Jackson Pain Center

PATIENT INFORMATION

(Please fill out completely - Please Print)

PATIENT INFORMATION				
Patient Name (Last, First, Maiden)	Date of Birth	Age	Social Security Number	
Address	City		State	Zip Code
Cell Phone	Home Phone		Spouse's Given Name	
EMPLOYMENT INFORMATION				
Employed? ☐ Yes ☐ No	Employer			
Address	City		State	Zip Code
Position	How Long?		Business Phone	
Spouse's Employment	Address			
Position	How Long?		Business Phone	
EMERGENCY INFORMATION				
Nearest Living Relative, other than Spouse	Relationship		Phone	
Address	City	State	Zip Code	
Employment				
INSURANCE INFORMATION				
If ANY insurance policy is not in YOUR name, this portion MUST be completed fully				
Insurance Company Name and Address	ID Number	Subscribers Name	Date of Birth	
	Group Number	Insurance Company Phone Number		
Insurance Company Name and Address	ID Number	Subscribers Name	Date of Birth	
	Group Number	Insurance Company Phone Number		
Referred by:				

ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process a claim on any insurance policy listed above. I hereby assign to and authorize payment directly to Jackson Pain Center, of all benefits payable under such insurance policy. I realize that the insurance benefits may not pay all of the bill, and I agree to pay the difference or the entire bill if necessary.

______________________________ Patient Signature

__________________ Date

Jackson Pain Center

J. Edwin Dodd, MD

www.jacksonpaincenter.net

(601) 355-7246

REV 9/17

PAIN EVALUATION

Date of Appt.

Name (Last, First, Middle)

Referring Physician

Current Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed | How Long?

Number of Children | Ages of Children

What is your Specific Occupation - Include Housewife (Briefly describe what you do)

Are you presently employed? ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Disabled | If unemployed/disabled,how long?

If you are Unemployed, or employed Part-time, is this due to your present Pain Condition? ☐ Yes ☐ No

How long have you been working for your present employer?
(or last employer if unemployed, disabled, retired, etc) __________ years

Have you attempted to return to work? ☐ Yes ☐ No | If yes, did you work ☐ Full Time ☐ Part Time

Did your employer allow you to return? ☐ Yes ☐ No

Since your pain condition began, which of the following people have you consulted for treatment and Pain Relief? **Please list their name beside their specialty.**

Name	Name
Allergist	Psychiatrist
Cardiologist (heart)	Radiologist
Dermatologist (skin)	Surgeon
Ear, Nose, or Throat	Psychologist
Endocrinologist	Chiropractor
General Practice and Family Practice	Hypnotist
Internal Medicine (Internist)	Acupuncturist
Neurologist (Nervous System)	Dentist
Obstetrician/Gynecologist	Clergyman
Ophthalmologist (eyes)	Faith Healer
Orthopedist (Bones, joints, and Muscles)	Other (Specify)
Pediatrician	
Plastic Surgeon	

Under what circumstances did the pain begin?

______	Accident at Work	______	Following Surgery
______	Accident at Home	______	Following Illness
______	Other Accident	______	Pain just began, I can't relate it to anything
______	At Work, not an accident	______	Other reasons or circumstances

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PAIN EVALUATION - page 2

Would you describe briefly the circumstances you checked regarding the beginning of your pain?

Please list the approximate date that you first experienced the pain for which you are seeking help today

In what part(s) of the body did the pain begin? (name ALL the parts)

Does the pain usually wake you at night? ☐ No ☐ Yes | If so, How many times a night ___

When it wakes you up, what do you do then? ☐ Empty bladder ☐ Take medication ☐ Sit up for a while ☐ Other (Describe) ______________________________

What do you do (activities) that will bring on pain, or make the pain worse?

What decreases the pain? (Massage, medicine, lying down, relaxing, etc) Describe exactly.

Have you been operated on for the pain? ☐ Never ☐ Once ☐ Twice ☐ Three times ☐ Four times ☐ Five times ☐ More than five times

Did any of the operations bring relief from the pain? ☐ Yes ☐ No

Have you had any nerve blocks (injections) for the pain? ☐ Yes ☐ No | How many? ________

Please list all physicians and locations where you received an injection procedure.

Did any of these injections bring relief from the pain? ☐ Yes ☐ No

If so, what was the longest period of relief from pain after an injection? ____________________________

What medications do you take for PAIN? (Name ALL medicines you take for pain at any time.
Tell how often you take each one.)

PAIN MEDICINE	DOSE	FREQUENCY	DATE STARTED

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PAIN EVALUATION - page 3

OTHER MEDICATIONS:

Please list for what illness or problem:

MEDICATION	DOSE	FREQUENCY	DATE STARTED

Please list ALL allergies.

