Unifour Pain Treatment Center
Patient Data Form

Please complete this form prior to your appointment. Please be as accurate as possible. The information is confidential and will be available to your health care team and their staff only.

PLEASE BRING THIS FORM WITH YOU ON YOUR NEXT VISIT.

Patient Information

Name of Patient: ______________________ Date of Birth: ______________

Address: ______________________ Home Phone: ______________

______________________ Work Phone: ______________

May we contact you at work? Yes ☐ No ☐

Email: ______________________ Cell: ______________

Social Security Number: ______________________ Sex: M ☐ F ☐ Age: ________

Contact person in case of emergency: Name: ______________________

Home phone: ______________________

Cell / Work phone: ______________________

Spouse's Social Security Number: ______________

Spouse's Employer: ______________________ Spouse's Date of Birth: ______________

Approximate distance from your house to our office: ________ Miles

How long is your expected travel time to our office? ________

Name, address, and phone of your pharmacy: ______________________

____

Insurance Information

Please Bring All Insurance Cards With You

Insurance Company: ______________________

Certificate No.: ______________ Group No.: ______________

Insured Name: ______________________

Relationship to you: ☐ self ☐ spouse ☐ other: ______________

Additional Insurance: ______________________

Certificate No.: ______________ Group No.: ______________

Insured Name: ______________________

Relationshop to you: ☐ self ☐ spouse ☐ other: ______________

RN Initials: ________

Prior Treatment

Please list the **full name, address, phone number, and practice** of your:

Family Physician or Internist	Referring Doctor (if different)
___	___
___	___
___	___

Below are listed different medical specialties. Indicate if you have seen any of these specialists for your pain condition. List doctor's **full name, location, and name of practice**. (Please fill in names that apply)

Specialty	Doctor's Name	Specialty		Doctor's Name
Allergist	___	Orthopedic Surgeon (bones)		___
Anesthesiologist	___	Pain Specialist		___
Cardiologist (heart)	___	Pediatrician (children)		___
Chiropractor	___	Plastic Surgeon		___
Dermatologist (skin)	___	Psychiatrist/Psychologist		___
Dentist/Oral Surgeon	___	Physiatrist (rehab)		___
Ear, Nose, & Throat	___	Radiation Oncologist		___
Endocrinologist	___	Rheumatologist (arthritis)		___
General/Family Practice	___			
Internal Medicine (internist)	___	Physical Therapy:	Therapist:	___
Neurologist (Nervous system)	___		Facility:	___
Neurosurgeon	___	Acupunturist		___
Obstetrician/Gynecologist	___	Herbalist		___
Oncologist/Hematologist (cancer/blood)	___	Other:		___
Ophthalmologist (eyes)	___	*No. of emergency room visits re: pain within the last year?*		___

Have you ever been to a **pain clinic** before? If so, please give name, location, and type of therapy performed:

___

___

HISTORY OF PRESENT ILLNESS:

When did your pain begin? ___

What part(s) of your body hurts? ___

If multiple areas of pain, which is the worst area? ___

RN Initials: ___

Please describe what happened or exactly how this pain began (if related to an accident, give date & details):

____

____

Do you know or have been told what is causing your pain? ______________________________

____

On the following scale, rate your pain right now: (check one)

PAIN SCALE: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Extreme Pain

On the following scale, rate your average daily pain: (check one)

PAIN SCALE: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Extreme Pain

On the following scale, rate your pain at its worst: (check one)

PAIN SCALE: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Extreme Pain

Describe your pain sensations: (check all that apply)

☐ Dull Ache	☐ Twisting	☐ Superficial (on surface)
☐ Burning	☐ Throbbing	☐ Deep
☐ Continuous	☐ Grinding	☐ Stinging
☐ Electric shock	☐ Pressure	☐ Other: ____________
☐ Sharp/stabbing	☐ Tearing	____________

What makes your pain BETTER: (check all that apply)

☐ Sitting	☐ Applying heat	☐ Medications
☐ Standing	☐ Applying cold	☐ Nerve blocks
☐ Moving around	☐ Massage	☐ Stretching
☐ Lying down	☐ Exercise	☐ Physical Therapy
		☐ Other: ____________

What make your pain WORSE: (check all that apply)

☐ Sitting	☐ Applying heat	☐ Medications
☐ Standing	☐ Lifting	☐ Nerve blocks
☐ Moving around	☐ Massage	☐ Physical therapy
☐ Lying down	☐ Exercise, bending	☐ Other: ____________
☐ Driving	☐ Damp weather	____________

Check the treatments you have tried for pain: ☐ Heat ☐ Cold ☐ Medications ☐ Physical Therapy

☐ Biofeedback ☐ Acupuncture ☐ Chiropractor ☐ Injections ☐ TENS ☐ Surgery

☐ Spinal Cord Stimulator ☐ Intrathecal Pump

☐ Other: ____

What treatment (including medications) has helped your pain **the most?** ______________________________

____

RN Initials: ________

PAST MEDICAL HISTORY / REVIEW OF SYSTEMS:

Please indicate if you have, or have had, any of the following medical conditions: (please answer all)

Cardiovascular:	**YES**		**NO**
Heart attack	☐	When: ______	☐
Stroke/TIA	☐	When: ______	☐
High blood pressure	☐		☐
Date of last EKG:	______		☐
Where performed:	______		
Chest pain/angina	☐		☐
Irregular heart beat	☐		☐

Gastrointestinal	**YES**		**NO**
Ulcers/gastritis	☐		☐
Frequent constipation	☐		☐
Frequent diarrhea	☐		☐
Heartburn/indigestion	☐		☐
Nausea	☐		☐
Incontienence of stool	☐		☐

Hematologic:	**YES**		**NO**
Immune diseases	☐		☐
Hemophilia	☐		☐
Taking blood thinner	☐	Name: ______	☐
Freq. nose bleeds	☐		☐
Bleeding problems (if yes, specify):		______	☐

Genitourinary:	**YES**		**NO**
Kidney function problems	☐		☐
Kidney stones	☐		☐
Problems urinating (if yes, specify):		______	☐
Sexual function problems	☐		☐

Musculoskeletal:	**YES**		**NO**
Fibromyalgia	☐		☐
Arthritis	☐		☐
Chronic Fatigue Syndrome	☐		☐
Skin color/temp changes	☐		☐

Constitutional:	**YES**		**NO**
Frequent Fevers	☐		☐
Freq. weight loss	☐	______ lbs.	☐
Freq. weight gain	☐	______ lbs.	☐
Freq. night sweats	☐		☐

Possibility you are pregnant? ☐ YES ☐ NO

RN Initials: ______

Respiratory:	**YES**		**NO**
Asthma	☐		☐
Smoking Now	☐	Packs per day: ______	☐
If quit, when: ______		Years smoked: ______	
Lung disease (if yes, specify):		______	☐
Sleep apnea	☐		☐
Snoring	☐		☐
CPAP	☐		☐
Chronic cough	☐		☐
Shortness of breath	☐		☐

Neurological:	**YES**		**NO**
Seizures/epileipsy	☐		☐
Numbness	☐	Where: ______	☐
Weakness	☐	Where: ______	☐
Headaches	☐	How often: ______	☐
Dizziness	☐	How often: ______	☐
Restless legs	☐		☐

Endocrine	**YES**		**NO**
Thyroid problems	☐		☐
Diabetes	☐		☐
On insulin	☐		☐
Liver problems (if yes, specify):		______	☐
Hepatitis (if yes, type?):		______	☐

Emotional/Psychiatric:	**YES**		**NO**
Depression	☐		☐
Anxiety/panic	☐		☐
Violent behavior	☐		☐
Irritability	☐		☐
Suicidal thoughts	☐		☐

Eyes, Ears, Nose, Throat:	**YES**		**NO**
Visual problems	☐		☐
Hearing loss	☐		☐
Bleeding gums	☐		☐
Problems swallowing	☐		☐

List major diseases / medical illnesses: ______

Height: ______ Weight: ______

On avarage, how many hours per night do you sleep? ___________ hrs.

