



NC Pain Management Services PA

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Dear Patient:

We would like to welcome you to our practice. We realize that you have a choice when selecting your Pain Specialist; and would like to thank you for choosing us. We are dedicated to providing you with the best possible medical care. Excellence is our commitment.

Your time is important to us. We appreciate the information that you are about to give us. To help you with your upcoming visit, we need some very important information. Simply follow these three easy steps:

STEP 1:

Please check off each item as it is completed. When finished, **do not mail these back**, instead bring them personally with you to your appointment.

Complete **Form 1**, the "Patient Data Questionnaire". (2 pages)

Complete **Form 2**, the "Medical Questionnaire". (5 pages)

STEP 2:

Call us at **(336) 538-7180**. Let us know that you have completed your forms and that you are ready to request your appointment. Write below your given appointment date and time.

Date: _____ Time: _____

STEP 3:

Please bring the following items with you, to your initial evaluation:

Bring with you the above completed paperwork.

Thank you for choosing to enroll in our practice and we look forward to assisting you with your needs.

NC Pain Management Services PA

Reminders:

- If for any unforeseen reason you are **unable to keep your reserved appointment**, we kindly request, that you promptly call and cancel it. This will allow us to offer the time that we had reserved for you, to another patients who may need immediate treatment.
- **Please, do not expect to receive any controlled substances on your initial appointment.** Practice Protocols developed to comply with North Carolina Medical Board Guidelines, Drug Enforcement Administration Guidelines, as well as State and Federal Controlled Substance Laws, restrict us from prescribing any controlled substances (Strong Pain Medications), on the first visit.

FORM 1: PATIENT DATA QUESTIONNAIRE

If there is any information that does not apply to your case, please leave the space blank.

Patient Information: Single Married Widowed Divorced

Last name: _____ First: _____ Middle initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

E-mail: _____

Date of birth: _____ Employer: _____ SS#: _____

Sex: Male Female

Spouse/Parent/Guardian Information:

Last name: _____ First: _____ Middle initial: _____

Date of birth: _____ Employer: _____ SS#: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Policy Holder: Self Spouse Parent/Guardian Other: _____

Policy Holder Information (only if different from above):

Last name: _____ First: _____ Middle initial: _____

Date of birth: _____ Employer: _____ SS#: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Emergency Contact:

Last name: _____ First: _____ Middle initial: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Referred by: Doctor: _____ Friend/Family: _____

Nurse: _____ Other: _____

Primary Insurance:

Insurance carrier: _____ Patient ID#: _____

Group#: _____ Phone#: _____

Secondary Insurance:

Insurance carrier: _____ Patient ID#: _____

Group#: _____ Phone#: _____

Tertiary Insurance:

Insurance carrier: _____ Patient ID#: _____

Group#: _____ Phone#: _____

Liability Injury Case:

Lawyer's name: _____

Office phone: _____ Fax number: _____

Date of Injury: _____ Liability Claim#: _____

Worker's Compensation Case:

Case Worker's name: _____

Office phone: _____ Fax number: _____

Date of Injury: _____ W.C. Claim#: _____

Assignment of benefits: I hereby authorize insurance carrier(s) to assign any benefits directly to "NC Pain Management Services, PA".

Patient's Signature: _____ Date: _____

Medical Records Release: I authorize the release of any and all medical or other information necessary to process my claims.

Patient's Signature: _____ Date: _____

FORM 2: MEDICAL QUESTIONNAIRE

The following information is essential to providing you with an accurate diagnosis and effective treatment.

