

## 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 \_\_\_\_\_

## 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

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\_\_\_\_\_ 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: \_\_\_\_\_

## 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:    Right    Left    Left    Right

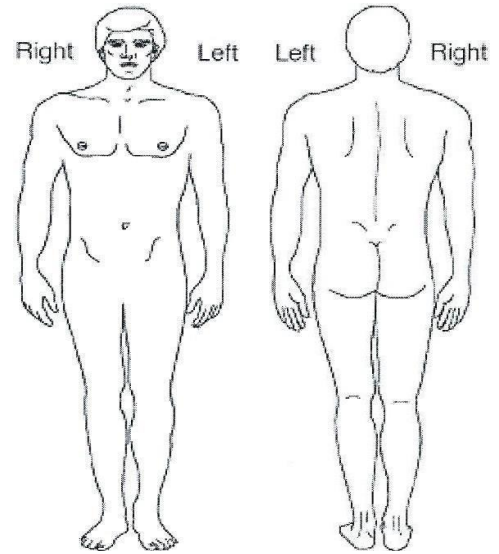
"N" = numbness

"S" = stabbing

"B" = burning

"P" = pins and needles

"A" = aching



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

- |                                      |                                     |   |  |
|--------------------------------------|-------------------------------------|---|--|
| <input type="checkbox"/> Aching      | <input type="checkbox"/> Numbness   | <input type="checkbox"/> Spasms         | <input type="checkbox"/> Throbbing               |
| <input type="checkbox"/> Cramping    | <input type="checkbox"/> Shock-like | <input type="checkbox"/> Squeezing      | <input type="checkbox"/> Tingling/Pins & Needles |
| <input type="checkbox"/> Dull        | <input type="checkbox"/> Shooting   | <input type="checkbox"/> Stabbing/Sharp | <input type="checkbox"/> Tiring/Exhausting       |
| <input type="checkbox"/> Hot/Burning |                                     |   |  |

## Factors that Affect your Pain

	Increases Pain	Decreases Pain	No Change
<input type="checkbox"/> Bending Backward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Changes in Weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing / Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting Objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Looking Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Looking Downward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Looking Side to Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rising from a Seated Position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

## 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

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Enjoyment of Life                      | <input type="checkbox"/> Normal Work              | <input type="checkbox"/> Sleep        |
| <input type="checkbox"/> General Activity                       | <input type="checkbox"/> Recreational Activities  | <input type="checkbox"/> Walking      |
| <input type="checkbox"/> Mood                                   | <input type="checkbox"/> Relationship with people | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> 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**
- |   |  |                                 |   |
|---|--|---------------------------------|---|
| <input type="checkbox"/> Balance Problems                 | <input type="checkbox"/> Fevers        | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting           |
| <input type="checkbox"/> Difficulty Walking               | <input type="checkbox"/> Sleep         | <input type="checkbox"/> Chills | <input type="checkbox"/> Bowel incontinence |
| <input type="checkbox"/> Numbness/Tingling - Where? _____ | <input type="checkbox"/> 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**
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Physical Therapy       | How many sessions? _____   | Date: _____   |
| <input type="checkbox"/> Chiropractic           | How many sessions? _____   | Date: _____   |
| <input type="checkbox"/> Psychological Therapy  | How many sessions? _____   | <input type="checkbox"/> Currently in Therapy <input type="checkbox"/> Not in Therapy |
| <input type="checkbox"/> Injection Therapy      | If so, list: _____   | Date: _____   |
|   | _____  | Date: _____   |
|   | _____  | Date: _____   |
|   | _____  | Date: _____   |
| <input type="checkbox"/> Spinal Cord Stimulator | <input type="checkbox"/> Trial Only <input type="checkbox"/> Permanent         |   |
|   | Date of Implant: _____   | Do you currently use it? <input type="checkbox"/> Yes <input type="checkbox"/> No     |
|   | Do you obtain relief? <input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| <input type="checkbox"/> Spine Surgery          | Type: _____  | Date: _____   |
| <input type="checkbox"/> Weight Loss Program:   | Type: _____  |   |
| <input type="checkbox"/> Other:                 | _____  |   |

