# New Patient Form

**First Name**

**Last Name**

**DOB**

**Age**

**Phone**

**Email**

**Gender**

- ◯ Male
- ◯ Female

**Height**

**Weight**

**Dominant Hand**

- ◯ Right
- ◯ Left

**Chief Complaint:**

**Pain Score 1 - 10**

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
- ◯ 10

**Quality of Pain: (please choose all that apply to your pain)**

- ☐ Aching
- ☐ Burning
- ☐ Cramping
- ☐ Crawling
- ☐ Muscle weakness
- ☐ Muscle Tenderness
- ☐ Numbness
- ☐ Pins/needles
- ☐ Pressure
- ☐ Shocking
- ☐ Shooting
- ☐ Spasms
- ☐ Stabbing
- ☐ Stinging
- ☐ Tenderness
- ☐ Throbbing
- ☐ Tightness
- ☐ Tingling
- ☐ Other

**Referring Physician**

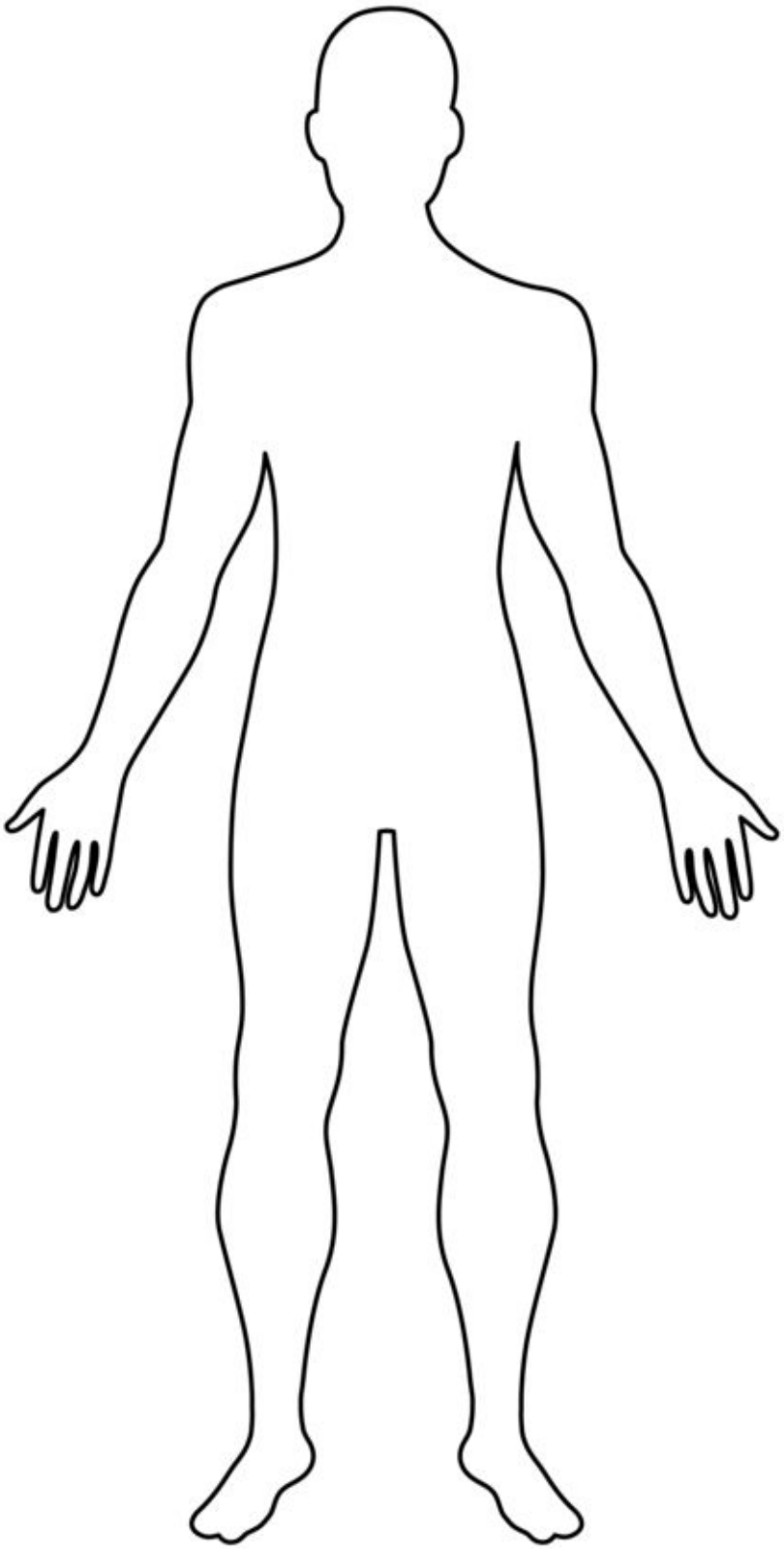
**How did you hear about us?**

**When did the pain start?**

**Where is it located?**

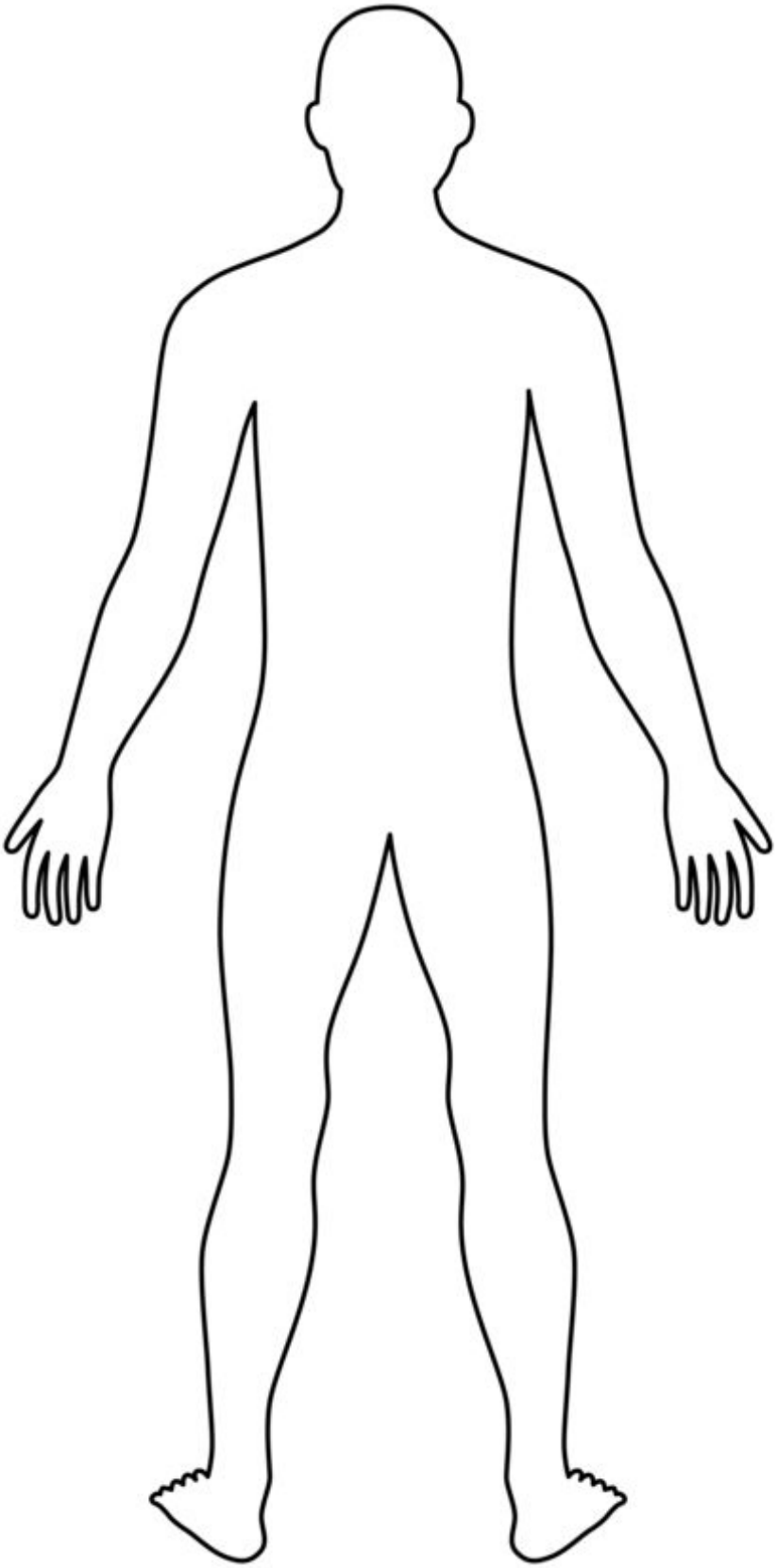
## FRONT

Please draw on the diagram below where your pain is located.



# BACK

Please draw on the diagram below where your pain is located.



**Does it radiate into your arms?**

- ◯ No
- ◯ Yes, right arm
- ◯ Yes, left arm
- ◯ Yes, both arms

**Does pain in legs decrease when you sit?**

- ◯ No
