NEVADA PAIN CARE
Care You Can Believe In

Follow-up Visit Intake Paperwork

BP:_____/ _____

Pulse: _____

In order to ensure that you are getting the best possible health care, we need this form completed in its entirety every visit. We cannot accept the word "same" - current health status is required

Your Name:_____ Date of Birth:_____ Date: _____

Has your medical coverage changed from your last visit? ❑ Yes ❑ No

Has your address changed since from your last visit? ❑ Yes ❑ No

Reason For Today's Visit

❑ Medication Refill ❑ Medication Change ❑ Post-Procedure Assessment ❑ Review MRI Results

Pain Description

Height:_____ Weight: _____

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain using a 0 – 10 scale:

_____ Your pain **right now**?

_____ Your **worst pain since your last visit**?

_____ Your **least pain since your last visit**?

_____ Your **average pain over the last month**?

Where is your worst area of pain located?

_____

Does this pain radiate (spread)? If so, where?

_____

Check all that describe your pain today:

❑ Aching ❑ Spasming

❑ Cramping ❑ Squeezing

❑ Dull ❑ Stabbing/Sharp

❑ Hot/Burning ❑ Throbbing

❑ Numb ❑ Tingling/Pins and Needles

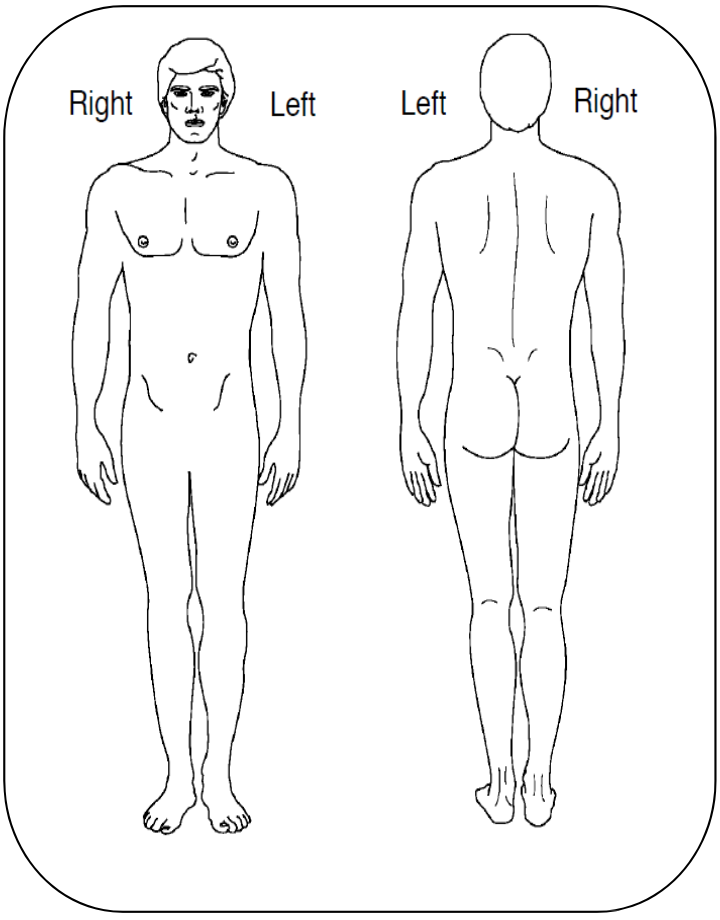
❑ Shock-like ❑ Tiring/Exhausting

❑ Shooting

Use the diagram to indicate the location and type of your pain with the following letters:

"**N**" = numbness "**P**" = pins and needles

"**A**" = aching "**S**" = stabbing "**B**" = burning



Mark all of the following activities that are adversely/negatively affected by your pain

❑ Enjoyment of Life ❑ Normal Work ❑ Sleep

❑ General Activity ❑ Recreational Activities ❑ Walking

❑ Mood ❑ Relationships with People ❑ Other: _____

Medications

Since your last visit, please list any **new changes *(from another physician)*** in the medications you are currently taking.

Medication Name	Dose	Change

Are you currently taking any blood-thinners or anticoagulants? ❑ **Yes** ❑ **No**

I am stable on my current medication regimen. ❑ Yes ❑ No

My medications help to improve my functioning and quality of life. ❑ Yes ❑ No

Pain relieved by taking medications □ 0% □ 10% □ 20% □ 30% □ 40% □ 50% □ 60% □ 70% □ 80% □ 90% □ 100%

Review of symptoms: mark all the following symptoms that you are currently suffer from

Cardiovascular: ❑ Bleeding Disorder ❑ Chest Pain ❑ Deep Vein Thrombosis
❑ Fainting ❑ High Blood Pressure ❑ Irregular Heartbeat ❑ Lightheadedness
❑ Shortness of Breath During Sleep ❑ Swelling in the Feet

Respiratory: ❑ Cough ❑ Wheezing ❑ Pulmonary Embolism
❑ Shortness of Breath on Exertion/Effort ❑ Shortness of Breath at Rest

Gastrointestinal: ❑ Abdominal Cramps ❑ Acid Reflux ❑ Coffee Ground Appearance in Vomit
❑ Constipation ❑ Dark and Tarry Stools ❑ Diarrhea ❑ Hernia ❑ Vomiting

Genitourinary/Nephrology: ❑ Blood in Urine ❑ Decreased Urine Flow/Frequency/Volume
❑ Erectile Dysfunction ❑ Flank Pain ❑ Painful Urination ❑ Pelvic Pressure

Musculoskeletal: ❑ Back Pain ❑ Joint Pain ❑ Joint Stiffness
❑ Joint Swelling ❑ Muscle Spasms ❑ Neck Pain

Neurological: ❑ Carpal Tunnel Syndrome ❑ Dizziness ❑ Headaches
❑ Instability When Walking ❑ Numbness/Tingling ❑ Seizures ❑ Tremors

Psychiatric: ❑ Depression ❑ Feeling Anxious ❑ Stress Problems
❑ Suicidal Thoughts ❑ Suicidal Planning

In the event that I am asked to provide a urine and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested. I have the right to refuse specific tests, but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the collection lab. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I understand that the laboratories may be out-of-network with my insurance. Payment in full is expected 30 days of being notified of any balance due. Please note that in the event that you fail to make payment when due, this account will be referred to a collection agency for collections. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

Signed: _____ **Date:** _____