American Pain and Wellness

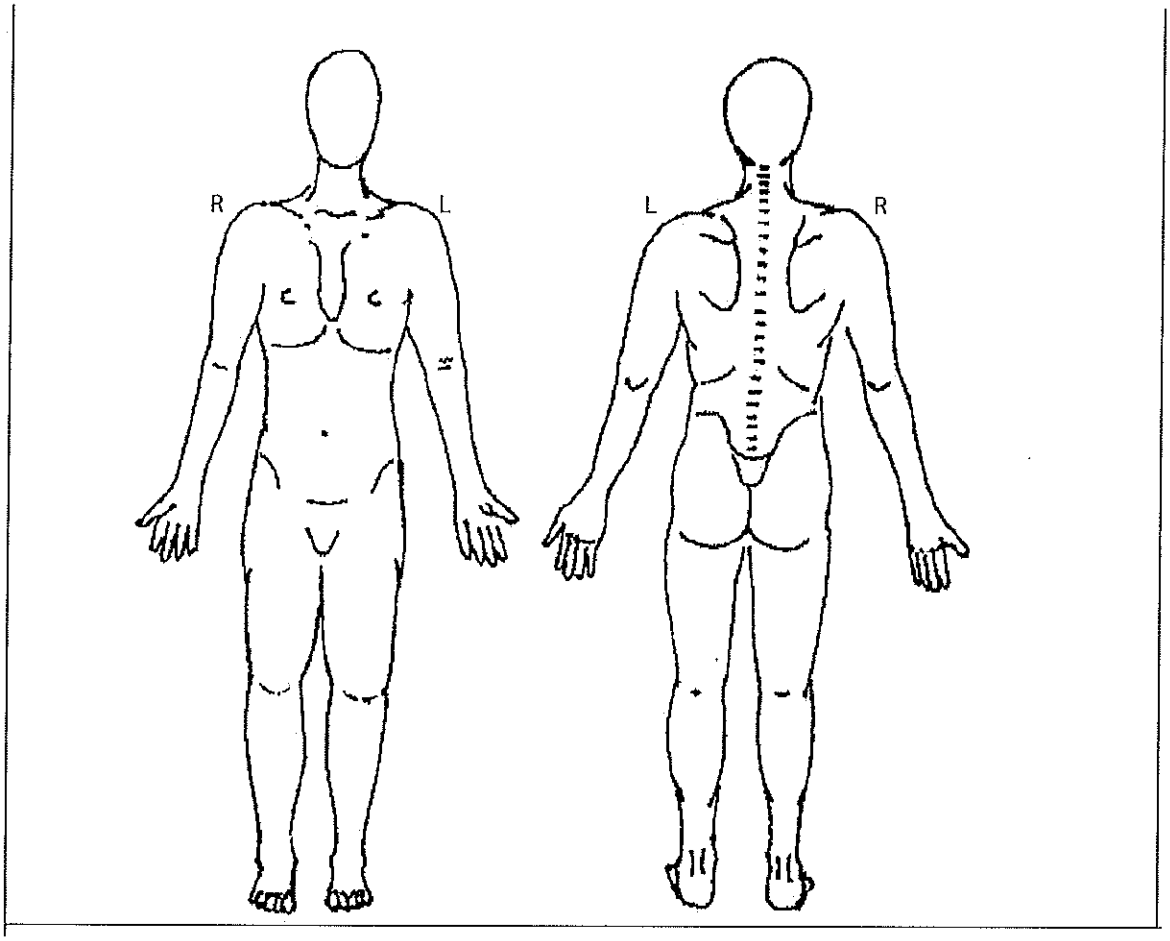
Patient Pain Profile

Date: _____ Name: _____ DOB: _____ Age: _____

Primary MD: _____ Referring MD: _____

Please mark the MAJOR areas of Pain you are experiencing.

A= ACHE P= PINS & NEEDLES B= BURNING S= STABBING N= NUMBNESS O= OTHER



Thinking back over the last 30 days, rate your pain at its lowest, highest and most consistent by circling the numbers below.
(You may do this when you print your forms or come in for your appointment)

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

Height _____ Weight _____ What is the date your pain began? _____

How did the pain begin? Work Accident ☐ Following Surgery ☐ Incident at home ☐ No Specific Event ☐

Motor Vehicle Accident ☐ Following Illness ☐

Onset of Pain: Sudden ☐ Gradual ☐ Is the pain constant ☐ Intermittent? ☐

Describe the injury. Specify the position of your body at the time of injury. (Twisting, turning, leaning, reaching)

_____

_____

Do you have any of the following? Please check all that apply on a REGUALR basis.

