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New Patient Demographics

Today's Date:_____ **Referring Provider:** _____

Your Name:_____ Gender: □ Male □ Female

Marital Status: □ Married □ Single □ Divorced □ Widowed □ Other:_____

Social Security Number: _____ - _____ -_____ Date of Birth:_____ Age:_____

Street Address:_____

City/State/Zip:_____

Physical Address Same as Mailing? □ Yes □ No

If not, please list mailing address:_____

Employer: _____ **Occupation**:_____

Your Email Address:_____@_____

Daytime Phone #: _____ □ Home □ Mobile □ Work

Emergency Contact Name:_____ **Relationship**:_____

Phone Number: _____ Phone Type (circle one): Home Work Cell

How did you hear about us? □ Insurance Co □ Employer □ Facebook □ Internet search □ Print Ad □ Family/Friend

Please check if: □ *This is an INJURY CLAIM* *or* □ *This is a WORKMAN'S Compensation Claim*

Primary Insurance:_____ **HOLDER Name**:_____

HOLDER DOB:_____ Relationship to you: _____

Secondary Insurance:_____ **HOLDER Name**:_____

HOLDER DOB:_____ Relationship to you:_____

Assignment of Benefits

I hereby authorize my insurance benefits be paid directly to Innovative Pain and Wellness. I am financially responsible for non-covered services and/or balances not paid by my insurance carrier. I also authorize release of any of my information required to process these claims. I authorize Innovative Pain and Wellness to provide my medical care, including diagnosis and treatment. I certify that the information on this form is accurate, complete and true.

Signature of Patient or Legal Representative_____ Date_____

Legal Representative Name_____ Date_____

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Clinical Information

Today's Date:_____ **Today's Provider:** _____

Your Name:_____ Date of Birth:_____

Height:_____ Weight:_____

Preferred Pharmacy

Pharmacy Name:_____ Phone Number: _____

Street Address:_____ City:_____ State:_____ Zip: _____

Pain Description

Use the pain scale described below to rate your pain for the questions below:

0 - Pain-free
1 - Very minor annoyance, occasional minor twinges
2 - Minor annoyance, occasional strong twinges
3 - Annoying enough to be distracting
4 - Can be ignored if you are involved in your work/task, but still distracting
5 - Cannot be ignored for more than 30 minutes
6 - Cannot be ignored for any length of time but can still go to work and participate in social activities
7 - Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 - Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9 - Unable to speak, crying out or moaning uncontrollably, near delirium
10 - Unconscious, pain makes you pass out

_____What number on the pain scale (0-10) best describes your pain **right now?**

_____What number on the pain scale (0-10) best describes your **worst pain?**

_____What number on the pain scale (0-10) best describes your **least pain?**

Where is your worst area of pain located?

_____

_____

Does this pain radiate? If so, where?

_____

_____

Please list any additional areas of pain:_____

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Onset of Symptoms

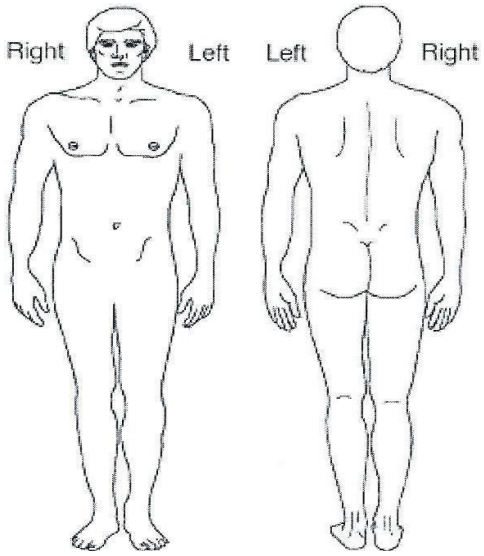
Approximately when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began, how has it changed? ☐ Decreased ☐ Increased ☐ Stayed the same

Use this diagram to indicate the location and type of your pain.
Mark the drawing with the following letters that best describe your symptoms:



"N" = numbness

"S" = stabbing

"B" = burning

"P" = pins and needles

"A"= aching

Pain Description - Check all the following that describe of your pain

☐ Aching	☐ Numbness	☐ Spasms	☐ Throbbing
☐ Cramping	☐ Shock-like	☐ Squeezing	☐ Tingling/Pins & Needles
☐ Dull	☐ Shooting	☐ Stabbing/Sharp	☐ Tiring/Exhausting
☐ Hot/Burning			

Factors that Affect your Pain

	Increases Pain	Decreases Pain	No Change
☐ Bending Backward	☐	☐	☐
☐ Bending Forward	☐	☐	☐
☐ Changes in Weather	☐	☐	☐
☐ Climbing Stairs	☐	☐	☐
☐ Coughing / Sneezing	☐	☐	☐
☐ Driving	☐	☐	☐
☐ Lifting Objects	☐	☐	☐
☐ Looking Forward	☐	☐	☐
☐ Looking Downward	☐	☐	☐
☐ Looking Side to Side	☐	☐	☐
☐ Rising from a Seated Position	☐	☐	☐
☐ Sitting	☐	☐	☐
☐ Standing	☐	☐	☐
☐ Walking	☐	☐	☐

What other factors worsen or affect you pain that is not listed above? _____

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Pain Frequency

What word best describes the frequency of your pain? ☐ Constant ☐ Intermittent

When is your pain at its worst? ☐ Mornings ☐ During the day ☐ Evenings ☐ Middle of the night

Mark all of the following activities that are adversely/negatively affected by your pain

☐ Enjoyment of Life ☐ Normal Work ☐ Sleep

☐ General Activity ☐ Recreational Activities ☐ Walking

☐ Mood ☐ Relationship with people ☐ Other:_____

☐ My goal is to resume normal activities

In the past three months, have you developed any new conditions?

☐ **I Have Not Recently Developed Any New Conditions**

☐ Balance Problems ☐ Fevers ☐ Nausea ☐ Vomiting

☐ Difficulty Walking ☐ Sleep ☐ Chills ☐ Bowel incontinence

☐ Numbness/Tingling - Where?_____ ☐Others: _____

Pain Treatment History

Please mark and list what previous pain treatments you have had (approximate dates):

☐ I **Have Not Had Any Prior Treatments for My Current Pain Complaints**

☐ Physical Therapy How many sessions?_____ Date: _____

☐ Chiropractic How many sessions?_____ Date: _____

☐ Psychological Therapy How many sessions?_____ ☐ Currently in Therapy ☐ Not in Therapy

☐ Injection Therapy If so, list:_____ Date: _____

_____ Date:_____

_____ Date:_____

_____ Date:_____

_____ Date: _____

☐ Spinal Cord Stimulator ☐ Trial Only ☐ Permanent

Date of Implant: _____ Do you currently use it? ☐ Yes ☐ No

Do you obtain relief? ☐ Yes ☐ No

☐ Spine Surgery Type: _____Date:_____

☐ Weight Loss Program: Type: _____

☐ Other: _____

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Diagnostic Tests and Imaging

What imaging/tests have you had done for your pain complaint?

☐ I **Have Not Had Any Diagnostic Tests Performed for My Current Pain Complaints**

Date	Facility	Type of Imaging

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

☐ I **Have Not had any Surgical Procedures Performed**

Abdominal Surgery

☐ Gallbladder removal_____

☐ Appendectomy_____

☐ Other_____

Female Surgeries

☐ Caesarean section_____

☐ Hysterectomy _____

☐ Laparoscopy _____

☐ Ovarian_____

☐ Other_____

Heart Surgery

☐ Valve replacement _____

☐ Aneurysm repair _____

☐ Other_____

Joint Surgery

☐ Shoulder _____

☐ Hip_____

☐ Knee_____

Spine / Back Surgery

☐ Discectomy (levels)_____

☐ Laminectomy

☐ Spinal fusion (levels)_____

Other Common Surgeries

☐ Hemorrhoid surgery_____

☐ Hernia repair _____

☐ Thyroidectomy _____

☐ Tonsillectomy_____

☐ Vascular surgery_____

Please list any other surgeries and dates (attach an additional sheet if necessary):

_____

_____

_____

Current Medications

Are you taking a prescribed **blood-thinner** medication? □ Yes □ No If yes, please check which one:

□ Aggrenox □ Coumadin □ Effient □ Eliquis □ Lovenox □ Plavix □ Pleta □ Pradaxa

□ Ticlid □ Warfarin □ Xarelto □ Other_____

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Who and approximately when was the last provider to prescribe you pain medications or other controlled substances? Attach an additional sheet, if required.

_____

_____

_____

Allergies

Do you have any known drug allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to:

Medication Name:	**Allergic Reaction Type:**

Please check if you are allergic to: ☐ Iodine or ☐ Tape

***Are you allergic to latex?** ☐ Yes ☐ No

Family History

Mark all appropriate diagnoses as they pertain to your biological **MOTHER AND FATHER** only.

	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures
Mother:	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father:	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other Medical Problems:_____

☐ **Have No Significant Family Medical History** ☐ **I Am Adopted (No Medical History Available)**

Social History

Are you capable of becoming pregnant? □ Yes □ No If so, are you currently pregnant? □Yes □ No

Highest level of education obtained: □ Grammar □ High School □ College □ Post-Graduate

Alcohol Use: □ Current Alcoholism □ Daily Limited Alcohol Use □ History of Alcoholism
□ Never Drinks Alcohol □ Social Alcohol Use

Tobacco Use: □ Current Tobacco Use □ Former Tobacco User □ Never Used Tobacco

Drug Use: □ Denies Any Illegal Drug Use □ Currently Using Illegal Drugs (Which:_____)
□ Currently Using Someone Else's Prescription Medication
□ Formerly Used Illegal Drugs (not currently using) (Which:_____)

Have you ever abused narcotic or prescription medications? □ Yes □ No (Which:_____)

Have you ever been discharged from a pain management practice in the past? □ Yes □ No

If so, please explain:_____

_____

_____

Which practice were you discharged from? _____

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Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical

☐ Cancer - Type
☐ Diabetes - Type
☐ HIV/AIDS

Head/Eyes/Ears/Nose/Throat

☐ Glaucoma
☐ Headaches
☐ Head Injury
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Migraines

Cardiovascular/Hematologic

☐ Anemia
☐ Bleeding Disorders
☐ Coronary Heart Disease
☐ Heart Attack
☐ High Blood Pressure
☐ High Cholesterol
☐ Mitral Valve Prolapse
☐ Murmur
☐ Pacemaker/Defibrillator
☐ Phlebitis
☐ Poor Circulation
☐ Stroke

Respiratory

☐ Asthma
☐ Bronchitis
☐ Emphysema/COPD
☐ Pneumonia
☐ Tuberculosis
☐ Valley Fever

Gastrointestinal

☐ Bowel Incntinence
☐ Acid Reflux/GERD
☐ Gastrointestinal Bleeding
☐ Constipation

Musculoskeletal

☐ Amputation
☐ Bursitis
☐ Carpel Tunnel Syndrome
☐ Chronic Low Back Pain
☐ Chronic Neck Pain
☐ Chronic Joint Pain
☐ Fibromyalgia
☐ Joint Injury
☐ Osteoarthritis
☐ Osteoporosis
☐ Phantom Limb Pain
☐ Rheumatoid Arthritis
☐ Tennis Elbow
☐ Vertebral Compression Fracture

Genitourinary/Nephrology

☐ Bladder Infection(s)
☐ Dialysis
☐ Kidney Infection(s)
☐ Kidney Stones
☐ Urinary Incontinence

Hepatic

☐ Hepatitis A (active/inactive/unsure)
☐ Hepatitis B (active/inactive/unsure)
☐ Hepatitis C (active/inactive/unsure)

Neuropsycholigical

☐ Alcohol Abuse
☐ Alzheimer Disease
☐ Bipolar Disorder
☐ Depression
☐ Epilepsy
☐ Prescription Drug Abuse
☐ Multiple Sclerosis
☐ Paralysis
☐ Peripheral Neuropathy
☐ Schizophrenia
☐ Seizures
☐ Reflex Sympathetic Dystrophy/ CRPS

