PAIN MANAGEMENT CENTER OF WISCONSIN, S.C.

Name_____ Date of Birth_____

Address_____City_____ State_____ Zip_____

Social Security #_____ Male___ Female___ Marital Status_____

Home Phone (____)_____ Work Phone (____)_____

Employer_____ Employer Address_____

City_____ State_____ Zip_____

Referring Physician's Name and Phone:_____

Health Insurance_____ Policy or Group #_____

If Under 18, Name of Parent or Guardian_____

Person to Contact in Case of Emergency_____ Phone_____
(Someone *not* living with you)

Cardholder / Person Responsible for Payment
(If same as above, **skip** this area)

Name_____ Relationship to Patient_____

Social Security #_____ DOB_____ Phone(____)_____

Address_____City_____ State_____ Zip_____

Employer_____ Work Phone(____)_____

Were you hurt in an auto accident? Yes____ No____ Were you hurt at work? Yes____ No____

Date of Injury: _____ State accident occurred in: Wisc.____ Ill.____ Other____

If in an auto accident, did you file an accident report with your insurance carrier? Yes____ No____

Name of Auto Insurance_____ Claim#_____

Worker's Comp Insurance_____ Claim#_____

Adjustor or Contact Person's Name_____ Phone_____

Attorney's Name & Phone_____

I have completed this form to the best of my ability, and I have provided all pertinent information (i e, insurance information) to the receptionist. I understand that I am solely responsible for any amount that is not covered under my insurance or through a settlement. Copayments, deductibles, and non-covered service payments will be made at the time services are rendered. Failure to comply may result in my being billed directly for all treatments. If needed I will contact the billing department to make payment arrangements.

_____ _____
PATIENT / GUARANTOR SIGNATURE DATE

INITIAL CONSULTATION

Name: _____ Date of Birth: _____

Age: _____ Sex: _____ Height: _____ Weight: _____

Is your problem related to:
☐ Job ☐ Accident Date of Injury: _____

How long have you had this problem? _____

Please describe your main problem: _____

_____

_____

_____

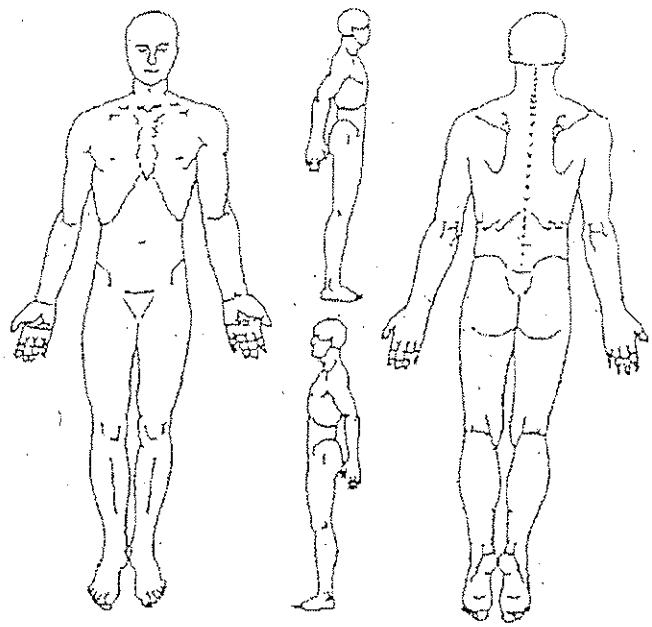
_____

_____

_____

Please MARK & RATE each pain 0-10

XXX=Pain 000=Numbness/Tingling



Check which apply

☐ Throbbing ☐ Shooting
☐ Stabbing ☐ Sharp
☐ Cramping ☐ Gnawing
☐ Burning ☐ Aching
☐ Sickening ☐ Exhausting
☐ Cruel ☐ Numbness/Tingling

Is your pain affected by:

	Better	Worse		Better	Worse
Rest	☐	☐	Walking	☐	☐
Sitting	☐	☐	Bending	☐	☐
Standing	☐	☐	Lying down to sleep	☐	☐

Have you been to Physical Therapy for this problem?
If Yes, what Dates: _____
Was It Helpful? ☐ Yes ☐ No

Please check (√) what you have had recently:

Fevers or Chills		Shortness of Breath		Rashes	
Double Vision		Difficulty Controlling Bowels		Numbness/Tingling in Hands/Feet	
Dizziness		Difficulty Controlling Bladder		Depression	
Swelling in Feet		Joint Swelling		Problems Sleeping	

Drug You Are Allergic To:	What Happens When You Take It?

Please list Other Doctors you have seen for your pain.

Physician	Specialty	Dates	Treatment

Have you ever had Injections or Surgeries for your pain? If "yes" please list in chronological order

Medicines you are taking for Pain Now	Dosage (Milligrams)	How Many Per Day?	Name Of Prescribing Doctor

Circle any Medicines you have taken in the Past	Did It Help?
Aspirin, Tylenol	
Celebrex, Motrin (Ibuprofen), Naprosyn/Aleve (Naproxen), Relafen, Toradol, Voltaren, Other Anti-Inflammatories:	
Darvocet, Dilaudid, Duragesic, Lortab, Morphine, Oxycontin, Percocet (Oxycodone), Vicodin (Hydrocodone), Demerol, Tylenol #3 (Codeine)	
Elavil, Prozac, Paxil, Other Antidepressants:	
Flexeril (Cyclobenzaprine), Norflex, Valium, Soma, Skelaxin	
Lamictal, Neurontin, Cymbalta, Lidoderm	

What Tests have you had	Date	Test	Date
Bone Scan		EMG	
CT Scan		MRI	

Family Member	Age	Living Or Deceased?	Medical History/Cause Of Death
Father			
Mother			

PAST MEDICAL HISTORY: Please **Circle** if you have had any of the following:

1. Lung disease, bronchitis, asthma, emphysema, pneumonia
2. Heart disease, bypass surgery, heart attack, high blood pressure, irregular heartbeat, pacemaker/defibrillator
3. Stroke, seizure, neuropathy, headaches
4. Kidney disease, blood in urine, stones
5. Arthritis, lupus, gout,
6. Esophageal reflux, ulcer, colon condition, liver disease
7. Thyroid condition, diabetes
8. Cancer, lymphoma, leukemia, HIV/AIDS
9. Depression, schizophrenia or other psychiatric disease
10. Polio

SOCIAL HISTORY

Occupation: _____

Working Status: ☐ Full Duty ☐ Light Duty ☐ Off Duty Per Doctor
☐ Unemployed ☐ Retired ☐ On Disability

If you are not working, how long have you been off? _____

Do you use **Tobacco**? ☐ No ☐ Yes -- **If yes, how many per day**?
Cigarettes _____ Cigars _____ Chewing Tobacco (Snuff) _____

Do you use **Alcohol**? ☐ No ☐ Yes -- **If yes, how many per day**?
Beer _____ Wine _____ Spirits _____

Have you ever had a problem with **drug or alcohol abuse**? ☐ Yes ☐ No
Do you use any **recreational drugs**? _____