General Information ❶

Name _____ Date:_____ _____ _____

Phone number where we may reach you _____ may we leave a message at this number? ☐ No ☐ Yes

Primary Care Physician _____ Ph: _____ Fax: _____

Referring Physician: _____ Ph: _____ Fax: _____

Occupation _____ Work Hours _____ Religious affiliation / practices _____

Marital Status ☐ single ☐ married ☐ divorced ☐ widowed

Number of Children _____ Ages of Children _____ Total Number in the Household _____

Do you have allergies to medication? ☐ No ☐ Yes please list _____

Do you drink alcohol? ☐ No ☐ Yes *specify frequency and amount:* _____

Do you use or have a history of recreational drug use? ☐ No ☐ Yes, Explain _____

Do you smoke/history of tobacco use ☐ No ☐ Yes _____ packs/day _____# yrs.

History of Detox Program ☐ No ☐ Yes When _____ Where _____

Do you have an advance directive? ☐ Yes - no copy on chart ☐ No - no information desired
☐ Yes - copy on chart ☐ No - information given

General Health History ❷

Do you suffer from any of the following conditions?

Please circle all that apply:

Constitutional: Recent Weight Change, Fatigue, Fever, Poor Appetite

Eyes, Ears: Poor Vision, Glaucoma, Cataracts, Poor Hearing, Ringing in the Ears, Vertigo

Nose, Mouth Throat: Sinusitis, Swollen Glands, Dentures, Hoarseness

Cardiovascular: High Blood Pressure, Heart Murmur, Irregular Rhythm, Heart Attack, Heart Failure, Palpitations, Chest Pains, Pace Maker, AICD, Edema

Respiratory: Wheezing, Asthma, Bronchitis, Emphysema, Tuberculosis

Gastrointestinal: Heart Burn, Nausea, Vomiting, Diarrhea, Constipation, Blood in Stool, Ulcer, Crohn's, Colitis, GERD

Genitourinary: Frequent Voiding, Enlarged Prostate, Incontinence, Sexual Dysfunction, Blood in Urine, Menstrual Irregularity, Kidney Failure, Dialysis

Musculoskeletal: Arthritis, Joint Swelling, Muscle Cramps, Tenderness, Carpal Tunnel Syndrome

Skin: Rash, Change in Skin Color or Appearance, Changes in Hair or Nails

Neurological: Seizures, Headaches, Migraines, Paralysis, Numbness, Tremors, Stroke, Parkinson's, Multiple Sclerosis

Psychiatric: Nervousness, Anxiety, Depression, Bipolar, Physical Abuse, Sexual Abuse

Endocrine: Thyroid Problems, Diabetes, Lupus, Fibromyalgia, Pituitary Dysfunction

Hematologic: Anemia, Easy Bruising, Taking Blood Thinners, Coumadin

Immunologic: Shingles, Immune Deficiency, HIV, Cancer Type _____ _____ Cancer Treatment _____ _____

Additional conditions: _____

List family medical history which may be significant.

Family History: _____Medical Conditions

Father: _____

Mother: _____

Sister(s): _____

Brother(s): _____

Have you ever had surgery? ☐ no ☐ yes *please list surgeries, approximate dates and facilities below:*

Surgery	*Approx. Date*	*Surgery*	*Approx. Date*

Pain Assessment

Describe your pain in your own words: _____

Does coughing, sneezing or straining increase your pain? ☐ Yes ☐ No

Accompanying symptoms with pain ☐ nausea ☐ vomiting ☐ constipation ☐ dizziness ☐ vision problems ☐ drowsiness ☐ weakness in extremities ☐ coordination ☐ numbness/tingling

When did you first notice the pain? *month* _____ *day* _____ *year* _____

Is this Workman's Compensation? ☐ no ☐ yes Are you in a Litigation? ☐ no ☐ yes

If work related injury, describe how you were injured. Include type of work _____

Please indicate your current status: ☐ Working without Restrictions ☐ Working with Restrictions ☐ Type _____ ☐ Not Working ☐ Home Maker ☐ Retired

Have been able to continue to work after your injury? ☐ no ☐ yes *If yes, are you working in the same capacity?* ☐ *no* ☐ yes

When did you first see your doctor for pain? _____ What type of physician? _____

Have you had any of the following?

X-ray	of what?	_____	_____MRI scan	of what?	_____
Myelogram			_____Bone scan	of what?	_____
EMG	of what?	_____	_____Discography	of what?	_____
CAT scan	of what?	_____	_____Other	of what?	_____

Have you had any of the following in the course of treatment for your pain?

_____ Acupuncture	_____ Chiropractic Treatments	_____ Trigger point injections
_____ Psychological Counseling	_____ Hypnosis	_____ Epidural steroid injections
_____ Biofeedback	_____ Physical therapy	_____ Operations _____
_____ Tens (electrical stimulation)	_____ Nerve blocks	_____ Other _____

Did any previous treatments help? ☐ no ☐ yes *describe:* _____

Medications have you taken in the past for pain that were effective? _____

_____

Medications taken in the past that were not effective? _____

_____

CHRONIC PAIN MANAGEMENT PROGRAM:

Defining pain is often difficult and very subjective. To provide some consistency in how the 0 – 10 pain rating scale is used, the following scale has been developed.

