

PARS INTERVENTIONAL PAIN & WELLNESS CENTER

1212 Garfield Avenue, Suite 202 Parkersburg, WV 26101

Phone: (304) 865-7277 / Fax: (304) 865-7273

You have been referred to our office for a pain evaluation. **Below is a detailed questionnaire that must be completely filled out and returned to our office before your appointment will be scheduled.**

You may mail or drop of the questionnaire to:

Pars Interventional Pain & Wellness Center
1212 Garfield Ave. Suite 202
Parkersburg, WV 26101

PATIENT REGISTRATION:

Patient Name: _____ Date: ____ / ____ / ____
Last Name First Name Middle Name
Address: _____ Home Phone: (____) ____-____
City: _____ Work Phone: (____) ____-____
State: _____ Zip Code: _____-____ Date of Birth: ____ / ____ / ____
Employer: _____ Social Security #: ____-____-____
Employer Address: _____ Marital Status: M S D W
Pharmacy: _____ Cell Phone: (____) ____-____
Primary Care Physician: _____ Referring Physician: _____

SUBSCRIBER INFORMATION (SPOUSE, PARENT, OR GUARDIAN):

Address: _____ Phone: (____) ____-____
City/State/Zip: _____
Employers Address: _____ Phone: (____) ____-____

INSURANCE:

1) _____ Phone: (____) ____-____
Primary Insurance Co. Name Address
Subscriber's Name Subscriber's I.D.# Group
2) _____ Phone: (____) ____-____
Secondary Insurance Co. Name Address
Subscriber's Name Subscriber's I.D.# Group

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone: (____) ____-____

Name: _____

NEW PATIENT DATA BASE

Sex: [] Male _____
[] Female Age _____ right or left handed

HISTORY:

1. What is the primary reason you are seeing the doctor? _____
2. Do you have any other concerns or complaints of pain? _____
3. When did the primary problem begin? _____
4. What makes it better? _____ Worse? _____
5. (Please Circle) **Standing:** *worse/better/same* **Walking:** *worse/better/same* **Sitting:** *worse/better/same*
6. Is it constant or intermittent? _____
7. Do you have weakness? Y/N if so, where? _____
8. Since the start of the symptom(s) has it become: **BETTER** **UNCHANGED** **WORSE**
9. Is this a result of an injury? If yes, explain: _____
10. Is this a Workman's Compensation problem? Y/N Do you have a lawyer? Y/N
11. What other treatment(s) have you had? *Injections / Chiropractic / Physical Therapy / Surgery*
12. Did any of the above help to relieve your symptoms? _____
13. Have you been seen at a pain center before? Y/N Where? _____
14. Have you ever been dismissed from a pain center? Y/N Reason? _____
15. Are you willing to work hard to achieve improved quality of life and pain relief? ___ NO ___ YES
16. Are you willing to try injections to help relieve your pain? ___ NO ___ YES
17. My personal goals are: _____

CURRENT PAIN SCALE DIAGRAM

Please place a mark on the line to signify the amount of pain you are in now.
No pain 0 _____ **10 Worst pain ever**

Please place a mark on the line to signify the worst amount of pain in the last week.
No pain 0 _____ **10 Worst pain ever**

Mark the areas on your body where you now feel pain. Use the **symbols** indicated below.
Include all affected areas.

Ache >>>> **Numbness -----** **Pins & Needles ●●●●** **Burning xxxxx** **Stabbing /////** **Other ++++++**

Name: _____

PAST MEDICAL HISTORY: CHECK ALL THAT APPLY & LIST DATES

<u>NOSE / SINUS:</u>	NO	YES	DATE	OTHER
Nasal Allergies				

<u>HEART / BLOOD VESSELS:</u>	NO	YES	DATE	OTHER
Irregular Heart Beat				
Congestive Heart Failure				
Heart Attack				
High Cholesterol				
High Blood Pressure				

<u>LUNGS / RESPIRATORY:</u>	NO	YES	DATE	OTHER
Asthma				
Bronchitis				
COPD				
Tuberculosis				

<u>STOMACH / DIGESTIVE:</u>	NO	YES	DATE	OTHER
Diverticulitis				
Colitis				
Stomach Ulcer				
Duodenal Ulcer				
GERD (heartburn)				
Hepatitis				
Irritable Bowel Syndrome				

<u>KIDNEY:</u>	NO	YES	DATE	OTHER
Renal Failure				
Dialysis				
Kidney Stones				

<u>MENTAL / EMOTIONAL:</u>	NO	YES	DATE	OTHER
Depression				
Anxiety				
Schizophrenia				

<u>GLANDS / HORMONES:</u>	NO	YES	DATE	OTHER
Insulin Dependent Diabetic				
Non-Insulin Dependent Diabetic				
Under Active Thyroid				
Over Active Thyroid				
Thyroid Surgery				

<u>BLOOD / LYMPH NODE PROBLEMS:</u>	NO	YES	DATE	OTHER
Anemia				
Bleeding Disorder				
Blood Clots				
Phlebitis				

<u>IMMUNE INFECTIOUS PROBLEMS:</u>	NO	YES	DATE	OTHER
HIV				
Infectious Mononucleosis				
Shingles				

Name: _____

PAST MEDICAL HISTORY: CHECK ALL THAT APPLY & LIST DATES

<u>CANCER</u>	NO	YES	DATE	OTHER
IF YES, PLEASE LIST TYPE & TREATMENT				

<u>FEMALE:</u>	NO	YES	DATE	OTHER
Last Menstrual Period				
Menopausal				
Pregnant or Possibility?				

