INTERVENTIONAL PAIN MANAGEMENT

PATIENT NAME ______________________________ DATE OF BIRTH ______________________________

REFERRING PHYSICIAN ______________________________ PHYSICIAN'S PHONE NUMBER ____________________

PRIMARY CARE PHYSICIAN ______________________________ PHYSICIAN'S PHONE NUMBER ____________________

YOUR INSURANCE CO ______________________________ POLICY NUMBER ______________________________

ARE YOU INVOLVED IN ANY COURT CASES? ☐ YES ☐ NO

IS YOURS A WORKER'S COMPENSATION CLAIM ☐ YES ☐ NO

AS YOU UNDERSTAND IT, WHY DID YOUR PHYSICIAN REFER YOU TO OUR CLINIC?

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ON A SCALE OF 1 TO 10, 10 BEING THE WORST PAIN YOU HAVE EVER FELT, WHAT DO YOU RATE YOUR PAIN?

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PLEASE LIST ALL CURRENT MEDICATIONS AND DOSES

MEDICATIONS	MEDICATIONS

DO YOU TAKE AMY BLOOD THINNERS LIKE **PLAVIX, COUMADIN,** OR **LOVENOX?** ☐ YES ☐ NO

ARE YOU CURRENTLY TAKING ASPIRIN? ☐ YES ☐ NO

PLEASE LIST ANY OTHER MEDICAL PROBLEMS THAT YOU HAVE. (ALERGIES, ASTHMA, DIABETES, HIGH BLOOD PRESSURE, ETC)

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PLEASE LIST ANY PREVIOUS PAIN PROCEDURES OR INJECTIONS THAT YOU HAVE HAD IN THE PAST.

INJECTION OR PROCEDURE	DATE	INJECTION OR PROCEDURE	DATE