Demographic Information

Patient Information

Name _____ Social Security #_____

Address _____ Date of Birth ___/___/_____ Age _____

City/State _____ Zip _____ Height _____ Weight _____

Email _____ Gender: ☐ Male ☐ Female ☐ Neutral Gender

Phone #_____ ☐ Home ☐ Mobile ☐ Work

Secondary Phone # _____ ☐ Home ☐ Mobile ☐ Work

Emergency Contact _____ Phone# _____ Relation _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White

☐ Native Hawaiian/Other Pacific Islander ☐ Other:_____

Ethnicity: ☐ Hispanic or Latino ☐ Not hispanic or Latino

Referral

Which physician referred you to our office? _____ Fax#_____

Who is your primary care or family physician? _____ Fax#_____

Pharmacy

Pharmacy Name _____ Phone # _____

Address _____ City/State _____

Insurance Information

Primary Insurance (ie,BC/BS)_____ Policy/I.D._____ Group#_____

Secondary Insurance (ie, BC/BS) _____ Policy/I.D._____ Group#_____

Complete this section if you are not the policyholder for your primary insurance

Insurance policy holder: ☐ Self ☐ Spouse ☐ Partner ☐ Other _____

Policy Holder Name _____ Date of Birth ___/___/___ Social Security #_____

Workers Compensation Information

Workers Comp Company _____ Agent Name _____

Phone # _____ Fax # _____

Claim # _____ Part of Body Injured_____ Date of Injury _____

Motor Vehicle Accident Information

Attorney Name: _____ Phone# _____ Fax # _____

Name of liable party Insurance_____ Claim/Policy # _____

Location of accident:_____

Part of Body Injured_____ Date of Injury _____

Oklahoma Pain Physicians will be filing a Physician's Lien with the Oklahoma County Clerk's office against the claim for all treatment related to the accident. If the claim should not be paid, the patient will be responsible for the billed charges in full and health insurance plans will not be filed for any treatment related to the accident in lieu of non-payment on the claim.

Patient Initials:_____

Past Medical History

Please check the following conditions you have or have had treatment for:

Head,Eyes,Ears,Nose,Throat

- ☐ Headaches
- ☐ Migraines
- ☐ Blindness
- ☐ Deafness
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Respiratory

- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Lung Cancer

Cardiovascular

- ☐ Heart Attack
- ☐ Blood Pressure
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ PVD/DVT

Hematologic

- ☐ Bleeding Disorder
- ☐ Protein C/S Deficiency
- ☐ Systemic Lupus Erythematosus
- ☐ Lymphoma
- ☐ Leukemia
- ☐ HIV/AIDS

Gastrointestinal

- ☐ Gastritis
- ☐ GERD (Acid Reflux)
- ☐ Bowel Incontinence
- ☐ Cirrhosis
- ☐ Liver Failure
- ☐ Pancreatitis
- ☐ Diabetes Type I or II

Musculoskeletal

- ☐ Amputation
- ☐ Chronic Low Back Pain
- ☐ Chronic Neck Pain
- ☐ Chronic Knee Pain
- ☐ Chronic Hip Pain
- ☐ Chronic Shoulder Pain
- ☐ Rheumatoid Arthritis

Musculoskeletal

- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Vertebral Body Fracture

Genitourinary/Kidney

- ☐ Kidney Cancer
- ☐ Kidney Stones
- ☐ Chronic Renal Failure
- ☐ Urinary Incontinence

Neurologic

- ☐ Multiple Sclerosis
- ☐ Restless Leg
- ☐ Epilepsy/Seizures
- ☐ Neuropathy
- ☐ Trigeminal Neuralgia
- ☐ Facial Neuralgia

Psychological

- ☐ Anxiety
- ☐ Depression
- ☐ Prescription Drug Use
- ☐ Illegal Drug Use
- ☐ Alcohol Abuse

Past Surgical History

Abdominal Surgery

- ☐ Gallbladder _____
- ☐ Appendix _____
- ☐ Hernia _____
- ☐ Other _____

Cardiac Surgery

- ☐ CABG _____
- ☐ Valve Repair _____
- ☐ Stent Placement _____
- ☐ Aneurysm repair _____

Spine & Back Surgery

- ☐ Cervical Fusion _____
- ☐ Lumbar Fusion _____
- ☐ Laminectomy _____
- ☐ Discectomy _____
- ☐ Other _____

Joint Surgery

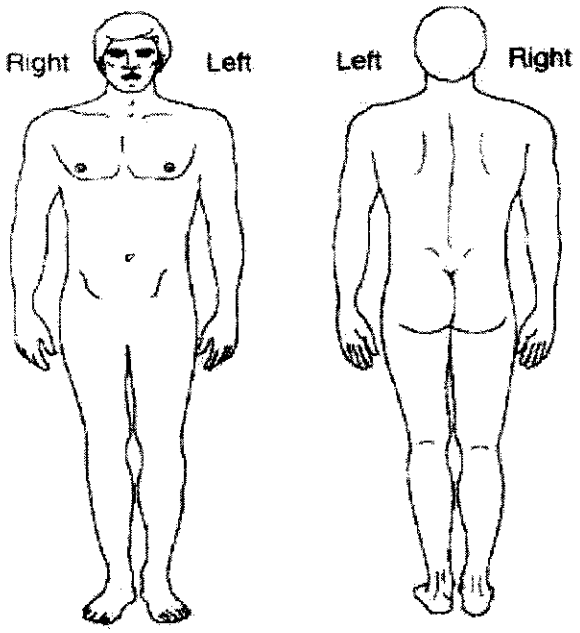
- ☐ Foot _____
- ☐ Knee _____
- ☐ Hip _____
- ☐ Elbow _____
- ☐ Shoulder _____

Patient Initials:_____

History & Physical

Location of Pain

Please describe your pain: Use the pictures below to mark the areas on your body where you feel the described sensations. Use the appropriate letters.



