New Patient Questionnaire

Name: _____ **Date of Birth:** _____ **Date:** _____

Phone: _____**Cell #**_____**Email:**_____

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

Current Medications:

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

Pharmacy Name/location:_____ **Pharmacy Phone #:**_____

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

☐ Coumadin ☐ Heparin ☐ Other _____
☐ Plavix ☐ Lovenox

History of Present Illness:
Chief complaint: ***(Describe your pain problem)***

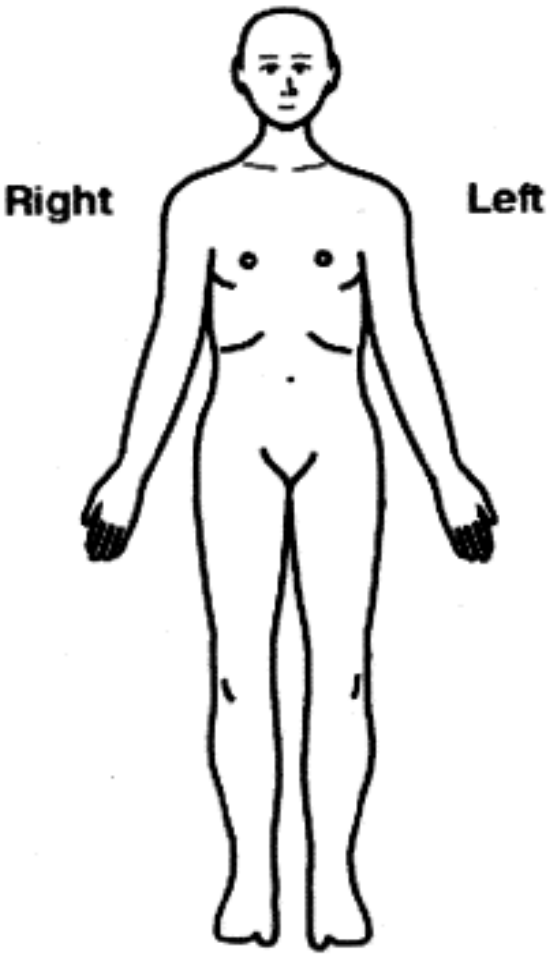
_____
_____

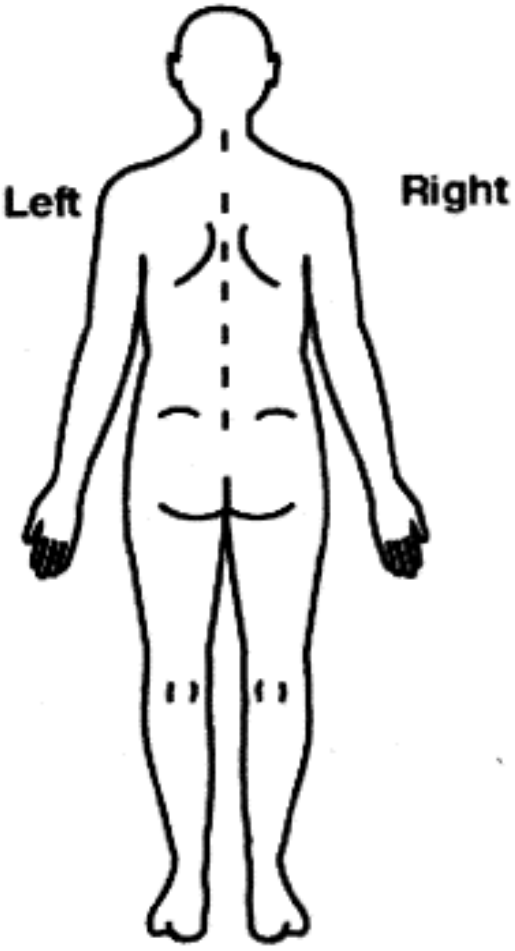
1. When did the pain first begin? _____ Years _____ Months _____ Weeks ago.
2. What caused your pain?
_____
3. How did the pain come on at first? ☐ Gradually? ☐ Suddenly? ☐ Explosively?
4. Where on your body does the pain start? _____
5. Where does the pain seem to travel? _____

Name: _____ Date of Birth: _____

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**

Name: _____ Date of Birth: _____

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:

_____

_____

Name: _____ Date of Birth: _____

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 □ Diabetes □ Thyroid Disease
Other _____

Cancers:

□ None □ Breast □ Prostrate □ Skin
Other _____

Hematological:

□ None □ Anemia □ Sickle Cell □ Bleeding Disorder
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 _____

Name: _____ Date of Birth: _____

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? _____

Name: _____ Date of Birth: _____

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

Patient Name:_____DOB:_____DATE:_____

Oswestry Neck/Back Pain Disability Questionnaire

This questionnaire has been designed to give us information as to how your pain is affecting your ability to manage in everyday life. Please answer by checking **ONE** box in each section for the statement which best applies to you.

