GLOBAL PAIN CARE
New Patient Form

Date: __________
Name: _______________________________ Date of Birth: __________

Chief Complaint (PLEASE CHOOSE ONLY ONE):
☐ Leg Pain  ☐ Abdominal Pain  ☐ Hip Pain
☐ Mid-Back Pain  ☐ Hand Pain  ☐ Chest Pain
☐ Low Back Pain  ☐ Shoulder Pain  ☐ Groin Pain
☐ Neck Pain  ☐ Arm Pain  ☐ Foot Pain
☐ Knee Pain  ☐ Ankle Pain  ☐ Generalized Pain
☐ Headache  ☐ Upper back pain

Describe your pain (select ALL that apply):
☐ Aching  ☐ Pinching
☐ Burning  ☐ Cramping
☐ Sharp  ☐ Pressure
☐ Shooting  ☐ Stinging/Numbness
☐ Throbbing

What makes your pain feel worse:
☐ Physical Activity  ☐ Lifting
☐ Movement  ☐ Cold Weather
☐ Standing  ☐ Sitting
☐ Walking  ☐ Lying down
☐ Bending
☐ Position change

What makes your pain feel better:
☐ Medications  ☐ Sitting
☐ Lying down  ☐ Standing
☐ Rest  ☐ Sleep
☐ Heat  ☐ Stretching
☐ Ice

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 (please circle):
  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 (please circle):
  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?

What other methods of pain treatment have been used in the past:
☐ Leg Pain    ☐ Abdominal Pain  ☐ Hip Pain
☐ Mid-Back Pain ☐ Hand Pain     ☐ Chest Pain
☐ Low Back Pain ☐ Shoulder Pain  ☐ Groin Pain
<table>
<thead>
<tr>
<th>Current Medications:</th>
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<tbody>
<tr>
<td>Medication Name</td>
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Allergies to medication: 

Past Medical History

☐ No medical history

☐ Asthma  ☐ Heart Failure  ☐ Ovarian Cyst
☐ Hepatitis  ☐ Tuberculosis  ☐ Bleeding Disorder
☐ Hepatitis B  ☐ Liver Disease  ☐ Irritable Bowel Syndrome
☐ Hepatitis C  ☐ Sleep Apnea  ☐ High Blood Pressure
☐ Seizures  ☐ Cancer  ☐ Blood Clots in Legs
☐ HIV/AIDS  ☐ Lupus  ☐ Heart Attack
☐ Diabetes  ☐ Anorexia/Bulimia  ☐ Kidney Stones
☐ Arthritis  ☐ Schizophrenia  ☐ Kidney Failure
☐ Migraines  ☐ Scleroderma  ☐ Other ______________________
☐ Depression  ☐ Endometriosis  ______________________
☐ Bronchitis  ☐ Liver Disease  ______________________
☐ Pancreatitis  ☐ Gastric Reflux  ______________________
☐ Obesity  ☐ Osteoarthritis  ______________________
☐ Anemia  ☐ Ankylosing Spondylitis  ______________________
☐ Stroke  ☐ COPD/Emphysema  ______________________

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