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

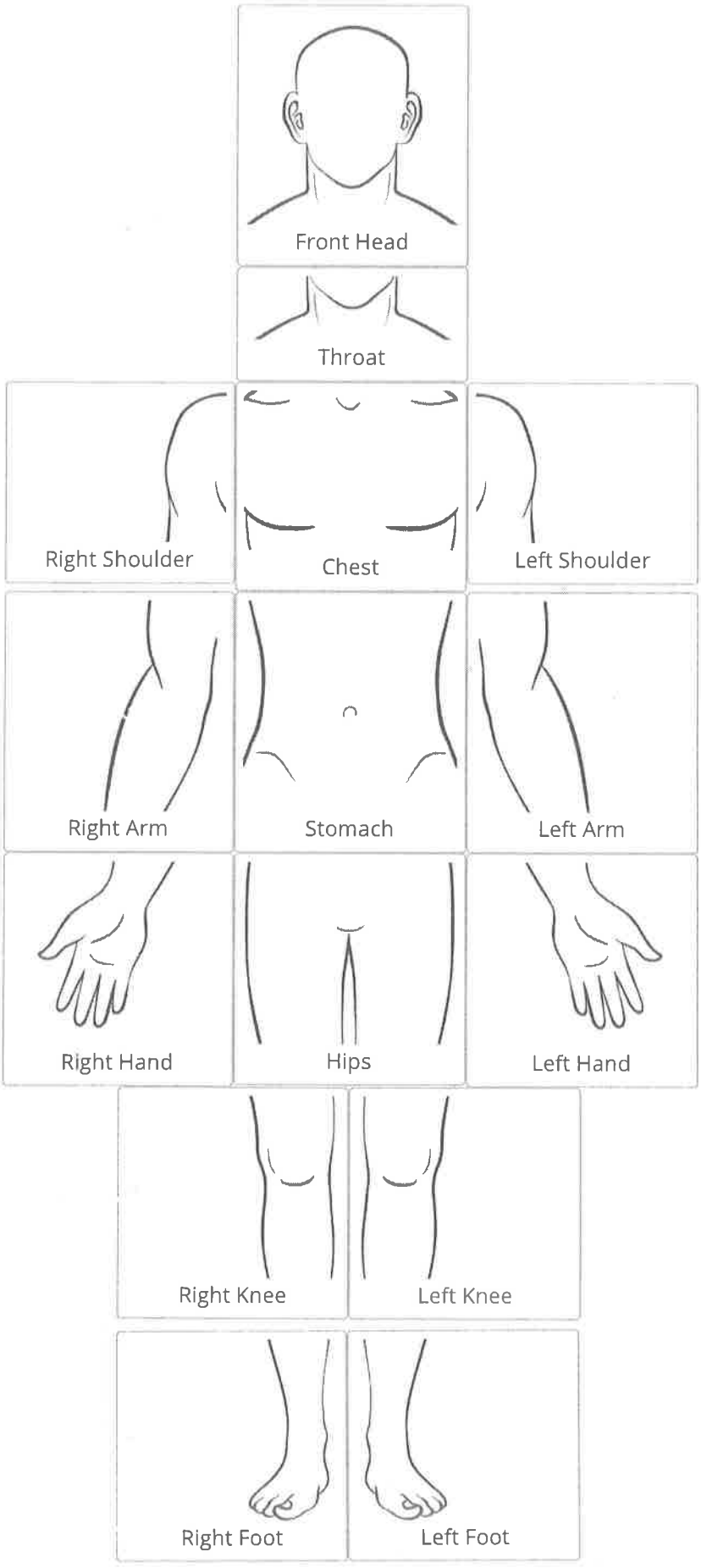
Referring Physician

How did you hear about us?