Part I – History of Present Illness		
Section 1 - Onset and Duration		
<input type="checkbox"/> Sudden onset	How long have you had Pain? _____	
<input type="checkbox"/> Gradual onset		
Date of onset: _____	(Days, Months, Years)	
Section 2 – Location – Please shade all areas where you have pain		
Section 3 – Cause of your pain – What started your pain?		
<input type="checkbox"/> Work-related accident or event	Date: _____	
Is this under "Workers Compensation"? Yes <input type="checkbox"/> NO <input type="checkbox"/>		
<input type="checkbox"/> Motor vehicle accident	Date: _____	
<input type="checkbox"/> Unknown	<input type="checkbox"/> Other (Briefly explain): _____	
Section 4 - Severity		
<input type="checkbox"/> Getting Better	Please indicate using a scale from 0 to 10, how bad your pain is:	
<input type="checkbox"/> Getting Worse		
<input type="checkbox"/> No change since its onset		
	1) At its worst: _____/10	
	2) At its best: _____/10	
	3) Now: _____/10	
	4) Most of the time: _____/10 (Average)	
Section 5 – Timing –When does the character of the pain get worse?		
<input type="checkbox"/> Not influenced by the time of the day.	<input type="checkbox"/> During activity or exercise	
<input type="checkbox"/> Mornings	<input type="checkbox"/> After activity or exercise	
<input type="checkbox"/> Afternoons	<input type="checkbox"/> After immobility	
<input type="checkbox"/> Night		
Section 6 – Aggravating Factors – What makes your pain worse?		
<input type="checkbox"/> Bending	<input type="checkbox"/> Motion	<input type="checkbox"/> Twisting
<input type="checkbox"/> Bowel Movements	<input type="checkbox"/> Nerve Blocks	<input type="checkbox"/> Walking
<input type="checkbox"/> Climbing	<input type="checkbox"/> Sitting (prolonged?)	<input type="checkbox"/> Walking uphill
<input type="checkbox"/> Eating	<input type="checkbox"/> Standing (prolonged?)	<input type="checkbox"/> Walking downhill
<input type="checkbox"/> Intercourse (Sex)	<input type="checkbox"/> Squatting	<input type="checkbox"/> Working
<input type="checkbox"/> Kneeling	<input type="checkbox"/> Stooping	
<input type="checkbox"/> Lifting	<input type="checkbox"/> Surgery made it worse	
Section 7 - Alleviating Factors – What makes your pain better?		
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Resting	<input type="checkbox"/> Walking
<input type="checkbox"/> Bending	<input type="checkbox"/> Sitting	
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Sleeping	
<input type="checkbox"/> Stretching	<input type="checkbox"/> Standing	
<input type="checkbox"/> Cold packs	<input type="checkbox"/> TENS	
<input type="checkbox"/> Hot packs	<input type="checkbox"/> Using a Brace	
<input type="checkbox"/> Hypnosis	<input type="checkbox"/> Relaxation Therapy	
<input type="checkbox"/> Lying down	<input type="checkbox"/> Physical Therapy	
<input type="checkbox"/> Medications	<input type="checkbox"/> Warm showers or baths	
<input type="checkbox"/> Nerve Blocks	<input type="checkbox"/> Chiropractic manipulations	
Section 8 – Associated Problems – Which of these do you have?		
<input type="checkbox"/> Color changes	<input type="checkbox"/> Numbness	
<input type="checkbox"/> Constipation	<input type="checkbox"/> Personality changes	
<input type="checkbox"/> Day-time Cramps	<input type="checkbox"/> Sadness	
<input type="checkbox"/> Night-time Cramps	<input type="checkbox"/> Spasms	
<input type="checkbox"/> Depression	<input type="checkbox"/> Suicidal Ideations	
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Sweating	
<input type="checkbox"/> Erectile dysfunction	<input type="checkbox"/> Swelling	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Temperature changes	
<input type="checkbox"/> Impotence	<input type="checkbox"/> Tingling	
<input type="checkbox"/> Inability to concentrate	<input type="checkbox"/> Vomiting	
<input type="checkbox"/> Inability to control bladder	<input type="checkbox"/> Weakness	
<input type="checkbox"/> Inability to control bowel	<input type="checkbox"/> Pain Wakes me up	
<input type="checkbox"/> Nausea	<input type="checkbox"/> Pain does not let me sleep	
Section 9 – Quality – Which of the following describes your pain?		
<input type="checkbox"/> Aching	<input type="checkbox"/> Fearful	<input type="checkbox"/> Sharp
<input type="checkbox"/> Agonizing	<input type="checkbox"/> Feeling of constriction	<input type="checkbox"/> Shooting
<input type="checkbox"/> Annoying	<input type="checkbox"/> Feeling of Weight	<input type="checkbox"/> Sickening
<input type="checkbox"/> Burning	<input type="checkbox"/> Getting longer	<input type="checkbox"/> Splitting
<input type="checkbox"/> Constant	<input type="checkbox"/> Getting shorter	<input type="checkbox"/> Stabbing
<input type="checkbox"/> Intermittent	<input type="checkbox"/> Heavy	<input type="checkbox"/> Superficial
<input type="checkbox"/> Cramping	<input type="checkbox"/> Horrible	<input type="checkbox"/> Tender
<input type="checkbox"/> Cruel	<input type="checkbox"/> Hot	<input type="checkbox"/> Throbbing
<input type="checkbox"/> Deep	<input type="checkbox"/> Itching	<input type="checkbox"/> Tingling
<input type="checkbox"/> Disabling	<input type="checkbox"/> Lancinating	<input type="checkbox"/> Tiring
<input type="checkbox"/> Distressing	<input type="checkbox"/> Nagging	<input type="checkbox"/> Toothache-like
<input type="checkbox"/> Dreadful	<input type="checkbox"/> Pressure-like	<input type="checkbox"/> Uncomfortable
<input type="checkbox"/> Dull	<input type="checkbox"/> Pulsating	<input type="checkbox"/> Work-related
<input type="checkbox"/> Exhausting	<input type="checkbox"/> Punishing	
Section 10 – Previous Examinations or Tests		
<input type="checkbox"/> Biopsy	<input type="checkbox"/> Endoscopy	<input type="checkbox"/> Nerve Conduction Test
<input type="checkbox"/> Bone Scan	<input type="checkbox"/> Epidurogram	<input type="checkbox"/> Neurological Evaluation
<input type="checkbox"/> CPT	<input type="checkbox"/> MRI Scan	<input type="checkbox"/> Neurosurgical Evaluation
<input type="checkbox"/> CT Scan	<input type="checkbox"/> Myelogram	<input type="checkbox"/> Orthopedic Evaluation
<input type="checkbox"/> CT-Myelogram	<input type="checkbox"/> Nerve Blocks	<input type="checkbox"/> Chiropractic Evaluation
<input type="checkbox"/> Discogram	<input type="checkbox"/> Spinal Taps	<input type="checkbox"/> Psychiatric Evaluation
<input type="checkbox"/> EMG/PNCV	<input type="checkbox"/> X-rays	
Section 11 – Previous Treatments – Please draw a star (*) next to those that helped.		
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Radiofrequency	
<input type="checkbox"/> Chiropractic manipulations	<input type="checkbox"/> Relaxation therapy	
<input type="checkbox"/> Cryoanalgesia	<input type="checkbox"/> Spinal Cord Stimulator	
<input type="checkbox"/> Epidural steroid injections	<input type="checkbox"/> Steroid Treatments (by mouth)	
<input type="checkbox"/> Facet blocks	<input type="checkbox"/> Strengthening exercises	
<input type="checkbox"/> Hypnotherapy	<input type="checkbox"/> Stretching exercises	
<input type="checkbox"/> Morphine pump	<input type="checkbox"/> TENS	
<input type="checkbox"/> Narcotic medications	<input type="checkbox"/> Traction	
<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Trigger point injections	
<input type="checkbox"/> Pool exercises		
Section 12 – Additional information		
1) Number of visits to the Emergency Room in the past 2 month: _____		
2) Number of Physicians that you have seen for this problem: _____		
3) Have you ever been seen by another pain management specialist or in another Pain Clinic? Yes <input type="checkbox"/> NO <input type="checkbox"/>		
4) Is there, or will there ever be any litigation related to your condition? Yes <input type="checkbox"/> NO <input type="checkbox"/>		
5) Are you considering pursuing disability? Yes <input type="checkbox"/> NO <input type="checkbox"/>		
Section 13 – Physician Notes		
Reviewing Doctor's Signature: _____		

ALLERGIES:

Agent/Medication that you are allergic to.	Type of reaction (What happens when exposed to it.)

PRIMARY CARE PHYSICIAN:

Name	Telephone Number	Fax Number

PHYSICIANS INVOLVED IN YOUR CARE: (IN THE PAST 2 YEARS)

Name	Specialty	Telephone Number

MEDICATIONS CURRENTLY TAKEN:

Name of medication	Dosage	How you take it.	Reason for medicine.	Prescriber.

INTERVENTIONAL RISK ASSESSMENT SECTION

Are you taking any **blood thinners**?

- Yes. Which?: _____
- No**

Are you taking any of the following **medications**? (Blood thinners)

- Aspirin or aspirin-containing medications (Goody powders; Excedrin; etc.)
- Ticlid
- Plavix
- Plaquenil
- Aggrenox
- Coumadin (Warfarin)
- Lovenox
- None** of the above.

Have you had a heart attack, in the past 6 month?

- Yes. When?: _____
- No**

Have you had to be **hospitalized for chest pain**, in the past 2 months?

- Yes. When?: _____
- No**

Have you had a **heart catheterization or stent** done, in the past 2 weeks?

- Yes. When?: _____
- No**

Are you currently taking any **antibiotics**? Or do you have any active infections (Cold, etc.) or have you ever had **MRSA or hepatitis**?

- Yes. Explain: _____
- No**

Do you have any **allergies to antibiotics, iodine, shellfish, or radiological contrast**?

- Yes. What?: _____
- No**

Do you have any of the following **conditions**? (These will need antibiotics prior to procedure.)

- Artificial heart valves.
- History of having had bacterial endocarditis. (Heart infection)
- Any congenital heart defect. (Repaired or not)
- A heart transplant.

- Any problems with the heart valves.
- Hypertrophic cardiomyopathy.
- Mitral valve prolapse.
- Recently implanted prosthetic joints. (less than 3 months)
- Newly placed cardiac stents. (less than 2 weeks)
- Renal disease, undergoing dialysis.
- The patient with hydrocephaly and VA shunts.
- None** of the above.

Have you ever been told that you need **antibiotics prior to dental work?**

Yes. When/who/why?: _____

No

Do you have any **medical conditions or** take any **medications that may decrease your immune system?** (e.i., AIDS, Cancer, Diabetes, Steroids, Methotrexate, etc.)

Yes. What?: _____

No

Female patients only: *If within reproductive years, then: Is there any possibility of being **pregnant?**

Yes. Recommend pregnancy test by PCP, Gynecologist, or OTC pregnancy test.

No

Post-Menopausal

Had Hysterectomy

Had Tubal Ligation

STATEMENT OF ACCURACY:

I hereby certify that I have personally filled out all 5 pages of this Form, to the best of my abilities. I also recognize that the accuracy of this document is essential to safely establish a correct diagnosis and effective treatment.

Name of person filling out Form: _____

Patient/Guardian's Signature: _____ Date: _____

Map to Pain Clinic

From: Raleigh, NC US

Driving Directions

1. Merge onto I-40 W. (61.45 miles)
2. Take the exit- exit number 141- toward ELON COLLEGE. (0.24 miles)
3. Turn LEFT onto HUFFMAN MILL RD. (0.40 miles)

Total Estimated Time: 1 hour, 2 minutes

Total Distance: 63.59 miles

From: Winston-Salem, NC US

Driving Directions

1. Merge onto I-40 E towards GREENSBORO. (43.18 miles)
2. Take the exit- exit number 141- toward ELON COLLEGE. (0.22 miles)
3. Turn RIGHT onto HUFFMAN MILL RD. (0.26 miles)

Total Estimated Time: 48 minutes

Total Distance: 47.02 miles