## 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 \_\_\_\_\_

### Joint Surgery

Shoulder \_\_\_\_\_

Hip \_\_\_\_\_

Knee \_\_\_\_\_

### Female Surgeries

Caesarean section \_\_\_\_\_

Hysterectomy \_\_\_\_\_

Laparoscopy \_\_\_\_\_

Ovarian \_\_\_\_\_

Other \_\_\_\_\_

### Spine / Back Surgery

Discectomy (levels) \_\_\_\_\_

Laminectomy \_\_\_\_\_

Spinal fusion (levels) \_\_\_\_\_

### Other Common Surgeries

Hemorrhoid surgery \_\_\_\_\_

Hernia repair \_\_\_\_\_

Thyroidectomy \_\_\_\_\_

Tonsillectomy \_\_\_\_\_

Vascular surgery \_\_\_\_\_

### Heart Surgery

Valve replacement \_\_\_\_\_

Aneurysm repair \_\_\_\_\_

Other \_\_\_\_\_

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

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## 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.

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## 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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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? \_\_\_\_\_

## 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 Incontinence
- 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)

### Neuropsychological

- 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:**



## Review of Symptoms

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

### Constitutional:

- |  |  |  |                                   |
|--|--|--|-----------------------------------|
| <input type="checkbox"/> Excessive Sweating  | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Night Sweats            | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Chills              | <input type="checkbox"/> Insomnia      | <input type="checkbox"/> Unexplained Weight Loss | <input type="checkbox"/> Fevers   |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Low Sex Drive | <input type="checkbox"/> Unexplained Weight Gain |                                   |

### Eyes:

- Recent Visual Changes

### Ears/Nose/Throat/Neck:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Nosebleeds     | <input type="checkbox"/> Earaches        | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Recurrent Sore Throat |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Dental Problems  |  |

### Cardiovascular:

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Bleeding Disorders   | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Lightheadedness                  | <input type="checkbox"/> Swelling in the Feet |
| <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath During Sleep |   |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Irregular Heartbeat |   |   |

### Respiratory:

- |   |   |  |                                   |
|---|---|--|-----------------------------------|
| <input type="checkbox"/> Cough              | <input type="checkbox"/> Shortness of Breath on Exertion/Effort | <input type="checkbox"/> Shortness of Breath at Rest | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Pulmonary Embolism |   |  |                                   |

### Gastrointestinal:

- |   |  |                                   |
|---|--|-----------------------------------|
| <input type="checkbox"/> Abdominal Cramps | <input type="checkbox"/> Coffee Ground Appearance in Vomit | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Acid Reflux      | <input type="checkbox"/> Dark Tarry Stools                 | <input type="checkbox"/> Hernia   |
| <input type="checkbox"/> Constipation     |  | <input type="checkbox"/> Vomiting |

### Musculoskeletal:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Back Pain     | <input type="checkbox"/> Joint Pain      | <input type="checkbox"/> Joint Swelling |
| <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Neck Pain      |

### Genitourinary/Nephrology:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Blood in Urine                        | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Pelvic Pressure |
| <input type="checkbox"/> Decreased Urine Flow/Frequency/Volume | <input type="checkbox"/> Flank Pain           |  |
|  | <input type="checkbox"/> Painful Urination    |  |

### Neurological:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Carpel Tunnel Syndrome | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Instability When Walking | <input type="checkbox"/> Seizures          |

### Psychiatric:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Depressed Mood  | <input type="checkbox"/> Stress Problems   | <input type="checkbox"/> Suicidal Planning |
| <input type="checkbox"/> Feeling Anxious | <input type="checkbox"/> Suicidal Thoughts |  |

## 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:** \_\_\_\_\_

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**Acceptance of Patient Financial Agreement:**

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

**\*\*Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**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:** \_\_\_\_\_

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**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:** \_\_\_\_\_

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**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:** \_\_\_\_\_