Unifour Pain Treatment Center complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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 ☐

Cell: _____ Email: _____

Social Security Number: _____

Sex: M ☐ F ☐ Age: _____

RN Initials: _____

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
Allergist	_____
Anesthesiologist	_____
Cardiologist (heart)	_____
Chiropractor	_____
Dermatologist (skin)	_____
Dentist/Oral Surgeon	_____
Ear, Nose, & Throat	_____
Endocrinologist	_____

RN Initials: _____

Specialty	Doctor's Name
General/Family Practice	_____
Internal Medicine (internist)	_____
Neurologist (Nervous system)	_____
Neurosurgeon	_____
Obstetrician/Gynecologist	_____
Oncologist/Hematologist (cancer/blood)	_____
Ophthalmologist (eyes)	_____
Orthopedic Surgeon (bones)	_____
Pain Specialist	_____
Pediatrician (children)	_____
Plastic Surgeon	_____
Psychiatrist/Psychologist	_____
Physiatrist (rehab)	_____
Radiation Oncologist	_____
Rheumatologist (arthritis)	_____
Physical Therapy: Therapist:	_____
Facility:	_____

RN Initials: _____

Specialty	Doctor's Name
Acupunturist	_____
Herbalist	_____
Other:	_____
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?

_____

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?

_____

RN Initials: _____

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	_____

RN Initials: _____

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

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

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

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

Check the treatments you have tried for pain:

- ☐ Heat
- ☐ Physical Therapy
- ☐ Chiropractor
- ☐ Surgery
- ☐ Cold
- ☐ Biofeedback
- ☐ Injections
- ☐ Spinal Cord Stimulator
- ☐ Medications
- ☐ Acupuncture
- ☐ TENS
- ☐ Intrathecal Pump
- ☐ Other: _____

RN Initials: _____

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

_____

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	☐		☐

RN Initials: _____

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	☐	☐

RN Initials: _____

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

RN Initials: _____

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	☐	☐

RN Initials: _____

List major diseases / medical illnesses: _____

_____

_____

Possibility you are pregnant? ☐ YES ☐ NO

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: _____

RN Initials: _____

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**

RN Initials: _____

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

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

RN Initials: _____

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

RN Initials: _____

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

Employment Information:

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

Employer Name and Address: _____

_____

RN Initials: _____

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: _____

_____

RN Initials: _____

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:

_____

_____

_____

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

RN Initials: _____

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: _____

_____

RN Initials: _____

FAMILY HISTORY:

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:_____

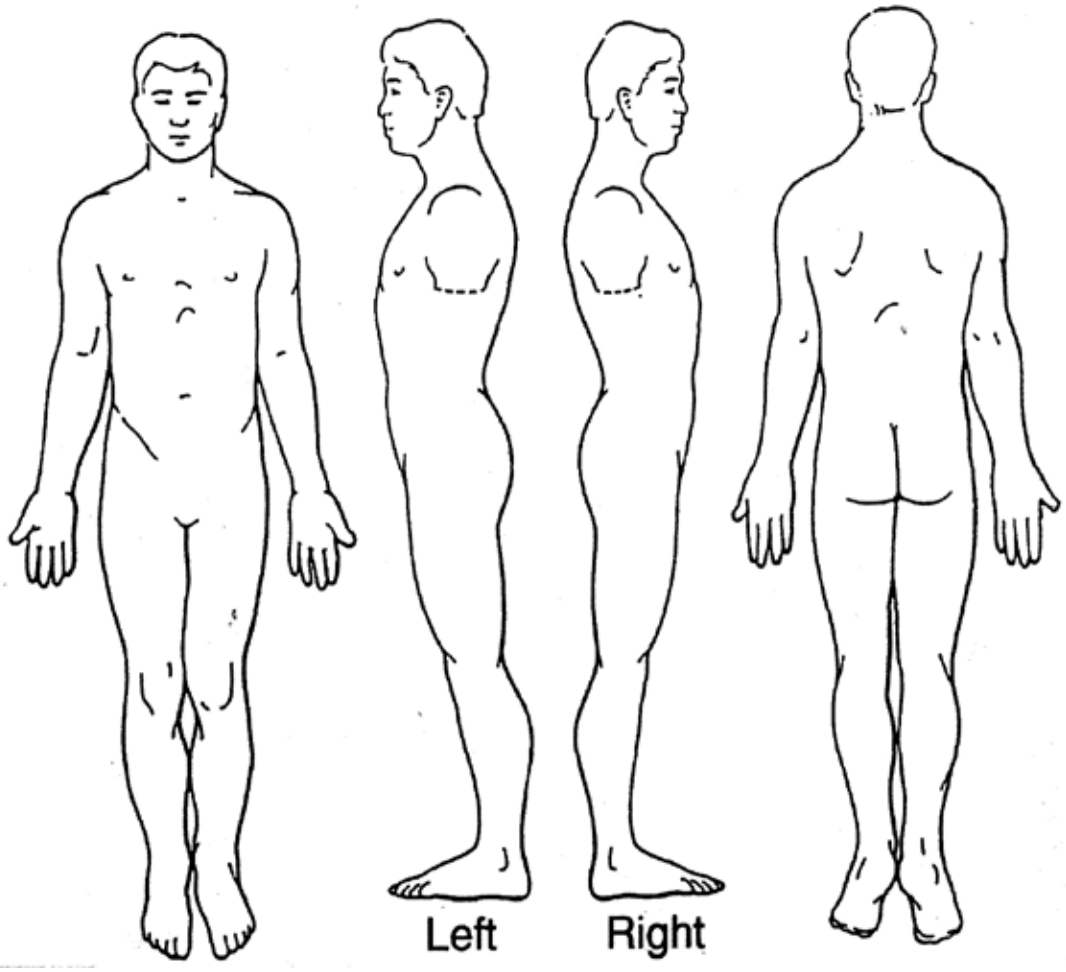
Date: _____ Time:_____

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®	☐	☐

	PAST	**NOW**
Dilaudid®/ Hydromorphone	☐	☐
Duragesic® Patch	☐	☐
Embeda®	☐	☐
Equagesic	☐	☐
Esgic®	☐	☐
Exalgo®	☐	☐
Excedrin®	☐	☐
Fioricet®	☐	☐
Fiorinal®	☐	☐
Goody's® Powder	☐	☐
Hydrocodone	☐	☐
Hysingla™	☐	☐
Kadian®	☐	☐

	PAST	NOW
Lidoderm® Patch	☐	☐
Lorect®/Lortab®	☐	☐
Methadone	☐	☐
Morphine	☐	☐
MS Contin®	☐	☐
Norco®	☐	☐
Nubain®	☐	☐
Opana® IR	☐	☐
Opana® ER	☐	☐
Oxycontin®	☐	☐
Oxy IR®	☐	☐
Percocet®	☐	☐
Percodan®	☐	☐
Propoxyphene	☐	☐

	PAST	NOW
Roxicet™/ Roxicodone®	☐	☐
Ryzolt®	☐	☐
Sedapap	☐	☐
Stadol® Injection	☐	☐
Stadol® Nasal Spray	☐	☐
Suboxone®	☐	☐
Talwin®	☐	☐
Tylenol®/ Acetaminophen	☐	☐
Tylenol® #3 or #4	☐	☐
Tylox®	☐	☐
Ultram®/Ultracet®	☐	☐
Vicodin®	☐	☐
Vicoprofen®	☐	☐

	PAST	NOW
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®	☐	☐

	PAST	NOW
Bextra®	☐	☐
Cataflam®	☐	☐
Celebrex®	☐	☐
Daypro®	☐	☐
Diclofenac	☐	☐
Dolobid®	☐	☐
Feldene®	☐	☐
Indocin®	☐	☐
Ketoprofen	☐	☐
Lodine®	☐	☐
Meclomen®	☐	☐
Mobic®	☐	☐
Motrin®	☐	☐
Nalfon®	☐	☐

	PAST	NOW
Naprosyn®	☐	☐
Nuprin®	☐	☐
Pensaid®	☐	☐
Relafen®	☐	☐
Toradol®	☐	☐
Trilisate®	☐	☐
Voltaren®	☐	☐
Voltaren® Gel	☐	☐

MUSCLE RELAXANTS

Baclofen	☐	☐
Flexeril®	☐	☐
Lioresal®	☐	☐

	PAST	NOW
MUSCLE RELAXANTS		
Norgesic™	☐	☐
Parafon Forte®	☐	☐
Robaxin®	☐	☐
Skelaxin®	☐	☐
Soma®	☐	☐
Zanaflex®	☐	☐
ANTI-CONVULSANTS		
Depakote®	☐	☐
Dilantin®	☐	☐
Gabitril®	☐	☐
Gralise™	☐	☐
Keppra®	☐	☐
Klonopin®	☐	☐

	PAST	NOW
Lamictal®	☐	☐
Lyrica®	☐	☐
Neurontin®/ Gabapentin	☐	☐
Phenobarbital	☐	☐
Tegretol®	☐	☐
Topamax®	☐	☐
Trileptal®	☐	☐
Zonegran®	☐	☐
STEROIDS		
Decadron®	☐	☐
Dexamethasone	☐	☐
Hydrocortisone	☐	☐
Medrol®	☐	☐

	PAST	NOW
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®	☐	☐

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

	PAST	NOW
Vivactil®	☐	☐
Wellbutrin®	☐	☐
Zoloft®	☐	☐

HERBAL:
(please list)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-828-324-4005.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-828-324-4005.