

COLQUITT REGIONAL

MEDICAL CENTER

COLQUITT REGIONAL PAIN MANAGEMENT SERVICES

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PATIENT INFORMATION

Date: _____ Date of Birth: _____

Patient Name: _____

Address: _____

Phone: Home: () _____ Work: () _____

Referring Physician: _____

Address: _____

City: _____

Phone: () _____ Fax: () _____

Primary Physician: _____

Address: _____

City: _____

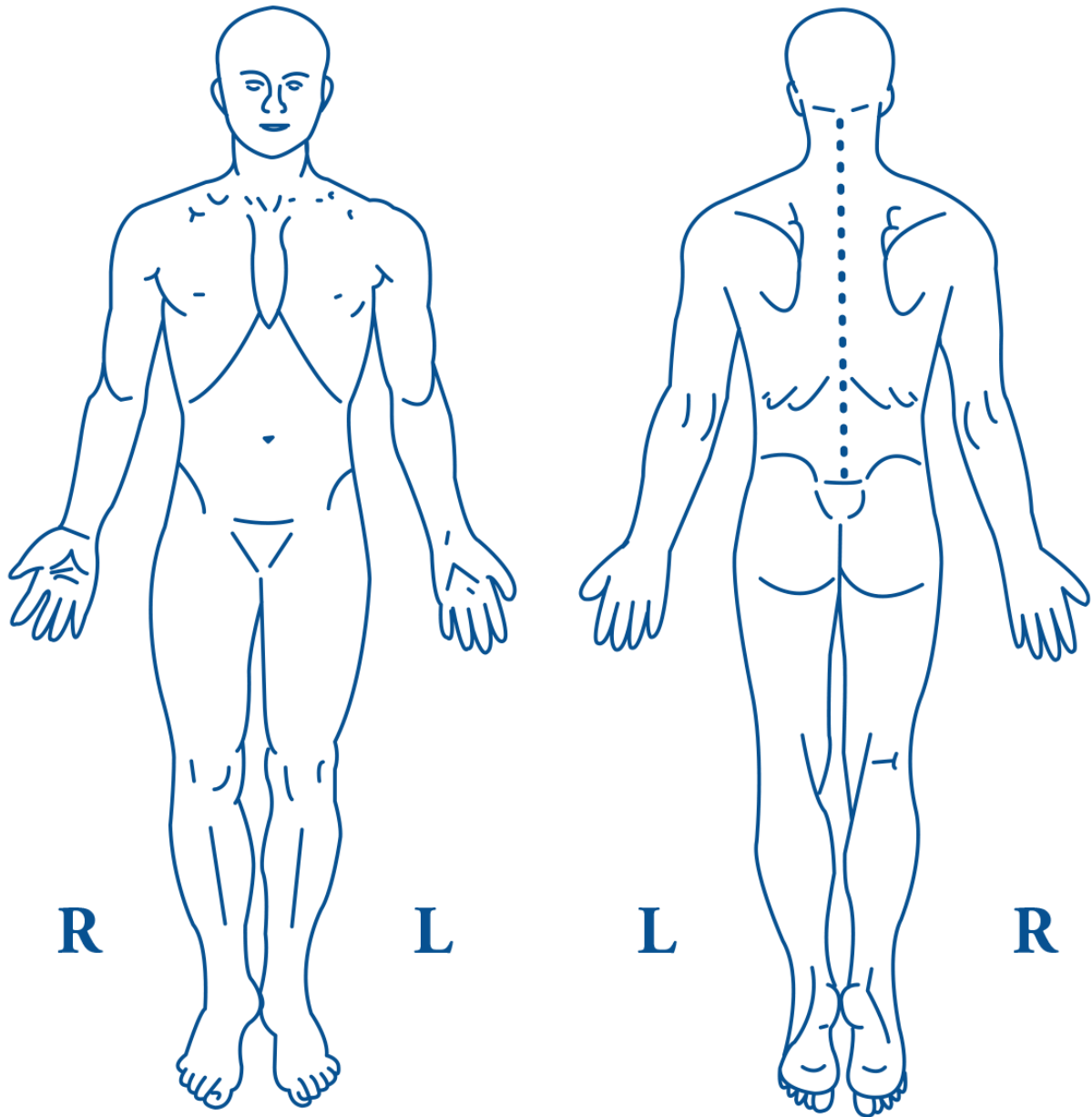
Phone: () _____ Fax: () _____

Your completed paperwork helps our physicians get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please contact our office at (229)-891-9548 if you have questions on how to complete any section of this form.

