INTEGRATED
PAIN SPECIALISTS

# PATIENT INFORMATION FORM

## Please Complete All Questions.

Account #_____

We welcome you as a patient and value our ongoing relationship during your course of treatment at Integrated Pain Specialists.

Patient **Legal** Name: Last _____ First _____ Middle _____

Preferred Name:_____

Social Security #: _____ Date of Birth: _____ Marital Status: _____ Sex: ☐M ☐ F

Address: (Box/Street) _____ Apt #: _____

City: _____ State: _____Zip Code:_____

Email Address:_____ **This WILL NOT BE USED to send or receive patient information.**
**E-Mails will include information pertaining to Integrated Pain Specialists.**

Race: (Please Circle): American Indian/ Native Alaskan, Asian, Black/African American, More than 1 race, Native Hawaiian, Other Pacific Island, White, Refused

Ethnicity (Please Circle): Are you Latino or Hispancic. Yes No Refused

Primary Phone: ☐ Cell ☐ Home ☐ Work (_____)_____

Secondary Phone: ☐ Cell ☐ Home ☐ Work (_____)_____

How would you like to be contacted? *Mark all that apply.*
☐ Call ☐ Text ☐ Email

Employer/School: _____ Retired: ☐ Yes ☐ No Disabled: ☐ Yes ☐ No

Name of Spouse/Closest Relative: (**Minors list both parents**) _____

Relationship: _____ Phone:_____

Referring Physician: _____ Primary Care Physician: _____

Primary Insurance: _____ ID #: _____ Group #: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

I authorize payment of benefits to Integrated Pain Specialists, including insurance payments, settlements from any lawsuit or workers' compensation proceedings, special case or lump sum settlements of which my attorney will pay upon receipt of any funds for services rendered by Integrated Pain Specialists I authorize Integrated Pain Specialists to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

**Signature:** _____ _____

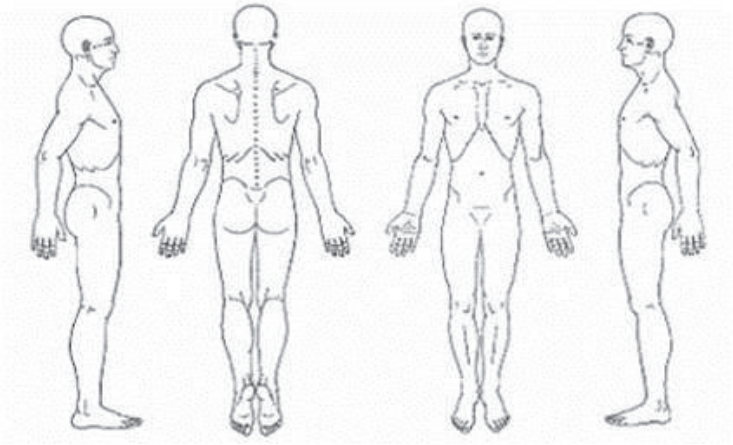
Patient or Legal Guardian if patient under 18 years old Date

## Notice of Privacy Practices Receipt Form

A copy of the Integrated Pain Specialists Notice of Privacy Practices was made available to me. Updated copies are available upon request at each visit.

**Signature:** _____ _____

Patient or Legal Guardian if patient under 18 years old Date



Mark affected areas: P=pain, T=Tingling, N=Numbness, B=Burning, S= Stiffness

**Date of Injury/ Surgery**

_____ Date of Injury (if applicable)

_____ Date of Surgery

- ☐ Injured at work
- ☐ Pain onset after Motor Vehicle Accident
- ☐ Attorney Involved
- ☐ Workman's Comp
- ☐ Pending lawsuit

**Onset of Pain**

☐ Chronic (> 3 months) ☐ Sudden (< 3 months) ☐ Gradual

_____ Date of onset of pain

_____ How long have you experienced this pain

**Quality of Pain**

| | |
|---|---|
| ☐ Burning | ☐ Shooting |
| ☐ Cramping | ☐ Dull/Aching |
| ☐ Tingling | ☐ Sharp |
| ☐ Throbbing | ☐ Numbness |