☐ **Other Diagnosed Condition:**

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Global Pain Scale Please answer all questions

INSTRUCTIONS: **For each question, please indicate your response by circling a number from 0 to 10**

YOUR PAIN: **0 = No Pain** **10 = Extreme Pain**

For the *past week,* the **best** my pain has been….	0	1	2	3	4	5	6	7	8	9	10
For the *past week*, the **worst** my pain has been	0	1	2	3	4	5	6	7	8	9	10
For the *past week*, my **average** pain has been	0	1	2	3	4	5	6	7	8	9	10
For the *past 3 months*, my **average** pain has been	0	1	2	3	4	5	6	7	8	9	10

YOUR FEELINGS:

During the past week, I have felt: **0 = Strongly Disagree 10 = Strongly Agree**

Afraid	0	1	2	3	4	5	6	7	8	9	10
Depressed	0	1	2	3	4	5	6	7	8	9	10
Tired	0	1	2	3	4	5	6	7	8	9	10
Anxious	0	1	2	3	4	5	6	7	8	9	10
Stressed	0	1	2	3	4	5	6	7	8	9	10

YOUR CLINICAL OUTCOMES:

During the past week: 0 = Strongly Disagree 10 = Strongly Agree

I had trouble sleeping	0	1	2	3	4	5	6	7	8	9	10
I had trouble feeling comfortable	0	1	2	3	4	5	6	7	8	9	10
I was less independent	0	1	2	3	4	5	6	7	8	9	10
I was unable to work (or perform normal tasks) ….	0	1	2	3	4	5	6	7	8	9	10
I needed to take more medication	0	1	2	3	4	5	6	7	8	9	10

YOUR ACTIVITIES:

During the past week, I was NOT able to: **0 = Strongly Disagree 10 = Strongly Agree**

Go to the store	0	1	2	3	4	5	6	7	8	9	10
Do chores in my home.	0	1	2	3	4	5	6	7	8	9	10
Enjoy my friends and family	0	1	2	3	4	5	6	7	8	9	10
Exercise (including walking)	0	1	2	3	4	5	6	7	8	9	10
Participate in my favorite hobbies…	0	1	2	3	4	5	6	7	8	9	10

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Review of Symptoms

Mark the following conditions/diseases that you ***currently suffer from***:

Constitutional:
- ☐ Excessive Sweating
- ☐ Chills
- ☐ Difficulty Sleeping
- ☐ Easy Bruising
- ☐ Insomnia
- ☐ Low Sex Drive
- ☐ Night Sweats
- ☐ Unexplained Weight Loss
- ☐ Unexplained Weight Gain
- ☐ Weakness
- ☐ Fevers

Eyes:
- ☐ Recent Visual Changes

Ears/Nose/Throat/Neck:
- ☐ Nosebleeds
- ☐ Sinus Problems
- ☐ Earaches
- ☐ Ringing in Ears
- ☐ Hearing Problems
- ☐ Dental Problems
- ☐ Recurrent Sore Throat

Cardiovascular:
- ☐ Bleeding Disorders
- ☐ Chest Pain
- ☐ Deep Vein Thrombosis
- ☐ Fainting
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Lightheadedness
- ☐ Shortness of Breath During Sleep
- ☐ Swelling in the Feet

Respiratory:
- ☐ Cough
- ☐ Pulmonary Embolism
- ☐ Shortness of Breath on Exertion/Effort
- ☐ Shortness of Breath at Rest
- ☐ Wheezing

Gastrointestional:
- ☐ Abdominal Cramps
- ☐ Acid Reflux
- ☐ Constipation
- ☐ Coffee Ground Appearance in Vomit
- ☐ Dark Tarry Stools
- ☐ Diarrhea
- ☐ Hernia
- ☐ Vomiting

Musculoskelatal:
- ☐ Back Pain
- ☐ Muscle Spasms
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Neck Pain

Genitourinary/Nephrology:
- ☐ Blood in Urine
- ☐ Decreased Urine Flow/ Frequency/Volume
- ☐ Erectile Dysfunction
- ☐ Flank Pain
- ☐ Painful Urination
- ☐ Pelvic Pressure

