Last Update: May 6, 2011

PATIENT INFORMATION FORM

To better serve your care, please complete the following and bring this form with you to your first appointment. Important: It is strongly recommended that you provide the following documents at the time of your evaluation:
1.) Your doctors' dictations for the last two years about your pain problem.
2.) A copy of reports for the tests listed under "K" in this questionnaire.

A. General Information:

Today's Date:_____

Name:_____ S.S.#_____

Age:_____ Sex: M F Date of Birth: _____

Address:_____

City: _____

Home Phone:_____

Work/Cell Phone:_____

Email: _____

B. Referral Source:

Physician: _____

Attorney: _____

Insurance Carrier:_____

Other: _____

Name of Primary Care Physician:_____

Address of Referral Source:_____

C. Chief Complaint:

(1) What is your main problem?

_____

_____

_____

D. History of Present Pain:

- ❖ Location: Please describe exactly where your pain is located on your body.

_____

_____

_____

_____

_____

(2) How many months ago did your pain begin? _____

(3) What event led to your present problem? (Please circle)

Cancer Disease Operation Injury Other _____

(4) What was the date of your injury? _____

(5) Do you have pain free intervals? Yes No
If so, how long do these intervals last? _____

(6) Short McGill Pain Questionnaire: Please check one box per file line that describes your pain in words and severity.

Throbbing	None	Mild	Moderate	Severe
Shooting	None	Mild	Moderate	Severe
Stabbing	None	Mild	Moderate	Severe
Sharp	None	Mild	Moderate	Severe

Cramping	None	Mild	Moderate	Severe
Gnawing	None	Mild	Moderate	Severe
Hot-Burning	None	Mild	Moderate	Severe
Aching	None	Mild	Moderate	Severe
Heavy	None	Mild	Moderate	Severe
Tender	None	Mild	Moderate	Severe
Splitting	None	Mild	Moderate	Severe
Tiring-Exhausting	None	Mild	Moderate	Severe
Sickening	None	Mild	Moderate	Severe
Fearful	None	Mild	Moderate	Severe
Punishing-Cruel	None	Mild	Moderate	Severe

(7) What factors aggravate your pain? (circle)

Massage	Anxiety	Lying Down
Sitting	Walking	Coughing
Sex	Running	Cold
Heat	Straining	Standing

(8) What helps your pain?

_____

_____

_____

(9) What is a comfortable position for you?

_____

_____

(10) Please describe your activities before your pain problem started.

_____

_____

_____

E. Previous physicians. Please complete the following information regarding doctors who have evaluated your pain problem. Start with the first doctor who evaluated your pain.

Doctor #1

Doctors Name: _____

Doctors Specialty: _____

Year of Doctors Care: _____

Doctors Diagnosis: _____

List Treatments Performed by Doctor_____

_____

Doctor #2

Doctors Name: _____

Doctors Specialty: _____

Year of Doctors Care: _____

Doctors Diagnosis: _____

List Treatments Performed by Doctor_____

_____

Doctor #3

Doctors Name: _____

Doctors Specialty: _____

Year of Doctors Care: _____

Doctors Diagnosis: _____

List Treatments Performed by Doctor_____

_____

Doctor #4

Doctors Name: _____

Doctors Specialty: _____

Year of Doctors Care: _____

Doctors Diagnosis: _____

List Treatments Performed by Doctor_____

_____

* If evaluated by more than four doctors for the pain problem, list their names and same information on the back of this page.

F. Social History

(1) Marital Status: Single Divorced Widowed Married

(2) Highest Level of Education: _____

(3) Children: Yes No How Many? _____ Ages_____

(4) Present source of financial support: (circle)

Personal earnings Workman's Comp Spouses earnings

Disability payment Pension Insurance

None Other_____

(5) Do you work? (circle) Full time Part time

(6) Do you smoke? Yes No Do you drink alcohol? Yes No

(7) Is there legal action pending? _____

G. Past medical history: (circle condition)

Asthma/breathing problems

Bleeding Problems

Diabetes

Liver Problems

Kidney problems

High Blood Pressure

Headaches

Other_____

H. Previous Treatments for pain:

Modalities	Yes	No	Effectiveness
Block			
TENS			
Physiotherapy			
Biofeedback			
Counseling			
Pain Management			
Surgery			
Other			

I. Surgical History

Surgeries performed on you and the dates that they were performed:

_____

_____

_____

_____

J. Medications:

(1) Allergies: _____

(2) Previous medication for pain:

Drug	Effectiveness	Side Effects

(3) Current Medications:

Drugs	Dosage	Purpose	Effectiveness	Doctor

K. This portion of the questionnaire is extremely important. Please provide the dates and the results of the tests listed below. Also, provide a copy of these reports (not films) at the time of your evaluation.

Previous Studied Laboratory Tests Performed to Evaluate Pain:

1. X-rays
2. CAT Scan
3. MRI
4. EMG
5. Nerve Conduction Studies
6. Myelogram
7. Thermogram
8. Bone Scan

L. Physical Status:

Height _____

Weight _____

IMPORTANT INFORMATION

1. Fees:

The fee schedule at the Institute can be found at the following site:

http://rsdhealthcare.org/Fee_Schedule.htm

2. Consultant's Role:

Our role in your care is that of a consulting physician. Your primary care physician will be responsible for prescribing your medications. The Institute will be available to consult with your doctor about your medications.

3. Patient instructions for Procedures:

-No food or drink 8 hours before procedure

-Take home medications with a sip of water, DO NOT take diabetic medication-bring it with you

-Bring any lung inhalers

-Do not bring any valuables

-Do not use any moisturizer / lotions on any extremities during the ketamine infusions.

-Arrive 30 minutes before procedure

-You cannot drive yourself home and need to make arrangements with a responsible person for transportation

4. Will Medicare reimburse you for your medical services at the Institute?

The Center is **OUT OF NETWORK** for Medicare. Any bills you pay for services at the Center **WILL NOT** be reimbursed to you by Medicare. Please inform our Receptionist if you are a Medicare Beneficiary.

Read and Understood:

Signature: _____ Date: _____