SEATTLE PAIN RELIEF

INTERVENTIONAL PAIN MEDICINE
35002 Pacific Highway South Suite A-105
Federal Way WA 98003
P: 253·944·1289 **F:** 253·944·1292

PATIENT INFORMATION

Date_____ Sex: □ M □ F

Patient_____

Address_____

City _____State_____Zip_____

□ Single □ Married □ Widowed □ Separated □ Divorced

Birth Date _____ Age: _____

Patient SS#_____

Occupation_____

Employer_____

Employed: □Full-Time □Part-Time □Not Working

If you are unemployed, is this due to your present pain condition: □ Yes or □ No

If you are currently unemployed, indicate how long you have been off of work:_____

PHONE NUMBERS

Home:_____Work: _____

Cell:_____Other:_____

Email:_____

Best time and place to reach you:_____

EMERGENCY CONTACT:_____

Relationship:_____

Phone Number:_____

Referring MD _____

Primary Care MD_____

Physicians currently involved in care:_____

_____

Spouse's Name_____

Spouse's SS#:_____DOB:_____

Whom may we thank for referring you?_____

INSURANCE

Insured:_____

Relationship: _____

Insurance Co:_____

ID Number:_____

☐ Auto Insurance

Additional Insurance:_____

Subscribers Name:_____

Birth Date:_____**SS#:**_____

Relationship to Patient:_____

Insurance Co:_____

ID Number:_____

ACCIDENT INFORMATION

Is this condition due to an accident: ☐ YES ☐NO

☐ Worker's Compensation

☐ Personal Injury/Liability

☐ Auto Accident

To whom have you made a report of this accident:

☐ Employer

☐ Workers Compensation

☐ Other

Attorney Name & Phone Number if applicable:

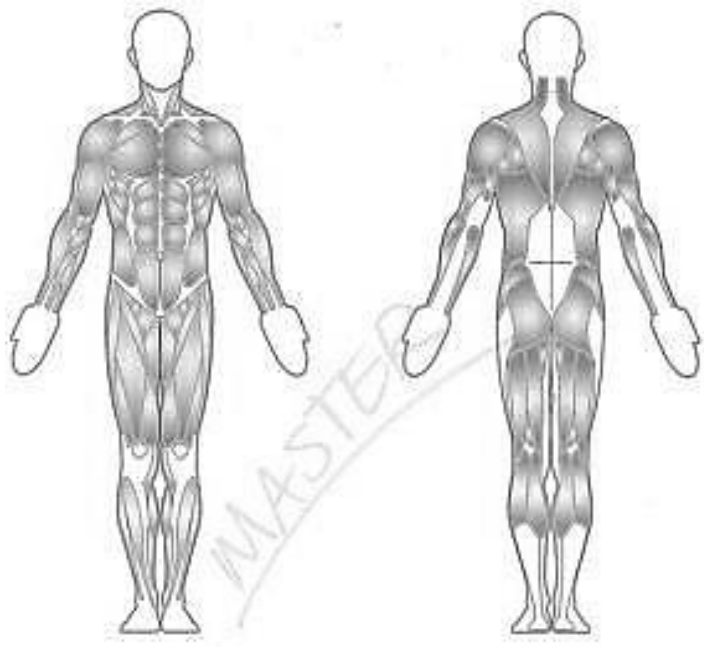
_____

_____

CHIEF COMPLAINTS OF PAIN

LOCATION OF PAIN/BODY SITE

PLEASE MARK THE LOCATIONS OF YOUR PAIN ON THE DIAGRAM



My pain is best described as:

□ Aching □ Sharp □ Penetrating
□ Throbbing □ Tender □ Nagging
□ Shooting □ Burning □ Numb
□ Stabbing □ Exhausting □ Miserable
□ Gnawing □ Tiring □ Unbearable
□ Intermittent □ Continuous

My pain is the result of:

□ Unknown □ After lifting heavy objects □ MVA
□ Shingles □ Work related □ Falling
□ Sports injury □ Physical altercation
□ Surgery _____ □ Disease _____
□ Other _____

My pain is present:

□ Continually □ Constantly □ Intermittently □ On a daily basis □ Only in the _____am _____pm
□ Only with walking □ weekly □ Only with activity such as _____

INTENSITY OF PAIN

Circle the number that best describes your pain at its worst during the last month:

No Pain										**Worst Pain Imaginable**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Average _____ Best_____ Worst_____

HOW DO THE FOLLOWING AFFECT YOUR PAIN (PLEASE CHECK ONE FOR EACH ITEM)?

	DECREASE	NO CHANGE	INCREASE
LYING DOWN			
STANDING			
SITTING			
WALKING			
EXERCISE			
RELAXATION			
COUGHING/SNEEZING			
PUSH/PULL			
BEND			

HEALTH HISTORY

DIAGNOSTIC STUDIES:

X-RAYS: □YES □ NO Date_____

*What Areas of the Spine*_____

MRI (Magnetic Resonance Imaging): □YES □ NO Date_____

*What Areas of the Spine*_____

PHYSICIAN INFORMATION

PCP Name: _____ Facility Name: _____ Phone Number: _____

Cardiologist Name: _____ Facility Name: _____ Phone Number: _____

Other:_____

PAIN TREATMENTS: Please check your response to the treatments you have tried.

