PainCARE
Dr. Daniel Bruning & Dr. Kimber Eubanks

Name_____ Date _____ Birthdate _____

Age _____ Sex: M ____ F ____ Height: _____ft. _____ in. Weight _____ lbs

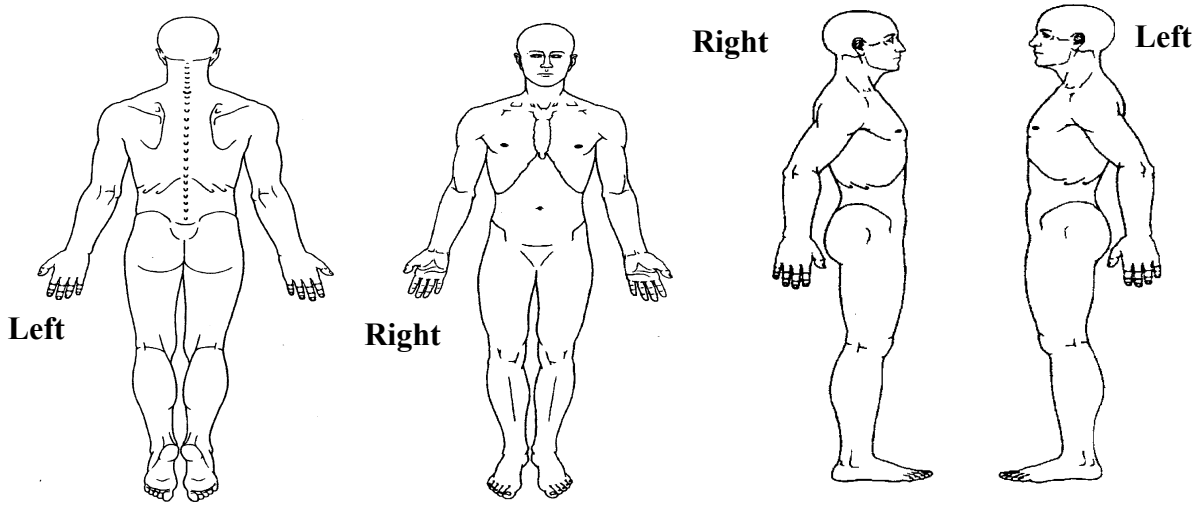
Referring Physician_____ **Primary Physician (Full Name)** _____

List all other physicians involved in your care and their specialty.

_____

What is your occupation (or previous occupation if retired)? _____

Please **draw** where your pain **primarily located** (Please use following diagram.)



Please circle below what makes your pain better:

Walking **Bending**
Standing **Twisting**
Sitting **Laying**

Other: _____

Please circle below what makes your pain worse:

Walking **Bending**
Standing **Twisting**
Sitting **Laying**

Other: _____

Please circle if you are taking the following medications.

Fish Oil **Excedrin (all kinds)** **Bufferin** **BC Powder** **Ecotrin**

Bayer Back & Body **Alka Seltzer** **Aspirin (Bayer Aspirin, Aspirin w/Caffeine)**

Please list ALL medications you are currently taking. Include vitamins, over-the-counter medications, herbal preparations, laxatives, or inhalers. Include medication name, dose *AND* frequency OR Provide a list of medications including name/dose & frequency

1._____ **7 .**_____

2. _____ **8.**_____

3. _____ **9.**_____

4. _____**10.**_____

5._____ **11.**_____

6. _____ **12.**_____

Do you currently have or are you being treated for an infection of any kind? <u>If yes, please explain:</u>

_____

_____

Is there any chance you could be pregnant? _____

Do you have any <u>allergies</u> to any medications, latex, iodine, contrast dye, or tape?

