Date:_______________ **PATIENT DATA FORM**

Please complete this form thoroughly. If a particular section does not apply to you, please indicate so. This information is vital in order to schedule an appointment at United Pain Center. ***We will not schedule an appointment unless we have all of this information.*** Thank you.

1. PATIENT INFORMATION

NAME__________________________________DATE OF BIRTH_____/_____/______ Sex M F

APT#________________ADDRESS____________________________CITY __________________

STATE___________ZIP___________RACE_________ COUNTRY OF ORIGIN____________________________

HOME PHONE#____________________ WORK PHONE#____________________CELL# ____________________

PREFFERED # TO CONTACT YOU _______________________SS# _______- ______- _______ RELIGION___________

EMAIL ADDRESS _____________________________@_____________________________

MARITAL STATUS (circle): Single Married Widow(ed) Divorced Separated Significant Other/Partner

2. PATIENT EMPLOYMENT INFORMATION

EMPLOYMENT STATUS: FULL PART-TIME SELF NOT EMPLOYED RETIRED

EMPLOYER____________________________________CITY________________________________

PHONE______________________________OCCUPATION________________________________

3. SPOUSE/PARTNER

RELATIONSHIP TO PATIENT_____________________NAME______________________________

SS#______-______-______ DATE OF BIRTH______/_____/_____

4. EMERGENCY CONTACT (OTHER THAN LISTED)

RELATIONSHIP TO PATIENT___________________NAME________________________________

HOME PHONE#____________________________CELL#________________________________

5. MEDICAL INFORMATION

REFERRING PHYSICIAN ____

DIAGNOSIS (BODY PART TO BE TREATED)____

PLEASE COMPLETE BOTH FRONT AND BACK OF THIS FORM

6. INSURANCE INFORMATION

NAME OF INSURANCE: ____________________

POLICYHOLDER NAME: ____________________ DATE OF BIRTH_____/_____/_____

EMPLOYER NAME____________________EFFECTIVE DATE____________________

GROUP NUMBER____________________ID # ____________________

CLAIMS MAILING ADDRESS____________________

CITY____________________STATE__________ZIP____________________

PHONE # TO CALL FOR BENEFITS INFORMATION (LISTED ON INSURANCE CARD)____________________

7. SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE____________________POLICYHOLDER NAME____________________

EMPLOYER NAME____________________EFFECTIVE DATE____________________

GROUP NUMBER____________________ ID # ____________________

CLAIMS MAILING ADDRESS____________________

CITY____________________STATE__________ZIP____________________

PHONE # TO CALL FOR ELIGIBILTY/BENEFITS (LISTED ON INSURANCE CARD)____________________

YOU MUST BRING INSURANCE CARDS AND PHOTO ID TO YOUR APPOINTMENT

UNITED PAIN CENTER,
A DEPARTMENT OF UNITED HOSPITAL
255 Smith Avenue N. Suite 100
St. Paul, MN 55102

New Patient Intake Form

Your completed intake paperwork helps our physicians and other providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk or call (651) 241-7246 if you have any questions on how to complete any section of this form.

Patient Information:

Today's Date: __________________ Gender:______________________ Date of Birth:________________________

Name: ____

Referring Physician: ____

Primary Care Physician: ____

Mental Health Provider(s): ____

Pharmacy: ____

Pain History:

What is your pain condition? ____

____

Please list any additional medical conditions? ____

____

Onset of Symptoms:

Approximately, when did this pain begin? ____

What caused your current pain episode? ____

How did your current pain episode begin? □ Gradually □ Suddenly

Since your pain began, how has it changed? □ Improved □ Worsened □ Stayed the same

Pain Description:

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now_____________ The Best It Gets ____________ The Worst It Gets ___________

What factors worsen or affect your pain? ____

____

What factors relieve your pain? ____

____

Are there any associated symptoms (numbness, tingling, weakness, incontinence, etc)? ___________________

____

What is your expectation and goal of your pain management treatment? _______________________________

____

Diagnostic Testing and Imaging:

Check all of the following tests that you have had related to your current pain condition:

□ MRI of the: ____

Date: ______________ Facility:____

□ X-Ray of the: ____

Date: _____________ Facility:____

□ CT Scan of the: ____

Date: ______________ Facility:____

□ EMG/Nerve Conduction Velocity (NCV) study of the:

____

Date: ______________ Facility:____

□ Other diagnostic testing: ____

□ **I have not had ANY diagnostic tests for my current pain.**

McGill Pain Questionnaire: what does your pain feel like? In each category below, check one word that best describes your current pain. Leave out categories that do not apply to you. On the diagram, shade in areas where you currently experience pain.

