

# PATIENT REGISTRATION FORM

Last Name _____ First Name _____ Middle _____			Occupation: _____ Job Title: _____		
Date of Birth: _____ Age: _____ Sex: _____			Work Address: _____ _____		
Social Security #: _____			Work Phone: _____		
Home Address: _____ _____			Work Fax: _____		
Home Phone: _____			Cell Phone: _____		
			E- Mail: _____ Pager: _____		
<b>PRIMARY INSURANCE</b>			<b>SECONDARY INSURANCE</b>		
Name: _____			Name: _____		
Policy # / Group #: _____			Policy # / Group #: _____		
Billing Address: _____ _____			Billing Address: _____ _____		
Phone: _____ Fax: _____			Phone: _____ Fax: _____		
<b>AUTO ACCIDENT INFORMATION</b>			<b>WORKER'S COMP. INFORMATION</b>		
Date of Accident: _____			Date of injury: _____		
Place of Accident: _____ State: _____			Claim Number: _____		
Police Notified? Insurance Co. notified?			Insurance co: _____		
Claim Number: _____			Billing Address: _____ _____		
Insurance co: _____			Phone: _____ Fax: _____		
Insurance Policy #: _____			Adjuster's Name: _____		
Billing Address: _____ _____			Employer's Name: _____		
Adjuster's Name: _____			Employer's Address: _____		
Phone: _____ Fax: _____			Phone: _____ Fax: _____		
<b>REFERRAL INFORMATION</b>			<b>PRIMARY CARE PHYSICIAN INFORMATION</b>		
Referring Physician: _____			Referral Needed: Yes ____ No ____ Co-Pay: \$ _____		
Address: _____ _____			PCP's Name: _____		
Phone: (     ) _____ Fax: (     ) _____			Address: _____ _____		
Reason for Referral:			Phone: _____ Fax: _____		

**Insurance Verification: By: \_\_\_\_\_ On: \_\_\_\_\_ Spoke to: \_\_\_\_\_ Records Requested: \_\_\_\_\_**

<p align="center"><b>MEDICO-LEGAL INFORMATION</b></p> <p>Are you in Litigation:      Yes _____ No _____</p> <p>Reason for Litigation: _____</p> <p>_____</p> <p>Lawyer's Name: _____</p> <p>Para Legal' s Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: (      ) _____ Fax: (      ) _____</p> <p>Do you want your medical records released to your lawyer?</p> <p>Yes _____ No _____</p>	<p align="center"><b>EMERGENCY CONTACT INFORMATION</b></p> <p>Name: _____</p> <p>Relationship: _____</p> <p>Home Address: _____</p> <p>_____</p> <p>Home Phone: (      ) _____</p> <p>Occupation: _____</p> <p>Work Address: _____</p> <p>_____</p> <p>Work Phone: (      ) _____</p> <p>Cell Phone: (      ) _____ Pager: _____</p>
<p align="center"><b>PHARMACY INFORMATION</b></p> <p>Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: _____ Fax: _____</p>	<p align="center"><b>PHARMACY INFORMATION</b></p> <p>Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: _____ Fax: _____</p>

#### **AUTHORIZATION FOR TREATMENT & FINANCIAL RESPONSIBILITY**

I authorize the Physician to provide treatment and to release medical information to my insurance company as may be necessary for payment of physician office claims. I authorize payment directly to my physician of the benefits otherwise payable to me but not to exceed regular charges for physician office claims. I understand that I am financially responsible to my physician for charges not covered by this authorization.

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

#### **AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize the physician to provide copies of my medical records to referring physician(s)/primary care physician(s)/hospital(s)/health care facilities(s)/lawyers/law enforcement authorities when requested. I also authorize my physician to allow managed care organization to access my medical information for quality review purposes.

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

#### **MEDICARE PATIENTS**

Medicare will only pay for services it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. In that case, I agree to be responsible for payment.

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**Patient's Name**

# Pain History Questionnaire

PLEASE HIGHLIGHT YOUR ANSWER WHEREVER APPLICABLE

Name: \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

DOB: \_\_\_ / \_\_\_ / \_\_\_ Age (Years): \_\_\_\_\_

☐ Dover

☐ Wilmington

☐ Lewes

Please provide the following medical information to the best of your ability:

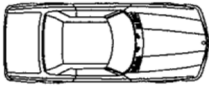
1. Describe your main reasons for this visit (I.E. Chief Complaint):

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2. Is your pain related to an accident / injury? YES NO\* When? (Month/Day/Year \_\_\_\_\_)

*\*(If your visit is **not** related to an accident or injury, please skip to Question 3 below)*

<p><b>1. Motor Vehicle Accident? YES / NO</b></p> <p>Driver / Passenger </p> <p>Seat Belt / Air Bag Deployed</p> <p>Indicate site of impact: "P" = Primary "S" = Secondary</p> <p>Did you hit your head? YES NO</p> <p>Any loss of consciousness? YES NO</p> <p>Memory Problems? YES NO</p> <p>Police Notified? YES NO</p> <p>Visit to Emergency Room YES NO</p>	<p><b>2. Work Related Injury:</b></p> <p>YES NO</p> <p>Has this injury been accepted as a Worker's Compensation claim?</p> <p>YES NO</p>
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Describe your accident / injury or history of problem in detail:

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3. Have any tests (x-rays, CT Scan, MRI) been done to evaluate this problem? YES NO

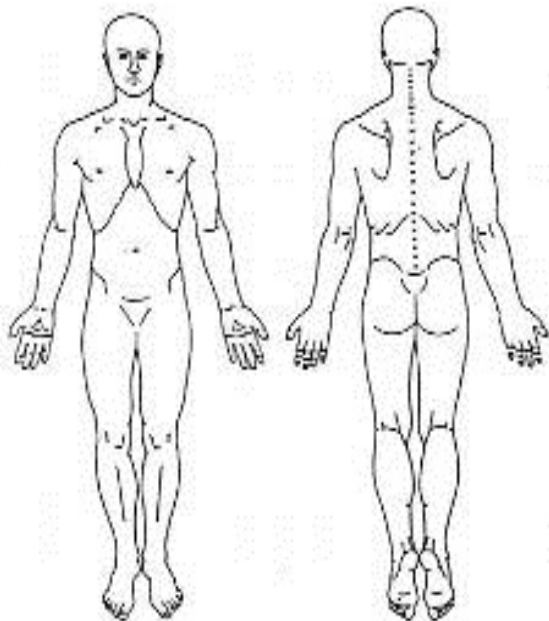
Tests	Facility Name	Location & Phone	Physician Name	Results
x-ray				
CT Scan				
MRI Scan				
Bone Scan				
EMG Testing				
Other				

History (cont'd) Name: \_\_\_\_\_ Reviewed By: \_\_\_\_\_

4. Have any other pain management physicians evaluated you for this problem? YES NO

Physicians Name	Location	Treatment History: Medications, Therapies, Injections (List and Describe)

5. INSTRUCTIONS: Mark these drawings according to where you hurt (if the back of your neck hurts, mark the drawing on the back of the neck, etc.,)



**Type of your pain: PLEASE HIGHLIGHT YOUR ANSWER**

Burning	Tiring	Nagging
Stabbing	Exhausting	Shooting
Miserable	Unbearable	Sharp
Numb/Tingling	Aching	Tender
Penetrating	Throbbing	

1. Please mention the level of your primary pain from 0 (no pain) to 10 (worst pain imaginable) for the following:

PRESENT level of pain:

WORST pain you've had:

AVERAGE level of pain (day to day):

2. Your present pain is... Constant Intermittent Worse in the... A.M. P.M.

3. Have your symptoms gotten Worse Better No Change

4. Which of the following activities increase your pain: **PLEASE HIGHLIGHT YOUR ANSWER**

Sitting	Standing	Walking	Lifting	Housework
Coughing	Sneezing	Lying flat on back	Lying flat on stomach	

5. What activities decrease your pain? **PLEASE HIGHLIGHT YOUR ANSWER**

Sitting Standing Walking Lying flat on back Lying flat on side with knees bent

6. Do you have any pain going down your: Right Arm Left Arm Right Leg Left Leg

7. Do you have difficulty sleeping because of pain? YES NO
8. Please rate your ability to cope with pain:  
(0 = Not able, 10= Very able)
9. Please rate your ability to perform activities of daily living, such as hygiene, household chores, transportation, etc.:  
(0 = Not able, 10 = Very able)
10. Please rate your ability to function and interact with family and friends:  
(0 = Not able, 10 = Very able)
11. Please rate your ability to work in your usual occupation:  
(0 = Not able, 10 = Very able)

**6. Functional History: PLEASE HIGHLIGHT YOUR ANSWER**

Pain is limiting the Activity			Comments				Comments
Sitting	Yes	No		Squatting	Yes	No	
Standing	Yes	No		Crawling	Yes	No	
Walking	Yes	No		Climbing	Yes	No	
Driving	Yes	No		Repeated arm motions	Yes	No	
Bending	Yes	No		Repetitive use of wrist/hands	Yes	No	
Turn/Twist	Yes	No		Reaching above shoulders	Yes	No	
Kneeling	Yes	No		Foot Controls	Yes	No	
Sleeping	Yes	No		Yard Work	Yes	No	
Appetite	Yes	No		Housework	Yes	No	
Working	Yes	No		Sexual Activity	Yes	No	
Emotion	Yes	No		Other: Specify:	Yes	No	
Concentration	Yes	No					

**7. Past Accidents/ Injuries- PLEASE HIGHLIGHT YOUR ANSWER**

Injury	Body Part (s) Injured	Treatment	Outcome Completely Healed Residual Pain (%)	Lawyer?	Case Open??
1 <sup>st</sup> Accident Date:				Yes No	Yes No
2 <sup>nd</sup> Accident Date:				Yes No	Yes No
Work Injury: Date:				Yes No	Yes No

**8. Pain Medications that you are taking for pain: PLEASE HIGHLIGHT YOUR ANSWER**

Name	Side effects?	Does it help?
		YES NO
		YES NO
		YES NO

**9. Medications and other treatments that you have tried in the past PLEASE HIGHLIGHT YOUR ANSWER:**

**Opioids:** Fentanyl (Actiq, Duragesic), Demerol, Hydrocodone (Vicodin, Lortab, Norco), Tramadol, Morphine, Oxymorphone, Methadone, Oxycodone, Hydromorphone, Tapentadol, Propoxyphene (Darvocet), Buprenorphine (Suboxone, Subutex), Codeine

**Anti-Inflammatories / Tylenol:** Diclofenac, Oxaprozin, Meloxicam, Nabumetone, Aspirin, Indomethacin, Ibuprofen, Acetaminophen, Celecoxib, Etodolac, Naproxen, Flector patch

**Muscle Relaxants:** Baclofen, Methocarbamol (Robaxin), Carisoprodol (Soma), Cyclobenzaprine (Flexeril), Metaxalone (Skelaxin), Tizanidine (Zanaflex)

**Antidepressants:** Cymbalta, Nortriptyline, Remeron, Wellbutrin, Effexor, Paxil, Serzone, Zoloft, Amitriptyline, Pristiq, Imipramine (Tofranil), Lexapro, Fluoxetine (Prozac), Trazodone

**Sleep Aids:** Zolpidem (Ambien), Lunesta, Rozerem, Xyrem, Restoril, Sonata

**Other Medications:** Axert, Hydroxyzine, Lyrica (Pregablin), Tegretol, Zonegran, Buspar, Imitrex, Maxalt, Topamax, Frova, Keppra, Gabapentin (Neurontin), Vistaril, Gabitril, Lldoderm Patch, Relpax, Zomig, Bupenorphine, Naloxone

**Other Herbal Remedies:**

**Marijuana:**

**Any other beliefs / Concerns:**

**10. Pain relieving injections (Spinal Injections) that you have had in the past: PLEASE HIGHLIGHT YOUR ANSWER**

Name	Side effects?	Did it help?	
		YES	NO
		YES	NO
		YES	NO
		YES	NO
		YES	NO

**11. Past Spine Surgical History: PLEASE HIGHLIGHT YOUR ANSWER**

Low Back Surgery: **Yes NO**

Mid Back Surgery: **Yes NO**

Neck Surgery: **Yes NO**

**12. Please list all spine surgeries:**

Type of Surgery	When and Name of Surgeon

**13. Please list all other surgeries, excluding the spine:**

Type of Surgery	When and Name of Surgeon

**14. Other treatments** You might have had in the past: **PLEASE HIGHLIGHT YOUR ANSWER**

Name		Did it help?
TENS unit		YES NO
Physical Therapy		YES NO
Chiropractic Therapy		YES NO
Massage Therapy		YES NO
Acupuncture		YES NO
Counseling		YES NO
Other (Specify):		YES NO

**17.****Describe your treatment expectations: PLEASE HIGHLIGHT YOUR ANSWER**

Spinal Injections?	YES	NO	NOT SURE	Spinal Surgery?	YES	NO	NOT SURE
Opioid Medications?	YES	NO	NOT SURE	Non Opioid Medications?	YES	NO	NOT SURE
Therapies?	YES	NO	NOT SURE	Acupuncture?	YES	NO	NOT SURE
Marijuana ( <b>SELF PAY</b> )	YES	NO	NOT SURE	TMS -Brain Stimulation?	YES	NO	NOT SURE

**15.** Some of the pain medications make patients to become dependent and at time make them addicted to the medications. Are you aware of such issues? **YES** **NO**

