

South Lake Pain Institute, PA

New Patient Consultation

Date: _____ Referring Physician: _____

Name: _____

DOB: _____

Reason for visit: _____

History of present pain problem

Age: _____ Sex: _____ Height: _____ Weight: _____

When did your pain start: _____

Location of your pain: _____

Description of your pain: _____

What event led to your present problem?:

Cancer Operation Car Accident Work Related Injury Other Injury: _____

Circle the words that describe your pain:

Aching	Tender	Throbbing		
Burning	Shooting	Sharp	Numb	Lacinating

Is your pain (circle one): Continous Intermittent (comes and goes)

If your pain is intermittent, how long does the pain last: _____

What makes your pain better? (Circle all that apply)

Sitting Standing Lying Flat Walking Twisting Coughing Sneezing Other: _____

What makes your pain worse? (Circle all that apply)

Sitting Standing Lying Flat Walking Twisting Coughing Sneezing Other: _____

Rate your pain by circling the number that best describes your pain **right now**:

No Pain 0 1 2 3 4 5 6 7 8 9 10

Rate your pain by circling the number that best describes your pain **with activity**:

No Pain 0 1 2 3 4 5 6 7 8 9 10

Does your pain interfere with your sleep? Yes No

How many work days did you miss in the last month due to pain? _____

(Circle those that apply) Do you have any:

numbness tingling extremity weakness bowel / bladder incontinence

What procedures have you had done to treat / diagnose your pain? (Check all that apply)

- tens unit cortisone joint injections epidurals physical therapy chiropractic care other

Procedure

Date

Doctor's name / speciality

_____	_____	_____
_____	_____	_____
_____	_____	_____

What test have been performed? (Check all that apply)

- X-rays CT scans MRI EMG/NCS Bone Scan

Allergies to Medications:

Medications

Name

Dosage

Frequency

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List **all** previous pain medications you have tried:

Medical Problems: Please list ongoing or previous medical problems

Past Surgical History

Type of operation

Date

_____	_____
_____	_____
_____	_____

Family History: Please list medical problems in **immediate family** and their relationship to you.

Social History

Do you Smoke? No Yes Pack/day: _____ Number of years: _____

Do you Drink? No Yes How much per day: _____

Have you tried any illicit drugs? No Yes What drugs: _____ How often: _____

Are there any substance abuse issues in the household? No Yes

If yes, please explain: _____

Marital Status (circle one): Single Married Divorced Widowed Children

Highest level of education completed (circle one):

High school technical / vocational college highest degree: _____

Employment Status: Are you currently employed? No Yes

Place of Employment: _____ Position: _____ Years: _____

Why did you leave? _____

Have you ever been involved in a lawsuit? No Yes

If yes, please explain: _____

Litigation History / Work Comp

Date of Injury: _____ Place of Employment: _____ Position: _____

Years there: _____ Time of Accident: _____

Circumstances:

Current work status: _____ Any restrictions: _____

Restrictions assigned by Dr. _____

What Dr. have you seen for this problem before: _____

Previous W/C Injuries: _____ Functional Capacity: _____

Evaluation performed: _____ % impairment given: _____

Disabled: _____ Date: _____ By Dr. _____

Motor Vehicle Accidents

Date of Injury: _____ Position in Car: _____ Seat Belt Yes No

Circumstances of Accident: _____

ER by Ambulance: _____ Treatment recommended in ER: _____

Previous MVA's: _____

Review of Systems Please circle any symptoms that you may be experiencing.

General:	fevers	chills	night sweats	malaise	weight gain	weight loss	loss of appetite	
Eyes:	vision problems		double vision		glaucoma	cataracts		None
	other: _____							
Ears:	hearing problems		ringing in the ears		earaches			None
	other: _____							
Nose:	nasal congestion		nosebleeds		infection			None
	other: _____							
Mouth:	problem swallowing		hoarse voice		bleeding gums			None
	other: _____							
Neck:	swollen glands		thyroid problems		other:	_____		None
Respiratory:	cough	difficulty breathing	asthma		other:	_____		None
Cardiac:	chest pain		high blood pressure		heart irregularity			None
	palpitations		swelling in the legs					
	other: _____							
Gastrointestinal:	heartburn		nausea		vomiting		constipation	None
	stomach upset		hepatitis		diarrhea			
	other: _____							
Urinary:	frequency		burning with urination		incontinence			None
	other: _____							
Musculoskeletal:	joint aches		muscle weakness		muscle cramps			None
	other: _____							
Neurology:	headache		dizziness		seizures			None
	numbness		tremors		stroke			
	other: _____							
Hematology:	blood disorder		bleeding gums					None
	other: _____							
Psych:	depression		anxiety		bipolar			None
	other: _____							
Infections:	HIV		Hepatitis					None
	other: _____							

Name: _____

Date: _____

DOB: _____

Please shade your area of pain.

