Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY

Height:_____ Weight:_____

Current Medications/Dosage/Frequency:_____

_____

_____

Allergies:_____

Past Surgeries:_____

Health Problems:_____

Race: ***(PLEASE CIRCLE)*** White Black Asian Native American Alaskan Native HISPANIC ORIGIN: YES NO

PLEASE CIRCLE ANY OF THE CONDITIONS OR SYMPTOMS THAT YOU HAVE RECENTLY NOTICED:

General:	Chills Fatigue Fever Sweats Feeling weak Weight change Headache
Eyes:	Change in vision
ENMT:	Hearing change Nasal discharge Rhinitis Altered sense of smell Altered sense of taste Difficulty swallowing Voice change
Cardiovascular:	Chest pain Irregular heartbeat Palpitations Other cardiovascular symptoms
Respiratory:	Difficulty breathing Cough Wheezing
Gastrointestinal:	Constipation Diarrhea Heartburn Indigestion Nausea Vomiting
Genitourinary:	Difficulty voiding Frequency Incontinence Pain on urination Blood in urine
Musculoskeletal:	Arthritis Pain Swelling.
Skin:	Skin symptoms Hair symptoms Nail symptoms.
Breast:	Breast problems.
Neurological:	Dizziness Fainting Paralysis Seizures.
Psychological:	Anxiety Depression Mood changes Sleep pattern disturbance Substance abuse
Endocrine:	Goiter Hormone problems Hormone treatment Steroid treatment Thyroid problems.
Hema/Lymph:	Hematologic symptoms

SOCIAL HISTORY

Do you smoke? □No/□Yes: If yes, how many packs/day _____ How many years have been smoking?_____

Have you ever smoked? □No/□Yes

Do you drink alcohol? □No/□Yes: If yes, how much & often do you drink? _____

Do you use recreational drugs? □No/□Yes: If yes, describe_____ Highest Grade Completed: _____

FAMILY HISTORY

(PLEASE LIST SIGNIFICANT MEDICAL PROBLEMS FOR:)

FATHER: _____

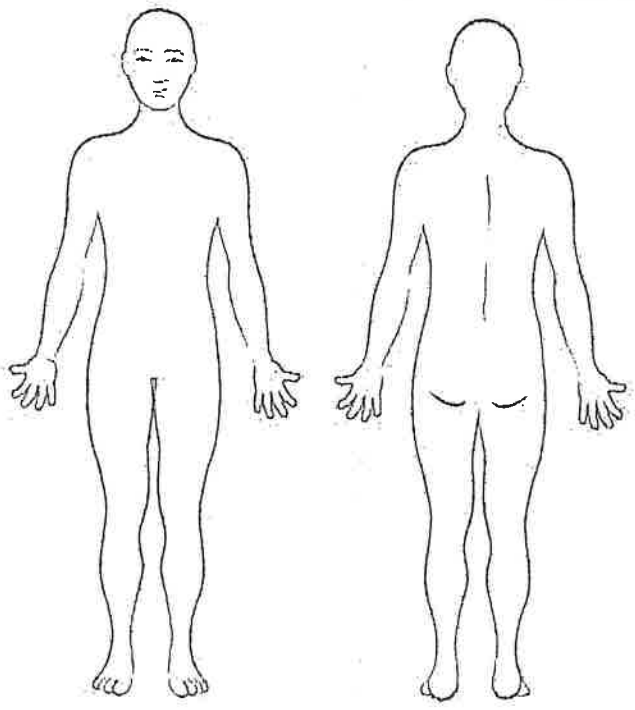
MOTHER: _____

PATIENT NAME: _____

PATIENT QUESTIONNARIE – Please circle or answer with appropriate response.
ALL QUESTIONS MUST BE COMPLETED TO THE BEST OF YOUR ABILITY PRIOR TO BEING SEEN.

1. Hand Dominance: ***(PLEASE CIRCLE)*** Right Left Ambidextrous
2. Is your injury: WORK RELATED or AUTOMOBILE RELATED. If so, date of accident _____
3. If automobile related were you the: DRIVER or PASSENGER/ SEAT BELTED or NON SEAT BELTED
4. Area of major pain complaint: NECK BACK OTHER _____
5. How long have you had this pain? _____
6. Does pain radiate into your upper or lower extremities? _____
7. Is your pain: CONSTANT or INTERMITTENT Is your pain: THROBBING/ BURNING/ ACHING/ SHARP
8. Do you have any numbness and tingling? _____ If yes, where? _____
9. Does the pain interfere with your sleep? _____ If yes, is it? MILD MODERATE SEVERE
10. At what time of the day does your pain seem to be worse? _____
11. Do you have any morning stiffness associated with this pain? _____
12. What types of treatment have you had to-date?
    - ☐ Medications (Please list) _____
    - ☐ Chiropractic Treatments (please list name) _____
    - ☐ Physical therapy (where) _____
      (when) _____
      Did physical therapy help? ☐No ☐ Yes _____
    - ☐ Epidural steroid injections (where and when) _____
    - ☐ Previous Orthopaedic or Neurosurgeon Consultations (where, when and with whom) _____
    - ☐ Previous Surgical Procedures (where, when, what was done and by whom) _____
13. List any tests you have had related to your current pain: ☐ X-ray ☐ CT scan ☐ MRI ☐ Bone scan ☐ EMG
    ☐ Blood tests ☐ Other _____
14. On a scale from 1-10, with 10 being the worst, what is your **average** daily pain scale? _____
    What makes your pain worse? _____
15. Are you limited: Walking? YES or NO If so, how far _____
16. Are you limited: Sitting? YES or NO If so, how long _____
17. Does anything help relieve your pain? _____

WHERE IS YOUR PAIN? *Please shade the areas of your pain in the diagrams below.*



PATIENT INFORMATION

DATE: _____

Last Name:_____ First Name:_____ MI:_____

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

*Home Phone:(___)_____ *Cell Phone: (___)_____

*Work Phone: (___)_____ ext_____

* To respect your privacy, please note the numbers given will be used to communicate with you regarding Appointment Scheduling, Lab Results, etc. Only list the phone number, or numbers you want us to call.

SS#_____ Date of Birth:_____ Age:_____

Nearest Relative:_____ Relationship:_____

Phone# of Nearest Relative Listed Above:_____

How did you hear about Comprehensive Pain Management Specialists? _____

****

MEDICAL INSURANCE INFORMATION

Primary Insurance Co:_____

ID#_____ Group #_____

Medical Record #:_____ Relationship to Subscriber:_____

Subscriber's Name_____ Date of Birth:_____ SS#_____

Secondary Insurance Co:_____

ID#_____ Group #_____

Medical Record #:_____ Relationship to Subscriber:_____

Subscriber's Name_____ Date of Birth:_____ SS#_____

****

I do voluntarily consent to and authorize medical and/or surgical care to be performed as necessary for my care to be provided by Comprehensive Pain Management Specialists.

I authorize the release of medical information to process this claim and I authorize the payment of medical benefits to this physician. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Comprehensive Pain Management Specialists for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

MEDICARE PATIENTS-Comprehensive Pain Management Specialists does participate with Medicare. This means that we have agreed to accept as payment, for our services to Medicare patients, the fee approved by Medicare. You, as the patient, remain financially responsible for the annual deductible and the 20% coinsurance which Medicare approves, but does not pay.

I have read the above information and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

_____ _____

Signature of the Patient (Parent/Guardian, if patient is a minor) Date

Center for Epidemiologic Studies Depression Scale (CES-D), NIMH

Below is a list of the ways you might have felt or behaved. Mark how often you have felt this way during the past week.

	During the Past Week			
	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me.	☐	☐	☐	☐
2. I did not feel like eating; my appetite was poor.	☐	☐	☐	☐
3. I felt that I could not shake off the blues, even with help from my family or friends.	☐	☐	☐	☐
4. I felt I was just as good as other people.	☐	☐	☐	☐
5. I had trouble keeping my mind on what I was doing.	☐	☐	☐	☐
6. I felt depressed.	☐	☐	☐	☐
7. I felt that everything I did was an effort.	☐	☐	☐	☐
8. I felt hopeful about the future.	☐	☐	☐	☐
9. I thought my life had been a failure.	☐	☐	☐	☐
10. I felt fearful.	☐	☐	☐	☐
11. My sleep was restless.	☐	☐	☐	☐
12. I was happy.	☐	☐	☐	☐
13. I talked less than usual.	☐	☐	☐	☐
14. I felt lonely.	☐	☐	☐	☐
15. People were unfriendly.	☐	☐	☐	☐
16. I enjoyed life.	☐	☐	☐	☐
17. I had crying spells.	☐	☐	☐	☐
18. I felt sad.	☐	☐	☐	☐
19. I felt that people disliked me.	☐	☐	☐	☐
20. I could not get "going".	☐	☐	☐	☐

SCORING: zero for answers in the first column, 1 for answers in the second column, 2 for answers in the third column, 3 for answers in the fourth column. The scoring of positive items (4, 8, 12, and 16) is reversed. Possible range of scores is zero to 60, with the higher scores indicating the presence of more symptomatology.