# THE PAIN CENTER

VIRGINIA WEST VIRGINIA

## COMPREHENSIVE PAIN CARE

**Name:** (Last) _____(First)_____(M.I.)_____ **Date**:_____/_____/_____

**Address**: _____

**City**: _____ **State**:_____ **Zip**:_____

Home Phone: _____/_____/_____ Cell Phone: _____/_____/_____ Work Phone: _____/_____/_____

Email Address: _____ ☐ Do not have email ☐Do not wish to provide

Date of Birth: _____/_____/_____ Gender: □Male □Female

Social Security Number _____/_____/_____

Emergency Contact:_____ Relationship:_____

Home Phone:_____/_____/_____ Cell Phone:_____/_____/_____

PCP Physician: _____Referring Physician: _____

**Marital Status:** ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Employment: ☐Employed ☐Unemployed ☐Disabled ☐Retired

Employer:_____Occupation:_____

Employer Address:_____

***Guarantor (if patient is under 18*** _____

Relationship:_____Home Phone:_____/_____/_____ Cell Phone:_____/_____/_____

Is this a: ☐Workers Compensation Injury ☐Accident Related Injury ☐Neither

**Primary Insurance Carrier:**_____

Policy #: _____ Group #: _____

Subscribers Name:_____

Subscribers Date of Birth: _____/_____/_____ Relationship to Patient:_____

**Secondary Insurance Carrier:**_____

Policy #: _____ Group #: _____

Subscribers Name:_____

Subscribers Date of Birth: _____/_____/_____ Relationship to Patient:_____

1839 W. Plaza Drive • Winchester, VA 22601
Phone (540) 773-2689 • Fax (540) 486-4166

1000 Tavern Road, Suite 300 • Martinsburg, WV 25401
Phone (304) 263-6165 • Fax (304) 263-6536

Name of Pharmacy: _____

Address: _____City: _____State_____Zip_____

Phone #: _____/_____/_____

**PLEASE READ THE FOLLOWING DOCUMENTS AND INITIAL BELOW:**

_____ **(initial)** **I have reviewed the Statement of Financial Policy**

_____ **(initial)** **I have reviewed the Patient Rights and Responsibilities**

_____ **(initial)** **I have reviewed the HIPPA Information and Consent Form**

**Language:** ☐English ☐Spanish ☐Other ☐Refuse to Report

**Race:** ☐Black or African American ☐ White ☐Hispanic ☐Other Race ☐Refuse to Report

**Ethnicity:** ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Refuse to Report

If you would like information to be obtained by family members, friends, etc…please list those below.
**If you do not have anyone listed below they will not be able to call into our office for information regarding your care including your appointment date or time.**

I authorize release of information to the following:

NAME _____ Relationship _____

NAME _____ Relationship _____

NAME _____ Relationship _____

I hereby consent to and authorize The Pain Center to apply the benefits on my behalf for the services rendered by Dr. Baksh and Staff. I request payment from my insurance or responsible party be made to The Pain Center. I certify that all information I have provided is correct to the best of my knowledge. I authorize the release of any medical information for this claim or any related claim. I permit a copy of this authorization be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay the medical services proved to me. I understand that payment is due when the statement is rendered.

**Patient/Guardian Signature:** _____ **Date:** _____**/**_____**/**____

# THE PAIN CENTER

VIRGINIA

WEST VIRGINIA

COMPREHENSIVE PAIN CARE

**Chief Complaint**

_____

_____

_____

**Smoking Status** (circle)

☐Current every day smoker ☐Current some day smoker ☐Former smoker ☐Never smoked

What is your usage per day? _____

**Alcohol Use** (circle)

☐Non-drinker ☐Drink socially ☐Drink daily ☐History of alcohol abuse

How much do you drink per week? _____

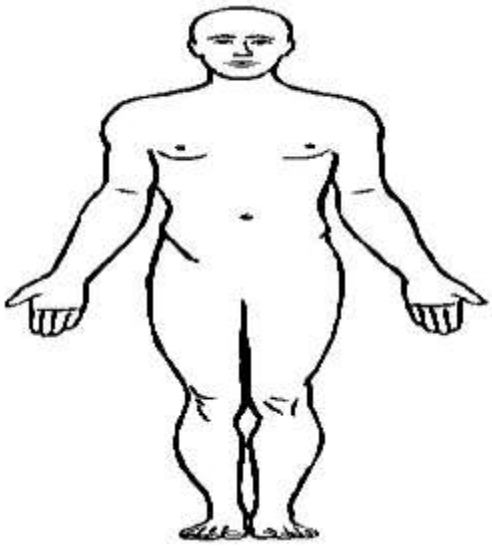
**Illicit Drug Use**

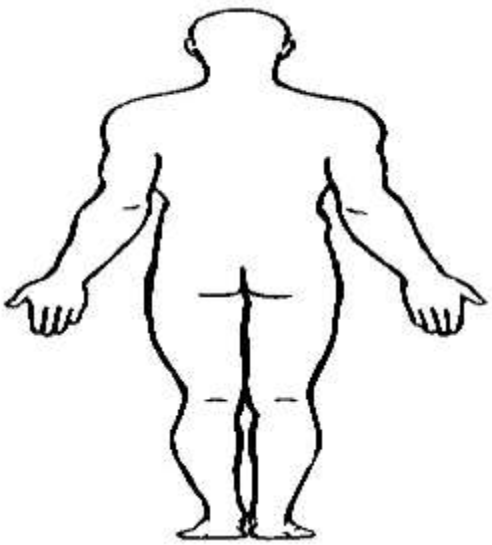
Do you use any illicit drug? ☐Yes ☐No

If yes, please specify ☐Marijuana ☐Cocaine ☐Heroin ☐Methamphetamines

☐Opioids ☐Inhalants ☐Other: _____

**Location of pain.** Draw X to indicate areas of deep pain. Draw Z to indicate areas of tingling and numbness. Use arrows to show areas that pain or tingling radiates/travels.





