Emed Pain Management

PATIENT LABEL

Name (First, MI, Last): _____

Date of Birth:_____ Age:_____ Sex (M/F):_____ Social Security # _____

Marital Status: □ Single □ Married Phone Number: (Cell)_____ (Home)_____

Street Address:_____ (Apt/Lot #)_____

City: _____ State: _____ Zip: _____

1) Emergency Contact Name:_____ Relation: _____

Emergency Contact Phone Number: _____

2) Emergency Contact Name:_____ Relation: _____

Emergency Contact Phone Number: _____

INSURANCE INFORMATION

FOR ACCURATE BILLING, PLEASE BE SURE TO PROVIDE ALL ACTIVE INSURANCE POLICY INFORMATION, INCLUDING MEDICARE AND MEDICAID IF APPLICABLE.

	Carrier/Insurance Name	Member/Policy Number	Subscriber Information
Primary Insurance			□ Self □ Name: DOB:
Secondary Insurance			□ Self □ Name: DOB:
Tertiary Insurance			□ Self □ Name: DOB:

Medicare Member #: _____ Florida Medicaid Member #: _____

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1. How Long Have you had your current pain (Circle ONE)? **Days Weeks Months Years**
2. Please circle ALL the areas that hurt

Head/Face	Neck	Middle Back
Low Back		
Left Shoulder	Right Shoulder	Both Shoulders
Left Elbow	Right Elbow	Both Elbows
Left Hand	Right Hand	Both Hands
Left Arm	Right Arm	Both Arms
Left Wrist	Right Wrist	Both Wrists
Left Hip	Right Hip	Both sides of Hip
Left Leg	Right Leg	Both Legs
Left Knee	Right Knee	Both Knees
Left Ankle	Right Ankle	Both Ankles
Left Foot	Right Foot	Both feet

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3. Of the areas listed above, which area hurts the **MOST**? _____
    a. Have you ever had surgery on this area? **YES NO**
    b. Is this pain the result of a major trauma or accident? **YES NO**
    c. Out of 10, please rate your **AVERAGE** pain. 1 2 3 4 5 6 7 8 9 10
    d. Does this prevent you from activities of daily living? **YES NO**
    e. Describe this pain: **SHARP ACHY CONSTANT THROBBING DULL STABBING**
    f. Does this pain radiate to (Circle any that apply): **LEGS ARMS BACK CHEST NECK**
    g. Is there tingling/numbness? **YES NO**
    h. Is there associated swelling in the area? **YES NO**
    i. Is your pain worse with movement? **YES NO**
    j. Are you currently taking any medication for your symptoms? **YES NO**
    k. Does anything improve your pain? **YES NO**
    l. Does anything make your symptoms worse? **BENDING WALKING STANDING SITTING LIFTING**

4. Of the areas listed above, which area hurts **SECOND MOST**? _____
    a. Have you ever had surgery on this area? **YES NO**
    b. Is this pain the result of a major trauma or accident? **YES NO**
    c. Out of 10, please rate your **AVERAGE** pain. 1 2 3 4 5 6 7 8 9 10
    d. Does this prevent you from activities of daily living? **YES NO**
    e. Describe this pain: **SHARP ACHY CONSTANT THROBBING DULL STABBING**
    f. Does this pain radiate to (Circle any that apply): **LEGS ARMS BACK CHEST NECK**
    g. Is there tingling/numbness? **YES NO**
    h. Is there associated swelling in the area? **YES NO**
    i. Is your pain worse with movement? **YES NO**
    j. Are you currently taking any medication for your symptoms? **YES NO**
    k. Does anything improve your pain? **YES NO**
    l. Does anything make your symptoms worse? **BENDING WALKING STANDING SITTING LIFTING**

