PREMIER PAIN & REHAB CENTER, PC
10184 VERREE ROAD
PHILADELPHIA, PA 19116
T: 215.934.6665 F: 215.934.5151

Who may we thank for referring you? _____

Name: _____ Date:_____
First Middle Last

Social Security # _____ Driver's License# _____
Address_____ City_____ State_____ Zip_____

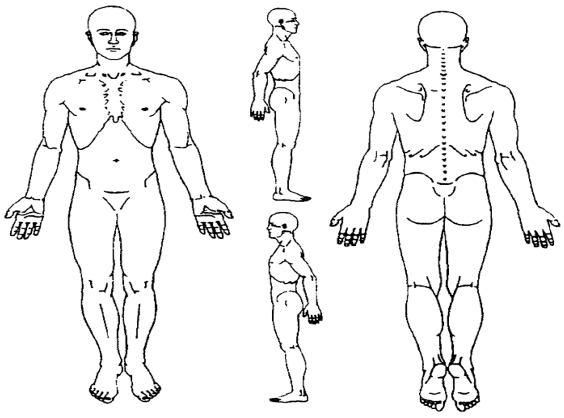
DOB: _____ Age_____ Sex: Male/ Female Email: _____
Home phone #_____ Cell #_____ Work #_____

Nearest friend or relative not living with you, in case of emergency:
Name: _____ Relationship: _____ Phone# _____

Primary Health Insurance: _____ ID# _____ Group# _____
Subscriber's Name: _____ DOB: _____ SS# _____

Are you currently involved in a lawsuit or disability case? Yes or No
If yes, please explain: _____
Attorney's Name: _____Phone# _____
Insurance Carrier: _____ Claim # _____

Reason for Office Visit: _____
Location of Pain: _____
How would you describe your pain? Sharp dull aching cramping numbness/tingling
(Circle all that apply) electric pressure tightness stabbing knife-like
Write any additional information regarding your pain below:



How long ago did your pain start? _____

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How has your pain affected your activities of daily living or ability to perform your job?

_____

Have you seen any other doctors and/or health care providers regarding this pain before today? Yes or No
Do you have XRAY, MRI, CT scan, or any other tests? Please list below:

Have you had any treatment(s) for your pain? Please list below:

Medications (NSAIDS, opioids, anti-depressants, etc): _____
Surgery/Injections: _____
Chiropractic/Physical Therapy: _____
Mental Health: _____
Other: _____

Past Medical History (Please list below):

Have you had any past and/or current psychiatric condition for which you received any treatment such as psychiatric, psychological, medications, hospitalizations, therapy, etc? If YES, please explain:

_____

Any personal or family history of bleeding disorders or bruising easily? If YES, please explain:

_____

Past Surgical History (Please list below):

Family History related to pain (Please list below):

Allergies (Please circle): Opioids NSAIDs IV contrast Anesthesia Latex

Any additional, please write: _____

Social History:

Marital Status: Single Married Partner Other: _____
Smoking YES or NO; If yes, how many packs per day? _____
Alcohol YES or NO; If yes, how many drinks per day? _____
Drug Use YES or NO; If yes, name of drug, how much, how often, and when did you last use?

Current Medications (Please list below):