Verde Pain Services
Pain Medicine

Rim Country Pain Services
Pain Medicine

Patient Health History Form **Date:____/____/____**

Name: ____ **Age:** ______ **DOB:**_______________________

Referring Provider: _________________________ **Primary Provider:** __________________________________

List all other providers involved in your care and their specialty: ______________________________________

____

When did your pain begin?____

Is it a result of an injury? **Yes**☐ **No**☐ If yes, please describe injury _______________________________________

Is your pain getting worse or has it improved? **Improving** ☐ **Getting worse** ☐

Describe your pain in as much detail as possible (where it is, how if feels, is it constant, does it come & go, etc)

____

____

____

____

Do you have any other symptoms such as numbness, weakness, and/or pins & needle sensations? Yes☐ **No**☐

If yes, please describe ____

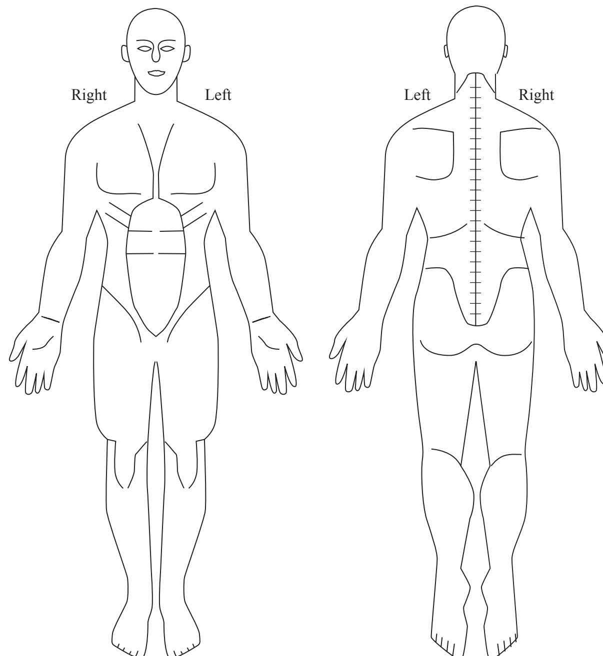
____

Has your pain affected your sleep, bowel, and/or bladder functions? **Yes** ☐ **No**☐ If yes, how so?

____

____

Please *SHADE IN*, on the drawings below, the areas where you have pain:



What makes your pain worse? Standing ☐ Sitting ☐ Walking ☐ Laying Down ☐
Other ____

What have you found that makes your pain better? ____

Medications that you have tried for pain relief: ____

What is your occupation? ____

Does the pain interfere with your ability to work? Yes ☐ **No** ☐ If yes, how? ______________________

Have you missed any work due to the pain? Yes ☐ **No** ☐ If yes, how much? ______________________

If you had an injury, was it work related? Yes ☐ **No** ☐

Are you on workmen's compensation? Yes ☐ **No** ☐

Are you involved in a lawsuit? Yes ☐ **No** ☐

Are you on disability? Yes ☐ **No** ☐ If yes, why and how long? ______________________

Have you been treated by a pain clinic? Yes ☐ **No** ☐ If yes, by whom and when? ______________________

Please list any previous treatments for your pain:

Treatment	Yes	No	Dates	Improved	No Change	Worse
Epidural Steroids						
Trigger Points						
Physical Therapy						
Surgery						
Chiropractor						
Counseling						
Other						

Have you had any of the following to evaluate your pain?

Test	Date	Place Done	Body Part
X-ray			
CT Scan			
MRI			
EMG			
Myelogram			
Laboratory			
Other			

Personal Health History

Please Check All Boxes That Apply

☐ glaucoma	☐ hearing loss	☐ diabetes	☐ thyroid
☐ cancer ____________	☐ chemotherapy	☐ radiation therapy	☐ bleeding disorder
☐ asthma	☐ copd	☐ emphysema	☐ oxygen use _________
☐ high blood pressure	☐ heart attack	☐ heart failure	☐ heart murmur
☐ irregular heart beat	☐ heart disease	☐ weight loss _________	☐ stomach ulcer
☐ constipation	☐ diarrhea	☐ nausea/vomiting	☐ liver disease
☐ HIV	☐ hepatitis ________	☐ urinary frequency	☐ difficult urination
☐ kidney disease	☐ kidney stones	☐ headache	☐ seizures
☐ strokes	☐ paralysis	☐ numbness__________	☐ tingling _________
☐ depression	☐ anxiety	☐ arthritis __________	☐ other ______________

Surgeries: ____

____

____

____

____

____

Allergies: ____

____

Health Habits:

Alcohol use Yes ☐ No☐ If yes, how much & often do you drink? ______________________

Tobacco use Yes☐ No☐ If yes, how much do you smoke?______________________

Marijuana use Yes☐ No☐ If yes, how often do you smoke?______________________

Cocaine use Yes ☐ No ☐

Heroin use Yes ☐ No ☐

Other____

____

Do you exercise regularly? Yes ☐ No☐ If yes, please describe your routine ______________________

Please List Daily Medications:

____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

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Patient Information

Patient's Name **Last**____________________ **First**____________________ **M.I.** _____

SS# ________________ **Date of Birth** ____/____/____ **Sex: M / F Marital Status** ______________

Home Address ____ **Apt#**__________

City ________________________________ **State** ____________ **Zip Code** __________

Home#__________________ **Work#** __________________ **Cell#** __________________

E-Mail Address____

Responsible Party Name
if patient is a minor **Last**____________________ **First**____________________ **M.I.** _____

Primary Insurance
Policyholder Name____________________ **Date of Birth** ____/____/____ **SS#**______________

Insurance Name ____

Policy# ____________________________________ **Group#**____________________

Secondary Insurance Information
Policyholder Name____________________ **Date of Birth** ____/____/____ **SS#**______________

Insurance Name ____

Policy# ____________________________________ **Group#**____________________

Injury is: Work Related?____________ **Car Accident?**______ **other (describe)** ________________

Date of injury if Applies ____/____/____ **State in which Accident occurred** __________________

Name of emergency contact ____

Relationship____

HIPAA Acknowledgement

I hereby acknowledge that I have been made aware the Verde/Rim Country Pain Services has a privacy policy in place in accordance with the Health Insurance Portability Act of 1996 (HIPAA). As a patient, I acknowledge that Verde/Rim Country Pain Services has a privacy policy in effect and has made this policy available to me. I am entitled to a copy of the privacy policy, if I desire.

x______________________________________ ___________________________

Patient signature or guardian for the minor patient **Date**