**Duration of Pain**

- ☐ Constant
- ☐ Frequent
- ☐ Intermittent
- ☐ Occasional

Current Pain Level

1 2 3 4 5 6 7 8 9 10

Best Pain in last 7 Days

1 2 3 4 5 6 7 8 9 10

Worst Pain in last 7 Days

1 2 3 4 5 6 7 8 9 10

**Pain Modifiers**

| | Relieved by | Worse With |
|---|---|---|
| Laying Down | ☐ | ☐ |
| Heat | ☐ | ☐ |
| Ice | ☐ | ☐ |
| Movement | ☐ | ☐ |
| Position changes | ☐ | ☐ |
| Coughing / sneezing | ☐ | ☐ |
| Sitting | ☐ | ☐ |
| Standing | ☐ | ☐ |
| Walking | ☐ | ☐ |
| Exercise | ☐ | ☐ |
| Bending | ☐ | ☐ |
| Lifting | ☐ | ☐ |
| Turning | ☐ | ☐ |
| Sit to Stand | ☐ | ☐ |
| Upright activity | ☐ | ☐ |

Other _____

**Miscellaneous Symptoms**

| | |
|---|---|
| ☐ Numbness of the Limbs | ☐ Clumsiness |
| ☐ Limb weakness | ☐ Urinary retention |
| ☐ Abnormality of walk | ☐ Urinary incontinence |
| ☐ Poor Balance | ☐ Fecal incontinence |

**Daily Activities Impaired by Pain**

| | |
|---|---|
| ☐ Work | ☐ Socializing |
| ☐ Yard Work, shopping | ☐ Sexual activity |
| ☐ Recreation | ☐ Driving |
| ☐ Exercise | ☐ Self Care |
| ☐ House work | |

**Previous Treatments:**

| | Have Not Tried | If tried, mark relief None | Moderate | Excellent |
|---|---|---|---|---|
| Back Brace | ☐ | ☐ | ☐ | ☐ |
| Physical therapy | ☐ | ☐ | ☐ | ☐ |
| Chiropractic | ☐ | ☐ | ☐ | ☐ |
| Exercise | ☐ | ☐ | ☐ | ☐ |
| Medication | ☐ | ☐ | ☐ | ☐ |
| Injections (types) | ☐ | ☐ | ☐ | ☐ |

_____

Other Therapy (types) ☐ ☐ ☐

_____

**Past Medical History**

- ☐ Stroke
- ☐ Seizure Disorder
- ☐ Hypertension
- ☐ Chest Pain / Coronary Artery Disease
- ☐ Heart Attack
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Arthritis
- ☐ Cancer
- ☐ Acid Reflex/Heart Burn
- ☐ Chronic Bronchitis
- ☐ COPD
- ☐ Clotting Disorder
- ☐ Thyroid Disease
- ☐ Depression
- ☐ Anxiety
- ☐ HIV / AIDS
- ☐ Osteoporosis
- ☐ Shingles
- ☐ Obstructive Sleep Apnea
- ☐ Migraine Headaches
- ☐ Recent Infection
- ☐ Other
- ☐ **NONE**

**Previous Imaging**

- ☐ MRI – cervical spine Date: _____
- ☐ MRI- thoracic spine Date:_____
- ☐ MRI – lumbar spine Date:_____
- ☐ CT- cervical spine Date:_____
- ☐ CT-thoracic spine Date:_____
- ☐ CT-lumbar spine Date:_____
- ☐ EMG Date:_____
- ☐ Xray – cervical spine Date:_____
- ☐ Xray – lumbar spine Date:_____
- ☐ Xray – thoracic spine Date:_____
- ☐ Bone Scan Date:_____

**Allergies**

| | **Reaction** |
|---|---|
| ☐ NONE | |
| ☐ Shellfish | _____ |
| ☐ Codeine | _____ |
| ☐ Penicillin | _____ |
| ☐ Contrast dye | _____ |
| ☐ Sulfa drugs | _____ |
| ☐ Seasonal allergies | _____ |
| ☐ Iodine | _____ |
| ☐ Latex | _____ |

Other_____

_____

**Surgical History**

- ☐ Back Surgery
- ☐ Hip replacement
- ☐ Knee Replacement
- ☐ Rotator Cuff Repair
- ☐ Knee Arthroscopy
- ☐ Heart Valve Replacement
- ☐ Coronary Artery Bypass Graft
- ☐ Cardiac Catheterization
- ☐ Cardiac Pacemaker
- ☐ Appendectomy
- ☐ Gallbladder Surgery
- ☐ Hernia Repair
- ☐ Thoracotomy – Chest Surgery
- ☐ Neck Surgery
- ☐ Brain Surgery
- ☐ Lung Surgery
- ☐ Tonsillectomy / Adenoidectomy
- ☐ Nephrectomy
- ☐ Laparoscopy
- ☐ Temporal Artery Biopsy
- ☐ Carotid Endarterectomy
- ☐ Cataract Surgery
- ☐ History of Tubal Ligation
- ☐ History of Cesarean Section
- ☐ History of Prostate Surgery
- ☐ Radiation of the Thyroid
- ☐ Thyroid Surgery
- ☐ **No Prior Surgeries**

