Bryant Specialty Clinic

Saline Health System

New Patient Information

Phone (501) 361-6000
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Web salineclinics.org

PATIENT INFORMATION & REGISTRATION

Name: Date of Visit:

Referring Physician: Date of Birth: Age:

Primary Care Physician: Sex: ☐ Male ☐ Female

Preferred Phone # ☐ Home ☐ Mobile ☐ Work

Emergency Contact Name: Relationship:

Emergency Contact Phone #

Employer & Occupation:

In compliance with the HITECH Act (EHR) to attain Meaningful Use, we are required to capture demographic data including your preferred language, race, and ethnicity. This is an important part of your medical history and will assist us during our clinical quality improvement process. Please complete the information below:

Primary Language:

☐ Arabic
☐ Chinese
☐ English
☐ French
☐ Korean
☐ Spanish
☐ Other:

Race:

☐ African-American
☐ Arabic
☐ Asian
☐ Caucasian
☐ Filipino
☐ Hispanic
☐ Other:

Ethnicity:

☐ Hispanic
☐ Non-Hispanic

Email Address:

Patient Portal:

As we continue in our efforts to provide you, our patients, with the highest quality of care, we are constantly looking for methods of working together with you to ensure that you are not only aware but also involved in the maintenance and improvement of your health. The Patient Portal offers us a way to better remain engaged with you.

☐ Opt-In *(You will receive a registration email to set up your account)*
☐ Opt-Out

ADVANCED DIRECTIVES INFORMATION

Advanced Directives are legal documents that allow you to spell out your decisions about end-of-life care ahead of time. Although advanced directives, by anesthesia standards, are waived at this facility, we will keep them on file at your request. The directives will be recognized by the receiving hospital in the case that a transfer is required from our facility due to emergency.

Do you have any advanced directives to share with us? ☐ Yes ☐ No

If yes, please provide all relevant advanced directives documentation to our front office staff to keep on record.

PRIMARY COMPLAINT

Reason for visit: **How long have you had pain?**

Onset of Pain *(please select the appropriate indicator listed below):*

☐ Pain Began With No Known Cause ☐ Injury Outside Of Work ☐ Injury at Work ☐ Illness (Not Injury)

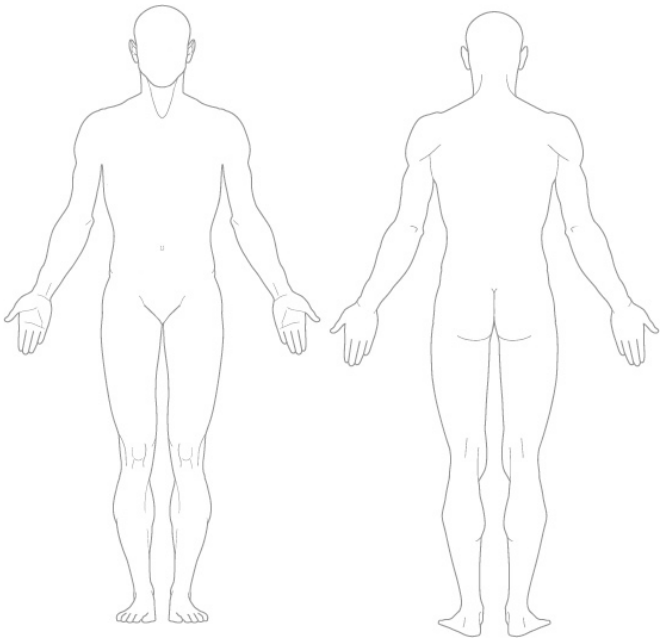
☐ Motor Vehicle Accident (PIP) ☐ Other

Explain how pain started:

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began, has your pain ☐ Increased ☐ Decreased ☐ Stayed the Same

Mark the location of your pain on the diagram below:



Mark 'X' for severe pain
Mark 'O' for less severe pain
Mark '' for tingling or burning*

Please circle the number that best describes the amount of pain you feel right now:

No Pain	0 1 2 3 4 5 6 7 8 9 10	*Severe Pain*

What pain level is a realistic goal for you? _____

What best describes your pain? *(select all that apply)*

☐ Aching / Cramping ☐ Numb
☐ Hot / Burning ☐ Stabbing / Sharp
☐ Dull ☐ Shooting
☐ Electrical ☐ Tingling

Frequency and duration of pain?

