Advanced Pain Management and Rehab Medical Group, Inc.

ADVANCED PAIN MANAGEMENT

Ravi Panjabi, M.D. **Ramesh Singa, M.D.**

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Ph: (510) 582- 8555 **Fax: (510) 581-8686**

Patient Information

First Name: _____ **Middle Name:**_____ **Last Name:** _____

Date of Birth: _____ **Gender:** **Male** **Female** **Age:** _____

Driver's License/State: _____ **SSN#:** _____

Mailing Address:_____ **City/State/Zip:** _____

Physical Address (if different):_____ **City/State/Zip:** _____

Check preferred:
( ) Home Phone: _____ **( ) Cell Phone:** _____ **( ) Work Phone:** _____

Email Address:_____

Ethnicity:
( ) Hispanic **( ) Non-Hispanic** **( ) Unknown** **( ) Decline to State**

Race:
( ) American Indian or Alaskan Native **( ) Asian** **( ) Black or African American** **( ) Decline to State**
( ) Native Hawaiian or other Pacific Islander **( ) White** **( ) other Race**

Language:
( ) English **( ) Spanish** **( ) other:** _____

Nationality:
( ) U.S. Citizen **( ) other**

Insurance Information:
( ) Worker's Compensation **( ) Automobile Insurance** **( ) LIEN** **( ) Private Insurance**
( ) PPO **( ) HMO** **( ) Medicare** **( ) Self Pay**

Primary Insurance Plan:

Payer Name: _____ **Plan:** _____

Group: _____ **Policy/ I.D. Number:** _____

Insurance Policy Holder:
( ) Self **( ) Spouse** **( ) Child** **( ) other**

If you are not the primary insurance policy holder, provide the following information.

Policy Holder Name: _____ **Date of Birth:** _____ **Gender:** **( ) Male** **( ) Female**

Mailing Address:_____ **City/State/Zip:** _____

SSN#: _____ **Phone Number:** _____ **Employer:** _____

Secondary Insurance Plan:

Payer Name: _____ **Plan:** _____

Group: _____ **Policy/ I.D. Number:** _____

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Insurance Policy Holder	( ) Self ( ) Spouse ( ) Child ( ) other		
If you are not the secondary insurance policy holder, complete the following information			
Policy Holder Name		Gender	( ) Male ( ) Female
City / State / Zip		Date of Birth	
Phone Number		Employer	

Referring Information	
Physician Name	Phone #
Address	Fax #
Primary Care Physician (if different from above)	Phone #
Address	Fax #
Attorney Name	Phone #
Address	Fax #
Emergency Contact Person	
Person Name	Phone #
Address	Fax #
Employment Status	
( ) Employed ( ) Retired ( ) Unemployed ( ) Disabled	
Employer	Occupation

Assignment of Benefits

I hereby give lifetime authorization for payment of insurance benefits to be made directly to “Advanced Pain Management”, for services rendered. I understand that I am financially responsible for all charges, whether or not they are covered by my insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize Advanced Pain Management to release all information necessary to secure the payment of benefit. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____

ADVANCED PAIN MANAGEMENT

Privacy Notice Acknowledgement

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communicating among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a notice of privacy practices (privacy notice), which provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this acknowledgement. I understand that the organization reserves the right to change their notice and practices and that prior to implementation will mail a copy of the revised notice to me at the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization I not required to agree to the restrictions requested.

I acknowledge receipt of this organization's notice of privacy practices (privacy Notice).

_____

Patient Signature: Date:

Version:2020.1

For Office Use Only	Date
( ) Patient refused or was unable to sign acknowledgement ( ) Reason for failure to obtain acknowledgement: ( ) Description of attempts to obtain acknowledge	

ADVANCED PAIN MANAGEMENT

APMR Financial Policy

We are committed to providing you with the best possible health care and customer service. Our goal is to provide and maintain a good physician-patient relationship through clear and open communication. All our medical policies have been carefully implemented to maximize the quality of time and treatment you receive from each of our providers. All of our administrative policies have been carefully designed to support your insurance, financial, and healthcare needs. To achieve our goal, please read our policies carefully, and if you have any questions, please do not hesitate to ask a member of our front office staff.

