ASSOCIATED PHYSICIANS Group
Your pain management and physical therapy specialists. ®

Welcome to Associated Physician's Group Pain Management Center!

The following document will serve as a summary of your health history during your initial visit to the APG Pain Management Center. **Please complete all sections; sign and date all pages. If you need assistance in filling out these forms, please call our office at 1-888-363-8333.**

Name _____ Date _____

MEDICAL HISTORY:

Medical Conditions: *please list all illnesses/conditions you have been diagnosed with.*

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

SURGERIES: *please list all surgeries and the month/year they were performed.*

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

ALLERGIES: Medications: _____

Food: _____

Check all that apply: ❒ Latex ❒ IV Contrast/Dye ❒ Betadine/Iodine ❒ Adhesive Tape

SOCIAL HISTORY:

Do you smoke? Y/N Packs/day? _____
Do you drink alcohol? Y/N Drinks/day? _____
Do you use drugs? Y/N Which? _____
_____
Are you a victim of abuse? Y/N _____
Are you currently involved in or planning a claim/lawsuit for:
Workman's Compensation? Y/N
Personal Injury/Insurance? Y/N
Other? Y/N_____
Are you on/applying for disability? Y/N

Patient Signature: _____ Date:_____

REVIEW OF SYSTEMS: *(Circle any and all that apply):*

Fevers	Ulcers/stomach pain	Vision Changes	Anxiety
Chills	Reflux/Indigestion	Ringing in the Ears	Suicidal Thoughts
Night Sweats	Blood in Urine	Numbness	Difficulty Sleeping
Rigors/Shakes	Frequent Urination	Weakness	Pain Worse at Night
Productive Cough	Burning/Pain with Urination	Loss of Balance	Weight Loss
Cold/Flu Symptoms	Difficulty Passing Urine	Difficulty Walking	Weight Gain
Rash/blisters/skin ulcers	Erectile Dysfunction	Loss of Bladder	Chest Pain
Constipation	Painful Intercourse	Control	Shortness of Breath
Diarrhea	Headaches	Seizures/Convulsion	Swelling/edema
Blood in Stool	Sleepiness	Panic Attacks	Wheezing
Vomiting Blood	Dizziness	Depression	Chronic Cough

PAIN HISTORY: How long have you had this pain?_____

PREVIOUS PAIN TREATMENTS: *(Circle all that apply):*

Injections/Nerve Blocks	Chiropractic Care	Massage/Acupressure	Pain Psychologist/CBT
Pain Clinic	TENS Unit	Acupuncture	Hypnosis
Physical Therapy	Deep Muscle Stimulation	Traction	Surgery

PREVIOUS PROCEDURES: *(Please list the date and place they were performed):*

PROCEDURE	DATE(S)	PLACE PERFORMED
X-Rays		
C.T./MRI		
Myelogram		
Ultrasound		
E.M.G.		
Treatment by Another Physician		
For what?		

CURRENT MEDICATIONS: *(Please list all medications you are currently taking, Prescription and Over the Counter):*

Name of medication and strength	# of doses /day

FAMILY HISTORY: *(Has anyone in your immediate family (mother, father, grandparents, brothers, sisters, children.)*

Heart Disease	Who_____	Epilepsy	Who_____
Hypertension	Who_____	Glaucoma	Who_____
Stroke	Who_____	Bleeding disorders	Who_____
Cancer	Who_____	Kidney disease	Who_____
Diabetes	Who_____	Thyroid disease	Who_____

Patient Signature: _____ Date:_____