Patient Information Form

Please complete the following questionnaire to help us better understand your complex pain problem.

☑☑ ***Please check appropriate boxes wherever indicated.***

Date Questionnaire Completed	
Full Name	
Street Address City, State Zip Code	
Home Phone #	( )
Cell Phone #	( )
Work Phone #	( ) Occupation: How Long: *May we contact you at work?* ☐ Yes ☐ No
Email address	☐☐ No ☐☐ Yes:
Birth Date	*(mm/dd/yyyy)* — *Ages 14-17 Require Parent/Guardian Approval We don't treat anyone under the age of 14,*
Age	
Gender	☐ Male ☐ Female
Treating Physician	
Emergency Contact	Name: Phone # ( ) Their relationship to you:
How did you hear about us?	☐ TV________________ ☐ Radio________________ ☐ Mail________________ ☐ Internet ________________ ☐ Friend/Employee ☐ Billboard/Sign
Are you pregnant?	☐ No ☐ Yes:

PAIN HISTORY

1. Please describe the pain/ problem that you are currently seeking relief from:

2. When did your pain first start and what was the cause? Please be as specific as possible.

   Day [   ]   Month [   ]   Year [   ]

Check ONE that applies best; if more than one applies, check the one that applies the best.

- ☐ Accident at work
- ☐ Accident at home
- ☐ Car accident
- ☐ After surgery
- ☐ After an illness
- ☐ Pain just began, no clear reason
- ☐ Other reasons (please describe) ____

TREATMENT HISTORY

1. Have you already been assessed by any medical specialists for your pain problem?

   ☐ No ☐ Yes: Please list:

Name of Specialist	Specialty (if known)	Date of Assessment /Treatment Received

2. On a scale of 1 -10 (10 being the worst) what is your pain level today:__________________

3. Reducing your level of pain is what priority in your life:

   - ☐ a. High
   - ☐ b. Moderate
   - ☐ c. Low

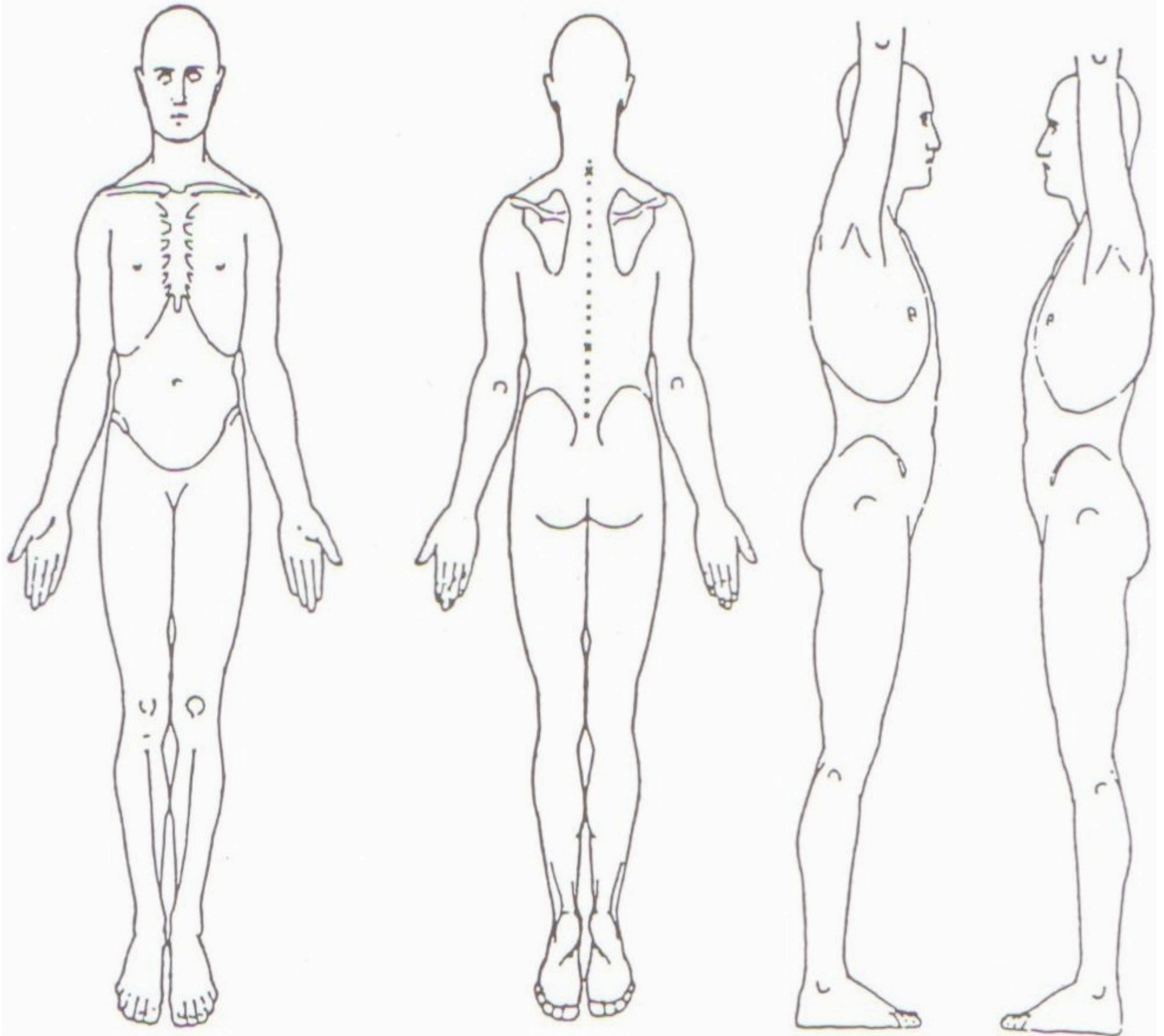
4. Your basic knowledge/understanding of what Pain Free Life Centers laser therapy does is:

