NEW PATIENT FORM

Welcome to Munshi Modern Pain. Your completed paperwork will help us get you know you and your medical history. We appreciate the time you've taken to fill out our form and your answers will allow us to create an individualized treatment plan for your pain. Please do not hesitate to ask our front staff if you have any questions regarding this form.

Name:_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

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

Date of Birth: _____

Email: _____

Primary Care Physician: _____ **Referring Physician:** _____

Preferred Pharmacy: _____

Pharmacy Address: _____

Pharmacy Phone: _____

Primary Insurance Payer: _____ **Plan:** _____

Policy/ID#: _____ **Group #:** _____

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Secondary Insurance Payer: _____ Plan:_____

Policy/ID#: _____ Group #: _____

Where is your primary pain? _____

How long has it been present? _____

Pain Intensity? (Rate 0 – 10, zero being no pain and ten being the type of pain that makes you pass out):

Today: _____ Worst: _____ Best: _____ Average: _____

What caused your pain? (Circle all that apply)

Gradually Suddenly Fall Lifting Bending Jumping

Car accident Work injury Other: _____

How often is your pain? (Circle): *Constant or Intermittent*

When is your pain worst? (Circle): *Morning, During day, Evenings*

Describe the pain symptoms: (Circle all that apply)

Aching Dull Cramping Throbbing Sore Sharp Pressure Burning

Stabbing Numb Pins/needles Tingling Lightning/electrical Spasming

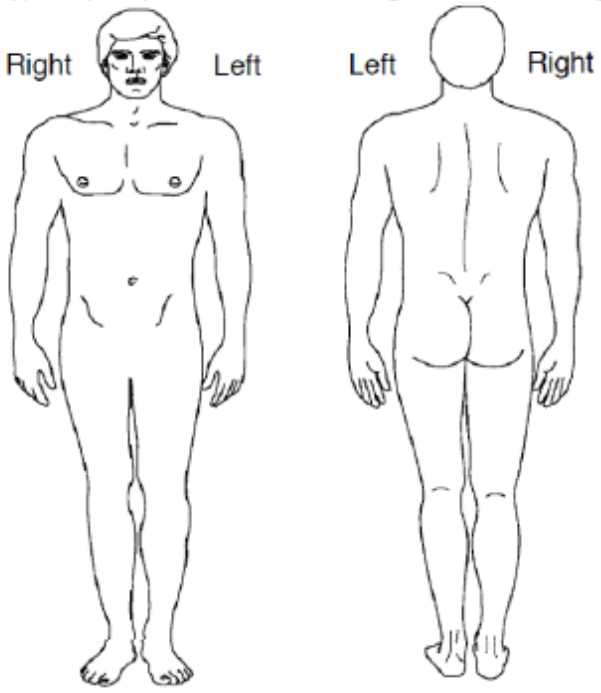
Does your pain travel or radiate to other areas of your body? (Circle)

Left: Head, Shoulder, Arm, Hand, Leg, Ankle, Top of foot, Bottom of foot

Right: Head, Shoulder, Arm, Hand, Leg, Ankle, Top of foot, Bottom of foot

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

"N" = numbness
"S" = stabbing
"B" = burning
"P" = pins and needles
"A" = aching



What makes your pain worse? (Circle all that apply)

Bending forwards Bending backwards Prolonged sitting Prolonged standing

Going upstairs Going downstairs Lifting Walking Increased activity

What makes your pain better? (Circle all that apply)

Lying flat Rest Heat Ice Massage Physical Therapy

Sitting Standing Exercise Injections Walking Medications

Stretching Leaning forward Leaning backwards Nothing

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Do you have any the following associated symptoms? (Circle all that apply)

New bowel incontinence *New bladder incontinence* *Fever*

Chills *Balance difficulties* *Unexpected weight loss* *History of cancer*

*Numbness (where?)*_____ *Motor weakness (where?)* _____

Previous medications tried in past to treat your pain?

_____ _____ _____ _____

_____ _____ _____ _____

What conservative treatments have you tried so far? (Circle all that apply)

Physical Therapy *Chiropractor* *Massage therapy* *TENS unit*

Acupuncture *Aquatic therapy* *Ultrasound* *Psychology*

Any interventional procedures tried in the past? (Circle all that apply)

Epidural steroid injections *Facet injections* *Radiofrequency ablation*

Sacroiliac joint injections *Trigger point injections* *Spinal cord stimulation*

Intrathecal pain pump *Joint injections* *Nerve blocks*

Past Medical History:

Mark the following conditions/diseases that you have been treated for in the past:

General Medical
- ❑ Cancer – Type _____
- ❑ Diabetes – Type _____
- ❑ HIV / AIDS

Head/Eyes/Ears/Nose/Throat
- ❑ Glaucoma
- ❑ Headaches
- ❑ Head Injury
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Migraines

Cardiovascular / Hematologic
- ❑ Anemia
- ❑ Bleeding Disorders
- ❑ Coronary Artery Disease
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Mitral Valve Prolapse
- ❑ Murmur
- ❑ Pacemaker/Defibrillator
- ❑ Phlebitis
- ❑ Poor Circulation
- ❑ Stroke

