



VIRGINIA

THE PAIN CENTER



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: _____

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:** ____/____/____



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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? _____

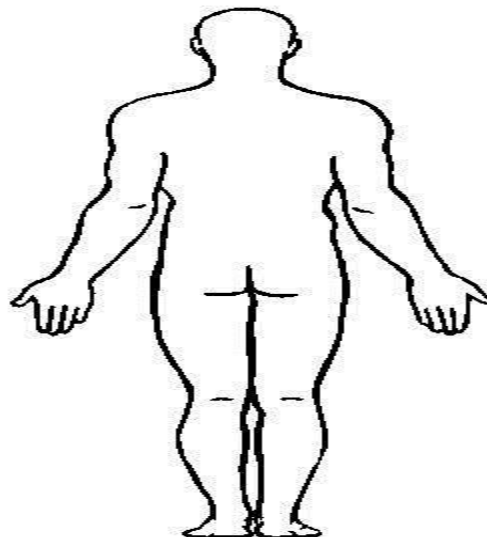
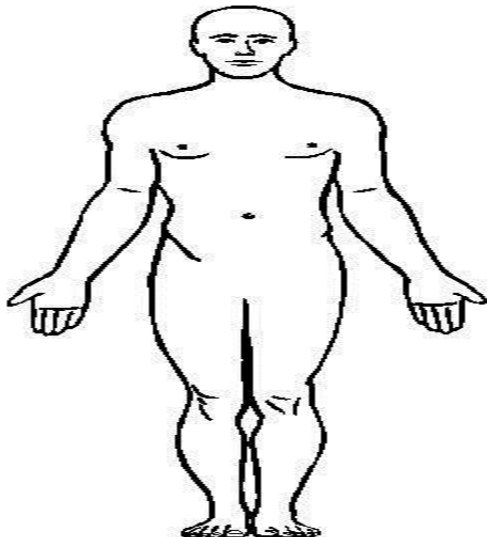
Illicit Drug Use

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.



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 _____

Please list ALL the MEDICATIONS you are CURRENTLY taking. 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:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Coronary Artery Stent | <input type="checkbox"/> Coronary Artery Bypass Graft | |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Carotid Endarterectomy | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gastric Bypass |
| <input type="checkbox"/> Cataract Extraction | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> 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 _____