CALMARE®
Pain Therapy Treatment

Rutherford Allied Medical

NEW PATIENT INFORMATION

CONFIDENTIAL PATIENT MEDICAL HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent record.

Name_____ Date of Birth _____ Sex M __ F __

Address _____

City_____

U.S. State _____ U.S. Zip _____ Country _____

Email Address _____

Home Phone _____ _____Cell _____

Emergency Contact _____ Cell _____

Are you currently employed? Yes No | Is the patient under age 18? Yes No

Patient Occupation_____ Employer _____

If under age 18, is the patient attending an on-site school at this time? Yes No

Are you: __Not disabled ___Completely disabled ___Partially disabled Date of disability: _____

Are you reliant on any devices for normal mobility (cane, wheelchair, etc.): Yes No

Marital Status __M __S __D__W Children & Ages _____ _____

Spouse's Name _____ Cell_____

Name / city of your personal care physician: _____

How else did you hear about Calmare Therapy NJ? _____

HIPAA POLICY

A notice of health information practices is posted in the waiting room for your examination. If you have any questions, please inquire at the front desk. I acknowledge that I have been informed of this policy.

Signed (patient or parent if minor): _____

Date: _____

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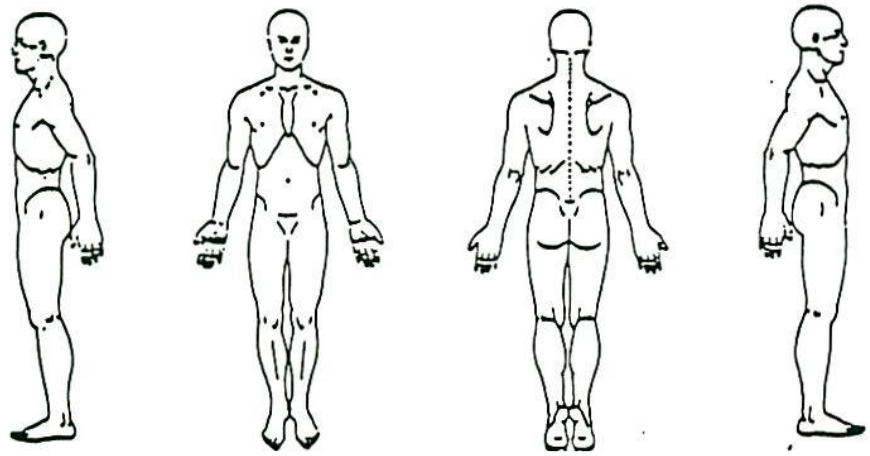
NEUROPATHIC HISTORY

Name: _____ **Date:**_____

Please complete the following information as accurately as possible. All information will be held in strict confidence and will not be divulged to others without your prior authorization (or parent/guardian's authorization in the case of a minor).

Below: Mark the type and location of pain on the body outlines below. Use code letters as indicated:

Pain Drawing Key		
A= Ache	**P**= Pins & Needles	**S**= Stabbing
B= Burning	**X**= Other	**N**= Numbness



CURRENT PAIN SCALE: ***(Mark your overall level or range of pain)***

No Pain (0) |----------|----------| (10) Worst Pain

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Please identify cause (diagnosis) of chronic pain:

_____

Month/year pain condition began:

_____

How did your condition start? Include approximate dates of injury or surgery.

_____
_____
_____

Is your problem due to a work-related injury? □Yes □No **If yes, please describe:**

_____
_____
_____

What doctors have you seen for this condition?

Doctor	**Month/Year of Treatment**	**Treatment Prescribed**
1.		
2.		
3.		
4.		
5.		

Did your chronic pain begin:

□ Immediately after a specific incident* □ After multiple incidents*
□ Gradually over time □ No specific reason noted

What makes your pain BETTER:

□ Lying down □ Sitting □ Standing □ Walking □ Movement/Exercise □ Inactivity
□ Nothing □ Other: _____

What makes your problem WORSE:

□ Lying down □ Sitting □ Standing □ Walking □ Movement/Exercise □ Inactivity
□ Nothing □ Other: _____

How often do you feel pain?

□ Constant (76-100%) □ Frequent (51-75%)
□ Occasional (26-50%) □ Intermittent (25% or less)

Since your problem began, the pain has:

□ Increased □ Decreased **or** □ Has not Changed

How would you grade your overall daily stress level?

□ None □ Minimal □ Moderate □ Great

Does your pain interfere with your interpersonal relationships?

_____

0 1 2 3 4 5 6 7 8 9 10
No Definitely

Does your pain interfere with your sleep?

_____

0 1 2 3 4 5 6 7 8 9 10
No Definitely

Is your condition affecting your ability to work/ participate in normal activities?
If yes, please explain:

_____

ADDITIONAL HEALTH ISSUES IN ADDITION CURRENT NEUROPATHY (PAIN)? Yes / No

If yes, list other medical conditions:

_____
_____

EYE Issues Yes / No
(blurred vision, eye pain, discharge, etc)

_____

EARS, NOSE, THROAT, MOUTH Issues Yes / No

_____

RESPIRATORY Yes / No
(asthma, emphysema, chronic bronchitis,

_____

CARDIOVASCULAR Yes / No
(diabetes, hypertension, heart problems)

_____

GASTROINTESTIONAL Yes / No
(diarrhea, constipation, hernia, ulcers, etc.)

_____

GENITOURINARY Yes / No
(painful urination, frequent urination, impotence, jaundice, etc.)

_____

LYMPHATIC Yes / No
(anemia, bleeding problems, problems with blood transfusions, etc.)

_____

TOBACCO USE Yes / No (frequency) _____

ALCOHOL USE Yes / No (frequency) _____

WOMEN ONLY – GYNECOLOGICAL ISSUES Yes / No
(Describe)

_____

CURRENT MEDICATIONS AND DAILY PRESCRIBED DOSAGE:

_____
_____
_____
_____

Allergies:

_____

Family History (parents, siblings' diseases, chronic conditions, causes of early death)

_____
_____
_____
_____

Vitals (if known): Height: _____ Weight: _____BP: _____

Any other information you would like to share that may be helpful in your treatment plan?

_____
_____
_____
_____

What are your expectations about undergoing Calmare Therapy? What is your goal?

_____
_____
_____

By my signature below, I attest that the above information is true and accurate:

Signature: _____ Date _____

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I hereby acknowledge by my signature I am authorizing Dr. Michael Cooney, Clinical Director, Calmare Therapy NJ, or his specified agent(s) to perform whatever diagnostic procedures they may deem medically necessary in order to adequately evaluate and treat my condition (or patient's condition, where I am the parent/legal guardian).

Patient's Signature: _____ Date: _____