Please rate your pain by circling the one number that best describes your pain at its **WORST** in the past

0* 1 2 3 4 5 6 7 8 9 **10****

*No pain **Pain as bad as you can imagine

Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the past

0* 1 2 3 4 5 6 7 8 9 **10****

*No pain **Pain as bad as you can imagine

Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**

0* 1 2 3 4 5 6 7 8 9 **10****

*No pain **Pain as bad as you can imagine

Has your pain led to increased depression or anxiety? ☐ no ☐ yes

PAIN GOALS (Acceptable Pain Level) _____

A. What is it that you want to do but pain keeps you from doing? _____

_____

B. What pain rating would allow you to do that? _____

_____

PAIN IMPACT: Check the box that best describes how pain is interfering with the following

Sleep	☐ does not interfere	☐ partially interferes	☐ completely interferes
Physical Activity	☐ does not interfere	☐ partially interferes	☐ completely interferes
Emotional Status	☐ does not interfere	☐ partially interferes	☐ completely interferes
Relationships with others	☐ does not interfere	☐ partially interferes	☐ completely interferes
Quality of life	☐ does not interfere	☐ partially interferes	☐ completely interferes

Where do you live? ☐ home ☐ apartment ☐ alone ☐ with family ☐ with friends

Does someone help you with daily activities? ☐ no ☐ yes *who?* _____

Do you need an assistance to get around? ☐ no ☐ yes: cane, walker, wheelchair

PAIN LOCATION / TYPE: Shade areas of pain and describe

Pain:

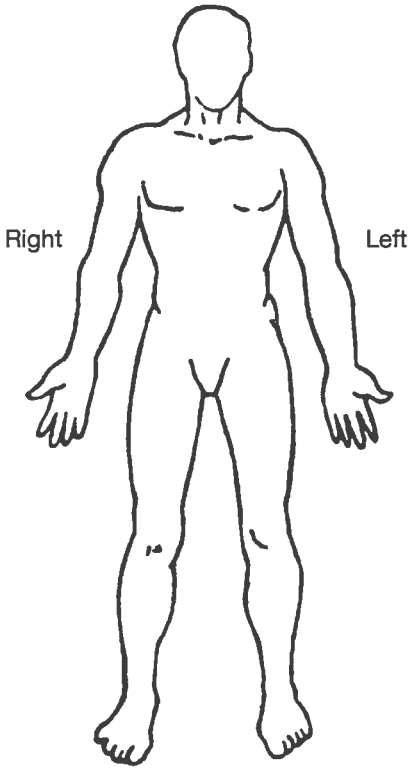
Aching – N N N / N N Burning – x x x x / x x x Numbness – = = / = = Stabbing – /// /// /// / /// /// Pins and needles – • • • • • / • • • • • Muscular Cramps – S S S / S S

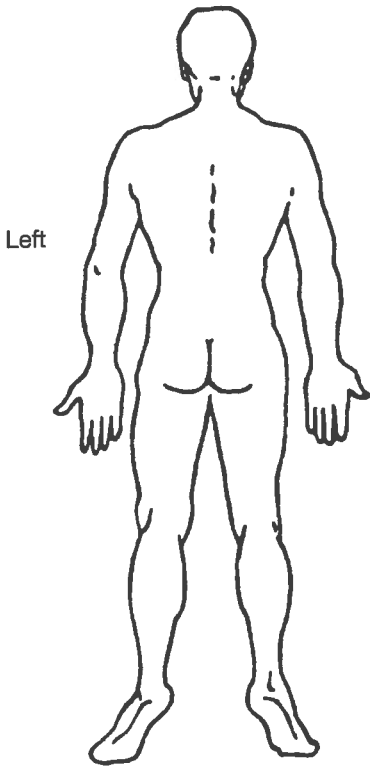
Height _____

Weight _____

Rt Handed _____

Left Handed _____





Duration of pain ☐ constant ☐ intermittent

What aggravates pain? _____ What relieves pain? _____

Completed by: _____ Date _____

Reviewed by _____ Date _____

Changes to interpreter/special assistance section to be added to hospital forms, per 3/06/02 LEP Committee meeting:

Use of interpreter or special assistance:

A. Patient required the following language or special assistance:

☐ Interpreter: ☐ Foreign Language (specify) _____ ☐ Sign Language

☐ Special assistance: Patient is blind or unable to read. Form was read to patient.

B. An **interpreter or special assistant provided by Sherman Health Systems** was used:

☐ Interpreter name/number: _____ ☐ Cross Cult. Comm. Dept. ☐ Pacific Interpreters

Signature: _____ ☐ Language Line

☐ Name of special assistant: _____

Date: _____ Time: _____ Signature: _____

C. ☐ **Patient declined offer of hospital provided interpreter/special assistant:**

Date: _____ Time: _____ Patient's signature declining service _____

Name/relationship of interp. or special assist. used _____