SPACE CITY PAIN SPECIALISTS
WE DON'T MANAGE PAIN. WE TREAT IT.

Date:_____

New Patient Paperwork

Name:_____ Age:_____ DOB:_____ Sex: ☐ Male ☐ Female

Emergency Contact Information

Name:_____ Relationship:_____

Phone Number:_____

I. Chief Complaint

In your own words, why are you here?

_____

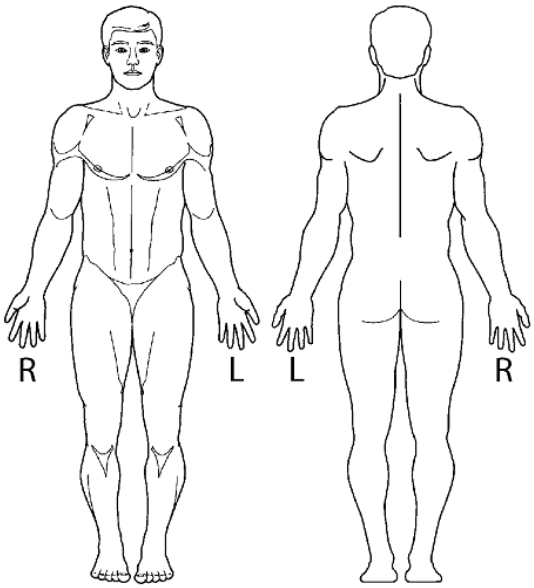
Referring Doctor: _____

Are you experiencing pain due to a car accident or work-related injury? ☐ YES ☐ NO

II. Check the word(s) which describes your pain.

☐Burning	☐Sharp	☐Pins & Needles
☐Sensitive	☐Aching	☐Electric
☐Throbbing	☐Shooting	☐Stabbing

On the diagram below, **shade** the area(s) where you *feel* pain. **Mark** the area(s) that hurt the *most* with an X.



III. When does your pain occur?

☐Constantly	☐ Occasionally
☐With Stress	☐ At the same time daily
☐Without Warning	☐ When I move a certain way

IV. History of Present Illness

When did the pain begin?

_____

What do you feel caused the pain?

_____

Do you have:

Numbness (location)_____

Tingling (location)_____

Weakness (location)_____

Current Medications:

Please list all current medications you are taking including dosage and frequency for each if known.

Medication Name	**Dosage**	**Frequency**

Pain Scale:

Circle on the scale how little or how much pain you have experienced recently.

My **CURRENT** pain is…….												
No Pain	–	1	2	3	4	5	6	7	8	9	10	– **Extreme Pain**
During the **past week,** the **BEST** my pain has been is…..……..												
No Pain	–	1	2	3	4	5	6	7	8	9	10	– **Extreme Pain**
During the **past week,** the **WORST** my pain has been is……												
No Pain	–	1	2	3	4	5	6	7	8	9	10	– **Extreme Pain**
During the **past week,** my **AVERAGE** pain has been……..												
No Pain	–	1	2	3	4	5	6	7	8	9	10	– **Extreme Pain**
During the past **3 months,** my average pain has been……												
No Pain	–	1	2	3	4	5	6	7	8	9	10	– **Extreme Pain**

Pain Disability Index:

Circle on the scale how little or how much your ability to perform is affected by your pain.

Family/Home Responsibilities: This category refers to the activities of the home or family. It includes chores or duties performed around the house (yard work) and errands or favors for other family members (driving children to school).											
No Pain	**-**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**- Unable to Perform**
Recreation: This category includes hobbies, sports and other similar leisure time activities.											
No Pain	**-**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**- Unable to Perform**
Social Activity: This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out and other social functions.											
No Pain	**-**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**- Unable to Perform**
Occupation: This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.											
No Pain	**-**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**- Unable to Perform**
Life-Support Activity: This category refers to basic life-supporting behaviors such as eating, sleeping and breathing.											
No Pain	**-**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**- Unable to Perform**

Name:_____

Are you currently on a blood thinner? ☐ Yes ☐ No If yes, which one?_____

Allergies: Please list any drug, food, contact or environmental allergies and reactions:

IV. History of Present Illness (Cont.)

a. What makes your pain **WORSE**? **(Please CHECK)**

☐ Coughing ☐ Sneezing ☐ Straining ☐ Walking ☐ Sitting ☐ Standing ☐ Heat
☐ Cold ☐ Bending Forward ☐ Bending Backward ☐ Lying Down ☐ Other:

b. What makes your pain **BETTER**? **(Please CHECK)**

☐ Coughing ☐ Sneezing ☐ Straining ☐ Walking ☐ Sitting ☐ Standing ☐ Heat
☐ Cold ☐ Bending Forward ☐ Bending Backward ☐ Lying Down ☐ Other:

c. Have you tried any previous treatments? **(Please CHECK)**

☐ Chiropractor ☐ Physical Therapy ☐ Acupuncture ☐ Massage ☐ Injections/Procedures (Please list below):

PROCEDURE	**MONTH/YEAR**	**BODY LOCATION**	**PHYSICIAN**

d. Medications previously tried for pain (Please list over-the-counter medicine as well):