**16.** Are you aware of any of your family members, friends and relatives who have experienced problems with prescription medication dependency and addiction? **YES** **NO**

If YES, Your comments: \_\_\_\_\_

**17.** Are you willing to change your prescription medications if the treating physician were to suggest some changes? **YES** **NO** If NO, Your comments: \_\_\_\_\_

**18. Past Medical History - PLEASE HIGHLIGHT YOUR ANSWER**

Diabetes	Yes	No		Thyroid Problems	Yes	No	
High Blood Pressure	Yes	No		Allergy Problems / Therapy	Yes	No	
Heart Disease	Yes	No		Kidney / Bladder / Prostate	Yes	No	
Heart Attack	Yes	No		Neurological problems	Yes	No	
Heart Surgery	Yes	No		Addiction /Substance abuse	Yes	No	
High Cholesterol	Yes	No		Mental Health / Psychiatric	Yes	No	
Respiratory Problems	Yes	No		Other:	Yes	No	
Stomach Problems	Yes	No		Bleeding Disorder	Yes	No	

**19.** All other regular medications if any: (ex: for blood pressure, diabetes, ulcers, blood thinners, over the counter meds)

Name	Dose	Prescribed By?	Side Effects?	Comments

**20. Please list any Drug Allergies:**

Name	Reaction	Name	Reaction

**History (cont'd) Name:** \_\_\_\_\_ **Reviewed By:** \_\_\_\_\_

IV Dye Allergy: YES NO

Latex Allergy: Yes NO

Seafood / Shell Fish Allergy: YES NO

**21. Family Medical History - Please check the "YES" or "NO". For "YES" answers, please explain relationship.**

Disease	YES	NO	Relationship	Disease	YES	NO	Relationship
Diabetes				Thyroid problems			
Hypertension (high blood pressure)				Allergy problems/Therapy			
Respiratory problems				<b>Prescription Drug Addiction</b>			
Stomach problems				Other medical diagnosis			
<b>Bleeding Disorder</b>				<b>Substance abuse/Illicit drugs</b>			
Cancer				<b>Anesthesia problems</b>			
Rheumatoid Arthritis				<b>Back Pain or Chronic Pain Problems</b>			

Are you currently: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated?Is your significant other working? ☐ YES\* ☐ NO \*Type of work: \_\_\_\_\_Where do you live? ☐ Trailer Home ☐ Apartment ☐ 2+ Story House ☐ Ranch-style HouseTransportation? ☐ Own a car ☐ Friends car ☐ Public Transportation ☐ Family member car**22. Social History:**

	YES	NO	Comments		YES	NO	Comments
Smoking				Working			
Drinking				Disabled			
Marijuana ( <i>Regular or Recreational</i> )				Applying for Disability			
Cocaine				On Short term Disability			
IV drug usage (Heroin)				On Long term Disability			
Incarceration (Arrests)							

**23. If you are not working now, do you see yourself? PLEASE HIGHLIGHT YOUR ANSWER**
☐ Returning to the same job ☐ Modified work ☐ Changing jobs - same employer ☐ Changing jobs - different employer  
☐ Retraining or returning to school ☐ Applying for early retirement
**24. Review of Systems: PLEASE HIGHLIGHT YOUR ANSWER Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_**

<b>GENERAL:</b>	Change of Appetite	Weight Loss or Gain	Fatigue	Fever
<b>NEURO:</b>	Weakness	Numbness	Tingling	Headaches Tremors
<b>GI:</b>	Nausea	Vomiting	Reflux	Constipation Diarrhea
<b>PSYCH:</b>	Depression	Anxiety	Memory Loss	Sleeplessness Mood Changes
<b>MUSCULO-SKELETAL:</b>	Spasms	Cramps	Joint Pain	Swelling Stiffness
<b>RESPIRATORY:</b>	Cough	Breathless	Chest Pain	
<b>CARDIAC:</b>	Chest Pain	Palpitations	Leg Edema	
<b>ENDOCRINE:</b>	Hot or Cold Intolerance	High Sugar	Excess Thirst	Increased Urination
<b>ENT:</b>	Change in Vision	Decreased Hearing	Change in Voice	
<b>GU:</b>	Loss of Bladder	Increased Frequency	Kidney Stones	

**25. I certify that the above information is true to the best of my knowledge.**

Print Name: \_\_\_\_\_ INITIALS: \_\_\_\_\_ Date: \_\_\_\_\_

**History (cont'd) Name: \_\_\_\_\_ Reviewed By: \_\_\_\_\_**