☐ Constant ☐ Intermittent ☐ Daily

Do you experience any of the following? *(select all that apply)*

☐ Weakness ☐ Numbness ☐ Tingling
☐ Loss of Bowel/Bladder Control ☐ Trouble with Balance

What makes your pain worse? *(select all that apply)*

☐ Bending Backwards ☐ Exercise ☐ Sitting
☐ Bending Forward ☐ Heat ☐ Standing
☐ Climbing Stairs ☐ Lifting ☐ Stress
☐ Cold ☐ Light Touch ☐ Walking
☐ Coughing / Sneezing ☐ Sexual Activity ☐ Work
☐ Driving

☐ Other:

What helps to relieve your pain? *(select all that apply)*

☐ Bath/Shower ☐ Lying Down ☐ Relaxation
☐ Exercise ☐ Medications ☐ Sitting
☐ Heat ☐ Meditation ☐ Standing
☐ Ice ☐ Physical Therapy ☐ Walking

☐ Other:

Pain interferes with *(select all that apply):*

☐ Appetite	☐ House Chores	☐ Shopping
☐ Cooking	☐ Job Performance	☐ Sleep
☐ Driving	☐ Self-Care	☐ Social Life
☐ Exercise	☐ Sex	☐ Traveling
☐ Hobbies		

Does your pain limit your ability to walk? ☐ YES ☐ NO

How long can you sit? ☐ Minimal ☐ 30 Minutes ☐ >1 Hour **How long can you stand?** ☐ Minimal ☐ 30 Minutes ☐ >1 Hour

To assist with walking, I use a: ☐ Cane ☐ Walker ☐ Wheelchair ☐ No Assistance Device

PRIOR WORKUP & TREATMENT

Have you ever had any of the following imaging studies?

☐ X-Ray of the	Date:	Facility:
☐ CT scan of the	Date:	Facility:
☐ MRI of the	Date:	Facility:
☐ EMG of the	Date:	Facility:
☐ Other:		

☐ **I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS**

PRIOR PAIN MEDICATIONS *(check all medications you have used in the past for treatment of pain)*

NSAIDS / Tylenol	☐ Aspirin	☐ Indocin	☐ Relafen
	☐ Celebrex	☐ Lodine	☐ Salsalate / Trilisate
	☐ Daypro	☐ Mobic	☐ Toradol
	☐ Feldene	☐ Motrin	☐ Tylenol
	☐ Ibuprofen	☐ Naproxen	
Opioids	☐ Codeine	☐ Hydrocodone	☐ Nucynta
	☐ Demerol	☐ Levorphanol	☐ Oxycodone (Percocet)
	☐ Dilaudid	☐ Methadone	☐ Oxycontin
	☐ Fentanyl	☐ Morphine / MSContin	☐ Tramadol
Anti-Depressants	☐ Bupropion (Wellbutrin)	☐ Duloxetine (Cymbalta)	☐ Paroxetine (Paxil)
	☐ Citalopram (Celexa)	☐ Escitalopram (Lexapro)	☐ Sertraline (Zoloft)
	☐ Desioramine	☐ Fluoxetine (Prozac)	☐ Venlafaxine (Effexor)
	☐ Desvenlafaxine (Pristiq)	☐ Imipramine (Tofranil)	
Anti-Anxiety	☐ Ativan	☐ Valium	
	☐ Klonopin	☐ Xanax	
Muscle Relaxants	☐ Baclofen	☐ Robaxin	☐ Valium (Diazepam)
	☐ Flexeril	☐ Skelaxin	☐ Zanaflex
	☐ Parafon Forte	☐ Soma	
Nerve Pain	☐ Amitriptyline	☐ Neurontin	☐ Tegretol
	☐ Cymbalta	☐ Nortriptyline	
	☐ Lyrica	☐ Savella	

Have you been treated at another pain management center or program? ☐ YES *(answer below)* ☐ NO

Where? When?

