

North Texas Precision Pain Care, P.A.

Treating the patient, not just the disease

New Patient Information Sheet

Appointment Date: _____ Appointment time: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E mail: _____

Sex: M / F Marital Status: S/M/D

DOB: ____/____/____ SSN: ____/____/____

Employer: _____ Occupation: _____

Chief Complaint: _____

Referring Physician: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Care Physician: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Insurance: _____

Benefits Phone # _____ Insured: _____

If other than self, DOB: ____/____/____ SSN: ____/____/____

ID #: _____ Group/Account #: _____

Insured Employer: _____ Work#: _____

Secondary Insurance: _____

Benefits Phone # _____ Insured: _____

If other than self, DOB: ____/____/____ SSN: ____/____/____

ID #: _____ Group/Account #: _____

Insured Employer: _____ Work#: _____

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Patient's name: _____

Patient's referral: _____

Patient's MR: _____

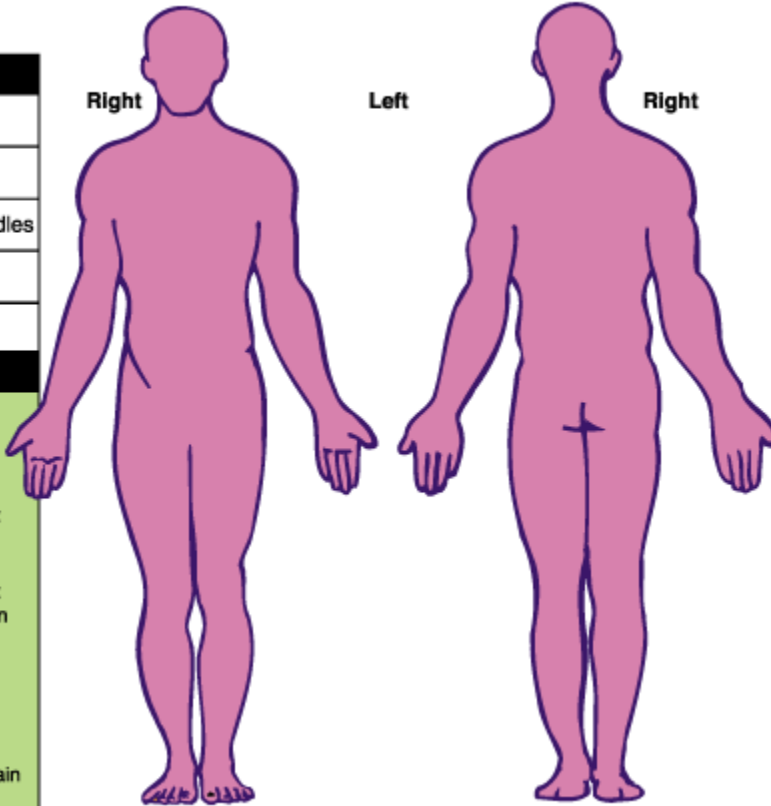
Date: _____

Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

RIGHT HANDED

LEFT HANDED

KEY	
////	Stabbing
XXXX	Burning
0000	Pins & Needles
====	Numbness
++++	Aching
PAIN LEVEL	
0	No pain
1	Mild pain; you are aware of it but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain; it may make you contemplate suicide



CIRCLE YOUR CURRENT PAIN LEVEL
0 1 2 3 4 5 6 7 8 9 10

Duration of pain: _____

Was there an injury that caused the pain if so please explain:

What makes the pain worst: _____

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What make the pain better: _____

At the present time do you have any: (circle ones that apply)

- | | | |
|----------------------|----------------------|-----------------|
| Loss of bowel | Loss of urine | Fever |
| Chills | Weakness | Numbness |

Pain medications you have tried in the past: _____

Treatments you have had in the past for your current problem: _____

X-ray, MRI, CT for the current problems: _____

What is the major thing you want to accomplish during this visit:

Past Medical History: _____

Past Surgical History: _____

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Current

medications: _____

Family medical problems (only your mother, father, sisters, brothers, and children):

Review of system:

Circle only problems which are **continually** bothering you at **present**

HEENT: eye problems ear problems nose problems throat problems

Cardiac: murmurs irregular beats high blood pressure chest pain heart attack

Pulmonary: difficulty breathing emphysema asthma bronchitis

GI: reflux ulcers bloody stools diverticulosis

GU: urinary tract infection bloody urine kidney stones fibroids

irregular menstrual bleed

Endo: diabetes thyroid disease anderson's disease cushing's disease

Rheum: rheumatoid arthritis gout scleroderma osteoarthritis

Heme: easy bleeding clots leukemia lymphoma low platelets

Derm: skin disorders

Neuro: seizures numbness weakness tremors

Psy: depression anxiety mania schizophrenia paranoia

Musk: muscle pain joint pain