

NEW PATIENT VISIT

Name _____ Date of Visit: _____ DOB: _____

What is the main problem for which you are seeking treatment? _____

1. Where is your pain located? (Show on diagram)

2. How long have you had this pain? _____

3. How did it start? _____

4. Is it constant or intermittent? (Please Circle)

5. How do you describe the pain? (Please check)

- | | | | |
|-----------------------------------|---|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Electric shock | <input type="checkbox"/> Pounding | <input type="checkbox"/> Stinging |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Heavy | <input type="checkbox"/> Sharp | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Knife Like | <input type="checkbox"/> Shooting | <input type="checkbox"/> Tightness |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Pressure Like | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Tingling |

6. Where does the pain radiate to? Left: Right: Both:

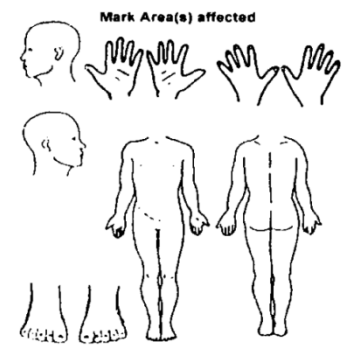
- | | | | | |
|-----------------------------------|-------------------------------|-------------------------------|--------------------------------|-------------------------------|
| <input type="checkbox"/> Buttocks | <input type="checkbox"/> Arm | <input type="checkbox"/> Hip | <input type="checkbox"/> Knees | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hand | <input type="checkbox"/> Legs | <input type="checkbox"/> Ankle | <input type="checkbox"/> Toes |

7. Severity of pain at its worst? 0 1 2 3 4 5 6 7 8 9 10

8. Severity of average pain? 0 1 2 3 4 5 6 7 8 9 10

9. What makes the pain worse?

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Driving | <input type="checkbox"/> Looking Up | <input type="checkbox"/> Sitting for too long | <input type="checkbox"/> Turning side to si |
| <input type="checkbox"/> Bowel Movements | <input type="checkbox"/> Going down stairs | <input type="checkbox"/> Menses | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Changing Positions | <input type="checkbox"/> Heat | <input type="checkbox"/> Movement | <input type="checkbox"/> Standing for too long | <input type="checkbox"/> Weather Changes |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Increased Activity | <input type="checkbox"/> Physical Activity | <input type="checkbox"/> Sleeping | |
| <input type="checkbox"/> Cold Weather | <input type="checkbox"/> Laying Flat | <input type="checkbox"/> Sexual Activity | <input type="checkbox"/> Turning left | |
| <input type="checkbox"/> Climbing Stairs | <input type="checkbox"/> Lifting | <input type="checkbox"/> Sit to stand transfers | <input type="checkbox"/> Turning Right | |



10. What makes the pain better?

- | | | | | |
|--|--|--|---|------------------------------------|
| <input type="checkbox"/> Assistive devices | <input type="checkbox"/> Heat | <input type="checkbox"/> Leaning forward | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Hot baths | <input type="checkbox"/> Leaning back | <input type="checkbox"/> Pool therapy | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Change in positions | <input type="checkbox"/> Ice | <input type="checkbox"/> Massage | <input type="checkbox"/> Rest | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Cold pack | <input type="checkbox"/> Injections | <input type="checkbox"/> Medications | <input type="checkbox"/> Squatting | <input type="checkbox"/> TENS unit |
| <input type="checkbox"/> Exercising | <input type="checkbox"/> Inversion Table | <input type="checkbox"/> Moving around | <input type="checkbox"/> Stretching | <input type="checkbox"/> Walking |

11. Associated Symptoms

- | | | | |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> Difficulty with sleep | <input type="checkbox"/> Need for sleeping pills | <input type="checkbox"/> Restricted activities | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Feeling Blue | <input type="checkbox"/> Non restful sleep | <input type="checkbox"/> Unable to fall asleep | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Frustrated | <input type="checkbox"/> Fevers | <input type="checkbox"/> Unable to stay asleep | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Loss of bowel/bladder function | <input type="checkbox"/> Chills | <input type="checkbox"/> Waking up | |
| <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Sweats | <input type="checkbox"/> Weakness | |

12. Do you feel numbness and or pins & needles in association with your pain?

No: If Yes: Numbness
 Pins and needles

13. Do you have weakness? No: If yes check boxes below:

Arms: Right: Left: Do you drop objects? No: Yes:

Legs: Right: Left: Have you fallen recently? No: Yes:

Do you have balance problems? No: Yes:

Other: (Please Describe)

14. How many blocks can you walk?

- Less than 1
- 2
- 3
- 4 or more

16. Sleep Disturbance

Do you have difficulty falling asleep? No: Yes:

Do you have difficulty remaining asleep? No: Yes:

Are you ever awakened by pain? No: Yes:

On average how many hours do you sleep? _____ hrs

15. How often during the day do you have to rest because of the pain?

- Never
- Seldom
- Sometimes
- Often
- Constantly

17. How long can you sit?

- Less than 15 minutes
- Up to 30 minutes
- Up to 1 hour
- 1 – 2 hours
- 2 hours or more

19. How long can you stand?

- Less than 15 minutes
- Up to 30 minutes
- Up to 1 hour
- 1 – 2 hours
- 2 hours or more

18. To assist walking, I use a:

- No assistance device
- Cane
- Walker
- Wheelchair

20. Which activities of daily living are affected by your pain? (check all that apply)

- Socialize with friends
- Participate in recreational activities
- Go to work
- Dress, or bath
- Perform household chores
- Exercise
- Other: _____

