SONORANSPINE

In Collaboration with HONORHEALTH

Pain Management New Patient

Name _____ Date of Birth ____/_____/_____ Date_____

Primary Doctor _____ Referring Doctor_____

Chief Complaint (check all that apply): ❑Neck Pain ❑Arm Pain ❑Back Pain ❑Leg Pain ❑Other: _____

How long has the pain (or your problem) been present? _____ Has it worsened recently? ❑No ❑Yes How recent? _____

What started your problem? (please PRINT) _____

Was the onset: ❑Gradual ❑Sudden

Is your problem (circle one): ❑Getting worse ❑Getting better ❑About the same

Do you exercise? ❑Daily ❑Regularly ❑Weekly ❑Occasionally ❑Never

Do you use an assistive device? ❑Yes ❑No (cane, walker, wheelchair, etc.) Type: _____

Please check all the words that describe your pain:

❑Burning ❑ Stabbing/Sharp ❑ Pins/Needles ❑Ache/Dull ❑Numbness

Please draw where you are experiencing pain on the diagram:

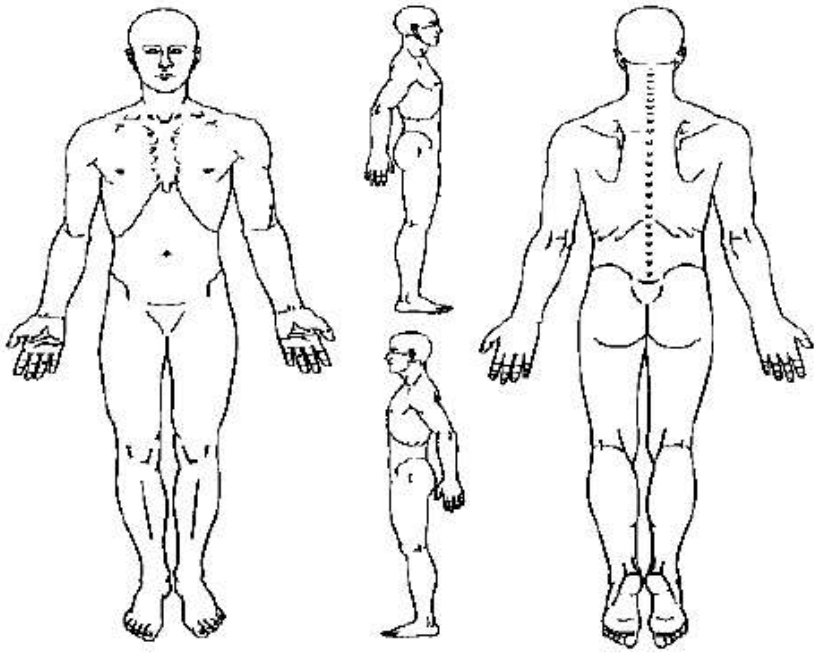
xxxx = Burning

///// = Stabbing/Sharp

oooo = Pins/Needles

vvvv = Ache/Dull

++++ = Numbness



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Check the activities that increase your pain:

☐ Gripping ☐ Arm Raising ☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Turning head
☐ Driving ☐ Climbing stairs ☐ Lifting ☐ Bending ☐ Twisting ☐ Coughing ☐ Going down stairs
☐ Other:_____

Check the activities that Improve your pain:

☐ Lying Down ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Heat ☐ Ice ☐ Other:_____

Please rate your pain from 0 to 10 (0=No Pain, 10=most severe pain imaginable)

Pain Today _____ Minimum Pain _____ Maximum Pain _____ Average Daily Pain _____

What number best describes your pain on average in the past week:

0 1 2 3 4 5 6 7 8 9 10
No pain Slight Moderate Severe

What number best describes how, during the past week pain has interfered with your enjoyment of life:

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Slight/Mild Moderate Completely interferes

How much has your activities of daily living improved since your last visit:

0 1 2 3 4 5 6 7 8 9 10
None Mild Moderate Very Significant

Current PAIN Medications

Include all prescription and non-prescription pain medications:

Name of Medication	Dose or strength	How often taken

Other non-pain medications that you currently take:

Please include any vitamins or nutritional supplements

1.	2.	3.
4.	5.	6.

Are you on any blood thinners? ☐ Yes ☐ No If yes, which one: _____

Do you have a pacemaker? ☐ Yes ☐ No

Do you have a defibrillator? ☐ Yes ☐ No

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Pain Treatment History - Interventions

Treatment	When (Date/years)	% Helped
Physical Therapy		
Manipulation/Massage		

Have you had injections in the past? Trigger point injections, Nerve Ablations, Epidural Steroid injections? ☐ Yes ☐ No

If Yes, which injections have you had and when did you have them?

Treatment	When (Date/years)	% Helped
Injections		

Any diagnostic testing for this condition?
☐ None ☐ Plain X-rays ☐ MRI scan ☐ CT scan ☐ Myelogram ☐ Nerve Tests (EMG, NCS)

Pain Treatment History - Past PAIN medication history

Name of past pain medication	Did it help?	Any side effects?

