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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_____

Clinical Information

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

Your Name:_____ Date of Birth:_____

Height:_____ Weight:_____

Pain Description and 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

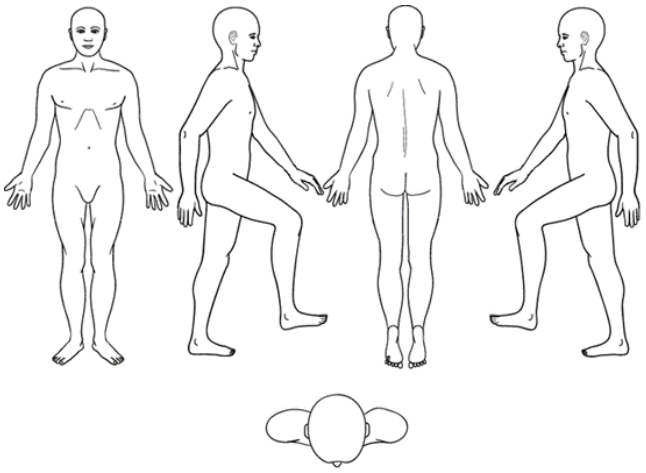
On the diagram, mark the location and type of symptoms.

(x) Sharp

(+) Numb/Tingling

(#) Dull/Aching

(B) Burning



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

_____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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Pain Description - Check all the following that describe 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?_____

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: _____

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Treatment History

Please mark and list what previous treatments you have had for this injury (approximate dates):

☐ I **Have Not Had Any Prior Treatments for My Current 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: _____

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
_____	_____	_____
_____	_____	_____
_____	_____	_____

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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):

_____

_____

_____

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Past Medical History

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

General Medical
- ☐ Cancer
- ☐ Diabetes
- ☐ HIV/AIDS

Head/ENT
- ☐ Glaucoma
- ☐ Headaches
- ☐ Head Injury
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Migraines

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

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

Gastrointestinal
- ☐ Bowel Incontinence
- ☐ Acid Reflux / GERD
- ☐ GI Bleeding
- ☐ Constipation

Musculoskeletal
- ☐ Amputation
- ☐ Bursitis
- ☐ Carpel Tunnel
- ☐ Fibromyalgia
- ☐ Joint Injury
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Phantom Limb Pain
- ☐ Rheumatoid Arthritis
- ☐ Tennis Elbow
- ☐ Compression Fracture

Genitourinary/Nephrology
- ☐ Bladder Infection
- ☐ Dialysis
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Urinary Incontinence

Hepatic
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

Neuropsychological
- ☐ Alcohol Abuse
- ☐ Alzheimer Disease
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Epilepsy
- ☐ Rx Drug Abuse
- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Peripheral Neuropathy
- ☐ Schizophrenia
- ☐ Seizures
- ☐ RSD/CRPS

- ☐ **Other Conditions:**

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
- ☐ Fever

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

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: _____

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: _____