APPOINTMENTS

Pain Management is a highly specialized field of medicine in which many patients must wait to be seen. We value the time we have set aside to see you and appreciate your understanding of the following terms and policies.

- New Patients: If you must cancel, please do so no less than 48 hours prior to your scheduled Initial Consult. This allows us to accommodate the next waiting patient. We do ask for your credit card information to "hold" your appointment. If you miss your appointment or do not cancel in time, your card will be charged $250.00.
- Returning Patients: If you cancel less than 48 hours, there is a charge of $75.00 for an office visit and $200 for a scheduled in-house procedure plus the charge of any medication that was ordered and cannot be returned. Multiple missed appointments may result in dismissal from the practice.
- Arriving Late: If you arrive more than 15 minutes late, we will do our best to accommodate you; however, it may be necessary to reschedule your appointment.
- Checking In: On arrival, you must sign in at the front desk and present your current insurance card at every visit. You are responsible for communicating any changes in your policy or personal information such as a change of name, address, referring physician, attorney, adjuster, etc., to the front desk.

INSURANCE (Including ALL LIENS CASES)

Payment is expected at the time of service as follows:

- Insurance Deductible , Co-Payments and Coinsurance: As a courtesy to you, we bill participating insurance companies – primary and secondary. At the time of your appointment, you are expected to pay any remaining deductible that has not been met, your co-payment, and any applicable coinsurance. (Additional information is provided to help clarify these terms.)
- A service fee equal to 10% of any late co-pay, coinsurance, or deductible, will be added to the payment and must be paid before or by your next scheduled appointment.
- Self-pay patients are expected to pay for services in FULL at the time of the visit.
- APMR accepts cash, personal checks, VISA, MasterCard, and American Express.

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APMR Financial Policy

Understanding Your Insurance:

- Deductible**:** A deductible is the initial amount of money an insured has to pay (out-of-pocket) before any benefits from the health insurance policy can be used. Most deductibles renew on an annual basis and begin in January with services covered under the calendar year. However, there are others that renew mid-year, in July. Some insurances allow for a "last quarter carry-over" whereby services during the last quarter of a year can be carried over and applied to the next year's deductible. If you are unsure which you have, contact your insurance agent.
- Co-Payment: A co-payment is a *fixed amount* you are required to pay for each medical service you receive, regardless of the cost of the service. Unlike a deductible that's usually paid once a year, a co-pay is paid *each time* a healthcare service is used.
- Coinsurance: Unlike the fixed amount of a co-pay, coinsurance is a *percentage* of the provider's cost of service after the deductible has been met (20% coinsurance is common). Coinsurance continues to be paid until you reach your "out-of-pocket" maximum. After that, the insurance company will pay for all covered services up to the policy's maximum, for the remainder of the year. Out-of-pocket maximum's have a wide range of possibilities depending upon the insurance – from $1000 to $5000 or more.

SPECIAL CIRCUMSTANCES

If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by our business office staff.

I have read and understand APMR's financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Patient Name	DOB
Responsible Party's Name	Relationship
Responsible Party's Signature	Date

ADVANCED PAIN MANAGEMENT

Financial Disclosure

The Following Notice is required by California Law (Business code 654.2, Labor Code 139.3)

Notice of Physician's Financial Interest

The facilities listed below are partly owned by Ravi Panjabi, M.D. and a such, Dr. Panjabi has a financial interest with or provides services to one or more of the facilities and/or doctors within those facilities. This information is being provided to you to help you make an informed decision about your health care.

Patient's Freedom of Choice

You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician at a different facility other than those listed below. This choice, however, may be affected by restrictions imposed by your insurance plan. Your doctor would be happy to discuss alternatives with you. Potential sources of information concerning alternatives can also be obtained from the Yellow Pages, the internet, or the county medical association.

The following address is provided for the filing of any complaints relevant to this notice or the services provided. Forms are available through the Office Manager who will answer any question you may have.

Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95834

Facilities:

Radiology Partners, L.L.C.
Redwood Surgery Center
Webster Surgery Center Castro Valley
Castro Valley Open MRI

Please check and sign below

( ) I hereby acknowledge receipt of this notice

( ) I acknowledge I have been given a copy for my files

Patient's Name:_____ Date: _____

Patient's Signature: _____

ADVANCED PAIN MANAGEMENT

Opiate Pain Management Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

- I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.
- I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines. In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.
- I further understand that if I break this Agreement, I will be discharged from this practice.
- I agree to participate in psychiatric or psychological assessments, if my doctor deems it necessary.
- I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.
- I will not use any illegal controlled substances, including methamphetamine, ecstasy, cocaine, etc., nor will I misuse or self-prescribe /medicate with legal controlled substances. I will not use alcohol. The use of alcohol may result in a fatal outcome.
- I will not share, sell or trade my medication with anyone. Also, I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.
- I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants from any other doctor. I will keep my doctor informed about all other medications I am taking and about all other doctors I am seeing.
- I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.
- I understand that I am being placed on these medications on a trial basis initially for 3 to 4 months. If my pain and function does not improve, I may be taken off these medications. I understand that these medications "will" cause physical dependence and "may" cause addiction. I understand that I will be required to take random urine analysis screenings at any time.
- I understand that any change in dosage regimen can be made only after permission from the doctor. If I have been allowed to increase the dose it is my responsibility to call the office and reschedule my appointment so that I don't run out of medications.
- I am responsible for making my next appointment ahead of time, in time for my next refill. I understand that if I do not make timely appointments, I run the risk of running out of medications and going into withdrawals.

I agree to use Pharmacy:_____ Location:_____ for filling prescriptions for all of my pain medicine. Phone: _____ Fax: _____

- I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.
- I authorize my doctor to provide a copy of this Agreement to my pharmacy.
- I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. Further if necessary, the doctor is authorized to discuss medication issues with my family members and other health care professionals to ensure compliance with my pain program.
- I agree that I will submit to a blood, urine, or saliva test if requested by my doctor to determine my compliance with my program of pain control medicine.
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
- I will bring all unused pain medicine to every office visit.
- I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered.

A copy of the document has been given to me. (PLEASE INITIAL)_____

This Agreement is entered into on this _____ day of _____, 20_____.

Patient Name _____**Signature Date** _____

Witnessed By_____ **Date** _____

Date _____

Patient Name _____

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
TOTAL		[ ]		

Total Score Risk Category Low Risk 0 – 3 Moderate Risk 4 – 7 High Risk $\geq$ 8

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	o	o	o	o	o
2. How often have you felt a need for higher doses of medication to treat your pain?	o	o	o	o	o
3. How often have you felt impatient with your doctors?	o	o	o	o	o
4. How often have you felt that things are just too overwhelming that you can't handle them?	o	o	o	o	o
5. How often is there tension in the home?	o	o	o	o	o
6. How often have you counted pain pills to see how many are remaining?	o	o	o	o	o
7. How often have you been concerned that people will judge you for taking pain medication?	o	o	o	o	o
8. How often do you feel bored?	o	o	o	o	o
9. How often have you taken more pain medication than you were supposed to?	o	o	o	o	o
10. How often have you worried about being left alone?	o	o	o	o	o
11. How often have you felt a craving for medication?	o	o	o	o	o
12. How often have others expressed concern over your use of medication?	o	o	o	o	o

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.

COMM™

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	O	O	O	O	O
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	O	O	O	O	O
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	O	O	O	O	O
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	O	O	O	O	O
5. In the past 30 days, how often have you seriously thought about hurting yourself?	O	O	O	O	O
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	O	O	O	O	O

 The COMM™ was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
7. In the past 30 days, how often have you been in an argument?	O	O	O	O	O
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	O	O	O	O	O
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	O	O	O	O	O
10. In the past 30 days, how often have you been worried about how you're handling your medications?	O	O	O	O	O
11. In the past 30 days, how often have others been worried about how you're handling your medications?	O	O	O	O	O
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	O	O	O	O	O
13. In the past 30 days, how often have you gotten angry with people?	O	O	O	O	O
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	O	O	O	O	O
15. In the past 30 days, how often have you borrowed pain medication from someone else?	O	O	O	O	O
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	O	O	O	O	O

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
17. In the past 30 days, how often have you had to visit the Emergency Room?	O	O	O	O	O

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1 – Pain intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2 – Personal care (washing, dressing etc)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

Section 4 – Walking*

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than 1/2 mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9 – Social life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10 – Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

.