Loss of Bowel ☐ Loss of Bladder ☐ Leg Weakness ☐ Fevers/Chills ☐

My pain is increased by only: Check ONLY the descriptors which usually worsen your pain.

Sitting ☐ Standing ☐ Bending Backwards ☐ Bending Forwards ☐ Walking Up Steps ☐

Walking Down Steps ☐ Sneezing ☐ Coughing ☐ Stress ☐ Straining ☐

Sleeping on Stomach ☐ Weather Changes ☐ Sexual Activity ☐ Other _____

My pain is improved by: ONLY check the descriptors which usually relieve your pain.

Sitting ☐ Relaxing ☐ Leaning Forward ☐ Lying on back ☐ Hot packs ☐ Cold Packs ☐

Medications ☐ Sleeping ☐ Lying on Side ☐ Fetal Position ☐ Other: _____

Have you had any diagnostic studies for your pain: X-Ray, CT/MRI, EMG, Discogram? Where (name of facility)?

_____

_____

Please note if you have had any of the additional treatments listed below?

TREATMENT	Did it work?
Physical Therapy	
Ultrasound	
TENS	
Hydro Therapy	
Traction	
Chiropractic	
Acupuncture	

Please note if you have had any of the spinal injections below

Injection	Location on the body	Date	Physician	Did it help?
Epidural				
Caudal				
Facet				
Medical Branch Block				
Trigger Point				
Sympathetic Block				

Please list any **SPINE surgeries** you have had?

Spinal Level	Type: Fusion, Disectomy, Laminectomy, etc,.	Date	Surgeon

Please list all past Surgeries & Dates:

_____

_____

_____

Past Medical History

Do you have any of the medical following conditions?

Cardiac: Arrhythmia ☐ Heart Attack ☐ Blocked Arteries ☐ High Blood Pressure ☐ High Cholesterol ☐

Other: _____

Pulmonary: Asthma ☐ Emphysema ☐ Bronchitis ☐ Sleep Apnea ☐ Smoker ☐

Other: _____

GI: Ulcers ☐ Reflux ☐ Diverticulitis ☐ Gall Stones ☐ Liver Disease ☐ Irritable Bowel ☐
Inflammatory Bowel ☐ Crohn's/Ulcerative Colitis ☐

Other: _____

GU: Kidney Disease ☐ Kidney Stones ☐ Endometriosis ☐ Fibroids ☐ Prostate Problems ☐

Other: _____

Endocrine: Diabetes ☐ Thyroid Disease ☐ Adrenal Disease ☐

Other: _____

Rheumatological: Osteoarthritis ☐ Ankylosing Spondylitis ☐ Rheumatoid Arthritis ☐
Polymyalgia Rheumatica ☐ Fibromyalgia ☐ Systemic Lupus ☐ Erthromitosis ☐

Other: _____

Hematological: Anemia ☐ Low Platelets ☐ Bleeding Disorder ☐

Other: _____

Neurological: Seizures ☐ Multiple Sclerosis ☐ Parkinson's ☐ Tremors ☐ Stroke ☐ Neuropathy ☐

Other: _____

Psychological: Anxiety ☐ Depression ☐ Excessive Alcohol Use ☐ Substance Abuse ☐

Other: _____

What medications have you taken for **pain** in the past?	Dosage	How many times a day?	Did it help?	List any side effects

List all current medications	Dosage	How many times a day?	Does it help?	List any side effects

Check any of the medications you are taking:

Aspirin ☐ Ticlid ☐ Plavix ☐ Warafin/Coumadin ☐ Aggrenox ☐

Herapin ☐ Levenox ☐ Fragmin ☐

Are you taking any **vitamin supplements**? Yes ☐ No ☐ If so, what? _____

Are you interested in learning about our recommended vitamin & nutritional programs? Yes ☐ No ☐

Please list any Medication, Anesthesia, Tape/Soap and/or Latex/Contrast Material **allergies.** _____

_____

_____

Social History

	How often per week?	How many years?	Have you quit? if so, when?
Smoking			
Alcohol			
Illegal Substances			

Check one that applies:

Employment Status: Full Time ☐ Part Time ☐ Temporary ☐ Disabled ☐ Retired ☐ Homemaker ☐ Student ☐

Does your occupation require you to bend in an awkward position? If so, please explain.

