Physicians
Pain Services

Updated 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? _____

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

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? _____

Physicians
Pain Services

ACKNOWLEDGEMENT OF RECEIPT OF PROFESSIONAL PAIN PHYSICIANS NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of Professional Pain Physicians 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: _____

_____

_____

Physicians
Pain Services

Patient's Name _____ DOB _____

MEDICAL AUTHORIZATION

I authorize Professional Physicians Pain Services, LLC, 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
Professional Pain Physicians 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 Professional Physicians Pain Services, LLC 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