References

1. Fairbank JC, Pynsent PB. The Oswestry Disability Index. Spine 2000 Nov 15;25(22):2940-52; discussion 52.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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Notes Date of Injury Location				
Duration (How long have you had the pain?)	( ) 1 Day ( ) 2 Days ( ) 3 Days ( ) 4 Days ( ) 5 Days ( ) 6 Days	( ) 1 Week ( ) 2 Weeks ( ) 3 Weeks	( ) 1 Month ( ) 2 Months ( ) 3 Months ( ) 4 Months ( ) 5 Months ( ) 6 Months ( ) 7 Months ( ) 8 Months ( ) 9 Months ( ) 10 Months ( ) 11 Months	( ) 1 Year ( ) 2 Years ( ) 3 Years ( ) 4 Years ( ) 5 Years ( ) 6 Years ( ) 7 Years ( ) 8 Years ( ) 9 Years ( ) 10 or More Years
Onset	( ) Sudden Onset ( ) While Bending ( ) While Driving ( ) While going downstairs ( ) While lifting weights ( ) While playing ( ) While standing up after prolonged standing		( ) Gradually over time ( ) While climbing ( ) When fallen down ( ) While jumping ( ) During motor accident ( ) While running ( ) While walking	
Frequency	( ) Constant ( ) Infrequent ( ) Seldom		( ) Intermittent ( ) Rare	
Quality	( ) Aching ( ) Hot-Burning ( ) Pressure Like ( ) Stabbing	( ) Cramping ( ) Numbing ( ) Sharp ( ) Throbbing	( ) Dull ( ) Pins and needles ( ) Shooting ( ) Tingling	
Radiation	( ) Bilaterally into the head ( ) Back ( ) Bilateral lower extremity	Left ( ) Head ( ) Shoulder ( ) Upper arm ( ) Forearm ( ) Hand ( ) Fingers ( ) Upper extremity ( ) Lower extremity ( ) Hip ( ) Thigh ( ) Knee ( ) Leg ( ) Ankle	Right ( ) Head ( ) Shoulder ( ) Upper arm ( ) Forearm ( ) Hand ( ) Fingers ( ) Upper extremity ( ) Lower extremity ( ) Hip ( ) Thigh ( ) Knee ( ) Leg ( ) Ankle	

Please circle the pain scores

	No pain										Worst pain you can imagine
Severity of pain at its worst	0	1	2	3	4	5	6	7	8	9	10
Severity of pain at its best	0	1	2	3	4	5	6	7	8	9	10
Severity of average pain	0	1	2	3	4	5	6	7	8	9	10
Severity of pain right now	0	1	2	3	4	5	6	7	8	9	10

