Tennessee Valley Pain Consultants
Leaders in Nonsurgical Pain Relief

PATIENT INFORMATION

HUNTSVILLE HOSPITAL
CENTER FOR PAIN MANAGEMENT

PATIENT'S LEGAL NAME		DATE OF BIRTH / /	AGE	DATE / /
HEIGHT AND WEIGHT _____FT _____IN _____LBS	SEX MALE FEMALE	REASON FOR VISIT:		MARITAL STATUS S M D W
ADDRESS	CITY	STATE	ZIP CODE	
THE BEST NUMBER TO CONTACT YOU: (CIRCLE ONE) CELL, HOME, OR OTHER. ENTER NUMBER BELOW. ( )	OTHER CONTACT NUMERS: (CIRCLE ONE) CELL, HOME OR OTHER. ENTER NUMBER BELOW. ( )	PERMISSION TO CONTACT YOU AT WORK IF NEEDED YES NO		
WORK ADDRESS / CITY / STATE / ZIP CODE		WORK PHONE NUMBER ( )		
SOCIAL SECURITY NUMBER - -	EMPLOYER ( )	OCCUPATION:		
EMERGENCY CONTACT AND RELATIONSHIP TO YOU		EMERGENCY CONTACT NUMBER ( )		
INSURANCE	POLICY NUMBER	GROUP NUMBER		
IF PERSON OTHER THAN YOU CARRIES THE INSURANCE ENTER THAT PERSON'S NAME BELOW	ENTER THE DATE OF BIRTH OF THE PERSON THAT CARRIES THE INSURANCE	ENTER THE SOCIAL SECURITY NUMBER OF THE PERSON THAT CARRIES THE INSURANCE		
SECONDARY INSURANCE	POLICY NUMBER	GROUP NUMBER		
IF PERSON OTHER THAN YOU CARRIES THE SECONDARY INSURANCE ENTER THAT PERSON'S NAME BELOW	ENTER THE DATE OF BIRTH OF THE PERSON THAT CARRIES THE SECONDARY INSURANCE	ENTER THE SOCIAL SECURITY NUMBER OF THE PERSON THAT CARRIES THE SECONDARY INSURANCE		

PAINHP

-OVER-

PAIN HISTORY FORM

NAME: _____ HT:_____ WT:_____

FAMILY DOCTOR: _____REFERRING DOCTOR:_____

LOCATION OF PAIN: _____

DESCRIPTION OF PAIN: (Circle all that apply)

ACHING	NUMBNESS	STINGING
BURNING	PRESSURE	TENDER
CRAMPING	SHARP	TINGLING
DULL	SHOOTING	THROBBING
HEAVINESS	STABBING	TWISTING

OTHER: _____

CURRENT PROBLEM IS RESULT OF: ☐ CAR ACCIDENT ☐ WORK ACCIDENT ☐ FALL

☐OTHER:_____ DO YOU HAVE AN ATTORNEY? ☐ NO ☐ YES

DATE OF ACCIDENT _____ DATE OF ONSET OF PAIN: _____

PAIN RATING (0-10 SCALE) ON A: GOOD DAY _____ BAD DAY _____

IS PAIN ALWAYS THE SAME? ☐ NO ☐ YES

FREQUENCY OF PAIN: ☐ CONSTANT ☐ INTERMITTENT ☐ RARE

DOES THE PAIN CAUSE (check all that apply): ☐ WEAKNESS ☐ FATIGUE

☐ IRRITABILITY ☐ ANXIETY ☐ DEPRESSION

WHAT ACTIVITIES/FACTORS MAKE YOUR PAIN WORSE? (Ex: Sitting, Standing, Walking, etc)

_____

WHAT ACTIVITIES/FACTORS MAKE YOUR PAIN BETTER? (Ex: Heat, Ice, Rest, Medication, etc)

_____

HAVE YOU BEEN TREATED BY A PAIN MANAGEMENT SPECIALIST? ☐ NO ☐ YES

WHO: _____ WHERE: _____

NAME ALL DOCTORS OR CHIROPRACTORS WHO HAVE TREATED YOU FOR PAIN:

_____

_____

PAIN HISTORY (CONTINUED)

HAVE YOU HAD ANY OF THE FOLLOWING TREATMENTS FOR YOUR PAIN?

