UNIFOUR PAIN TREATMENT CENTER
PATIENT DATA FORM

Please complete this form prior to your appointment. Please be as accurate as possible. The information is confidential and will be available to your health care team and their staff only.

PLEASE BRING THIS FORM WITH YOU ON YOUR NEXT VISIT.

Patient Information:

Full Name: _____ Date of Birth: _____

Address: _____ Home Phone: ( ) _____

_____ Work Phone: ( ) _____

May we contact you at work? Yes ( ) No ( )

Email (optional): _____ Cell: ( ) _____

Social Security Number: _____ Sex: Male ( ) Female ( ) **Age:** _____

Contact person in case of emergency: Name: _____

Home Phone: _____

Cell / Work Phone: _____

Spouse's Social Security Number: _____

Spouse's Employer: _____ Spouse's Date of Birth: _____

Approximate distance from your house to our office: _____ miles

How long is your expected travel time to our office? _____

Name, address, and phone of your pharmacy: _____

_____

Insurance Information: ***Please Bring All Insurance Cards With You***

Insurance Company: _____

Certificate No.: _____ Group No.: _____

Insured Name: _____

Relationship to you: ( ) self ( ) spouse ( ) other _____

Additional Insurance: _____

Certificate No.: _____ Group No.: _____

Insured Name: _____

Relationship to you: ( ) self ( ) spouse ( ) other _____

RN Initials: _____

Prior Treatment:

Please list the name, address, and phone of your:

Family Physician or Internist	Referring Doctor (if different)
_____	_____
_____	_____
_____	_____

Below are listed different medical specialties. Indicate if you have seen any of these specialists for your pain condition: (please fill in names that apply)

Specialty	Doctor's Name	Specialty	Doctor's Name
Allergist	_____	Orthopedic Surgeon (bones)	_____
Anesthesiologist	_____	Pain Specialist	_____
Cardiologist (heart)	_____	Pediatrician (children)	_____
Chiropractor	_____	Plastic Surgeon	_____
Dermatologist (skin)	_____	Psychiatrist/Psychologist	_____
Dentist/Oral Surgeon	_____	Physiatrist (rehab)	_____
Ear, Nose, & Throat	_____	Radiation Oncologist	_____
Endocrinologist	_____	Rheumatologist (arthritis)	_____
General/Family Practice	_____		
Internal Medicine (internist)	_____	Physical Therapy Therapist:	_____
Neurologist (nervous system)	_____	Facility:	_____
Neurosurgeon	_____	Acupuncturist	_____
Obstetrician/Gynecologist	_____	Herbalist	_____
Oncologist/Hematologist (cancer/blood)	_____	Other	_____
		No. of emergency room visits re: pain within the last year?	_____
Ophthalmologist (eyes)	_____		

Have you ever been to a **pain clinic** before? If so, please give name, location, and type of therapy performed:

_____

_____

HISTORY OF PRESENT ILLNESS:

When did your pain begin? _____

What part(s) of your body hurts? _____

_____

If multiple areas of pain, which is the worst area? _____

RN Initials: _____

Please describe what happened or exactly how this pain began (if related to an accident, give date & details):
_____
_____

Do you know or have been told what is causing your pain?_____
_____

On the following scale, rate your pain right now: *(circle one)*

PAIN SCALE: 0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

On the following scale, rate your average daily pain: *(circle one)*

PAIN SCALE: 0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

On the following scale, rate you pain at its worst: *(circle one)*

PAIN SCALE: 0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

Describe your pain sensations: *(check all that apply)*

Dull ache	___	Twisting	___	Superficial (on surface)	___
Burning	___	Throbbing	___	Deep	___
Continuous	___	Grinding	___	Stinging	___
Electric shock	___	Pressure	___	Other: _____	
Sharp/stabbing	___	Tearing	___	_____	

What makes your pain BETTER: *(check all that apply)*

Sitting	___	Applying heat	___	Medications	___
Standing	___	Applying cold	___	Nerve blocks	___
Moving around	___	Massage	___	Stretching	___
Lying down	___	Exercise	___	Physical Therapy	___
				Other: _____	
				_____	

What makes your pain WORSE: *(check all that apply)*

Sitting	___	Applying heat	___	Medications	___
Standing	___	Lifting	___	Nerve blocks	___
Moving around	___	Massage	___	Physical therapy	___
Lying down	___	Exercise, bending	___	Other: _____	
Driving	___	Damp weather	___	_____	

What treatment (including medications) has helped your pain the most? _____
_____