PROVIDER USE ONLY:

PRI: S__________ A___________ E__________M_____________ PRI (T)___________PPI_____________

1. ___ Flickering
   ___ Quivering
   ___ Pulsing
   ___ Throbbing
   ___ Beating
   ___ Pounding

2. ___ Jumping
   ___ Flashing
   ___ Shooting

3. ___ Pricking
   ___ Boring
   ___ Drilling
   ___ Stabbing
   ___ Lancinating

4. ___ Sharp
   ___ Cutting
   ___ Lacerating

5. ___ Pinching
   ___ Pressing
   ___ Gnawing
   ___ Cramping
   ___ Crushing

6. ___ Tugging
   ___ Pulling
   ___ Wrenching

7. ___ Hot
   ___ Burning
   ___ Scalding
   ___ Searing

8. ___ Tingling
   ___ Itchy
   ___ Smarting
   ___ Stinging

9. ___ Dull
   ___ Sore
   ___ Hurting
   ___ Aching
   ___ Heavy

10. ___ Tender
    ___ Taut
    ___ Rasping
    ___ Splitting

11. ___ Tiring
    ___ Exhausting

12. ___ Sickening
    ___ Suffocating

13. ___ Fearful
    ___ Frightful
    ___ Terrifying

14. ___ Punishing
    ___ Grueling
    ___ Cruel
    ___ Vicious
    ___ Killing

15. ___ Wretched
    ___ Blinding

16. ___ Annoying
    ___Troublesome
    ___ Miserable
    ___ Intense
    ___ Unbearable

17. ___ Spreading
    ___ Radiating
    ___ Penetrating
    ___ Piercing

18. ___ Tight
    ___ Numb
    ___ Drawing
    ___ Squeezing
    ___ Tearing

19. ___ Cool
    ___ Cold
    ___ Freezing

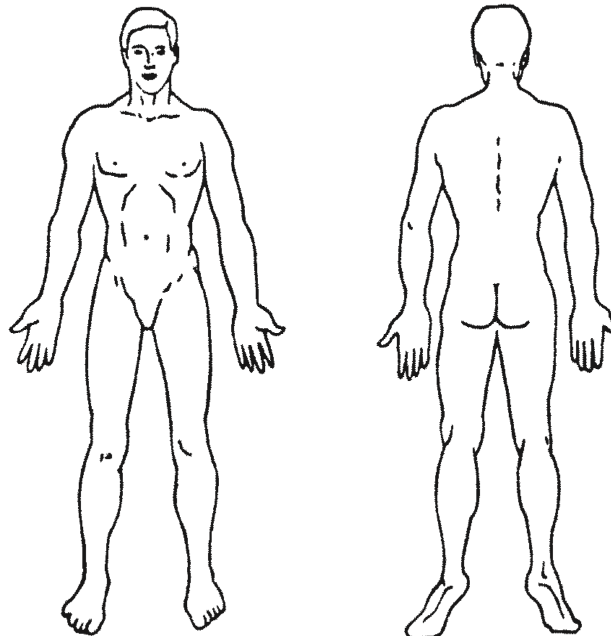
20. ___ Nagging
    ___ Nauseating
    ___ Agonizing
    ___ Dreadful
    ___ Torturing

PPI
0 ___ No pain
1 ___ Mild
2 ___ Discomforting
3 ___ Distressing
4 ___ Horrible
5 ___ Excruciating

___ Brief
___ Momentary
___ Transient

___ Rhythmic
___ Periodic
___ Intermittent

___ Continuous
___ Steady
___ Constant



Please Check All Of The Following Treatments You Have Had for Pain Relief:

	No Change	Worsened Pain	Helped Pain
Spine Surgery	□	□	□
Physical Therapy	□	□	□
Chiropractic Care	□	□	□
Mental Health Therapy	□	□	□
Brace Support	□	□	□
Acupuncture	□	□	□
Hot/Cold Packs	□	□	□
Massage Therapy	□	□	□
TENS Unit	□	□	□
Medical Cannabis	□	□	□

Interventional Pain Treatment History:

