



New Patient Pain History Form

Name: _____ Date of Birth: ___/___/_____ Today's Date: ___/___/_____

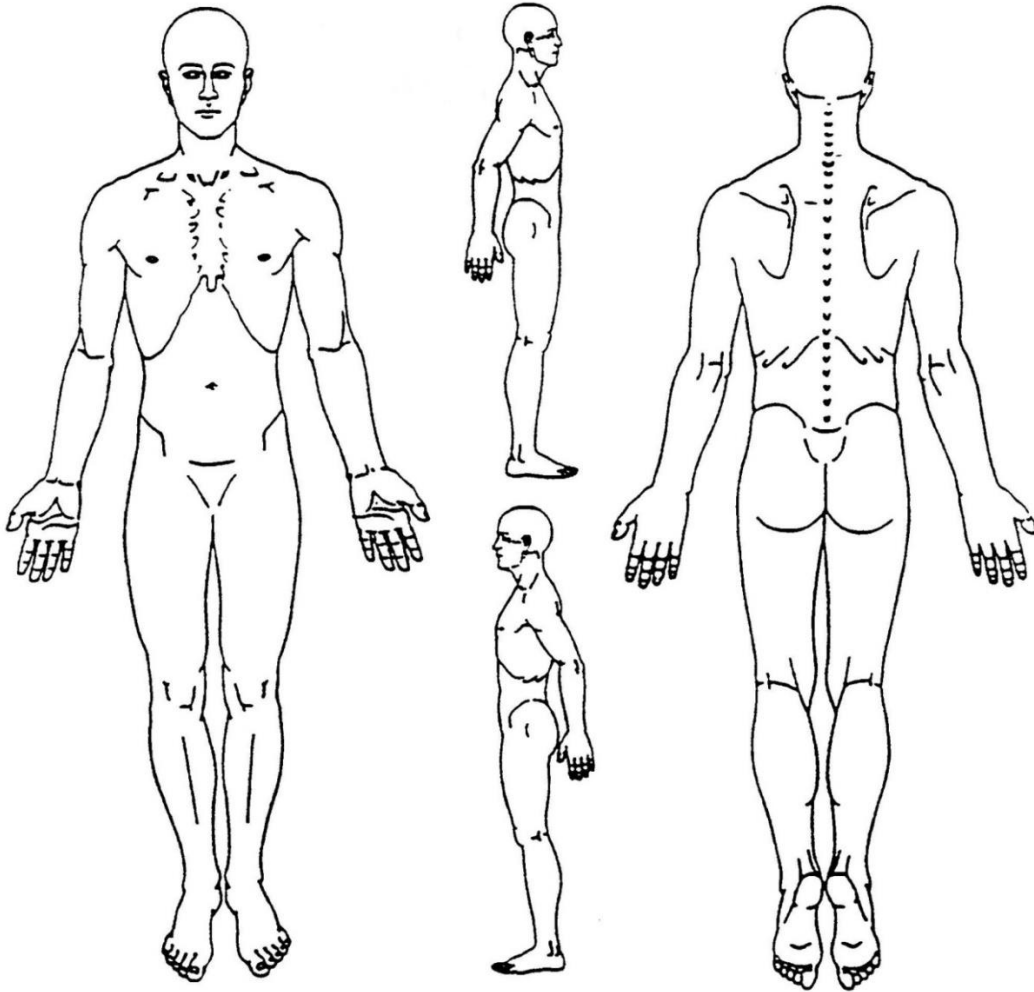
Date the Pain Began: ___/___/_____ Dominate Hand: Right or Left

Reason for visit: _____

Describe what caused the pain (accident, injury, etc.): _____

Pain

1. Pain/Symptom Description - Mark the affected areas on your body where you feel your typical pain and/or symptom and place a **star** by where you are most affected.



2. How would you describe the kind of pain/associated symptoms that you have:
 Sharp Stabbing Aching Dull Burning Cramping Pins and needles Throbbing
 Numbness - If so, where? _____ Weakness - If so, where? _____
3. Pain compared to when it first started: Improved by ____% Worsened by ____% No Change
4. Pain Severity: If "0" is no pain and "10" is the worst pain imaginable, please note your pain over the past two weeks by circling the appropriate number:
- | | | | |
|--------------------|---------|-------------|----------|
| Pain at its worst: | [0 1 2] | [3 4 5 6 7] | [8 9 10] |
| | Mild | Moderate | Severe |
| Pain at its least: | [0 1 2] | [3 4 5 6 7] | [8 9 10] |
| | Mild | Moderate | Severe |
| Pain on average: | [0 1 2] | [3 4 5 6 7] | [8 9 10] |
| | Mild | Moderate | Severe |
- Pain Frequency: Constant Intermittent, ____ # of hours in pain per day
- Time of Day Pain is at its Worst: Morning Afternoon Evening Nighttime
- How Often You Stop Activity Due to Pain: Never Rarely Occasionally
 Several Times a Day Spend Most of the Day Lying/Sitting
5. Activities which relieve pain: _____
6. Activities which increase pain: _____
7. Medications you take to relieve pain (please list all): _____

