WELCOME TO OUR OFFICE

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Social Security Number: _____

Sex: [ ] M [ ] F Marital Status: [ ] S [ ] M [ ] W [ ] D

Occupation: _____ Employer: _____

Work Phone Number: _____ Extension: _____ Cell Phone Number: _____

Primary Care Physician: _____ Phone #: _____

Primary Care Physician's Address: _____ City: _____ State: _____ Zip Code: _____

Referring Physician: _____ Phone #: _____

Referring Physician's Address: _____ City: _____ State: _____ Zip Code: _____

EMERGENCY CONTACT

Name: _____ Home Phone #: _____

Relationship: _____ Work Phone#: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy Address: _____ City: _____ State: _____ Zip Code: _____

IF THIS IS RELATED TO A MOTOR VEHICLE ACCIDENT OR WORKER'S COMPENSATION PLEASE FILL OUT THIS SECTION

[ ] MVA Related [ ] Worker's Compensation Related

Adjuster: _____ Phone Number: _____ Extension: _____

Billing Address: _____ City: _____ State: _____ Zip Code:_____

Claim Number: _____ Date of Incident: _____

PRIMARY INSURANCE

Insurance Company: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Subscriber's Social Security #:_____

Relationship: [ ] Self [ ] Husband/Wife [ ] Father/Mother [ ] Other _____

SECONDARY INSURANCE

Insurance Company: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Subscriber's Social Security #:_____

Relationship: [ ] Self [ ] Husband/Wife [ ] Father/Mother [ ] Other _____

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS:

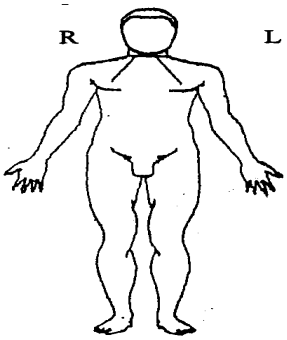
Authorization is hereby granted to release information as may be necessary to process and complete my claims. I hereby authorize payment of medical benefits to be paid directly to the attending physician for services rendered.

_____ _____

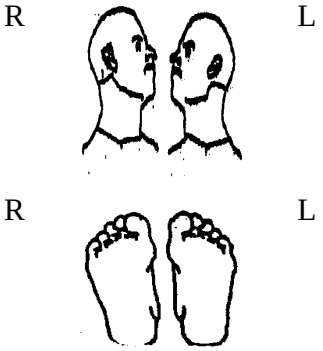
Patient's Signature Date

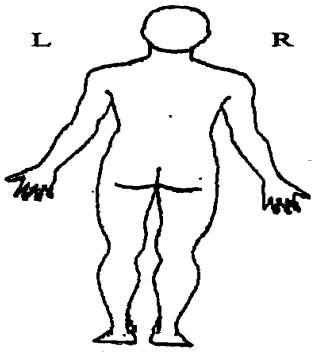
Center for Pain Management and Rehabilitation
635 East Main Street, Bridgewater NJ 08807
Phone: (908) 231-1131 Fax: (908) 231-1132

Shade in painful areas in the diagram below. (Please circle the most painful area)



Front





Back

FOR PHYSICIAN'S USE ONLY—DO NOT WRITE BELOW THIS LINE

Allergy:

Intensity: 1 2 3 4 5 6 7 8 9 10 out of 10

Current Description of Pain:

Location:

Aggravating:

Alleviating:

Weakness/Numbness:

Bowel/Bladder:

Current Medications:

Physical Exam:

BP: Pulse: Oxygen Sat: Resp: Temp: Ht: Wt:

ROM:

Neurological Exam:

Impression:

Plan:

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Previous Medications (Check appropriate boxes below if you have used these types of medications for your current pain problem and circle the medications that you have used)

[ ] **Narcotics** (i.e., Demerol, Morphine, Dilaudid, MS Contin, Methadone, Darvon, Percocet, Talwin, Vicodin, Codeine, Tylenol 3, Tylox, Fentanyl Patch)

[ ] **NSAIDS** (i.e., Aspirin, Motrin, Ibuprophen, Dolobid, Toradol, Advil, Naprosyn, Relafen, Orudis)

[ ] **Sedatives / Relaxants** (i.e., Ativan, Xanax, Valium, Librium, Flexeril, Parafon Forte)

[ ] **Antidepressants** (i.e., Elavil, Pamelor, Desipramine, Effexor, Desyrel, Prozac, Zoloft, Paxil, Serzone, Remeron)

[ ] **Anticonvulsants** (i.e., Neuronton, Klonipin, Tegretol, Dilantin)

[ ] **Neuropathic Pain Medications** (i.e., Baclofen, Mexitil, Phenoybenzamine, Ultram, Prazocin)

Previous Treatments (Please circle all that apply)

Acupuncture	Traction	TENS Unit	Psychiatrist
Chiropractor	Warm Heat	Psychologist	Other (specify) _____
Biofeedback	Massage	Physical Therapy	_____
		Duration of Physical Therapy: _____	

Review of Symptoms (Please circle all that apply)

Fever	Shortness of Breath	Black Bowel Movement	History of Easy Bruising
Weight Loss	Wheeze	Nausea	Urinary Frequency
Sweats	Chest Pain	Weakness/Paralysis of Arms & Legs	Difficult to Urinate
Swelling	Palpitations	Headache	Bowel or Bladder Incontinence
Rash	Abdominal Pain	Lightheadedness	Pregnancy
Cough	Constipation	Dizziness	Other (specify) _____
Sputum Production	Diarrhea	Vision Changes	_____

[ ] No Relevant Positive Systems

Sleep # hour/night _____

Past Medical History (Please circle all that apply)

Arrythmia	Liver Disease	Cancer
High Blood Pressure	Kidney Disease	Rheumatologic Disease
Angina/Coronary Artery Disease	Peptic Ulcer	Diabetes
Heart Attack	Other GI Illness	Skin Condition
Heart Failure	Bleeding Disorder	Depression
Emphysema or Asthma	Taking Anticoagulants	Migraine Headache
Stroke	Thyroid Disease	Other (specify) _____
Seizures		_____

[ ] No relevant PMH

This page reviewed by attending physician.

Signature of Attending Physician Date

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Past Surgical History (Please indicate date, type of surgery and physician's name)

Date	Surgery	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications (Please fill out all medications that you are using at this time)

Drug	Dose	How many times/day	Date Started
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____
5._____	_____	_____	_____
6._____	_____	_____	_____
7._____	_____	_____	_____
8._____	_____	_____	_____
9._____	_____	_____	_____
10_____	_____	_____	_____

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Signature of Attending Physician Date

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Social History *(Please complete information below)*

Do you drink alcohol? [ ] Yes [ ]No Do you smoke cigarettes? [ ] Yes [ ] No

If yes, specify quantity If yes, specify # of packs per day

Current employment status (check one): [ ] Employed full-time [ ] Employed part-time [ ] Retired

[ ] Self-employed [ ] Unemployed due to pain [ ] Unemployed due to other reasons

Present or most recent occupation

Marital history: [ ] Single [ ] Married [ ]Remarried [ ] Divorced [ ] Separated [ ] Widowed

Litigation history: *is there any litigation in progress in regard to your pain condition?* [ ] Yes [ ] No

With whom do you live with? [ ] Self [ ] Spouse [ ] Children [ ] Parents [ ]Friends

[ ] Other:

Family History

Mother: Living / Deceased Cause:

Father: Living / Deceased Cause:

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Illicit Drug Use

Miscellaneous

_____

_____

_____

_____

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