□ Epidural Steroid Injection – (circle levels that apply) Cervical/Thoracic/Lumbar

□ Joint Injection – Joint(s) ____

□ Medial Branch Blocks/Facet Injections – (circle levels that apply) Cervical/Thoracic/Lumbar

□ Nerve Blocks – Area/Nerve(s) ____

□ Radiofrequency Nerve Ablation – (circle levels that apply) Cervical/Thoracic/Lumbar

□ Intrathecal Pain Pump – ____

□ Spinal Cord Stimulator – Trial Only/Permanent Implant ____

□ Trigger Point Injections – Where? ____

□ Vertebroplasty/Kyphoplasty – Level(s)? ____

□ Other ____

Which of these procedures listed above have helped with your pain? ___________________________________

Please list the names of other Pain Physicians you may have seen in the past ___________________________

Past Medical History:

Please check the following conditions/diseases that you have been treated for in the past:

Cancer/Oncology	ENT
□ Cancer - Type ______________________	□ Glaucoma
□ Cancer - Type ______________________	□ Vertigo
□ Cancer - Type ______________________	□ Hearing Problems
Cardiovascular/Hematologic	□ Nosebleeds
□ Anemia	**Respiratory**
□ Heart Attack	□ Asthma
□ Coronary Artery Disease	□ Bronchitis/Pneumonia
□ High Blood Pressure	□ Emphysema/COPD
□ Peripheral Vascular Disease	**Musculoskeletal/Rheumatologic**
□ Stroke/TIA	□ Bursitis
□ Bleeding Disorders	□ Carpal Tunnel Syndrome
□ Heart Valve Disorders	□ Fibromyalgia
□ Presence of Stent	□ Osteoarthritis
□ Presence of Pacemaker/Defibrillator	□ Osteoporosis
Gastrointestinal	□ Rheumatoid Arthritis
□ GERD (Acid Reflux)	□ Chronic Joint Pain
□ Gastrointestinal Bleeding	□ Other Arthritic Conditions
□ Stomach Ulcers	**Mental Health**
□ IBS/Crohns Disease	□ PTSD
Urological	□ Bipolar Disorder
□ Chronic Kidney Disease	□ ADHD
□ Kidney Stones	□ Depression
□ Urinary Incontinence	□ Anxiety
□ Dialysis	□ Overdose
Neurological	□ Self Harm
□ Multiple Sclerosis	□ Addiction
□ Peripheral Neuropathy	**Endocrinology**
□ Seizures	□ Diabetes - Type ____________________
□ Balance Disorder	□ Hyperthyroidism
□ Head Injury	□ Hypothyroidism
□ Headaches	**Other Diagnosed Conditions**
□ Migraines	□ __________________________________
□ Stroke	□ __________________________________

Please check the following physicians or specialists you have consulted with for your medical care:

□ Acupuncturist □ Neurosurgeon □ Mental Health Provider □ Chiropractor
□ Internist □ Orthopedic Surgeon □ Rheumatologist □ Physical Therapist
□ Neurologist □ Other ____

Past Surgical History: Please list any surgical procedures you have had in the past, including date:

1. ____
   Date: ______________________ Facility: ____
2. ____
   Date: ______________________ Facility: ____
3. ____
   Date: ______________________ Facility: ____
4. ____
   Date: ______________________ Facility: ____
5. ____
   Date: ______________________ Facility: ____

□ **I have never had any surgical procedures performed.**

Family History: Please check appropriate diagnoses as they pertain to your parents and siblings:

□ Arthritis	□ Cancer	□ Diabetes
□ Headaches/Migraines	□ High Blood Pressure	□ Kidney Problems
□ Liver problems	□ Osteoporosis	□ Rheumatoid Arthritis
□ Seizures	□ Stroke	

□ Other ____

□ **I have no significant family medical history**

Please use this space to provide any additional information:

____

____

____

____

____

Social History:

Occupation: ____________________________ When was the last time you worked? ______________________

□ Temporary Disability □ Permanent Disability □ Retired □ Unemployed

Are you currently under Worker's Compensation? □ Yes □ No

Is there an ongoing lawsuit related to your visit today? □ Yes □ No

Who lives in your current household? ____

Do you use any tobacco products? □ Yes □ No

If yes, what kind, how much per day? _________________________ Number of years ______________________

Do you drink alcohol? □ Yes □ No

If yes, how much? ________________________________ How often? ____________________________

Do you use recreational drugs? □ Yes □ No

If yes, which drugs do you use? ____

Do you think you are addicted to the use of alcohol or recreational drugs? □ Yes □ No

Do you use alcohol or recreational drugs to cope with your pain? □ Yes □ No

Have you ever been through alcohol or chemical dependency treatment? □ Yes □ No

Do you have any family members that have abused alcohol or drugs? □ Yes □ No (If Yes, who?)

