Follow-Up Intake Paperwork

NEVADA PAIN CARE
Care You Can Believe In

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.

****** OFFICE USE ONLY ******
Room _____ **Roomer** _____
UDS: IA Lab NA
Quest LabCorp CPL
PHQ-9: Yes No
INJ: T+B12 TPI Tor B12 _____
BP: _____ / _____ Pulse: _____

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

What was the date of your LAST appointment? _____ (Month) _____ (Year)
Has your MEDICAL COVERAGE changed from your last visit? Yes No _____
Has your ADDRESS changed since your last visit? Yes No _____
Has your PHONE NUMBER changed since your last visit? Yes No _____

Reason for Today's Visit

☐ Medication Refill ☐ Medication Change ☐ In-Office Injection/Botox ☐ Review MRI/X-ray

Pain Description

Use the pain scale described below to rate your pain for the questions below:

0 – Pain Free
1 – Very minor annoyance, occasional minor twinges.
2 – Minor annoyance, occasional strong twinges.
3 – Annoying enough to be distracting.
4 – Can be ignored if you are really involved in your work/task, but still distracting.
5 – Cannot be ignored for more than 30 minutes.
6 – Cannot be ignored for any length of time, but you can still go to work and participate in work activities.
7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort.
8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9 – Unable to speak, crying out or moaning uncontrollably, near delirium.
10 – Unconscious, pain makes you pass out.

Height: _____

Weight: _____

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?

_____

Is your pain constant or intermittent?

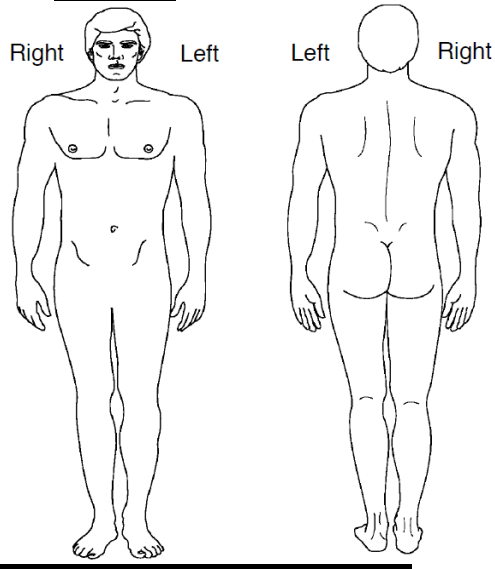
_____

MARK all that describe your pain today.

☐ Aching
☐ Hot/Burning
☐ Numb
☐ Tingling/Pins and Needles
☐ Stabbing/Sharp
☐ Shooting/Shock like

Use the diagram to indicate the location and type of your pain with the <u>following</u> 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
☐ Mood
☐ General Activity
☐ Walking
☐ Recreational Activities
☐ Relationships with People
☐ Other: _____

Medications

Since your last visit, please list **ANY NEW** medications you are **NOW** 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 (circle): 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Review of symptoms: Mark ALL of the following symptoms that you currently suffer from

Cardiovascular:

- ☐ Bleeding Disorder
- ☐ Chest Pain
- ☐ Fainting
- ☐ Deep Vein Thrombosis
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Lightheadedness
- ☐ Shortness of Breath During Sleep
- ☐ Swelling in Feet

Respiratory:

- ☐ Cough
- ☐ Pulmonary Embolism
- ☐ Shortness of Breath on Exertion/Effort
- ☐ Shortness of Breath at Rest
- ☐ Wheezing

Gastrointestinal:

- ☐ Abdominal Cramps
- ☐ Acid Reflux
- ☐ Constipation
- ☐ Vomiting
- ☐ Dark and Tarry Stools
- ☐ Diarrhea
- ☐ Hernia
- ☐ Coffee Ground Appearance in Vomit

Genitourinary/Nephrology:

- ☐ Blood in Urine
- ☐ Flank Pain
- ☐ Decreased Urine Flow/Frequency/ Volume
- ☐ Erectile Dysfunction
- ☐ Painful Urination
- ☐ Pelvic Pressure

Musculoskeletal:

- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Muscle Spasms
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Leg Pain

Neurological:

- ☐ Carpal Tunnel Syndrome
- ☐ Headaches
- ☐ Seizures
- ☐ Numbness/Tingling
- ☐ Dizziness
- ☐ Tremors
- ☐ Instability When Walking

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 the 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 of 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 the network with my insurance. Payment in full is expected 30 days of being notified of any balance due. Please note that if 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: _____