Premier Pain Solutions
2813 E. Camelback Road, Suite 430
Phoenix, Arizona 85016
P602.354.5659 F: 602.354.5896

Pain Procedures Performed At:
Premier Pain Center
10255 N. 32nd Street
Phoenix, Arizona 85028
P: 602.354.5659 F: 602.354.5896

Patient Information (confidential):

Name: ____ Date: ________________
(First) (Middle) (Last)

Address: __________________________________ City __________ State_____ Zip ________

Phone: Home (____)______________ Work (____)______________ Cell (____)______________

Birth Date: ______________ SS# _____-_____-_____ E-Mail: ________________________

Employer (if Minor, Parent's Employer) ________________________ Address: ____________________

Spouse Name (if Minor, Parent's Name) ______________________________ Phone: (____)__________

Primary Care Physician: ____________________________________ Phone: (____)__________

Person to Contact in Emergency: ________________________________ Phone: (____)__________

Who Should We Thank for Referring You? __________________ Address: ____________________

Responsible Party:

Do you have medical insurance coverage: □ Yes □ No

Name of Person Responsible for this Account: ______________________ Relationship to Patient: __________

SS# _____-_____-_____ Birth Date: ____________________

Insurance Company: __________________________ Policy No.: __________________________

Do you have additional insurance? □ Yes □ No If yes, please complete the following:

Name of Insured: ____________________________ Relationship to Patient: ____________________

SS# _____-_____-_____ Birth Date: ______________

If you are covered under worker's compensation or motor vehicle insurance, enter info below:

Name of Worker's Comp or Motor Vehicle Accident Insurance Carrier ______________________________

Employer ______________________________

Claim Number ______________________ Date of Injury: ______________________

Adjuster/Case Manager: ______________________________ Phone:______________________

Carrier Address: ____

Additional Questions:

Are you currently working? □ Yes □ No

If you are not working, when did you last work? ____________________

Is the problem related to any other accident or injury? □ Yes □ No

If yes, what the date of the accident? ____________________

Is there any legal action pending? □ Yes □ No

Attorney: ______________________________ Phone: ______________________________

Height: ________________ Weight: ________________

Allergies & Drug Reactions:

□ Penicillin □ Latex
□ Sulfa Drugs □ Betadine
□ Codeine □ Contrast Dye
□ Other ________________
□ Other ________________
□ Other ________________
□ Other ________________

Current Medications:	Dosage:	Frequency:

Pain Procedures Performed At:

Premier Pain Center

Patient Name ______________________________

Date Of Birth ______________________________

Past Medical History

CARDIOVASCULAR
- ☐ Abnormal Heart Rhythm
- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Carotid Artery Disease
- ☐ Deep Vein Thrombosis
- ☐ Hypertension
- ☐ Heart Attack
- ☐ Peripheral Vascular Disease

PULMONARY
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ COPD
- ☐ Pulmonary Embolism
- ☐ Sleep Apnea
- ☐ Tuberculosis

PSYCHIATRIC
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ OCD
- ☐ Schizophrenia

NEUROLOGICAL
- ☐ Alzheimer's disease
- ☐ ADD/ADHD
- ☐ Stroke/CVA
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Seizure Disorder
- ☐ TIA

MUSCULOSKELETAL
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Lupus

EYES
- ☐ Cataracts
- ☐ Glaucoma

GASTROINTESTINAL
- ☐ Gallstones
- ☐ Crohn's Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease
- ☐ Ulcerative Colitis

ENDOCRINE
- ☐ Addison's Disease
- ☐ Cushing's Disease
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

CANCERS
- ☐ Type ______________________________

Remission? ☐ YES ☐ NO

Other:

____

____

HEMATOLOGICAL
- ☐ Iron Def Anemia
- ☐ Bleeding Disorder

ALLERGY/IMMUNE/SKIN
- ☐ Eczema
- ☐ Psoriasis
- ☐ Chronic Sinusitis
- ☐ Immune Deficiency

ENDOCRINE
- ☐ Addison's Disease
- ☐ Cushing's Disease
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Past Surgical History

COMMON (GENERAL)
- ☐ Cataract
- ☐ Tonsillectomy
- ☐ Pacemaker/AICD
- ☐ Coronary Artery Bypass
- ☐ Coronary Stent
- ☐ Heart Valve Replacement
- ☐ Appendectomy
- ☐ Gall Bladder
- ☐ Gastric Banding/Bypass

COMMON SPINE
- ☐ Cervical Fusion
- ☐ Lumbar Fusion
- ☐ Lumbar Laminectomy
- ☐ Spinal Cord Stimulator
- ☐ Spinal Drug Pump
- ☐ Lumbar Discectomy
- ☐ Vertebroplasty
- ☐ Kyphoplasty

COMMON ORTHOPEDIC
- ☐ Carpal Tunnel
- ☐ Shoulder Arthroscopy
- ☐ Rotator Cuff Repair
- ☐ Knee Scope
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ ORIF (SURGERY TO FIX BROKEN BONE)

What Bone? ____________________

COMMON MALE/FEMALE
- ☐ TURP (Prostate)
- ☐ Open Prostatectom
- ☐ Bladder Sling
- ☐ Caesarean Section
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ Breast Lumpectomy
- ☐ Mastectomy

Other/Enter Details Here:

____

____

Family History: Do you have a family history of:

☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ None of These ☐ Other ______________________________

Social History:

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

Current Occupation: ______________________________ Working Now? ☐ Yes ☐ No

Education: ☐ High School ☐ GED ☐ College ☐ Masters ☐ Doctorate

Do you currently smoke? ☐ No ☐ Yes

Have you smoked in the past? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes If yes, how often? ☐ Daily ☐ Weekly ☐ Rarely

Do you have a history of alcoholism? ☐ No ☐ Yes

Have you ever had a substance abuse problem? ☐ No ☐ Yes

What substance(s) did you abuse? ______________________________

Pain Procedures Performed At:

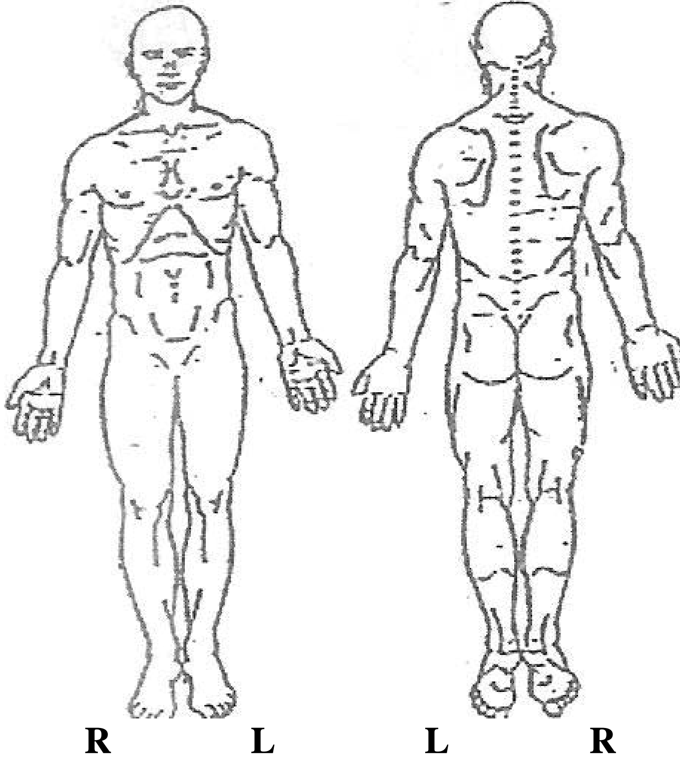
Premier Pain Center

Patient Name ______________________________

Date Of Birth ______________________________

History of Current Pain Problem – Please Complete Each Section

Color IN Your Usual Pain Areas



R L L R

Which is your SINGLE worst area?

☐ Headache ☐ Facial ☐ Chest
☐ Neck ☐ Shoulder ☐ Abdomen
☐ Upper Back ☐ Arm ☐ Flank
☐ Mid-Back ☐ Elbow ☐ Pelvis
☐ Low-Back ☐ Hand ☐ Genitals
☐ Buttock ☐ Leg ☐ Rectal
☐ Hip ☐ Knee
☐ Tailbone ☐ Ankle

Onset

When did you first have this pain?

☐ Past 24 HRS ☐ Past 4 WKS ☐ Past 1-3 YRS
☐ Past 7 DAYS ☐ Past Year ☐ > 3 YRS Ago

Was there a specific date?

☐ No ☐ Yes ______________________________

Related Event

☐ NONE
☐ VEHICLE ACCIDENT
☐ FALL
☐ LIFTING INJURY
☐ SURGERY
☐ OTHER ________________
____

WORK-RELATED?

☐ YES ☐ NO

When is your pain WORST?

☐ No Particular Time
☐ Morning
☐ Afternoon
☐ Evening
☐ Middle of the Night

Words that describe your pain:

☐ Sharp
☐ Shooting
☐ Burning
☐ Electrical
☐ Tingling
☐ Numb
☐ Dull
☐ Aching
☐ Pressure
☐ Throbbing
☐ Crampy
☐ Indescribable
☐ OTHER ______________________________
____

Pain Worse With:

☐ Walking
☐ Standing
☐ Sitting
☐ Bending Forward
☐ Bending Backward
☐ Laying Flat
☐ Lifting
☐ Coughing
☐ Riding in Car
☐ OTHER ______________________________
____
☐ Pushing for Bowel Movement
☐ Pressing on Area
☐ Physical Exertion
☐ NONE- Pain is Spontaneous

Pain Better With:

☐ Stopping Activity
☐ Changing Position
☐ Sitting
☐ Laying Flat
☐ Rest
☐ Ice
☐ Heat
☐ TENS
☐ Elevation
☐ Relaxation
☐ Passage of Time
☐ NONE
☐ OTHER ______________________________
☐ OTHER ______________________________
☐ OTHER ______________________________
☐ OTHER ______________________________

(OVER)

Pain Procedures Performed At:

Premier Pain Center

Patient Name ______________________________

Date Of Birth ______________________________

History of Current Pain Problem (continued) – Please Complete Each Section

Pain Severity	0 = No Pain		5 = Borderline Tolerable			10 = Pain "Sufficient to Pass Out"					
Current	0	1	2	3	4	5	6	7	8	9	10
Average	0	1	2	3	4	5	6	7	8	9	10
Best in 24hrs	0	1	2	3	4	5	6	7	8	9	10
Worst in 24hrs	0	1	2	3	4	5	6	7	8	9	10

Treatments Tried:

Treatment	**Pain Relief**	**Treatment**	**Pain Relief**
☐ Rest	☐ Some ☐ None	☐ Oral Steroids	☐ Some ☐ None
☐ Ice	☐ Some ☐ None	☐ Steroid Injections	☐ Some ☐ None
☐ Heat	☐ Some ☐ None	☐ TENS/Skin Stim	☐ Some ☐ None
☐ Physical Therapy	☐ Some ☐ None	☐ SYNVISC/HYALGAN INJ	☐ Some ☐ None
☐ Exercise	☐ Some ☐ None	☐ Other ______________________	☐ Some ☐ None
☐ Pain Psychology	☐ Some ☐ None	☐ Other ______________________	☐ Some ☐ None

Functional Impact:

How often does pain stop you from doing activities of daily living (household chores, etc)?

☐ Never ☐ Sometimes ☐ Most of the Time ☐ All the time

How often does pain interfere with walking?

☐ Never ☐ Sometimes ☐ Most of the Time ☐ All the time

Additional Questions:

Have you had SURGERY in the body region where you currently have pain?	☐ Yes	☐ No
Do you have problems with CONTROL over your bowels or bladder?	☐ Yes	☐ No
Are you currently taking ANTIBIOTICS, or have you been on antibiotics in the past 7 days?	☐ Yes	☐ No
Have you had a dose of oral, or injected STEROIDS in the past 14 days?	☐ Yes	☐ No
Do you usually take BLOOD THINNERS such as Coumadin, Plavix, Aggrenox, Ticlid, etc?	☐ Yes	☐ No
Is there any chance you might be PREGNANT now?	☐ Yes	☐ No
Is it likely you could become PREGNANT in the next year?	☐ Yes	☐ No

Review of Systems: Do you have any of these symptoms now or in the recent past?

GENERAL
- ☐ Fever
- ☐ Severe Shaking Chills

EYES
- ☐ Blurred Vision
- ☐Sensitivity to light

EARS/NOSE/THROAT
- ☐ Nose Bleeds
- ☐ Bleeding Gums

ALLERGIC/IMMUNE
- ☐ Seasonal Allergies
- ☐ Latex Allergies

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Swelling in Ankles

PULMONARY
- ☐ Cough
- ☐ Shortness of Breath

MUSCULOSKELETAL
- ☐ Joint Pain
- ☐ Muscle Pain

GENITOURINARY
- ☐ Blood in Urine
- ☐ Urinary Incontinence

GASTROINTESTINAL
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

NEUROLOGICAL
- ☐ Dizziness
- ☐ Numbness
- ☐ Weakness
- ☐ Seizures

ENDOCRINE
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Measured Blood Sugars >200

INTEGUMENTARY
- ☐ Rash
- ☐ Hair or Nail Growth Change
- ☐ Skin Color or Texture Change

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Sleep Disturbance
- ☐ Manic Episodes

HEMATOLOGIC/LYMPH
- ☐ Easy Bruising
- ☐ Swollen or Tender Lymph Nodes