PAIN CHART

Mark the areas on your body where you feel the described sensations using the appropriate symbol from the list below. Please include all affected areas.

Pin & Needles =	ooo	Burning =	xxx	Aching =	^^^	Stabbing =	///	Other =	###
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Pain Score: Please indicate your pain level on a scale of 0-10 with "0" + no pain and "10" =worst pain imaginable.

Present Pain

0 1 2 3 4 5 6 7 8 9 10

Worst is gets

0 1 2 3 4 5 6 7 8 9 10

Most of the time

0 1 2 3 4 5 6 7 8 9 10

Best that it gets

0 1 2 3 4 5 6 7 8 9 10

HISTORY OF PRESENT COMPLAINT

1. Age: _____ Male _____ Female _____
2. Where is your problem located? Neck ___ Arm ___ Back ___ Hip ___ Leg ___ Other _____
3. How long have you had this problem? _____ Since? ___/___/___
4. Briefly, please give details of how this problem originally started:

5. Was this from a work-related injury? No ___ Yes ___ Is it under workers compensation No ___ Yes ___
6. Are there any law suits pending or being contemplated related to your problems? Yes ___ No ___
if yes, please give your attorney's name and phone number: _____
7. Please describe your present pain/problem now (what you feel, where, when, etc.):

8. Have you had spinal surgery in the past: (Check one) Yes ___ No ___ (If no skip question 9)
How many times? _____
What type of surgery(s) was/were performed? Discectomy ___ Laminectomy ___ Fusion ___
Unknown ___ other: _____
What spinal level? _____ Did you improve from your spine surgery procedure? _____
9. Which of the following best describes your ratio for neck & arm or back & leg discomfort
 - A. 100% back pain and 0% leg pain
 - B. 75% back pain and 25% leg pain
 - C. 50% back pain and 50% leg pain
 - D. 25% back pain and 75% leg pain
 - E. 0% back pain and 100% leg pain
 - A. 100% neck pain and 0% arm pain
 - B. 75% neck pain and 25% arm pain
 - C. 50% neck pain and 50% arm pain
 - D. 25% neck pain and 75% arm pain
 - E. 0% neck pain and 100% arm pain
10. For any pain/numbness in your arm(s) or leg(s), which side is worse? (Choose one if appropriate)

Leg Symptoms

- A. 100% left leg and 0% right leg
- B. 75% left leg and 25% right leg
- C. 50% left leg and 50% right leg
- D. 75% right leg and 25% left leg
- E. 100% right leg and 0% left leg

Arm Symptoms

- A. 100% left arm and 0% right arm
- B. 75% left arm and 25% right arm
- C. 50% left arm and 25% left arm
- D. 75% right arm and 25% left arm
- E. 100% right arm and 0% left arm

HISTORY OF PRESENT COMPLAINT (CONT.)

11. Please choose letters A – F (in first column) to answer the questions in column two.

- | | |
|--------------------------|-------------------------------|
| A. Unable to tolerate | How long can you sit? _____ |
| B. About 15 minutes only | |
| C. About 30 minutes only | How long can you stand? _____ |
| D. About 45 minutes | |
| E. About 1 hour | How long can you walk? _____ |
| F. Indefinitely | |

12. Which of the following activities change the nature of your pain?

	Aggravates	Relieves	Neither
Sitting	—	—	—
Standing	—	—	—
Walking	—	—	—
Leaning/Bending forward	—	—	—
Lying on your side	—	—	—
Lying on your back	—	—	—
Lying on your stomach	—	—	—
Rising from sitting	—	—	—
Changing positions	—	—	—
Coughing/Sneezing	—	—	—
Driving	—	—	—

Now go back and CIRCLE **the most aggravating activity** and the **most relieving activity**.

