HEALTH HISTORY

Name: _____

Date: ____/____/____

SYMPTOMS: Check the symptoms you currently have or have had in the past year.

General
( ) Chills
( ) Depression
( ) Dizziness
( ) Fainting
( ) Fever
( ) Forgetfulness
( ) Loss of sleep
( ) Loss of weight
( ) Nervousness
( ) Numbness
( ) Sweat

Gastrointestinal
( ) Bloating
( ) Bowel changes
( ) Constipation
( ) Diarrhea
( ) Excessive hunger
( ) Gas
( ) Hemorrhoids
( ) Indigestion
( ) Nausea
( ) Poor appetite
( ) Rectal bleeding
( ) Stomach pain
( ) Vomiting
( ) Vomiting blood

Eye,Ear,Nose,Throat
( ) Bleeding gums
( ) Blurred vision
( ) Crossed eyes
( ) Difficulty swallowing
( ) Double vision
( ) Earache
( ) Ear discharge
( ) Hay fever
( ) Hoarsness
( ) Loss of hearing
( ) Nosebleeds
( ) Persistent Cough
( ) Ringing in ears
( ) Sinus problems
( ) Vision – Flashes/Halos

Cardiovascular
( ) Chest pain
( ) High blood pressure
( ) Irregular heart beat
( ) Low blood pressure
( ) Poor circulation
( ) Rapid heart beat
( ) Swelling of ankles
( ) Varicose veins

Skin
( ) Bruise easily
( ) Hives
( ) Itching
( ) Change in moles
( ) Rash
( ) Scars
( ) Sore that won't heal

Genito-Urinary
( ) Blood in urine
( ) Frequent urination
( ) Lack bladder control
( ) Painful urination

Conditions: Check the conditions you have or have had in the past.

( ) AIDS
( ) Alcoholism
( ) Anemia
( ) Anorexia
( ) Appendicitis
( ) Arthritis
( ) Asthma
( ) Bleeding Disorder
( ) Breast Lump
( ) Bronchitis
( ) Bulimia
( ) Cancer
( ) Cataracts
( ) Chemical Dependency
( ) Chicken Pox
( ) Diabetes
( ) Emphysema
( ) Epilepsy
( ) Glaucoma
( ) Goiter
( ) Gonorrhea
( ) Gout
( ) Heart Disease
( ) Hepatitis
( ) Hernia
( ) Herpes
( ) High Cholesterol
( ) HIV Positive
( ) Kidney Disease
( ) Liver Disease
( ) Measles
( ) Migraines
( ) Miscarriage
( ) Mononucleosis
( ) Multiple Sclerosis
( ) Mumps
( ) Pacemaker
( ) Pneumonia
( ) Polio
( ) Prostate Problems
( ) Psychiatric Care
( ) Rheumatic fever
( ) Scarlet Fever
( ) Stroke
( ) Suicide Attempt
( ) Thyroid Problems
( ) Tonsillitis
( ) Tuberculosis
( ) Typhoid Fever
( ) Ulcers
( ) Vaginal Infections
( ) Venereal Disease

(Over Please)

Medications (List medications you are currently taking.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergies (to medications or substances)

1. _____
2. _____
3. _____

Family History: (Check if your blood relatives had any of the following)

Disease	Relationship to you
Arthritis,Gout	_____
Asthma,Hayfever	_____
Cancer	_____
Chemical Dependency	_____
Diabetes	_____
Heart disease,Strokes	_____
High blood pressure	_____
Kidney Disease	_____
Tuberculosis	_____
Other	_____

Surgeries

Year	Hospital	Reason for Hospitalization
1.		
2.		
3.		

Health Habits: (Check the substances you use and how often.)

( ) Caffeine _____
( ) Tobacco _____
( ) Drugs (Illegal) _____
( ) Alcohol _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ Signature

_____ Date

THE PAIN TREATMENT CENTER
PATIENT REGISTRATION FORM

PATIENTS NAME: _____ _____ _____
LAST NAME FIRST NAME INITIAL

Hm. Address: _____ City: _____ Zip: _____

Hm. Phone#: _____ Alternate# _____ Sex: M____ F____

DOB: _____ SS# _____ Marital Status: S M D W O

Spouse Name: _____ Ph.# _____

Referred by: _____ Ph.# _____

PCP or Treating Dr.: _____ Ph.# _____

Emergency Contact: _____ Ph.# _____

Patient's Employer: _____ Ph.# _____

Is your medical condition related to an accident? YES_____ NO _____ DATE: _____

If yes, please mark: Work injury:_____ Automobile Accident: _____ Other: _____

Primary Ins.: _____ Ph.#: _____

Policy Holder: _____ Relationship: _____

DOB: _____ SS#: _____

Secondary Ins. _____ Ph.#: _____

Policy Holder: _____ Relationship: _____

DOB: _____ SS#: _____

Language: __English ___ Spanish ___ Other _____

Race: ___ White ___ African American ___ Asian ___ Other _____

Ethnicity: ___ American ___ Hispanic ___ Other _____

You must give us permission to bill your insurance company by singing the statement below.
I request that payment of authorized benefits be made directly to C.T. JUDY DAI, M.D.
I authorize the release of all information required to determine these benefits or the benefits payable to related services.