8. Current exercise activities: _____

Diagnostic tests performed for this condition:

<u>Test</u>	<u>Date</u>	<u>Location</u>
<input type="checkbox"/> X-Rays	_____	_____
<input type="checkbox"/> CT Scan	_____	_____
<input type="checkbox"/> MRI	_____	_____
<input type="checkbox"/> Bone Scan	_____	_____
<input type="checkbox"/> EMG (nerve test)	_____	_____
<input type="checkbox"/> Other	_____	_____

List the doctors (Primary Care, MD Specialist, Osteopathic Specialist, Chiropractor, or Therapist) you have seen in the last year for your condition:

<u>Doctor's Name</u>	<u>Type of Doctor</u>	<u>Location</u>	<u>Approximate Date</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Effect of treatment(s) you have had, or are currently receiving, for your pain:

<u>Treatment</u>	<u>Helped</u>	<u>Made Things Worse</u>	<u>No Difference</u>	<u>Currently Receiving</u>
Heat/Ice/Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TENS Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epidural Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Brace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Healthcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



New Patient Health History Form

Name: _____ Today's Date: ____/____/____

Date of Birth: ____/____/____ PCP: _____

Allergies and Medications:

Medication allergies: _____

List any other allergies: _____

Current Medications:

Medication	Dose/Frequency	Used to Treat	For How Long?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Medical History (please check those which apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Chronic Pain (>3 months) | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> GERD/Ulcers/Gastritis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Nerve/Muscle disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Work Related Injury |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Motor Vehicle Accident | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> DVT |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Pulmonary | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disease | |

Nerve/Muscle Disease (please specify): _____

Any other relevant medical history: _____

Family History (please place a check mark indicating relation of relative)

Status:	Alive	Deceased	Unknown	No Known Issues	Arthritis	Cancer	Depression	Diabetes	Early Death (<50yo)	Heart Disease	High Blood Pressure	Lung Disease	Neurological Disorder	Osteoporosis	Stroke	Spine Problems	Drug/Alcohol Abuse	Thyroid Disease
Mother																		
Father																		
Sister																		
Brother																		
Maternal Grandmother																		
Maternal Grandfather																		
Paternal Grandmother																		
Paternal Grandfather																		
Daughter																		
Son																		

Other relevant family history: _____

Surgical History (please check those which apply and provide approximate year performed):

- | | | |
|---|--|--|
| <input type="checkbox"/> Appendectomy _____ | <input type="checkbox"/> Gall Bladder _____ | <input type="checkbox"/> Neck Surgery _____ |
| <input type="checkbox"/> Back Surgery _____ | <input type="checkbox"/> Heart Surgery _____ | <input type="checkbox"/> Orthopedic and/or Joint Surgery _____ |
| <input type="checkbox"/> Breast Surgery _____ | <input type="checkbox"/> Hernia Repair _____ | <input type="checkbox"/> Tonsillectomy _____ |
| <input type="checkbox"/> C-Section _____ | <input type="checkbox"/> Hysterectomy _____ | |

Any other relevant surgical history: _____

Social History

1. Marital status: Married Domestic Partner Widowed Never Married Divorced/Separate
Whom do you live with: Spouse Children Parents Roommate(s) Partner
 Alone Other _____
2. Highest grade or level of education completed: _____
3. Tobacco Use: Never Current Former (Quit Date: _____)
a. Type(s) of tobacco used: Cigarettes Cigars Pipe Chewing Tobacco
b. Average number of packs per day: _____ Age when started using tobacco: _____
4. Cups of coffee per day? _____ Cups of other caffeinated beverages per day? _____
5. Do you use alcohol? Yes No If so, average number of alcoholic beverages per week: _____
a. Times in the past year you consumed 4+ drinks in one day: _____
b. Do you use alcohol to control your pain? Yes No
6. Drugs you have used:
a. at any time: Stimulants Hallucinogens Marijuana Cocaine Meth None of these
b. in the past 12 months: Stimulants Hallucinogens Marijuana Cocaine Meth None of these
7. Are you currently employed? Yes No
a. If so, how many hours per week do you work? _____
b. Where do you work? _____
c. What type of work do you do? _____
8. Are you currently on disability or involved in a disability claim? Yes No
9. Are you currently involved in a legal claim? Yes No
a. If so, are you represented by an attorney? Yes No If yes, please provide name: _____

Review of Symptoms (Check all those which apply):

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fever | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Urinary Frequency | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> New Rash |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Loss of Control of Urine | <input type="checkbox"/> Vision Change | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Night Pain | <input type="checkbox"/> Loss of Control of Bowels | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Skin Breakdown |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Constipation | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Depressed Mood |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Nausea | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Black Stools | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> 2 or More Falls in the Last Year <u>OR</u> 1 With Injuries | |

Northwest Map and Directions

From the South

- Travel North on I-5
- At the 1-5 split, stay left toward City Center
- Follow signs to I-405/City Center/Beaverton exit (exit 299B)
- Take Exit 2B, Everett Street, onto 14th Street
- Continue on 14th Street. Turn left onto NW Marshall Street

