# GLOBAL PAIN CARE
## New Patient Form

**Date: _____**

**Name: _____ Date of Birth: _____**

**Chief Complaint (PLEASE CHOOSE ONLY ONE):**

- ☐ Leg Pain
- ☐ Mid-Back Pain
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Knee Pain
- ☐ Headache
- ☐ Abdominal Pain
- ☐ Hand Pain
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Ankle Pain
- ☐ Upper back pain
- ☐ Hip Pain
- ☐ Chest Pain
- ☐ Groin Pain
- ☐ Foot Pain
- ☐ Generalized Pain

**Describe your pain (select ALL that apply):**

- ☐ Aching
- ☐ Burning
- ☐ Sharp
- ☐ Shooting
- ☐ Throbbing
- ☐ Pinching
- ☐ Cramping
- ☐ Pressure
- ☐ Stinging/Numbness

**What makes your pain feel worse:**

- ☐ Physical Activity
- ☐ Movement
- ☐ Standing
- ☐ Walking
- ☐ Bending
- ☐ Position change
- ☐ Lifting
- ☐ Cold Weather
- ☐ Sitting
- ☐ Lying down

**What makes your pain feel better:**

- ☐ Medications
- ☐ Lying down
- ☐ Rest
- ☐ Heat
- ☐ Ice
- ☐ Sitting
- ☐ Standing
- ☐ Sleep
- ☐ Stretching

**Rate your pain 0-10 (0=no pain, 10=worst pain) circle ONE:**

Level of pain at its worst: 1 2 3 4 5 6 7 8 9 10
Level of pain at its best: 1 2 3 4 5 6 7 8 9 10
Level of pain on average: 1 2 3 4 5 6 7 8 9 10

**Does the pain radiate to any part of your body?**
(For example: low back pain shoots down to my legs)

_____
_____

**Have you had an MRI, X-Ray or CT scan?** Yes ☐ No ☐
If yes, where was the imaging done? _____

**Physicians visited in the last year?**

_____
_____

**What pain medications have you tried in the past?**

_____
_____

**How long have you had the pain?** _____

**Have you had spinal surgeries in the past?** Yes ☐ No ☐
What kind of spinal surgery? _____

**Did you improve from your spine surgery procedure?** Yes ☐ No ☐

**Which of the following do you experience more pain, if any (<u>please circle</u>):**
More back pain than leg pain
More leg pain than back pain
Even amount of pain in back and leg

**Which of the following do you experience more pain, if any (<u>please circle</u>):**
More neck pain than arm pain
More arm pain than neck pain
Even amount of pain in arm and neck

**What other methods of pain treatment have been used in the past?**

**<u>What other methods of pain treatment have been used in the past:</u>**

| | | |
|---|---|---|
| ☐ Leg Pain | ☐ Abdominal Pain | ☐ Hip Pain |
| ☐ Mid-Back Pain | ☐ Hand Pain | ☐ Chest Pain |
| ☐ Low Back Pain | ☐ Shoulder Pain | ☐ Groin Pain |

**Current Medications:**

| Medication Name | Dosage | How many times a day |
| --- | --- | --- |
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**Allergies to medication:** _____
_____
_____
_____
_____

## Past Medical History

☐ **No medical history**

☐ Asthma
☐ Hepatitis
☐ Hepatitis B
☐ Hepatitis C
☐ Seizures
☐ HIV/AIDS
☐ Diabetes
☐ Arthritis
☐ Migraines
☐ Depression
☐ Bronchitis
☐ Pancreatitis
☐ Obesity
☐ Anemia
☐ Stroke

☐ Heart Failure
☐ Tuberculosis
☐ Liver Disease
☐ Sleep Apnea
☐ Cancer
☐ Lupus
☐ Anorexia/Bulimia
☐ Schizophrenia
☐ Scleroderma
☐ Endometriosis
☐ Liver Disease
☐ Gastric Reflux
☐ Osteoarthritis
☐ Ankylosing Spondylitis
☐ COPD/Emphysema

☐ Ovarian Cyst
☐ Bleeding Disorder
☐ Irritable Bowel Syndrome
☐ High Blood Pressure
☐ Blood Clots in Legs
☐ Heart Attack
☐ Kidney Stones
☐ Kidney Failure
☐ Other _____
_____
_____

## Surgical History:

☐ **No known surgical history**

1._____ _____
(Month/year) (Procedure)
2._____ _____
(Month/year) (Procedure)
3._____ _____
(Month/year) (Procedure)
4._____ _____
(Month/year) (Procedure)
5._____ _____
(Month/year) (Procedure)

6._____ _____
(Month/year) (Procedure)
7._____ _____
(Month/year) (Procedure)
8._____ _____
(Month/year) (Procedure)
9._____ _____
(Month/year) (Procedure)
10._____ _____
(Month/year) (Procedure)

**Social History:**

Are you currently working? ☐ Yes No ☐

Company_____ Occupation_____

Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Who do you live with? _____

What do you live in? ☐ House ☐ Apartment ☐ Mobile Home
☐ Condo/Townhome

Are you a cigarette smoker? ☐ Yes ☐ No
If yes, how much do you smoke a day? _____

Any drugs or substance abuse? ☐ Yes ☐ No
If yes, what's the name of the drug? _____
When last used? _____

**Family History:**

Mother ☐ Alive ☐ Deceased
Father ☐ Alive ☐ Deceased
Siblings ☐ Alive ☐ Deceased
Children ☐ Alive ☐ Deceased

How many Brothers? _____ Healthy? Yes No
How many Sisters? _____ Healthy? Yes No
How many Sons? _____ Healthy? Yes No
How many Daughters? _____ Healthy? Yes No