RN Initials: _____

PAST MEDICAL HISTORY / REVIEW OF SYSTEMS:

Please indicate if you have or have had any of the following medical conditions: (please answer all)

Cardiovascular:	**YES**		**NO**
Heart attack	_____	When?	_____
Stroke/TIA	_____	When?	_____
High blood pressure	_____		_____
Date of last EKG:	_____		_____
Where performed:	_____		
	_____		
Chest pain/angina	_____		_____
Irregular heart beat	_____		_____

Gastrointestinal:			
Ulcers/gastritis	_____		_____
Frequent constipation	_____		_____
Frequent diarrhea	_____		_____
Freq. heartburn/indigestion	_____		_____
Nausea	_____		_____
Incontinence of stool	_____		_____
Hematologic:			
Immune diseases	_____		_____
Hemophilia	_____		_____
Taking blood thinner	_____	Name:	_____
Frequent nose bleeds	_____		_____
Bleeding problems	_____	Specify:	_____
Genitourinary:			
Kidney function problems	_____		_____
Kidney stones	_____		_____
Problems urinating	_____		_____
Specify type of problem: _____			
Sexual function problems	_____		_____
Musculoskeletal:			
Fibromyalgia	_____		_____
Arthritis	_____		_____
Chronic Fatigue Syndrome	_____		_____
Skin color/temp changes	_____		_____
Constitutional:			
Frequent fevers	_____		_____
Recent weight loss	_____	lbs.	_____
Recent weight gain	_____	lbs.	_____
Frequent night sweats	_____		_____

Respiratory:	**YES**		**NO**	
Asthma	_____		_____	
Smoking now	_____		_____	
# packs per day	_____			
If quit, when? _____	# years smoked ____			
Lung disease	_____	Specify: _____		
Sleep apnea	_____		_____	
Snoring	_____		_____	CPAP? ____
Chronic cough	_____		_____	
Shortness of breath	_____		_____	

Neurological:			
Seizures/epilepsy	_____		_____
Numbness	_____	Where?	_____
Weakness	_____	Where?	_____
Headaches	_____	How often?	_____
Dizziness	_____	How often?	_____
Restless legs	_____		_____
Endocrine:			
Thyroid problems	_____		_____
Diabetes	_____		_____
On insulin?	_____		_____
Liver problems	_____	Specify:	_____
Hepatitis	_____	Type?	_____
Emotional/Psychiatric:			
Depression	_____		_____
Anxiety/panic	_____		_____
Violent behavior	_____		_____
Irritability	_____		_____
Suicidal thoughts	_____		_____
Eyes, Ears, Nose, Throat:			
Visual problems	_____		_____
Hearing loss	_____		_____
Bleeding gums	_____		_____
Problems swallowing	_____		_____

List major diseases / medical illnesses:

_____

_____

_____

Possibility you are pregnant? **( ) yes ( ) no**

RN Initials: _____

Your Height: _____

Weight: _____

On average, how many hours per night do you sleep? _____ hrs.

If you awaken frequently, what is the cause? _____

Have you ever been diagnosed with cancer? ( ) yes ( ) no
If yes, type of cancer: _____

Date of last cancer follow-up: _____ Doctor treating you for cancer: _____

How much alcohol (beer, wine, liquor) do you consume per week? _____ /week

Do you use any street drugs? ( ) yes ( ) no If yes, specify:_____

Have you ever had a problem with drugs or alcohol in the past? ( ) yes ( ) no
If yes, specify: _____

MEDICATIONS:

Please list all your current medications below (include over-the-counter drugs):

Name of Drug & Strength	**Number Taken per Day**	**Prescribing Doctor**

Have you been on any of the following medications for your current pain problem?:
( ) narcotics ( ) tranquilizers ( ) muscle relaxants ( ) anti-inflammatory ( ) steroids

List all things (including medications & tape) that you are **ALLERGIC** or have bad reactions to:

_____ _____
_____ _____
_____ _____

Have you ever had a reaction to intravenous **contrast (dye)** or **iodine**? **( ) yes ( ) no**

Are you allergic to any shellfish? **( ) yes ( ) no**

RN Initials: _____

SURGICAL HISTORY:

Have you ever had surgery to relieve your current pain condition? ( ) yes ( ) no

If yes, indicate surgeon name, location procedure performed at (i.e. hospital name), date, and type of surgery:

_____

_____

If no, have you been told you may need surgery for your current pain problem? ( ) yes ( ) no

List all major surgeries which you have had in the past:

Name of Surgery	Where & Date Performed	Name of Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had a problem with anesthesia? ( ) yes ( ) no
If yes, please specify: _____

SOCIAL HISTORY:

Current Marital Status: Single ( ) Married ( ) Widowed ( ) Divorced ( )

Number of children _____ Ages of children _____ Children living with you _____

Highest level of education completed:
( ) grade school ( ) high school ( ) college/technical ( ) graduate school

Is there pending litigation related to your pain or a previous accident? ( ) yes ( ) no
If yes, your attorney's name, address, and phone: _____

_____

Goals:

Please indicate the types of things you would like to be doing, but cannot because of pain:

_____

_____

_____

Of the things listed above, which one is the most important to you?

_____

Do you believe that 100% pain relief is possible in your condition?
( ) yes ( ) no ( ) don't know

RN Initials: _____

Employment Information:

A. If you are currently **EMPLOYED**, please answer the following:
(if not, skip to section B)

Employer Name and Address: _____

_____

I am employed: ( ) full-time ( ) part-time Average hours worked per week _____

How long have you been with your current employer? _____

Are you currently on Workmen's Compensation? ( ) yes ( ) no

Do you like your job? ( ) All the time ( ) Most of the time ( ) Some of the time
( ) Rarely or not at all

Are your duties at work restricted by your employer currently (e.g. light duty)? ( ) yes ( ) no

Briefly describe what you do at work; include time standing, sitting, lifting and weight of items lifted if applicable:

_____

_____

_____

B. If you are currently **NOT EMPLOYED**, please answer the following:

Have you ever been employed? ( ) yes ( ) no If no, skip to next section.

Last Employer Name and Address: _____

_____

Please state whether ( ) unemployed ( ) disabled ( ) retired How long? _____

If disabled, state reason(s) and physician who authorized disability:

_____

_____

Did you like your job? ( ) All the time ( ) Most of the time ( ) Some of the time
( ) Rarely or not at all

Briefly describe what you did at work, include time standing, sitting, lifting and weight of items lifted if applicable:

_____

_____

_____

RN Initials: _____

Have you stopped working because of your current pain condition? ( ) yes ( ) no

If yes, have you attempted to return to work? ( ) yes ( ) no
If yes, ____ full-time or ____ part-time.

Do you want to return to work? ( ) yes ( ) no

FAMILY HISTORY:

Does any member of your immediate family have a problem with drugs or alcohol?
( ) yes ( ) no If yes, please specify: _____

Do any members of your immediate family have a chronic pain condition?
( ) yes ( ) no If yes, please specify: _____

Does your immediate family have a history of hereditary diseases or other major illness?
( ) yes ( ) no If yes, please list: _____

DIAGNOSTIC STUDIES:

Indicate which of the following studies/tests you have had to work-up your **current pain problem**:

Type of Study (check all that apply)		**Where Performed**	**Approximate Date**
MRI	____	_____	_____
CT scan	____	_____	_____
Myelogram	____	_____	_____
EMG/nerve study	____	_____	_____
Plain x-rays	____	_____	_____
Bone scan	____	_____	_____
Ultrasound	____	_____	_____
Sleep study	____	_____	_____
Blood flow study	____	_____	_____
Stress test/treadmill	____	_____	_____
Cardiac cath	____	_____	_____
Nerve block/steroid inj	____	_____	_____
Other:	____	_____	_____

RN Initials: _____

PLEASE FILL OUT PAIN DIAGRAM AND MEDICATION HISTORY FORM ATTACHED TO THIS PACKET

I give permission to discuss my medications, medical condition, and/or billing issues with (spouse, significant other, family, friends, etc.):

_____

By signing below, I acknowledge that the above information is true and accurate to the best of my knowledge.

Your Signature: _____ Date: _____

RN Signature: _____ Date: _____

Thank you very much for taking time to provide us with this needed information.
If you have any questions, please call (828) 324-4005.

Mark on the drawing the exact spot where your pain is with a solid black dot. If the pain starts at that spot and radiates elsewhere (travels to another part of your body), draw a line from the spot where it starts to where it ends. If it is a whole area that hurts, shade in that area with a pencil.

Next to the places on drawing where you showed the pain, put an "E" if the pain is external (on the outside surface). If the pain is internal (inside the body) mark it with and "I". If the pain is both internal and external, mark "EI".

Mark also "C" for Constant, "O" for Often, or "S" for Seldom depending on how much of the time you experience the pain.