James E. Wilson, M.D.
Interventional Pain Specialist

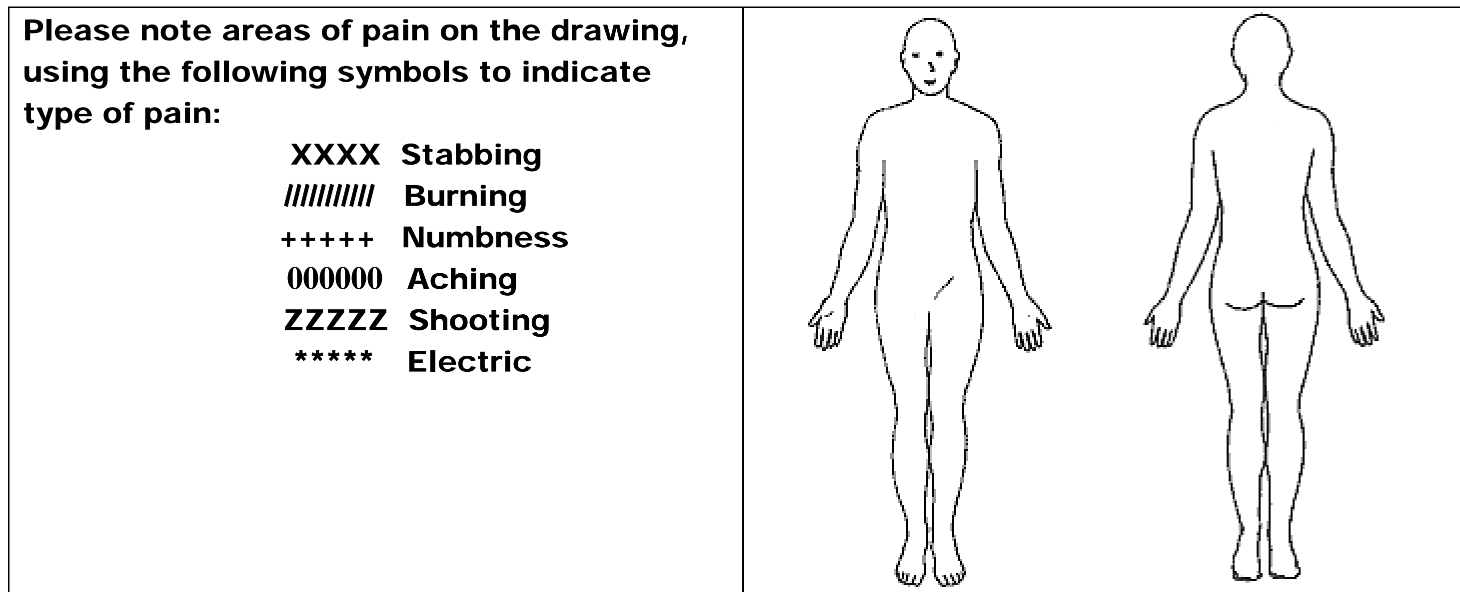
Health and Pain History

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? _______________________________________
____
____



Health History – Page 2

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:

____Asthma or Lung Problems
____Heart Problems
____Stroke
____High Blood Pressure
____Blood Clots
____Bleeding Tendency
____Bruise Easily
____Cancer
____Diabetes
____Other
____Depression
____Kidney or Liver Problems
____Hepatitis
____ Seizures
____Thyroid Problems
____Sickle Cell Disease
____Glaucoma
____HIV Positive
____Stomach Ulcers/Hiatial Hernia

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: ____________________
ID# ____________________ **Grp #:** ________
Address: ______________________________
City: ______________ **St:** ____ **Zip:** _______
Phone #: ______________ **Eff Date:** ______
Policyholder's Name: _________________
Policyholder's Date of Birth: ___/___/___

Secondary Insurance: ________________
ID# ____________________ **Grp #:** _______
Address: ______________________________
City: _______________ **St:** ____ **Zip:** ______
Phone #: ______________ **Eff Date:** ______
Policyholder's Name: _________________
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:** _________________________