13. If the symptoms of your present pain have changed, please indicate the most appropriate statement: (Circle one)

- A. My symptoms have remained the same since the time of onset.
- B. My symptoms are more severe since the time at onset.
- C. My symptoms are less severe since the time of onset.

14. How have the symptoms of your present pain changed: (Circle one)

- A. No change in symptoms.
- B. My symptoms have worsened over time.
- C. My symptoms have improved over time.

HISTORY OF PRESENT COMPLAINT (CONT.)

15. Of the following list of treatments, please indicate the effect of those which have been used in an attempt to help your present injury: (Check one of each)

	Which type	Helpful	No Help	Not Used
Anti Inflammatory	_____	_____	_____	_____
Muscle Relaxants	_____	_____	_____	_____
Narcotic Pain Medications	_____	_____	_____	_____
Acetaminophen/Tylenol	_____	_____	_____	_____
Hot Packs	_____	_____	_____	_____
Ice	_____	_____	_____	_____
TENS Unit / Muscle Stim	_____	_____	_____	_____
Physical Therapy Treatment	_____	_____	_____	_____
Back / Neck Exercises	_____	_____	_____	_____
Chiropractor	_____	_____	_____	_____
Epidural Block / Injection	_____	_____	_____	_____
Facet Block / Injection	_____	_____	_____	_____
SI Joint Block / Injection	_____	_____	_____	_____
Trigger Point Injection	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____

16. Please indicate whether you have had any of the following studies and write when / where the most recent was:

	Yes	No	When / Where	Yes	No	When / Where
Regular X-ray	—	—	_____	—	—	_____
CT Scan of Spine	—	—	_____	—	—	_____
EMG	—	—	_____	—	—	_____
Bone Scan	—	—	_____	—	—	_____

17. Have you had any past episodes of similar pain or injury? Yes or No (please describe)

18. List all other physicians with whom you have consulted in the past year for this problem.

SOCIAL HISTORY

19. Current work status: Working full duty Working restricted duty (Since _____)
Retired Disabled (Since____) Student Homemaker Unemployed
Company: _____ Occupation: _____
Title: _____ How long have you worked for this company? _____
20. Marital status: Single Married Divorced Widowed
21. Number of Children: _____
22. I live: Alone With: _____
23. I live in a: House Apartment Assisted living Nursing home
24. Are you a cigarette smoker? Yes Never Quit-How long ago did you quit? _____
If answered "yes" or "quit", how much do or did you smoke per day?
Less than 1/2 pack 1/2 pack 3/4 pack 1 pack More (How many?)____
How old were you when you started smoking? _____
25. Do you drink any alcoholic beverages? (Check one)
None 0 to 3 per month 1 to 2 drinks per week 1 to 2 drinks per day 3 to 5 drinks per day
More than 5 drinks per day. How many? _____ Alcoholic in past? Yes No
26. Have you ever had a problem with drug dependence? Yes No
If yes, then: Cocaine Heroin Marijuana Narcotics Other: _____
27. Please write any additional information that you feel is important for us to know.

Sensory Defects

Loss of Hearing or Deaf.....Yes No

Loss of Vision or Blind.....Yes No

Respiratory (Lung or Breathing Problems)

Asthma / Wheezing.....Yes No

Emphysema / COPD.....Yes No

Lung Disease.....Yes No

Sleep Apnea.....Yes No

Tuberculosis.....Yes No

Cardiac (Heart Problems)

Heart Attack.....Yes No

Heart Disease.....Yes No

Heart Failure.....Yes No

Heart Murmur.....Yes No

Rheumatic Fever.....Yes No

High Blood Pressure.....Yes No

High Cholesterol.....Yes No

Vascular (Circulation Problems)

Wounds or Sores.....Yes No

Peripheral Artery Disease..Yes No

Peripheral Vascular disease..Yes No

Gastrointestinal (GI or Abdominal Problems)

Liver Disease.....Yes No

Hepatitis.....Yes No

Gall Bladder Problems.....Yes No

Crohn's / UC / IBS.....Yes No

Ulcers.....Yes No

Renal (Kidney Problems)