From the West

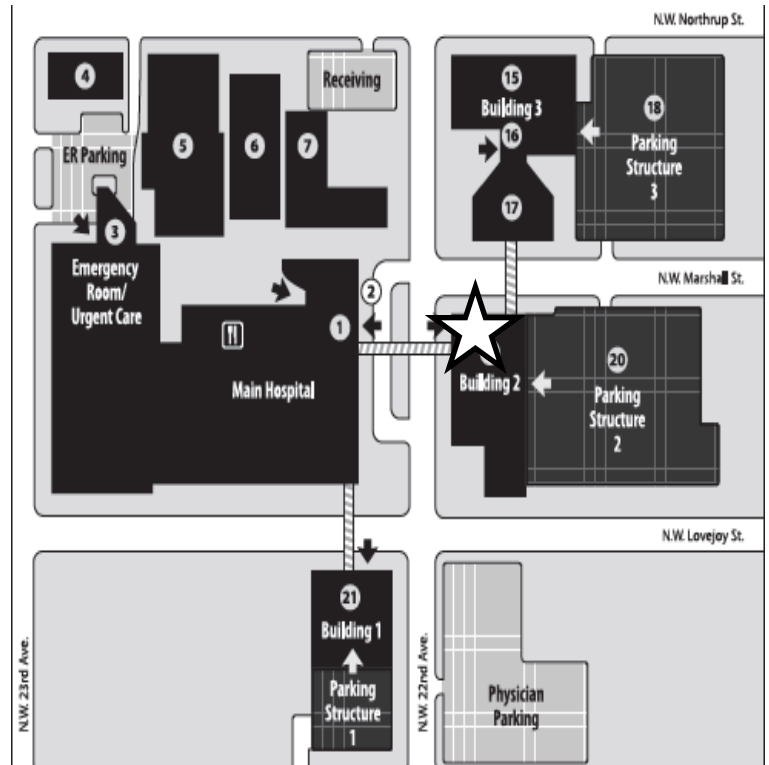
- Travel East on US26/Sunset Highway
- Exit onto I-405 – Seattle/St Helens
- Take exit 2B, Everett Street, onto 14th Street
- Continue on 14th Street. Turn left onto NW Marshall Street
- Turn left into Parking Structure 2 between 21st and 22nd Ave

From the East

- Travel West on I-84
- Follow signs to I-5 North (right lanes)
- Follow I-5 North to Exit 302B
- Take exit 302B across the Fremont Bridge, stay to the right
- Take Vaughn Street Exit (Exit 3)
- Turn left onto NW 23rd Ave (first light after Vaughn St exit)
- Turn left onto NW Northrup Street
- Turn right onto NW 22nd Ave
- Turn left onto NW Marshall
- Turn right into Parking Structure 2

From the North

- Travel South on I-5
- Take exit 302B across the Fremont Bridge
- Cross the Willamette River on Fremont Bridge, stay to the right
- Take Vaughn Street Exit (Exit 3)
- Turn left onto NW 23rd Ave (first light after Vaughn St exit)
- Turn left onto NW Northrup Street
- Turn right onto NW 22nd Ave
- Turn left onto NW Marshall
- Turn right into Parking Structure 2



Parking at the Good Samaritan Campus

We have several options for parking:

Use our parking structure. You may park for free in any of the three parking structures, which have gates. Please take a ticket upon entering and, at the conclusion of your appointment, RMA will issue you a parking validation ticket free of charge. If you enter the parking structure and exit within 15 minutes, no validation is required.

Valet parking. You may use Legacy's free valet parking from 7 a.m. to 5 p.m. at the main hospital entrance, N.W. 22nd Avenue and Marshall Street.

Street parking. Street parking may be available. Please observe all posted placards.

Handicapped parking. The easiest accessible handicap parking to RMA is on level H of parking structure 2.

Tualatin Map and Directions

From the South

- Travel North on I-5
- Take exit 289, turn right at the light
- Follow the curve to the right, proceed on SW 65th Ave
- Turn left into the entrance to Legacy Meridian Park Medical Center
- Make the second left and park in any designated patient space
- Inside the building, take the elevator to the second floor to reach Suite 250

From the West

- Travel to I-5
- Follow remaining directions from the South or North (according to your proximity to the Nyberg St exit)

From the East

- Travel West on I-205
- Take exit 3, turn right onto Stafford Road
- Turn left onto Borland Road and proceed to SW 65th Avenue (approximately 4 miles)
- Turn right onto SW 65th Ave
- Make the first right into Legacy Meridian Park Medical Center
- Make the second right and park in any designated patient space
- Inside the building, take the elevator to the second floor to reach Suite 250

From the North

- Travel South on I-5
- Take exit 289, turn left at the light
- Cross the overpass and proceed on Nyberg Road
- Follow the curve to the right, proceed on SW 65th Ave
- Turn left into the entrance to Legacy Meridian Park Medical Center
- Make the second left and park in any designated patient space
- Inside the building, take the elevator to the second floor to reach Suite 250

