Legacy Pain
and Spine Specialists

NEW PATIENT

Chart # ____________ Insurer ___________________

1. **TODAY'S DATE:**___________________Primary care physician:____
2. Name:____DOB:_______/______/______Age:______________

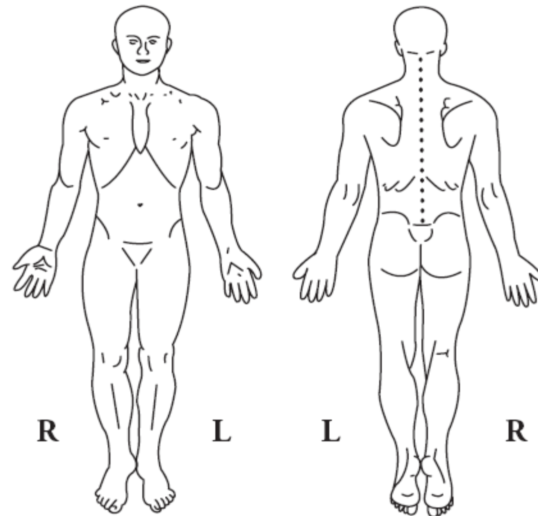
Please mark or color the areas on your body where you feel pain. Circle where it hurts the most.

Pain Score
Please indicate your pain level on a scale of 0-10 with "0" = no pain and "10" = worst pain imaginable

Present Pain
0 1 2 3 4 5 6 7 8 9 10

Most of the time
0 1 2 3 4 5 6 7 8 9 10

Worst is gets
0 1 2 3 4 5 6 7 8 9 10



3. **ALLERGIES:** ____
4. Briefly, please describe your present pain/problem: ____
   ____
5. Describe how your pain originally started: ❑ Work ❑ Auto ❑ Other Date of Injury?_____________/______/_____
   Details: ____
6. Describe the **frequency** of your pain:
   ❑ Constant ❑ Intermittent ❑ Daytime ❑ Nighttime
7. Describe the **quality** of your pain:
   ❑ Aching ❑ Burning ❑ Throbbing ❑ Shooting ❑ Sharp ❑ Dull
   Other description: ____
8. Which of the following activities **improve** your pain? ❑ Nothing ❑ Heat ❑ Medications ❑ Lying down
   ❑ Physical therapy ❑ Changing positions ❑ Sitting ❑ Standing ❑ Other
9. Which of the following activities **worsen** your pain? ❑ Sitting ❑ Standing ❑ Walking ❑ Lying down
   ❑ Bending forward/backward ❑ Movement/Activity ❑ Coughing/Sneezing ❑ Climbing stairs ❑ Other
10. Have you attempted any of the following therapies? ❑ Physical Therapy ❑ TENS Unit ❑ Chiropractor
    ❑ Massage Therapy ❑ Acupuncture ❑ Biofeedback ❑ Other
11. Do you smoke or use tobacco products? ❑ Yes ❑ No If yes, explain: _________________________________
12. Have you ever abused alcohol, abused prescription drugs or tried illicit drugs? ❑ Yes ❑ No
13. Have any of your relatives ever abused alcohol, abused prescription drugs or tried illicit drugs? ❑ Yes ❑ No
14. Are you taking Xanax, Ativan, Valium or Klonopin? ❑ Yes ❑ No
15. Are you currently being treated by a psychiatrist or psychologist? ❑ Yes ❑ No If yes, who: ___________________

Please complete both pages of this form.

16. Does your pain keep you awake at night? ❑ Yes ❑ No
17. Have you ever received any pain injections? ❑ Trigger Point ❑ Steroid Injection ❑ Other
18. What pain medications have you tried (including Tylenol, Advil, Goody's, etc.)? What was the effect?

Pain Medication	Dosage	How often	Effect

19. Have you had any of the following studies? ❑ X-Ray ❑ MRI/CT ❑ EMG ❑ Bone Scan
    Describe where/when completed: ____________________
20. **PERSONAL** Medical History: Have ***you*** ever had problems with any of the following? (Please check all that apply)
    ❑ Respiratory (Asthma/Lung Disease) ❑ High Blood Pressure ❑ HIV/AIDS ❑ Heart Disease/Arrhythmia
    ❑ Kidney or Liver Disease ❑ Diabetes ❑ Stroke/Seizure ❑ Sleep Apnea ❑ Congestive Heart Failure
    ❑ Gastritis/stomach ulcer ❑ Cancer ❑ Arthritis/Osteoporosis ❑ Thyroid ❑ Bleeding disorder/clotting
    Other problems (please explain): ____________________
21. **FAMILY** Medical History: Have ***your relatives*** had problems with any of the following? (Please check all that apply)
    ❑ Respiratory (Asthma/Lung Disease) ❑ High Blood Pressure ❑ HIV/AIDS ❑ Heart Disease/Arrhythmia
    ❑ Kidney or Liver Disease ❑ Diabetes ❑ Stroke/Seizure ❑ Thyroid ❑ Congestive Heart Failure
    ❑ Arthritis/Osteoporosis ❑ Cancer ❑ Bleeding disorder/clotting Other problems: ____________________
22. Please list any surgeries you have had and approximate dates:

Surgery	Physician	Date

23. Have you had any RECENT non-surgical hospitalization(s)? ❑ Yes ❑ No

Reason	Date	Hospital	Complications

24. What is your current work status: ❑ Working Full Duty ❑ Working Restricted Duty (Since__________)
    ❑ Disabled (Since__________) ❑ Unemployed ❑ Retired ❑ Student
25. Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
26. I live: ❑ Alone ❑ Assisted living/Nursing home ❑ Spouse/Family ❑ Other: ____________________
27. Have you ever been diagnosed with any of the following?
    ❑ Depression ❑ Anxiety ❑ Dementia ❑ Other Mental Illness (please explain) ____________________
28. If you have abused alcohol or drugs, please describe: ____________________
    ____
29. If your relatives have ever abused alcohol or drugs, please describe: ____________________
    ____
30. Are you involved in any litigation regarding this pain? ❑ Yes ❑ No (If yes, please list attorney below)
    Attorney:__________________ Contact Information (Phone or E-mail): ____________________
31. Please write additional information that you feel is important for us to know.
    ____
    ____

Thank you!