CT Integrated Pain Consultants
Zhaodi Gong, MD/PhD

# Patient Data Sheet

**Today's Date: ____/___/_____**

## Your Information

Last Name: ________________ First: ____________________ MI: _________________
Sex: M ☐ F ☐ Date of Birth: ____/____/______ Age: _____ SSN: ________________
Address: _________________________________________________________________
Home phone: ______________________ Cell phone: ___________________________
Can we leave message on Home? Y N or Cell? Y N
Are you currently employed? Y N Name of Employer: ______________________
Occupation: _____________________________

## Emergency Contact

Name: ________________________________ Relationship: ______________________
Contact phone number: _________________________

## Referring Physician

Name: ________________________________ Specialty: ______________________
Office address: ________________________________________________________
Office phone: ________________________ Fax: _____________________________

## Primary Care Provider (PCP)

Name: _______________________________ Specialty: _______________________
Office address: ________________________________________________________
Office phone: ________________________ Fax: _____________________________

## Insurance Information

**Primary** Insurance Company: ________________________________________________
ID#: ________________________________ Group #: ______________________________
Subscriber's Name: ______________________ Subscriber's DOB: _________________
Subscriber's SSN: __________________ Relationship to Subscriber: ________________

**Secondary** Insurance Company (if applicable) __________________________________
ID#: ________________________________ Group #: ______________________________



125 Kings Highway North, lower level, Westport, CT 06880 T 203-557-3331 F 203-557-6688

**Past Medical History** (please circle)

***Cardiovascular*** system: high blood pressure, angina, heart attack, heart failure, irregular heartbeat, heart murmur, other ________________________________________

***Respiratory*** system: asthma, bronchitis, emphysema/COPD, pneumonia, other

___________________________________________________________________________

***Digestive*** system: acid reflux (GERD), stomach ulcer or gastritis, hepatitis, pancreatitis, gall bladder problem, other ___________________________________________________

***Urinary*** system: kidney stone, urinary tract infection, enlarged prostate, bladder problem, other _____________________________________________________________

***Neurological*** system: stroke, headache, syncope (pass out), seizure, movement disorder, dementia, other ____________________________________________________

***Endocrine*** system: diabetes, thyroid problem, high cholesterol, other _______________

***Musculoskeletal system***: joint pain, joint swelling, joint stiffness, fracture, arthritis, chronic back pain, fibromyalgia, other__________________________________________

***Rheumatology disease***: lupus, rheumatoid arthritis, other ________________________

***Hematology & Oncology***: cancer, bleeding disorder, bone marrow disorder, DVT (clot in deep vein), PE (clot in the lung), taking blood thinner (aspirin, Plavix, Coumadin, etc.), other _____________________________________________________________________

***Psychiatric system***: depression, anxiety, bipolar, post-traumatic stress disorder (PTSD), obsessive compulsive disorder (OCD), drug addiction, other ________________

**Past Surgery History** (please list ALL previous surgeries with dates)

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

**Allergy**: _______________________________________________________________



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**Pain medications:** please list ALL medications you are currently taking for **Pain** including over the counter medications and herbs.

Name of Drug Dose Frequency Prescriber for the drug

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

Please list all the pain medications you took in the past and reason for discontinuation:

_______________________________________________

_______________________________________________

## Pharmacy Information

Name: ___________________ Address: ________________________________________

Phone number: ____________________ Fax: __________________________________

## Pain Treatment History

Besides medication, what other modalities are you using to manage pain?

| | | |
|---|---|---|
| Ice pack or heating pad | patch or ointment | TENS unit |
| Acupuncture | massage | physical therapy |
| Chiropractic | biofeedback | Yoga, Qigong, Pirate |
| Psychotherapy | naturopathic | pain procedures (below) |

Have you had any of pain procedures (epidurals or nerve blocks) in the past? Y N

If yes, what procedure, when, where and with whom? ___________________________

_______________________________________________

Was it helpful? Y N How long did the pain relief last? __________________________

Did you see any pain specialists in the past? ____________________________________

Can we request your medical record from your previous pain physician's office?

Y N **If yes, please sign the attached Release of Information form.**



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## Pain Description:

Location (where): ___________________________________________

**Symptom key**

| | |
|---|---|
| ===== | Aching |
| dddd | Stiffening |
| ^^^^ | Tightness |
| cccc | Cramping |
| xxxx | Burning |
| //// | Stabbing |
| 000 | Numbness |
| ttttt | Tingling |
| ssss | Sensitive |
| pppp | Other |

Duration (how long): _____________________________________________________

Onset (when and how did it start): __________________________________________



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Is this work-related injury? Y N Works-comp attorney ________

Is the pain constant ☐ or intermittent (come and go) ☐ ? Radiation? Y N

Description of the pain (i.e. sharp, dull, stabbing, achy, throbbing, etc.)

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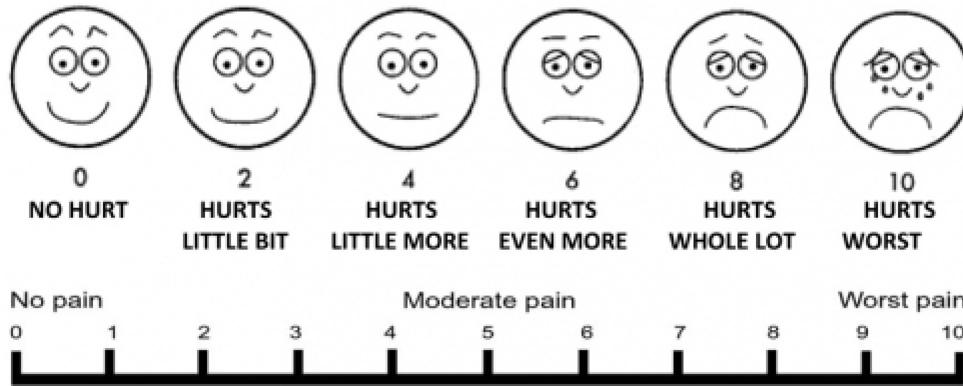
Severity of pain: number your pain using the pain score scale below




Worse pain score? ___ /10 Best pain score? ____ /10 Average ___ /10

What makes the pain better? (i.e. heat, cold, medication, resting, etc.)

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What makes the pain worse?

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Have you ever experienced any numbness or tingling in any part of your body? Y N

Have you ever experienced any weakness in your arms or legs? Y N

Have you ever lost control of your bowel or bladder? Y N

Signature: ______________________________

Print: ______________________________ Date: ___________________



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