   - ☐ a. High
   - ☐ b. Moderate
   - ☐ c. Low

5. Which, if any, forms of medical laser application have you experienced (i.e. electrolysis, tattoo removal, lasik, etc.)

   ____
   ____
   ____
   ____
   ____

PAIN DIAGRAM: Please shade (in pencil) where you are currently experiencing pain/other symptoms:
(If submitting electronically, complete this page in the office.)



DO YOU HAVE ANY HISTORY OF:

- ☐ **Cancer (No chemotherapy in the past 30 days)**
- ☐ Weight loss in the past 6 months
- ☐ Night sweats/fevers in the past 6 months
- ☐ Diabetes
- ☐ None of the above

MEDICATIONS/ALLERGIES

1. Please list any allergies you might have. (Include latex, alcohol, over the counter and herbal medications.)

 ____

 ____

2. What medications are you **currently** taking for your pain?

Drug Name	Dosage	How often?	Date Started	Side Effects?	Is it Effective?
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No

3. What medications have you **tried in the past** for your pain but have stopped using?

Drug Name	Were there side effects?	Was it effective?
	☐Yes ☐No	☐Yes ☐No
	☐Yes ☐No	☐Yes ☐No
	☐Yes ☐No	☐Yes ☐No

Opiate History: Opiate (narcotic) medications include:

Codeine, Morphine, Hydromorphone (Dilaudid), Oxycodone (Percocet, Endocet), Tramadol (Tramacet), and Fentanyl patch, or ***Vicoden (*Must be 24 hours since last dose)**
Please ask if you are not sure if your medication is an opiate.

(a) I AM currently taking OPIATE medication.
- ☐ Yes: Please answer the following questions.
- ☐ No: **Please go to next page.**

(b) Please tell us about the opiate prescription you are **currently** taking or any injections you are receiving:

Drug Name	How many tablets are in a prescription?	How many days are there between refills?

MEDICAL/SURGICAL HISTORY

1. Do you currently have any of the following conditions? ☑☑ Check all that apply.

- ☐ Heart disease
- ☐ Lung disease
- ☐ Diabetes
- ☐ Stroke
- ☐ Blood clotting problems
- ☐ Weakness in your arms or legs
- ☐ None of the above
- ☐ Bowel problems
- ☐ Bladder problems
- ☐ Weight loss in the past 6 months
- ☐ Night sweats/fevers in the last 6 months
- ☐ Cancer If yes, what type?

____

2. List by year (starting at childhood), as best you can, all illnesses and operations you have had previously.

Year	Surgical Operation (e.g. Back Fusion)	Year	Medical Illness (e.g. Measles, diabetes)

I have informed Pain Free Life Centers of the following:

I have never been diagnosed with any form of cancer and to my knowledge I have the following sicknesses, illnesses, and/or medical conditions (If none, write “none”):

____

I regularly use and/or consume the following: tobacco products, alcohol products and/or controlled substances (if none write ”none”):

____

I have regularly received or regularly receive the following injections (cortisone or others) from my medical care provider (if none write “none”): (Indicate if received in last 5 days)

____

Signature:______________________________ Date:______________________