- ◯ Yes

**Does it radiate into your legs?**

- ◯ No
- ◯ Yes, right leg
- ◯ Yes, left leg
- ◯ Yes, both legs
- ◯ Yes, but decreases when I sit down

**Was this due to a MVA or Work Injury?**

**Date of Injury?**

**What makes the pain BETTER?**

**What makes the pain WORSE?**

**Do you sleep well?**

- ◯ Yes
- ◯ No

**Do you fall asleep easily?**

- ◯ Yes
- ◯ No

**Do you wake up easily?**

- ◯ Yes
- ◯ No

**Do you have any numbness?**

- ◯ Yes
- ◯ No

**If yes, where?**

**Do you have any weakness?**

- ◯ Yes
- ◯ No

**If yes, where?**

**Do you have any bladder or bowel incontinence?**

- ◯ Yes
- ◯ No

**Have you had surgery for your pain?**

**Past Treatments:**

- ☐ Nerve Blocks
- ☐ Epidural Steroid Injection
- ☐ Chiropractor
- ☐ Physical Therapy
- ☐ Other

**Other Treatment: With Whom / How Long Ago?**

**Radiology Testing**

- ☐ Xrays
- ☐ MRI
- ☐ CT Scan

**Radiology Test - Where / Date:**

**Smoker:**
- ◯ Yes
- ◯ No
- ◯ I use smokeless tobacco
- ◯ I Quit

**Packs per day:**

**Number of years:**

**Alcohol:**
- ◯ None
- ◯ Occasional
- ◯ Daily

**How much per week:**

**Recreational Drugs:**
- ◯ Yes
- ◯ No

**Do you have any history of prescription medication Abuse/Overuse**
- ◯ Yes
- ◯ No

**Do you have any history of addiction:**
- ◯ Yes
- ◯ No

**Working status:**
- ◯ Currently working
- ◯ Retired
- ◯ Unemployed
- ◯ Disabled

**Occupation:**

**Marital Status/Children:**
- ◯ Married
- ◯ Single
- ◯ Divorced
- ◯ Widowed

**How many children do you have?**

**Have you ever been treated by another Pain Management Physician? Who/When:**

**Who is your primary care physician:**

**Who is your cardiologist:**

**Who is your Psychiatrist/Psychologist:**

**Please select any medical conditions you have been diagnosed with:**

- ☐ ADHD/ADD
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Cancer
- ☐ Cataracts
- ☐ COPD
- ☐ Depression
- ☐ Diabetes - Insulin Dependent
- ☐ Diabetes - Non-Insulin
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Hyperlipidemia (high Cholesterol)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ IBS
- ☐ Memory Loss
- ☐ Pacemaker/Defibulator
- ☐ Parkinson's Disease
- ☐ Renal Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vertigo
- ☐ Other