NERVE BLOCKS/INJECTONS: WHEN _____WHERE _____

EPIDURALS: WHEN_____WHERE _____

PHYSICAL THERAPY: WHEN_____WHERE_____

NARCOTICS: PLEASE LIST_____

OTHER MEDICATIONS: PLEASE LIST_____

☐ TENS UNIT ☐ ACCUPUNCTURE ☐ BIOFEEDBACK ☐ HYPNOSIS

SURGERY: _____ WHEN: _____ WHERE: _____

PAIN PUMP: ☐ NO ☐ YES TYPE: _____

SPINAL CORD STIMULATOR: ☐ NO ☐ YES TYPE: _____

Have you had any of the following studies?

X-RAY: WHEN: _____ WHERE: _____

MRI: WHEN: _____ WHERE: _____

CT SCAN: WHEN: _____ WHERE: _____

MYELOGRAM: WHEN: _____ WHERE: _____

EMG: WHEN: _____ WHERE: _____

OTHER: _____

_____

_____

_____

_____

_____

-OVER-

FAMILY HISTORY

Please fill in the circle completely if you have a family member with the following. ☐ Unknown/Adopted

Condition	Father	Mother	Brother	Sister	Son	Daughter	Other
Arthritis	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Bleeding Problems	☐	☐	☐	☐	☐	☐	☐
Cancer _____Type	☐	☐	☐	☐	☐	☐	☐
COPD/Lung Disease	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
HIV/AIDS	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐	☐
Psychiatric Illness	☐	☐	☐	☐	☐	☐	☐
Sickle Cell	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

MARITAL STATUS: _____ NUMBER OF CHILDREN: _____

DO YOU LIVE ALONE? ☐ NO ☐ YES OCCUPATION: _____

SCHOOL LEVEL: ☐GRADE SCHOOL ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL

CURRENT SMOKER? ☐NO ☐YES PACKS PER DAY _____ YEAR STARTED _____

DOES ANYONE OTHER THAN YOU SMOKE IN YOUR HOME? ☐ NO ☐ YES

SMOKELESS TOBACCO: ☐NO ☐ YES CANS PER DAY _____ YEAR STARTED _____

DRINK ALCOHOL? ☐ NO ☐ YES TYPE: _____ AMOUNT: _____

RECREATIONAL DRUG USE? ☐ NO ☐ YES LIST THE DRUGS YOU HAVE USED: _____

HISTORY OF SUBSTANCE ABUSE: ☐ NO ☐Y ES _____

HISTORY OF REHAB FOR ALCOHOL OR SUBSTANCE ABUSE? ☐ NO ☐ YES WHEN_____

DO YOU EXERCISE? ☐ NO ☐ YES HOW OFTEN_____TYPE OF EXERCISE: _____

DISABLED? ☐ NO ☐ YES REASON FOR DISABILITY_____ YEAR DISABLITIY BEGAN: _____

HEALTH HISTORY

MEDICAL HISTORY: CIRCLE ALL THAT APPLY

ARTHRITIS	LIVER DISEASE	HEART DISEASE
ASTHMA	KIDNEY DISEASE	ULCERS
CANCER (TYPE)	MIGRAINES	STROKE
DIABETES	BLEEDING PROBLEMS	THYROID DISEASE
COPD/LUNG DISEASE	SICKLE CELL	HIV/AIDS
HEPATITIS	TUBERCULOSIS	FIBROMYALGIA
HIGH BLOOD PRESSURE	CHRONIC FATIGUE	PSYCHIATRIC ILLNESS

OTHER: _____

SURGERY HISTORY: PLEASE LIST ALL PAST SURGERIES

SURGERIES	YEAR	SURGEON	COMPLICATIONS

-OVER-

MEDICATIONS: LIST **ALL** MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING VITAMINS, HERBALS AND OVER THE COUNTER MEDICATIONS

MEDICATION	DOSAGE	FREQUENCY	REASON FOR TAKING

MEDICATION ALLERGIES: ☐ NONE LATEX ALLERGY: ☐ NO ☐ YES Reaction: _____

MEDICATION	REACTION

HEALTH HISTORY (CONTINUED)

Are you on blood thinning medication (i.e. aspirin, Plavix, Coumadin, Xarelto, etc)

☐NO ☐ YES List: _____ Date of last dose: _____

Are you currently on: Steroids? ☐ NO ☐ YES
Antibiotics? ☐ NO ☐ YES
Chemotherapy? ☐ NO ☐ YES

Have you ever had problems with sedation or general anesthesia? ☐ No ☐ Yes
Explain: _____

Do you have a family history of problems with anesthesia? ☐ NO ☐ YES
Explain: _____

Have you had any recent: Surgeries
Procedures
Major dental work

Do you have: ☐ Pacemaker ☐ Metallic Fragment ☐ Foreign body
(Check all that apply) ☐ Aneursym clip or coil

Last Menstrual Period_____ Are you pregnant? ☐ No ☐ Yes
Are you lactating? ☐ No ☐ Yes

REVIEW OF SYSTEMS

Please mark ALL THAT APPLY TO YOU

GENERAL:
- Fever
- Chills
- Sweats
- Loss of appetite
- Fatigue/weakness
- Weight loss
- Problems sleeping

EYES:
- Wears glasses or contacts
- Blurred vision
- Double vision
- Eye pain
- Sensitive to light
- Glaucoma

EARS/NOSE/THROAT:
- Earache
- Ear Discharge
- Ringing in ears
- Decreased hearing
- Nasal Congestion
- Sore throat
- Hoarseness

CARDIOVASCULAR:
- Chest pains
- Palpitations
- Fainting
- Shortness of breath
- Swelling of hands or feet
- Heart attack
- High blood pressure
- Pacemaker

RESPIRATORY:
- Frequent cough
- Coughing up blood
- Shortness of breath
- Wheezing
- Asthma
- Tuberculosis
- COPD/Emphysema

GASTROINTESTINAL:
- Nausea or vomiting
- Diarrhea
- Constipation
- Change in bowel habits
- Bowel incontinence
- Blood in stool
- Stomach ulcers
- Indigestion/heartburn
- Hepatitis: jaundice
- Swallowing problems

GENITOURINARY:
- Vaginal discharge/bleeding
- Incontinent of urine
- Blood in urine
- Frequent urination
- Kidney stones
- Pelvic pain
- Irregular menstrual periods

MUSCULOSKELETAL:
- Back pain
- Joint pain
- Joint swelling
- Muscle cramps
- Muscle weakness
- Stiffness
- Arthritis
- Restless legs
- Leg pain at night

SKIN:
- Rash
- Itching/dryness
- Change in hair
- Change in skin color
- Change in nails
- Suspicious lesions

Neurological:
- Paralysis
- Numbness/tingling sensations
- Convulsions or Seizures
- Frequent falls

PSYCHIATRIC:
- Depression
- Anxiety
- Memory loss
- Confusion
- Suicidal
- Bipolar disorder

ENDOCRINE:
- Cold intolerance
- Heat intolerance
- Diabetes
- Excessive thirst
- Thyroid disease

HEMATOLOGICAL:
- Bruise easily
- Bleed easily
- Anemia
- Blood clots

ALLERGY/IMMUNE:
- Hives or rash
- Seasonal allergies
- HIV exposure
- Persistent infections

OTHER HEALTH ISSUES:

_____
_____
_____
_____

Stroke
Head Injury
Vertigo/Dizziness
Frequent headaches

PLEASE SIGN: _____ **DATE**: _____