Pain & Wellness of Centers of Georgia

FOR SECURITY REASONS, WE DO NOT ALLOW OCCUPIED VEHICLES IN OUR PARKING LOT.

I understand that if I receive a ride here, the people that accompany me **MAY NOT** wait in the parking lot.

I may bring one guest inside with me while I am here, but any additional guest must leave and come back to pick me up once I am COMPLETELY finished with my doctor's appointment. Meaning AFTER I have seen the doctor and checked out.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Pain & Wellness Centers of Georgia
4905 LaVista Road
Tucker, Georgia

Date: ____-____-____

General Information

Patient Name: _____ ___ _____
(Last Name) (M. I.) (First Name)

Social Security: ____-____-_____ Date of Birth: ____-____-____

Gender: Male or Female

Street Address: _____ City: _____

State: _____ Zip: _____

Home Phone: ____-____-____ Cell Phone: ____-____-____

Emergency Contact:

Emergency Contact: _____

Home Phone: ____-____-____ Cell Phone: ____-____-____

Relationship: _____

Medical History:

Location of pain: _____ Duration of pain: _____

How did the pain start: _____

Have you ever been to a pain clinic in the past: ☐ Yes ☐ No

Are you currently seeing and receiving medical treatment for your current condition? ☐ Yes ☐ No

If yes please explain treatment and why you are here to see us:

_____

_____

_____

Patient Signature: _____ Date: _____

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INFORMATION ABOUT YOUR PRIMARY PAIN PROBLEM

1. What is your main reason/primary diagnosis for coming to the clinic today?
   _____
   _____
2. How long have you had the pain? _____
3. Which of the following best describes how the pain began: **Check all that apply.**
   ___ Accident at home ___Accident at work
   ___ Work Related ___ Motor vehicle accident
   ___ After surgery ___ After an illness
   ___ Just began ___ Came on gradually
   - Other: _____
4. How do you best describe your pain? ___ Dull ache __ Shooting __ Burning __Sharp __ Throbbing __ Other: _____
5. Do you have any of the following with you pain?
   a. Tingling/numbness in the hands/feet __ Yes __ No
   b. Weakness in the hands/feet __ Yes __ No
   c. Pain radiating to arm/hands/forearms __ Yes __ No
   d. Pain radiating to thigh/buttock/leg/feet __ Yes __ No
   e. Dragging the foot while walking __ Yes __ No
   f. Difficulty holding bladder or bowels __ Yes __ No
6. Do you need to use any of the following to walk or support since the pain started? __ Cane __ Walker __ Crutches __ Braces
7. Which affects your pain? Mark B for Better 7 W for Worse; leave blank if there is not effect.

__Massaging or rubbing	__ Coughing	__ Strong emotions	__ Standing
__ Sudden movement	__ Anxiety	__ Getting out of bed	__ Running
__ Noise	__ Heat	__ Sitting	__ Bright light
__ Cold weather	__ Lying down	__ walking	__ Bending
__ Vibration	__ Ice	__ Physical Therapy	__ Straining
__ Wet climate	__ Fatigue	__ Reaching	__ Lifting

__ Other: _____

Treatment you have tried:

8. List all surgical procedures that you have had. Use separate sheet if needed.

Procedure	Part of the Body	Date

9. Have you ever attended Chronic Pain management program? __Yes __No
If Yes, Where? _____ When? _____ (Year)

INFORMATION ABOUT YOUR MEDICAL HISTORY

10. Please check any of the following that you have had within the past 6 months:

__ Anxiety attach __ Feeling tired/low energy __ Painful sex/Intercourse
__ back pain __ Headaches __ racing/pounding heart
__ Bloated __Joint pain __Seizures
__ Chest pain __ Loss of consciousness __ Low mood
__ Sleep problems __ Shortness of breath __ Diarrhea or constipation
__ Dizziness __ Loss of memory ___ Trouble walking
__ Easy bleeding __ Vision __ Nausea/Vomiting
__ Painful menstruation __ Fainting spells/blackouts
__ Other : _____