If you awaken frequently, what is the cause? ______________________________

Have you ever been diagnosed with cancer? ☐ YES ☐ NO

If yes, type of cancer: ______________________________

Date of last cancer follow-up: Doctor treating you for cancer: ______________________________

How much alcohol (beer, wine, liquor) do you consume per week? ________ /week

Do you use any street drugs? ☐ YES ☐ NO If yes, specify: ______________________________

Have you ever used prescription drugs for non-medical reason? ☐ YES ☐ NO

Have you ever had a problem with drugs (prescription or non-prescription) or alcohol in the past? ☐ YES ☐ NO

If yes, specify: ______________________________

Have you ever been arrested/convicted due to charges related to drugs (prescription or non-prescription) or alcohol? ☐ YES ☐ NO

If yes, specify: ______________________________

MEDICATIONS:

Please list all your current medications below (include over-the-counter drugs):

Name of Drug & Strength	Number Taken per Day	Prescribing Doctor

Have you ever been on any of the following medications for your current pain problem?

☐ narcotics ☐ tranquilizers ☐ muscle relaxants ☐ anti-inflammatories ☐ steroids

List all things (including medications & tape) that you are **ALLERGIC** or have bad reactions to:

____

____

Have you ever had a reaction to intravenous **contrast (dye)** or **iodine**? ☐ YES ☐ NO

Are you allergic to any shellfish? ☐ YES ☐ NO

RN Initials: ___________

SURGICAL HISTORY:

Have you ever had surgery to relieve your current pain condition? ☐ YES ☐ NO

If yes, indicate surgeon name, location procedure performed at (i.e. hospital name), date, and type of surgery:

____

____

If no, have you been told you may need surgery for your current pain problem? ☐ YES ☐ NO

List all major surgeries which you may had in the past:

Name of Surgery	Where & Date Performed	Name of Surgeon

Have you ever had a problem with anesthesia? ☐ YES ☐ NO

If yes, please specify: ____

SOCIAL HISTORY:

Current Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Number of children ______ Ages of children ___________ Children living with you ________

Highest level of education completed:

☐ Grade School ☐ High School ☐ College/Technical ☐ Graduate School

Is there pending litigation related to your pain or a previous accident? ☐ YES ☐ NO

If yes, your attorney's name, address, and phone: ____

____

Goal:

Please indicate the types of things you would like to be doing, but cannot because of pain:

____

____

____

Of the things listed above, which one is the most important to you?

____

Do you believe that 100% pain relief is possible in your condition? ☐ YES ☐ NO ☐ DON'T KNOW

RN Initials: ___________

Employment Information:

A. If you are currently **EMPLOYED**, please answer the following:
(if not, skip to section B)

Employer Name and Address: ____

____

I am employed: ☐ full-time ☐ part-time Average hours worked per week __________

How long have you been with your current employer? ______________________________

Are you currently on Workmen's Compensation? ☐ YES ☐ NO

Do you like your job? ☐ All the time ☐ Most of the time ☐ Some of the time ☐ Rarely or not at all

Are your duties at work restricted by your employer currently (e.g. light duty)? ☐ YES ☐ NO

Briefly describe what you do at work; include time standing, sitting, lifting and weight of items lifted if applicable:

____

____

____

B. If you are currently **NOT EMPLOYED**, please answer the following:

Have you ever been employed? ☐ YES ☐ NO If no, skip to next section.

Last Employer Name and Address: ____

____

Please state whether ☐ unemployed ☐ disabled ☐ retired How long? ______________

If disabled, state reason(s) and physician who authorized disability:

____

____

Did you like your job? ☐ All the time ☐ Most of the time ☐ Some of the time ☐ Rarely or not at all

Briefly describe what you did at work, include time standing, sitting, lifting, and weight of items if applicable:

____

____

____

RN Initials: __________

Have you stopped working because of your current pain condition? ☐ YES ☐ NO

If yes, have you attempted to return to work? ☐ YES ☐ NO

If yes, _____ full-time or ______ part-time.

