PAIN MEDICINE ASSOCIATES, PC

Name:_____Social Security #: _____

Date of Birth:____/____/_____ Sex: ( ) Female ( ) Male

Address: _____
Street Address City State Zip

Home Phone:_____ Cell Phone: _____

Alternate Phone: _____ Email: _____

Employer: _____
Name Address

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

Race: ( ) White ( ) African American ( ) Hispanic ( ) Asian ( ) Other not listed

Insurance Information
Please complete entire section

Health Ins.: _____Policy#:_____Group#:_____

Subscriber Information (if other than self) Name: _____ DOB: _____

Relationship to Patient:_____ SS# _____

* *Is the visit due to a work-related injury? ( ) Yes ( ) No
* *Is the visit due to an auto-related accident? ( ) Yes ( ) No
* *Have you ever been seen in another pain clinic? ( ) Yes ( ) No If yes, please list name and phone number of clinic _____

Whom may we contact in the case of an emergency?

Name:_____ Phone:_____Relationship:_____

Physician Information

Family Physician Name: _____

Phone and Address: _____

Referring Physician Name:_____

Phone and Address: _____

Pharmacy:_____Location/phone: _____

PAIN MEDICINE ASSOCIATES, PC

Lifetime Authorization

I. TREATMENT AUTHORIZATION – I, the below named patient, hereby give Pain Medicine Associates, Physicians, and staff consent for medical treatment.

II. RELEASE OF INFORMATION - I, the below named patient, hereby authorize any physician/staff of Pain Medicine Associates examining and /or treating me to release to any third party payor (such as an insurance company or governmental agency) any medical condition or records concerning diagnosis and treatment as necessary to determine the benefits payable.

I, the below named patient, hereby authorize the release of any medical information to my referring physician as well as my family physician (if they are not the same).

III. PHYSICIAN INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment directly to any physician of Pain Medicine Associates.

IV. MEDICARE/MEDICAID —I authorize any holder of medical or other information about to release to Social Security Administration any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance payments pertaining to treatment shall be assigned to Pain Medicine Associates' physicians.

V.1 PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by my insurance or third party within a reasonable period of time, not to exceed sixty (60) days.

I understand that I will be charged a $25.00 no show fee if I do not cancel scheduled appointment 24 hours in advance.

_____ _____

Patient Signature Date

MEDIGAP (SECONDARY INSURANCE) SIGNATURE
Medicare Patient's with a secondary insurance

I request that payment of authorized MEDIGAP benefits be made on my behalf to Pain Medicine Associates, P.C., for any services rendered to me. I authorize Pain Medicine Associates, P.C., physicians/staff to release any medical information necessary to determine benefits payable.

_____ _____

Patient's Name Date

PAIN MEDICINE ASSOCIATES, PC

HIPAA
ACKNOWLEDGEMENT

I, _____, acknowledge that I have received a copy of PAIN MEDICINE ASSOCIATES, PC, Notice regarding Privacy of Health Information and Patient Rights and Responsibilities and have been advised that a copy is available upon request.

_____ _____

Please Print Name of Patient DOB

_____ _____

Signature Date

_____ _____

Witness Relationship to Patient

CONTACT INFORMATION

I,_____, give my permission for PAIN MEDICINE ASSOCIATES, PC, to contact me at the following (please initial and fill in the numbers accordingly, including area code).

Please check all that may apply:

- ☐ Office may leave message on answering machine or voicemail
- ☐ Office may call cell phone: ( ) _____-_____
- ☐ Office may call patient at work: ( ) _____-_____
- ☐ Office may leave message with spouse and/or significant other.
- ☐ Office should only speak with patient.
- ☐ Information may be given to other family members (please list):

_____

_____

_____

I understand that in order for Pain Medicine Associates to provide quality care, I give permission to Pain Medicine Associates' physicians and employees to contact my primary care physician, referring physician, physical therapist, psychologist, pharmacists and other practitioners. I understand that Pain Medicine Associates' release to contact others involved in my care is a part of good medical practice.

