JOHNSON MEMORIAL HEALTH

1125 West Jefferson St. | Franklin, Indiana | 46131

NEW PATIENT SUMMARY FORM

Patient Name: _____ Date of Birth: _____

Instructions: Please complete all questions to the best of your ability. The Pain Management physician and staff will use this information to learn more about your pain history and prior treatments.

1. What caused the pain to begin? When did it begin?_____
2. Did the pain begin gradually or suddenly? _____
3. Where did you go for initial treatment? _____
4. Please list the other doctors you have seen for *this condition:* _____

Doctor's Name	Type of Doctor (Neurologist, Neurosurgeon, etc.	City, State	Month /Year

5. Have you had any testing (x-ray, Myelogram, etc.) for your pain? ☐ No ☐ *Yes (Please complete table below.)*

Test (x-ray, MRI, etc,)	Where was test done? (Facility name, City, State)	Month/Year

6. What assistive devices you use because of your pain: Wheelchair /Walker /Cane/ Brace/ Reacher/ _____
7. Place a check mark in the box that describes the treatments you have used in the past and the relief it provided:

Treatments	Significant Relief	Moderate Relief	Minimal Relief	No Relief
Injections **Type:** _____				
Chiropractic				
Physical Therapy				
TENS				
Massage				
Bracing				
Occupational Therapy				
Acupuncture / Pressure				
Other.				

Please complete the *back of this form that* describes the medications you have used to treat this pain.

Patient Signature: _____ ***Date:*** _____ ***Time:*** _____