Align Interventional Pain
E. MORGAN POLLARD, M.D.

New Patient Information

Name:_____ Date of Birth: _____

Reason for Visit: ☐ Back Pain ☐ Neck Pain ☐ Other_____

When did the pain begin (approximate month, year)? _____

Did the pain begin after an accident or injury? If yes, briefly describe:

_____

Please rate the severity of your pain on a scale of 1-10. Pain of 1 is just noticeable, Pain of 10 is the worst pain you've experienced.

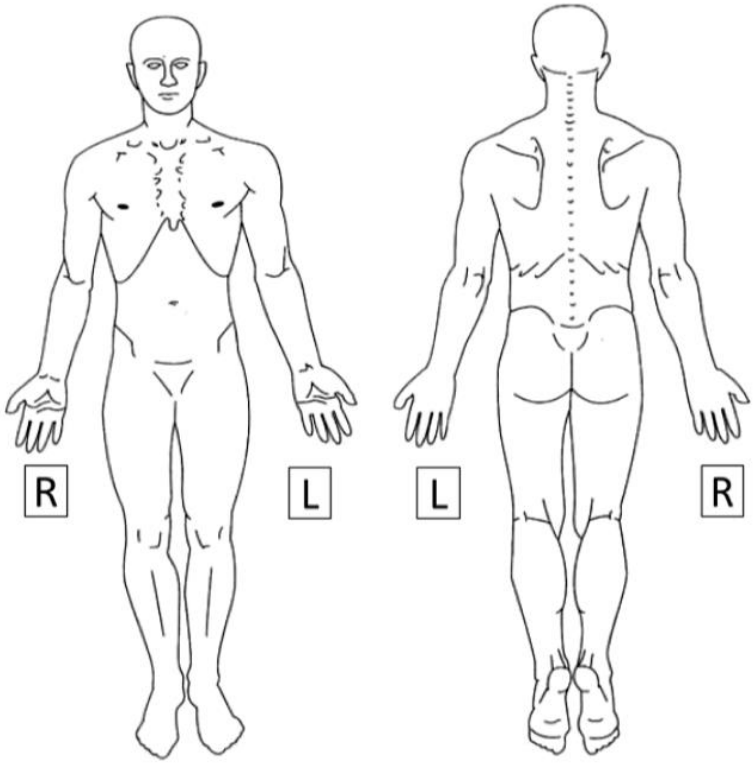
Today: _____ / 10 Good days: ___ / 10 Bad Days: ___ / 10

How often do you have pain? ☐ Occasionally (25% of the time) ☐ Intermittently (50% of the time) ☐ Frequently (75% of the time) ☐ Constantly (100% of the time)

What makes your pain better? ☐ Walking ☐ Laying down ☐ Leaning forward ☐ Rest ☐ Heat ☐ Ice ☐ Previous interventions: _____ ☐ Medications: _____ ☐ Other: _____

What makes your pain worse? ☐ Standing ☐ Sitting ☐ Laying down ☐ Walking ☐ Bending forward ☐ Bending Backward ☐ Standing from chair ☐ Coughing/Sneezing ☐ Lifting ☐ Exercise ☐ Other: _____

Please mark the location of your pain.



Please use the following symbols:

Aching: XXXXXXX

Burning: ^^^^^^^^

Stabbing: ////

Numbness: ======

Pins and Needles: +++++

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Do you have any of the following symptoms?

☐ Fevers ☐ Bowel Incontinence ☐ Bladder Incontinence ☐ Joint Swelling

☐ Weakness in arms/legs ☐ Numbness or tingling (in area that would touch a saddle if you were riding a horse)

Have you ever had surgery on your back, neck, or joints? Circle one. YES NO

If yes, please list:

SURGERY	SURGEON	YEAR	Were symptoms better, same, or worse after?

What have you tried for your pain?

☐ Physical Therapy ☐ Chiropractic care ☐ Heat ☐ Massage ☐ Acupuncture

☐ TENS ☐ Psychotherapy ☐ Biofeedback ☐ Injections

☐ NSAIDs (ibuprofen/Advil, naproxen/Aleve) ☐ acetaminophen (Tylenol)

☐ gabapentin (Neurontin) ☐ pregabalin (Lyrica) ☐ duloxetine (Cymbalta)

☐ Opioids: please list _____

☐ Other: _____

Have you had any imaging studies to investigate your pain?