**Social History**

**Alcohol Use:**

☐ Yes ☐ No Do you Drink, Drinks per Day _____

☐ Yes ☐ No Possible problem with alcohol

**Tobacco Use:**

☐ Yes ☐ No Smoking

_____ Cigarettes per day

☐ Yes ☐ No Previous History of Smoking

☐ Yes ☐ No Illicit Drug Use

☐ Yes ☐ No History of Alcoholics Anonymous (AA)

☐ Yes ☐ No History of Narcotics Anonymous (NA)

**Marital Status:**

☐ Yes Currently Married

☐ Yes Single

☐ Yes Divorced

☐ Yes Widowed

**Employment Status**

☐ Yes ☐ No

Occupation _____

☐ Yes Physical disability affecting ability to work

☐ Yes Occupation Student

☐ Yes Occupation Homemaker

☐ Yes Unemployed

☐ Yes Retired

**Family History**

- ☐ Suicide
- ☐ Mental Illness
- ☐ Alcoholism
- ☐ Drug/ Substance Abuse
- ☐ Cancer
- ☐ Acute Heart Attack
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Early Death (non-natural cause)
- ☐ Other Family History

Please specify family member for each marked item:

_____
_____
_____
_____

**Medications**

**Current Prescriptions:** (Include ALL RX's)

| | Medication | Dose | Frequency |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ |
| 6. | _____ | _____ | _____ |
| 7. | _____ | _____ | _____ |
| 8. | _____ | _____ | _____ |
| 9. | _____ | _____ | _____ |

Are you taking blood thinners? ☐ Yes ☐ No

**Previously Tried Pain Medications:**
(explain why the medication was discontinued)

| | | |
|---|---|---|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |

Preferred Pharmacy:_____

# Review of Systems

**Head/Neck/Eyes**

- ☐ Headache
- ☐ Neck Pain
- ☐ Swollen Glands in the neck
- ☐ Pain in or around the eyes
- ☐ Vision Problems
- ☐ **No Head Neck or Eye Problems**

**Musculoskeletal**

- ☐ Back Pain
- ☐ Shoulder Pain
- ☐ Shoulder Swelling
- ☐ Stiffness in the Morning
- ☐ Generalized Arthritis
- ☐ **No Musculoskeletal Problems**

**Cardiovascular**

- ☐ Chest Pain or Discomfort
- ☐ High Blood Pressure
- ☐ Palpitations
- ☐ **No Cardiovascular Problems**

**Gastrointestinal**

- ☐ Change in bowel habit
- ☐ Vomiting
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Blood in Stool
- ☐ **No Gastrointestinal Problems**

**Systemic**

- ☐ Recent Weight Gain
- ☐ Recent Weight Loss
- ☐ Feeling tired (fatigue)
- ☐ Fever
- ☐ **No Constitutional Problems**

**Psychiatric**

- ☐ Anxiety
- ☐ Insomnia
- ☐ Nightmares
- ☐ Depression
- ☐ Suicidal Ideation
- ☐ **No Psychiatric Problems**

**Pulmonary**

- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ **No Respiratory Problems**

**Neurologic**

- ☐ Difficulty with balance / walking
- ☐ Dizziness
- ☐ Numbness or Tingling
- ☐ Frequent Headaches
- ☐ **No Neurologic Problem**

**Hematological**

- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ **No Hematological Problems**

**Skin**

- ☐ Itching
- ☐ Skin Rash
- ☐ Skin Swelling, mass, or lump
- ☐ **No Skin Problems**

**Other**

- ☐ Other

_____

_____

_____

PATIENT SIGNATURE: _____ DATE: _____

(Or Legal Guardian if patient is under 18 years old)

REVIEW OF THE ABOVE INFORMATION HAS BEEN COMPLETED WITH PATIENT.

PHYSICIAN SIGNATURE: _____ DATE: _____