21. Do you have any of the following (Please check)

Dizziness/vertigo: Fibromyalgia:

22. Who have you seen for this pain? _____

23. What test have you undergone? _____

24. What treatment have you tried in the past for your pain (Please check your response to all treatments you have tried)

Physical Therapy	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
TENS Therapy	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Pool Therapy	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Biofeedback	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Pain Management	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Psychiatric Therapy	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Epidurals	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Acupuncture	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Chiropractic Manipulations	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Spine Surgery	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Nerve Blocks	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Other: _____	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Other: _____	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief
Other: _____	<input type="checkbox"/> No Relief	<input type="checkbox"/> Some Relief	<input type="checkbox"/> Good Relief

26. List all meds you are taking now? Dosage? How many?

27. Are you allergic to any medications? _____

28. Do you have any other medical problems? _____

29. Have you ever had any surgeries? When? _____

30. Do you drink alcohol? Yes: No: **If yes how often?** _____

31. Smoke cigarettes? Yes: No: **If yes how much?** _____

32. Do you use nonprescription drugs? _____

33. Have you ever had a history of drug or substance abuse? Yes: No:

34. Marrital status? _____

35. Are you currently working? Yes: No: **What kind of work do you do?** _____

Are you on disability? Yes: No: **Are you pregnant?** Yes: No:

36. Does anyone in your family have a history of related medical problems?

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT HISTORY AND PRE OPERATIVE QUESTIONNAIRE

Name _____ DOB: _____ Height: _____ Weight: _____

CHECK ONE:

YES NO

- () () 1. Do you wear contact lenses?
- () () 2. Do you have dentures, caps or loose teeth?
- () () 3. Do you wear a hearing aide?
- () () 4. Do you wear a prosthetic device such as a glass eye or an artificial limb?
- () () 5. Do you have difficulty moving your joints, arms legs or back?
- () () 6. Do you drink alcohol? How many times a week? _____ month? _____
- () () 7. Do you smoke? How many a day? _____ month? _____
- () () 8. Have you ever had a bad reaction or allergy to a medication or drug?
Names of meds and the reactions: _____
- () () 9. Have you ever taken cortisone or steroid preparation within the past two years?
Drug: _____ How much? _____ When? _____
- () () 10. Have you ever had a serious illness? Please explain: _____
- () () 11. Have you ever had any of the following:
- | | | |
|---------------------------|-------------------------------|---------------------|
| [] shortness of breath | [] wheeze(asthma) | [] heart attack |
| [] cough or bronchitis | [] ankle swelling | [] numbness |
| [] chest pain | [] heart murmur | [] seizure problem |
| [] irregular heartbeat | [] high blood pressure | [] diabetes |
| [] hepatitis or jaundice | [] easy bruising or bleeding | [] kidney problems |
| [] joint stiffness | [] muscle weakness | [] other |
- () () 12. Are you presently being treated for any medical problems? Explain: _____
- () () 13. Do you take any medicines or drugs?
Name and dose _____
- () () 14. Have you ever had an operation?
Name and date of surgery: _____
- () () 15. Have you ever had a blood transfusion?
- () () 16. Have you or any family member had a reaction or death related to a local or General Anesthesia?

Patient Signature _____ Date: _____

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J. Druet M.D.
S. Uraine M.D.
J. K. Ehlers PA-C
H. Brickle PA-C

Name (Last, First, M.I.) _____

Address _____ Date of Birth: _____ Age _____ M/ F

City, State, Zip _____ Social Security #: _____

Phone: _____ Cell: _____ Marital Status: Single Married Divorced Widowed

Emergency Contact _____ Phone #: _____

How did you hear about us: _____

Employer _____ Occupation _____

Address _____ Phone #: _____

Referring Physician _____ Phone #: _____

Insurance Company _____ Customer Service #: _____

Billing Address _____ Pre-Cert #: _____

City, State, Zip _____ E-Mail: _____

Subscriber Name _____ Subscriber Date of Birth _____

Insurance ID# _____ Subscriber Social Security _____

Group/Account _____ Effective Date _____

Subscriber Employer _____ Contact #: _____

Work Comp Claim# _____ WCAB# _____

Adjuster _____ Phone #: _____

Date of Injury _____ Fax #: _____

Nurse Case Manager _____ Phone #: _____

Fax #: _____

Attorney _____ Phone #: _____

Address _____ Fax #: _____

City, State, Zip _____

Work Comp Personal Injury



Temecula Pain Management

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I _____, fully understand and agree to all terms and conditions stated in the printed or electronic versions of the patient information forms named below. Temecula Pain Management will provide hard copies for your records upon request, or you may go to www.paintemgroup.com to obtain the forms.

(Please sign, print, and date the following four spaces indicating that you have read, understand, and agree to the patient information forms.)

1. Office Policies

Signature

Print Name

Date

2. Assignment and Instruction for Direct Payment Carol McNamara CRNA or Karen Bernard CRNA, Private & Group Accident & Health Insurance

Signature

Print Name

Date

Signature if other than policy holder

Print Name

Date

3. Assignment and Instruction for Direct Payment to Temecula Pain Management Center Private & Group Accident & Health Insurance

Signature

Print Name

Date

Signature if other than policy holder

Print Name

Date

4. H.I.P.A.A. (Protected Healthcare Information)

Signature

Print Name

Date

5. Disclosure Statement

Signature

Print Name

Date