2124 Route 35 South,
Holmdel, NJ, 07733.

Tel: (732) 788 0349
Fax: (877) 211 6276
E-mail: info@gramercypaincenter.com
www.gramercypaincenter.com

Date:_____

Name: _____
(Last) (First) (Middle)

Address: _____
(City) (State) (Zip)

Home: (___) _____ Work: (___) _____ Cell: (___) _____

Age: _____DOB:_____ SS#:_____ Email: _____

M F Height: _____ Weight: _____ Occupation: _____

Emergency Contact: _____ Tel. # (____)_____

Referring MD: _____ Telephone: (____) _____

Address: _____
(City) (State) (Zip)

Primary MD: _____ Telephone: (____) _____

Address: _____
(City) (State) (Zip)

Primary Insurance Carrier: _____

Policy Number: _____

Secondary Insurance: _____

Pharmacy Name, Address, Phone #: _____

Expected Goals from Treatment at Gramercy Pain Center:

_____

_____

_____

Chief Complaint: _____

_____

Medical History: ***Please*** ***list all issues***

_____

_____

_____

_____

Surgical History: ***List type of surgery***

_____

_____

_____

Allergies:

Do you have any allergies to medication, foods, dye (iodine)? ☐ Yes ☐ No

If yes please list: _____

Any **Latex allergies?** ☐ Yes ☐ No *Reaction:* _____

Pain Medications:
Please list all your current **pain** medications-prescriptions and non-prescriptions: *(please include your dosage and how many per day)*

_____ _____ _____

_____ _____ _____

Please list all your current **non-pain** medications: *(please give doses and how often you take your medication incl*uding **non-prescription** and **herbal**)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

List any doctors, chiropractors, physical therapy, treatment plans or other health care professionals who have treated your pain and treatment done:

_____

_____

Family History of Medical Problems: _____

_____

Social History:

Do smoke / Did smoke / Never smoked Packs per day: _____ For how many years:_____

Do you drink alcohol? □ Yes □ No What do you drink: _____ How frequent: _____

Have you ever used any illegal/illicit drugs? □ Yes □ No (i.e.: marijuana, heroin, cocaine, etc.)

Please explain and list: _____

Marital status: □ Single □ Married □ Divorced □ Widowed □ Other: _____

With whom do you live? _____ No. of children: _____

Are there any substance abuse issues in the household? □ Yes □ No

If yes, please explain: _____

Are you able to take care of yourself? □ Yes □ No
If no please enter name of care giver: _____

Work History	Job	Yrs Worked	Reason for leaving
_____		_____	_____
_____		_____	_____

