PAINMED P.C.

MICHAEL P. TOSHOK, D.O.

Specializing in Evaluation & Treatment of Chronic Pain

Demographics

Name (first, mi, last):_____ **DOB:**___/___/_____

Address (no PO Box please): _____

_____

SSN: _____ - ____ - _____ **Gender:** ☐ M ☐ F **Marital Status:** ☐ S ☐ M ☐ D ☐ W

Ethnicity: ☐ Latino ☐ Not Latino ☐ Declined

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Other ☐ Declined

Primary Language: ☐ English ☐ Spanish ☐ Indian ☐ Russian ☐ Other ☐ Declined

Home #: _____ **Cell #:** _____ **Work #:** _____

Email: _____ **Occupation:**_____

Employer: _____ **Employer Address:**_____

Referring MD: _____ **Primary MD:** _____

Emergency Contact:_____ **Phone #:**_____ **Relationship:**_____

Pharmacy Name: _____ **Pharmacy Address:** _____

Pharmacy Phone: _____ **Pharmacy Fax:** _____

How did you hear about our office? _____

Insurance

Is your visit related to: 1) Worker's Comp? 2) Motor Vehicle Accident? (If yes, circle one)

WC or MVA Insurance Name: _____

WC or MVA Address: _____

Adjuster/Case Mgr Name: _____ **Claim #:**_____

Phone #: _____ **Ext.**_____ **Date of Accident:** ____/____/_____

Body part(s) injured? _____

Attorney Name: _____

Address: _____

Phone #: _____ **Fax#:**_____

Health Insurance: _____ **Effective Date:** ___/___/_____

Health Ins. Address: _____

Member ID #: _____ **Group #:** _____

Policyholder's Name: _____ **Referral required: Y N**

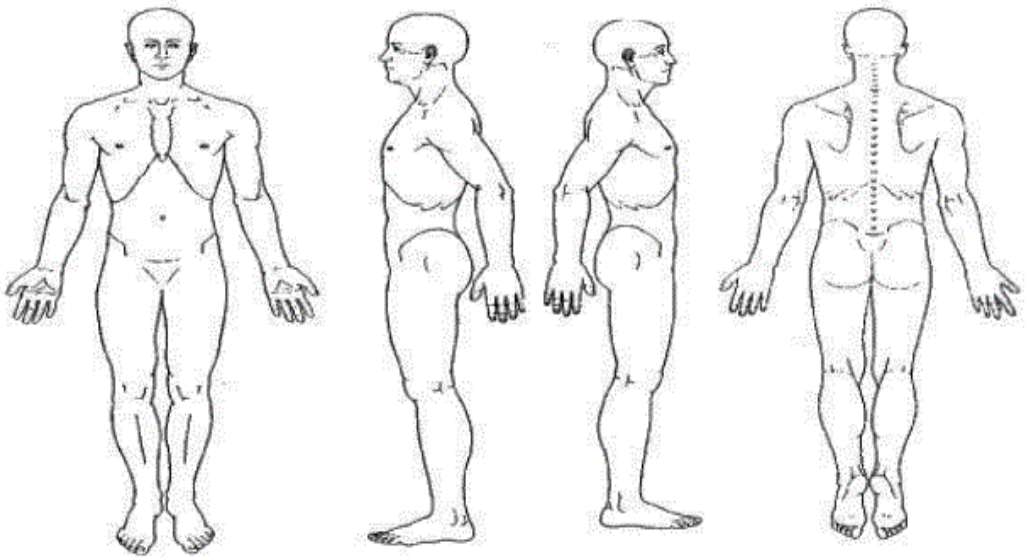
Policyholder's DOB: ___/___/_____ **SSN#:** _____ - ____ - _____ **Deductible $**_____

Co-Pay $_____ **Relation to Insured:** _____

Policyholder's Employer: _____

*****Please bring driver's license and insurance card along with you to your appointment*****

Please mark the diagram: P=Pain, B=Burning, T=Tingling, N=Numbness, W=Weakness



Pain Scale: (Circle the number that represents your current level of pain.)

NO PAIN **UNBEARABLE**

0 1 2 3 4 5 6 7 8 9 10

When your pain is at its worst? _____ **When your pain is at its best?** _____

How long have you been in pain? _____

Is your pain: ☐ Constant (100% of the time) ☐ Frequent (75% / time) ☐ Intermittent (50% / time) ☐ Occasional (25% / time)

How would you describe your pain: ☐ Sharp ☐ Aching ☐ Burning ☐ Throbbing ☐ Shooting ☐ Electric like ☐ Indescribable

☐ Other: _____

What worsens your pain? ☐ Standing ☐ Walking ☐ Sitting ☐ Activity ☐ Bending ☐ Twisting ☐ Lying down

What relieves your pain? ☐ Medication ☐ Sitting ☐ Lying down ☐ Standing ☐ Physical therapy

