New Patient Questionnaire

Name: _____ **Age:** _____ **Today's Date:** _____

Phone: _____ **Work / Cell #:** _____

Name of Doctor you are seeing today: _____

Primary Care Doctor's Name: _____
Phone number or Fax**:** _____

The name of the Doctor who referred you to us: _____
Phone number or Fax**:** _____

Have you ever been seen at another pain clinic? If so,

a. When? _____
b. By Whom? _____

Vital Signs: (to be taken by the staff)

Weight _____ Height _____

Blood Pressure _____/_____ Pulse _____ Respirations _____ Temperature _____

Allergies to Medicines:

_____ _____ _____
_____ _____ _____

Current Medications

Drug	Dose	Drug	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you on any blood thinners? ☐ **YES** ☐ **NO**

☐ Coumadin ☐ Heparin ☐ Effient ☐ Aspirin
☐ Plavix ☐ Lovenox ☐ Fish Oil ☐ Other _____

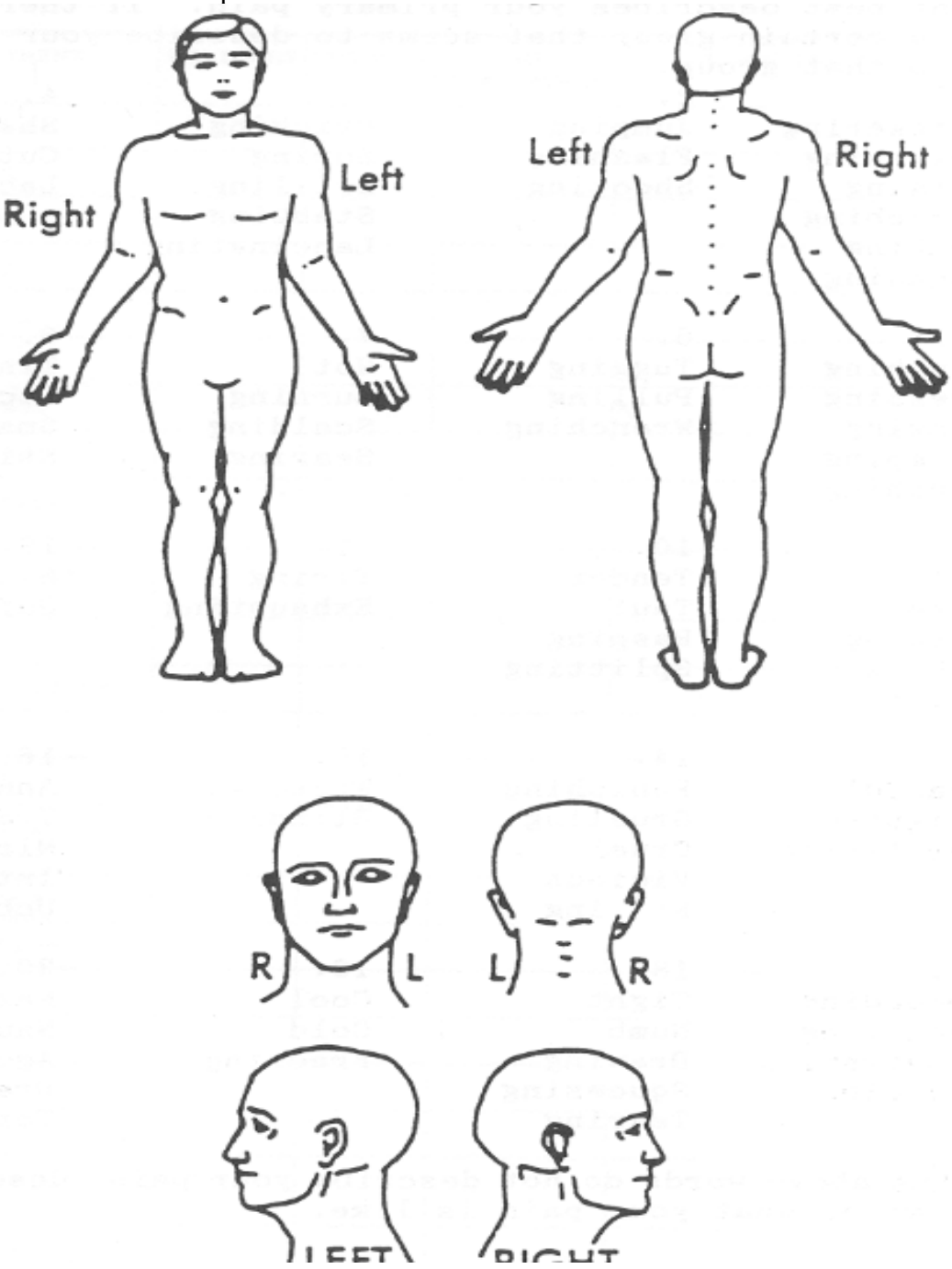
History of Present Illness

Chief complaint: ***(Describe your pain problem)***

_____
_____
_____

1. When did the pain first begin? _____ Years _____ Months _____ Weeks ago.
2. What caused the pain? _____
3. How did the pain come on at first? ☐ Gradually? ☐ Suddenly? ☐ Explosively?
4. Where on your body does the pain start? _____
5. Where does the pain seem to travel? _____

Location of your pain:
Please use the figures below to shade in the area where you have pain. If your pain moves around, put an "X" where it starts and draw an arrow to where it spreads.



6. Rate your pain intensity: On a scale of 1 to 10, with "0" representing no pain, "1" representing a nuisance which would not interfere with daily activities (ie., toothache) while "10" would be the most severe pain imaginable (suicidal pain, having a baby or pain of a kidney stone), which number would describe you pain?

a. what is your pain like *today*?	0	1	2	3	4	5	6	7	8	9	10
b. what is your *least* pain?	0	1	2	3	4	5	6	7	8	9	10
c. what is your *worst* pain?	0	1	2	3	4	5	6	7	8	9	10
d. overall *average* pain?	0	1	2	3	4	5	6	7	8	9	10

7. Which words best describe your pain? (check all of the following that applies):

□ shooting □ dull □ sharp □ burning
□ throbbing □ aching □ electric shock

8. Which of the following best describes the quality of the pain? (check the one that applies):

□ severe □ moderate □ mild