TREATMENT	NEVER TRIED	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
SURGERY				
TRACTION				
INJECTION				
TYPE:				
PHYSICAL THERAPY				
ACUPUNCTURE				
CHIROPRACTIC				
PSYCHOLOGICAL				

PAST MEDICAL HISTORY

MEDICAL HISTORY:

□ Heart Disease □ Stroke □ Cancer □ Arthritis □ Diabetes □ Hypertension
□ Asthma □ Thyroid □ Anxiety □ Depression □ Bleeding Disorders
□ Other _____

PAST SURGICAL HISTORY:

List all surgical procedures you have had (include pacemaker/defibrillator, joint replacement/fusion or vascular stints) and the date:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

SOCIAL HISTORY:

Marital Status:

What is your current marital status? □ Single □ Married □ Divorced □ Widowed □ Separated

Has your marital status changed since your pain problem began? □ Yes □ No

Residence: □ House □ Apartment □ Condo □ Mobile Home

Number of people living with you: _____ Number of children living with you: _____

FAMILY HISTORY:

Has anyone in your family suffered from chronic pain? □ Yes □ No

If yes, what condition: _____

LEGAL MATTERS

Are you presently involved in a lawsuit? □ Yes □ No

If yes, please explain: _____

PAST MEDICAL HISTORY CONITNUED

EDUCATION:

What is the highest level of education you've finished? _____

EMPLOYMENT:

Are you currently working? □ Yes □ No □ Retired
Is this the same occupation you had before your pain stared? □ Yes □ No
If not working, has the pain forced you to stop working? □ Yes □ No
If not working, what was your occupation before your pain problem? _____
Does your spouse work? □ Yes □ No Occupation:_____
Are you being treated under Workers Compensation? □ Yes □ No
Are you currently receiving disability benefits? □ Yes □ No

WORK HISTORY:

Occupation: _____ Years Worked: _____
Reason for Leave: _____

HABITS:

Do you smoke or use tobacco in any form? □ Yes □ No How many packs/day? _____ # years_____
Do you drink alcoholic beverages? □ Yes □ No How many drinks/day? _____
Do you use any recreational or street drugs? □ Yes □ No If yes, please list: _____
Do you drink caffeinated beverages? □ Yes □ No If yes, how much per day: _____

Which of the following drugs or substance, if any, have you used in the PAST? (Check all that apply)
Next to each drug or substance that you've checked, indicate if you used it occasionally "O" or "F", or continuously "C"

□ Alcohol ___ O ___ F ___ C □ Barbiturates ___ O ___ F ___ C □ Cocaine ___ O ___ F ___ C
□ Heroin ___ O ___ F ___ C □ Amphetamines ___ O ___ F ___ C □ Marijuana ___ O ___ F ___ C
□ Other _____ ___ O ___ F ___ C

Are you PRESENTLY using any of the drugs or substance below? (Check all that apply)
Next to each drug or substance that you've checked, indicate if you used it occasionally "O" or "F", or continuously "C"

□ Alcohol ___ O ___ F ___ C □ Barbiturates ___ O ___ F ___ C □ Cocaine ___ O ___ F ___ C
□ Heroin ___ O ___ F ___ C □ Amphetamines ___ O ___ F ___ C □ Marijuana ___ O ___ F ___ C
□ Other _____ ___ O ___ F ___ C

CURRENT MEDICATIONS:

List all medications you are currently taking:

1. _____Dose:_____Frequency:_____
2. _____Dose:_____Frequency:_____
3. _____Dose:_____Frequency:_____
4. _____Dose:_____Frequency:_____
5. _____Dose:_____Frequency:_____
6. _____Dose:_____Frequency:_____
7. _____Dose:_____Frequency:_____
8. _____Dose:_____Frequency:_____

ALLERGIES:

Please indicate the names of any medications to which you are allergic: _____

_____

What type of reaction did you have? _____

I am allergic to contrast dye used for X-ray: ☐ Yes ☐ No Do you take Aspirin, Plavix or Coumadin? ☐ Yes ☐ No

Are you afraid of needles/sharp objects? ☐ Yes ☐ No

Intolerances: (include side effects form pervious medications, i.e.; gastritis, nauseas, constipation, etc.)

_____

_____

What are your treatment goals at Seattle Pain Relief?

_____

_____

_____

_____

HIPAA PRIVACY PRACTICES

I, _____ have received a copy of the HIPAA Notice of Privacy Practices.

I have read and understand my rights as afforded to me under the Health Insurance Portability and Accountability Act (HIPAA). I understand that I may ask questions of the office.

Name: _____

Signature: _____ Date: _____