Absolute Pain Relief

Name_____ **Nickname**_____**How did you hear about us** _____

Address_____**City**_____**State**_____**Zip**_____

Cell Phone_____**Home Phone** _____ **SSN**_____

Home Email_____ **Date of Birth**_____ **Age**_____ **Gender** ❑Male❑Female❑Unspecified

Emergency Contact:_____**Contact Phone #**_____

Marital Status ❑Single❑Married❑Other **Children** ❑ YES ❑ NO How Many_____

Employment Status ❑ Employed ❑ FT Student❑ PTStudent❑ Other❑ Retired❑ Self Employed

Occupation_____**Employer**_____ **Employer Phone** _____

Do you have insurance? ❑Yes ❑No **Insurance Name:**_____

Primary insured?❑Yes ❑No **If no, primary insured name and relationship to self:** _____Their DOB_____

Family Physician _____ **Phone** _____

Current medications, COMPLETE FULLY:

RX Medication/Over The Counter	Dosage	Frequency	Circle how taken
1)			**Orally Topically Injectable**
2)			**Orally Topically Injectable**
3)			**Orally Topically Injectable**
4)			**Orally Topically Injectable**
5)			**Orally Topically Injectable**

List any known allergies you have had to any medications, foods or environment:

1) _____ **3)** _____

2) _____ **4)** _____

Do you suffered from seasonal allergies? ❑ Yes ❑ No **If Yes, have you had allergy testing before? ❑ Yes ❑ No**

Do you suffer from food sensitivity? ❑ Yes ❑ No **If Yes, have you had food sensitivity testing before? ❑ Yes ❑ No**

FAMILY HISTORY: Please check any condition that YOU or YOUR FAMILY have or have had in the past. Please state (P) for Patient or (F) for family**

❑ Alcoholism	**(P or F)**	❑ High Blood Pressure	**(P or F)**	❑ Stroke	**(P or F)**
❑ Anemia	**(P or F)**	❑ Kidney Disease	**(P or F)**	❑ Suicide Attempt	**(P or F)**
❑ Asthma	**(P or F)**	❑ Liver Disease	**(P or F)**	❑ Thyroid Disease	**(P or F)**
❑ Cancer/Tumor	**(P or F)**	❑ Hepatitis	**(P or F)**	❑ Heart Disease	**(P or F)**
❑ Diabetes	**(P or F)**	❑ Lung Disease	**(P or F)**	❑ Ulcers	**(P or F)**
❑ Drug Abuse	**(P or F)**	❑ Rheumatic Arthritis	**(P or F)**	❑ HIV or Other Immune Disease	**(P or F)**
❑ Depression	**(P or F)**	❑ Osteoarthritis	**(P or F)**	❑ High Cholesterol	**(P or F)**
❑ Epilepsy/Seizures	**(P or F)**	❑ Osteoporosis	**(P or F)**	❑ Other _____	

Past Health History: Please mark any condition you have now or had in the past

General
❑Weight Loss
❑Fatigue
❑Fever

MSK
❑Joint Pain
❑Stiffness
❑Muscle Pain
❑Swollen Joints

Psychiatric
❑Anxiety
❑Depression

GU
❑Erectile Dysfunction
❑Leaky Bladder
❑Blood in Urine
❑Frequent Urination
❑Painful urination

ENT
❑Difficult Hearing
❑Ear Ringing
❑Vertigo
❑Sinus Trouble
❑Chronic Sore Throat

Hematology
❑Easy Bruising
❑Easy Bleeding

Endocrine
❑Hair Loss
❑Weight Gain

Respiratory
❑Coughing
❑Asthma
❑Difficult Breathing

Cardiovascular
❑Heart Murmur
❑Chest Pain
❑Palpitations
❑Short of Breath
❑Fainting
❑Swollen Ankles

Females Only
❑Abnormal Mammo
❑Abnormal Pap
Pregnant Y N

GI
❑Heartburn
❑Nausea
❑Constipation
❑Diarrhea
❑Abdominal Pain

Eyes
❑Glasses
❑Eye Pain
❑Double Vision

Skin
❑Rash
❑Itching
❑Lesions

Neurological
❑Strength Loss
❑Numbness
❑Tremors
❑Memory Loss
❑Headaches
Frequency_____

Patient Signature: _____ Date: _____ Dr Initials _____

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1st Chief Complaint: _____ When did it start?_____ Gradual / Sudden

Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe

Circle the percentage of the day you experience the complaint:
10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10) _____

2nd Chief Complaint :_____ When did it start?_____ Gradual / Sudden

Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe

Circle the percentage of the day you experience the complaint:
10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10) _____

3rd Chief Complaint: _____ When did it start?_____ Gradual / Sudden

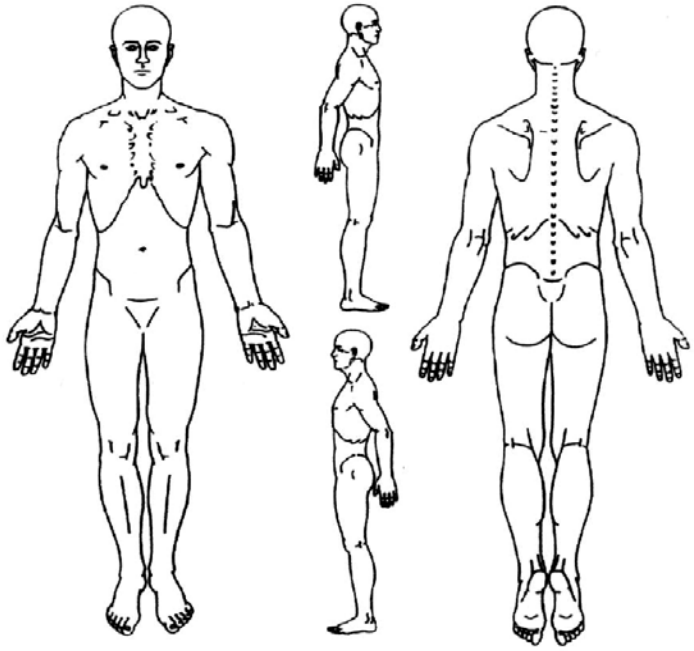
Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe

Circle the percentage of the day you experience the complaint:
10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10) _____

Using the letters below, please show <u>where</u> you are experiencing <u>all</u> of your current complaints:

A: Ache
B: Burning
C: Cramping
D: Dull Pain
F: Stiffness
N: Numbness
R: Throbbing
S: Soreness
T: Tingling
X: Sharp Pain
SP: Shooting Pain
RP: Radiating Pain



Have you ever had tests for your present condition? ❑MRI ❑X-ray ❑ CT ❑Other _____

Do you have a pacemaker? ❑Yes ❑No

Do you drink alcohol? ❑ Yes ❑No If Yes, what is frequency _____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke? _____

When was your last Physical examination? _____

When did you last have blood work? ❑ Within a Year ❑ Over a Year ❑ Not Sure

Any Surgeries? ❑ Yes ❑No If yes, list:_____

_____

Patient Name (please print): _____

Patient Signature: _____ Date: _____ Dr. Initials _____