PREVIOUS TREATMENTS *(select all that apply)*:

☐ Acupuncture
☐ Biofeedback
☐ Blocks or Injections
☐ Bracing – Type: _____
☐ Chiropractic Manipulation
☐ Home Exercise Program
☐ Nerve blocks
☐ Physical Therapy - Date Completed: _____
☐ Surgery
☐ Other: _____

☐ **I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS**

MEDICATION THERAPY

Please list all of the medications you are taking now. Include all over-the-counter, herbal, and other supplemental medications and vitamins.

☐ **I HAVE PROVIDED MY PHYSICIAN WITH A PRINTED MEDICATION LIST**

Medication	Dose (mg)	How Often? (# times/day)	What is this medication for?	Date Started?	Prescribing Doctor

Do you take any blood thinning medications? ☐ YES ☐ NO ; If Yes, which one? _____

PAST MEDICAL HISTORY

Please check all that apply.

Cardiovascular

☐ Chest Pain
☐ Heart Attack
☐ Heart Disease
☐ Heart Rhythm Disturbances
☐ Diabetes
☐ Insulin
☐ High Blood Pressure
☐ Colitis
☐ Irritable Bowel Syndrome
☐ High Cholesterol

Respiratory

☐ Asthma
☐ COPD/Emphysema
☐ Chronic Bronchitis
☐ Anticoagulation
☐ Venous Insufficiency
☐ Low Blood Pressure
☐ Hiatal Hernia

Gastrointestinal

☐ Acid Reflux/GERD
☐ Ulcers
☐ Polyps
☐ Easy Bruising
☐ Arterial Insufficiency
☐ Bowel Problems
☐ Blood Thinners
☐ Embolism
☐ Liver Disease

Endocrine

☐ Obesity
☐ Hypothyroid
☐ Hyperthyroid
☐ Frequent Pneumonia
☐ Positive TB Test
☐ Frequent Colds/Sore Throat
☐ Blood Clots
☐ Gallbladder Problems
☐ Special Diet

Hematologic

☐ Bleeding Disorders
☐ Anemia
☐ Hepatitis A, B, C
☐ Pancreatitis
☐ Abnormal Chest X-Ray
☐ Crohn's Disease
☐ Other

Neurological

- ☐ Memory Problems
- ☐ Seizures
- ☐ Stroke
- ☐ Movement Disorder
- ☐ Muscular Dystrophy
- ☐ Neuropathy
- ☐ Migraine
- ☐ Epilepsy
- ☐ Headaches

Psychological

- ☐ Nervous Breakdown
- ☐ Depression
- ☐ Anxiety
- ☐ Panic Disorder
- ☐ Psychosis
- ☐ Alcohol or Drug Abuse
- ☐ Other

Genitourinary

- ☐ Sexual Dysfunction
- ☐ Sexually Transmitted Disease
- ☐ Prostate Disease
- ☐ Kidney Problems
- ☐ Chronic Infection
- ☐ Bladder Problems

Musculoskeletal

- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Back Problems
- ☐ Neck Problems

Miscellaneous

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Visual Problems
- ☐ Hearing Loss
- ☐ Chronic Skin Disorder
- ☐ Pregnancy

General

- ☐ Medical Equipment
- ☐ Cane
- ☐ Walker
- ☐ Wheel Chair
- ☐ Hospital Bed
- ☐ Oxygen

Allergic/ Immunological

- ☐ Autoimmune Disorder
- ☐ Lupus, Sjogren's
- ☐ Raynaud's Syndrome
- ☐ Immune Deficiency
- ☐ HIV

Cancer

- ☐ Site
- ☐ Diagnosis Date:
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Other

ALLERGIES

Please list any known drug, food, or environmental allergies and indicate the adverse effect/reaction:

Medications Allergic To	Reaction To Medication

- ☐ Contrast/IV Dye
- ☐ Iodine
- ☐ Latex
- ☐ Shellfish
- ☐ Other (specify): _____
- ☐ **I HAVE NO KNOWN ALLERGIES**