_____ _____

Date Signature

PAIN MEDICINE ASSOCIATES PMA
Patient Pain Data Questionnaire (PPDQ)

Patient Name:_____

Date of Birth:_____

Date: _____

YOUR BACKGROUND

1. What are we seeing you for today?_____
2. How long have you been experiencing your pain? _____
3. What is your pain level today on a scale of 1-10 where a score of 0 means no pain, and 10 means the worst pain you have ever felt. _____.
4. Is your pain ☐Constant ☐Intermittent ☐Varies in intensity?
5. How has the intensity of your pain changed since it first began? ☐Increased ☐Decreased ☐Stayed the same
6. Is your pain the result of an accident or injury? ☐Yes ☐No
   If yes, date of injury _____
   Brief description of injury: _____
   _____
   _____
   If yes, is this a Workman's Comp. Claim? ☐Yes ☐No
7. Is there pending litigation concerning your pain? ☐Yes ☐No
8. Do you currently work? ☐Yes ☐No
   If no, date last worked: _____
9. Are you rated as disabled because of your pain? ☐Yes ☐No
10. Do you consider yourself disabled by pain? ☐Yes ☐No

FACTORS AFFECTING YOUR PAIN

How do the following activities or therapies affect your pain?

Activities	More Pain	Less Pain	No Effect	Not Tried
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying Flat	☐	☐	☐	☐
Shifting Positions	☐	☐	☐	☐
Bending Forward	☐	☐	☐	☐
Lifting Objects	☐	☐	☐	☐

Therapies	Helps a little	Helps a lot	No Effect	Not Tried
Resting	☐	☐	☐	☐
Tylenol	☐	☐	☐	☐
NSAIDS	☐	☐	☐	☐
RX Pain Medicines	☐	☐	☐	☐
Muscle Relaxers	☐	☐	☐	☐
Steroids by mouth	☐	☐	☐	☐
Physical Therapy	☐	☐	☐	☐
Chiropractic	☐	☐	☐	☐
Massage	☐	☐	☐	☐
Surgery	☐	☐	☐	☐
Injections, trigger points	☐	☐	☐	☐
Injections, epidurals	☐	☐	☐	☐
Injections, other types	☐	☐	☐	☐
TENS unit	☐	☐	☐	☐

CONSEQUENCES OF PAIN*

Do you feel your pain has ***caused***, or caused you to ***think about***, any of the following. Check ***neither*** if not applicable or no effect.

	Caused	Think About	Neither
Difficulty performing Activities of Daily Living	☐	☐	☐
Inability to perform Activities of Daily Living	☐	☐	☐
Loss of control of bowel	☐	☐	☐
Loss of control of bladder	☐	☐	☐
Difficulty falling asleep	☐	☐	☐
Restless sleep	☐	☐	☐
Inability to sleep	☐	☐	☐
Decreased social activity	☐	☐	☐
Decreased family interaction	☐	☐	☐
Decreased desire for sex	☐	☐	☐
Feeling depressed	☐	☐	☐
Diagnosis of depression	☐	☐	☐
Irritable	☐	☐	☐
Feelings of suicide	☐	☐	☐

*Please note, although the above consequences may be related to your pain, many of these are psychosocial consequences and are beyond the scope of treatment available in our clinic.

Allergies

Are you **allergic** to **shellfish**? ☐ No ☐ Yes
Are you **allergic** to **I.V. Dye**? ☐ No ☐ Yes
Are you **allergic** to any **other medications**? ☐No ☐ Yes, list:

Surgical History

Have you ever had **surgery**? ☐ No ☐ Yes, list:
(Please list most recent surgeries, including date or approximate date)

Have you ever had difficulty with **anesthesia**? ☐ No ☐ Yes:
☐ Difficult/slow to wake up ☐ Weakness waking up
☐ High fever ☐ Nausea and/or vomiting

Revised 9/29/22

PAIN MEDICINE ASSOCIATES PMA
Patient Medical Data Questionnaire (PMDQ)

Patient Name:_____

Date of Birth:_____

Date: _____

Review Of Systems/Medical History

How do you consider your **overall health**?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Females: Are you **pregnant**? ☐ No ☐ Yes ☐ Maybe

Date of last menstrual period _____

Please check any of the following that you currently have or have recently had:

1. **Musculoskeletal**
   ☐ Joint Pains ☐ Joint Stiffness ☐ Joint Swelling ☐ Unsteady Gait
2. **Neurological**
   ☐ Numbness ☐ Headaches ☐ Tingling ☐ Tremors ☐ Dizziness
3. **Constitutional/Symptom**
   ☐ Weight Loss ☐ Weight Gain ☐ Fever
4. **Integumentary**
   ☐ Itching ☐ Rash ☐ Scarring/keloids ☐ Poor Healing Wounds
5. **Hematologic/Lymphatic**
   ☐ Easy Bleeding ☐ Easy Bruising ☐ Enlarged Lymph Nodes
6. **Allergic/Immunologic**
   ☐ Immunosuppression ☐ Allergic reaction to foods/environment
7. **Cardiovascular**
   ☐ Chest Pain ☐ Palpitations ☐ Fainting ☐ Heart Murmur ☐ Leg Cramps
8. **Endocrine**
   ☐ Excessive thirst or urination ☐ Heat/cold intolerance
9. **ENT and MOUTH**
   ☐ Nose Bleeds ☐ Ringing in Ears ☐ Hoarseness
10. **Eyes**
    ☐ Redness ☐ Blurred Vision ☐ Corrective Lenses
11. **Gastrointestinal (G.I.)**
    ☐ Heartburn ☐ Nausea/vomiting ☐ Constipation ☐ Diarrhea ☐ Bloody/tarry stools
12. **Genitourinary**
    ☐ Frequent urination ☐ Difficult/painful urination ☐ Incontinence ☐ Blood in urine
13. **Respiratory**
    ☐ Shortness of breath ☐ Wheezing ☐ Cough ☐ Hurts to breath
14. **Psychiatric**
    ☐ Nervousness ☐ Depression ☐ Anxiety ☐ Hallucinations

15. **Other medical problems not listed:** (please list)

PAIN MEDICINE ASSOCIATES PMA
Patient Medical Data Questionnaire (PMDQ)

Patient Name:_____

Date of Birth:_____

Date: _____

SOCIAL HISTORY:

1. Do you **smoke**? ☐No ☐Yes, _____ packs per day.
   If no, did you **ever** smoke? ☐No ☐Yes, date quit_____
2. Do you **drink**? ☐No ☐Yes, _____ drinks / beers per day.
   If no, did you **ever** drink? ☐No ☐Yes, date quit_____
   Do you, or did you ever, have a drinking problem? ☐No ☐Yes
   If yes, have you sought professional treatment? ☐No ☐Yes
3. Do you use any other **recreational drugs**? ☐No ☐Yes
   If yes: ☐Cocaine ☐Marijuana ☐Other: _____
4. Are you: ☐Married ☐Divorced ☐Single
5. Do you live with: ☐Spouse ☐Companion ☐Friend ☐Family member ☐Alone
6. How many people live in your household? _____
7. How many **children** do you have: _____ girls _____ boys
   Children's ages: girls: _____ boys _____
   Number of children living at home: _____, ages _____
8. Your **occupation**: _____
9. Spouse's/companion's occupation: _____
10. Are you **disabled**? ☐No ☐Yes
    Is your spouse/companion disabled? ☐No ☐Yes
11. Do you have any history of the following:
    Physical abuse ☐No ☐Yes
    Sexual abuse ☐No ☐Yes
    Verbal abuse/neglect ☐No ☐Yes
    Domestic violence ☐No ☐Yes
    Travel outside the U.S. ☐No ☐Yes
12. Do you own pets? ☐No ☐Yes
13. Do you have smoke detectors in your home? ☐No ☐Yes
14. Are you taking a blood thinner? ☐No ☐Yes
    If yes, who prescribes this? _____

PAST MEDICAL HISTORY:

☐ Anemia	☐ Anxiety
☐ Asthma	☐ Bipolar Disorder
☐ Bursitis	☐ COPD
☐ Depression	☐ Esophageal Reflux(GERD)
☐ Hypercholesterolemia	☐ Hyperlipidemia
☐ Hypertension	☐ Hyperthyroid
☐ Hypothyroid	☐ Kidney Disease
☐ Liver Disease	☐ Osteoarthritis
☐ Osteoporosis	☐ Rheumatoid Arthritis
☐ Seizure Disorder	☐ Sleep Apnea
☐ Type I Diabetes	☐ Type 2 Diabetes

Family History

Please check if any **blood relative** of yours have, or have a history of, any of the following:

	Mother	Father
High blood pressure	☐	☐
Heart attack	☐	☐
Asthma	☐	☐
Chronic pain	☐	☐
Fibromyalgia	☐	☐
Depression	☐	☐
Anxiety disorder	☐	☐
Epilepsy	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
Osteoarthritis	☐	☐
Rheumatoid arthritis	☐	☐
Osteoporosis	☐	☐

PAIN MEDICINE ASSOCIATES, PC

Patient Name _____ Date of Birth _____ Date _____

DRUG INFORMATION SHEET

* *Please complete and bring medications with you to your appointment* *

MEDICATION	STRENGTH	HOW OFTEN/HOW IS DOSE TAKEN	PRESCRIBING PHYSICIAN
EXAMPLE: TYLENOL	500 MG	2 TIMES A DAY BY MOUTH	DR. JONES

Include prescriptions, over-the-counter medications, herbals and vitamin

Revised 9/29/22

_____ _____