9. Which of the following best describes the quality of the pain? (circle all that applies):

□ constant □ mostly in the morning □ mostly in the evening
□ intermittent □ mostly in the afternoon □ very variable

10. As time goes on, is this pain getting:

□ worse □ better □ about the same

11. Which of the following symptoms is this pain associated with? (check all that applies):

□ numbness □ weakness □ nausea / vomiting
□ tingling □ headache □ bowel / bladder dysfunction

12. Which of the following make the pain worse? (check all that applies):

□ coughing □ sneezing □ exercise □ walking
□ sitting □ standing □ lying down □ sexual activity
□ weather changes □ bright lights □ noise □ cold
□ driving □ menstrual cycle □ touch □ rolling in bed
□ moving from sitting to standing □ taking stairs □ stress / fatigue

13. Which factors seem to relieve the pain? (check all that applies):

□ sitting □ standing □ lying down □ alcoholic drinks
□ sexual activity □ heat □ massage □ medicines
□ walking □ ice □ relaxation

14. Which of the following previous treatments have you tried? (check all that applies):

□ physical therapy □ cold therapy □ relaxation training
□ chiropractic care □ bed rest □ occupational therapy
□ acupuncture □ surgery □ cortisone injection
□ biofeedback □ traction □ epidural steroid injection
□ psychologist □ nerve blocks □ heat
□ TENS unit □ trigger point injections □ Other: _____

15. Have you ever had any previous Physical Therapy? If so,

When: _____

Where: _____

16. List all the past medications you have taken for your pain problem:

_____

_____

_____

PAST MEDICAL HISTORY:

17. In your past, have you ever had any of the following health problems? *(check all that apply or writ in).*

Cardiovascular:

□ None □ High Blood Pressure □ Heart Attack □ Angina (chest pain)
□ Congestive Heart Failure

Other _____

Endocrine:

□ None □ Bleeding Disorder □ Diabetes □ Thyroid Disease

Other _____

Cancers:

□ None □ Breast □ Prostrate □ Skin

Other _____

Hematological:

□ None □ Anemia □ Sickle Cell

Other _____

Autoimmune:

□ None □ Fibromyalgia □ Lupus □ TMJ
□ Osteoarthritis □ Rheumatoid Arthritis

Other _____

Renal:

□ None □ Kidney Stones □ Kidney Infections

Other _____

Genitourinary:

□ None □ Prostrate Problems □ Urinary Incontinence □ Bladder Infections

Other _____

Central Nervous System:

□ None □ Stroke □ Headaches □ Migraines
□ Nerve Damage □ Seizures

Other _____

Gastrointestinal:

□ None □ Peptic Ulcer Disease □ Irritable Bowel Syndrome □ GERD
□ Diverticulosis

Other _____

Pulmonary:

□ None □ Asthma □ Chronic Bronchitis □ Pneumonia

Other _____

Infectious Disease:

□ None □ Hepatitis □ Mononucleosis

Other _____

Psychiatric:

□ None □ Depression □ Anxiety □ Panic Attacks
□ ECT Treatments □ Alcoholism □ Drug Addiction

Other _____

PAST SURGICAL HISTORY:

18. Have you had any surgeries in the past? Please list (*even if they seem unrelated to your pain problem).*

Date	Procedure	Doctor	Facility

FAMILY HISTORY:

19. How is the general health of your family? Please write in any serious health problems or diseases. Also, please indicate if any of your family has ever had similar pain problems as you.

Mother _____ Brother _____

Father _____ Sister _____

SOCIAL HISTORY: Tell us a little about yourself.

Marital Status: □ Married □ Divorced □ Widowed □ Single

Are you pregnant or do you plan to become pregnant? □ Yes □ No

How many children do you have? _____ children.

Who do you live with at home? _____

How far did you get in your education? _____ level.

Describe your occupational status:

- □ Employed. What work do you do? _____
- □ Retired. What occupation did you have? _____
- □ Unemployed.
- □ Disabled. What was the cause of your disability? _____
- □ If married, describe your spouse's occupation: _____

Are you being treated under Workmen's Compensation? □ Yes □ No

Are you currently receiving disability benefits? □ Yes □ No

Are you involved in legal action related to your pain problem or considering it in the future? □ Yes □ No

If yes, describe your current state of litigation:

_____

_____

HABITS: *(Please check or write in all that apply)*

Tobacco

□ No tobacco □ Quit smoking for _____ years _____ packs/day of smoking

Alcohol

□ No alcohol □ Social consumption of alcohol _____ beverages/day containing alcohol

Caffeine

□ No Caffeine _____ beverages/day containing caffeine

Exercise

□ None □ Rarely □ Regularly

Drugs

Do you use or have you ever used recreational drugs? □ Yes □ No

If yes, which drugs? _____

Have you ever had drug or alcohol dependency? □ Yes □ No

If yes, which drugs? _____

20. Have you had any of the following tests performed within the last 24 months?

Test	Date	Facility where it was tested	Results
Xray			
CT Scan			
MRI			
Laboratory			
EMG			
Myleogram			
Other			

REVIEW OF SYSTEMS

21. Are you experiencing any of the following symptoms with regularity that is different than what you listed before? If so, please check.

General:
- ☐ weight
- ☐ appetite changes
- ☐ fever / chills
- ☐ disturbed sleeping habits

Eye:
- ☐ eye infections
- ☐ blurred vision
- ☐ double vision
- ☐ blindness

Psychiatric:
- ☐ depression
- ☐ mood swings
- ☐ anxiety

ENT:
- ☐ hearing loss
- ☐ hoarseness
- ☐ sore throat
- ☐ bloody nose
- ☐ sinusitis

Cardiac
- ☐ chest pain
- ☐ heart murmur
- ☐ skipped beats

Genitourinary:
- ☐ bladder incontinence
- ☐ difficulty urinating

Endocrine:
- ☐ hot or cold flashes

Respiratory:
- ☐ cough
- ☐ coughing up blood
- ☐ wheezing
- ☐ shortness of breath
- ☐ difficulty in breathing with exertion

Gastrointestinal:
- ☐ constipation
- ☐ diarrhea
- ☐ bloody stools
- ☐ nausea / vomiting
- ☐ bowel incontinence

Hematological:
- ☐ easy bruisability
- ☐ difficulty in clotting the blood

Neurologic:
- ☐ headaches
- ☐ dizziness
- ☐ falling
- ☐ seizures
- ☐ numbness
- ☐ tremor

Skin:
- ☐ lacerations
- ☐ abrasions
- ☐ pustules
- ☐ nodules
- ☐ tremors
- ☐ breast changes

OSWESTERY QUESTIONNAIRE

Could you please complete this questionnaire. It is designed to give us information as to how your pain has affected your ability to manage in everyday life.

Please answer every section. Circle ***one number only*** in each section that most closely describes you ***today***.

Section 1: Pain Intensity
0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain is severe at the moment.
5. The pain is the worst imaginable at the moment.

