RIVER OAKS PAIN MANAGEMENT

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WELCOME TO OUR PRACTICE. PLEASE HELP US BY COMPLETING THIS QUESTIONNAIRE.

NEW PATIENT HISTORY

DATE:_________________

LAST NAME:______________________ FIRST NAME:__________________________ DATE OF BIRTH______________ AGE:_______

ADDRESS:____ CITY:______________ STATE:________ ZIP CODE:_________

SOCIAL SECURITY #:_____________________ DRIVER'S LICENSE #:______________________ STATE_________________________

Insurance Company: _________________________ Insured Name: ___________________________

INSURED SOCIAL SECURITY # ________________________ Insured DATE OF BIRTH:_______________________________

Referring Source:_________________________________ **Phone** #____

1. **INITIAL DATE OF INJURY OR ONSET OF PAIN**:__________________
2. **WHAT PART OF YOUR BODY HURTS? HOW DID YOUR PAIN OCCUR**?____

____

____

____

3. **PLEASE LIST IN CHRONOLOGICAL ORDER THE NAMES OF ALL DOCTORS YOU HAVE SEEN FOR THIS CONDITION:**

1. DOCTOR:__________________________________ APPROXIMATE DATE OF FIRST VISIT:__________________________

WHAT STUDIES DID HE/SHE DO?

EMG: ☐ YES ☐ NO

RESULTS:____

MRI: BACK ☐ YES ☐ NO NECK: ☐ YES ☐ NO

RESULTS:____

____

OTHER STUDIES:____

____

WHAT WAS THE DIAGNOSIS GIVEN FOR YOUR PROBLEM:____

WHAT TREATMENTS HAVE BEEN DONE?

THERAPIES:____

MEDICATIONS:____

____

SURGERIES:____

OTHER:____

2. DOCTOR:__________________________________ APPROXIMATE DATE OF FIRST VISIT:__________________________

WHAT STUDIES DID HE/SHE DO?

EMG: ☐ YES ☐ NO

RESULTS:____

MRI: BACK ☐ YES ☐ NO NECK: ☐ YES ☐ NO

RESULTS:____

OTHER STUDIES:____________________________________

WHAT WAS THE DIAGNOSIS GIVEN FOR YOUR PROBLEM:____________________

WHAT TREATMENTS HAVE BEEN DONE?

THERAPIES:____

MEDICATIONS:______________________________________

SURGERIES:____

OTHER:____

3. DOCTOR:____________________ APPROXIMATE DATE OF FIRST VISIT:________________

WHAT STUDIES DID HE/SHE DO?

EMG: ☐ YES ☐ NO

RESULTS:____

MRI: BACK ☐ YES ☐ NO NECK: ☐ YES ☐ NO

RESULTS:____

OTHER STUDIES:____________________________________

WHAT WAS THE DIAGNOSIS GIVEN FOR YOUR PROBLEM:____________________

WHAT TREATMENTS HAVE BEEN DONE?

THERAPIES:____

MEDICATIONS:______________________________________

SURGERIES:____

OTHER:____

(IF YOU NEED ADDITIONAL PAGES PLEASE ASK THE RECEPTIONIST)

4. **WHICH OF THE TREATMENTS WERE INEFFECTIVE?**____________________

5. **WHICH OF THESE TREATMENTS WORSENED YOUR CONDITION OR GAVE YOU SIDE EFFECTS? PLEASE EXPLAIN:**________

6. **PLEASE DESCRIBE YOUR CURRENT CONDITION:**____________________

7. **YOUR PAIN HAS LIMITED WHICH OF THE FOLLOWING ACTIVITES?**

☐ ENJOYMENT OF LEISURE ACTIVITIES

☐ OTHER ACTIVITIES. PLEASE

EXPLAIN____

PHYSICIAN NOTES

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8. **CURRENT MEDICATIONS:**

DRUG	STRENGTH	# PER DAY

IF YOU NEED MORE SPACE, PLEASE USE OTHER SIDE OF PAPER

9. **ARE ANY OF YOUR CURRENT MEDICINES CAUSING YOU PROBLEMS? IF SO, PLEASE DESCRIBE**:______________________________

____

10. **ARE THERE ANY MEDICINES YOU CANNOT TAKE?**

DRUG	SIDE EFFECT

IF YOU NEED MORE SPACE, PLEASE USE OTHER SIDE OF PAPER

11. **PLEASE LIST YOUR OTHER MEDICAL PROBLEMS (FOR EXAMPLE: DIABETES, HIGH BLOOD PRESSURE, ETC.):**_______________

____

____

____

IF YOU NEED MORE SPACE, PLEASE USE OTHER SIDE OF PAPER

12. PLEASE LIST YOUR PREVIOUS SURGERIES:

    1. ____________________ DOCTOR:__________ YEAR:__________
    2. ____________________ DOCTOR:__________ YEAR:__________
    3. ____________________ DOCTOR:__________ YEAR:__________
    4. ____________________ DOCTOR:__________ YEAR:__________
    5. ____________________ DOCTOR:__________ YEAR:__________

    IF YOU NEED MORE SPACE, PLEASE USE OTHER SIDE OF PAPER

13. **ARE YOU CURRENTLY WORKING?** ☐ YES ☐ NO

PLEASE EXPLAIN YOUR JOB TITLE AND ACTIVITIES:____________________

PLEASE DESCRIBE ANY RESTRICTIONS:____________________

14. **DO YOU NEED TO DRINK ALCOHOL TO TAKE AWAY THE PAIN?** ☐ YES ☐ NO
15. **WHEN WAS THE LAST TIME YOU DRANK AN ALCOHOLIC BEVERAGE?**____________________
16. **HAVE YOU EVER HAD A PROBLEM WITH ALCOHOL?** ☐ YES ☐ NO
17. **HOW MUCH DO YOU SMOKE?** ☐ NONE ☐ __________ PACKS PER DAY
18. **IF YOU ARE A FORMER SMOKER, WHEN DID YOU QUIT?**____________________-
19. **DO YOU SUFFER FROM ANY OF THE FOLLOWING?**

    ☐ ULCER DISEASE
    ☐ CONSTIPATION
    ☐ HEMORRHOIDS
    ☐ PROBLEMS WITH URINATION
    ☐ DIFFICULTY WITH SEXUAL FUNCTION
    ☐ EXCESSIVE FATIGUE
    ☐ GENERALIZED WEAKNESS
    ☐ WEAKNESS OF AN ARM OR LEG
    ☐ LOSS OF BALANCE
    ☐ MEMORY LOSS
    ☐ DEPRESSION
    ☐ DIFFICULTY WITH APPETITE
    ☐ DIFFICULTY WITH SLEEP
    ☐ DIFFICULTY WITH ENJOYMENT
    ☐ DIFFICULTY WITH RELATIONSHIPS AT HOME
    ☐ DIFFICULTY WITH RELATIONSHIPS AT WORK
    ☐ DIFFICULTY WITH FINANCES
    ☐ EASY BRUISING

20. PLEASE EXPLAIN ANY OTHER CURRENT ISSUES OR PROBLEMS:____________________

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THANK YOU FOR COMPLETING THE ABOVE QUESTIONNAIRE. PLEASE RETURN TO THE RECEPTIONIST.