V. Past History

Medical History: Please **CHECK** those that apply **TO YOU** (not your family)

☐ Peripheral Neuropathy	☐ Easy Bruising/ Bleeding	☐ Heart Attacks	☐ High Blood Pressure	☐ Thyroid Disease
☐ Poor Circulation	☐ Irregular Heartbeat	☐ Arthritis	☐ Sleep Apnea	☐ Other:
☐ Reflux/Gerd	☐ Overweight	☐ Depression	☐ Diabetes	
☐ Anxiety	☐ Bipolar Disorder	☐ Heart Failure	☐ Osteoporosis	
☐ Stroke Side: ☐ R ☐ L	☐ Kidney Disease TYPE:	☐ Lung Disease: TYPE:	☐ Cancer: TYPE:	

Surgical/Hospitalization History:

Operation or Illness	Date	Operation or Illness	Date
1)		**5)**	
2)		**6)**	
3)		**7)**	
4)		**8)**	

Social History:

Where do you work?		☐ Full Time ☐ Part Time ☐ Unemployed ☐ Disabled ☐ Retired
Do you exercise regularly?	☐ Yes ☐ No	What type? How often?
Do you smoke or vape?	☐ Yes ☐ No	vape/day If YES, how often? cigs/day packs/week
Do you drink alcoholic beverages?	☐ Yes ☐ No	drinks drinks If YES, how often? /day /week
Has your pain ever stopped you from working?	☐ Yes ☐ No	If YES, explain:
Are you suing anyone about your pain problems?	☐ Yes ☐ No	If YES, explain:
What is your marital status?	☐ Single ☐ Married ☐ Divorced ☐ Widowed	Who do you currently live with? ☐ Spouse ☐ Child ☐ Relative ☐ Facility ☐ Alone

Family History: Please check any **FAMILY** illnesses. Only include your biological parents, brothers and sisters.

Illness	Relationship	Illness	Relationship	Illness	Relationship
☐ Stroke	☐ Mom ☐ Dad ☐ Brother ☐ Sister	☐ Panic Attacks	☐ Mom ☐ Dad ☐ Brother ☐ Sister	☐ Lung Disease	☐ Mom ☐ Dad ☐ Brother ☐ Sister
☐ Diabetes	☐ Mom ☐ Dad ☐ Brother ☐ Sister	☐ Heart Disease	☐ Mom ☐ Dad ☐ Brother ☐ Sister	☐ High Blood Pressure	☐ Mom ☐ Dad ☐ Brother ☐ Sister
☐ Obesity	☐ Mom ☐ Dad ☐ Brother ☐ Sister	☐ Back Problems	☐ Mom ☐ Dad ☐ Brother ☐ Sister	☐ Depression	☐ Mom ☐ Dad ☐ Brother ☐ Sister
☐ Cancer	☐ Mom ☐ Dad ☐ Brother ☐ Sister	☐ Kidney Disease	☐ Mom ☐ Dad ☐ Brother ☐ Sister	☐ Bipolar Disorder	☐ Mom ☐ Dad ☐ Brother ☐ Sister
☐ Other:					

Name:_____

Name:_____

VI. Review of Systems

Please **CHECK** all CURRENT conditions you have. **CHECK** "Negative" if you have no complaints.