Please list **ALL** previous surgeries and the approximate date. (Use back for additional space)

REVIEW OF SYSTEMS

Please circle any of the following problems that apply to you now in the past 3 months

General:	weight loss	weight gain	fatigue	
Respriartory:	hemoptysis	shortness of breath	wheezing	
Cardiovascular:	ankle edema	chest pain	palpatations	
Gastrointestinal:	abdominal pain	blood in stool	vomiting	reflux
Genitourinary:	frequency	hesitancy	flank pain	
Neurological:	numbness	tingling in legs/arms	headaches	seizures
	uncoordination	bowel/bladder control	sensory alterations	weakness
Musculoskeletal:	gait abnormalities	muscle pain	joint swelling	
Skin:	rash	sores/abscess	itching	mass(es)
Hematologic:	bleeding tendecies	easy bruising	swollen lymph nodes	
Psychologic:	mood swings	agitation	anxiety	

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PAIN EVALUATION - page 4

PAST MEDICAL HISTORY

Please Circle all that Apply to you

Glaucoma	High Blood Pressure	Asthma	COPD(emphysema)
Stroke	Pulmonary Embolus	Breast Cancer-R or L	Diabetes Mellitus
Heart failure	Kidney Stones	Lung cancer	Tuberculosis
Depression	Hiatal Hernia(GERD)	Lymphoma	Thyroid Disease
Arthritis	Seizure Disorder	Hepatitis	Pancreatitis
HIV/AIDS	Prostate Enlargement	Anemia	Prostate Cancer
Meningitis	Atrial Fibrillation	GI Bleeding	Stomach Ulcers
Leukemia	Heart Attack (MI)	Liver Disease	Any mental illness
Fibromyalgia	Irritable Bowel Syndrome	Chronic Joint Pain	Migraine Headaches
Chronic Sinusitus	Kidney Disease	Sleep Apnea	Interstital Cystitis

Please list **ANY** other medical problems that you might have that are not listed above.

Family History: Does anyone in your family have a similar problem? ☐Yes* ☐No

Are there any hereditary diseases in your family? ☐Yes* ☐No

*If Yes, please list:

List any major medical problems in your family:

Do you smoke? ☐No ☐Yes | If so, how many packs per day?__________

Do you drink alcohol? ☐No ☐Yes | If so, how much per day? ___________

Your Height __________________ | Your Weight _________________

Is this pain or injury a Worker's Compensation case? ☐Yes ☐No

Do you have any litigation (lawsuits) pending or planned which are related to this injury or pain?

☐No ☐Yes

If you answered Yes to a litigation pending or planned, please explain who you are suing and why.

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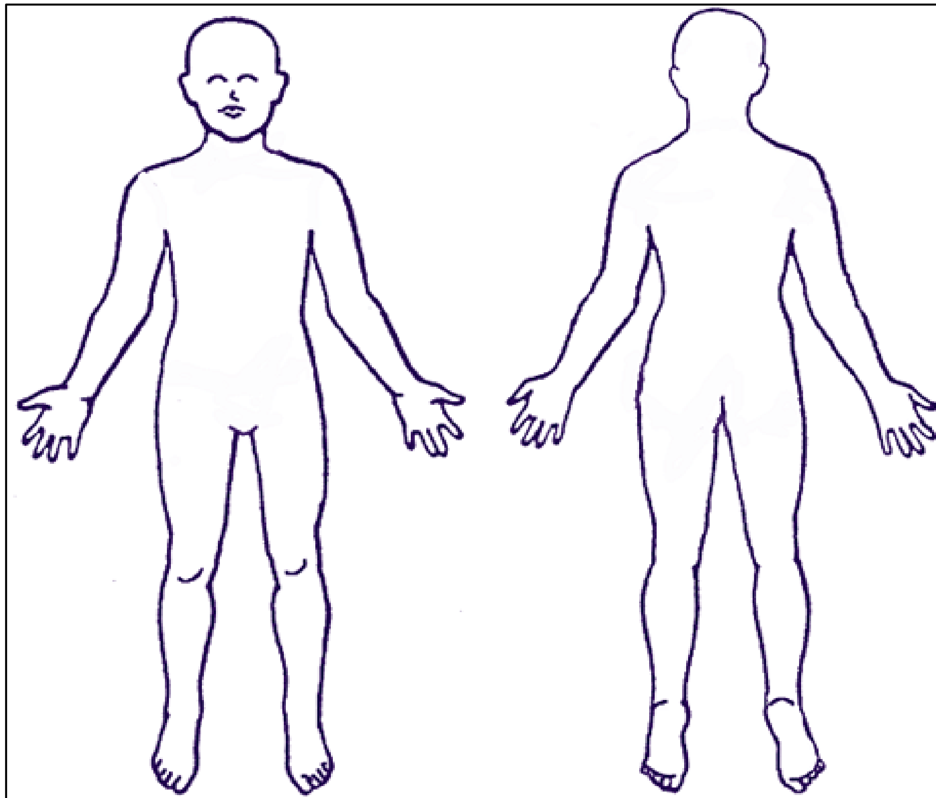
PAIN EVALUATION - page 5

Mark on the drawing the exact spot where your pain is. Mark this with a solid dot (**.**) If the pain starts at that spot and radiates elsewhere (travels to another part of your body), draw a line from the spot where it starts to where it ends. If it is a whole area that hurts, shade in that area.

FRONT **BACK**



FRONT **BACK**

PLEASE CIRCLE THE APPROPRIATE WORDS THAT DESCRIBE YOUR PAIN

Aching	Shooting	Dull	Constant
Burning	Tingling	Tight	Radiating
Cramping	Hotness	Heavy	Annoying
Numbness	Coldness	Intense	Severe
Stinging	Soreness	Brief	Unbearable
Stabbing	Sharp	Transient	Excruciating