☐ MRI ☐ X-ray ☐ CT scan ☐ EMG ☐ Bone Scan ☐ Other: _____

Medications:

Please list all medications including herbal and over-the counter drugs. If needed we will provide additional paper.

If taking opioids or any other controlled substance, please list name of prescribing physician.

NAME OF MEDICATION	DOSE and FREQUENCY

Are you taking any blood thinners?

☐ Coumadin (Warfarin) ☐ aspirin ☐ Pradaxa (dabigatran) ☐ Xarelto (rivaroxaban)

☐ Plavix (clopidogrel) ☐ Lovenox (enoxaparin) ☐ Other: _____

Reason for taking blood thinners: _____

Prescribing physician: _____

Review of Systems:

Please check below if you have experienced any of these symptoms in the past 6 months:

Fever	Y☐ N ☐	Palpitations	Y☐ N ☐	Seizures	Y☐ N ☐
Weight gain	Y☐ N ☐	Shortness of breath	Y☐ N ☐	Psychological problems	Y☐ N ☐
Weight loss	Y☐ N ☐	Abdominal pain	Y☐ N ☐	Depression	Y☐ N ☐
Chills/Night sweats	Y☐ N ☐	Black/tarry stools	Y☐ N ☐	Anxiety	Y☐ N ☐
Changes to vision	Y☐ N ☐	Urinary Incontinence	Y☐ N ☐	Fatigue	Y☐ N ☐
Dental problems	Y☐ N ☐	Leg or arm swelling	Y☐ N ☐	Swollen glands	Y☐ N ☐
Chest pain	Y☐ N ☐	Skin wounds	Y☐ N ☐	Easy bruising	Y☐ N ☐
Irregular heart beat	Y☐ N ☐	Rash	Y☐ N ☐	Easy bleeding	Y☐ N ☐

Allergies:

☐ No Known Medication Allergies

Please list all medications you are allergic to, including iodine contrast and latex

MEDICATION	REACTION

Past Medical History:

Please check any of the following medical illnesses that you have been diagnosed with, and list the approximate year of diagnosis. Please list any other medical illnesses you have under "Other".

☐ Anxiety/Depression – year of diagnosis: _____

☐ Diabetes – year of diagnosis: _____

☐ High blood pressure – year of diagnosis: _____

☐ Heart disease – year of diagnosis: _____

☐ Neurological disease: _____ – year of diagnosis: _____

☐ Lung disease – year of diagnosis: _____

☐ Cancer – type: _____ – year of diagnosis: _____

☐ Rheumatologic disease (autoimmune)- type: _____ – year of diagnosis:_____

☐ Vascular disease – year of diagnosis: _____

☐ Kidney disease – year of diagnosis: _____

☐ Bipolar disorder – year of diagnosis: _____

☐ Schizophrenia – year of diagnosis: _____

☐ Substance use disorder – year of diagnosis: _____

☐ GI Bleed – year of diagnosis: _____

☐ Other: _____

Social History:

Things you enjoy: _____

Who do you live with? _____

Employment Status:

- ☐ Employed Full Time – Occupation: _____
- ☐ Employed Part Time – Occupation: _____
- ☐ Retired – prior Occupation: _____
- ☐ Unemployed – prior Occupation: _____
- ☐ Disabled – prior Occupation: _____
- ☐ Work in the home (ex. "home-maker", "stay-at-home parent", etc.)
- ☐ Student – field of study: _____

Do you smoke? YES NO

If yes: Packs/day: _____ Years: _____

Do you use alcohol? YES NO

If yes: Drinks/day:_____ Years:_____

Other substance use? YES NO

If yes: List substances:_____ Last used: _____

Have you ever been to therapy, rehab, or been hospitalized due to substance use?

_____

Family History:

CONDITION	RELATION
☐ Back pain	
☐ Neck pain	
☐ Autoimmune or Rheumatologic disease	
☐ Cancer	
☐ Neurologic disease	
☐ Depression or anxiety	
☐ Other psychiatric disease: _____	
☐ Substance use disorder	
☐ Other condition(s) which you feel might be important to mention: _____	