Nathan Overbey, MD, Brandon Valantine, DO,
& Cooper Yates, MD.
14100 Parkway Commons Drive STE. #201, Oklahoma City, Oklahoma 73134
Office: (405) 749-2765 | Fax: (405) 749-6209

{ New Patient Information }

Patients Legal Name: Last	M.I.	First:	Gender:	Date of Birth:	Age:
Patient's Address:			Soc. Sec. Number:		
City:	State:	Zip Code:	Email Address:		
Home Phone:	Cell Phone:	Work Phone:	Preferred Language:		
Race:	Emergency Contact:		Phone # of Emergency Contact:		
Marital Status: (please circle one) Single	Divorced	Married	Widowed		
Primary Care Physician		Cardiologist (If applicable):			
Advanced Directive (check all that applies) Living Will Healthcare POA DNR None					

Primary Insurance Carrier: ____

Policy Holder: ____

Relationship to the Patient: ________________ Carrier's SS# ________________ Carrier's DOB: __________

Secondary Insurance Carrier: ____

Relationship to the Patient: ________________ Carrier's SS# ________________ Carrier's DOB: __________

______________________________ ______________

Patient Signature **Date**

Nathan Overbey, MD, Brandon Valantine, DO,
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OSH Pain Management
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{New Patient Packet}

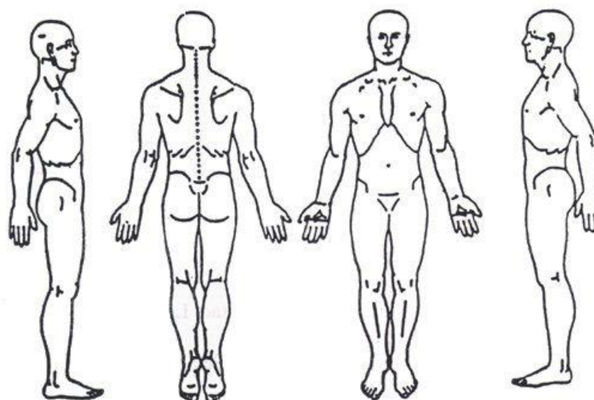
Name: ____ | DOB: ________________ | Age: _______

What is your pain score for today? Please ***circle*** below:

1 2 3 4 5 6 7 8 9 10

Rate pain on a scale from 0(no pain) to 10(excruciating):

At **WORST**: _______ At **LEAST**: _______ On **Average**: _______



Height: ________ **Weight:** __________

Please ***circle*** the area of pain above

Please *circle* all that apply:

Is your pain constant? **YES or NO**

When did your pain start? _________

Is this due to a work injury? _________ Date of Injury? __________

Is this due to Motor Vehicle Accident or Personal Injury? ________ Date of Injury? ____________

{Describing your pain} **Aching Dull Burning Throbbing Sharp Stabbing Shooting Pressure Squeezing Tightness Cramping Spasming Pins and Needles Numbness Tingling Weakness**

{What makes your pain worse?} **Lifting Bending Squatting Stooping Twisting Sitting Standing Walking Driving Reaching Looking-up Exercise/Increased-Activity House/Yard-work Coughing**

{What makes your pain better?} **Ice Heat Massage Rest Lying-down Sitting Standing/Walking Change-of-position Medications Stretching Manipulation/Chiropractor Physical Therapy TENS Acupuncture**

Have you ever done physical therapy for this problem? **YES** or **NO** If yes, when? ____________________

Do you use any aids to better assist you when walking? ____

What medications have you tried for your pain? ____

____

Please list other previous treatments for your pain (i.e. injections, nerve blocks, TENS units, acupuncture,

chiropractic care, surgery, or stimulator). ____

Do you have any bowel or bladder incontinence, fever chills? **YES** or **NO**

Do you currently have any allergies? ____

PLEASE LIST:

Medical Problems (Please circle all that apply)

Hypertension	Diabetes	Stroke	Coronary Artery Disease
COPD	Sleep Apnea	Seizures	Atrial Fibrillation

Other____

Surgical History: (type of surgery, date, and Surgeon): ____

____

____

____

Are we authorized to view your online medication history? YES or NO

If yes, please list current over the counter medications. If no, please list all medications:

____

____

____

Do you currently take any blood thinners or aspirin? **YES** or **NO (**If so what type?) ______________________

Social History:

Social status: **Married** **Single** **Divorced** **Widowed**

Do you drink alcohol? (please circle one) **No** **Occasionally** **Socially** **Frequently**

Do you smoke/vape? (please circle one) **YES** or **NO**

History of alcohol or drug abuse? **YES** or **NO**

Employment Status: **Employed** **Self-employed** **Unemployed** **Retired** **Disabled**

Use of Medical marijuana and/or recreational **Yes** or **No**

Family History:

Father: Medical Problems: ____

Mother: Medical Problems: ____

Review of Symptoms: (**CIRCLE ALL THAT APPLY)**

Constitutional: Fever, Fatigue, Weight gain, Weight loss, Generalized weakness

HEENT: headache, dizziness, loss of vision, corrective lenses, blurry vision, hearing loss, sinus problems, sore throat, hoarseness

Respiratory: Shortness of breath, Wheezing, Cough, Sleep apnea

Cardiovascular: Chest pain, Blood Clots, Irregular heartbeat, Feet swelling

Gastrointestinal: Abdominal Pain, Heartburn, Frequent constipation,

Genitourinary: Infections, difficulty urinating, diminished ability to control urine, urinary infection

Musculoskeletal: Muscle weakness, Muscle pain or tenderness, Joint pain, Joint stiffness, Joint swelling

Neurological: Trouble walking, Fainting spells, Memory loss, Tremors

Psychiatric: Anxiety, Depression, Sleeping difficulty

Endocrine: Excessive thirst, Excessive urination

Hematologic: Anemia, Easy bruising or bleeding

Skin: Itching, Rashes, Sores

____ ______________________

Signature **Date**