Kidney Failure.....Yes No

Kidney Disease.....Yes No

Kidney Stones.....Yes No

Immunologic / Infectious Disease

Aids.....Yes No

HIV.....Yes No

Auto-immune.....Yes No

Endocrine

Diabetes.....Yes No

Low Blood Sugar.....Yes No

Thyroid Problems.....Yes No

Musculoskeletal (Bone, Joint, or Muscle Problems)

Arthritis.....Yes No

Osteoporosis.....Yes No

Neurological (Brain or Nerve Problems)

Stroke.....Yes No

TIA.....Yes No

Seizures.....Yes No

Headaches / Migraines.....Yes No

Mental Health

Alzheimer's.....Yes No

Anxiety.....Yes No

Dementia.....Yes No

Depression.....Yes No

Mental Illness.....Yes No

Hematologic (Blood Problems)

Anemia.....Yes No

Bleeding Disorder.....Yes No

Clotting Problems.....Yes No

Sickle-Cell Disease.....Yes No

Oncologic (Cancer)

Breast.....Yes No

Colorectal.....Yes No

Leukemia.....Yes No

Lymphoma.....Yes No

Prostate.....Yes No

Urinary / Bladder.....Yes No

Chemotherapy.....Yes No

Radiation Therapy.....Yes No

Other Medical Illnesses (please list)

OTHER SURGICAL / MEDICAL HISTORY

Have you had any of the following implants? Yes No

Implantable Cardioverter – Defibrillator Yes No Pacemaker Yes No (date) ___ / ___ / ___

Spinal Cord Stimulator Yes No (date) ___ / ___ / ___

Have you had any of the following operations? Yes No

Appendix Yes No (date) ___ / ___ / ___ Mastectomy Yes No (date) ___ / ___ / ___

Brain (date) Yes No (date) ___ / ___ / ___ Prostate Removal Yes No (date) ___ / ___ / ___

Gall Bladder Yes No (date) ___ / ___ / ___ Spine / Joint Yes No (date) ___ / ___ / ___

Heart Yes No (date) ___ / ___ / ___ Thyroid Yes No (date) ___ / ___ / ___

Hernia (date) Yes No (date) ___ / ___ / ___ Tonsils Yes No (date) ___ / ___ / ___

Hysterectomy Yes No (date) ___ / ___ / ___ **Other** (specify) _____ (date) ___ / ___ / ___

Have you had any of the following transplants? Yes No

Heart Yes No (date) ___ / ___ / ___ Lung Yes No (date) ___ / ___ / ___

Kidney Yes No (date) ___ / ___ / ___ Pancreas Yes No (date) ___ / ___ / ___

Liver Yes No (date) ___ / ___ / ___ Other (specify) _____ Yes No (date) ___ / ___ / ___

Have you or your family ever had any complications due to dye or contrast? Yes No

Have you had any previous non-surgical hospitalization(s)? (please use last page for additional space)

Reason for Hospitalization	Date	Hospital Name	Any Complications?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY MEDICAL HISTORY

Please indicate whether any of your BLOOD RELATIVES have had any of the medical illnesses listed below

	Mother	Father	Grandparent	Sibling	Child
If history is unknown, please check:	_____	_____	_____	_____	_____
Respiratory.....	_____	_____	_____	_____	_____
Tuberculosis.....	_____	_____	_____	_____	_____
Cardiovascular.....	_____	_____	_____	_____	_____
Heart Attack.....	_____	_____	_____	_____	_____
Heart Disease.....	_____	_____	_____	_____	_____
High Blood Pressure.....	_____	_____	_____	_____	_____
Endocrine.....	_____	_____	_____	_____	_____
Diabetes.....	_____	_____	_____	_____	_____
Low Blood Sugar.....	_____	_____	_____	_____	_____
Thyroid Disease.....	_____	_____	_____	_____	_____
Neurological.....	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Mental Health.....	_____	_____	_____	_____	_____
Alzheimer's.....	_____	_____	_____	_____	_____
Dementia.....	_____	_____	_____	_____	_____
Depression.....	_____	_____	_____	_____	_____
Mental Illness.....	_____	_____	_____	_____	_____
Hematologic.....	_____	_____	_____	_____	_____
Bleeding Disorder.....	_____	_____	_____	_____	_____
Oncologic.....	_____	_____	_____	_____	_____
Cancer.....	_____	_____	_____	_____	_____