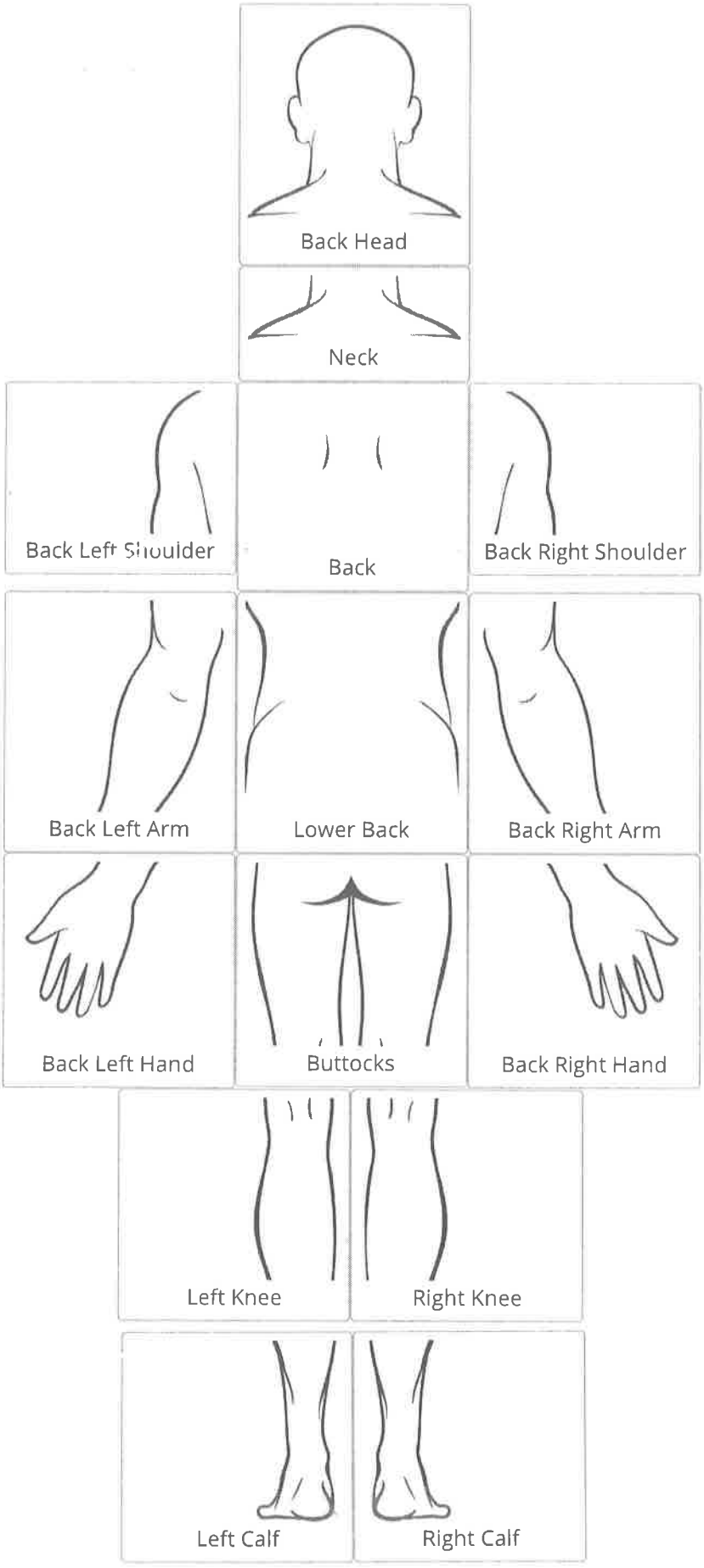
When did the pain start?

Where is it located?

Front


Front Head
Throat
Right Shoulder
Chest
Left Shoulder
Right Arm
Stomach
Left Arm
Right Hand
Hips
Left Hand
Right Knee
Left Knee
Right Foot
Left Foot

Back


Back Head
Neck
Back Left Shoulder
Back
Back Right Shoulder
Back Left Arm
Lower Back
Back Right Arm
Back Left Hand
Buttocks
Back Right Hand
Left Knee
Right Knee
Left Calf
Right Calf

Does it radiate into your arms?
No
Yes, right arm
Yes, left arm
Yes, both arms

Does it radiate into your legs?
No
Yes, right leg
Yes, left leg
Yes, both legs
Yes, but decreases when I sit down

Does pain in legs decrease when you sit?
No
Yes

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:

If diagnosed with cancer, what type?

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:

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
Mumps
Chicken pox
Rheumatic fever
Hepatitis A
Hepatitis B
Hepatitis C
HIV
AIDS
Herpes (oral)
Herpes (genital)
Shingles
Post-herpatic neuralgia

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

17. In the past 30 days, how often have you had to visit the Emergency Room?

Never
Seldom
Sometimes
Often
Very Often