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**Frequency of pain**

☐Constant ☐Intermittent (comes and goes)

**Description of pain**

☐Aching ☐Burning ☐Radiating Pain ☐Sharp ☐Shooting

☐Electric Like ☐Stabbing ☐Dull ☐Deep ☐Tingling

**Severity**

☐Minor ☐Moderate ☐Severe

**Pain Intensity**

Rate your pain on a scale of 0 to 10 (0 is no pain and 10 is the worst pain possible) _____

**Duration and Onset of Pain**

How long have you had this pain? Specify days, months or years (example 6 months or 1 year)

_____

**Describe how your pain started**

☐Gradual ☐Sudden ☐Triggered

If triggered please explain (example if pain was caused by a fall or car accident, etc.)

_____

_____

**What makes your pain worse?**

☐Twisting ☐Sneezing ☐Coughing ☐Touch of Skin

☐Standing ☐Sitting ☐Bending Forward ☐Bending Backward

☐Walking ☐Exercise ☐Cold ☐Heat ☐Stress

Other:_____

_____

**What makes your pain better?**

☐Standing ☐Sitting ☐Bending Forward ☐Bending Backwards

☐Walking ☐Medications ☐Exercise ☐Injections

☐Cold ☐Heat ☐Rest ☐ Change Positions Frequently

☐Other:_____

_____

**What treatments have you tried for your pain?**

☐Medications ☐Physical Therapy ☐Acupuncture ☐Injections ☐TENS Unit

☐Chiropractic Care ☐Pain Management Service Elsewhere ☐Psychology/Counseling

Please specify your response (examples list names of medications tried, name of previous pain management, type of injections, etc.)

_____

_____

_____

**Are any of the following symptoms associated with your pain?**

☐Numbness ☐Swelling ☐Joint Pain ☐Muscle Pain ☐Tingling ☐Nausea

☐Palpitations ☐Dizziness ☐Vomiting ☐Seizures ☐Fainting

☐Shortness of Breath ☐Radiating Pain

**Are you allergic to any medications, food, etc.** Please specify (example Penicillin causes rash)

_____

_____

_____

**Are you currently taking a blood thinner medication for a blood clotting disorder?**

☐Yes ☐No If yes, specify the name of medication _____

**<u>Please list ALL the MEDICATIONS you are CURRENTLY taking</u>.** Specify the name, dose and frequency (example Ibuprofen 800mg two times daily). You may also attach CURRENT MEDICATION LIST.

**Medication Name** **Dose** **Frequency**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**Family Medical History.** Please list any family medical problems (example diabetes, heart attack, stroke, type of cancer, etc.)

Father:_____

_____

Mother: _____

_____

Sister(s):_____

_____

Brother(s):_____

_____

**Past Surgical History:**

☐Angioplasty ☐Coronary Artery Stent ☐Coronary Artery Bypass Graft

☐Pacemaker ☐Carotid Endarterectomy ☐Appendectomy ☐Gastric Bypass

☐Cataract Extraction ☐Tonsillectomy ☐Adenoidectomy ☐Hysterectomy

Fracture Repair (specify where the fracture was located)

_____

_____

Arthroscopy (specify the joint and the side)

_____

_____

Joint Replacement (specify the joint and the side)

_____

_____

Have you ever had surgery on your spine?

☐Yes ☐No If yes, please specify the location of the spine

☐Cervical (neck) ☐Thoracic ☐Lumbar

Please list any other surgeries you have undergone

_____

_____

**What diagnostic testing have you undergone related to this pain?**

☐MRI ☐CT Scan ☐XRAY ☐Nerve Conduction Study

Please specify the name of facility where testing was done:

_____

**In the past have you had any of the following medical problems? (Please check all that apply to you.)**

**Cardiovascular**

☐Arrhythmia (irregular heartbeat)
☐Coronary artery disease
☐Congestive heart failure
☐Hyperlipidemia (high cholesterol)
☐Hypertension (high blood pressure)
☐Myocardial infarction (heart attack)
☐Poor circulation
☐Other_____

**Gastrointestinal**

☐Cholelithiasis (gallstones)
☐Cirrhosis
☐Colon polyps
☐GERD (gastroesophageal reflux disease, indigestion)
☐Peptic ulcer disease
☐Other_____

**Musculoskeletal/Connective Tissue**

☐Chronic pain
Specify_____
☐Fibromyalgia
☐Fractures
Specify:_____
☐Osteoarthritis
☐Osteoporosis

☐Rheumatoid arthritis
☐Other_____

**Neurologic**

☐Carotid stenosis
☐CVA (stroke, TIA)
☐Headaches
☐Multiple sclerosis
☐Parkinson's disease
☐Seizure disorder
☐Other_____

**Pulmonary**

☐Asthma
☐COPD (chronic obstructive pulmonary disease)
☐Chronic bronchitis
☐Tuberculosis
☐Other_____

**Renal/Genitourinary**

☐BPH (benign prostatic hypertrophy)
☐Endometriosis
☐Kidney disease or stones
☐Renal failure

☐Urinary incontinence or retention
☐Other_____

**Endocrine**

☐Diabetes ☐Type I ☐Type II

☐Hyperthyroidism
☐☐Hypothyroidism

☐Other_____

**Hematologic**

☐Anemia
☐Other_____

**Psychiatric**

☐Anxiety
☐Bipolar disorder
☐Depression
☐Obsessive/Compulsive disorder
☐Post-traumatic stress disorder

☐Other_____