

Appointment Date:

**New Patient Paperwork**

Name: Age: DOB: Sex: Male Female

**Emergency Contact Information**

Name: Relationship:

Phone Number:

**I. Chief Complaint Referring Doctor:**

In your own words, why are you here?

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

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



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

Burning Sharp Pins & Needles

Sensitive Aching Electric

Throbbing Shooting Stabbing

**III. When does your pain occur?**

Constantly Occasionally

A person standing and standing in front of the camera

Description automatically generated 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**

**Global Pain Scale**

**Instructions:** For each question, please indicate your response by circling a number from 1 to 10.

**Pain Scale:**

|  |  |
| --- | --- |
| My **CURRENT** pain is… | None – **1 2 3 4 5 6 7 8 9 10** – Extreme |
| During the **past week,** the **BEST** my pain has been is… | None – **1 2 3 4 5 6 7 8 9 10** – Extreme |
| During the **past week,** the **WORST** my pain has been is... | None – **1 2 3 4 5 6 7 8 9 10** – Extreme |
| During the **past week,** my **AVERAGE** pain has been... | None – **1 2 3 4 5 6 7 8 9 10** – Extreme |
| During the past **3 months,** my average pain has been… | None – **1 2 3 4 5 6 7 8 9 10** – Extreme |

**Your Feelings:** During the past week I have felt…

|  |  |
| --- | --- |
| …afraid | Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree |
| …depressed | Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree |
| …tired | Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree |
| …anxious | Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree |
| …stressed | Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree |

**Your Clinical Outcomes:** During the past week…

|  |  |
| --- | --- |
| …I had trouble sleeping | Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree |
| …I had trouble feeling comfortable | Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree |
| …I was less independent | Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree |
| …I was unable to work (or perform normal tasks) | Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree |
| …I needed to take more medication | Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree |

**Your Activities:** During the past week, I was **NOT** able to…

|  |  |
| --- | --- |
| …go to the store | Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree |
| …do chores in my home | Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree |
| …enjoy my friends and family | Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree |
| …exercise (including walking) | Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree |
| …participate in my favorite hobbies | Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree |

Name: DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy Name: Phone Number:**

**Pharmacy Address:**

**Are you currently taking a blood thinner?** Yes No If yes, which one?

**Allergies:** Please list any drug or medication allergies and reactions:

**IV. History of Present Illness**

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

Coughing Sneezing Straining Walking Sitting Standing Heat

Cold Bending Forward Bending Backward Lying Down Other:

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

Coughing Sneezing Straining Walking Sitting Standing Heat

Cold Bending Forward Bending Backward Lying Down Other:

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

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

**Procedure Month/Year Body Location Physician/Provider**

1. Prescriptions and over-the-counter medications previously tried for pain:

**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: |

Name: DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 | If YES, how often?  cigs/day packs/week vape/day |
| Do you drink alcoholic beverages? | Yes  No | If YES, how often?  drinks/day drinks/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 | With whom do you currently live?  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 Brother  Dad Sister | Panic Attacks | Mom Brother  Dad Sister | Lung Disease | Mom Brother  Dad Sister |
| Diabetes | Mom Brother  Dad Sister | Heart Disease | Mom Brother  Dad Sister | High Blood Pressure | Mom Brother  Dad Sister |
| Obesity | Mom Brother  Dad Sister | Back Problems | Mom Brother  Dad Sister | Depression | Mom Brother  Dad Sister |
| Cancer | Mom Brother  Dad Sister | Kidney Disease | Mom Brother  Dad Sister | Bipolar Disorder | Mom Brother  Dad Sister |
| Other: | | | | | |

Name: DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**VI. Review of Systems**

Please **CHECK** all CURRENT conditions you have. **CHECK** “Negative” if you have none of these conditions.

Constitutional

Decline in Health Fatigue Weakness Weight Gain

Weight Loss Negative

Head

Aneurysm Frequent Headaches Head Injury Migraines

PainNegative

Eyes

Cataracts Eyeglass Use Glaucoma Vision Loss Negative

Ears

Hearing Aids Hearing Impairment Negative

Respiratory

Asthma Bronchitis Cough Short of Breath while Resting

Tuberculosis Use of Oxygen Wheezing Negative

Cardiovascular

Chest Pain Cool Extremity(s) Heart Murmur High Blood Pressure

Leg Pain while Walking Low Blood Pressure Palpitations

Short of Breath during Exertion Swelling of Legs Thrombophlebitis

Ulcers on Legs Varicose Veins Negative

Gastrointestinal

Abdominal Pain Constipation Diarrhea Bladder Disease Heartburn

Liver Disease Nausea/Vomiting Rectal Bleeding Swallowing Problem Negative

Musculoskeletal

Arthritis Deformities Joint Pain Joint Stiffness

Lower Back Pain Mid Back Pain Muscle Spasms Neck Pain

Restricted Motion Scoliosis Negative

Psychiatric

Anxiety Behavioral Change Depression Disorientation

Disturbing Thoughts Excessive Thoughts Hallucinations Psychiatric Disorders

Negative

Skin

Dryness Eczema Hives or Rashes Color Change Negative

Neurological

Blackouts Burning Dizziness Fainting Loss of Consciousness

Memory Loss Numbness Paralysis Speech Disorders Strokes

Tingling Tremors Unsteady Gait Weakness Negative

Name: DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**VI. Review of Systems (Continued)**

Please **CHECK** all CURRENT conditions you have. **CHECK** “Negative” if you have none of these conditions.

Endocrine

Diabetes Excessive Hair Growth Goiter Increased Thirst Loss of Hair

Thyroid Disease Use of Injectable Meds (Ozempic, Insulin, etc.) Negative

Hematologic

Anemia Bleeding Easily Brusing Easily Deep Vein Thrombosis

Pulmonary Embolism Transfusion Reaction Negative

Allergies

Food Allergies Seasonal Allergies Negative

Urinary

Blood in Urine Excessive/Frequent Urination Flank Pain Incontinence

Stones Negative

**Please answer the questions below by checking 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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Description automatically generated with medium confidence

**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:

Representative Name (if applicable):

Patient/Parent/Guardian/Legal Representative Signature Date