Section 2: Personal care (washing, dressing, etc.)
0. I can look after myself normally without causing pain.
1. I can look after myself normally but it is very painful.
2. It is painful to look after myself; I'm slow and careful.
3. I need some help but manage most of my personal care.
4. I need help everyday in most aspects of my personal care.
5. I do not get dressed / wash with difficulty and stay in bed.

Section 3: Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me from lifting heavy weights off the floor but I can mange if they are conveniently positioned;
3. Pain prevents me from lifting heavy objects but I can manage light to medium weights if conveniently positioned
4. I can only lift light weight.
5. I cannot lift or carry anything at all.

Section 4: Walking
0. Pain does not prevent me walking any distance.
1. Pain prevents me walking more than 1 mile.
2. Pain prevents me walking more than a quarter mile.
3. Pain prevents me walking more than 100 yards
4. I can only walk using a stick or crutches.
5. I am in bed most of the time and have to crawl to the toilet

Section 5: Sitting
0. I can sit in any chair as long as I like.
1. I can sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ an hour
4. Pain prevents me from sitting more than 10 minutes.
5. Pain prevents me from sitting at all.

Section 6: Standing
0. I can stand as long as I want without extra pain.
1. I can stand as long as I want but it gives me extra pain.
2. Pain prevents me from standing more than 1 hour.
3. Pain prevents me from standing more than ½ hour.
4. Pain prevents me from standing more than 10 minutes.
5. Pain prevents me from standing at all.

Section 7: Sleeping
0. My sleep is never disturbed by pain.
1. My sleep is occasionally disturbed by pain.
2. Because of pain, I have less than 6 hours of sleep.
3. Because of pain, I have less than 4 hours of sleep.
4. Because of pain, I have less than 2 hours of sleep.
5. Pain prevents me from sleeping at all.

Section 8: Sex Life
0. My sex life is normal and causes me no extra pain.
1. My sex life is normal and causes some extra pain.
2. My sex life is nearly normal but it very painful.
3. My sex life is severely restricted by pain.
4. My sex life is nearly absent because of pain.
5. Pain prevents any sex life at all.

Section 9: Social Life
0. My social life is normal and causes me no extra pain.
1. My social life is normal but increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, ie; sports, etc.
3. Pain has restricted my social life, I do not go out often.
4. Pain has restricted social life to my house.
5. I have no social life because of pain.

Section 10: Traveling
0. I can travel anywhere without pain.
1. I can travel anywhere but it gives extra pain.
2. Pain is bad but I manage journeys over 2 hours.
3. Pain restricts me to journeys of less than 1 hour.
4. Pain restricts me to short necessary journeys less than 30 minutes.
5. Pain prevents me from traveling except to receive treatment.

Oswestrey Score: _____

ACKNOWLEDGEMENT OF RECEIPT OF
PHYSICIANS PAIN SERVICES
NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of Physicians Pain Services Notice of Privacy Practices.

_____	_____	_____
Name (Print)	Signature	Date

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____

Relationship: _____

Phone Number(s): _____

Alternate Contact Name: _____

Relationship: _____

Phone Number(s): _____

OFFICE USE ONLY

Date acknowledgement received: _____ INT _____

OR

Reason acknowledgement was not obtained: _____

_____

Patient's Name _____ DOB _____

MEDICAL AUTHORIZATION

I authorize Physicians Pain Services to release or obtain any medical information related to its treatment of the patient. A photocopy of this authorization shall be construed as effective and as valid as the original.

ASSIGNMENT OF BENEFITS

I hereby assign all medical, to include major medical benefits to which I am entitled, including private insurance and any other health plan to:

SOUTH COUNTY ANESTHESIA ASSOCIATES, LTD
Physicians Pain Services Billing Company

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment shall be construed as effective and as valid as the original. I understand that I am responsible for notifying Physicians Pain Services of any insurance restrictions including pre-certification for treatment and the need to obtain a referral form. I also understand that I am financially responsible for all charges whether or not they paid by the insurance. I hereby authorize said assignee to release to release all information necessary to secure payment.

This Release Form is valid for one year from the date signed.