Have you ever taken medications differently than prescribed for you? ☐Yes ☐ No
If yes, Please explain: _____

Do you have a history of drug addiction or dependence? ☐ Yes ☐ No
If yes, explain treatments: _____

Allergies ☐ No Known Drug Allergies

Any Medication Allergies	Describe Reaction

Are you experiencing any of the following? Please mark all that apply

☐ Anxiety
☐ Double vision
☐ Blurry Vision
☐ Bowel Incontinence
☐ Chest Pain
☐ Constipation
☐ Cough
☐ Depression
☐ Difficulty Breathing
☐ Dizziness
☐ Drowsiness
☐ Fatigue
☐ Fever
☐ Headache
☐ Hearing Changes
☐ Heartburn
☐ Insomnia
☐ Memory Loss
☐ Mood swings
☐ Nausea
☐ Rash
☐ Seizure
☐ Shortness of Breath
☐ Swelling
☐ Urinary hesitancy
☐ Urinary incontinence
☐ Urinary urgency
☐ Unexplained weight loss
☐ Vomiting
☐ Wounds or Ulcers

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Past Medical History

Are you affected by any of the following? ☐ No medical Problems

☐ Abnormal heart rhythm
☐ Alcoholism
☐ Anemia
☐ Ankylosing spondylitis
☐ Anxiety
☐ Asthma
☐ Bleeding disorders
☐ Blood clots
☐ Cancer (type:_____)
☐ Depression
☐ Diabetes
☐ Fibromyalgia
☐ Glaucoma
☐ Gout
☐ Gynecological Issue
☐ Heart Attack
☐ Heart Failure
☐ Hepatitis
☐ High Cholesterol
☐ HIV/AIDS
☐ Irritable bowel syndrome
☐ Kidney Problem
☐ Liver Disease
☐ Lung Disease (type: _____)
☐ Nausea
☐ Osteoporosis
☐ Peripheral neuropathy
☐ Peripheral vascular disease
☐ Rheumatoid arthritis
☐ Seizures
☐ Sleep apnea
☐ Stomach ulcers
☐ Stroke
☐ Thyroid disease
☐ Other:

Surgical History

1.	2.	3.
4.	5.	6.

Family History- Check all that apply:

☐ Unknown ☐ Diabetes ☐ Heart Disease ☐ Obesity ☐ Stroke ☐ Cancer ☐Spinal Disorder ☐Vascular Disease

Social History

Marital Status: ☐ Single ☐ Married ☐ Cohabitating ☐ Widowed ☐ Divorced

Living Status: ☐ Along ☐ Spouse ☐ Parents ☐ Roommate ☐ Assisted Living

Work Status: ☐ Employed (Occupation: _____) ☐ Unemployed ☐ Disabled ☐ Retired

Do you use tobacco?: ☐ No ☐ Yes If yes, How much and for how long? _____

Do you drink alcohol? ☐ No ☐ 1-2 drinks/week ☐ 3-4 drinks/ week ☐ 5 or more drinks/week ☐ No longer drink

X _____ Date: _____

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Name _____ Date of Birth _____

Opioid Questionnaire

1. Family History of substance abuse?

Alcohol	Yes ◯	No ◯
Illegal drugs	Yes ◯	No ◯
Prescription drugs	Yes ◯	No ◯

2. Personal history of substance abuse?

Alcohol	Yes ◯	No ◯
Illegal drugs	Yes ◯	No ◯
Prescription drugs	Yes ◯	No ◯

3. Are you between the ages of 16 and 45 years old? Yes ◯ No ◯

4. History of preadolescent sexual abuse? Yes ◯ No ◯

5. Any personal history of psychological disease?

Attention Deficit Disorder	Yes ◯	No ◯
Obsessive-Compulsive Disorder, Bipolar, or Schizophrenia		
Depression	Yes ◯	No ◯

_____ _____

Patient Signature Date

HONORHEALTH™

Medical Group

New Patient Registration – Demographics and Insurance

Patient: Name/First _____Middle_____Last_____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: M | F

Patient street address: _____

Patient address additional: _____

City: _____ State: _____ ZIP: _____-_____

Primary Phone Number: (_____) _____-_____Mobile | Home | Work

Secondary Phone Number: (_____) _____-_____Mobile | Home | Work

Email address: _____

What is your primary language? _____ Interpreter Required? Yes | No

Marital Status: Divorced | Legally Separated | Married | Other | Sig. Other | Single | Widowed

Religious preference: _____ ☐ I prefer to not answer.

The U. S. government requires we ask the following two questions:

1. How do you identify your ethnicity?
   _____Hispanic or Latino _____ Not Hispanic or Latino
   _____ I prefer to not answer.

2. How do you identify your race?
   _____ American Indian or Alaska Native _____ Black or African American
   _____ Native Hawaiian _____ Other Pacific Islander
   _____ White or Caucasian _____ Asian
   _____ I prefer to not answer

Who is your primary care physician? _____

Name of the primary care practice: _____

Employment Status: Full-Time | Part-Time | Retired | Disabled | Student | Unemployed

Employer Name: _____

How many employees work at your company? ☐ 1-19 ☐ 20-99 ☐100+ ☐ Don't know

Patient Name: First_____ Middle_____ Last_____ Date of Birth: ____/_____/_____

Who would you like to list as an **emergency contact**?

Name: _____

Address: _____

_____

Relationship to you: _____

Phone Number: (_____) _____-_____ Mobile | Home | Work

Who is the **guarantor** of your account? Who is financially responsible for any amount not paid by the insurance company? Please write "self" if you are financially responsible.

Guarantor: Name/ First_____Middle_____Last_____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: M | F

Address: _____

_____

Phone Number: (_____) _____-_____ Mobile | Home | Work

Medical Insurance Company Name: _____

Member/Subscriber Identification #: _____ Group #: _____

Medical Insurance Company Address: _____

Relationship of the insurance subscriber to the patient: Self | Parent | Spouse | Other: _____

Subscriber: Name/ First_____Middle_____Last_____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: M | F

Address: _____

_____

Phone Number: (_____) _____-_____ Mobile | Home | Work

Do you have any additional insurance? Yes | No
Please present all insurance cards.