Section 1 – Pain intensity ○ I have no pain at the moment ○ The pain is very mild at the moment ○ The pain is moderate at the moment ○ The pain is fairly severe at the moment ○ The pain is very severe at the moment ○ The pain is the worst imaginable at the moment	Section 6 – Standing ○ I can stand as long as I want without extra pain ○ I can stand as long as I want but it gives me extra pain ○ Pain prevents me from standing for more than 1 hour ○ Pain prevents me from standing for more than 30minutes ○ Pain prevents me from standing for more than 10minutes ○ Pain prevents me from standing at all
Section 2 – Personal care (washing, dressing etc) ○ I can look after myself normally without causing extra pain ○ I can look after myself normally but it causes extra pain ○ It is painful to look after myself and I am slow and careful ○ I need some help but manage most of my personal care ○ I need help every day in most aspects of self-care ○ I do not get dressed, I wash with difficulty and stay in bed	Section 7 – Sleeping ○ My sleep is never disturbed by pain ○ My sleep is occasionally disturbed by pain ○ Because of pain I have less than 6 hours sleep ○ Because of pain I have less than 4 hours sleep ○ Because of pain I have less than 2 hours sleep ○ Pain prevents me from sleeping at all
Section 3 – Lifting ○ I can lift heavy weights without extra pain ○ I can lift heavy weights, but it gives extra pain ○ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table ○ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned ○ I can lift very light weights ○ I cannot lift or carry anything at all	Section 8 – Sex life (if applicable) ○ My sex life is normal and causes no extra pain ○ My sex life is normal but causes some extra pain ○ My sex life is nearly normal but is very painful ○ My sex life is severely restricted by pain ○ My sex life is nearly absent because of pain ○ Pain prevents any sex life at all
Section 4 – Walking ○ Pain does not prevent me walking any distance ○ Pain prevents me from walking more than 1 mile ○ Pain prevents me from walking more than ½ mile ○ Pain prevents me from walking more than 100yards ○ I can only walk using a stick or crutches ○ I am in bed most of the time	Section 9 – Social life ○ My social life is normal and gives me no extra pain ○ My social life is normal but increases the degree of pain ○ Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport ○ Pain has restricted my social life and I do not go out as often ○ Pain has restricted my social life to my home ○ I have no social life because of pain
Section 5 – Sitting ○ I can sit in any chair as long as I like ○ I can only sit in my favorite chair as long as I like ○ Pain prevents me sitting more than one hour ○ Pain prevents me from sitting more than 30minutes ○ Pain prevents me from sitting more than 10minutes ○ Pain prevents me from sitting at all I can only walk using a stick or crutches	Section 10 – Traveling ○ I can travel anywhere without pain ○ I can travel anywhere but it gives me extra pain ○ Pain is bad but I manage journeys over two hours ○ Pain restricts me to journeys of less than one hour ○ Pain restricts me to short necessary journeys under 30minutes ○ Pain prevents me from traveling except to receive treatment

References 1. Fairbank JC, Pynsent PB. The Oswestry Disability Index. Spine 2000 Nov 15;25(22):2940-52; discussion 52

TOTAL:_____

Pain _____ /10 at worst and _____ /10 at best.

FINANCIAL RESPONSIBILITY:

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible for any charges not covered by my insurance plan. It is my responsibility to know my plan benefits, in some cases exact benefits cannot be determined until the insurance has received the claim; at which time I will be billed the remainder of the charges. I understand that I am responsible for the entire balance of the bill if the submitted claim or any part of it are denied for payment. By signing this form, I am accepting financial responsibility as explained above for all payment of medical services received. I authorize the disclosure of my medical information and medications to other physicians involved in my care.

***Patients who fail to show for their scheduled appointment or did not notify the office within 24 hours of their scheduled appointment time shall be subject to a "No Show/Cancellation" fee of $50.00. In the event of an actual emergency and prior notice could not be given, consideration will be given, and a one-time exception may be granted.**

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:

GATEWAY MEDICAL SOLUTIONS
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, 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 till revoked by me in writing.

_____

Print Name:

_____ _____

Signature of patient or responsible individual Date

(Signature) by signing I am acknowledging that all the information given is true and accurate to the best of my knowledge

PRIVACY PRACTICES:

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 consent to secure exchange of my protected health information across other practices and facilities.
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_____

Print Name: _____

Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

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"

RACE:	**PREFERED LANGUAGE:**
American Indian	English
Native Eskimo	Other
Asian	Indian
Native Hawaiian	Spanish
African American	Russian
Caucasian	Refused
Hispanic	
Other Race	
Refused	
ETHNICITY:	**PREFERRED METHOD OF CONTACT:**
Hispanic	Home Phone
Latino	Cell Phone
Non-Hispanic or Latino	Work Phone
Refused	E-Mail