

Name: \_\_\_\_\_

Chart #: \_\_\_\_\_

Date: \_\_\_\_\_



I N T E R N E T

Neil B. Kirschen, M.D.  
Steven M. Shoum, M.D.  
Michael Luvin, M.D.  
Robert Iadevaio, M.D.  
Jacob J. Rauchwerger, M.D.

PATIENT DEMOGRAPHIC

Patricia Kirschen, L.Ac.  
Candra Snyder, ANP  
Nichole Lopez, FNP

Do you have an Advance Directive  
 YES  NO  
If yes, is it on file with us.  
 YES  NO

Is this related to: Motor Vehicle Accident?  YES  NO  
Work Related Accident?  YES  NO  
If YES, Please ask for additional required form

Patient Last Name		First Name		MI	Date of Birth	Age	Sex M F	
Patient Address			City	State	Zip Code	Social Security #		
Marital Status	Race	Religion	Ethnicity		Country of Birth			
Mother's Maiden Name	Father's First Name		Patient Telephone #		Cell Phone#			
Emergency Contact	Relationship	Telephone #	Primary Language Spoken					
Policy Holder Employer Name		Employer Telephone #		Employer Address				
Patient's Retirement Date	Disabled? <input type="checkbox"/> YES <input type="checkbox"/> NO		Retired? <input type="checkbox"/> YES <input type="checkbox"/> NO		Referred to us by:			
Primary Reason(s) for Visit			Family Doctor		Telephone #			
1st Insurance		Policy #	Group #	Policy Holder Date of Birth				
Policy Holder Name		Relationship to Pt.	Insurance Billing Address					
2nd Insurance		Policy #	Group #	Policy Holder Date of Birth				
Policy Holder Name		Relationship to Pt.	Insurance Billing Address					
3rd Insurance		Policy #	Group #	Policy Holder Date of Birth				
Policy Holder Name		Relationship to Pt.	Insurance Billing Address					
<b>PLEASE HAVE PHOTO I.D. AND ALL INSURANCE CARDS AVAILABLE</b>								

Name: \_\_\_\_\_

Chart#: \_\_\_\_\_

I N T E R N E T

Neil B. Kirschen, M.D.  
Steven M. Shoum, M.D.  
Michael Luvin, M.D.  
Robert Iadevaio, M.D.  
Jacob J. Rauchwerger, M.D.



Patricia Kirschen, L.Ac.  
Candra Snyder, ANP  
Nichole Lopez, FNP

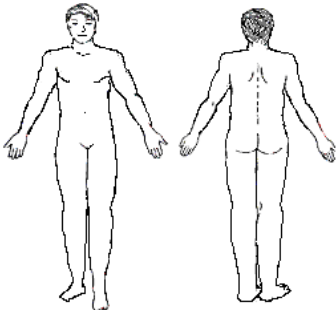
## Comprehensive Pain Evaluation and History

Date (Fecha): \_\_\_\_\_

Height (Altura) \_\_\_\_\_ Weight (Peso) \_\_\_\_\_ lbs Age (Edad) \_\_\_\_\_ Right handed or left handed? \_\_\_\_\_

- ☉ What is the complaint which you are seeking help for? (Cual es su dolor?)
  
  - ☉ Is the pain related to an injury, accident, cancer, surgery, or other disease? (Es relacionado a un tipo de accidente, cancer, cirugia o enfermedad?)
  
  - ☉ When did the pain begin? How long has it been present? (Cuando empezo su dolor y cuanto tiempo lo tiene?)
  
  - ☉ Since it began how has the quality changed? e.g. Increased, decreased, unchanged. (Como ha cambiado su dolor? Tiene mas, menos, sin cambios desde el inicio del dolor)
  
  - ☉ How often does the pain occur? **Circle ONE** (Con que frecuencia le ocurre su dolor? Marque Uno  
Nonstop-continuous, Several times a day, Once a day several times a week (Seguido y constante,  
Several times a month, Other \_\_\_\_\_ Varias veces por mes o por semana )
  
  - ☉ **For the following please use 0-10** (Del # 0 al 10, con diez siendo el dolor mas grave anote como le afecta su dolor?)  
*0 = no pain disruption, 10 worst pain imaginable extremely disruptive*
- |  |   |
|--|---|
| Pain at its worse ever? Maximo Dolor _____ | Effect on work/school? Efecto en el trabajo/escolar _____         |
| Pain at its best ever? Minimo Dolor _____  | Effect on household chores? Efecto en obras de domicilio _____    |
| Pain currently worst? Dolor Ahorra _____   | Effect on social/family interactions? Efecto en familia _____     |
| Pain currently best? _____                 | Effect on leisure activity? Efecto en actividades de recreo _____ |
| Pain currently most of the time? _____     | Effect on sexual activity? Efecto en actividad sexual _____       |

☉ Please shade in the affected areas (Marque las areas de su dolor)



☉ Which characteristics describe your pain? **Circle all that apply.** (Marque las descripciones de su dolor)

Denote how often? (Always, Often, Rarely for each circled)

Throbbing (Palpitante)	Gnawing	Tight (Apretado)	Punishing/cruel (Castigado/Cruel)
Shooting	Hot-burning (Arde)	Squeezing	Pins/needles (Sentir como agujas)
Stabbing (Apuñalado)	Aching (Agotado)	Splitting	Numb (Entumecido)
Sharp (Agudo)	Heavy (Pesado)	Tiring/Exhausting (Cansado)	Fearful (Miedoso)
Cramping (Calambres)	Tender (Tierno)	Sickening (Enfermiso)	

☉ What makes the pain better? (Que le alivia su dolor?)

☉ What makes the pain worse? (Que le empeora su dolor?)

☉ What specialist have you seen for the pain? Surgeon, Neurologist, Chiropractor, Physical therapist, psychiatrist?

Que especialistas ha consultado para su dolor? Cirujano, Neurologo, Quiropractico, Terpatia Fisica, Siquiatra?

Date seen Physical therapist (Fechas que tuvo terapia fisica?) \_\_\_\_\_

Date seen Chiropractor (Fechas que tuvo tratamientos quiropracticos) \_\_\_\_\_

Date seen Other (Fechas de otros especialistas?) \_\_\_\_\_

☉ What therapies have you tried for the pain? Circle & write in others. Surgery, nerve blocks, brace, physical therapy, biofeedback, relaxation, TENS, injections, acupuncture, chiropractic, massage, hypnosis, counseling-psychotherapy, heat, ultrasound, etc. (Que terapias le han hecho para su dolor? Marque todas y escriba si no estan listadas: Cirugia, inyecciones, terapia fisica, relajacion, maquina TENS, acupuntura, quiropractico, masajes, ultrasonido)

☉ What medicine do you currently take for your pain? Specify next to each who prescribes them to you and whether: Helps, No-help or Not sure. Include over the counter, herbal and alternative preparations. (Que medicina esta tomando para su dolor? Especifique a lado de cada una si le ayuda. Incluya todas medicinas farmaceuticas y naturales)

☉ What other medication have you taken for pain? Why were they stopped? (Que otras medicinas ha tomado para su dolor? Porque las dejo de tomar?)

☉ Please list **all other medications** you are currently taking. Including over the counter herbal and alternative supplements. (Liste todo tipo de medicamentos que esta tomando incluyendo vitaminas y hierbas naturales)

☉ Please list **all allergies** which you have, including foods. (Anote todo tipo de **ALERGIAS**, incluyendo comidas)

**PATIENT NAME:** \_\_\_\_\_

☉ Do you or have you had (check all that apply)

- |  |  |  |                                   |
|--|--|--|-----------------------------------|
| <input checked="" type="checkbox"/>        | <input checked="" type="checkbox"/>        | <input checked="" type="checkbox"/>                        | <input type="checkbox"/>          |
| <input type="checkbox"/> Hypertension      | <input type="checkbox"/> Depression        | <input type="checkbox"/> Kidney disease                    | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart attack (MI) | <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Bipolar disorder                  |                                   |
| <input type="checkbox"/> Stroke            | <input type="checkbox"/> Urinary retention | <input type="checkbox"/> Liver diseases                    |                                   |
| <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> Low energy        | <input type="checkbox"/> Thyroid disease                   |                                   |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Nausea/ Vomiting  | <input type="checkbox"/> Arrhythmia (irregular heart beat) |                                   |
| <input type="checkbox"/> Migraines         | <input type="checkbox"/> Constipation      | <input type="checkbox"/> Easy bruising/ Bleeding           |                                   |
| <input type="checkbox"/> Seizures          | <input type="checkbox"/> Diarrhea          | <input type="checkbox"/> Excessive thirst                  |                                   |
| <input type="checkbox"/> Ulcer             | <input type="checkbox"/> Heart failure     | <input type="checkbox"/> Difficulty sleeping               |                                   |

☯ Please list all other **medical conditions** you have, or other medical conditions you have, or are under treatment for?  
(Liste todas sus condiciones medicas)

☯ Have you ever been diagnosed or treated for Cancer? (Tiene cancer o lo han tenido)  
What type(s)? (Que tipo de Cancer?)

What therapies? e.g. Radiation, Surgery, Chemo/Hormonal therapy (Radiacion, Cirugia, Quimoterapia)  
When? (Cuando)

☯ Do you or have you used **illicit or un-prescribed drugs? If so, which ones.** (Usted usa drogas ilegales? Cuales)

☯ Do you share drugs? (Comparte sus drogas?)

☯ Do you use **tobacco**? What type? How much/often? (Fuma cigarros? Cuantos?)

☯ How much **alcohol** do you consume in a week? (Cuantas bebidas alcolicas toma semanal?)

☯ Please list all previous **surgeries** and dates? (Anote todas las cirugias y fechas )

☯ What is your current employment status? What type of work do/did you do? (Esta trabajando? Que tipo de trabajo hace?)

☯ Does anyone in your family have a history of chronic pain? Who and what Pain? (Tiene familiares que sufren de dolor cronico? Quienes y que tipos de dolores?)

☯ Does anyone in your family have a history of substance abuse? (Tiene historia familiar de abuso de sustancias en su familia? Alcolismo, drogas?)

☯ Are you involved in any lawsuits ? (Tiene un caso legal ahorra contra alguien?)

☯ How much relief do you expect to obtain? \_\_\_\_\_% Reduction in my pain. (Que porcentaje de alivio espera? \_\_\_\_%)

**PATIENT NAME:** \_\_\_\_\_