



PIEDMONT
Interventional
PAIN CARE, PA
Robert B. Wilson, II, MD
Pain Medicine Specialist

320 W. Jake Alexander Blvd.
Salisbury, NC 28147-1364
704-797-0065 ph 704-797-0067 fx
www.piedmontpaincare.com

NEW PATIENT INFORMATION RECORD

Failure to complete this entire form PRIOR to your appointment may result in rescheduling. This information is kept confidential and will be available to your health care team.

PLEASE BRING THIS COMPLETED FORM WITH YOU ON YOUR NEXT VISIT

Today's Date: _____
Last Name: _____ First: _____ MI: _____
Social Security #: _____ Date of Birth: ____ / ____ / ____ Sex: ____ Age: ____
Home Telephone: () _____ Cell Phone: () _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail (optional) _____ Fax: () _____
Marital Status: _____ Spouse's Name: _____
Referring Physician: _____ **Telephone:** () _____
Primary Care Physician: _____ **Telephone:** () _____

PRIMARY INSURANCE

Insurance Company: _____ Policy Holder's Name: _____
Policy Holder's DOB: _____ Relationship to patient: _____
Policy #: _____ Group #: _____ Benefits #: () _____
Policy Holder's Employer: _____

SECONDARY INSURANCE

Insurance Company: _____ Policy Holder's Name: _____
Policy Holder's DOB: _____ Relationship to patient: _____
Policy #: _____ Group #: _____ Benefits #: () _____
Policy Holder's Employer: _____

PATIENT EMPLOYER INFORMATION

Full-Time Part-Time Unemployed Student Retired Legally Disabled
Employer's Name: _____ Address: _____
City: _____ State: _____ Zip: _____ Work Telephone: () _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Telephone () _____

COMPREHENSIVE PAIN QUESTIONNAIRE

Complete this form before your first appointment at PIEDMONT INTERVENTIONAL PAIN CARE. Your careful answers will help us to understand your pain problem and design the best treatment program for you.

CHARACTERISTICS OF PAIN (Chief Complaint)

What is the main problem for which you are seeking treatment at Piedmont Interventional Pain Care for pain relief? _____

HISTORY OF PRESENT ILLNESS

Pain Location

Please describe the location(s) of your pain: _____

Onset of Pain (Cause)

How did your current pain start?

- | | |
|--|---|
| <input type="checkbox"/> Injury at work | <input type="checkbox"/> Motor vehicle accident |
| <input type="checkbox"/> Injury, not at work | <input type="checkbox"/> Illness |
| <input type="checkbox"/> Treatment caused (e.g., radiation, surgery, etc.) | <input type="checkbox"/> Undetermined |
| <input type="checkbox"/> Other: _____ | |

Progression of Pain

- Slow/Gradual Rapid/Sudden

Pain Rating

Current Pain Level:	0	1	2	3	4	5	6	7	8	9	10
Maximum Pain Level:	0	1	2	3	4	5	6	7	8	9	10
Minimum Pain Level:	0	1	2	3	4	5	6	7	8	9	10

Pain Duration

How long have you had your current pain problem(s)? _____ weeks _____ months _____ years

Frequency/Timing of Pain

How often do you have your pain? (please check one)

- | | |
|---|---|
| <input type="checkbox"/> Constantly (100% of the time) | <input type="checkbox"/> Intermittently (30% to 60% of the time) |
| <input type="checkbox"/> Nearly constantly (60% to 95% of the time) | <input type="checkbox"/> Occasionally (less than 30% of the time) |

In general, during the past month, when has your pain been the worst? (please check one)

- Morning Afternoon Evening Night No typical pattern

Activities and Your Pain

Place a check mark next to the activities that you have avoided or limited during the past month because of pain:

- | | |
|--|--|
| <input type="checkbox"/> Going to work | <input type="checkbox"/> Having sexual relations |
| <input type="checkbox"/> Performing household chores | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Doing yard work or shopping | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Socializing with friends | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Participating in recreation | <input type="checkbox"/> Walking |

Associated Symptoms

- "Pins and Needles" Numbness Tingling Weakness

Pain Quality

How would you describe the pain?

- Burning Cutting Sharp Throbbing Other: _____
 Cramping Dull, aching Pressure Shooting

Relieving and Aggravating Factors

How do the following affect your pain? (please check one for each item)

	Decrease	No Change	Increase
Lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relaxation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Attempted Treatments

Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right.

Treatment	Date (approx)	No Relief	Moderate Relief	Excellent Relief
<input type="checkbox"/> Bed rest	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Traction	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Surgery	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nerve block or other injections	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> TENS	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical Therapy	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Exercise	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heat	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ice	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Biofeedback	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Psychotherapy	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chiropractic	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Effect on Sleep

- No effect Pain makes it difficult to fall asleep Pain makes it difficult to stay asleep

Effect on Bowel and Bladder Control

- No effect Loss of bladder control Loss of bowel control

Assisting Device

Devices used to assist ambulation

- Cane Walker Wheelchair None

MEDICATIONS

Please list all of your current medications below:

Name of Drug	Strength	# of times taken per day	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Over The Counter _____

***If your list of medications exceeds these lines, attach a written list.**

PAST MEDICAL HISTORY

Medical

Have you had any of the following health problems? (please check all that apply)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Angina or chest pain | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Seizure or epilepsy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes or high blood sugar | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Asthma or wheezing | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> TIA or stroke |
| <input type="checkbox"/> Bleeding problem | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Reflux (GERD) | |
| <input type="checkbox"/> Cancer: please specify what type: _____ | | | |

NOTE: If you checked yes to any of the above problems, please give an explanation: _____

ALLERGIES

Do you have any drug allergies that you are aware of? Yes No

List all items (medicines and non medicines) that you are **ALLERGIC** to and the type of reaction it causes:

ITEM	REACTION	ITEM	REACTION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had a reaction to intravenous contrast dye or iodine? Yes No

Are you allergic to any shellfish? Yes No

SURGICAL HISTORY

List all major surgeries that you have had in the past:

Name of Surgery	Where Performed	When	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any problems with anesthesia related to any surgery? Yes No If yes, specify: _____

Have you ever had surgery to relieve your current pain condition? Yes No

Have you been told you may need surgery for your current pain problem? Yes No

GENERAL FAMILY ILLNESS

Please check any health problems that are known to run in your family and place the relationship in the blank:

M = Mother F = Father Grandmother = GM Grandfather = GF S = Siblings C = Children

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Angina or chest pain ____ | <input type="checkbox"/> Chronic cough ____ | <input type="checkbox"/> Kidney disease ____ | <input type="checkbox"/> Seizure or epilepsy ____ |
| <input type="checkbox"/> Arthritis ____ | <input type="checkbox"/> Diabetes or high blood sugar ____ | <input type="checkbox"/> Liver disease ____ | <input type="checkbox"/> Thyroid disease ____ |
| <input type="checkbox"/> Asthma or wheezing ____ | <input type="checkbox"/> Heart attack ____ | <input type="checkbox"/> Peptic Ulcer ____ | <input type="checkbox"/> TIA or stroke ____ |
| <input type="checkbox"/> Bleeding problem ____ | <input type="checkbox"/> High blood pressure ____ | <input type="checkbox"/> Reflux (GERD) ____ | |
| <input type="checkbox"/> Cancer: please specify what type: _____ | | | |
| <input type="checkbox"/> Other: please specify: _____ | | | |

SOCIAL HISTORY

Marital Status

- | | | |
|--|------------------------------------|---|
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Remarried | <input type="checkbox"/> Spouse Deceased |
| <input type="checkbox"/> Engaged | <input type="checkbox"/> Separated | <input type="checkbox"/> Significant other Deceased |
| <input type="checkbox"/> Married living w/spouse | <input type="checkbox"/> Single | |

Living Arrangements

- | | | |
|--|---|--|
| <input type="checkbox"/> Living alone | <input type="checkbox"/> Living with children | <input type="checkbox"/> Living with spouse/partner and children |
| <input type="checkbox"/> Living with friends | <input type="checkbox"/> Living with spouse/partner | <input type="checkbox"/> Living with other |

Employment

Your current or former occupation: _____

Current employment status (please check all that apply):

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Employed full-time | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> Employed part-time | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Student | <input type="checkbox"/> Homemaker |
| <input type="checkbox"/> Unemployed or working part time, because of pain | |

SOCIAL HISTORY CONTINUED

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

- | | |
|--|--|
| <input type="checkbox"/> 1 - 3 weeks | <input type="checkbox"/> 12 - 18 months |
| <input type="checkbox"/> 1 - 3 months | <input type="checkbox"/> 19 - 24 months |
| <input type="checkbox"/> 4 - 7 months | <input type="checkbox"/> 25 or more months |
| <input type="checkbox"/> 8 - 11 months | |

Please indicate any of the following claims you have related to your pain problem:

- | | |
|--|--|
| <input type="checkbox"/> Workers' compensation | <input type="checkbox"/> Other Insurance |
| <input type="checkbox"/> Personal injury/liability (unrelated to work) | <input type="checkbox"/> None |
| <input type="checkbox"/> Social Security Disability Insurance (SSDI) | |

Substance Abuse

Do you have a history of:

- | | | | |
|-------------------------------|--|--|--------------------------------|
| Tobacco use? | <input type="checkbox"/> Yes - Currently | <input type="checkbox"/> Yes - In the past | <input type="checkbox"/> Never |
| Alcoholism? | <input type="checkbox"/> Yes - Currently | <input type="checkbox"/> Yes - In the past | <input type="checkbox"/> Never |
| Illicit (illegal) drug abuse? | <input type="checkbox"/> Yes - Currently | <input type="checkbox"/> Yes - In the past | <input type="checkbox"/> Never |

Have you ever been in a detoxification program for drug abuse? Yes No

Psychological Treatment

Have you ever had psychiatric, psychological, or social work evaluation or treatments for any problem, including your current pain? Yes No

If yes, when? _____

Have you ever considered suicide? Yes No

REVIEW OF SYSTEMS

Please check all items you feel are applicable to you.

General:

- Do you have a change in appetite? Decreased Increased
- Chills?
- Decreased energy level?
- Fatigue?
- Fever? Daily Every few days High Low Recurrent Weekly
- Unusual Sweats? Night Sweats
- Weight Change? Gain Loss

Eyes:

Change in Vision?

Respiratory:

Shortness of breath?

Cardiovascular:

- Do you have palpitations (awareness of fast heart)?
- Do you have chest pain/pressure?

VITAL SIGNS

Height: _____ Weight: _____ lbs.