Yes__ No __

Please list Allergies to Medications and Reactions:

_____

Section 3 <u>Preventative Health Questions</u>

1. **Have you ever had a flu shot? If so, what month was your most recent flu shot done? _____**
2. **Have you ever had a pneumonia vaccination (shot)? If so, what year? _____**
3. **Have you ever had a mammogram? If so, what year was your most recent mammogram done? _____**
4. **Have you ever had a colorectal (colonoscopy) screening? If yes, what year was your most recent screening? _____ What type of screening was performed (colonoscopy or occult blood test)? _____**
5.

Have you had any of the following treatments for your CURRENT pain?

<u>Treatment</u>	*Yes/No*	*Dates completed (ex: 01/2021-03/2021)*	*Frequency (ex: 3x/week)*	*Did this help your pain?*
<u>Physical Therapy</u>				
<u>Home Exercises</u>				
<u>Chiropractic</u>				
<u>Pain Injections</u> <u>(epidural, facets, SI, trigger point, radiofrequency ablation)</u>				

<u>Please rate your pain-</u> **Please mark your average (A) pain and your maximum (M) pain on the line below:**

0 1 2 3 4 5 6 7 8 9 10

No Pain____|_____|_____|____|____|____|____|____|____|____|____ Worst Pain Imaginable

Please rate your pain as of right now from 0-10: _____

Please <u>circle</u> any of the following activities of daily living that you have had difficulty doing because of your pain:

Using the toilet Dressing Bathing Eating Getting up from a bed or chair

If you have experienced <u>NO</u> difficulty with the above activities of daily living please check this box: ☐

<u>Review of Systems Mark anything you are CURRENTLY experiencing</u>

<u>General:</u>
__Fatigue, lack of energy
__Fever/Chills
__Weight Loss >10 pounds

<u>Neurology:</u>
__Seizures
__Fainting/Black Outs
__Tremor

<u>Hematology:</u>
__Easy Bruising
__Abnormal Bleeding

<u>Respiratory:</u>
__Wheezing
__Coughing

<u>Psychiatric:</u>
__Anxiety
__Depression

<u>Gastrointestinal:</u>
___ANY NEW ONSET OF BOWEL/BLADDER INCONTINENCE

<u>Skin:</u>
__Rash

<u>Musculoskeletal:</u>
__Joint Pain
__Joint Stiffness

<u>HEENT:</u>
__Deafness
__Glasses/Contacts
__Headaches
__Hearing Loss
__Cataracts

<u>Cardiovascular</u>
__Chest Pain
__Irregular Heartbeat
__Palpitations
__Shortness of Breath
__Swelling of Extremities

___All others Negative

<u>Past Medical History</u>

Please mark any health problem you have had in the past

__Asthma
__Cancer Type: _____
__Bleeding Ulcers
__High Blood Pressure
__Atrial Fibrillation
__Pacemaker (__year)
__Defibrillator
__Sleep Apnea (CPAP/BiPAP)
__Migraines
___Seizures

__Infectious condition (i.e. Hepatitis)
___Kidney Disease
___Heart Issues (CHF, Stents, Blood Thinner)
__TIA
__Stroke
__Diabetes
__PTSD
__Anxiety
__Fibromyalgia

<u>If Diabetic:</u>
Do you have: Type I or Type II

How often do you check your blood sugars: __ Daily
__ Weekly
__ As Needed
What does your average blood sugar run? _____

Who manages your diabetes? PCP or Endocrinologist

Have you had any surgery to the area of your CURRENT pain? If so, please list:
Date: _____ Surgery: _____ Surgeon: _____

Date: _____Surgery: _____Surgeon: _____

____Check here if no previous surgery

<u>Tobacco Use:</u> Are you currently a smoker? Yes/No Are you a former smoker? Yes/No

<u>Alcohol Use:</u> Do you currently drink alcohol? Yes/No If yes, # of drinks per week? _____

Name of who will drive you home today _____

OFFICE USE ONLY BELOW THIS LINE

Form Reviewed

_____ M.D. Date _____ _____ R.N. Date_____

_____M.D. Date _____ _____ R.N. Date_____

Additional Nurse/Physician notes: