

STERLING GROUP



PAIN MANAGEMENT

STERLING GROUP PAIN MANAGEMENT SERVICES

ROYCE COPELAND, DO • SAVANNA McMILLAN, NP-C

PATIENT INFORMATION

Date: _____ Date of Birth: _____

Patient Name: _____

Address: _____

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

Referring Physician: _____

Address: _____

City: _____

Phone: () _____ Fax: () _____

Primary Physician: _____

Address: _____

City: _____

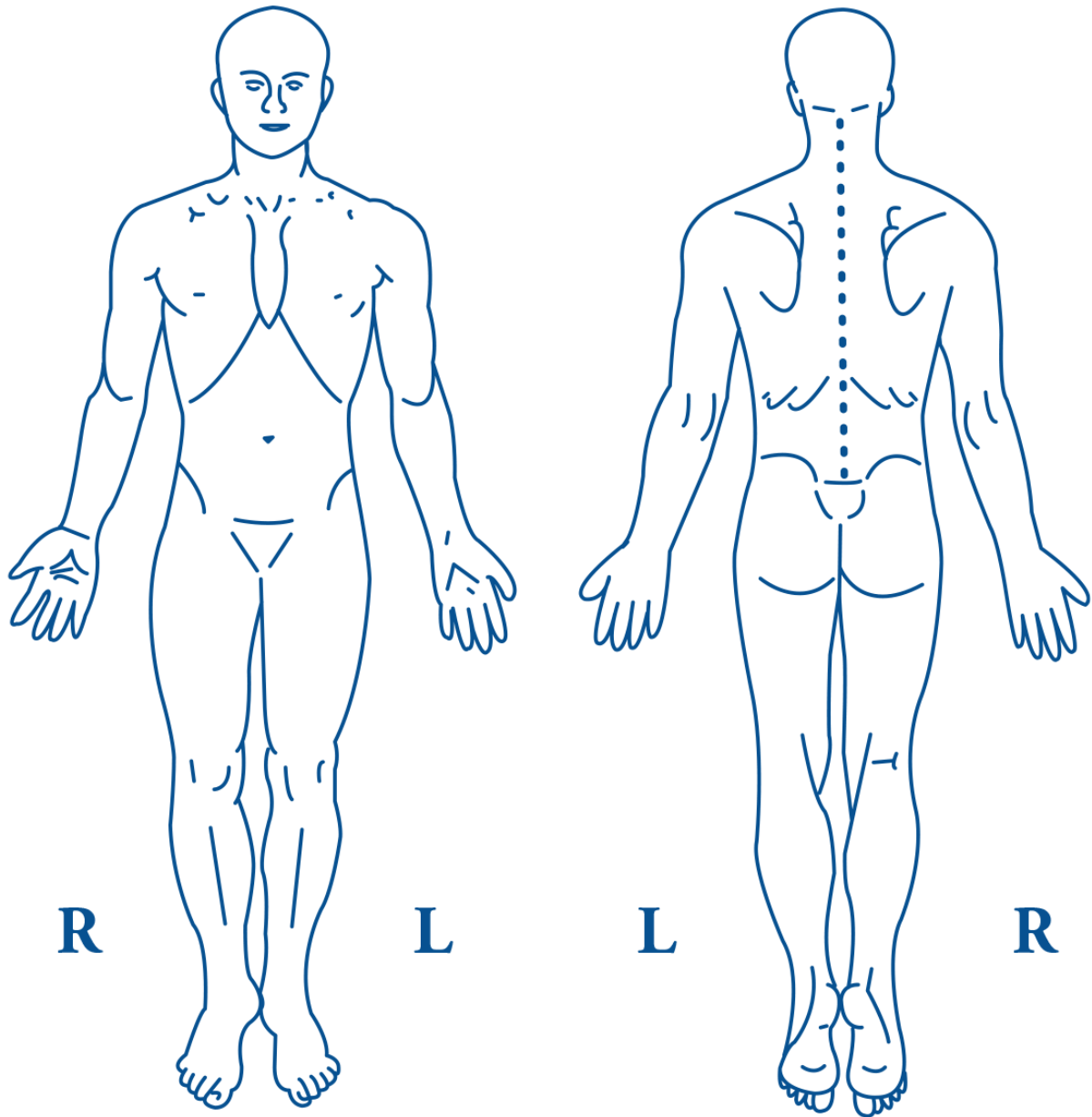
Phone: () _____ Fax: () _____

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 =	###
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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 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.

[illegible]

ALLERGIES

Please list all allergies that you have below

[illegible]

STERLING GROUP

PAIN MANAGEMENT

Sterling Group Pain Management Services
Royce Copeland, DO
Savanna McMillan, NP-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		