11. Have you ever received mental health treatment? __Yes __No
If Yes, When and for what condition:
_____

12. Do you have any allergies? __Yes __No
If Yes, Please list all known allergies:
_____

13. Do you have any blood relatives (immediate family) with a history of any of the following?
__ Alcoholism __ Depression __ Headache __ Suicide
__ Chronic pain __ Disability __ Mental Illness __ Other:
(Please specify): _____

INFORMATION ABOUT YOUR MEDICATIONS

14. **Present Medications:** List all prescribed and over-the-counter medications (Tylenol, Aspirin, etc.), nutritional supplements, herbal remedies, ad homeopathic remedies you are currently taking. Please include medications for pain, sleep, chronic conditions, etc.

Medication	Dosage/ day	Side effects (if any)	How effective

15. **PAST:** List medications (include over-the-counter, herbal and homeopathic) taken in the past. Use additional sheet of paper if you need more space to answer pain medication questions.

Medication	Dosage/ day	Side effects (if any)	Why discontinued

CONCLUSION:

Additional comments or more information about current or past pain medications, pain treatments, or surgical procedures for pain.

Social History

1. Who are you currently living with? (circle as many that applies)
Live alone Spouse/partner Parents Roommate Children; ages _____

2. Describe your home situation (who does most of the chores)
_____
_____
_____

3. Are you currently experiencing any stressful situations? (circle the one that applies)

Martial/relationship stress	Yes	No
Stress at work	Yes	No
Financial stress	Yes	No
Stress with your family	Yes	No
Stress with your friends	Yes	No

INFORMATION ABOUT YOUR HABITS

1. In a typical week, how many days do you get exercise? _____days
2. In a typical week, how many days do you drink alcohol? _____ days
3. In a typical day, how many drinks do you have? _____ (number of drinks)

(1 drink= 12 ounce can of beer, 4 ounces of wine, or a 1 ounce shot of hard liquor).

4. Have people upset you by criticizing your drinking or drug use?
   Yes No
5. Have you ever felt you should cut down on your drinking or drug use?
   Yes No
6. Have you ever participated in a substance abuse treatment program?
   Yes No
7. Do you use tobacco?
   Yes No

(cigarettes, cigars, chewing tobacco, pipe, nicotine replacement)
If Yes, amount per day _____ Number of years _____

8. Do you drink regular coffee, tea, colas or other caffeinated drinks?

Yes No

If Yes, how much per day? _____ (number of drinks) _____ (ounces/drink)

9. Do you use street drugs or drugs not prescribed by your doctor?

Yes No

Marijuana Cocaine Methamphetamine Heroin Other _____

INFORMATION ABOUT YOUR SLEEP

1. Trouble falling asleep because of pain?

a. Never b. 1-2 times/week c. 3-5 times/week d. 6-7 times/week

2. Wake up in the night because of pain?

a. Never b. 1-2 times/week c. 3-5 times/week d. 6-7 times/week

3. How long does it take to return to sleep? _____

4. How often do you need medication to fall asleep?

a. Never b. 1-2 times/week c. 3-5 times/week d. 6-7 times/week

5. What sleep medications do you take? (include over-the-counter medications)

_____

_____

6. In general, how many hours of sleep for you get per night? _____

7. How many hours of sleep do you need to feel rested? _____

8. Do you take daytime naps?

Yes No

Psychological History

Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle all that applies)

1. Little interest or pleasure in doing things
   Never rarely sometimes always
2. Feeling down, depressed, or hopeless
   Never rarely sometimes always
3. Trouble falling asleep
   Never rarely sometimes always
4. Feeling tired or having little energy
   Never rarely sometimes always
5. Poor appetite or overeating
   Never rarely sometimes always
6. Feeling bad about yourself
   Never rarely sometimes always
7. Trouble concentrating on things
   Never rarely sometimes always
8. Moving or speaking slowly
   Never rarely sometimes always
9. Thoughts that you would be better off dead
   Never rarely sometimes always
10. Thoughts of hurting others
    Never rarely sometimes always

Patient Name: _____
Patient Signature: _____
Date: ____-____-____