

**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: _____

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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	_____	Physical Therapy Therapist:	_____
Internal Medicine (internist)	_____	Facility:	_____
Neurologist (nervous system)	_____	Acupuncturist	_____
Neurosurgeon	_____	Herbalist	_____
Obstetrician/Gynecologist	_____	Other	_____
Oncologist/Hematologist (cancer/blood)	_____	<i>No. of emergency room visits</i>	_____
Ophthalmologist (eyes)	_____	<i>re: pain within the last year?</i>	_____

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:

	<u>YES</u>	<u>NO</u>
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:

	<u>YES</u>	<u>NO</u>
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: _____
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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-inflammatories () 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
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

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: _____

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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	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.*

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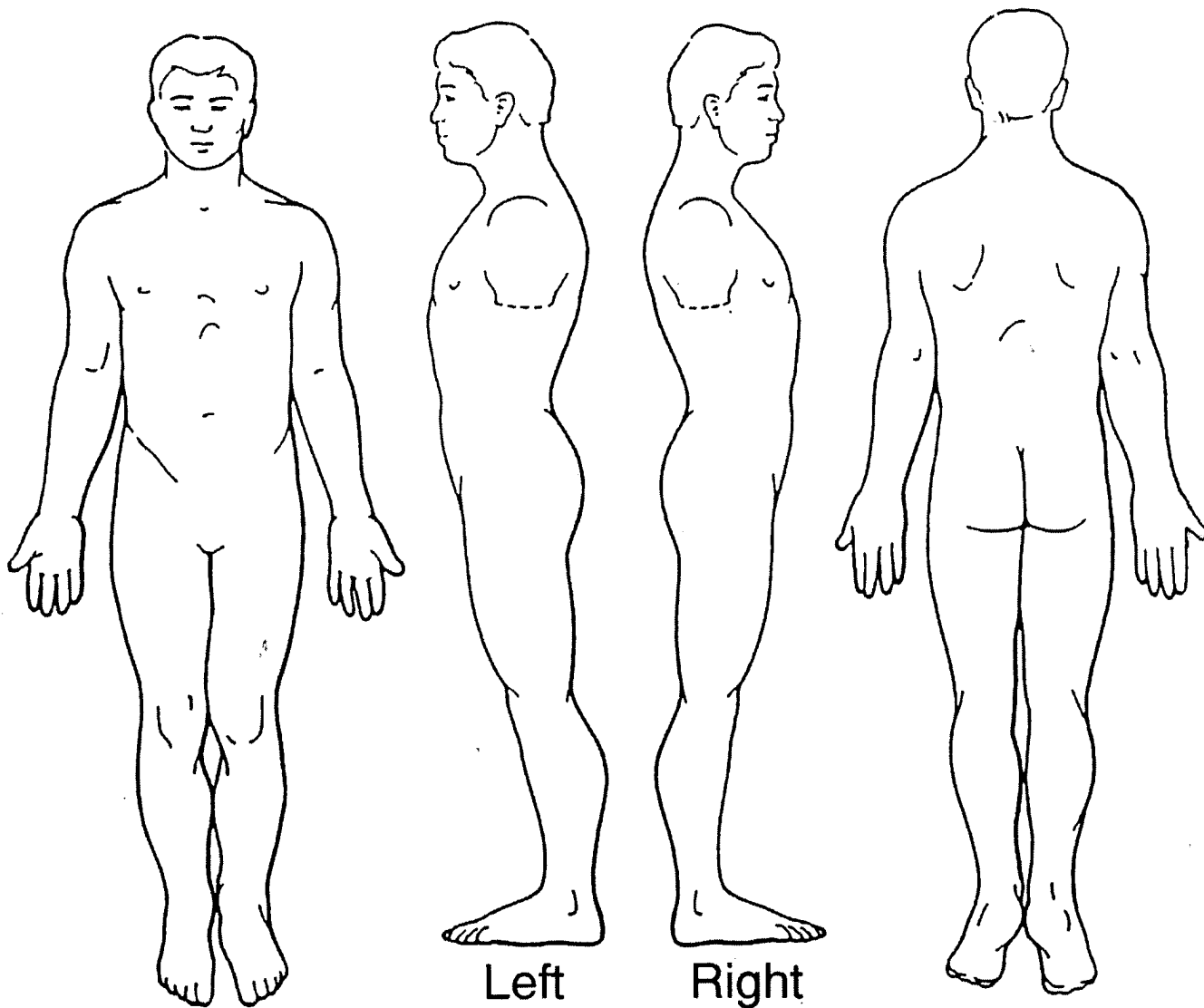
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Mark on the drawing the exact spot where your pain is with a solid black dot. If the pain starts at that spot and radiates elsewhere (travels to another part of your body), draw a line from the spot where it starts to where it ends. If it is a whole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



(PLEASE COMPLETE AND BRING WITH YOU TO INITIAL VISIT)

Name: _____

Date: _____

MEDICATIONS

Please underline each medication you have used in the past.

Please circle each medication you are now using.

ANALGESICS

- Acetaminophen
- Actiq
- Anacin
- Anexia
- Aspirin
- Avinza
- BC Powder
- Bufferin
- Buprenex
- Butalbital
- Codeine
- Darvocet
- Darvon
- Demerol
- Dilaudid
- Durabac
- Duragesic Patch
- Equagesic
- Esgic
- Excedrin
- Fioricet
- Fiorinal
- Goody's Powder
- Hydrocodone
- Kadian
- Lidoderm Patch
- Lorcet/Lortab
- Methadone
- Morphine
- MS Contin
- Norco
- Nubain
- Oxycontin
- OxyIR
- Percocet
- Percodan
- Phrenalin
- Propoxyphene
- Roxicet/Roxicodone
- Sedapap
- Stadol Injection
- Stadol Nasal Spray
- Talwin
- Tylenol
- Tylenol #3 or #4
- Tylox
- Ultram/Ultracet
- Vicodin
- Vicoprofen
- Wygesic
- Zydone

**ANTI-MIGRAINE
MEDICATIONS**

- Amerge
- Axert
- Bellergal
- Cafergot
- DHE-45 Injection
- DHE Capsule
- Droperidol
- Duradrin
- Ergomar
- Ergotrate
- Imitrex Injection
- Imitrex Nasal Spray
- Imitrex Tablet
- Lidocaine
- Maguard
- Maxalt
- Methergine
- Midrin
- Migranal
- Relpax
- Sansert
- Wigraine
- Zomig

**ANTI-
INFLAMMATORIES**

- Advil
- Aleve
- Anaprox
- Ansaid
- Arthrotec
- Aspirin
- Bextra
- Cataflam
- Celebrex
- Daypro
- Diclofenac
- Disalcid
- Dolobid
- Feldene
- Ibuprofen
- Indocin
- Ketoprofen
- Lodine
- Meclomen
- Mobic
- Motrin
- Nalfon
- Naprosyn
- Nuprin
- Orudis
- Relafen

- Toradol
- Trilisate
- Vioxx
- Voltaren

**MUSCLE
RELAXANTS**

- Baclofen
- Dantrium
- Flexeril
- Lioresal
- Norflex
- Norgesic
- Parafon Forte
- Robaxin
- Skelaxin
- Soma
- Zanaflex

**ANTI-
CONVULSANTS**

- Depakote
- Dilantin
- Gabitril
- Keppra
- Klonopin
- Lamictal
- Lyrica
- Neurontin
- Phenobarbital
- Tegretol
- Topamax
- Trileptal
- Zarontin
- Zonegran

STEROIDS

- Decadron
- Dexamethasone
- Hydrocortisone
- Medrol
- Prednisone

**SLEEPING PILLS/
TRANQUILIZERS**

- Ambien
- Ativan
- Benadryl
- BuSpar
- Dalmane
- Halcion
- Librax
- Librium
- Lorazepam

- Lunesta
- Melatonex
- Melatonin
- Restoril
- Seconal
- Seroquel
- Sonata
- Thorazine
- Tranxene
- Trilafon
- Tylenol PM
- Valium
- Xanax
- Zyprexa

**ANTI-
DEPRESSANTS**

- Anafranil
- Amitriptyline
- Celexa
- Desipramine
- Desyrel
- Doxepin
- Effexor
- Elavil
- Imipramine
- Lexapro
- Lithium
- Luvox
- Nardil
- Nortriptyline
- Pamelor
- Paxil
- Prozac
- Remeron
- Serzone
- Sinequan
- Tofranil
- Trazodone
- Vivactil
- Wellbutrin
- Zoloft

**HERBAL:
(please list)**

**Other medications
used for pain not
listed above:**