_____

_____

Does anyone in your family suffer from chronic pain?

Parent ☐ Sibling ☐ Spouse ☐ Child ☐ Grandparent ☐

Review of System: Check those that apply on a REGULAR basis

General: Weight Loss ☐ Weight Gain ☐ Fever ☐ Chills ☐ Insomnia ☐

HEENT: Eye Problems ☐ Ear Problems ☐ Nose Problems ☐ Throat Problems ☐

Cardiac: Chest Pain ☐ Fainting Spells ☐ **Pulmonary:** Shortness of Breath ☐ Cough ☐ Bloody Sputum ☐

GI: Blood in stool ☐ Constipation ☐ Diarrhea ☐ Loss of Bowel ☐

GU: Difficulty Urinating ☐ Loss of Urine ☐ Bloody Urine ☐

Musculoskeletal: Joint Pain ☐ Muscular Pain ☐ Osteoporosis ☐

Neurological: Seizures ☐ Tremors ☐ Weakness ☐ **Psychiatric:** Depression ☐ Anxiety ☐

What do you expect from this consultation? _____

Print Form

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize: _____ (Facility Name)

_____ (Facility Address)

_____ (Facility City/State/Zip)

To Release To: _____ (Recipient Name)

_____ (Street Address)

_____ (City, State, Zip)

Telephone Number_____ Fax No._____

The following information from the medical record of:

Patient Name: _____ (first, last) Date of Birth:_____ (mm/dd/yyyy)

Social Security No: _____-_____-_____ Date(s) of Treatment: _____

Patient Address: _____ Telephone: _____

Information to be released:

☐ Discharge Summary	☐ History & Physical	☐ Operative Record	☐ Pathology Report
☐ Laboratory Reports	☐ Consultation Reports	☐ EKG/ECHO	☐ Blood Type
☐ ER Records	☐ Progress Notes	☐ Radiology reports	☐ Radiology films/CD
☐ Complete Chart	☐ Abstract/Basics	☐ Face Sheet	☐ Itemized Bill

☐ Other (specify):_____

The information specified above is to be released for the following purpose:

☐ Treatment/Consultation ☐ Patient Request ☐ Billing or Claims ☐ Attorney ☐ Social Security

☐ Other (specify) _____

Substance Use/Abuse Treatment, Psychiatric, Genetic Testing, and/or HIV/AIDS Records Release

Federal and State law requires specific authorization from patients to release sensitive information. I understand that if my medical or billing record contains information in reference to drug, tobacco and/or alcohol use/abuse, psychiatric care, genetic testing, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I must specifically agree to its release by checking Yes or No in the appropriate box. (TX HB 300)

Substance use or abuse treatment…	☐ YES-Disclose	☐ NO-Do not Disclose.
Psychiatric Care and/or mental health records…	☐ YES-Disclose	☐ NO-Do not Disclose.
Genetic Testing…	☐ YES-Disclose	☐ NO-Do not Disclose.
HIV/AIDS testing and/or treatment…	☐ YES-Disclose	☐ NO-Do not Disclose.

Time Limit and Right to Revoke

I understand this authorization will be valid for 180 days from the date signed to release any records created up to the date of signature unless revoked prior to that time or unless otherwise specified as follows. Any records created after the date of this authorization will require a new authorization. I desire this authorization to be in effect until _____ (expiration date/event). Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at the above address.

Authorization and Re-disclosure

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my healthcare may not be conditioned on whether I sign this authorization form. I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal and state privacy regulations. I authorize the medical facility to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for reproduction of record copies and/or CD's. A copy or facsimile of this authorization is as valid as the original.

Preferred method of Reproduction: ☐ CD ☐ Paper - We will try to accommodate preference where practicable.

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Authority to sign if not Patient (Documentation may be required)