____

Check if you have ever had: _____ Blackouts ________DWI/DUI _______Injuries related to chemical use

Current Medications:

Are you currently taking any blood thinners or anti-coagulants? □ Yes □ No

If yes, which ones? □ Aspirin □ Plavix □ Coumadin □ Lovenox □ Other ___________________________________

Please list all medications you are currently taking including, vitamins. Attach additional sheet if needed

	Medication Name	Dose	Frequency
1.	___________________________________	______________	_______________
2.	___________________________________	______________	_______________
3.	___________________________________	______________	_______________
4.	___________________________________	______________	_______________
5.	___________________________________	______________	_______________
6.	___________________________________	______________	_______________
7.	___________________________________	______________	_______________

Please list all previously prescribed pain medications. Attach additional sheet if needed

	Medication Name	Dose	Frequency
1.	______________________	__________	__________
2.	______________________	__________	__________
3.	______________________	__________	__________
4.	______________________	__________	__________
5.	______________________	__________	__________

Allergies:

Do you have any medication allergies? □ Yes □ No

If so, please list all medications that you are allergic to. Attach additional sheet if needed.

	Medication Name	Allergic Reaction
1.	______________________	______________________
2.	______________________	______________________
3.	______________________	______________________
4.	______________________	______________________
5.	______________________	______________________

Topical Allergies: □ Latex □ Iodine □ Medical Tape □ IV Contrast

Mental Health:

Have you ever been evaluated or treated by a mental health provider? (for example, a psychologist, counselor, family therapist, psychiatrist)

□ Yes (please describe): ____

□ No

Have you ever been diagnosed and or hospitalized with a mental health condition? (for example, depression, anxiety, panic disorder, substance use disorder, PTSD, ADHD, bipolar disorder):

□ Yes (please describe): ____

□ No

Do you have a history of self-harm?

□ Yes (please describe): ____

____

□ No

Review of Systems: Please check & discuss symptoms you currently have:

	√	Discuss		√	Discuss
GENERAL			Black/Tarry Stool		
Unintentional wt loss			Abdominal Pain		
Unintentional wt gain			Change in Bowel Habit		
Fevers			Decreased Appetite		
Chills			**GENITOURINARY**		
Night Sweats			Painful Urination		
Excessive Fatigue			Blood in Urine		
Insomnia			Incontinence		
HEAD			Discharge		
Headache			STD History		
EYES			**MUSCULOSKELETAL**		
Vision changes			Back Pain		
EARS			Joint Pain		
Decreased Hearing			Joint Swelling		
Ringing in Ears			Joint Redness		
Earaches			Muscle Aches		
NOSE			**ENDOCRINOLOGY**		
Recurrent nosebleed			Heat/Cold Intolerance		
Sinus infections			Increased Thirst		
NECK			Change in Hair Pattern		
Stiffness			**SKIN**		
Enlarged gland			Changes in Moles		
MOUTH			Rashes		
Hoarseness			**HEMATOLOGY**		
Sore throat			Easy Bruising		
CARDIOVASCULAR			Anemia		
Chest Pain with Resting			Abnormal Bleeding		
Chest Pain with Activity			Enlarged Lymph Nodes		
Palpitations			**NEUROLOGY**		
Sleep on > 2 pillows			Headaches		
Leg Swellings			Fainting		
Hypertension			Dizziness		
Leg Pain with Exercise			Seizures		
PULMONARY			Numbness/Tingling		
Shortness of Breath			Blurred Vision		
Recurrent Cough			Decreased Memory		
Sputum Production			Abnormal Gait		
Coughing up Blood			Tremor		
Asthma/Wheezing			**GYNECOLOGY**		
Tuberculosis Exposed			Abnormal Periods		
GASTROINTESTINAL			Heavy Periods		
Nausea/Vomiting			**MENTAL HEALTH**		
Diarrhea/constipation			Depression		
Red blood in stool			Anxiety		
			Nervousness		