COLORADO **PAIN SPECIALISTS**, PC

NEW PATIENT INFORMATION

Please fill out all of the information on this page **Date:____/____/____**

Name:____ DOB___/___/____Age:__________

Referring Physician:____ Ph#:___________________________

Primary Care Physician:____ Ph#:___________________________

Other Physician:____ Ph#:___________________________

***Chief Complaint*::**____

____

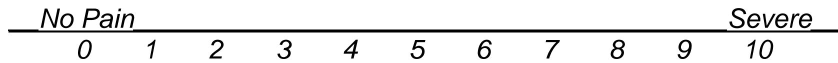
How did your pain start? □ *Work* □ *Auto* □ *Other* *Date of Injury?* ___/___/____

*Describe onset of symptoms::*____

____

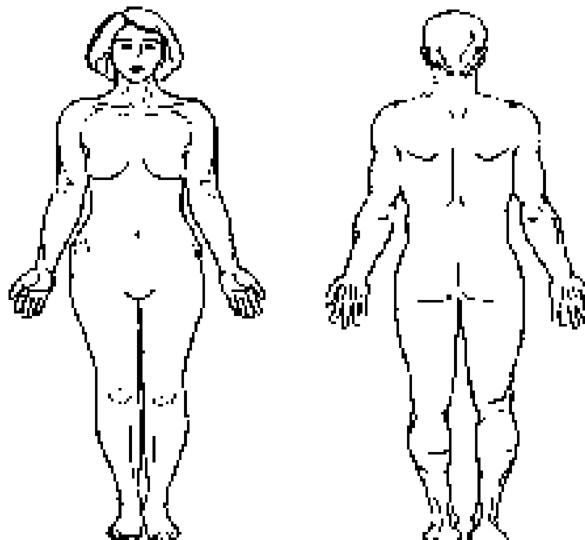
Pain Intensity:

Please mark this line with the intensity of your average pain using all of the following letters:



P = Present Pain *M = Most of the time* *W = Worst it gets* *L = Least it gets*

Pain Diagram: Please mark or shade areas where you have your pain. Put an X where it hurts the most.



Colorado Pain Specialists

toll free 1-866-356-4040 p303-268-4040 f303-736-4147

Functional History:

- *Are you working?* □ *Yes* □ *No* *If yes:* □ Full time □ Part time □ Restricted duty

  If no, date last worked:___/___/___
- *What activities of daily living are you able to perform:* □ Housekeeping □ Childcare □ Yard work □ Cooking □ Errands(grocery, dry cleaners, etc) □ Getting out of bed/showering/dressing □ Daily hygiene □ Driving
- *Is your pain restricting your activities of daily living?* □ *Yes* □ *No* *If yes, how?*___________________________
  ____
- *What activities/sports/hobbies do you enjoy?*____
  ____
- *Is your pain restricting your activities/sports/hobbies?* □ *Yes* □ *No If yes, how?*___________________________
  ____

Describe your pain*:* □ Constant □ Intermittent □ *Sharp* □ *Dull* □ *Achy* □ *Burning* □ *Stabbing* □ *Searing* □ *Throbbing* □ *Shooting* □ *Cramping*____
____

My pain is improved by*:* □ *Sitting* □ *Standing* □ *Walking* □ *Laying* □ *Bending forward* □ *Bending back*
*Describe in detail:*____

My pain is worsened by*:* □ *Sitting* □ *Standing* □ *Walking* □ *Laying* □ *Bending forward* □ *Bending back*
□ Sneeze/cough □ Bowel movement
*Describe in detail:*____

Diagnostic Testing*:* □ *X-rays* ________□ *MRI/CT*_________ □ *EMG/NCV*__________ □ *Other*_______________
*When/Where:*____

Previous Pain Injections*:* □ *Trigger Points* □ *Epidurals* □ *Facet Injections* □ *Discogram*
□ *Other:*____

Other Therapies*:* □ *Physical Therapy* □ *Chiropractic* □ *Massage Therapy* □ *Acupuncture* □ *Biofeedback*
□ *Other:*____

Previous Pain Medications Tried and Effect:

Medications	Dosage	Effect

Current Medications:

Medications	Dosage	Doctor Prescribing

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Allergies: ☐ None ☐ Penicillin ☐ Sulfa ☐ Iodine ☐ IVP dye ☐ Latex ☐ Eggs ☐ Other____________________

Describe Reaction:____

Past Medical History: Have you ever had problems with any of the following? (Please check box and explain)

☐ High Blood Pressure ☐ Asthma/Lung Disease ☐ Heart Disease/Arrhythmia ☐ Cancer ☐ Arthritis

☐ Diabetes ☐ Gastritis or Ulcers ☐ Congestive Heart Failure ☐ Stroke/Seizure ☐ MI

☐ HIV or exposure ☐ Kidney or Liver Disease ☐ Sleep Apnea ☐ Endocrine disease(thyroid)

Other : (please explain):____

____

Past Surgical History:

Please list any surgeries you have had and approximate dates(use back of sheet if more room is needed)

____ Physician:_______________________Date:________________

____ Physician:_______________________Date:________________

____ Physician:_______________________Date:________________

Psychiatric History:

☐ Depression/Manic Depression ☐ Anxiety ☐ Bipolar Disease ☐ Schizophrenia ☐ Mixed Personality Disorder

☐ ANY type of addiction history ☐ Substance abuse ☐ Other:_______________________

Are you currently seeing a psychiatrist or psychologist? _____Yes_____No

If yes, whom?____

Have you had any recent thoughts or ideations of suicide or harming others?_____Yes_____No

Social History:

What is your occupation:____

Do you smoke?_____Yes_____No If yes, how much?____

Do you drink alcohol?_____Yes_____No If yes, what and how much?_____________________________________

Do you use or have you ever used: ☐ Marijuana ☐ Cocaine ☐ Other illicit drug(s)

If yes, what and how much?____

Are you involved in litigation regarding this pain?_____Yes_____No (if yes, please list attorney below)

Attorney:____ Ph#:________________________

Review of Systems: Do you currently or have you ever had any of the following?

☐ Are you pregnant? ☐ Change in skin ☐ Tendency to bruise/bleed ☐ Dizziness

☐ Shortness of Breath ☐ Chest Pain ☐ Nausea/Heartburn ☐ Joint Pain/Stiffness

☐ Leg Swelling/Pain ☐ Shakiness/Sweating ☐ Frequent Urination ☐ Unexplained Weight Change

☐ Fatigue ☐ Numbness/Weakness ☐ Fever/Chills ☐ Sleep Disturbance

Other: (please explain)____

____

Family History: Do any of your immediate family members have/had any of the following: ☐ Cancer

☐ Diabetes ☐ Arthritis/Rheumatologic Disease ☐ High Blood Pressure/Heart Disease ☐ Asthma/Lung Disease

☐ Degenerative Spine Disease

Comments:____

Patient Information:

Patient Name:____

Address:____City:___________State:_____Zip:_______

Home Phone:(____)___________ Work Phone:(____)_____________Cell Phone or Pager:(____)_______________

Date of Birth:____/____/____ Social Security Number:_____-____-_____ Sex: M ___F___Marital Status:________

Drivers License #____________________State___

Employer:____

Address:______________________________City:___________State___Zip_________

Referring Physician:________________________________Phone;(___)___________Fax:(___)__________

Address:____City:_______________State:___Zip:_______

Primary Insurance Company Name:____

Type:_____WC_____Auto_____Other Date of Injury:_____/_____/________

Adjuster Name:_________________________________Phone:(____)___________ Fax:(____)___________

Address:_____________________________________City:_____________________State:___Zip:_______

Policy Holder Name:____Relationship:__________________

Claim #____________________________________Group#________________Policy #_______________

Secondary Insurance Company Name:____

Type:_____WC_____Auto_____Other Date of Injury:_____/____/_____

Adjuster Name:_________________________________Phone:(____)___________Fax:(____)____________

Address:____City:____________State:___Zip:________

Policy Holder Name:__________________________Relationship(if not patient)___________

Claim #______________________Group #____________________________Policy #__________________

Supplemental Data:

Spouse's Name:____Phone:(____)___________________

Emergency Contact:____Phone:(____)___________________

Who would you like reports sent to? (please provide name, address & phone)

____ Phone:(____)____________

____ Phone:(____)____________

Authorization to pay benefits to the physician: I hereby authorize payment of all benefits directly to the physicians of Colorado Pain Specialists for all surgical and/or medical services provided to me. I realize that I am responsible to forward any such monies paid to me and to pay for all co-payments, deductibles and any non-covered services.

Signature of Patient:____Date:______/______/___________

Authorization to release information: I verify that all the information contained on these information sheets is true and correct, to the best of my knowledge and belief. I hereby authorize the physicians of Colorado Pain Specialists to release any information acquired in the course of my treatment necessary to process insurance claims and to or from other physicians or medical facilities that may be pertinent and necessary to my care and treatment.

Signature of Patient:____Date:______/______/____________