Patient's Name: _____

Aspire Pain Medical Center

Welcome to *Aspire* Pain Medical Center. We are looking forward to providing you with the best care to manage your needs.

Please take the time to complete the following questionnaire as accurately and completely as possible. We rely on this information for your personalized care. If you have any questions about any of the following sections, please call our front desk at (949) 574-4033.

Initial Pain Management Questionnaire

Today's Date: _____ Your best contact phone #:_____
Name: (First, Middle, Last):_____
Date of Birth: _____ Gender : ☐ Male ☐ Female
Address: _____
City _____ State _____
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ I refuse to answer this question
Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Insurance information:
Name of insurance: _____ Insurance phone number _____
Policy #: _____Group ID: _____ Effective date: _____
Co-pay: _____ Deductible: _____

Your Preferred Pharmacy:
Name: _____ Address:_____
Phone: (____) _____ City _____ State ____

How Did You Hear About Us?
_____

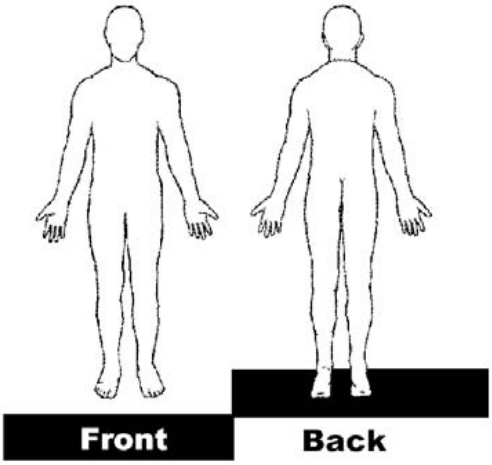
Your Referring Physician: (First and last name):
_____ Phone: _____

Please tell us in one sentence why you are here? (ie. Lower back pain.)

_____
_____
_____

Patient's Name: _____

Please draw in your pain on the following diagram:



About how long ago did your pain start?

_____

How did your pain begin? (Accident, Fall, Gradually, Suddenly, etc.)

_____

_____

How frequent is your pain? ☐ Constant or ☐ Intermittent (comes and goes)

Which words describe your pain?

☐ Throbbing ☐ Aching ☐ Sharp ☐ Shooting ☐Dull ☐Tingling ☐ Burning

☐ Pins & Needles ☐ Hot ☐ Cold ☐ Gnawing ☐ Squeezing

☐ Spasming/Cramping ☐ Tender (Sensitive to touch)

Which activities are you not able to perform due to your pain?

_____

Which activities make your pain worse? (ie. Sitting, standing, walking, etc.)

_____

_____

Which activities make your pain better?

_____

How do you rate the intensity of your pain? (0=no pain & 10=worse pain imaginable)
0 1 2 3 4 5 6 7 8 9 10

How does your pain affect your sleeping?

☐ I sleep well ☐ I have difficulty falling asleep ☐ I have difficulty maintaining my sleep.

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2043 Westcliff Drive, Suite 301
Newport Beach, CA 92660
PHONE (714) 574-4033
FAX (714) 574-4038

Patient's Name: _____

What type of doctors have you seen for the above condition?

□ physical therapy □ chiropractor □ acupuncture □ neurology □ rheumatology □ addiction
□ orthopedic surgeon □ podiatry □ spine surgeon _____ □ pain management _____
□ other _____

Have you had imaging/diagnostic studies for this condition? (i.e. X-ray, MRI, CT, EMG, sleep, etc.)
If so, please provide the following information**:**
Type of test/study: _____
Date: _____
Facility name and phone number where test was performed: _____

What have you done so far for your pain?

	Helped	Did not help
☐ Surgery	☐	☐
☐ Physical Therapy	☐	☐
☐ Acupuncture	☐	☐
☐ Chiropractic treatment	☐	☐
☐ Biofeedback therapy	☐	☐
☐ Massage	☐	☐
☐ Trigger point injections	☐	☐
☐ Epidural Injections	☐	☐
☐ Other injections	☐	☐
☐ Other _____	☐	☐

Do you have allergies to any medication? ☐ No ☐ Yes
If yes, please list medication and the type of reaction:
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____

What medications have you tried in the past for your pain?

Medication	Helped	Did not help
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐

Patient's Name: _____

What MEDICATIONS do you currently take?

Medication	Dose	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please let us know if you take any of the following "Blood Thinners":

☐ Aspirin ☐ Coumadin/Warfarin ☐Plavix ☐ Aggrenox ☐ Lovenox

☐ Pradaxa ☐ Other blood thinner: _____

PLEASE LIST ALL OF THE SURGERIES you have had in the past:

Surgery	Date (month/year)
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any serious illness or medical conditions that we should know about? If so, please list: (ie. Diabetes, Hypertension, Hepatitis, etc.)

_____

_____

SOCIAL HISTORY:

Children:

Do you have any children? ☐ Yes ☐ No If so, what year/years were they born? _____

Drug use history:

Have you ever had any problem with addiction or substance abuse? ☐ Yes ☐ No

If yes, please explain:

Education:

What is your highest level of education? _____

Employment: Do you work? ☐Yes ☐No

If yes, what do you do? _____ How many hours per week? _____

If no, when was the last time you worked? _____What did you do? _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other:

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Patient's Name: _____

Pregnancy: Are you or can you be pregnant? ☐ Yes ☐ No

Tobacco Use:

Do you currently smoke? ☐ Yes ☐ No

Do you smoke Marijuana? ☐ Yes ☐ No

If yes, do you have a medical marijuana license? ☐ No ☐ Yes License expiration date: _____

*If applicable, please provide a copy of your medical marijuana license to us.

REVIEW OF SYSTEMS:

Have you experienced any of the following symptoms during the last 7 days?

Constitutional:

☐ Fever
☐ Chills
☐ Night sweats
☐ Difficulty sleeping
☐ Weakness
☐ Fatigue
☐ Unexplained weight loss

Head/Eyes/Ears/Nose/Throat

☐ Visual change or difficulty with vision
☐ Snoring
☐ Hoarseness
☐ Difficulty swallowing
☐ Nose Bleeds
☐ Difficulty hearing or ringing in the ears

Cardiovascular:

☐ History of chest pain or heart attack
☐ Shortness of breath
☐ Swelling in the ankles or feet

Respiratory:

☐ Wheezing
☐ Cough
☐ Blood in sputum

Gastrointestinal:

☐ Nausea
☐ History of Jaundice
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Black or tarry stools

Genitourinary:

☐ Frequency
☐ Difficulty urinating
☐ Incontinence
☐ Blood in urine
☐ Kidney stones

Patient's Name: _____

Musculoskeletal:

☐ Back pain
☐ Neck Pain
☐ Joint swelling
☐ Joint pain/Stiffness
☐ Muscle spasm
☐ Difficulty walking

Skin:

☐ Rash
☐ Mole changes
☐ Skin Ulcerations

Neurological:

☐ Seizure
☐ Stroke
☐ Numbness
☐ Tingling
☐ Syncope

Hematological/Lymphatic

☐ Node Swelling
☐ Easy Bruising
☐ Bleeding Disorder

Psychiatric:

☐ Depression
☐ Suicidal Thoughts
☐ Anxiety
☐ Stressed

Endocrine:

☐ Diabetes
☐ Thyroid Disorder
☐ Adrenal Insufficiency

**I certify that the above information is accurate, complete and true.

I authorize the care providers at Aspire Pain Medical Center to treat my condition as necessary.

I agree to actively participate in my care to optimize its effectiveness.

I give my consent for the care providers at Aspire Pain Medical Center to retrieve and review my medical records. I understand that this will become part of my medical records.

SiGNATURE **PRINT NAME** **DATE**

_____ _____ _____

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