



# Interventional Pain

SPECIALISTS

## Health and Pain History

Date: \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Diagnosis 1. \_\_\_\_\_ 2. \_\_\_\_\_

## Diagnostic Testing Information (MRI, Xray, etc.)

Date/Test	Results	Facility where performed

Location of pain: \_\_\_\_\_

When did your pain start? \_\_\_\_\_

Pain is described as:    \_\_\_burning \_\_\_aching \_\_\_stabbing \_\_\_numbness  
                                  \_\_\_tingling \_\_\_electric \_\_\_other: \_\_\_\_\_

Pain level:                    1    2    3    4    5    6    7    8    9    10

Pain is:                        \_\_\_constant \_\_\_intermittent

Pain is increased by:    \_\_\_sitting \_\_\_standing \_\_\_walking \_\_\_lifting  
                                  \_\_\_bending \_\_\_driving \_\_\_arching back \_\_\_lying  
                                  \_\_\_sneezing \_\_\_coughing \_\_\_other: \_\_\_\_\_

Pain is decreased by:    \_\_\_sitting \_\_\_standing \_\_\_walking \_\_\_lying  
                                  \_\_\_medications \_\_\_other: \_\_\_\_\_

Pain wakes you up:    \_\_\_times per night

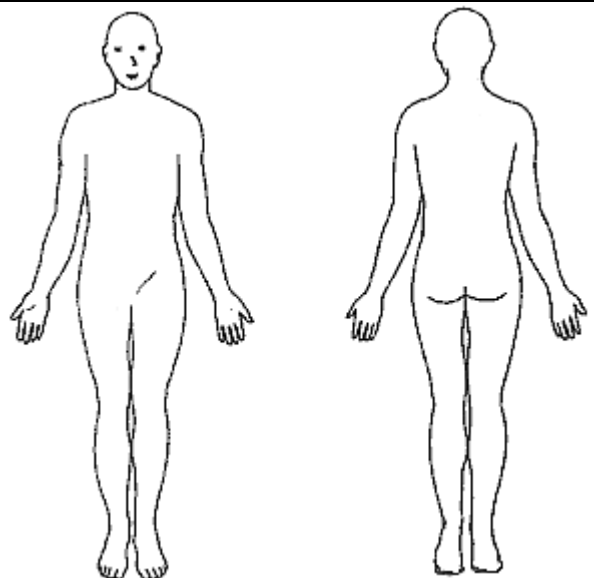
What activities make your pain worse? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please note areas of pain on the drawing, using the following symbols to indicate type of pain:

- XXXX Stabbing
- //////// Burning
- +++++ Numbness
- 00000 Aching
- ZZZZZ Shooting
- \*\*\*\*\* Electric



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Height\_\_\_\_ Weight\_\_\_\_ R/L Handed \_\_\_\_

Current Medications (include ASA, NSAIDS, Blood Thinners)

Medication Name	Dosage	Quantity

Please List Any Allergies to Medications or Shellfish

Medication Name	Allergic Reactions

Please check any of the following conditions which you have now or have had in the past:

- |  |  |
|--|--|
| <input type="checkbox"/> Asthma or Lung Problems | <input type="checkbox"/> Depression                    |
| <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Kidney or Liver Problems      |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Hepatitis                     |
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Seizures                      |
| <input type="checkbox"/> Blood Clots             | <input type="checkbox"/> Thyroid Problems              |
| <input type="checkbox"/> Bleeding Tendency       | <input type="checkbox"/> Sickle Cell Disease           |
| <input type="checkbox"/> Bruise Easily           | <input type="checkbox"/> Glaucoma                      |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> HIV Positive                  |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Stomach Ulcers/Hiatial Hernia |
| <input type="checkbox"/> Other                   |  |

If yes, please explain briefly: \_\_\_\_\_

Previous Surgeries: \_\_\_\_\_

Social History: Do you smoke? If yes, how much? \_\_\_\_\_  
Do you drink alcohol? If yes, how much? \_\_\_\_\_  
History of drug abuse? If yes, please explain: \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Are you currently involved in litigation? If yes, please explain: \_\_\_\_\_

Family History: Heart Disease    Diabetes    Depression    Cancer    Arthritis  
Lung Disease    Other: \_\_\_\_\_

# Registration Form

## PATIENT INFORMATION

Name: _____	Date of Birth: ___/___/___	Sex: M___ F___
Address: _____	City: _____	State: ___ Zip: _____
Home #: _____	Wk #: _____	Cell #: _____
SS#: _____	Marital Status: _____	

## EMPLOYMENT INFORMATION

Employer: _____	Occupation: _____
Address: _____	City: _____ State: ___ Zip: _____
Phone #: _____	

## PARENT/GUARDIAN INFORMATION

Name: _____	Date of Birth: ___/___/___	Relation to Pt.: _____
Address: _____	City: _____	State: ___ Zip: _____

## INSURANCE INFORMATION

Primary Insurance: _____	Secondary Insurance: _____
ID# _____ Grp #: _____	ID# _____ Grp #: _____
Address: _____	Address: _____
City: _____ St: ___ Zip: _____	City: _____ St: ___ Zip: _____
Phone #: _____ Eff Date: _____	Phone #: _____ Eff Date: _____
Policyholder's Name: _____	Policyholder's Name: _____
Policyholder's Date of Birth: ___/___/___	Policyholder's Date of Birth: ___/___/___

## AUTO/WORKMAN'S COMP INFORMATION

Date of Accident: ___/___/___	Insurance Co Name: _____
Address: _____	City: _____ St: ___ Zip: _____
Claim # _____	Contact Person: _____ Tel #: _____

## EMERGENCY CONTACT

Name: _____	Relation to Patient: _____
Tel #: _____	Wk #: _____ Cell #: _____

I hereby authorize James E. Wilson, M.D. to release to my insurance company any information acquired in the course of my examination or treatment which is necessary to process claims for services rendered. I hereby authorize and direct my insurance carrier to pay directly to Dr. Wilson any benefits due me under my insurance plan. I certify that the information above is correct and I understand that any remaining unpaid balance after contractual discounts are taken into consideration will be my responsibility.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_