☐ Chiropractic manipulation ☐ Heat ☐ Ice ☐ Other: _____

Does your pain affect any of the following? ☐ Concentration ☐ Work duties ☐ Activities of Daily Living ☐ Physical Activity

☐ Appetite ☐ Sleep ☐ Other: _____

What treatment have you had for your pain? Please be specific:

☐ Physical therapy (when, how long, where):_____

☐ Chiropractor (when, how long, with whom):_____

☐ Acupuncture (when, how long, with whom):_____

☐ Injections (when, with whom):_____

☐ Surgery (when, with whom): _____

☐ Other: _____

Patient Name: _____

PAST MEDICAL HISTORY

Cardiac
☐ Hypertension ☐ Hypercholesterolemia ☐ Coronary heart disease/MI ☐ Irregular heart beat ☐ Atrial fibrillation/flutter
☐ Internal cardiac defibrillation/pacemaker ☐ Peripheral vascular disease
☐ If other:_____

Pulmonary
☐ Smoker ☐ Asthma ☐ COPD/Emphysema ☐ Sleep Apnea ☐ Lung Cancer
☐ If other:_____

Gastrointestinal
☐ GERD ☐ Gastritis ☐ Gastric ulcer ☐ Irritable bowel disease ☐ Hepatitis ☐ Liver cirrhosis
☐ If other:_____

Renal
☐ Renal insufficiency ☐ Renal failure ☐ Kidney stones
If other:_____

Endocrine
☐ Diabetes ☐ Diabetic peripheral neuropathy ☐ Grave's disease ☐ Hypothyroid
☐ If other:_____

Musculoskeletal
☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Sjogren's disease ☐ Degenerative joint disease ☐ Fibromyalgia ☐ Lyme's disease
☐ If other:_____

Neurological
☐ Stroke ☐ TIA ☐ Migraines ☐ Seizure disorder ☐ Multiple sclerosis ☐ Alzheimer's disease ☐ Dementia
☐ If other:_____

Psychiatric
☐ Depression ☐ Anxiety ☐ Bipolar ☐ Schizophrenia ☐ Panic disorder ☐ Post traumatic stress disorder ☐ History of alcohol/drug abuse
☐ If other:_____

Hematological
☐ Anemia ☐ Low platelets ☐ Bleeding disorder ☐ Blood clots ☐ Leukemia ☐ Lymphoma
☐ If other:_____

SURGICAL HISTORY

Please list past surgeries:

DATE	SURGERY	DATE	SURGERY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY

Do you currently smoke tobacco?
☐ Yes ☐ No ☐ Ex-smoker When? _____
If yes: How many packs/day_____ How many years? ____
If ex-smoker: Quit when? _____
Do you currently drink alcohol?
☐ Beer ☐ Liquor ☐ Wine
Amount per day? _____ Amount per week?_____
Do you currently use any illicit drugs? _____
Currently Working? ☐ Yes ☐ No ☐ Full-Time ☐ Part-Time
Occupation_____

FAMILY HISTORY

Condition	Family Member
☐ High Blood Pressure	_____
☐ Heart Disease	_____
☐ Lung Disease	_____
☐ Cancer (what type?)	_____
☐ Diabetes	_____
☐ Bleeding Problems	_____
☐ Problems w/ Anesthesia	_____
☐ Other:_____	_____

Patient Name: _____

MEDICATION	DOSE / FREQUENCY	MEDICATION	DOSE / FREQUENCY

Allergies: **Reaction:**

_____ _____

_____ _____

_____ _____

Allergies: **Reaction:**

_____ _____

_____ _____

_____ _____

Imaging Studies with dates:

☐ MRI _____ ☐ EMG _____

☐ CT Scan _____ ☐ Other _____

☐ X-Ray _____

Have you recently had any of the following problems or symptoms?

Unexpected Weight Gain	☐ Yes ☐ No	Unexpected Weight Loss	☐ Yes ☐ No	Fever or Chills	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Fainting Spells	☐ Yes ☐ No	Arm / Leg Swelling	☐ Yes ☐ No
Breathing Difficulties	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Cough	☐ Yes ☐ No
Abdominal Pain	☐ Yes ☐ No	Nausea or Vomiting	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	Blood in Urine	☐ Yes ☐ No	Painful Urination	☐ Yes ☐ No
Difficulty Urinating	☐ Yes ☐ No	Loss of Bowel Control	☐ Yes ☐ No	Bloody Stool	☐ Yes ☐ No
Loss of Bladder Control	☐ Yes ☐ No	Rashes or Lesions	☐ Yes ☐ No	Bruising Easily	☐ Yes ☐ No
Joint Pain	☐ Yes ☐ No	Difficulty Walking	☐ Yes ☐ No	Vision Changes	☐ Yes ☐ No
Depression / Anxiety	☐ Yes ☐ No	Headaches / Migraines	☐ Yes ☐ No	Seizures / Stroke	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No	Blood Clots	☐ Yes ☐ No	Anemia	☐ Yes ☐ No