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Worsening factors	( ) Bending ( ) Defecation ( ) Heat ( ) Lifting ( ) Sneezing ( ) Turning to the left ( ) Walking	( ) Changing Positions ( ) Going upstairs ( ) Increased Activity ( ) Movement ( ) Standing a long time ( ) Turning to the right	( ) Coughing ( ) Going downstairs ( ) Lying flat ( ) Sitting a long time ( ) Standing up straight ( ) Turning side to side
Relieving factors	( ) Assistive Device ( ) Exercise ( ) Lying flat ( ) Medication ( ) Sitting	( ) Changing Position ( ) Heat ( ) Massage ( ) Physical Therapy ( ) Standing	( ) Cold ( ) Injections ( ) Manipulation ( ) Rest ( ) Walking
Associated symptoms	( ) Difficulty staying asleep due to pain ( ) Frustrated because of pain ( ) Involuntary loss of bowel and bladder control ( ) Need for sleeping pills ( ) Numbness ( ) Restful sleep ( ) Tingling ( ) Unable to stay asleep	( ) Feeling blue all the time ( ) Increase of pain with coughing or sneezing ( ) Muscle Cramp ( ) Non-restful sleep ( ) Recent fevers, chills, or sweats ( ) Restrictions on activities ( ) Unable to fall asleep	
History of vertigo/dizziness	( ) No ( ) Yes		
History of falls	( ) No ( ) Yes		
History of fibromyalgia	( ) No ( ) Yes		
Use of supporting device	( ) Cane ( ) Crutches	( ) Walker ( ) Wheelchair	
Comments			
Caregivers you have visited	( ) Pain medicine physician ( ) Internist ( ) Neurologist ( ) Orthopedist ( ) Sports Medicine ( ) Rehabilitation Medicine ( ) Podiatrist ( ) Urologist	( ) Family Physician ( ) Physical Therapist ( ) Rheumatologist ( ) General Surgeon ( ) Anesthesiologist ( ) Osteopathic Physician ( ) Nurse Practitioner ( ) Endocrinologist	( ) Spine Surgeon ( ) General Practitioner ( ) Chiropractor ( ) Gynecologist ( ) Occupational Medicine ( ) Acupuncturist ( ) Psychiatrist ( ) Neurosurgeon
Tests undergone in the past	( ) X-Rays ( ) Discogram ( ) CT Myelogram ( ) Nerve Conduction Study ( ) PT PTT INR ( ) Electrolytes ( ) Chest X-Ray	( ) CAT Scan ( ) Neural Block ( ) Flexion/Extension Film ( ) EEG ( ) Rheumatologic Panel ( ) Lumbar Puncture ( ) Hepatic Profile	( ) EMG Test ( ) Myelogram ( ) Bone Scan ( ) CBC ( ) Neuropathy Panel ( ) EKG ( ) MRI Scan

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Medicines taken in the past	( ) Alpha 2 Agonist ( ) Baclofen ( ) Codeine ( ) Depakote/Depakote ER ( ) Fentanyl/Actiq ( ) Hydrocodone ( ) Lyrica ( ) Muscle Relaxant ( ) Norflex ( ) Pamelor/Nortriptyline ( ) Protroptyline ( ) Soma ( ) Ultram/Ultram ER	( ) Antidepressant ( ) Beta-Blockers ( ) Darvocet ( ) Desipramine ( ) Flexeril/Cyclobenzaprine ( ) Hydromorphone ( ) Methadone ( ) Narcotics ( ) Opana ( ) Paxil ( ) Robaxin ( ) Tegretol ( ) Zonegram/Zonisamide	( ) Anti-inflammatory Meds ( ) Calcium Channel Blockers ( ) Darvon ( ) Elavil/Amitriptyline ( ) Gabitril ( ) Keppra ( ) MS Contin ( ) Neurontin/Gabapentin ( ) Oxycodone/Oxycontin ( ) Percocet ( ) Skelaxin ( ) Topamax/Topiramate ( ) Zanaflex/Tizanidine
Treatment undergone in the past	( ) Bed Rest ( ) Chemical Denervation ( ) Epidural Blood Patch ( ) Facet Injection ( ) Ice ( ) Intrathecal Infusion Pump ( ) Manipulation ( ) Occipital Nerve Block ( ) Psychiatric Treatment ( ) Stellate Ganglion Block ( ) TENS ( ) Trigger Point Injection	( ) Biofeedback ( ) Cryo-Denervation ( ) Epidural Steroid Injection ( ) Ganglion Impar Block ( ) Injection Therapy ( ) IDET ( ) Massage ( ) Physical Therapy ( ) Radiofrequency Denervation ( ) Superior Hypogastric Block ( ) Therapeutic Injection ( ) Vertebroplasty	( ) Celiac Plexus Block ( ) Discography ( ) Exercise ( ) Heat ( ) Intercostal Field Block ( ) Lumbar Sympathetic Block ( ) Nerve Block ( ) Piriformis Injection ( ) Sacroiliac Joint Injection ( ) Surgery ( ) Traction
Prior Treatments of any help?	( ) No ( ) Yes		
When was the prior tx started?	( ) After couple of days after the onset ( ) Immediately after the pain started ( ) After a few months wait	( ) When the home remedies and other OTCs did not work ( ) Immediately after the surgery	
Comments			
( ) No Known Allergies Allergy 1. 2. 3. 4. 5.	Reaction 1. 2. 3. 4. 5.		

