25495 Medical Center Dr.
Murrieta, CA 92562
Tel. (951) 506-9536

Temecula Pain Management Group, Inc

J. Druet M.D.
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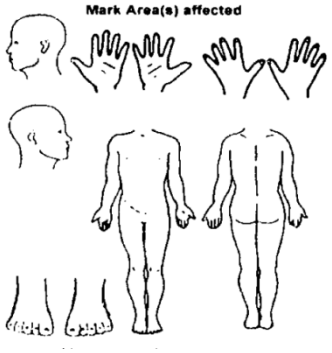
NEW PATIENT VISIT

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)

☐ Aching	☐ Electric shock	☐ Pounding	☐ Stinging
☐ Burning	☐ Heavy	☐ Sharp	☐ Throbbing
☐ Cramping	☐ Knife Like	☐ Shooting	☐ Tightness
☐ Dull	☐ Pressure Like	☐ Stabbing	☐ Tingling

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

☐ Buttocks	☐ Arm	☐ Hip	☐ Knees	☐ Foot
☐ Shoulder	☐ Hand	☐ Legs	☐ Ankle	☐ 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?

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

10. What makes the pain better?

☐ Assistive devices	☐ Heat	☐ Leaning forward	☐ Physical therapy	☐ Sitting
☐ Acupuncture	☐ Hot baths	☐ Leaning back	☐ Pool therapy	☐ Standing
☐ Change in positions	☐ Ice	☐ Massage	☐ Rest	☐ Swimming
☐ Cold pack	☐ Injections	☐ Medications	☐ Squatting	☐ TENS unit
☐ Exercising	☐ Inversion Table	☐ Moving around	☐ Stretching	☐ Walking

11. Associated Symptoms

☐ Difficulty with sleep	☐ Need for sleeping pills	☐ Restricted activities	☐ Depression
☐ Feeling Blue	☐ Non restful sleep	☐ Unable to fall asleep	☐ Weight Loss
☐ Frustrated	☐ Fevers	☐ Unable to stay asleep	☐ Headaches
☐ Loss of bowel/bladder function	☐ Chills	☐ Waking up	
☐ Muscle cramps	☐ Sweats	☐ 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

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

- ☐ Never
- ☐ Seldom
- ☐ Sometimes
- ☐ Often
- ☐ Constantly

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

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

18. To assist walking, I use a:

- ☐ No assistance device
- ☐ Cane
- ☐ Walker
- ☐ Wheelchair

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

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	☐ No Relief	☐ Some Relief	☐ Good Relief
TENS Therapy	☐ No Relief	☐ Some Relief	☐ Good Relief
Pool Therapy	☐ No Relief	☐ Some Relief	☐ Good Relief
Biofeedback	☐ No Relief	☐ Some Relief	☐ Good Relief
Pain Management	☐ No Relief	☐ Some Relief	☐ Good Relief
Psychiatric Therapy	☐ No Relief	☐ Some Relief	☐ Good Relief
Epidurals	☐ No Relief	☐ Some Relief	☐ Good Relief
Acupuncture	☐ No Relief	☐ Some Relief	☐ Good Relief
Chiropractic Manipulations	☐ No Relief	☐ Some Relief	☐ Good Relief
Spine Surgery	☐ No Relief	☐ Some Relief	☐ Good Relief
Nerve Blocks	☐ No Relief	☐ Some Relief	☐ Good Relief
Other: _____	☐ No Relief	☐ Some Relief	☐ Good Relief
Other: _____	☐ No Relief	☐ Some Relief	☐ Good Relief
Other: _____	☐ No Relief	☐ Some Relief	☐ Good Relief

25. Do you experience any of the following?

Constitutional

☐ Fever ☐ Chills ☐ Hot Flashes ☐ Night Sweats ☐ Weight Loss

Eyes

☐ Blurred Vision ☐ Double Vision ☐ Photophobia

HENT

☐ Loss of Balance ☐ Syncope ☐ Deafness/hearing loss ☐ Head injuries

Cardiovascular

☐ MI ☐ Chest Pain ☐ Irregular Heartbeat ☐ High BP ☐ Limp Swelling
☐ Phlebitis ☐ DVT ☐ PVD ☐ Angina ☐ CHF

Respiratory

☐ Shortness of breath ☐ COPD/Emphysema ☐ Sleep Apnea

Gastrointestinal

☐ Heart Burn ☐ Nausea/Vomiting ☐ Diarrhea ☐ Constipation ☐ Bloody Stool
☐ Ulcers ☐ GERD ☐ Jaundice/Hepatitis

Genitourinary

☐ Blood in Urine ☐ Kidney Failure ☐ Bladder problems ☐ Kidney Stones ☐ Problem Urinating

Musculoskeletal

☐ Muscle Pain ☐ Muscle cramps ☐ Muscle twitches ☐ Neck pain ☐ Loss of muscle bulk
☐ Back pain ☐ Joint pain ☐ Joint stiffness ☐ Joint swelling ☐ Tremors
☐ Fractures ☐ Arthritis ☐ Limitation of joint movement ☐ Night cramps ☐ Posture abnormalities

Neurological

☐ Headache ☐ Seizures ☐ Blackouts ☐ Trouble W/Memory ☐ Trouble Concentrating
☐ Decrease in Cognitive skills ☐ Stroke ☐ Involuntary movements ☐ Speech Difficulties ☐ Spasticity

Physiological

☐ Depression ☐ Anxiety ☐ Family History of Psychiatric Disorder

Hematologic

☐ Abnormal Bleeding ☐ Anemia ☐ Blood Clotting ☐ High/low Blood Counts

Endocrine

☐ Thyroid Problem ☐ Diabetes

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:** _____

TEMECULA PAIN MANAGEMENT GROUP
Paintemgroup.com

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PATIENT HISTORY AND PRE OPERATIVE QUESTIONAIRE

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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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

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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