Desert Valley Advanced Pain Management, PLLC

Date _____ **Patient Information**

Name_____ Date of Birth_____ Gender: M ____ F ____

Permanent Address_____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone_____ Social Security_____

Work Phone _____ Marital Status: M__ S__ D__ W__ Contact name and phone number (Someone who does not live with you) _____

Employer _____ Phone number _____ Can we contact you at work?_____

Pharmacy Number _____ Location _____

Primary Care Dr. _____ Phone _____ Fax _____

Medical Insurance Information

Card holder name_____ Date of birth_____ Phone # _____

Relationship to patient _____ Mailing address _____ City_____ State_____

- Primary Insurance _____ Co-pay_____ Phone_____

Member ID#_____ Group#_____

Address_____ City_____ State_____ Zip_____

- Second Insurance _____ Co-pay_____ Phone_____

Member ID#_____ Group#_____

Address_____ City_____ State_____ Zip_____

Emergency Contact Information

Emergency Contact person _____ Phone _____

Mailing Address _____ City _____ State _____ Zip _____

Workman's Compensation Information

Date of Injury _____ Claim # _____ Name of Employer Involved _____

Site of Injury_____ Insurance Carrier_____ Phone_____

Claims Address_____ City_____ State_____ Zip_____ Fax_____

Case Worker_____ Phone_____ Fax_____

PHYSICIANS

Please list all physicians that are treating or referring you to this office

- Doctor _____ Specialty _____ Phone# _____

Address_____ City_____ State_____ Zip_____ Fax _____

- Doctor _____ Specialty _____ Phone# _____

Address_____ City_____ State_____ Zip_____ Fax _____

- Doctor _____ Specialty _____ Phone# _____

Address_____ City_____ State_____ Zip_____ Fax _____

- Doctor _____ Specialty _____ Phone# _____

Address_____ City_____ State_____ Zip_____ Fax _____

- Doctor _____ Specialty _____ Phone# _____

Address_____ City_____ State_____ Zip_____ Fax _____

Pharmacy Information

Patient Pharmacy Information:

- Pharmacy Name _____ Phone # _____

Address/ Major cross streets _____ Fax# _____

- Pharmacy Name _____ Phone # _____

Address/ Major cross streets _____ Fax# _____

- Pharmacy Name _____ Phone # _____

Address/ Major cross streets _____ Fax# _____

- Pharmacy Name _____ Phone # _____

Address/ Major cross streets _____ Fax# _____

PATIENT HISTORY QUESTIONNAIRE

Please read the following carefully and answer All the question to the best of your ability. This will assist in making a treatment plan for you. Our records are confidential and only provided for review with written permission from the patient.

Name (First) _____ (Last) _____ Date _____

Age _____ Height_____ Weight _____

History of Present Illness

What is the main complaint for which you are seeking treatment at the Pain Management Center? _____

_____

_____

How long have you had the pain you are currently experiencing? Months _____ Years_____

What caused your pain to start? _____

Please circle the level of your pain on a scale of 0 to 10 (0=no pain, 10= worst pain)

Present level of pain:	1	2	3	4	5	6	7	8	9	10
Worst pain:	1	2	3	4	5	6	7	8	9	10
Least pain:	1	2	3	4	5	6	7	8	9	10

Using the same scale, what level of pain is acceptable for you? _____

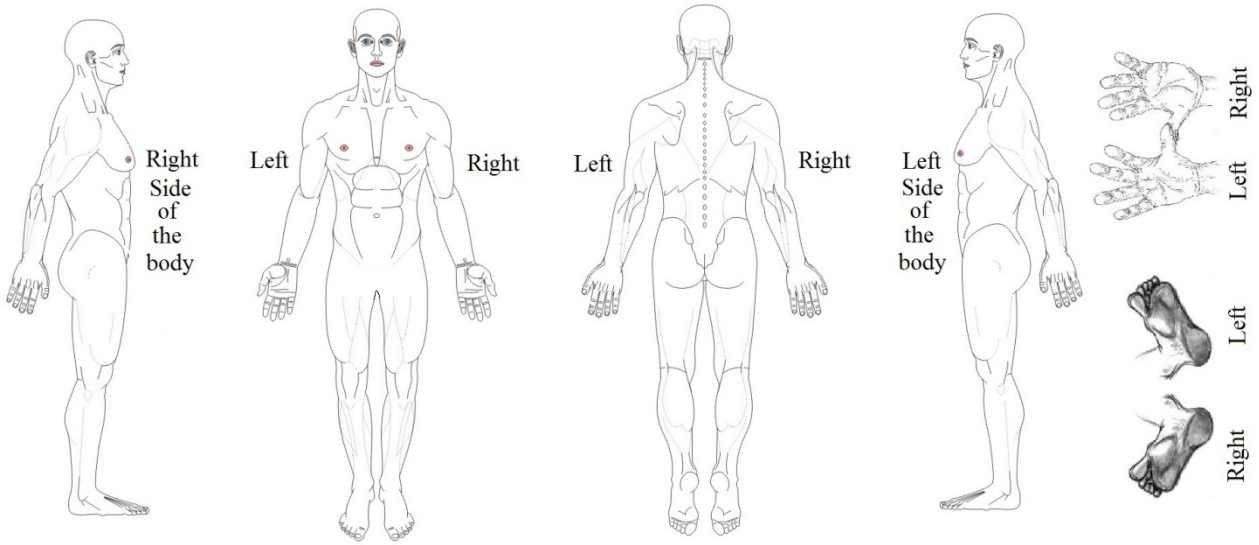
What type of pain do you have? (Please circle all that pertain to your pain)