( ) No Known Current Medication Drug Name 1. 2. 3. 4. 5.	Drug Name 6. 7. 8. 9. 10.
( ) No Known Past Medical History Ailment 1. 2. 3. 4. 5.	Since When 1. 2. 3. 4. 5.

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( ) No Known Past Surgical History Surgery Name 1. 2. 3. 4. 5.	 Since when 1. 2. 3. 4. 5.
( ) Non-Contributary Family History Problem 1. 2. 3. 4. 5.	 Relation 1. 2. 3. 4. 5.

Social History (Please Answer ALL Questions)

Family

Marital Status	
Number of children	
Nature of exercise	
Pets	
Sexual History	

Use of Drugs/Alcohol/Tobacco

Are you concerned about the amount you drick	
Do you drink alcohol?	
Do you use tobacco?	
Caffeine intake:	
Do you use recreational or street drugs?	( ) Never Used ( ) Current Use ( ) History Use
Used street drugs with needle?	( ) No ( ) Yes

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Work History

Employment type	
Nature of work	
Occupational exposure	( ) None ( ) Current ( ) History of exposure
Exposure to health hazards	
Health hazards at home	( ) No ( ) Yes
Duration of current profession	
Satisfaction with work	( ) Satisfied ( ) Dissatisfied ( ) Very Satisfied ( ) Very Dissatisfied
Stress level at work	( ) Low ( ) Medium ( ) High

Constitutional Symptoms (Please Check Mark)

Fever	( ) Denies ( ) Reports	Fatigue	( ) Denies ( ) Reports
Chills	( ) Denies ( ) Reports	Hot Flashes	( ) Denies ( ) Reports
Night Sweats	( ) Denies ( ) Reports	Weight Loss	( ) Denies ( ) Reports
Appetite	( ) Denies ( ) Reports	Physical Strength	( ) Denies ( ) Reports

HEENT

Headache	( ) Denies ( ) Reports	Dizziness	( ) Denies ( ) Reports
Double Vision	( ) Denies ( ) Reports	Loss of Vision	( ) Denies ( ) Reports
Corrective lenses/contacts	( ) Denies ( ) Reports	Pain in eye	( ) Denies ( ) Reports
Earache	( ) Denies ( ) Reports	Discharge from ear	( ) Denies ( ) Reports
Deafness/hearing loss	( ) Denies ( ) Reports	Frequent nosebleed	( ) Denies ( ) Reports
Sinus Problems	( ) Denies ( ) Reports	Smelling sense change	( ) Denies ( ) Reports
Sore Throat	( ) Denies ( ) Reports	Swallowing Difficulty	( ) Denies ( ) Reports
Taste Difficulty	( ) Denies ( ) Reports	Hoarseness	( ) Denies ( ) Reports

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Respiratory

Trouble Breathing	( ) Denies ( ) Reports	Shortness of Breath	( ) Denies ( ) Reports

Musculoskeletal

Muscle Pain	( ) Denies ( ) Reports	Muscle Cramp	( ) Denies ( ) Reports
Muscle Twitch	( ) Denies ( ) Reports	Muscle Wasting	( ) Denies ( ) Reports
Muscle Weakness	( ) Denies ( ) Reports	Muscle Pain or Tenderness	( ) Denies ( ) Reports
Loss of Muscle Bulk	( ) Denies ( ) Reports	Neck Pain	( ) Denies ( ) Reports
Shoulder Pain	( ) Denies ( ) Reports	Back Pain	( ) Denies ( ) Reports
Joint Pain	( ) Denies ( ) Reports	Joint Stiffness	( ) Denies ( ) Reports
Joint Swelling	( ) Denies ( ) Reports	Morning Stiffness	( ) Denies ( ) Reports
Abnormal Joint	( ) Denies ( ) Reports	Limitation of Joint Movement	( ) Denies ( ) Reports
Fractures	( ) Denies ( ) Reports	Arthritis	( ) Denies ( ) Reports
Swollen Joints	( ) Denies ( ) Reports	Night Cramps	( ) Denies ( ) Reports
Atrophy	( ) Denies ( ) Reports	Posture Abnormalities	( ) Denies ( ) Reports

