JEFFREY WARD, MD
REHABILITATION MEDICINE / PAIN MANAGEMENT
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Last Name _____ First Name _____ MI _____

Date of Birth _____

Home Address_____
Street *City* *State* *Zip*

Mailing Address if different_____
Street *City* *State* *Zip*

Home Phone _____ Work Phone _____ Other/Cell Phone _____

Email _____

In case of a future appointment, please send appointment reminder by (please circle) Email / Phone / Neither

EMPLOYMENT INFORMATION (if employed)

Employer Name: _____

Responsible Person: (if different from patient) Relationship to Patient _____

Last Name _____ First Name _____Telephone # _____

Address_____
Street *City* *State* *Zip*

EMERGENCY CONTACT

Name _____ Telephone # _____ Relationship to Patient _____

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Insurance _____

Member ID Number _____ Group # _____

Name of Subscriber (if not self) _____

Relationship to Patient: □ Self □ Parent □ Spouse □ Partner □ Other

SECONDARY INSURANCE

Name of Insurance _____

Member ID Number _____ Group # _____

Name of Subscriber (if not self) _____

Relationship to Patient: □ Self □ Parent □ Spouse □ Partner □ Other

Chief Complaint: _____ When did it start? _____

HISTORY OF PRESENT ILLNESS: (circle all that apply)

Pain has been present for: Days / Weeks / Months / Years / Decades
Pain is: Improving / Worsening / Stable / Constant / Intermittent
Pain is due to: Car accident / Injury / Unknown / Other: _____

Is there a related lawsuit or workers compensation claim? Yes / No

Do particular positions or activities worsen the pain? _____

What reduces the pain? _____

Is there new: Weakness (not pain related) / Loss of feeling / Bowel/bladder accidents?

Prior therapies, injections, treatments: _____

Current Physicians: PCP:_____ Surgeon:_____Other:_____

PAST MEDICAL HISTORY: (circle all that apply)
Diabetes Heart disease High blood pressure Cancer Stroke Lung disease Liver disease
Kidney disease Ulcers Depression Asthma Other: _____

PAST SURGICAL HISTORY: _____

MEDICATIONS: _____
_____

OVER THE COUNTER MEDICATIONS: _____

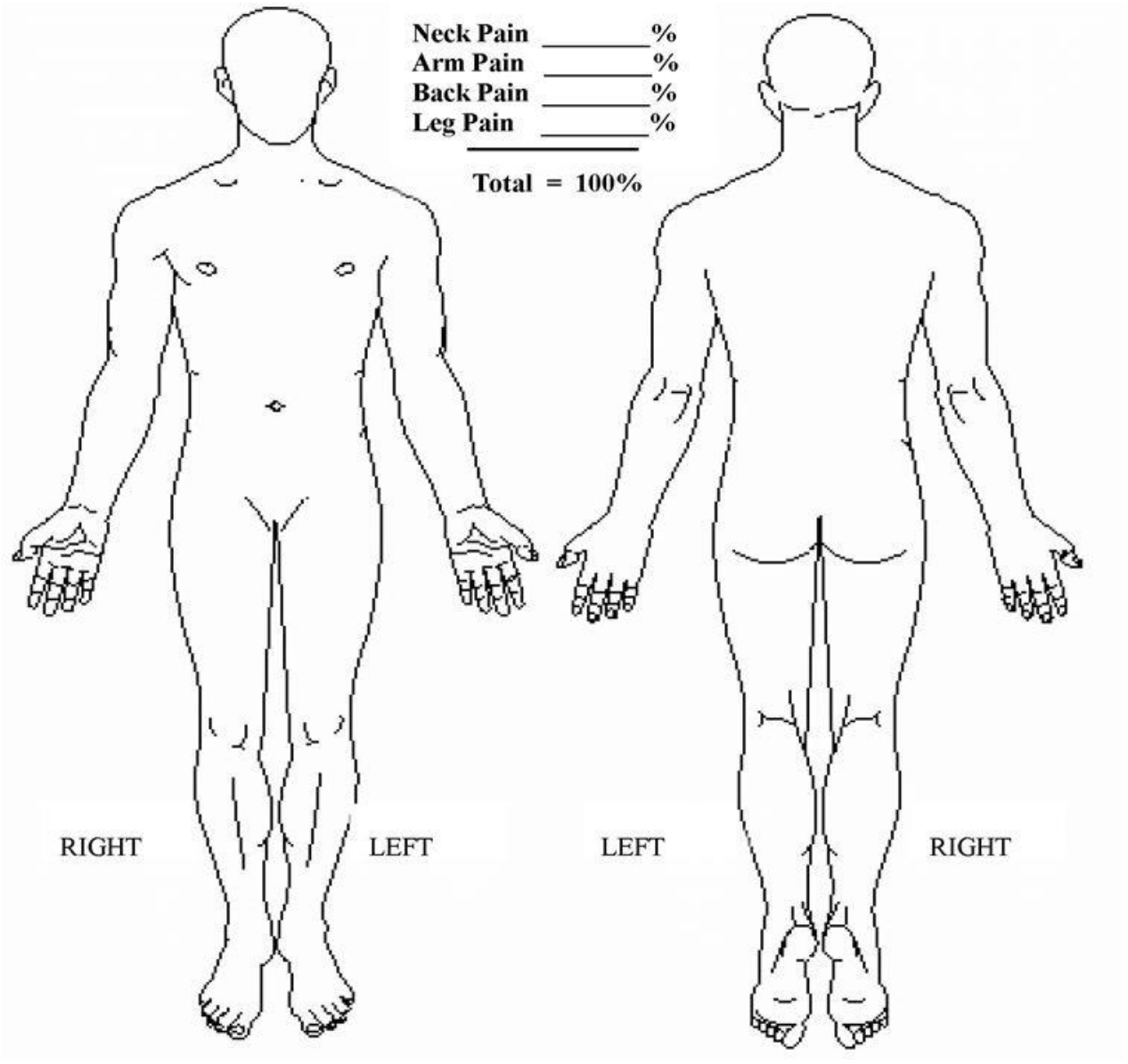
MEDICATION ALLERGIES: _____

SOCIAL HISTORY: (circle all that apply)
Married / Single / Divorced / Widowed Do you have children (how many)?_____
Alcohol Use: _____ Tobacco use: _____ Street Drugs: _____
Highest Level of Education: Grade school / HS / GED / Trade school / College / Post-grad
Occupation: Last worked:
Hobbies:
Goals of Treatment:

FAMILY HISTORY:
Heart disease / Cancer / Neurological disease / Stroke / Substance abuse / Other

REVIEW OF SYSTEMS: (*only circle if new complaint*)
Weight loss / Fever / Dizziness / Recent change in vision or double vision / Chest pain / Shortness of breath / Wheezing / Nausea / Vomiting / Diarrhea / Constipation / Bloody stools / Blood in urine / Rash / Easy bruising / New onset seizures / Recent memory loss / Hot or cold temperature intolerance / Suicidal thoughts / Sexual problems or decreased libido / Fatigue / Headache

On the diagrams below, shade in the areas where you have pain. Place an X in the area of your worst pain.



How bad is your pain now?

❶_____❷_____❸_____❹_____❺_____❻_____❼_____❽_____❾_____❿

NO PAIN INTERMEDIATE PAIN WORST PAIN