New Patient Questionnaire

Name: _____ **Date of Birth:** _____ **Date:** _____
Phone: _____ **Cell #**_____ **Email:**_____

Social Security#_____

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? _____

Allergies to Medicines:

_____ _____ _____
_____ _____ _____

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?

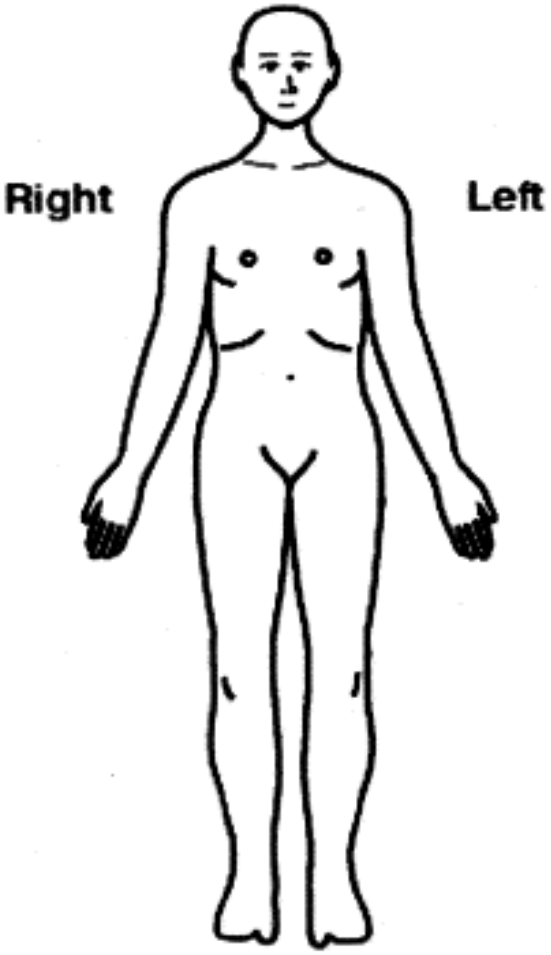
_____

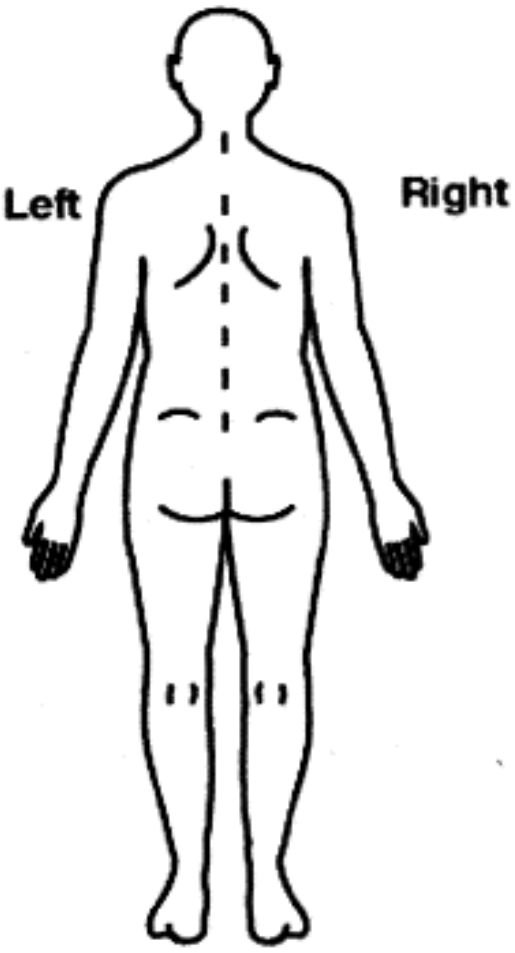
3. How did the pain come on at first? ☐ Gradually? ☐ Suddenly? ☐ Explosively?
4. Where on your body does the pain start? _____
5. Where does the pain seem to travel? _____

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

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

Physicians Pain Services

Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.
For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

CURRENT Pain ____/10 ; Pain at BEST ____ /10 ; Pain at WORST ____ /10

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Self-Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping, and breathing.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Please Print Name: _____

Signature: _____ **Date:** _____

***PDI=SUM (Points for all 7 parameters)** ***The higher the index the greater the persons disability due to pain**

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 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