Neurological:
- ☐ Carpel Tunnel Syndrome
- ☐ Dizziness
- ☐ Headaches
- ☐ Instability When Walking
- ☐ Numbness/Tingling
- ☐ Seizures

Psychiatric:
- ☐ Depressed Mood
- ☐ Feeling Anxious
- ☐ Stress Problems
- ☐ Suicidal Thoughts
- ☐ Suicidal Planning

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		OFFICE USE ONLY	
	Mark Each that Applies	item Score If **Female**	Item Score if **Male**
Family History of Substance Abuse:			
Alcohol	❑	1	3
Illegal	❑	2	3
Drugs	❑	4	4
Prescription Drugs			
Personal History of Substance Abuse:			
Alcohol	❑	3	3
Illegal	❑	4	4
Drugs	❑	5	5
Prescription Drugs			
Your Age (Mark box if 16-45)	❑	1	1
Personal History of Preadolescent Sexual Abuse:	❑	3	0
Personal History of Psychological Disease:			
Attention Deficit Disorder, *OR* Obsessive Compulsive Disorder, *OR* Bipolar, *OR* Schizophrenia	❑	2	2
Depression	❑	1	1
❑ **None of the above apply to me**	**TOTAL**		

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Urine Drug Testing Information

At Innovative Pain and Wellness, the safety and wellbeing of our patients is a top priority. When our patients warrant narcotic (opioid) therapy, there are many factors that go into the decision-making process of medication management. As part of our safety and compliance program one of those factors is Urine Drug Testing or "UDT".

As many of you know, we are undergoing a significant cultural shift at the state and federal level with respect to narcotic (opioid) therapy. In addition to a governmental shift in thinking, there exists a significant change in the medical community in what we call the "local standard of care". These changes are part of a concerted effort to decrease the associated adverse effects of narcotic (opiate) therapy, and protect you, the patient.

At Innovative Pain and Wellness, we adhere to these federal, state, and local guidelines with respect to narcotic (opiate) therapy. Performing urine drug testing on patients is part of those guidelines. To simplify this process for providers, CMS (Center for Medicare and Medicaid Services) has published guidelines for appropriate UDT. These guidelines mandate a certain number of screening tests, as well as confirmatory tests, each year for each patient undergoing narcotic (opiate) therapy. For each patient, the number of tests may be different based on differences in treatment and medical history.

In finding various labs to work with, Innovative Pain and Wellness has made every effort to assure that our patients' UDT process, as well as laboratory billing process, will be in their best interest. We must use third party laboratories for our urine specimens. If you should have questions or comments regarding your UDT billing, explanation of benefits, or bills received, please contact the laboratory directly. IPW does not financially benefit from UDT and will be unable to answer billing questions about UDT.

By signing this document, you are stating that you have read, and understand its content. As always, we appreciate your understanding in this manner, and the trust you put into us for your pain management needs. Thank you.

_____ _____ _____

Print Name DOB Date

_____

Signature

Patient Name:_____
(Please print)

Acknowledgement of Notice of Privacy Practices:

I have been offered a copy of the Notice of Privacy Practices. I understand that Innovative Pain and Wellness has the right to change its Notice of Privacy Practices from time to time and that I may contact Innovative Pain and Wellness at any time to obtain a current copy.

****Signature**: _____Date: _____

Acceptance of Patient Financial Agreement:

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Policy.

****Signature**: _____Date: _____

Notice of Electronic Access to Prescription History:

By signing below, I authorize Innovative Pain and Wellness to obtain my medication history from my pharmacy electronically.

****Signature**: _____Date: _____

Notice of Diagnostic Release:

By signing below, I authorize Innovative Pain and Wellness to release my current diagnosis to my pharmacy to validate my need for pain management prescriptions and to secure such as needed.

****Signature**: _____Date: _____

Authorization of Release of Health Information:

I hereby authorize Innovative Pain and Wellness and its Employees permission to discuss, send and/or receive my personal health information **to/with the following individual(s):**

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

I further authorize Innovative Pain and Wellness to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care. I also authorize the release of information that may be necessary in the processing of any insurance claims.

****Signature**: _____Date: _____