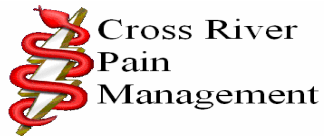


DATE: \_\_\_\_\_



## NEW PATIENT INFORMATION SHEET

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ SEX: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ MARITAL STATUS: M S D W

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_

PATIENT'S EMPLOYER \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_ TELEPHONE NUMBER (\_\_\_\_) \_\_\_\_\_

SPOUSE'S NAME (Parent if minor) \_\_\_\_\_

SPOUSE/PARENT DATE OF BIRTH AND SS # \_\_\_\_\_

CHIEF COMPLAINT: \_\_\_\_\_

REFERRING PHYSICIAN NAME \_\_\_\_\_

ADDRESS/PHONE NUMBER \_\_\_\_\_

SPECIALITY OF REFERRING PHYSICIAN (eg. Internal Medicine) \_\_\_\_\_

PRIMARY CARE PHYSICIAN'S NAME: \_\_\_\_\_

### INSURANCE INFORMATION:

Primary Insurance Co. (W/C, N/F) \_\_\_\_\_ ID # \_\_\_\_\_ Eff Date \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_ Contact: \_\_\_\_\_

Name of Policyholder: \_\_\_\_\_ Social Security # \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID # \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:** I hereby authorize any insurance benefits to be paid directly to the physician and I understand I am responsible for non-covered services. I also authorize the physician to release any information required in the processing of the claim.

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



PATIENT QUESTIONNAIRE

This form is to be completed one time by each patient. It is to be completed before your first visit to the center. Although the questionnaire contains personal information, it is vital that you answer the questions so that the Pain Management team can tailor a plan of care for you.

Our records are strictly confidential and no unauthorized person is permitted to see your case record without your written permission.

Patient's (YOUR) Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

Cell:(\_\_\_\_)\_\_\_\_\_ Gender (Please check): \_\_\_ F \_\_\_ M Marital Status: S M D W

Date of Birth: \_\_\_\_\_ Age:\_\_\_\_\_ Height: \_\_\_\_\_ Weight:\_\_\_\_\_

Your Occupation: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_)\_\_\_\_\_

Referring Physician's Name/Address/phone:  
\_\_\_\_\_

What is the problem you would like us to help you with?  
\_\_\_\_\_

Please mark the event, or events, which led to your present pain:  
\_\_\_\_\_Accident (Auto \_\_\_\_\_ Date\_\_\_\_\_) Work \_\_\_\_\_Injury Date \_\_\_\_\_

Are you working? \_\_\_\_\_ F/T \_\_\_ P/T \_\_\_ If not working, when did you stop? \_\_\_\_\_

When did the pain start and how did it start?  
\_\_\_\_\_  
\_\_\_\_\_

How often does the pain occur?  
\_\_\_\_\_ Continuously \_\_\_\_\_ Several times \_\_\_\_\_ Once or twice a day  
\_\_\_\_\_ Several times a week \_\_\_\_\_ Less than three or four times a month

**CROSS RIVER PAIN MANAGEMENT  
PATIENT QUESTIONNAIRE**

What do you think causes your pain?

-----

What makes the pain better?

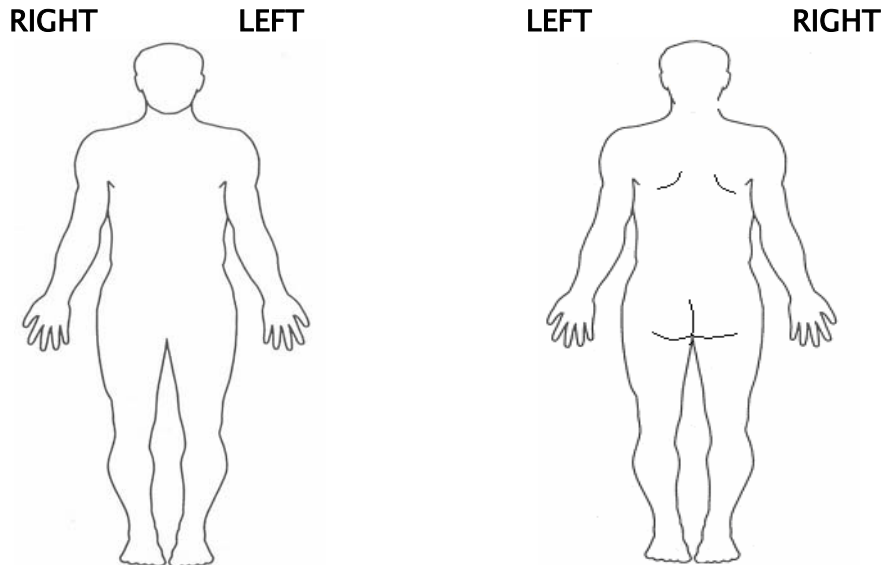
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What makes the pain worse?

-----

Does the pain interrupt your sleep? Yes\_\_\_\_ No\_\_\_\_ Sometimes\_\_\_\_\_

In the figure provided, please indicate the location and description of your pain by circling and placing the corresponding words next to the areas.



Circle the number that best describes your pain.

<b>At its WORST</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>At its BEST</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>On AVERAGE</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>Comfort Goal/"can live with"</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>

**0=NONE**  
No Pain  
At all

**1-3=MILD**  
Interfering little  
with activities of  
Daily living

**4-6=MODERATE**  
Interfering significantly  
with activities of daily  
living

**7-10=SEVERE**  
Disabling; unable to  
perform activities  
of daily living

Patient's (YOUR) Full Name: \_\_\_\_\_

CROSS RIVER PAIN MANAGEMENT  
PATIENT QUESTIONNAIRE

STUDIES & PAST PAIN TREATMENTS	DATES	RESULTS
---- Nerve Block or Injections	-----	-----
---- Back Surgery	-----	-----
---- CAT scan	-----	-----
---- MRI/Other	-----	-----
---- Physical Therapy	-----	-----
---- Chiropractor	-----	-----
---- Other	-----	-----

LIST CURRENT PAIN AND SLEEP MEDICATIONS:

Name	Dosage	Time Used
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----

Patient's (YOUR) Full Name: \_\_\_\_\_

Patient's (YOUR) Full Name: \_\_\_\_\_

Which medications have you tried for your pain? Are they helpful? For how long-effective? And which ones are you currently taking?

	No help	Some help	Great help	Lasts for how long	Now taking?		
Baclofen						<b>Muscle Relaxants</b>	
Metaxolone (Skelaxin)							
Tizanidine HCL (Zanaflex)							
Carisoprodol (Soma)							
Methocarbamol (Robaxin)							
Diazepam (Valium)							
Cyclobenzaprine (Flexeril)							
Lunesta						<b>Sleeping Agents</b>	
Restoril							
Ambien							
Gabapentin (Neurontin)						<b>Neuropathic Pain Agents</b>	
Zonisamide (Zonegran)							
Cymbalta							
Elavil (Amitriptyline)							
Topiramate (Topomax)							
Desipramine (Norpramine)							
Gabapril							
Codeine							<b>Analgesics (Pain Agent)</b>
Meperidine (Demerol)							
Hydrocodone (Vicodin)							
Hydrocodone (Norco)							
Hydromorphone (Dilaudid)							
Hydromorphone (Palladone)							
Fentanyl (Duragesic)							
Fentanyl (Actiq)							
Morphine (MS Contin)							
Morphine (Avinza)							
Oxycodone (Percocet)							
Oxycontin							
Propoxy (Darvocet)							
Nabumetone (Relafen)							
Naproxen (Naprosyn)							
Lidocaine (Lidoderm patch)							
Aspirin							
Methadone							
Trilisate						<b>Anti-inflammatorys</b>	
Ibuprofen (Motrin, Advil)							
Acetaminophen (Tylenol)							
Ketorolac (Toradol)							
Clonazepam (Klonopin)							
Clonidine							

**PAST MEDICAL HISTORY/REVIEW OF SYSTEMS**

**Endocrine:**

\_\_\_ Diabetes \_\_\_ Thyroid  
\_\_\_ Insulin \_\_\_ Non-Insulin  
Medications for diabetes  
-----

**Eyes:**

Glaucoma: \_\_ narrow angle \_\_ wide angle

**Cardio:**

\_\_\_ High Blood Pressure  
\_\_\_ Heart Attack \_\_\_ Valve Problem  
\_\_\_ Heart Surgery \_\_\_ Angina

**Circulation:**

\_\_\_ Peripheral vascular disease  
\_\_\_ Chronic edema

**Neurological:**

\_\_\_ CVA/Stroke \_\_\_ Seizures

**Respiratory:**

\_\_\_ Emphysema \_\_\_ Asthma \_\_\_ COPD

**Gastrointestinal:**

\_\_\_ Ulcers \_\_\_ Heartburn /Reflux  
\_\_\_ Liver Problems

**Genitourinary:**

\_\_\_ Urination problems \_\_\_ Kidney stones  
\_\_\_ Erectile dysfunction

**Musculoskeletal :**

\_\_\_ Arthritis \_\_\_ Joint Replacement

**Psychiatric Difficulties:**

\_\_\_ Depression \_\_\_ Anxiety \_\_\_ Claustrophobia

**Hematologic Difficulties**

\_\_\_ Platelets low \_\_\_ Bleeding \_\_\_ Poor Clotting

**Do You Use:**

\_\_\_ Tobacco: How Much \_\_\_\_\_  
\_\_\_ Alcohol: How Much \_\_\_\_\_  
-----

\_\_\_ Street Drugs: Which ones and How Much  
-----

\_\_\_ History of Alcohol or Drug Rehab  
-----

**Allergic/Immunologic:**

Do you have allergies to the following?  
\_\_\_ Lavender \_\_\_ Shellfish \_\_\_ Eggs  
\_\_\_ Contrast/CAT scan dye

**Family History:**\_\_\_\_\_

**Any Other Medical History:**

-----  
-----  
-----

**Medication Allergies:**

-----  
-----  
-----

**Surgical History:**

-----  
-----  
-----  
-----

**Do You Require Antibiotics Prior to Invasive Procedures, Surgeries or Dental Procedures? \_\_\_ Yes \_\_\_ No**

If Yes, what do you take?\_\_\_\_\_

**Problems with Anesthesia?**

-----  
**History of Sleep Apnea? \_\_\_**  
-----

**List Your Current Medication & Dosage**  
aspirin\_\_\_\_ Ibuprofen\_\_\_\_\_

-----  
-----  
-----  
-----  
-----  
-----

**Patient's (your) Full Name:** \_\_\_\_\_ **5**

CROSS RIVER PAIN MANAGEMENT  
PATIENT QUESTIONNAIRE

Are you suing anyone because of your pain or injury? Yes \_\_\_ No \_\_\_

Are there things causing stress in your life other than your current pain problem?

Yes \_\_\_ No \_\_\_

If yes, please describe:\_\_\_\_\_

When you are in pain, how often is your husband/ wife/ other family supportive and encouraging?

Never\_\_\_ Seldom \_\_\_\_ Sometimes \_\_\_\_ Frequently \_\_\_\_ Always \_\_\_

Are you receiving compensation or disability? Yes \_\_\_ No \_\_\_

Do you have an application for compensation or disability payments pending?

Yes \_\_\_ No \_\_\_

Is your pain the result of an accident? Yes \_\_\_ No \_\_\_

If yes, where did it occur? (Circle One) Home Work Vacation Care

Other (describe)\_\_\_\_\_

What are you expecting from treatment at the Pain center? Also, please include any additional information which we should know.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient's (your) Full Name:\_\_\_\_\_