Patient Questionnaire

Today's Date: _____/_____/_____

Your Information:

Last Name:_____ First: _____ Middle: _____

Date of Birth:_____/_____/_____ Age:_____ SS#:_____

Street:_____City:_____ State:_____ Zip Code:_____

Home Phone: (_____)_____ Work Phone: (_____)_____

Email address: _____

Emergency Contact:

Name:_____ Relation: _____

Street:_____City:_____ State:_____ Zip Code:_____

Home Phone:(____)_____ Work: (____)_____

Referring Physician:

Name:_____ Specialty:_____

Street:_____City:_____ State:_____ Zip Code:_____

Phone: (____)_____ Fax: (____)_____

Primary Care Provider (PCP):

Name:_____

Street:_____City:_____ State:_____ Zip Code:_____

Phone:(____)_____ Fax: (____)_____

Pharmacy:

Name:_____

Street:_____City:_____ State:_____ Zip Code:_____

Phone:(____)_____

We can share information with your:

Spouse: _____ Significant Other: _____ Parent: _____ Children: _____ PCP: _____

Signature: _____

Marital status:_____ Number of children:_____

With whom do you live?_____

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Please describe your pain complaint and location:

How and when did the pain start, and how has it changed since that time?

Please indicate on the following what makes the pain better (+) or worse (-):

____Heat	____Cold	____Humidity
____Sitting	____Standing	____Lying Down
____Coughing	____Fatigue	____Walking
____ Noise	____Anxiety/Emotions	____Massage
____Alcohol	____Caffeine	____Body position
____Sneezing	____Stairs	____Bowel movements
____Driving	____Vibrations	____Housework

0	1	2	3	4	5	6	7	8	9	10
no pain		mild		discomforting		distressing		horrible		excruciating

Using this pain scale, please number your pain:

- at it's worst? _____
- at it's least? _____
- average this month? _____

Circle any of the following that you currently use:

cane	wheelchair	crutches	brace
scooter	walker	prosthesis	collar

Please circle any treatments you have undergone for your pain problem. Place a (+) next to those that were effective and a (-) next to those that were not:

Acupuncture	Hypnosis	TENS unit
Bed Rest	Massage Therapy	Traction
Biofeedback	Physical Therapy	Trigger Point Injections
Chiropractor	Psychotherapy	Ultrasound
Exercise	Relaxation Training	Other:

Have you had any previous pain procedures like epidurals or nerve blocks? YES NO

When and with whom? _____

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Please list <u>ALL MEDICATIONS</u> you <u>CURRENTLY</u> take, including non-prescription medications and herbal formulas:

Name of Drug Dose Frequency

Please list <u>PAIN MEDICATIONS</u> you have taken in the <u>PAST</u>:

Name of Drug Dose Frequency Effectiveness

Are you allergic to any foods (including shellfish and eggs), medications (including local anesthetic), or latex?

Drug Type of Reaction

Please check any past or present medical conditions that apply to you:

___ angina	___kidney disease	___ cancer
___ heart attack	___hepatitis	___ lupus
___ heart failure	___stomach ulcers	___ fibromyalgia
___ palpitations	___GERD	___ arthritis
___ heart murmur	___diabetes	___bleeding problems
___ irregular heart beat	___ seizures	___ thyroid problems
___ high blood pressure	___depression	___ high cholesterol
___ asthma	___ stroke	___ bladder problems
___ fractures	___ headaches	___ enlarged prostate

List <u>ALL previous surgeries</u> with dates:

_____

Are you currently employed?_____ Occupation:_____

If unemployed, for how long?_____ Is this due to a pain condition?_____

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Family history:

Alcohol abuse	N	Y
Illegal drug use	N	Y
Prescription drug abuse	N	Y

Personal history:

Alcohol abuse	N	Y	Describe:
Illegal drug use	N	Y	Describe:
Prescription drug abuse	N	Y	Describe:

Mental health:

Diagnosis of ADD, OCD, bipolar, schizophrenia	N	Y
Diagnosis of depression	N	Y

Other:

Age 16-45 years	N	Y
History of pre-adolescent sexual abuse	N	Y

****

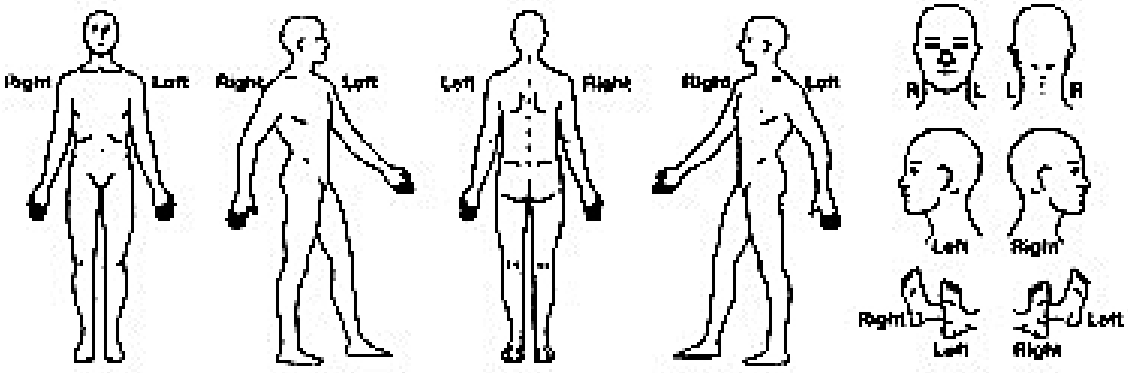
What is your height? _____ current weight? _____

Latest blood pressure? _____/_____

Do you smoke? _____ If yes, how many packs/ years? _____

Do you drink alcohol? _____ If yes, how much _____

Please mark the area(s) of the body where your pain is on the figures below:



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North American Partners in Pain Management, LLP

RELEASE AND ASSIGNMENT

I hereby assign all medical and / or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Blue Shield, HMOs and commercial insurance to North American Partners in Pain Management, LLP.

North American Partners in Pain Management, LLP, bills only for the professional component of these services.

I understand that I am financially responsible for all charges for the hospital and for anesthesia if these services are used.

I understand that I am financially responsible for all charges whether or not covered by said insurance.

I authorize release of any information required to secure payment on my behalf.

I the undersigned am aware that there is a $50.00 late cancellation fee for any appointment or procedure that is not cancelled at least twenty-four hours in advance.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to North American Partners in Pain Management, LLP, for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agencies any information needed to determine these benefits or the benefits payable for related services.

PRINT PATIENT NAME _____ PATIENT SIGNATURE _____

SOCIAL SECURITY NUMBER _____ DATE _____

AUG-28-2013 10:20 From:516-496-6562