Do you want to return to work? ☐ YES ☐ NO

Sexual history:

Are you sexually active? ☐ YES ☐ NO

Do you protect yourself from sexually transmitted diseases and HIV (e.g. use of condoms)? ☐ YES ☐ NO

Have you, or do you currently have, a sexually transmitted disease (e.g. herpes, chlamydia, gonorrhea, etc) ☐ YES ☐ NO

If so, please specify type and year: ____

Do you have a history of sexual abuse? ☐ YES ☐ NO When? ________________________________

Military history:

Have you ever served in the armed forces? ☐ YES ☐ NO

If so, branch, years of service, location: ____

Do you have any pain and/or psychiatric conditions as a result of military service? ☐ YES ☐ NO

If so, please specify what those are: ____

<u>FAMILY HISTORY:</u>

Does any member of your immediate family have a problem with drugs or alcohol? ☐ YES ☐ NO

If yes, please specify: ____

____

____

Do any of your immediate family have a chronic pain condition? ☐ YES ☐ NO

If yes, please specify: ____

____

____

Does your immediate family have a history of hereditary diseases or other major illness? ☐ YES ☐ NO

If yes, please specify: ____

____

____

RN Initials: ___________

DIAGNOSTIC STUDIES:

Indicate which of the following studies/tests you have had to work-up your **current pain problem**:

Type of Study	(check all that apply)	Where Performed	Approximate Date
MRI	_____	______________________________	______________________________
CT scan	_____	______________________________	______________________________
Myelogram	_____	______________________________	______________________________
EMG/nerve study	_____	______________________________	______________________________
Plain x-rays	_____	______________________________	______________________________
Bone scan	_____	______________________________	______________________________
Ultrasound	_____	______________________________	______________________________
Sleep study	_____	______________________________	______________________________
Blood flow study	_____	______________________________	______________________________
Stress test/treadmill	_____	______________________________	______________________________
Cardiac cath	_____	______________________________	______________________________
Nerve block/steroid inj	_____	______________________________	______________________________
Other:	_____	______________________________	______________________________

RN Initials: ___________

PLEASE FILL OUT PAIN DIAGRAM AND MEDICATION HISTORY FORM
ATTACHED TO THIS PACKET

I give permission to discuss my medications, medical condition, and/or billing issues with (spouse, significant other, family, friends, etc.):
____

By signing below, I acknowledge that the above information is true and accurate to the best of my knowledge.

