MAIDEN LANE
MEDICAL

Jennifer Zocca, M.D. New Patient Form

Date:_____ Referring Provider:_____

Primary Care Provider:_____

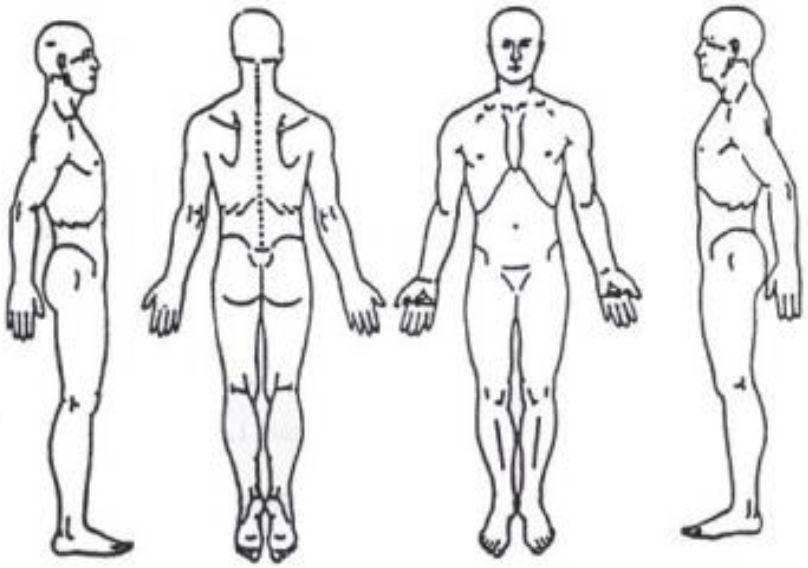
Pain History:

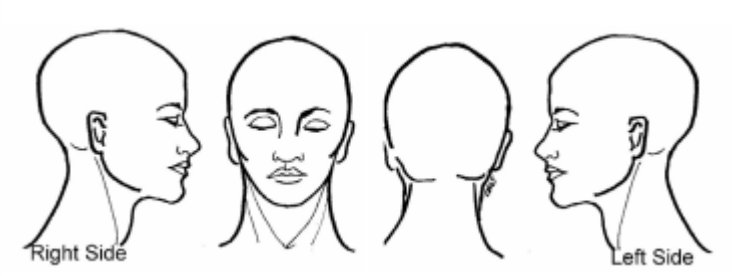
When did your pain start? Any obvious causes? Do you have a theory as to what is causing your pain?_____

_____

_____

Please indicate on the figures below by using shading where your pain is located:





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My pain is located primarily in my: (include if the pain starts in one body part and radiates into others)_____

_____

Circle which number on the 0-10 scale, 10 being most severe, that your pain is CURRENTLY:

1 2 3 4 5 6 7 8 9 10

Circle which number on the 0-10 scale, 10 being most severe, that your pain is when it is the WORST:

1 2 3 4 5 6 7 8 9 10

Circle which number on the 0-10 scale, 10 being most severe, that your pain is when it is the LEAST:

1 2 3 4 5 6 7 8 9 10

Circle which number or range of numbers you consider to be a MANAGEABLE level of pain:

1 2 3 4 5 6 7 8 9 10

How would you describe your pain? Circle the words that best fit:

Sharp	Aching	Shooting	Stabbing	Burning
Electrical	Pins/Needles	Dull	Spasms	Throbbing

Other (Please describe):_____

Is the pain associated with numbness or tingling?

No Yes (please describe): _____

Is the pain associated with weakness? (This means you have difficulty moving a part of your body, not generalized weakness.)

No Yes (please describe):_____

Is the pain associated with changes in your bowel or bladder habits?

No Yes (please describe):_____

What makes the pain BETTER:

_____

_____

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What makes the pain WORSE:

_____

_____

How long can you sit? _____min ____hours How long can you stand? _____min _____hours
How long can you walk? _____min or _____distance

What percentage of the day are you in pain? (Circle)
100%/all the time 75%/most of the time 50%/Some of the time 25%/rarely

What time of day is worse for your pain? (Circle)
Morning Afternoon Evening When trying to Sleep

Are you currently not working due to your pain?
No Yes (details on when stopped, on disability?)_____

Are you involved in a lawsuit relating to your pain?
No Yes
(details):_____
_____

Therapies:
Please list all CURRENT pain medications including dosages and who prescribed this medication:

Medication	Dose/Frequency	Who prescribed	Effective?

** Please note that we will be confirming opioid dosages with the New York State Prescription Monitoring program (Istop) and with prior records**

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Please list all PAST pain medications including dosages and who prescribed this medication. Include over the counter medications and ointments/creams as well as HERBAL medications:

Medication	Dose/Frequency	Who prescribed	Effective?	Side effects

Have you tried medical marijuana?

No Yes (provide details of who certified, if currently using, effectiveness):_____

_____

Please indicate which procedures you have had, provide the date and effectiveness.

- Trigger point injection: Date(s)_____Effective? _____
- Epidural steroid injection: Date(s)_____ Effective?_____
- Facet joint injection/Medial Branch Blocks: Date(s)_____Effective?_____
- Facet joint Radiofrequency Ablation: Date(s)_____ Effective?_____
- Sacroiliac joint injection: Date(s)_____Effective?_____
- Hip Joint injection: Date(s)_____ Effective?_____
- Hip Bursa injection: Date(s)_____ Effective?_____
- Knee Joint injection, steroid/cortisone: Date(s)_____ Effective?_____
- Knee joint injection, viscosupplementation: Date(s)_____ Effective?_____
- Knee nerve block, radiofrequency ablation: Date(s)_____ Effective?
- Shoulder injection, steroid/cortisone: Date(s)_____Effective?_____
- Nerve block: Type_____ Date(s)_____ Effective?_____
- Spinal cord stimulator: Type_____ Date Implanted_____ Effective?_____
- Intrathecal Pump: Date Implanted_____ Who manages?_____ Effective?_____

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- PRP: Where was it injected in your body?_____ Date_____Effective?_____
- Stem Cells: Where was it injected in your body?_____
  Date_____Effective?_____
- Other: Please Specify as many details as you
  know_____
  _____

What surgeries have you had FOR YOUR PAIN:

Type	Surgeon	Date	Effective?	Complications?

Please circle any other modalities that you have participated in, date and effectiveness.

Type	Dates	Effective?
Physical Therapy		
Psychotherapy		
Acupuncture		
Massage		
Mindfulness Therapies (Meditation)		
Chiropractor		
Brace		
TENS		
Other		

Is there anything else you want us to know about your pain?

_____
_____
_____