Neurological

Seizures	( ) Denies ( ) Reports	Blackout	( ) Denies ( ) Reports
Trouble with Memory	( ) Denies ( ) Reports	Trouble Concentrating	( ) Denies ( ) Reports
Gait Disturbance	( ) Denies ( ) Reports	Headaches	( ) Denies ( ) Reports
Stroke	( ) Denies ( ) Reports	Loss of Strength	( ) Denies ( ) Reports
Fainting Spells	( ) Denies ( ) Reports	Memory Loss	( ) Denies ( ) Reports
Involuntary Movements	( ) Denies ( ) Reports	Poor Coordination	( ) Denies ( ) Reports
Sputum Production	( ) Denies ( ) Reports	Coughing up blood	( ) Denies ( ) Reports
Sleep Apnea	( ) Denies ( ) Reports	Orthopnea	( ) Denies ( ) Reports
Wheezing	( ) Denies ( ) Reports	Respiratory Infection	( ) Denies ( ) Reports

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Cardiovascular

Chest Pain	( ) Denies ( ) Reports	Poor Circulation	( ) Denies ( ) Reports
Blood Clots	( ) Denies ( ) Reports	Irregular Heartbeat	( ) Denies ( ) Reports
Thumping the chest	( ) Denies ( ) Reports	Limb Swelling	( ) Denies ( ) Reports
Feet Swelling	( ) Denies ( ) Reports	Varicose Veins	( ) Denies ( ) Reports
PND	( ) Denies ( ) Reports	Phlebitis	( ) Denies ( ) Reports

Gastrointestinal

Abdominal		Indigestion	
Gastroesophageal	( ) Denies ( ) Reports	Heartburn	( ) Denies ( ) Reports
Nausea or Vomiting	( ) Denies ( ) Reports	Vomiting Blood	( ) Denies ( ) Reports
Frequent Constipation	( ) Denies ( ) Reports	Frequent Diarrhea	( ) Denies ( ) Reports
Stomach Ulcer	( ) Denies ( ) Reports	Painful Bowel Movement	( ) Denies ( ) Reports
Chronic Bloating	( ) Denies ( ) Reports	Blood in Stool	( ) Denies ( ) Reports
Hemorrhoids/Piles	( ) Denies ( ) Reports	Jaundice	( ) Denies ( ) Reports

Genitourinary

Incontinence	( ) Denies ( ) Reports	Blood in Urine	( ) Denies ( ) Reports
Kidney Stones	( ) Denies ( ) Reports	Difficulty in Urination	( ) Denies ( ) Reports
Numbness	( ) Denies ( ) Reports	Spasticity	( ) Denies ( ) Reports
Weakness	( ) Denies ( ) Reports	Tremors	( ) Denies ( ) Reports

Psychiatric

Anxiety	( ) Denies ( ) Reports	Depression	( ) Denies ( ) Reports
Mood Swings	( ) Denies ( ) Reports	Nervousness	( ) Denies ( ) Reports
Sleeping Difficulty	( ) Denies ( ) Reports		

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Endocrine

Excessive Thirst	( ) Denies ( ) Reports	Heat or Cold Intolerance	( ) Denies ( ) Reports
Excessive Urination	( ) Denies ( ) Reports	Thyroid Problem	( ) Denies ( ) Reports
Diabetes	( ) Denies ( ) Reports	Polyuria	( ) Denies ( ) Reports

Hematologic

Bleeding Disorder	( ) Denies ( ) Reports	Anemia	( ) Denies ( ) Reports
Easy Bruising	( ) Denies ( ) Reports	Blood Transfusion	( ) Denies ( ) Reports

Skin

Itching	( ) Denies ( ) Reports	Rashes	( ) Denies ( ) Reports
Boils	( ) Denies ( ) Reports		

Signature:

Date: