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Date: _____

Name: _____
(Last) (First) (Middle)

Address: _____
(City) (State) (Zip)

Home: () _____ Work: () _____ Cell: () _____

Age: _____ DOB: _____ SS#: _____ Email: _____

M F Height: _____ Weight: _____ Occupation: _____

Emergency Contact: _____ Tel. # () _____

Referring MD: _____ Telephone: () _____

Address: _____
(City) (State) (Zip)

Primary MD: _____ Telephone: () _____

Address: _____
(City) (State) (Zip)

Primary Insurance Carrier: _____

Policy Number: _____

Secondary Insurance: _____

Pharmacy Name, Address and Telephone number: _____

Expected Goals from Treatment at Gramercy Pain Center:

Chief Complaint: _____

Medical History: *Please list all issues*

Surgical History: *List type of surgery*

Allergies:

Do you have any allergies to medication, foods, dye (iodine)? Yes No

If yes please list: _____

Any **Latex allergies?** Yes No *Reaction:* _____

Medications:

Please list all your current **pain** medications-prescriptions and non-prescriptions: *(please include your dosage and how many per day)*

Please list all your current **non-pain** medications: *(please give doses and how often you take your medication including non-prescription and herbal)*

List any doctors, chiropractors, physical therapy, treatment plans or other health care professionals who

have treated your pain and treatment done:

Family History of Medical Problems: _____

Social History:

Do/Did you smoke? Yes No How many packs per day: _____ For how many years: _____

Do you drink alcohol? Yes No What do you drink: _____ How frequent: _____

Have you ever used any illegal/illicit drugs? Yes No (i.e.: marijuana, heroin, cocaine, etc.)

Please explain and list: _____

Marital status: Single Married Divorced Widowed Other: _____

With whom do you live? _____ No. of children: _____

Are there any substance abuse issues in the household? Yes No

If yes, please explain: _____

Are you able to take care of yourself? Yes No

If no please enter name of care giver: _____

Work History	Job	Yrs Worked	Reason for leaving
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_____	_____	_____	_____
_____	_____	_____	_____

Legal Matters

Are you presently involved in a lawsuit? Yes No

If yes please explain: _____

Are you filing for disability? Yes No

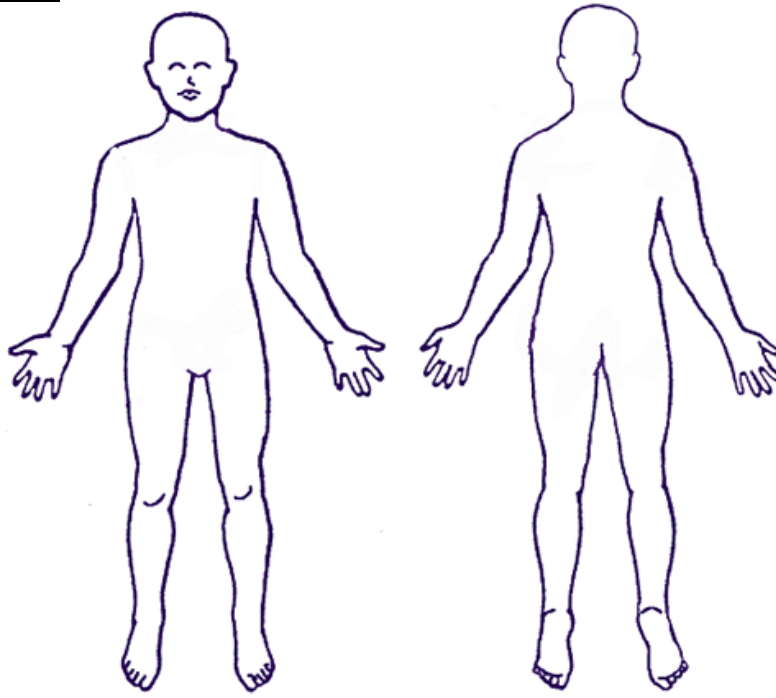
If yes please explain: _____

Review of System:

Have you ever had any of the following? (Please check either Yes or No)

	Yes	No		Yes	No		Yes	No
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>
						Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis: type: _____			Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Back Problem	<input type="checkbox"/>	<input type="checkbox"/>				Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> when: _____			Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Depression/ Anxiety		
Chronic fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	GERD/Indigestion		
Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Other Psychiatric conditions: _____		
Cough (persistent or bloody)	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Other conditions: _____		
Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>

Physical Exam & Pain Focus



1. Please indicate on the diagram above the **location of your pain**. Use an asterisk (*) to show where the pain starts and is most severe. Use an arrow to show the direction or how the pain travels. You may use more than one asterisk and arrow. By each asterisk please rate the level of pain using 0-10.

2. **Pain site in order of severity:** 1 _____ 2 _____ 3 _____

3. Please check the **words that best describe your pain:**

- Dull Stabbing Tender Shock like Numb Throbbing Gnawing
- Burning Penetrating Unbearable Shooting Sharp Tingling Nagging

4. **What time of day is your pain the worst?** (Please check one) Morning Afternoon Evening Night Time

Please rate your pain **WHEN IT IS WORST** on the numerical scale below. "0" indicates no pain. "5" indicates mild to discomforting pain. "10" indicates severe, excruciating and debilitating pain.

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild		Discomforting		Distressing		Horrible		Excruciating

5. **What time of day is your pain the least?** (Please check one) Morning Afternoon Evening Night Time

Please rate your pain **WHEN IT IS LEAST** on the numerical scale below. "0" indicates no pain. "5" indicates mild to discomforting pain. "10" indicates severe, excruciating and debilitating pain.

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild		Discomforting		Distressing		Horrible		Excruciating

6. **Duration of pain** _____

7. **What makes the pain better or worse:** _____