DAYTON OUTPATIENT CENTER

Pain Management

PATIENT HISTORY FORM

(Must be filled out by new patients before seen by Physician)

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST)	M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER

LEGAL SEX □ MALE □ FEMALE	AGE	ORIENTATION □ HETEROSEXUAL □ HOMOSEXUAL □ BISEXUAL □ SOMETHING ELSE _____ □ CHOOSE NOT TO DISCLOSE

EMPLOYMENT STATUS □ FULL TIME □ PART TIME □ RETIRED □ DISABLED □ FULL-TIME STUDENT	JOB TITLE / DATE LAST WORKED

PRIMARY CARE PHYSICIAN □ NONE	PHONE NUMBER

PREVIOUS PAIN DOCTOR □ NONE	PHONE NUMBER

CAUSE OF PAIN

DATE PAIN STARTED	LOCATION OF PAIN	PAIN LEVEL /10	CONSTANT □ YES □ NO	PAIN WORSE □ AM □ PM □ None

WORK INJURY □ YES □ NO	BWC □ YES □ NO	CLAIM #	ACTIVE □ YES □ NO	ATTORNEY NAME / PHONE NUMBER

AUTO ACCIDENT □ YES □ NO	DATE OF ACCIDENT	ATTORNEY NAME / PHONE NUMBER

OTHER ACCIDENT □ YES □ NO	TYPE	ATTORNEY NAME / PHONE NUMBER

Any previous testing? □ YES □ NO □ MRI □ CT scan □ Xray □ EMG/NCV □ OTHER

Where was testing done? _____ Date of testing: _____

Are you having trouble sleeping due to pain? □ YES □ NO Trouble staying asleep? □ YES □ NO

Activities that worsen pain □ Lifting □ Bending □ Twisting □ Sitting □ Standing □ Other_____

Does stress affect your pain? □ YES □ NO Source of stress: _____

Things that help your pain? □ YES □ NO What helps? _____

TYPE OF PAIN

MARK YOUR AREAS OF PAIN ON THE DRAWINGS BELOW

DESCRIBE PARTS OF THE BODY

STABBING _____

BURNING _____

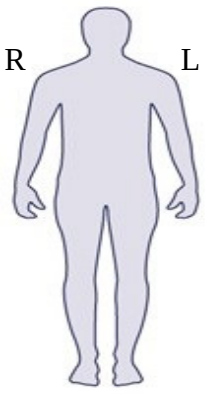
ACHING _____

NUMBNESS _____

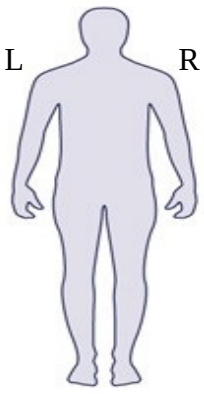
PINS & NEEDLES _____

JOINT PAIN _____

FRONT OF BODY



BACK OF BODY



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MEDICAL HISTORY

PATIENT NAME (LAST, FIRST)	M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER

HEIGHT	WEIGHT	TOBACCO USE □ YES □ NO	ALCOHOL USE □ YES □ NO
		How much? PPD YRS.	How much?

Please list your past surgeries with dates or provide list _____

_____

Have you ever been diagnosed with any of these? (check any that apply)

- □ Angina
- □ Arthritis
- □ Blood disorders
- □ Cancer
- □ CHF
- □ COPD/Emphysema
- □ Coronary Heart Disease
- □ Diabetes
- □ Heart Attack
- □ Hepatitis
- □ High blood pressure
- □ Intestinal Issues
- □ Kidney stones
- □ Liver Disease
- □ Seizures
- □ Stroke
- □ Thyroid Disease
- □ Ulcers/Gastritis

Have you ever had any of the following happen to you? (check any that apply)

- □ Head (history of trauma)
- □ Bloody stool
- □ Skin rash
- □ Painful joints
- □ Allergies
- □ Chest pain
- □ Passing out
- □ Bloody Urine
- □ Upset stomach/nausea
- □ Swelling
- □ Depression/Anxiety
- □ Hearing loss
- □ Diarrhea/Constipation
- □ Shortness of breath
- □ Weakness/Loss of strength
- □ Dizziness
- □ Eyesight changes
- □ Alcohol/Substance abuse

Have you ever had any pain treatments? (check any that apply)

- □ Trigger point injections
- □ SI joint injections
- □ Accupuncture
- □ Aquatic/Pool Therapy
- □ Epidural steroid injections
- □ Spinal Cord Stimulator
- □ Chiropractor
- □ Addiction Counseling
- □ Facet joint injections
- □ Morphine/Intrathecal pump
- □ Physical therapy
- □ Psychological counseling

Circle a number the best describes how your pain interferes with the following activities

(0 is the lowest with no interference and 10 indicates complete interference)

GENERAL ACTIVITY

0 1 2 3 4 5 6 7 8 9 10

MOOD

0 1 2 3 4 5 6 7 8 9 10

NORMAL WORK (INCLUDING WORK OUTSIDE THE HOME AND HOUSEWORK)

0 1 2 3 4 5 6 7 8 9 10

RELATIONSHIPS WITH FAMILY, FRIENDS AND CO-WORKERS

0 1 2 3 4 5 6 7 8 9 10

ABILITY TO SLEEP

0 1 2 3 4 5 6 7 8 9 10

QUALITY OF LIFE (Hobbies, Sex or Any Daily Activities)

0 1 2 3 4 5 6 7 8 9 10

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MEDICAL HISTORY
MEDICATIONS

PATIENT NAME (LAST, FIRST)	M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER

Please list all your Allergies

_____

_____

Please list your current PAIN medications _____

_____

Have you tried other pain medications in the past? If so, what? _____

_____

Please list any other medications you take currently or provide a list _____

_____

_____

Do you have any side effects from current medications? If so, what? _____

Are you concerned about your use of pain medications? ☐ YES ☐ NO

Have you ever used marijuana, cocaine or any other illegal drugs in the past? ☐ YES ☐ NO

Do you have any history of substance abuse? ☐ YES ☐ NO (check any that apply)

☐ Alcohol ☐ Illegal Drugs ☐ Prescription Drugs

Any family history of substance abuse? ☐ YES ☐ NO (check any that apply)

☐ Alcohol ☐ Illegal Drugs ☐ Prescription Drugs

Any history of psychological disorders in the past or present? ☐ YES ☐ NO (check any that apply)

☐ Attention Deficit Disorder ☐ Bipolar ☐ Schizophrenia

☐ Depression ☐ Anxiety

I certify all my answers are true and are answered to the best of my knowledge.

Patient Signature _____ Date _____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, do hereby authorize the release of my protected health information (PHI), as indicated herein; between the following parties:

FROM: _____

_____

_____

_____

TO: **DOC Pain Management**
1010 Woodman Drive
Dayton, Ohio 45432
Fax:937-252-3700
Phone:937-252-2000

I authorize the use or disclosure of the following PHI: (Please list dates of service, condition or event for releases)

I request these records to be released for the following purpose:

Pain Management Treatment

I authorize this release effective for 180 days from the date of my signature below. If not specified, this authorization shall be effective for one (1) year. I understand, as set forth in the provider's Notice of Privacy Practices, I have the right to revoke this authorization, in writing at any time. I understand revocation is not effective to the extent the provider has relied on this authorized release.

I also make the following qualification: If the information specified above contains information related to treatment for drug and/or alcohol abuse or HIV test results; I understand I have the right to inspect or copy my PHI and I have the right to refuse to sign this authorization

Patient Name _____ Date of Birth _____ SSN _____

Patient Signature or Guardian, or Durable Power of Attorney _____ Date _____

Patient unable to sign due to: _____ Relationship to Patient _____

OFFICE USE ONLYDO NOT WRITE BELOW THIS LINE**

FOR OFFICE USE ONLY: (Make sure only minimum necessary information is released)

☐**Surgery Records** ☐**Pain Clinic Records** ☐ **Imaging Records** ☐**Testing Records**

Indicate PHI released by checking boxes below

☐ Face Sheet	☐ Operative Reports	☐ Physician Orders
☐ H&P	☐ Radiology Reports	☐ Therapy Reports
☐ Discharge Summary	☐ Office Notes	☐ Emergency treatment
☐ Consultation Reports	☐ Pathology Reports	☐ Other:_____
☐ Laboratory Reports	☐ Physician Progress Notes	

Medical Record Clerk Signature _____ Date _____