_____ _____

Signature of patient or responsible individual Date

_____ _____

Office Staff -Authorization Date

Physicians
Pain Services

Dr. Michael Boedefeld Dr. Chad Shelton

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

You have the right to obtain a copy of our most current Privacy Notice.
You have a right to request that we restrict how your protected health information is used or disclosed.
You have the right to request a correction or an amendment to your medical record. This will be considered at the discretion of the physician and if not granted you have the right to file a disagreement to be held in your medical record.
You have a right to request an alternate means of communication.
You have a right to revoke your consent in writing. A revocation will not apply to the use and disclosure of your information prior to revoking your consent.
Your medical information will be disclosed when required by federal, state, or local law or to any public health authority that is required to collect such information for the purpose of controlling disease, injury, or disability. In addition it will be disclosed to further your treatment, obtain payment for services rendered and to run the practice and insure quality of care for all patients.
A message to call our office may be left on your telephone recorder or with a family member but no medical information will be left with anyone other than you unless requested in writing.
If you wish for someone other than yourself to be involved in your medical care, you must identify this person/persons. You are not obligated to assign anyone to be involved in your medical care.
All reasonable efforts will be made, by the staff of Physicians Pain Services, L.L.C., to protect your private health information both physically and on electronic submission of information.
I have been informed and understand the Privacy Policy of Physicians Pain Services, L.L.C. I understand that all reasonable efforts will be to protect my private healthcare information by the doctors and their staff.
I agree to permit my protected health information to be used and disclosed for purposes of furthering my treatment, obtaining payment for services rendered and health care operations.
I wish to have the following person/persons involved in my medical care and give my permission for him/her to discuss my medical care with my physician or his staff.

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Signature of Patient_____Date_____

Print Name_____

AUTHORIZATION TO OBTAIN & DISCLOSE MEDICAL INFORMATION

Patient Information
Name(Last,First,MI)_____

Address_____

Alias/Other names_____ Date of Birth_____

Please OBTAIN information FROM the following:

_____
Name of health care provider

_____
Address

_____
City, State, Zip code

_____
Phone/Fax

Please SEND my health information TO:

_____
Name of health care provider

_____
Address

_____
City, State, Zip code

_____
Phone/Fax

For Billing Inquiries: Professional Pain Physicians uses South County Anesthesia Associates, LTD as our Billing Company

Information to be disclosed (Please check only one box)

- ☐ Complete copy of official medical record (contains all discharge summaries, all outpatient notes, all pathology reports, and all clinic summaries, x-ray, EKG and lab reports)
- ☐ Most recent 2 years of complete record
- ☐ Records pertaining to the following date(s) or condition(s):_____
- ☐ Other:_____

If the information to be disclosed contains any of the types of special information below, additional laws relating to the use and disclosure of it apply. With my initials, I authorize disclosure of the following information:

_____ Mental health information _____ Developmental disabilities
_____ Alcohol or drug treatment _____ HIV/AIDS-related information &/or results

Duration: This authorization will begin immediately and remain in effect until (date) _____ or not more than one year from the authorization date below.
Restrictions: I understand that if the person(s) and/or organization(s) authorized by this form to receive my medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release my medical information without my prior permission.
Rights: I understand that I am under no obligation to sign this form, and that my refusal to sign will not affect my ability to obtain treatment. I have the right to inspect or copy the medical information authorized here, with certain exceptions provided under state and federal law. I understand I have the right to revoke this authorization, in writing, at any time before it ends, and Professional Pain Physicians has 30 days to comply with my written request. My written revocation will not affect any disclosures of my medical information that the person(s) and/or organization(s) have already made, in reliance on this authorization, before the time I revoke it.
Copying Fees: If I am requesting disclosure/release of medical information to other hospitals, clinics, or healthcare providers for further medical care, no copying fees will be charged. I must pay for copies I request for other purposes.

Signature: I have read this authorization, or had it read to me, and I understand it.

_____ _____
Patient or Personal Representative Date

_____ _____ _____
Relationship to Patient Office use only-records sent by Date Sent

Name_____

The following are questions we are required to ask. Please circle one in each category. If you are uncomfortable answering any of these please circle "REFUSED"

E-Mail Address: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Address: _____

_____

RACE:

- American Indian
- Native Eskimo
- Asian
- Native Hawaiian
- African American
- Caucasian
- Hispanic
- Other Race
- Refused

PREFERED LANGUAGE:

- English
- Other
- Indian
- Spanish
- Russian
- Refused

ETHNICITY:

- Hispanic
- Latino
- Non-Hispanic or Latino
- Refused

PREFERRED METHOD OF CONTACT:

- Home Phone
- Cell Phone
- Work Phone
- E-Mail