Piercing	Stabbing	Shooting	Burning	Itching	Tingling	Grinding
Throbbing	Cramping	Aching	Stinging	Squeezing	Numbing	Stiffness
Swelling	Headache	Other: _____				

How often do you have pain? _____

When is your pain worst? Morning Afternoon Evening No Pattern

Please SHADE or MARK the areas on the diagrams below where your pain is located:



Past History: Family and Social

Please circle yes or no if you or your family members have any of the following problems?

High Blood Pressure	Yes	No	Diabetes	Yes	No	Heart Problems	Yes	No
Respiratory Problems	Yes	No	Stroke	Yes	No	Cancer	Yes	No
Bleeding Problems	Yes	No	HIV/AIDS	Yes	No	Other: _____		

If you marked yes on any of the above please explain:_____

Social History	Martial Status	Single__	Married __	Divorced__	Widowed__
	Tobacco use	Never__	Quit, When _____		Packs per day___
	Alcohol use	Never__	Rarely __	Moderate__	Daily__
	Drugs (Street) use	Never__	Type and Frequency_____		

Occupation or last job? _____

Past hospitalization, surgeries, and injuries (approximate date) _____

_____

List of current Medications_____

_____

Do you have any allergies or adverse reactions to medications? (Pills of injections) _____

_____

Have you ever had an injection to control you pain? _____ If yes, what kind did you have, did it help and for how long did it work? _____

Have you ever taken or been given any of these medications?

Anticoagulants (blood thinners)	Yes	No	When_____
Cortisone or Steroids	Yes	No	When_____
Local Anesthetic (by Dr/Dentist)	Yes	No	When_____

Have you had any problems with the above Medications? _____

Please list if you have had any of the following tests and if they were done in the last 24 hours?

Date Facility where test was done? Ordering Phycian

X-Ray _____

CT Scan _____

MRI_____

EMG_____

Mylogram/Bone Scan_____

Review of System

Please circle yes or no, if you have any or the following problems?

Constitutional			**Ears/Nose/Throat**			**Eyes**		
Good general health	Yes	No	Hearing loss/Ringing	Yes	No	Glasses	Yes	No
Recent weight change	Yes	No	Sinus Problem	Yes	No	Blurred	Yes	No
Night sweats/fever	Yes	No	Nose Bleeds	Yes	No	Double	Yes	No
Fatigure	Yes	No	Voice Change	Yes	No	Glaucoma	Yes	No
Cardiovasscular			**Respiratory**			**Neurological**		
Chest Pain	Yes	No	Shortness of Breath	Yes	No	Headaches	Yes	No
Palpitations	Yes	No	Coughing	Yes	No	Tremors	Yes	No
Heart Trouble	Yes	No	Wheezing/Asthma	Yes	No	Seizures	Yes	No
Swelling Hands/Feet	Yes	No	Enlarged Glands	Yes	No	Numbness	Yes	No
Endocrine			**Musculoskeletal**			**Psychiatric**		
Excessive Urine	Yes	No	Pain/Cramps	Yes	No	Insomnia	Yes	No
Excessive Thirst	Yes	No	Stiffness/Swelling	Yes	No	Confusion	Yes	No
Thyroid Disease	Yes	No	Joint Pain	Yes	No	Depression	Yes	No
Hormone Problem	Yes	No	Trouble Walking	Yes	No	**Genitourinary**		
Gastrointestinal			**Integumentary**			Blood in Urine	Yes	No
Nausea/Vomiting	Yes	No	Bruise Easily	Yes	No	Kidney Stones	Yes	No
Abdominal Pain	Yes	No	Change in Hair/Nails	Yes	No	Sexual Problem	Yes	No
Rectal Bleeding	Yes	No	Rashes or Itching	Yes	No	Menstrual Pain	Yes	No
Bowel Problems	Yes	No	Breast Pain Lump	Yes	No			

PATIENT STATEMENT: To the best of my knowledge, all the above information is accurate and complete.

Signed: _____ Date: _____

For Office Use Only

Physician Statement: I Have review the questionnaire with the patient.

Signed: _____ Date:_____