GLOBAL PAIN MANAGEMENT, LLC

Welcome to Global Pain Management, LLC. We are honored that you have chosen us as your health care provider. We are looking forward to your appointment with our office, please note below the information that is needed so that your visit goes as smoothly as possible.

You are required to bring the following:

- New Patient Packet completely filled out
- Insurance Card
- Photo ID
- Referral
- Any relevant MRI's or X-Ray report(s). You may bring films but we will also need the REPORTS (Referring Physician should have this)
- Current list of medication(s)

If you are being seen due to a Workman's Compensation case or an Automobile accident case, you will need to bring in a letter of APPROVAL authorizing you to be seen at our office.

Please arrive 15 minutes prior to your scheduled appointment time.

PLEASE NOTE: Narcotic medications may not be prescribed at the first visit.

If you have any questions or concerns please feel free to contact the office at 443-825-4050.

OFFICE LOCATION: 8055 RITCffiE HIGHWAY STE 101, PASADENA, MD 21122. We are located directly behind the Dunkin Donuts and Bob Evans.

GLOBAL PAIN MANAGEMENT, LLC

Thank you for choosing Global Pain Management. Please complete the form below to help us learn more about your pain.

Name: _____

Date of Birth: _____
Today's date: _____

Primary Care Physician:

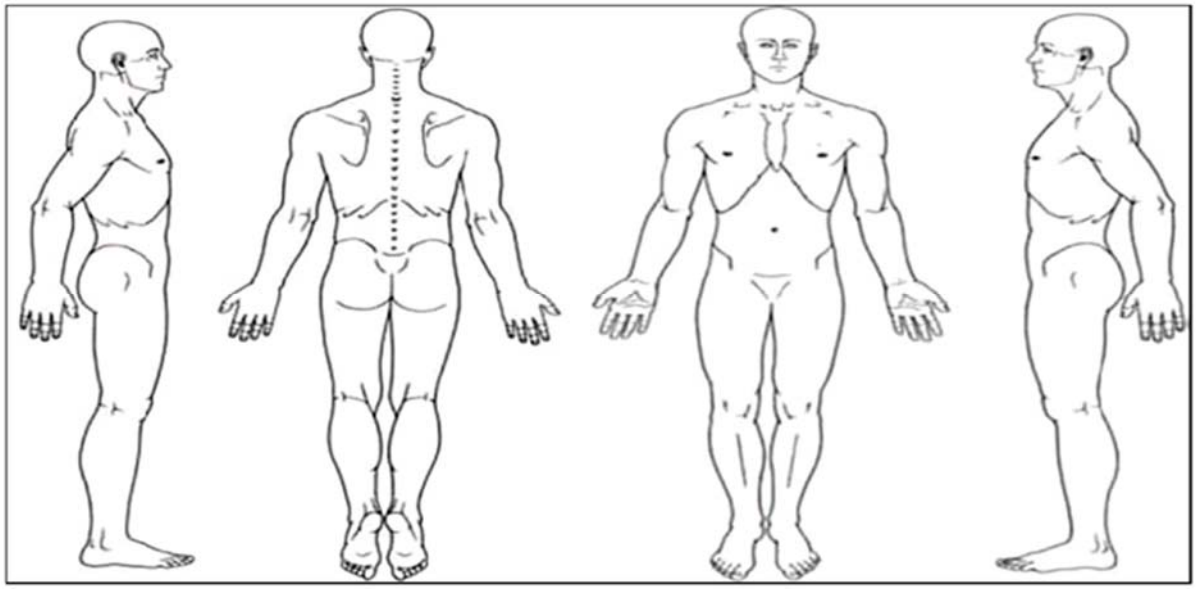
Name: _____
Address: _____
_____
_____
Phone Number: _____

Referring Physician:

Name: _____
Address: _____
_____
_____
Phone Number: _____

Where is your pain located? _____

Please use the diagram below to indicate where most of your pain is located.



When did your pain begin? If your pain is related to a specific injury, what date did the injury begin?

Month: _____ Day: _____ Year: _____

Is your pain related to a specific injury (car accident, job-related, fall, etc)?
_____

Please circle the AVERAGE daily level of your pain

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst pain imaginable)

Please circle the level of pain that is acceptable for you

0 1 2 3 4 5 6 7 8 9 10

Please circle the words that best describe your pain

dull aching throbbing sharp shooting stabbing burning

electric numbness tingling weakness spasm/ tightness cold

Please let us know how the following treatments influence your pain. Please check all that apply.

treatment	worsens	relieves	no difference	never tried
exercise				
walking				
massage				
heat				
cold				
TENS therapy				
medications				
injections				
acupuncture				
biofeedback				

Please indicate which of the following medications that you have tried in the past to treat your pain

naproxen _____
ibuprofen _____
meloxicam ____
tramadol _____
hydrocodone ___
Percocet _____

Butrans _____
morphine _____
fentanyl _____
methadone ____
opana _____
oxycontin _____

gabapentin _____
Lyrica _____
Topamax _____
amitripyline _____
nortriptyline _____

Have you ever been treated by another pain medicine specialist? No Yes

If so, what is the name of the doctor or practice? _____

8055 Ritchie Highway, Suite 101, Pasadena, MD 21122. Tel 443-825-4050. Fax 443-825-4051
www.globalpainmd.com

Please circle the medical conditions that you have, or have had in the past

diabetes high blood pressure GERD heart disease high cholesterol asthma COPD

seizures cancer kidney stones kidney failure cirrhosis thyroid disease

depression anxiety schizophrenia bipolar disorder ADHD OCD

Please list all surgeries that you have had

date	surgical procedure

Please list your current medications

medication	strength (milligrams)	times per day	Is it effective? (Yes or No)	prescribing doctor

Please list allergies to food or medications

_____
_____
_____
_____
_____
_____
_____

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Are you currently employed? Yes No

Please briefly describe your current or past occupation _____ _____

Are your presently being treated as a result of a claim made to Worker's Compensation? Yes No

Are you currently applying for, or receiving, disability benefits? Yes No

Are you involved in any legal action relating to your pain? Yes No

Please indicate your marital status

single married divorced widowed separated

Do you smoke cigarettes? No Yes _____ **packs per day, since age** _____

Do you consume alcohol? No Yes

If yes, how how often and how much do you drink? _____

Do you currently use , or have you previously used, recreational drugs? No Yes

Have you ever abused prescription drugs? No Yes

Have you ever been treated for alcohol, drug, or substance abuse? No Yes

Has anyone in your family ever abused alcohol, illegal drugs, or prescription drugs? No Yes

REVIEW OF SYSTEMS

Please circle any problems, illnesses or injuries that you have had.

Constitutional:
fever, chills, night sweats, weight gain, weight loss, fatigue, body aches, decreased appetite

Eyes:
pain, redness, vision changes, itching, discharge

ENT:
ear pain, hearing loss, nasal congestion, sore throat, ringing in ears

Respiratory:
shortness of breath, cough, wheezing, sputum production

Cardiovascular:
chest pain, palpitations, leg swelling

GI:
abdominal pain, constipation, diarrhea, bloody stools, nausea, vomiting, reflux

Neurological:
headache, weakness, numbness, dizziness, difficulty speaking

Musculoskeletal:
neck pain, lower back pain, thoracic pain, joint pain, joint swelling

Skin:
rash, itching

Enodocrine:
frequent urination, increased thirst, heat intolerance, cold intolerance

Psychiatric:
anxiety, depression, insomnia