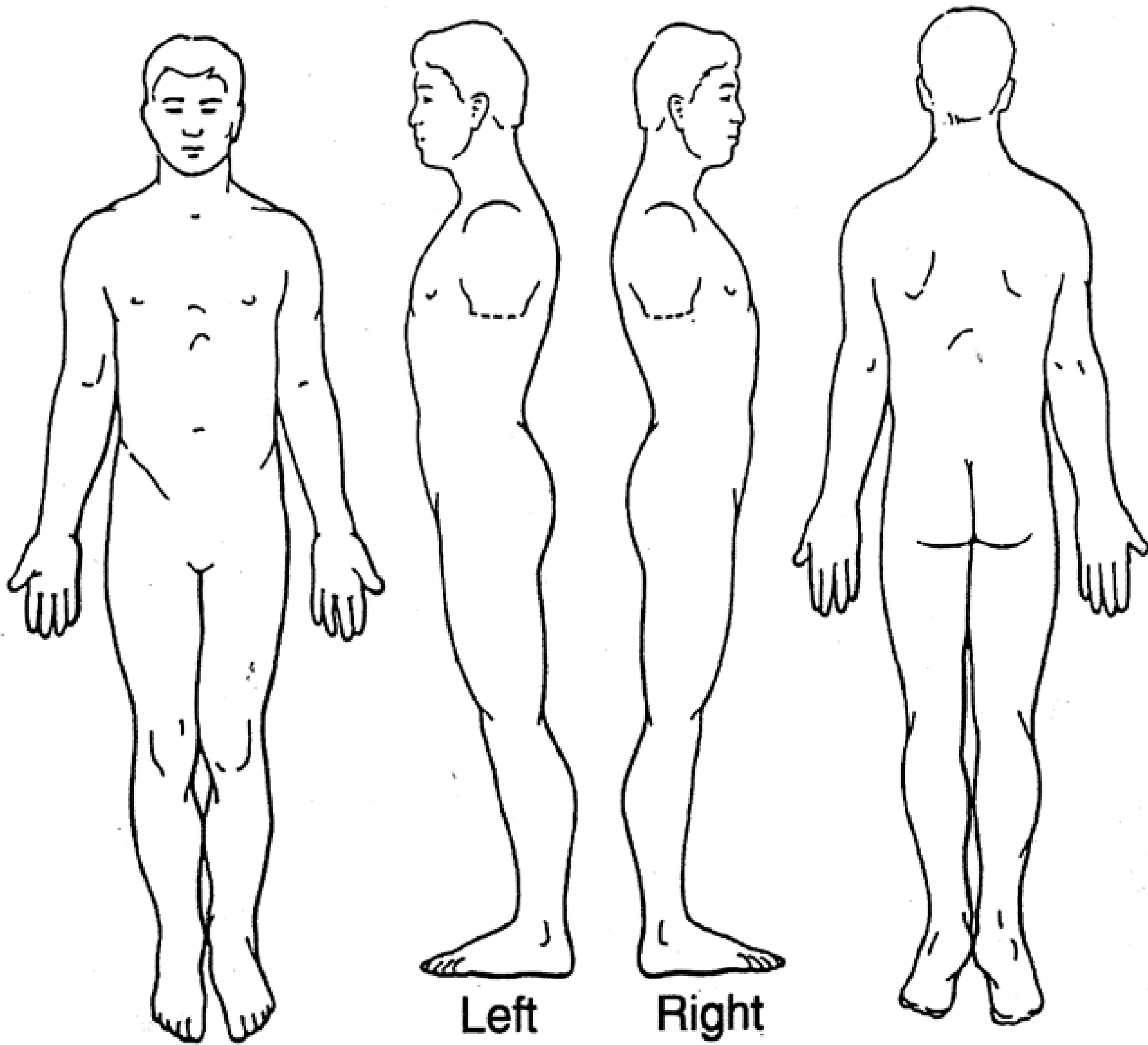
Your Signature: ________________________________ Date: __________ Time: ____________________

RN Signature: ________________________________ Date: __________ Time: ____________________

Physician Signature: ________________________________ Date: __________ Time: ____________________

Mark on the drawing the exact spot where your pain is with a solid black dot. If the pain starts at that spot and radiates elsewhere (travels to another part of your body), draw a line from the spot where it starts and to where it ends. If it is a whole area that hurts, shade in that area with a pencil.

Next to the places on drawing where you showed the pain, put an “E” if the pain is external (on the outside surface). If the pain is internal (inside the body) mark it with “I”. If the pain is both internal and external, mark “EI”.
Mark also “C” for constant, “O” for Often, or “S” for Seldom depending on how much of the time you experience the pain.



Please mark each medication you have used in the **past**. Please mark each medication you are **now** using.

ANALGESICS	PAST	NOW
Actiq®		
Anacin®		
Aspirin®		
Avinza®		
BC® Powder		
Bufferin®		
Buprenex®/Buprenorphine®		
Butrans® Patch		
Butalbital		
Codeine		
Darvocet		
Darvon®		
Demerol®		
Dilaudid®/Hydromorphone		
Duragesic® Patch		
Embeda®		
Equagesic		
Esgic®		
Exalgo®		
Excedrin®		
Fioricet®		
Fiorinal®		
Goody's® Powder		
Hydrocodone		
Hysingla™		
Kadian®		
Lidoderm® Patch		
Lorect®/Lortab®		
Methadone		
Morphine		
MS Contin®		
Norco®		
Nubain®		
Opana® IR		
Opana® ER		
Oxycontin®		
Oxy IR®		
Percocet®		
Percodan®		
Propoxyphene		
Roxicet™/Roxicodone®		
Ryzolt®		
Sedapap		
Stadol® Injection		
Stadol® Nasal Spray		
Suboxone®		
Talwin®		
Tylenol®/Acetaminophen		
Tylenol® #3 or #4		
Tylox®		
Ultram®/Ultracet®		
Vicodin®		
Vicoprofen®		
Zydone®		