**Other:**

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**If diagnosed with cancer, what type?**

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**If diagnosed with cancer, is it in remission?**

- [ ] Yes
- [ ] No

**Please select if you have any of the following:**

- [ ] Anxiety
- [ ] Depression
- [ ] Memory Loss
- [ ] Suicidal Ideation
- [ ] ADHD/ADD
- [ ] Other

**Other:**

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**ALLERGIES:**

**SURGICAL HISTORY**

**Current Medications: List all medications you are currently taking including over the counter medication, herbs, and vitamins. Include: Medication Name | Strength | Dose | Prescriber**

**Family Medical History:** Please list any outstanding medical conditions:

**Mother**

**Father**

**Siblings**

**Maternal Grandfather**

**Maternal Grandmother**

**Paternal Grandfather**

**Paternal Grandmother**

**Other:**

**REVIEW OF SYSTEMS:** Please select if you **have** or **had** any of the following:

**General / Constitutional**
- [ ] Chills
- [ ] Fatigue
- [ ] Fever
- [ ] Weight loss
- [ ] Weight gain

**Eyes**
- [ ] Blurring
- [ ] Eye pain
- [ ] Wear contacts
- [ ] Wears glasses

**Ears, Nose, Throat**
- [ ] Decreased hearing
- [ ] Wears hearing aid
- [ ] Sinus trouble
- [ ] Sore throat
- [ ] Dental pain
- [ ] Difficulty swallowing

**Cardiovascular**
- [ ] Ankle swelling
- [ ] Chest pain
- [ ] Circulation problems
- [ ] Heart murmurs
- [ ] High or low blood pressure
- [ ] Mital valve prolapse

**Pulmonary**
- [ ] Asthma
- [ ] Bronchitis
- [ ] Cough
- [ ] Shortness of breath

**Gastrointestinal**
- [ ] Adominal pain
- [ ] Anorexia
- [ ] Constipation
- [ ] Diarrhea
- [ ] Heartburn
- [ ] Peptic ulcers
- [ ] Nausea or Vomiting
- [ ] Reflux

**Genitourinary**
- [ ] Frequent urination
- [ ] Blood in urine
- [ ] Incontinence
- [ ] Kidney stones
- [ ] Pain with urination

**Musculoskeletal**
- [ ] Arthritis
- [ ] Osteoporosis
- [ ] Muscle pain
- [ ] Muscle wasting
- [ ] Fractures

**Skin**
- [ ] Rash
- [ ] Nail changes
- [ ] Bumps/nodules

**Neurologic**
- [ ] Blackouts
- [ ] Headaches
- [ ] Memory loss
- [ ] Numbness
- [ ] Weakness
- [ ] Seizures
- [ ] Stroke
- [ ] Loss of balance
- [ ] Vertigo

**Endocrine**
- [ ] Diabetic
- [ ] Hypothyroidism
- [ ] Hyperthyroidism

**Hematologic / Lymphatic**
- [ ] Anemia
- [ ] Bruises easily
- [ ] Bleeding disorder
- [ ] Taking blood thinners

**Infectious Diseases**
- [ ] Measles
- [ ] Chicken pox
- [ ] Hepatitis A
- [ ] Hepatitis C
- [ ] AIDS
- [ ] Herpes (gential)
- [ ] Post-herpatic neuralgia
- [ ] Mumps
- [ ] Rheumatic fever
- [ ] Hepatitis B
- [ ] HIV
- [ ] Herpes (oral)
- [ ] Shingles