5. Of the areas listed above, which area hurts **THIRD MOST**? _____
    a. Have you ever had surgery on this area? **YES NO**
    b. Is this pain the result of a major trauma or accident? **YES NO**
    c. Out of 10, please rate your **AVERAGE** pain. 1 2 3 4 5 6 7 8 9 10
    d. Does this prevent you from activities of daily living? **YES NO**
    e. Describe this pain: **SHARP ACHY CONSTANT THROBBING DULL STABBING**
    f. Does this pain radiate to (Circle any that apply): **LEGS ARMS BACK CHEST NECK**
    g. Is there tingling/numbness? **YES NO**
    h. Is there associated swelling in the area? **YES NO**
    i. Is your pain worse with movement? **YES NO**
    j. Are you currently taking any medication for your symptoms? **YES NO**
    k. Does anything improve your pain? **YES NO**
    l. Does anything make your symptoms worse? **BENDING WALKING STANDING SITTING LIFTING**

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Current Medications:

Medication	Dose	Frequency	Reason

Allergies:

□ None	□ Medication_____	□Latex	□ Food
□Pollen	□Other	□Contrast Dye	

Specify:_____

PAST SURGICAL HISTORY: Please list the year you had any of the following procedures.

_____Appendectomy _____Gallbladder _____Hernia Repair
_____Tonsillectomy _____Heart surgery/Cath _____OTHER
_____Hysterectomy _____Vasectomy _____OTHER

Hospitalizations / Major Traumas:

Date	Reason	Any Procedures Done

Family History:

Relative	Age if living	Age of Death	Major Illnesses/Cause of Death
Mother			
Father			
Brother(s)			
Sister(s)			
Children			

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Social History:
Tobacco Use: □ Never □ Quit □ Currently**;**

- How many cigarettes/day? _____
- How soon after waking up do you have your first cigarette? **_____**
- Are you ready to quit? _____

Alcohol Use: □ Never □ Quit □ Currently

- How often do you drink alcohol? _____

Illegal Drug Use: □ Never □ Quit □ Currently

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General
□ Weight loss or gain
□ Fatigue
□ Fever or chills
□ Weakness
□ Trouble sleeping

Ears, Nose, Throat, Mouth
□ Decreased hearing
□ Tinnitus (Ringing in ears)
□ Earache
□ Ear Drainage
□ Epistaxis (Nose Bleed)
□ Sinus Pain
□ Sore Throat
□ Hoarseness
□ Thrush
□ Dry Mouth
□ Toothache
□ Pain with Swallowing
□ Stiffness
□ Runny Nose

Respiratory
□ Cough
□ Sputum
□ Wheezing
□ Coughing up blood
□ Shortness of breath
□ Painful with breathing
□ Asthma

Vascular
□ Calf pain with walking
□ Leg cramping

Psychiatric
□ Depression
□ Anxiety
□ Difficulty Concentrating
□ Paranoia
□ Sadness
□ Mania
□ Altered Mental Status

Cardiovascular
□ Hypertension
□ Hyperlipidemia
□ Chest Pain or Discomfort
□ Tightness
□ Palpitations
□ Shortness of breath with activity
□ Difficulty breathing lying down
□ Swelling
□ Sudden awakening from sleep with shortness of breath

Gastrointestinal
□ Abdominal Pain/Cramping
□ Difficulty Swallowing
□ Heartburn/ Indigestion
□ Change in appetite
□ Black Tarry Stool
□ Nausea/ Vomiting
□ Diarrhea
□ Vomiting Blood
□ Rectal Bleeding
□ Change in bowel habits
□ Constipation

Genitourinary
□ Urine Frequency
□ Blood in Urine
□ Incontinence
□ Dysuria
□ Nocturia
□ Hematuria
□ Polyuria
□ Pain or Burning with Urination
□ Difficulty with Erection
□ Vaginal Discharge
□ Vaginal Pain
□ Menopause

Musculoskeletal
□ Muscle or joint pain
□ Stiffness
□ Back pain
□ Worsens with Activity
□ Joint Swelling
□ Decreased Range of Motion
□ Arthritis
□ Weakness
□ Muscle Cramping

Neurologic
□ Changes in Sight, Smell, Hearing, or Taste
□ Headache
□ Fainting
□ Seizures
□ Weakness
□ Trouble with Balance
□ Numbness/Tingling
□ Tremor
□ Memory Loss
□ Speech Problems
□ Fainting

Other
_____
_____
_____
_____
_____