_____ _____
Signature Date

BRIEF PAIN INVENTORY

Date: ____/____/____

Name: _____
Last First Middle Initial

1. Marital Status (at present): ( )Single ( )Married ( )Widow ( )Separated/Divorced

2. Education (circle only the highest grade or degree completed):

Grade 0 1 2 3 4 5 6 7 8 9 10

11 12 13 14 15 16 M.A/M.S

Professional degree (please specify): _____

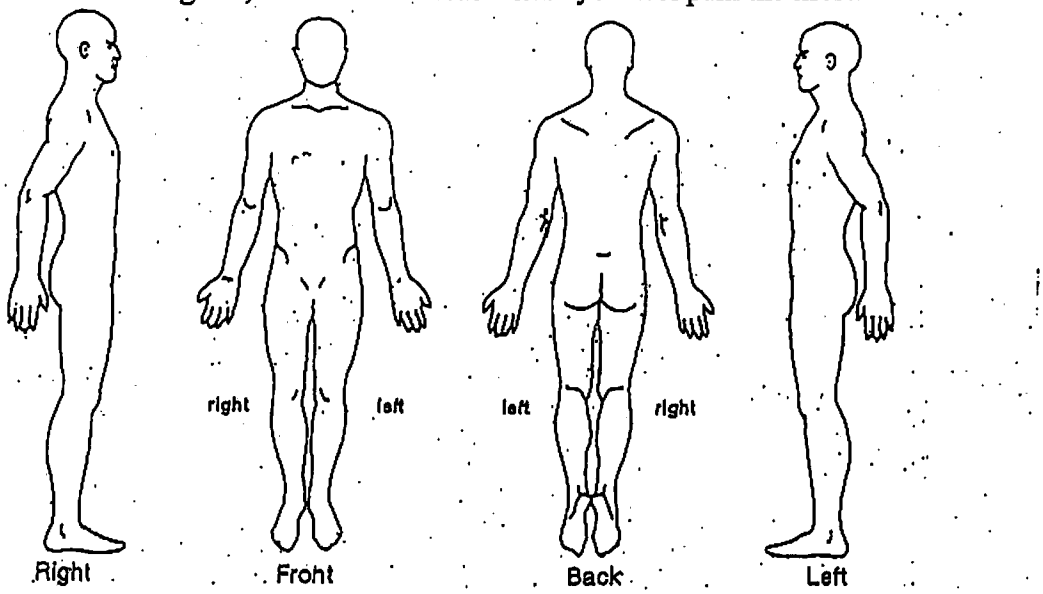
3. Current Occupation: _____
(specify titles: if you are not working tell us your previous occupation)

4. Spouses's Occupation: _____

5. For each of the following words, check yes or no if it applies to your pain.

Aching	( ) Yes	( ) No	Burning	( ) Yes	( ) No
Throbbing	( ) Yes	( ) No	Exhausting	( ) Yes	( ) No
Shooting	( ) Yes	( ) No	Tiring	( ) Yes	( ) No
Stabbing	( ) Yes	( ) No	Penetrating	( ) Yes	( ) No
Gnawing	( ) Yes	( ) No	Nagging	( ) Yes	( ) No
Sharp	( ) Yes	( ) No	Numb	( ) Yes	( ) No
Tender	( ) Yes	( ) No	Miserable	( ) Yes	( ) No

6. On the diagram, shade in the areas where you feel pain the most.



7. Please rate your pain by circling one number that best describes your pain at its worst in the last week.

0 1 2 3 4 5 6 7 8 9 10
No pain Severe Pain

8. Please rate your pain by circling one number that best describes your pain at its least in in the last week.

0 1 2 3 4 5 6 7 8 9 10
No pain Severe Pain

9. Please rate your pain by circling one number that best describes your pain on average.

0 1 2 3 4 5 6 7 8 9 10
No pain Severe pain

10. Please rate your pain by circling one number that tells how much pain your in now.

0 1 2 3 4 5 6 7 8 9 10
No pain Severe pain

11. What kind of things make your pain feel better (for example: heat, medicine, rest?)

_____

_____

12. What kind of things make your pain worse (for example: walking, standing, lifting?)

_____

_____

13. Circle the number that best describes during the last week, how pain has interfered with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10
No interference Completely interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10
No interference Completely interferes

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10
No interference Completely interferes

D. Normal work (includes housework and work outside the home)

0 1 2 3 4 5 6 7 8 9 10
No interference Completely interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10
No interference Completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10
No interference Completely interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
No interference Completely interferes