ANTI-MIGRAINE MEDICATIONS	PAST	NOW
Amerge®		
Axert®		
Bellergal		
DHE-45® injection		
DHE® Capsule		
Duradrin		
Ergomar®		
Ergotrate®		
Frova®		
Imitrex® Injection		
Imitrex® Nasal Spray		
Imitrex® Tablet		
Lidocaine		
Maxalt®		
Midrin®		
Replax®		
Sansert®		
Zomig®		

ANTI-INFLAMMATORIES	PAST	NOW
Advil®/Ibuprofen		
Aleve®/Naproxen		
Anaprox®		
Ansaid®		
Arthrotec®		
Aspirin®		
Bextra®		
Cataflam®		
Celebrex®		
Daypro®		
Diclofenac		
Dolobid®		
Feldene®		
Indocin®		
Ketoprofen		
Lodine®		
Meclomen®		
Mobic®		
Motrin®		
Nalfon®		
Naprosyn®		
Nuprin®		
Pensaid®		
Relafen®		
Toradol®		
Trilisate®		
Voltaren®		
Voltaren® Gel		

MUSCLE RELAXANTS	PAST	NOW
Baclofen		
Flexeril®		
Lioresal®		

MUSCLE RELAXANTS	PAST	NOW
Norgesic™	☐	☐
Parafon Forte®	☐	☐
Robaxin®	☐	☐
Skelaxin®	☐	☐
Soma®	☐	☐
Zanaflex®	☐	☐

ANTI-CONVULSANTS	PAST	NOW
Depakote®	☐	☐
Dilantin®	☐	☐
Gabitril®	☐	☐
Gralise™	☐	☐
Keppra®	☐	☐
Klonopin®	☐	☐
Lamictal®	☐	☐
Lyrica®	☐	☐
Neurontin®/Gabapentin	☐	☐
Phenobarbital	☐	☐
Tegretol®	☐	☐
Topamax®	☐	☐
Trileptal®	☐	☐
Zonegran®	☐	☐

STEROIDS	PAST	NOW
Decadron®	☐	☐
Dexamethasone	☐	☐
Hydrocortisone	☐	☐
Medrol®	☐	☐
Prednisone	☐	☐

SLEEPING PILLS/ TRANQUILIZERS	PAST	NOW
Ambien®	☐	☐
Ativan®	☐	☐
Benadryl®	☐	☐
BuSpar®	☐	☐
Dalmane®	☐	☐
Halcion®	☐	☐
Librax®	☐	☐
Librium®	☐	☐
Lorazepam	☐	☐
Lunesta®	☐	☐
Melatonex®	☐	☐
Melatonin	☐	☐
Restoril®	☐	☐
Rozerem®	☐	☐
Seconal®	☐	☐
Seroquel®	☐	☐
Sonata®	☐	☐
Thorazine®	☐	☐
Tranxene®	☐	☐
Trilafon®	☐	☐
Tylenol® PM	☐	☐
Valium®	☐	☐
Xanax®	☐	☐
Zyprexa®	☐	☐

ANTI-DEPRESSANTS	PAST	NOW
Abilify®	☐	☐
Anafranil®	☐	☐
Amitriptyline	☐	☐
Celexa®	☐	☐
Cymbalta®	☐	☐
Desipramine	☐	☐
Desyrel®	☐	☐
Doxepin®	☐	☐
Effexor®	☐	☐
Elavil®	☐	☐
Geodon®	☐	☐
Imipramine	☐	☐
Lexapro®	☐	☐
Lithium	☐	☐
Luvox®	☐	☐
Nardil®	☐	☐
Nortriptyline	☐	☐
Pamelor®	☐	☐
Paxil®	☐	☐
Pristiq®	☐	☐
Prozac®	☐	☐
Remeron®	☐	☐
Savella®	☐	☐
Serzone®	☐	☐
Sinequan®	☐	☐
Tofranil®	☐	☐
Trazodone®	☐	☐
Vivactil®	☐	☐
Wellbutrin®	☐	☐
Zoloft®	☐	☐

HERBAL:
(please list)