PAST SURGICAL HISTORY

Type of Surgery	Date

☐ **I HAVE NOT HAD ANY SURGICAL PROCEDURES DONE**

PAST HOSPITALIZATION

Reason For Hospitalization	Date

☐ I HAVE NO HISTORY OF HOSPITALIZATION

FAMILY HISTORY

Please specify any medical or psychiatric conditions common among BIOLOGICAL family members only:

☐ Anxiety / Depression
☐ Arthritis
☐ Cancer
☐ Diabetes
☐ Headaches
☐ Heart Disease / Stroke
☐ High Blood Pressure
☐ Kidney Problems
☐ Liver Problems
☐ Rheumatoid Arthritis
☐ Seizures
☐ Substance Abuse
☐ Other: _____

☐ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY

SOCIAL HISTORY

Are you a smoker?

☐ CURRENT, How Many? _____
☐ FORMER ☐ NEVER

Do you drink alcohol?

☐ YES, How Much? _____
☐ NO

Do you use illicit street drugs?

☐ YES, Which Ones? _____
☐ NO

What is your marital status?

☐ Single ☐ Married ☐ Cohabitating ☐ Separated
☐ Divorced ☐ Widowed

Who do you live with?

☐ Alone ☐ Spouse ☐ Children ☐ Parents

Are you pregnant, or planning a pregnancy?

☐ YES ☐ NO

PAST PSYCHOLOGICAL HISTORY

Have you ever had psychiatric or psychological evaluation or treatment for any problem, including pain?

☐ YES, Treated For: ☐ ADD ☐ OCD ☐ Bipolar ☐ Schizophrenia ☐ Other: _____
☐ NO

Have you ever been treated for symptoms of depression?

☐ YES, When? _____
☐ NO

Have you ever considered/planned/attempted suicide?

☐ YES, When? _____
☐ NO

REVIEW OF SYSTEMS

Do you have any of the following?

General	☐ Fatigue ☐ Fever	☐ Weight Loss/Gain ☐ Other: _____	
HEENT	☐ Cataract ☐ Glaucoma	☐ Hearing Loss ☐ Other: _____	
Cardiovascular	☐ AICD/Pacemaker ☐ Chest Pain ☐ Claudication	☐ Heart Attack ☐ Heart Failure ☐ Heart Murmur	☐ Hypertension ☐ Irregular Heartbeat ☐ Other: _____
Respiratory	☐ Asthma ☐ Bronchitis ☐ Cough	☐ Emphysema ☐ Pulmonary Embolus ☐ Sleep Apnea	☐ SOB ☐ TB ☐ Other: _____
Gastrointestinal	☐ Cirrhosis ☐ Diverticulitis ☐ Gall Bladder Disease	☐ GERD ☐ Hepatitis ☐ Hyperlipidemia	☐ Irritable Bowel ☐ Peptic Ulcer Disease ☐ Other: _____
Genitourinary	☐ Dialysis ☐ Renal Failure	☐ Transplant ☐ Other: _____	
Musculoskeletal	☐ Back Pain ☐ Joint Pain	☐ Neck Pain ☐ Rheumatoid Arthritis	☐ Other: _____
Neurological	☐ Dizziness ☐ Seizures	☐ Stroke ☐ Other: _____	
Psychiatric	☐ Anxiety / Stress ☐ Bipolar	☐ Depression ☐ Suicidal Thoughts/Planning	☐ Other: _____
Endocrine / Metabolic	☐ Diabetes ☐ Lupus	☐ Thyroid Disease ☐ Other: _____	
Hematologic / Lymphatic	☐ Anemia ☐ Bleeding/Clotting Problems	☐ DVT ☐ Other: _____	

Cancer: ☐ YES ☐ NO ; If Yes, Type: _____

Chemo: ☐ YES ☐ NO

Radiation: ☐ YES ☐ NO

CERTIFICATION

I certify that the above information is accurate, complete, and true. I understand that this will become part of my medical record.

X _____

Patient Signature (Patient, Guardian, or Representative) Date

_____

Printed Name