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema / COPD
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Valley Fever

Gastrointestinal
- ❑ Bowel Incontinence
- ❑ Acid Reflux (GERD)
- ❑ Gastrointestinal Bleeding
- ❑ Constipation

Musculoskeletal
- ❑ Amputation
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Chronic Low Back Pain
- ❑ Chronic Neck Pain
- ❑ Chronic Joint Pain
- ❑ Fibromyalgia
- ❑ Joint Injury
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Phantom Limb Pain
- ❑ Rheumatoid arthritis
- ❑ Tennis Elbow
- ❑ Vertebral Compression Fracture

Genitourinary/Nephrology
- ❑ Bladder Infection(s)
- ❑ Dialysis
- ❑ Kidney Infection(s)
- ❑ Kidney Stones
- ❑ Urinary Incontinence

Hepatic
- ❑ Hepatitis A (active / inactive / unsure)
- ❑ Hepatitis B (active / inactive / unsure)
- ❑ Hepatitis C (active / inactive / unsure)

Neuropsychological
- ❑ Alcohol Abuse
- ❑ Alzheimer Disease
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Epilepsy
- ❑ Prescription Drug Abuse
- ❑ Multiple Sclerosis
- ❑ Paralysis
- ❑ Peripheral Neuropathy
- ❑ Schizophrenia
- ❑ Seizures
- ❑ Reflex Sympathetic Dystrophy/CRPS
- ❑ Other Diagnosed Conditions

_____

Past Surgical History: _____

_____

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Current Medications:

Please indicate which (if any) of the following **blood-thinners** you are taking:

❑ Aggrenox ❑ Coumadin ❑ Effient ❑ Eliquis ❑ Lovenox ❑ Plavix ❑ Pletal ❑ Pradaxa

❑ Ticlid ❑ Warfarin ❑ Xarelto ❑ Other _____

Please list **ALL** medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Allergies: _____

Family History:

Mark all appropriate diagnoses as they pertain to your biological *MOTHER AND FATHER* only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother													
Father													

Other medical problems: _____

❑ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY ❑ I AM ADOPTED (No Medical History Available)

Social History:

Are you capable of becoming pregnant? ❑ Yes ❑No *If so*, are you currently pregnant? ❑ Yes ❑No

Highest level of education obtained: ❑ Grammar school ❑ High School ❑ College ❑ Post-graduate

Alcohol Use: ❑ Current Alcoholism ❑ Daily Limited Alcohol Use ❑ History of Alcoholism
❑ Never Drinks Alcohol ❑ Social Alcohol Use

Tobacco Use: ❑ Current Tobacco User ❑ Former Tobacco User ❑ Never Used Tobacco

Illegal Drug Use: ❑ Denies Any Illegal Drug Use ❑ Currently Using Illegal Drugs (Which: _____)

Review of Systems:

Mark the following symptoms that you currently suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.*

Constitutional:	❑ Chills	❑ Difficulty Sleeping	❑ Easy Bruising
❑ Excessive Sweating	❑ Excessive Thirst	❑ Fatigue	❑ Fevers
❑ Insomnia	❑ Low Sex Drive	❑ Night Sweats	❑ Tremors
❑ Unexplained Weight Gain	❑ Unexplained Weight Loss	❑ Weakness	
Eyes:	❑ Recent Visual Changes		
Ears/Nose/Throat/Neck:	❑ Dental Problems	❑ Earaches	❑ Hearing Problems
❑ Nosebleeds	❑ Recurrent Sore Throats	❑ Ringing in the Ears	❑ Sinus Problems

Cardiovascular: ❑ Bleeding Disorder ❑ Chest Pain ❑ Deep Vein Thrombosis
❑ Fainting ❑ High Blood Pressure ❑ Irregular Heartbeat ❑ Lightheadedness
❑ Shortness of Breath During Sleep ❑ Swelling in the Feet

Respiratory: ❑ Cough ❑ Wheezing ❑ Pulmonary Embolism
❑ Shortness of Breath on Exertion/Effort ❑ Shortness of Breath at Rest

Gastrointestinal: ❑ Abdominal Cramps ❑ Acid Reflux ❑ Constipation
❑ Coffee Ground Appearance in Vomit ❑ Dark and Tarry Stools ❑ Diarrhea
❑ Hernia ❑ Vomiting

Musculoskeletal: ❑ Back Pain ❑ Joint Pain ❑ Joint Stiffness
❑ Joint Swelling ❑ Muscle Spasms ❑ Neck Pain

Genitourinary/Nephrology: ❑ Blood in Urine ❑ Decreased Urine Flow/Frequency/Volume
❑ Erectile Dysfunction ❑ Flank Pain ❑ Painful Urination ❑ Pelvic Pressure

Neurological: ❑ Carpal Tunnel Syndrome ❑ Dizziness ❑ Headaches
❑ Instability When Walking ❑ Numbness/Tingling ❑ Seizures ❑ Tremors

Psychiatric: ❑ Depressed Mood ❑ Feeling Anxious ❑ Stress Problems
❑ Suicidal Thoughts ❑ Suicidal Planning