REVIEW OF SYSTEMS:

(X Check all that apply)

General Health Problems:

Change in appetite Unintended weight loss Sleeping problems Fever
 Fatigue Weight Gain

Head / Face:

Headache Face Pain

Eye:

Blurred Vision Double Vision Loss of Vision Wear glasses or contacts

Ear:

Hearing Loss Ringing in the Ears Dizziness Wear hearing aid(s)

Mouth / Throat:

Changing in voice Snoring Sore Throat Mouth Ulcers
 Dentures: upper / lower

Neck:

Neck lumps or masses Neck pain Swollen glands

Stomach Problems:

Stomach Pain Constipation Diarrhea Heartburn
 Indigestion Nausea Vomiting Hemorrhoids

Urinary Problems:

Urinating more than usual Kidney Stones Difficulty or painful urinating Kidney Dialysis
 Blood in urine

Bones / Joints / Muscles:

Back spasms Back pain Painful Joints Stiffness
 Swollen Joints Muscle Cramps Shoulder pain

Brain / Nervous System:

Change in alertness Seizures Stroke Numbness
 Loss of consciousness

Name: _____

REVIEW OF SYSTEMS:

(X Check all that apply)

Heart / Circulation:

____ Blacking out or fainting ____ Leg Cramps ____ Irregular Heartbeat ____ Chest Pain
____ Swelling of the feet/ankles ____ Heart Murmurs ____ Bluish color to lips/fingernails

Problems with Glands / Hormones:

____ Feel cold all the time ____ Increased appetite ____ Feel uncomfortably hot ____ Increased thirst
____ Increased fatigue ____ Neck has enlarged ____ Unwanted weight change

Problems with Allergies:

____ Food intolerances ____ Frequent sneezing ____ Post nasal drainage ____ Hives
____ Reaction to insect bites/stings

Mental / Psychiatric:

____ Anxiety ____ Depression ____ Compulsive behavior(s) ____ Hallucinations
____ Suicidal thoughts/tendencies

Lung or Respiratory Problems:

____ Shortness of breath ____ Wheezing ____ Non-Productive Cough ____ Productive Cough

Problems with Blood / Lymph Nodes:

____ Bleed heavily after injury ____ Bruise easily

Skin:

____ Rash ____ Itching ____ Psoriasis ____ Eczema
____ Dry flaking skin

PAST SURGICAL HISTORY & HOSPITALIZATIONS

Do you have a cardiac pacemaker? ____ NO ____ YES

Have you ever had **Neck** or **Back** surgery? ____ NO ____ YES

If yes, list:

Surgery: _____ Location: _____ Date: _____ Surgeon: _____

Surgery: _____ Location: _____ Date: _____ Surgeon: _____

Surgery: _____ Location: _____ Date: _____ Surgeon: _____

Surgery: _____ Location: _____ Date: _____ Surgeon: _____

Do you have any metal implants? ____ NO ____ YES If yes, are you able to have an MRI if needed? ____ NO ____ YES

Do you have cardiac stents in place? ____ NO ____ YES

Have you ever had any other surgeries? ____ NO ____ YES

If yes, list surgery and date done

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Name: _____

FAMILY HISTORY:

	MOTHER	FATHER	BROTHER	SISTER	OTHER
Heart Disease					
High Blood Pressure					
Asthma					
Lung Cancer					
Bone Cancer					
Arthritis (Circle Type) Rheumatoid Arthritis or Osteoarthritis					
Diabetes					
Stroke					
Bleeding / Clotting Problems					
<i>Female Health:</i> Breast Cancer	___ Mother	___ Sister	Other: _____		
<i>Male Health:</i> Prostate Cancer	___ Father	___ Brother	Other: _____		

SOCIAL HISTORY:

Have you ever used Tobacco in any form? ___ NO ___ YES
If yes, what Type of Tobacco _____, How Much _____, How Often _____
From _____ to _____(year)

Do you drink Alcoholic beverages? ___ NO ___ YES
If yes, what Type of Alcohol _____, How much _____, How Often _____

Do you now, or have you ever taken illegal drugs? ___ NO ___ YES If yes, please list: _____

Do you drink Caffeinated beverages? ___ NO ___ YES If yes, please list: _____

Marital Status: ___ Single ___ Married ___ Separated ___ Divorced ___ Living with partner ___ Widowed

List individuals living with you and relationship to you:

Relationship: _____

Relationship: _____

Relationship: _____

Do you have children: ___ NO ___ YES If yes, how many: _____

Are you independent in all personal activities such as:

- Dressing yourself - Bathing - Toilet - Cooking - Walking - Getting out of bed

If the answer is NO to any or these, please explain limitations: _____

Working Status: ___ Full-time employed ___ Part-time employed ___ Homemaker ___ Retired ___ Disabled

Occupation: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____

Date: _____