other _____Reaction _____

Current Medications

☐ I am currently NOT on ANY medications or Vitamins.

1.Drug Name_____Strength_____

2.Drug Name_____Strength_____
Frequency _____Indication_____

3.Drug Name_____Strength_____
Frequency _____Indication_____

4.Drug Name_____Strength_____
Frequency _____Indication_____

5.Drug Name_____Strength_____
Frequency _____Indication_____

6.Drug Name_____Strength_____
Frequency _____Indication_____

7.Drug Name_____Strength_____
Frequency _____Indication_____

8.Drug Name_____Strength_____
Frequency _____Indication_____

9.Drug Name_____Strength_____
Frequency _____Indication_____

10.Drug Name_____Strength_____
Frequency _____Indication_____

Name_____ DOB: _____

Current Medications (Continued)

11.Drug Name_____Strength_____
Frequency _____Indication_____

12.Drug Name_____Strength_____
Frequency _____Indication_____

13.Drug Name_____Strength_____
Frequency _____Indication_____

14.Drug Name_____Strength_____
Frequency _____Indication_____

15.Drug Name_____Strength_____
Frequency _____Indication_____

16.Drug Name_____Strength_____
Frequency _____Indication_____

17.Drug Name_____Strength_____
Frequency _____Indication_____

18.Drug Name_____Strength_____
Frequency _____Indication_____

19.Drug Name_____Strength_____
Frequency _____Indication_____

20.Drug Name_____Strength_____
Frequency _____Indication_____

21.Drug Name_____Strength_____
Frequency _____Indication_____

22.Drug Name_____Strength_____
Frequency _____Indication_____

Past Medical History

☐ No Known Past Medical History
☐ Diabetes
☐ Bleeding/Clotting Disorder
☐ Arthritis
☐ Stroke
☐ Blood Thinners Why? _____
☐ Cancer Where? _____
☐ Sleep Apnea
☐ Substance Abuse
☐ Other _____
☐ Other_____
☐ Other_____
☐ Other_____
☐ Other_____
☐ Other_____
☐ Other _____
☐ Other_____
☐ Other_____
☐ Other_____
☐ Other_____
☐ Other_____
☐ Other_____
☐ Other_____

Past Surgical History

☐ No Known Past Surgical History
Comment _____

1.Surgery Name _____
When _____ Dr._____

2.Surgery Name _____
When _____ Dr._____

3.Surgery Name _____
When _____ Dr._____

4.Surgery Name _____
When _____ Dr._____

5.Surgery Name _____
When _____ Dr._____

6.Surgery Name _____
When _____ Dr._____

7.Surgery Name _____
When _____ Dr._____

8.Surgery Name _____
When _____ Dr._____

9.Surgery Name _____
When _____ Dr._____

10.Surgery Name _____
When _____ Dr._____

11.Surgery Name _____
When _____ Dr._____

Name_____ DOB: _____

Family History

☐ Non-Contributory Family History

☐ Spine Disease: Relation_____

☐ Cancer: Relation_____

☐ Arthritis: Relation_____

☐ Bleeding Disorders: Relation_____

☐ Substance Abuse: Relation_____

☐ Other _____ Relation_____

☐ Other _____ Relation_____

Comments: _____

Social History

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of Children

_____ Boys _____ Girls

Nature of Exercise:

☐ Walking ☐ Running ☐ Hiking ☐ Weight Lifting

☐ Swimming ☐ Cardio ☐ No Exercise, Sedentary

Other _____

Alcohol Use

Do you drink alcohol?

☐ Yes ☐ No ☐ Quit

If you answered "Yes", what kind?

☐ Beer ☐ Wine ☐ Mixed Drinks ☐ Other ____

Average number of drinks per week? _____

If you quit alcohol use, how long ago ? _____

Comments _____

_____

Tobacco Use

Do you **smoke?** ☐ Never Smoker ☐ Quit ☐ Current Smoker

If you "Quit" smoking, how long ago?_____

If you are a current smoker, how often do you smoke? ☐ Every Day ☐ Some Days ☐ Heavy Tobacco Smoker ☐ Light Tobaco Smoker

Problems with Prescription Drugs

Have you ever abused **prescription drugs?**

☐ Yes ☐ Never ☐ Quit

If Yes, what drug?_____

If Quit, what drug?_____

How long ago did you quit? _____

Problems with Illicit Drugs

Have you ever used **Illicit drugs?**

☐ Yes ☐ Never ☐ Quit

If Yes, what drug(s)?_____

How long ago did you quit? _____

Work History

Highest level of **education?**

☐ Grade School ☐ High School ☐ Some College

☐ College Graduate ☐ Advanced Degree

What is your **work status?**

☐ Full time ☐ Part Time ☐ Unemployed ☐ Retired

If working, what is your job description?

_____

_____

_____

Are you on **Disability?**

☐ Yes ☐ No ☐ Applied

If you are on disability, please tell us why?

_____

How long have you been on disability?

_____

Review of Systems

Have you recently experienced any of the following symptoms? Check yes to those that apply. **Name :_____ DOB_____**

Constitutional Symptoms	
Symptom	**Yes**
Fever	
Chills	
Night Sweats	
Fatigue	
Weight Loss	
Other _____	
☐ ***None of the above***	

Respiratory	
Symptom	**Yes**
Trouble Breathing	
Asthma	
Sputum Production	
Bloody Sputum	
Sleep Apnea	
Wheezing	
Shortness of Breath	
COPD/Emphysema	
Cough	
Coughing up Blood	
Orthopnea	
Respiratory Infections	
Other_____	
☐ ***None of the above***	

Gastrointestinal	
Symptom	**Yes**
Abdomen Pain	
Nausea or Vomiting	
Frequent Diarrhea	
Frequent Constipation	
Stool Incontinence	
Other_____	
☐ ***None of the above***	

Neurological	
Symptom	**Yes**
Seizures	
Vertigo	
Weakness	
Numbness	
Tremors	
Other_____	
☐ ***None of the above***	

Skin	
Symptom	**Yes**
Pruritus	
Sores	
Rashes	
Other_____	
☐ ***None of the above***	

HEENT	
Symptom	**Yes**
Sinus Problems	
Sore Throat	
Tinnitus	
Frequent Nose Bleeds	
Hearing Loss	
Other_____	
☐ ***None of the above***	

Genitourinary	
Symptom	**Yes**
Hesitancy	
Blood in Urine	
Pain on Urination	
Other _____	
☐ ***None of the above***	

Psychiatric	
Symptom	**Yes**
Anxiety	
Alcohol Abuse	
Insomnia	
Depression	
Drug Abuse	
Other_____	
☐ ***None of the above***	

EYES	
Symptom	**Yes**
Blurry Vision	
Eye Pain	
Dry Eyes	
Discharge	
Decreased Vision	
Other _____	
☐ ***None of the above***	

Cardiovascular	
Symptom	**Yes**
Chest Pain	
Pedal Edema	
Can't Lay Flat	
Palpitations	
Syncope (fainting)	
Other_____	
☐ ***None of the above***	

Musculoskeletal	
Symptom	**Yes**
Muscle Pain	
Joint Pain	
NSAID Use	
Muscle Weakness	
Joint Swelling	
Other_____	
☐ ***None of the above***	

Hematologic	
Symptom	**Yes**
Easy Bruising	
Blood Thinners (meds)	
Easy Bleeding	
Blood Clots	
Swollen Lymph Nodes	
Other_____	
☐ ***None of the above***	