

NEW PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is necessary for you to fill out this form. It is important for your doctor to know that you have carefully reviewed every area of this form. **Please fill out every item, and remember to sign and date page 4.** This information will be entered into our system and you are welcomed to a copy upon request.

Full Name _____ Date of Birth ___/___/___ SSN ____-____-____

M ___ F___ Marital Status M ___ S ___ D ___ L ___ W ___ Hm Phone (____) _____ Cell# (____) _____

Mailing Address _____ City _____ State _____ Zip _____

Physical Address _____ City _____ State _____ Zip _____

Employer Name/Address _____ WK# (____) _____

Emergency Contact Name _____ Phone #(____) _____ Relationship _____

Primary Insurance _____ Ph# (____) _____ ID# _____ Group# _____

Subscriber Name _____ Subscriber Date of Birth ___/___/___

Secondary Insurance _____ Ph# (____) _____ ID# _____ Group# _____

Subscriber Name _____ Subscriber Date of Birth ___/___/___

Pharmacy Name _____ Phone #(____) _____ Location _____

Primary Care Physician _____ Referring Physician _____

(Current Medications)

Are you taking ANY kind of medication now?

(This includes prescription, over-the-counter or herbal medications)

Yes ___ No ___ If yes, please list below *include dosages.*

<u>Medication Name</u>	<u>Dosage</u>	<u>How often Taken</u>

(Medication Allergies)
ARE YOU ALLERGIC TO ANY MEDICATIONS?

Yes ___ No ___

If yes, please list below.

Name of Medication	Type of Reaction (Rash, Swelling, etc.)

Have you had any problems with anesthesia? Yes ___ No ___

Have you had major surgery or procedures? Yes ___ No ___

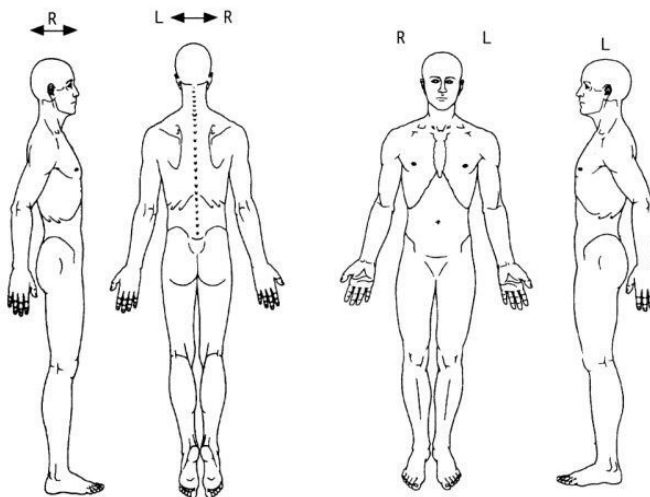
If yes, please list below.

Type of Surgery or Procedure	List any and all medical problems you have been diagnosed with presently or in the past

Please answer all of the following questions to the best of your ability. This information will assist us in treating your pain. Thank you for your cooperation.

Age _____ Height _____ Weight _____

 What is the **main** reason you are here to see the Physician Today? _____

Please mark or shade in the area(s) where your pain is located:


1. Please **Circle** the words that best describe your pain.

Aching Throbbing Cramping Stabbing Stinging Burning Radiating

2. On a scale of 0-10, (*where 0 is no pain and 10 is the worst pain you can imagine*), please rate the following:

At it's best 0 1 2 3 4 5 6 7 8 9 10

At it's worst 0 1 2 3 4 5 6 7 8 9 10

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

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

3. How long have you had the pain? _____

4. Is your pain the result of:

Illness? **Yes**____ **No**____ If Yes, please explain and give dates _____

Accident? **Yes**____ **No**____ If Yes, please explain and give dates _____

5. Are you presently involved in litigation resulting from this accident? **Yes**____ **No**____

*If Yes, please provide name of attorney _____

6. Please indicate which of the following affects your pain:

	Increases Pain	Decreases Pain	No Pain
Liquor			
Stimulants			
Eating			
Heat			
Cold			
Physical Activity			
Movement			
Lying Down			
Sitting			
Standing			
Sexual Intercourse			
Urination			
Bowel Movement			
Tension			
Bright Lights			
Loud Noises			
Fatigue			
Sneezing & Coughing			

7. Average hours of sleep at night? _____ Does your pain awaken you from sleep? **Yes**___ **No**___
8. What is your occupation? _____ Are you presently working? **Yes**___ **No**___
9. What diagnostic test(s) have you had? Please indicate when and where they were done.

	Date	Location
X-Ray		
EMG		
CT Scan		
Myelogram		
Discogram		
MRI Scan		
Other _____		

10. Please check any of the following treatments you have had for this pain problem. Include dates and results.

	Pain Relief		Date
	Yes	No	
Nerve Blocks			
Epidural Steroids			
Physical Therapy			
Traction			
Chiropractor			
Psychologist			
Hypnosis, Biofeedback			
Comprehensive Pain Clinic			
Other _____			

11. Are you currently taking anti-coagulants or blood thinners, such as, Coumadin, Aspirin, Plavix, Ticlid, anti-inflammatories or any others?

Yes___ **No**___ Please circle above or list here _____.

I authorize the doctor or insurance company to release any information required for this claim. I authorize my insurance benefits to be paid directly to North Lakes Pain Consultants. I understand that even though I have assigned benefits to be paid directly to the physician, I am still responsible for the entire bill.

Signature _____ **Date** ___/___/___