ADVANCED PAIN CARE
65 Springfield Ave, Springfield, NJ 07081
Phone: (908)242-3688 Fax: (800)615-1868

NIGNNING HE, MD
Board Certified Anesthesiologist
Fellowship Trained in Pain Medicine

HEALTHCARE PATIENT REGISTRATION

Today's Date: _____ Referral Doctor: _____ Family Doctor: _____

Name: _____ DOB: _____ SSN#: _____

Gender: □ *Male* □ *Female* Marital Status: □ *Married* □ *Single* □ *Divorced*

Street Address: _____City: _____ State: _____ Zip Code: _____

Home phone: _____ Mobile phone: _____ Alternate phone: _____

Email:_____

Emergency Contact: _____ Relationship: _____ Phone: _____

Current Employment Status: □ *Full time* □ *Part time* □ *Retired* □ *Student* □ *Home maker*
□ *Unemployed* □ *Disabled* □ *Self-employed*

Most Recent Occupation: _____ Employer: _____

Primary Insurance: _____ Secondary Insurance: _____

Height: _____ Weight: _____

Do you smoke? □ *Yes* □ *No* If Yes, how much? _____

Do you consume alcohol? □ *Yes* □ *No* If Yes, how often? _____

Do you have any allergies? □ *Yes* □ *No* If Yes, please list _____

Please list your CURRENT medical conditions (why you visit today):

_____
_____
_____
_____

Please list your PAST medical conditions and medical care provider:

_____
_____
_____
_____

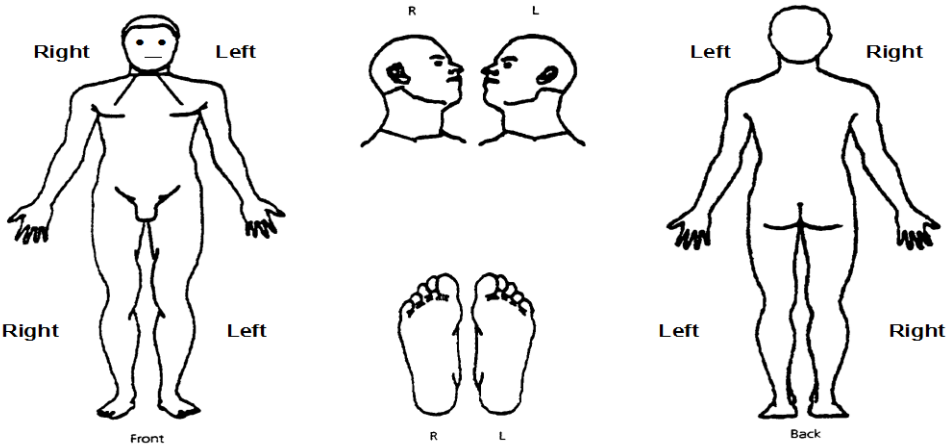
Please list all past surgeries and year:

_____
_____
_____
_____

Please list medications with dosage and frequency you are taking:

_____
_____
_____
_____
_____

Location of Pain: Please shade in the painful areas in the diagram below. Put “x” on areas of tingling, “o” on burning areas, and “*” on areas with no feeling at all.



Least Pain level (0 being the least amount of pain): 0 1 2 3 4 5 6 7 8 9 10

Worst Pain level (0 being the least amount of pain): 0 1 2 3 4 5 6 7 8 9 10

Which of the following treatments have you had for your pain? Check all that apply.

□ O*ver the counter Pain Killer (such as Motrin, Advil, Aspirin, Aleve, Tylenol)*

□ *Surgery* □ *Physical Therapy* □ *Massage* □ *Acupuncture* □ *Chiropractic*

□ *Nerve blocks and injections (such as epidurals, facet injections, etc)*

□ *TENS* □ *Botulinum Toxin* □ *Biofeedback/Relaxation training* □ *Counseling/Psychotherapy*

□ *Other:* _____

Which of the following make your pain feel worse? Check all that apply.

□ *Sitting* □ *Standing* □ *Walking* □ *Lying down* □ *Bending forward* □ *Bending backwards* □ *Morning hours*

□ *Evening hours* □ *Coughing, Sneezing* □ *Damp weather* □ *Physical therapy* □ *Getting out of bed* □ *Stress*

□ *Other:* _____

Which of the following make your pain feel better? Check all that apply.

□ *Sitting* □ *Standing* □ *Walking* □ *Lying down* □ *Bending forward* □ *Bending backwards* □ *Morning hours*

□ *Evening hours* □ *Relaxation* □ *Physical therapy* □ *Acupuncture* □ *Heat* □ *Ice pack* □ *Alcoholic*

□ *Other:* _____

Signature_____ Date_____