Constitutional:	Endocrine (Cont.):	Gastrointestinal:	Musculoskeletal (Cont.):
☐ Negative	☐ Excessive Urination	☐ Negative	☐ Paralysis
☐ Chills	☐ Increased Thirst	☐ Gallbladder Disease	☐ Restricted Motion
☐ Fever	☐ Fatigue	☐ Abdominal Pain	☐ Back Problems
☐ Weight Loss	☐ Goiter	☐ Black Tarry Stool	☐ Joint Pain
☐ Decline in health	☐ Heat Intolerance	☐ Frequency Change-BM	☐ Weakness
☐ Weakness	☐ Neck Pain	☐ Stool Color Change	☐ Deformities
☐ Fatigue	☐ Sweats	☐ Stool Changes	☐ Joint Stiffness
☐ Weight Gain	☐ Thyroid Trouble	☐ Constipation	**Neurological:**
Psychiatric:	☐ Weakness	☐ Decreased Appetite	☐ Negative
☐ Negative	☐ Weight Gain	☐ Diarrhea	☐ Blackouts
☐ Hallucinations	☐ Weight Loss	☐ Excessive Thirst	☐ Burning
☐ Nervousness	☐ Cold intolerance	☐ Hemorrhoids	☐ Dizziness
☐ Depression	**Cardiovascular:**	☐ Jaundice	☐ Fainting
☐ Memory Loss	☐ Negative	☐ Nausea	☐ Head Injury
☐ Disorientation	☐ High Blood Pressure	☐ Vomiting	☐ Headaches
☐ Mood Changes	☐ Palpitations	☐ Swallowing Problems	☐ Memory Loss
☐ Disturbing Thoughts	☐ Shortness of breath upon exertion	☐ Recent Abdominal X-Ray	☐ Numbness
☐ Psychiatric Disorders	☐ Shortness of breath when lying flat	☐ Hepatitis	☐ Paralysis
Head:	☐ Swelling of Legs	☐ Laxative Use	☐ Speech
☐ Negative	☐ Varicose Veins	☐ Rectal Bleeding	☐ Disorder Strokes
☐ Dizziness	☐ Cool Extremities	☐ Antacid Use	☐ Tingling
☐ Headaches	☐ Heart Murmur	☐ Excessive Hunger	☐ Tremors
☐ Fainting	☐ History of Heart Attack	☐ Heartburn	☐ Unsteady Gait
☐ Pain	☐ Recent ECG/EKG	☐ Infections	**Ears:**
☐ Head Injury	☐ Thrombophlebitis	☐ Liver Disease	☐ Negative
☐ Sweats	☐ Discolored Extremity	☐ Rectal Pain	☐ Discharge
Respiratory:	☐ Heart Tests (Not EKG)	☐ Vomiting Blood	☐ Dizziness
☐ Negative	☐ Leg Pain – Walking	**Allergic:**	☐ Hearing Aid
☐ Asthma	☐ Rheumatic Fever	☐ Negative	☐ Infections
☐ Bronchitis	☐ Ulcers on Legs	☐ Coughing	☐ Pain
☐ Cough	☐ Chest Pain	☐ Sneezing	☐ Ringing
☐ Positive TB Test	☐ Hair Loss on Legs	☐ Itchy Eyes	☐ Hearing Impairment
☐ Coughing Blood	**Hematologic:**	☐ Wheezing	**Genitourinary/Urinary:**
☐ Pain	☐ Negative	☐ Runny Nose	☐ Negative
☐ Pleurisy	☐ Anemia	☐ Watery Eyes	☐ Bed Wetting
☐ Recent Chest X-Ray	☐ Easy Bruising	☐ Hives	☐ Blood in Urine
☐ Shortness of Breath	☐ Lumps	☐ Recurrent Infection	☐ Burning
☐ Sputum	☐ Radiation Exposure	**Musculoskeletal:**	☐ Flank Pain
☐ Tuberculosis	☐ Swollen Glands	☐ Negative	☐ Frequency
☐ Wheezing	☐ Bleeding Easily	☐ Arthritis	☐ Retention
Endocrine:	☐ Transfusion Reaction	☐ Gout	☐ Excessive Urination
☐ Negative	☐ Blood Clots	☐ Muscle Cramps	☐ Pain on Urination

Urinary (Cont.):	Skin (Cont.):	Skin (Cont.):	Eyes (Cont.):
☐ Waking to Urinate	☐ Dryness	☐ Rashes	☐ Recent Injury
☐ Stones	☐ Skin Color Change	Eyes:	☐ Pain with light
☐ Urgency	☐ Nail Appearance Change	☐ Negative	☐ Infections
☐ Incontinence	☐ Eczema	☐ Cataracts	☐ Glaucoma
☐ Infections	☐ Hair Texture Change	☐ Discharge	☐ Eyeglass Use
☐ Urine Discoloration	☐ Hives	☐ Double Vision	Other Health Concerns:
Skin:	☐ Itching	☐ Unusual Sensations	
☐ Negative	☐ Nail Texture Change	☐ Excessive tearing	
☐ Easy Bruising	☐ Mole Size Increased	☐ Eye Pain	

Please answer the questions below by circling either Yes or No.

Are you between the ages of 16 and 45?	**Yes**	**No**
Do you have a FAMILY history of alcohol abuse?	**Yes**	**No**
Do you have a FAMILY history of illegal drug abuse?	**Yes**	**No**
Do you have a FAMILY history of prescription drug abuse?	**Yes**	**No**
Do you have a PERSONAL history of depression?	**Yes**	**No**
Do you have a PERSONAL history of ADD, OCD, bipolar disorder or schizophrenia?	**Yes**	**No**
Do you have a PERSONAL history of alcohol abuse?	**Yes**	**No**
Do you have a PERSONAL history of illegal drug abuse?	**Yes**	**No**
Do you have a PERSONAL history of prescription drug abuse?	**Yes**	**No**
Do you have a PERSONAL history of preadolescent sexual abuse?	**Yes**	**No**

I acknowledge that I have received, read, and understand Space City Pain Specialists *Consents, Agreements, and Acknowledgements* including the *General Waiver of Liability, Consent for Treatment, Urine Testing Agreement,* and *Notice of Privacy Practices.*

Patient's Name:_____ **Date of Birth:**_____

Signature:_____ **Date:**_____

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Medical Record Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my Protected Health Information to the person(s) or entity listed below:

Space City Pain Specialists, LLP
17448 HWY 3, Suite 136
Webster, TX 77598
Phone: 281.338.4443
Fax: 281.338.8821

The reason or purpose for this release of information are as follows:

Continuity of Care

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Examiners.

In addition to the authorization of release of information to my healthcare provider, I also authorize the release of my Protected Health Information to any one of the following individuals:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Limitations on the information you may release subject to this release form are as follows:

_____

_____

_____

Patient Name: _____ Date of Birth: _____

Patient/Parent/Guardian/Legal Representative Signature: Representative Name:

_____ _____

Date: _____