Legal Matters

Are you presently involved in a lawsuit? □ Yes □ No

If yes please explain: _____

Are you filing for disability? □ Yes □ No

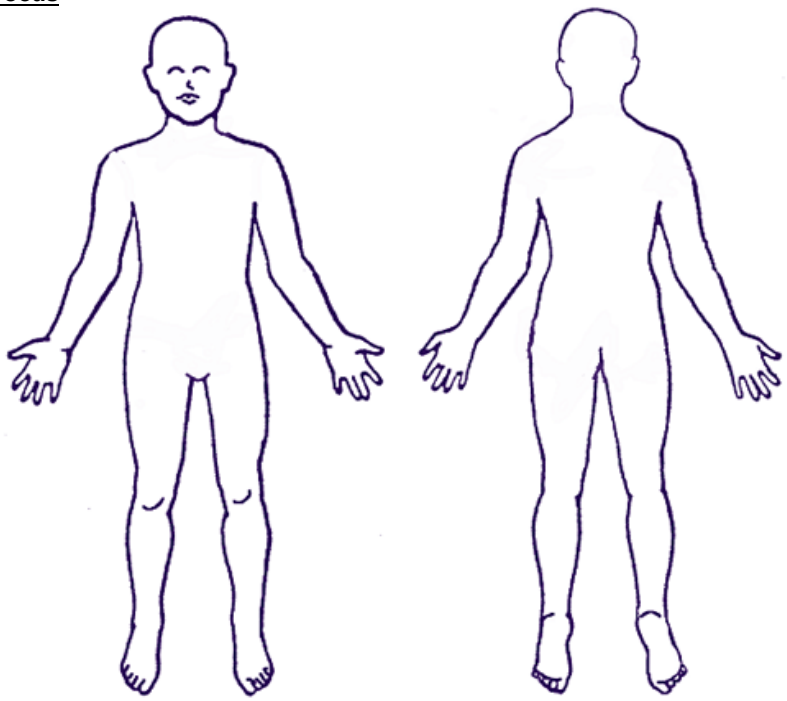
*If yes please explain:*_____

Review of System:

Have you ever had any of the following? *(Please check either Yes or No)*

	Yes	No		Yes	No		Yes	No
Anemia	☐	☐	Epilepsy/Seizures	☐	☐	Migraines	☐	☐
Anorexia	☐	☐	Glaucoma	☐	☐	Mitral valve prolapse	☐	☐
Arthritis	☐	☐	Heart Disease	☐	☐	Multiple Sclerosis	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐	Mumps	☐	☐
						Pacemaker	☐	☐
			Hepatitis: type: _____			Pneumonia	☐	☐
Back Problem	☐	☐				Stroke	☐	☐
Bleeding tendency	☐	☐	☐when:_____			Thyroid Problem	☐	☐
Blood disease	☐	☐	Hernia	☐	☐	Tonsillitis	☐	☐
Cancer	☐	☐	Herpes	☐	☐	Tuberculosis	☐	☐
Chemotherapy	☐	☐	High blood pressure	☐	☐	Ulcer	☐	☐
Chicken Pox	☐	☐	HIV/AIDS	☐	☐	Depression/ Anxiety		
Chronic fatigue syndrome	☐	☐	Jaundice	☐	☐	GERD/Indigestion		
Circulatory problems	☐	☐	Kidney disease	☐	☐	Other Psychiatric conditions:_____		
Cough (persistent or bloody)	☐	☐	Liver disease	☐	☐			
Diabetes	☐	☐	Low blood pressure	☐	☐	Other conditions: _____		
Emphysema/COPD	☐	☐	Measles	☐	☐	_____		

Physical Exam & Pain Focus



1. Please indicate on the diagram above the **location of your pain**. Use an asterisk (*) to show where the pain starts and is most severe. Use an arrow to show the direction or how the pain travels. You may use more than one asterisk and arrow. By each asterisk please rate the level of pain using 0-10.

2. **Pain site in order of severity**: 1_____ 2_____ 3_____

3. Please check the **words that best describe your pain**:

□ Dull	□ Stabbing	□ Tender	□ Shock like	□ Numb	□ Throbbing	□ Gnawing
□ Burning	□ Penetrating	□ Unbearable	□ Shooting	□ Sharp	□ Tingling	□ Nagging

4. **What time of day is your pain the <u>worst</u>**? (Please check one) □ Morning □ Afternoon □ Evening □ Night Time

Please rate your pain **WHEN IT IS WORST** on the numerical scale below. "0" indicates no pain. "5" indicates mild to discomforting pain. "10" indicates severe, excruciating and debilitating pain.

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild		Discomforting		Distressing		Horrible		Excruciating

5. **What time of day is your pain the <u>least</u>**? (Please check one) □ Morning □ Afternoon □ Evening □ Night Time

Please rate your pain **WHEN IT IS LEAST** on the numerical scale below. "0" indicates no pain. "5" indicates mild to discomforting pain. "10" indicates severe, excruciating and debilitating pain.

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild		Discomforting		Distressing		Horrible		Excruciating

6. **Duration of pain** _____

7. **What makes the pain worse**: _____

8**. What makes the pain better:** _____