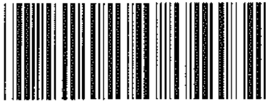
ADDRESSOGRAPH



NHF325

NORTHSIDE HOSPITAL FORSYTH

AFFIX PATIENT LABELS OVER THIS BOX

Age: ________ Weight: ________

Stated Reason for Visit: ____________________

Referring Physician: ____________________ #________

Y	N	
		HEALTH HISTORY: - Check all that apply
☐	☐	**Oral:** ☐ TMJ **Vision:** ☐ Glasses ☐ Blind/Visual Impairment **Hearing:** ☐ Hearing Loss ☐ Hearing Aid ☐ Other:________
☐	☐	**Respiratory:** ☐ Asthma ☐ Bronchitis ☐ COPD/Emphysema ☐ Shortness of Breath ☐ Sleep Apnea/CPAP ☐ Other: ________
☐	☐	**Cardiac:** ☐ Heart Attack ☐ Chest Pain/Angina ☐ Irregular Heart Beat ☐ Heart Failure ☐ High Blood Pressure ☐ Other: ________
☐	☐	**Neurological:** ☐ Stroke/TIA ☐ Seizures ☐ Spinal Cord Injury ☐ Dizziness ☐ Burning (where) ________ Numbness/Tingling (where) ________ ☐ Other ________
☐	☐	**Musculoskeletal:** ☐ Neck Pain ☐ Back Pain ☐ Limb Pain (where) ________ ☐ Arthritis ☐ Swelling/stiffness ☐ Weakness ☐ Limitation of Activity ☐ Recent Falls ☐ Unsteady Gait ☐ Other: ________
☐	☐	**Cancer:** ________ ☐ Chemotherapy ☐ Radiation Therapy ☐ Other:________
☐	☐	**Endocrine:** ☐ Diabetes Insulin Control ☐ Diabetes Oral Medication Control ☐ Diabetes Diet Control ☐ Thyroid Problems ☐ Other:________
☐	☐	**Gastrointestinal:** ☐ Ulcer ☐ Hiatal Hernia ☐ Chronic Heartburn ☐ Liver Disease ☐ Constipation ☐ Other:________
☐	☐	**Skin:** ☐ Rashes ☐ Recurrent Lesions ☐ Raynaud's ☐ Other:________
☐	☐	**Hematologic:** ☐ Prolonged Bleeding ☐ Anemia ☐ Easy Bruising ☐ Lymphedema ☐ **Blood Thinning Agents** Type ________
☐	☐	**Infectious Disease:** ☐ TB ☐ Herpes ☐ HIV/AIDS ☐ Hepatitis ☐ Other ________
☐	☐	**Genitourinary:** ☐ Kidney Stones ☐ Frequent Urinary Tract Infections ☐ Other:________
☐	☐	**Reproductive: Are you pregnant?**

OPERATION/THERAPY/PROCEDURE	ANESTHESIA	SURGICAL/ANESTHESIA COMPLICATIONS	YEAR

MRI/XRAY

Type________ Date ________ Where ________ Phone Number ________

Type________ Date ________ Where ________ Phone Number ________

Type________ Date ________ Where ________ Phone Number ________

Previous Treatment for Current Problem ____________________

Y	N	
		EMOTIONAL/SPIRITUAL/CULTURAL NEEDS:
☐	☐	**Mental/Emotional:** ☐ Anxiety ☐ Depression ☐ Job Loss ☐ Divorce ☐ Death of Someone Close to You ☐ New Job ☐ Under Care of Psychiatrist/Psychologist Name ________
☐	☐	Do you have concerns about your safety, the safety of anyone in your home or the security of your property?
☐	☐	**Habits:** ☐ Tobacco #PPD ______ Quit ______ ☐ Street Drugs ☐ Marijuana ☐ Cocaine Quit ______ ☐ Alcohol Use Amt ______ Quit ______

Completed by: ____________________ Date/Time: ____________ Patient/Responsible Adult

Subsequent Visit #1 Review ____________________ Initial/Date/Time

Subsequent Visit #2 Review ____________________ Initial/Date/Time

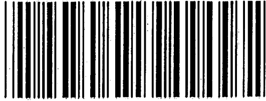
Subsequent Visit #3 Review ____________________ Initial/Date/Time

☐ Complete/Review/Update Medication Allergy/Sensitivity Database ☐ Complete/Review/Update Medication Reconcilation (form #PSO1000).

Reviewed by: ____________________ RN Date/Time: ____________ *See Pain Treatment Center Follow-Up Visit Form for futher details.

PAIN TREATMENT CENTER ADMISSION DATABASE

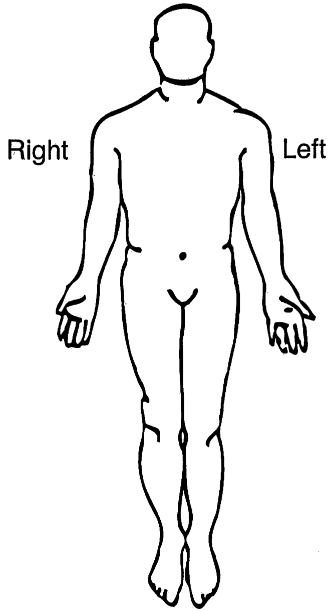
ADDRESSOGRAPH

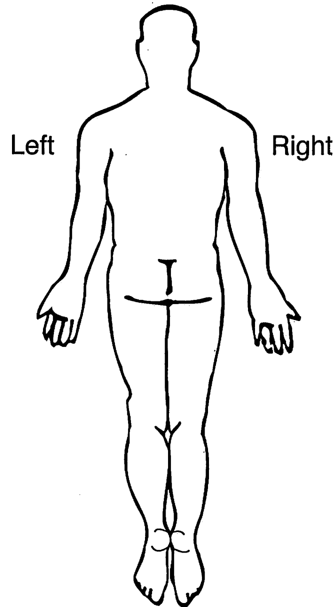


NORTHSIDE HOSPITAL

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES





Use the following symbols as they apply to your pain.

Numbness/Pins and Needles: :::::::::

Burning: BBBBB

Aching: vvvvvv

Stabbing: /////////

Pregnant **Yes** ____ **No** ____

Blood Thinners **Yes** ____ **No** ____

Mark the areas on this body where you feel the pain. Include all the affected areas.

Pain Profile-Severity: (Circle)

At it's worst the pain is	0 (no pain)	1	2	3	4	5	6	7	8	9	10 (unbearable)
At it's least the pain is	0 (no pain)	1	2	3	4	5	6	7	8	9	10 (unbearable)
At present, the pain is	0 (no pain)	1	2	3	4	5	6	7	8	9	10 (unbearable)
Realistically, I would like my pain to be	0 (no pain)	1	2	3	4	5	6	7	8	9	10 (unbearable)

Pain Profile-Duration: (Circle)

Since initial onset Pain has   Worsened   Unchanged   Improved

My Pain is now experienced   100% (all day and night)   75% (most of the day and night)

50% (half of the day/night)   25% (part of the day and night)

______ Daily times/month   ______ Times/week   Variable-comes and goes

My Pain is worse when: ____________________

You must have a driver for our procedure, unless otherwise directed by staff. My driver is:

NAME OF DRIVER ____________________   PHONE NUMBER/WAITING ROOM # 7810 ____________________

RN

PATIENT SIGNATURE   DATE/TIME   REVIEWED BY   DATE/TIME

Reorder #10338   NH0899 HPF
Piedmont Graphics   Rev. 04/18/07

PAIN TREATMENT CENTER PAIN ASSESSMENT