**Gynecologic**
- [ ] Pregnant
- [ ] Post Menstrual Period

IT IS SEGURA NEUROSCIENCE AND PAIN CENTER'S PRACTICE NOT TO PRESCRIBE BENZODIAZEPINES (XANAX, ATIVAN, VALIUM, KLONOPIN) AND SOMA. BY CHECKING BELOW YOU ACKNOWLEDGE THAT YOU UNDERSTAND AND ARE AWARE THAT EXTREME SLEEPINESS, RESPIRATORY DEPRESSION, COMA, AND DEATH CAN OCCUR WITH THE USE OF THESE MEDICATIONS AT THE SAME TIME.

Clinical guidelines from the U.S. Centers for Disease Control and Prevention (CDC) and existing labeling warnings regarding combined use caution prescribers about co-prescribing opiods and benzodiazepines to avoid potential serious health outcomes. The actions of the FDA today are consistent with the CDC.

**There are dangers of certain medication interactions with chronic opioid use.**

◯ Yes, I understand

**COMM**

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past thirty days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

**1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?**

◯ Never
◯ Seldom
◯ Sometimes
◯ Often
◯ Very Often

**2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work, or appointments)**

◯ Never
◯ Seldom
◯ Sometimes
◯ Often
◯ Very Often

**3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)**

◯ Never
◯ Seldom
◯ Sometimes
◯ Often
◯ Very Often

**4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?**

◯ Never
◯ Seldom
◯ Sometimes
◯ Often
◯ Very Often

**5. In the past 30 days, how often have you seriously thought about hurting yourself?**

◯ Never
◯ Seldom
◯ Sometimes
◯ Often
◯ Very Often

**6. In the past 30 days, how much of your time was spent thinking about opiod medications (having enough, taking them, dosing schedule, etc.)?**

- ◯ Never
- ◯ Seldom
- ◯ Sometimes
- ◯ Often
- ◯ Very Often

**7. In the past 30 days, how often have you been in an argument?**

- ◯ Never
- ◯ Seldom
- ◯ Sometimes
- ◯ Often
- ◯ Very Often

**8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?**

- ◯ Never
- ◯ Seldom
- ◯ Sometimes
- ◯ Often
- ◯ Very Often

**9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?**

- ◯ Never
- ◯ Seldom
- ◯ Sometimes
- ◯ Often
- ◯ Very Often

**10. In the past 30 days, how often have you been worried about how you're handling your medications?**

- ◯ Never
- ◯ Seldom
- ◯ Sometimes
- ◯ Often
- ◯ Very Often

**11. In the past 30 days, how often have others been worried about how you're handling your medications?**

- ◯ Never
- ◯ Seldom
- ◯ Sometimes
- ◯ Often
- ◯ Very Often

**12. In the past 30 days, how often have had to make an emergency phone call or show up at the clinic without an appointment?**

- ◯ Never
- ◯ Seldom
- ◯ Sometimes
- ◯ Often
- ◯ Very Often

**13. In the past 30 days, how often have you gotten angry at people?**

- ◯ Never
- ◯ Seldom
- ◯ Sometimes
- ◯ Often
- ◯ Very Often

**14. In the past 30 days, how often have you had to take more of your medication than prescribed?**

- ◯ Never
- ◯ Seldom
- ◯ Sometimes
- ◯ Often
- ◯ Very Often

**15. In the past 30 days, how often have you borrowed pain medication from someone else?**

- ◯ Never
- ◯ Seldom
- ◯ Sometimes
- ◯ Often
- ◯ Very Often

**16. In the past 30 days, how often have you used your pain medication for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?**

- ◯ Never
- ◯ Seldom
- ◯ Sometimes
- ◯ Often
- ◯ Very Often

- ◯ Never
- ◯ Seldom
- ◯ Sometimes
- ◯ Often
- ◯ Very Often

**Date** **Signature over Printed Name**