Sterling Group Pain Management

Sterling Group Pain Management services

Eliran Bracha, DO • Lisa Speigner, FNP-C

Patient Information

Date: _____ Date of Birth: _____

Patient Name: _____

Address: _____

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

Referring Physician: _____

Address: _____

City: _____

Phone: ( ) _____ Fax: ( ) _____

Primary Physician: _____

Address: _____

City: _____

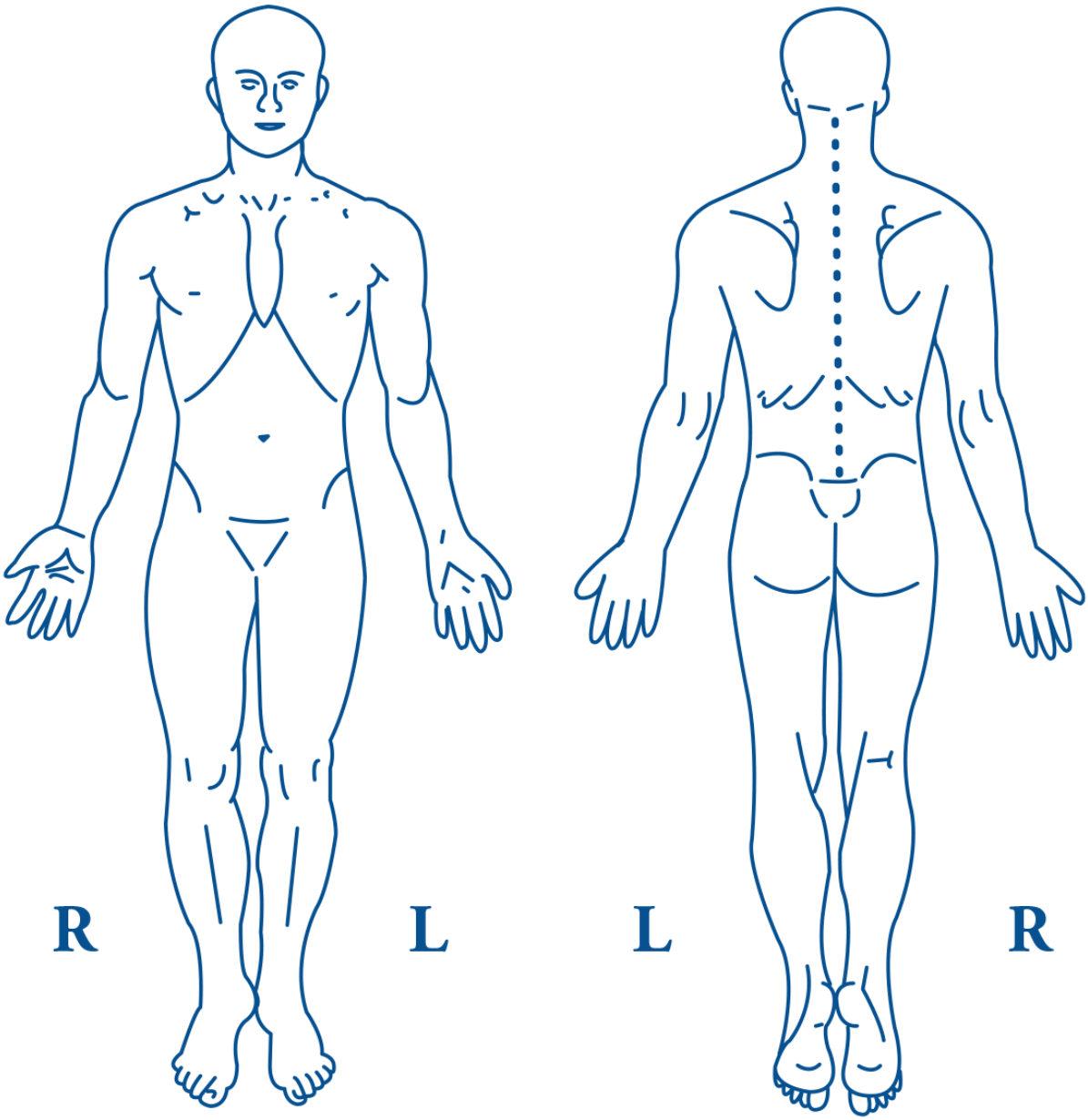
Phone: ( ) _____ Fax: ( ) _____

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 = ###



Pain Score: Please indicte 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 ½ pack __ ½ pack __ ¾ 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	_____	_____	_____	_____	_____

Current Medications

Please list all current medications that you are taking below.

Medication	Dosage	Frequency	Reason Prescribed

Allergies

Please list all allergies that you have below

SUBSTANCE	REACTION

STERLING GROUP
PAIN MANAGEMENT

Sterling Group Pain Management Services
Eliran Bracha, DO
Lisa Speigner, FNP-C

Authorization for Release of Medical Records (To obtain records from another Professional Medical Facility)

I,_____, authorize that my recent medical records be released to:
Person Authorizing Release

Sterling Group
Pain Management Services
P.O. Box 40
Moultrie, Ga 31776

Please list the name of the physician(s) who referred you to us or any physician, person(s), business(s) you would allow us to request or release your personal Health information.

To:_____ (primary care physician)
_____ (referring physician)
_____ (other physician)
_____ (significant other)
_____ (attorney/case manager
_____ (other care takers)

I understand that this authorization allows the release of all information in my medical records to include lab test results, x-rays, and any surgery information. This authorization allows records at be mailed or faxed. I understand that I may revoke this consent at anytime. This consent will automatically expire without my expressed revocation 1 year from the date on this form.

_____
Patient Last Name First Name MI

_____
Address

_____
City State Zip

_____
Patient's Date of Birth SSN

_____
Patient/Guardian Signature