



# PAIN PROGRAM

2001 Errecart Boulevard Elko, NV 89801 775-748-2195

HEALTH ASSESSMENT  
NEW PATIENT

Your Name: \_\_\_\_\_

Date: \_\_\_\_\_

Referring doctor? \_\_\_\_\_

Who is your family or internal medicine doctor? \_\_\_\_\_

Is the reason for your visit because of a work related injury? Yes No Don't Know

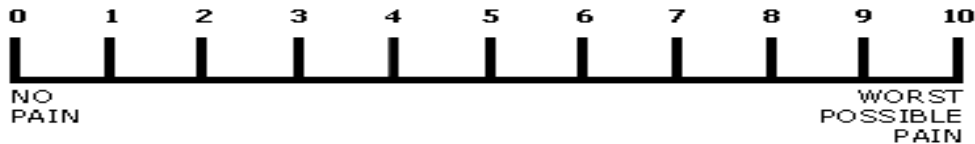
Where is the location of the pain you are experiencing? \_\_\_\_\_  
\_\_\_\_\_

When did your pain begin? Can you identify a specific cause of your pain (example: accident, automobile accident, fall, etc.)? \_\_\_\_\_  
\_\_\_\_\_

What does your pain feel like (dull, sharp, burning, prick, ache, throb, other) \_\_\_\_\_  
\_\_\_\_\_

Is the pain: constant comes and goes

Please rate and circle your current level of discomfort according to the scale below:



Do you use any assistive devices? Cane Walker Crutches Limbs Other \_\_\_\_\_

What medication do you take for your pain problem?

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_

Do you currently take medication that thins your blood or slows clotting?  
(Examples are: coumadin, plavix, aspirin, lovenox, teclid or heparin) Yes No

If yes please list: \_\_\_\_\_

Do you currently take any other medications, supplements, herbs or vitamins?

Yes No If yes, please list below:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_
- 7. \_\_\_\_\_ 8. \_\_\_\_\_
- 9. \_\_\_\_\_ 10. \_\_\_\_\_

Please Complete Other Side

Patient Sticker

Do you have any allergies, including medication, food, or latex? Yes No  
If yes, please explain:

Do you have or have you had any clotting, coagulation or bleeding disorders?  
Yes No If yes, please list: \_\_\_\_\_

Please check if you have any of the following. If yes, please briefly explain:

- Cardiac / heart problems \_\_\_\_\_
- Lung / pulmonary problems \_\_\_\_\_
- Intestinal / stomach problems \_\_\_\_\_
- Urinary problems \_\_\_\_\_
- Bone, joint, or muscle problems \_\_\_\_\_
- Hematology / blood disorders (anemia, high cholesterol, etc.) \_\_\_\_\_
- Cancer \_\_\_\_\_

Have you had any of the following? If yes, please check:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures / epilepsy  | <input type="checkbox"/> Acid reflux      |
| <input type="checkbox"/> Emphysema / COPD    | <input type="checkbox"/> Heart attack         | <input type="checkbox"/> Hepatitis        |
| <input type="checkbox"/> Angina / chest pain | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Depression       |
| <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Asthma               |   |
| <input type="checkbox"/> Osteoporosis        |   |   |

Have you had surgery / x-ray / pain procedures in the past (examples appendectomy, epidural steroid injection, MRI, colonoscopy, etc.)? Yes No If yes, please list:

- |          |           |
|----------|-----------|
| 1. _____ | 2. _____  |
| 3. _____ | 4. _____  |
| 5. _____ | 6. _____  |
| 7. _____ | 8. _____  |
| 9. _____ | 10. _____ |

Did you bring an x-ray or lab reports with you today? Yes No

Do you have a history of chemical, substance, or drug abuse? Yes No  
How much alcohol do you drink, how often and how many years? \_\_\_\_\_

How much tobacco do you use, how often and how many years? \_\_\_\_\_  
How often do you use recreational drugs and which kind? \_\_\_\_\_

Are you: Married Single Divorced Widowed

Highest level of education? 8 9 10 11 12 13 14 15 16 Masters PhD

Does anyone assist you with feeding, bathing, walking or dressing? Yes No

How many children do you have? \_\_\_\_\_ Are they available to assist you? Yes No

If you work, what is your job title or description? \_\_\_\_\_

Do you attend church, if so, which one? \_\_\_\_\_

Who accompanied you to your visit today? \_\_\_\_\_ Relationship \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_