NOVA INTERVENTIONAL
PAIN AND SPINE

PATIENT HISTORY

PLEASE BRING TO YOUR APPOINTMENT – DO NOT MAIL

Date of Initial Visit: _____ Referring Provider: _____ Clinic: _____

Evaluation: Patient Last Name: _____ Patient First Name: _____ MI: _____

Date of Birth: _____ Patient Age: _____ Height: _____ Weight: _____

Primary Care Provider: _____ Clinic/Practice: _____

INSURANCE INFORMATION

Primary Provider: _____
ID Number: _____
Subscriber: _____

Relationship to Patient:
☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Provider: _____
ID Number: _____
Subscriber: _____

Relationship to Patient:
☐ Self ☐ Spouse ☐ Parent ☐ Other

CURRENT PHARMACY

Pharmacy Phone Number: _____ Pharmacy Name: _____

Pharmacy Address: _____

_____

MEDICATIONS

Allergies:_____

_____

_____

Current Medications: _____

_____

_____

Are you taking medications to treat Diabetes? No ☐ Yes ☐

Are you taking blood thinning medications? No ☐ Yes ☐

***Females Only*:**

Is there any chance you could be pregnant? No ☐ Yes ☐

Date of your last menstrual cycle: _____

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History of Present Illness

Chief Complaint (reason for visit): _____

_____

How long have you had the pain you currently feel? _____

What caused the pain to start? _____

_____

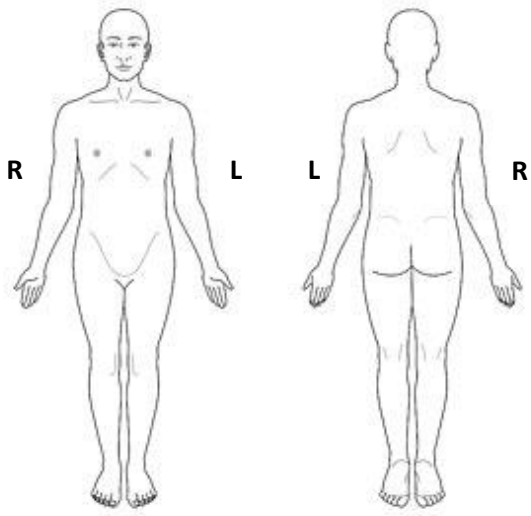
Pain level today: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (unbearable)

Over the past 2 weeks, please identify your pain levels below:

Average pain level: 0 1 2 3 4 5 6 7 8 9 10

Severe pain level: 0 1 2 3 4 5 6 7 8 9 10

Please shade in the areas where you have pain in the diagram below.



Is this pain the result of an injury? _____

Complete this section only if condition is a result of an accident or injury.

Is the pain from an automobile accident or work-related injury? _____

Date of injury: _____

Location of accident: _____

How did accident occur? _____

If work-related injury, please provide employer and phone number: _____

_____

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What is the quality of the pain?

☐ Aching	☐ Cramping	☐ Nagging	☐ Raw	☐ Sore	☐ Tightness
☐ Burning	☐ Drilling	☐ Penetrating	☐ Sharp	☐ Stabbing	☐ Undetermined
☐ Cold	☐ Gnawing	☐ Pins & Needles	☐ Shock-like	☐ Stinging	☐ No change since onset
☐ Crushing	☐ Heaviness	☐ Pressure	☐ Shooting	☐ Throbbing	☐ Other: _____

Associated Symptoms

Numbness or Tingling (Arms/Legs): _____

Weakness (Arms/Legs): _____

Urinary Incontinence: _____

Loss of Control of Bowels: _____

Swelling – Where? _____

Redness: _____

Cool or pale skin: _____

Other: _____

Prior Diagnostic Testing

Test Type	Date	Location
X-Ray		
MRI		
EMG		
CT Scan		
Myelogram		

Prior Treatment

Treatment Type	Have you tried?	Pain relief: Y/N	When
Physical Therapy/TENS			
Prior Pain Clinic			
Chiropractor/Acupuncture			
Injections			

Past Medical History

Please circle if you have a history of any of the following.

Neurological
Migraines
Seizures

Psychiatric
Anxiety
Bipolar
Depression
Panic Attacks

Cardiovascular
A-Fib
CAD
High Blood Pressure
High Cholesterol
Stroke

Respiratory
Asthma
COPD
Emphysema
Lung Disease
Sleep Apnea
Tuberculosis

Endocrine/Immune
Overactive Thyroid
Cancer
Diabetes
Hepatitis
HIV/AIDS
Underactive Thyroid

Gastrointestinal
Bleeding Ulcers
Cirrhosis
Gallbladder Problems
IBS
Liver Disease
Liver Failure
Hepatitis A, B, C

Genitourinary
Kidney Disease
Kidney Failure
Kidney Stones

Musculoskeletal
Gout
Degenerative Disk Disease
Osteoarthritis
Osteopenia
Osteoporosis
Rheumatoid Arthritis

Hematologic
Anemia
Blood Clots
Hemophilia

Past or Present
Emotional Abuse
Sexual Abuse
Substance Abuse
Physical Abuse

Other: _____

_____

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Past Surgical History

Type of Surgery	Date	Were there any complications? (Y/N)

Social History

Do you currently use tobacco? (Y/N) _____ Type: _____ QTY: _____ Day Week Month

Do you drink alcohol? (Y/N) _____ Type: _____ QTY: _____Day Week Month

Do you have problems with alcohol use or dependency? (Y/N) _____

Do you use illicit drugs? (Y/N) _____ Type: _____

Have you ever abused prescription drugs? (Y/N) _____

Was a doctor ever concerned or said you were becoming addicted to prescription drugs? (Y/N) _____

Mood

Has the pain affected your mood? (Y/N) _____ If so, how? _____

Have you ever had thoughts of wanting to die? (Y/N) _____

Do you have thoughts of harming yourself or another? (Y/N) _____ If yes, please explain: _____

Employment History

Current or Last Job: _____ Employer: _____

Present Employment Status: ☐ Full Time ☐ Part Time ☐ Leave of Absence ☐ Self-Employed ☐ Retired ☐ Homemaker

Are you still working? (Y/N) _____ If no, when was your last day of work? _____

Are you disabled? (Y/N) _____ Are you receiving disability payments? (Y/N) _____ If yes, how long? _____

Do you have a Worker's Compensation or Social Security disability application pending? (Y/N) _____

Are you now, or do you anticipate a lawsuit because of your pain or injury? (Y/N) _____

Please be aware this Patient Medical History must be completed and signed prior to your appointment. If help is needed with this form, the patient or patient's representative must arrive at least 45 minutes prior to appointment time so that we can assist, otherwise, the appointment will need to be re-scheduled for a later date.

_____ _____
Patient Signature Date

_____ _____
Reviewed by Date