"S" Stabbing A" Aching "B" Burning "P" Pins & Needles "N" Numbness

Quality of Pain

Check all of the following that describes your pain symptoms:

☐ **Achy** ☐ **Throbbing** ☐ **Pins & Needles** ☐ **Hot/Burning**

☐ **Cramping** ☐ **Squeezing** ☐ **Tingling** ☐ **Numbness**

☐ **Dull** ☐ **Spasms** ☐ **Shock like** ☐ **Stabbing** ☐ **Sharp**

☐ **Shooting** ☐ **Tiring/Exhausting**

Severity of Pain

0 (none) 1-2 (slight) 3-4 (mild) 5-6 (moderate) 7-8 (severe) 9-10 (extreme)

_____Rate your **CURRENT** pain level on a scale of 0 to 10?

_____Rate your **LEAST** pain on a daily basis, on a scale of 0 to 10?

_____ Rate your **WORST** pain on a daily basis, on a scale of 0 to 10

_____ Rate your **AVERAGE** daily pain on a scale of 0 to 10?

Duration of Pain

How long has your current pain episode lasted?

☐ ____ **Minutes** ☐ _____**Hours** ☐ _____**Days** ☐ _____**Months** ☐ _____**Years**

Timing of Pain

What word best describes the frequency of your pain? ☐ **Constant** ☐ **Intermittent** ☐ **Both**

When is your pain at its worst? ☐ **Mornings** ☐ **Mid-day** ☐ **Late-afternoon** ☐ **Evenings** ☐ **Entire Day**

Context of Pain

When did pain begin? ☐ **0-3 months** ☐ **4-12 months** ☐ **1- 5 years** ☐ **> 5 yrs, How long?**_____

What caused your pain? ☐ **Motor vehicle accident** ☐ **Other** _____

How did your current episode begin? ☐ **Gradually** ☐ **Suddenly** ☐ **Gradually and Suddenly**

Since your pain has started, how has it changed? ☐ **Improved** ☐ **Worsened** ☐ **Stayed the same**

Patient Initials:_____

Modifying Factors

Check all of the following that makes your pain symptoms WORSE:

☐ Exercise ☐ Bending ☐ Stress ☐ Physical Therapy ☐ Physical Activity ☐ Lying ☐ Coughing ☐ Surgery

☐ Standing ☐ Sitting ☐ Heat ☐ Medications ☐ Lifting ☐ Rest/Relaxation ☐ Cold

Check all of the following that makes your pain symptoms BETTER:

☐ Exercise ☐ Bending ☐ Injection Therapy ☐ Physical Therapy ☐ Physical Activity ☐ Lying ☐ Coughing

☐ Surgery ☐ Standing ☐ Sitting ☐ Heat ☐ Medications ☐ Lifting ☐ Rest/Relaxation ☐ Cold

Associated Signs & Symptoms

Do you have any of the following symptoms? Please mark all that apply.

☐ Bowel Incontinence ☐ Bladder Incontinence ☐ Difficulty Walking ☐ Balance Problems ☐ Numbness

☐ Tingling

☐ I have NO symptoms mentioned above.

Previous Treatments

☐ Chiropractic
☐ Physical Therapy
☐ Acupuncture
☐ Home Exercises
☐ Tens Unit
☐ Spine Surgery
☐ Psychological Therapy
☐ Epidural injections
☐ Medial Branch Blocks
☐ Sacroiliac injections
☐ Ablation Therapy
☐ Spinal Cord Stimulator
☐ Vertebro/Kyphoplasty
☐ Medications

Imaging Studies

☐ MRI ☐ CT Scan ☐ EMG/NCV ☐ Bone Scan ☐ X-Ray ☐ Other: _____

☐ No diagnostic test or imaging performed for my current pain symptoms.

Patient Initials:_____

Please check any blood thinners you are taking:

☐ Aspirin ☐ NSAID ☐ Lovenox (enoxaparin) ☐ Coumadin (Warfarin) ☐ Pletal (cilostazol)

☐ Pradaxa (dabigatran) ☐ Plavix (clopidogrel) ☐ Eliquis (apixaban) ☐ Xarelto (rivaroxaban)

☐ Other: _____

Prescribing Physician _____ **Phone Number:** _____

Please list all medications you are taking:

Medication	Dose	Frequency	Prescribing Physician

Allergies

Do you have any drug allergies? ☐ Yes ☐ No **List all allergies & Reactions**

_____

_____

_____

Family History

Please mark each box that is pertinent to your family history (Biological *mother* and *father* only)

	Mother	Father
Diabetes	☐	☐
High blood pressure	☐	☐
Heart Disease	☐	☐
Headaches	☐	☐
Substance abuse	☐	☐
Stroke	☐	☐
Arthritis	☐	☐

☐ I have no significant family medical history.

☐ I am adopted.

Patient Initials:_____

Social History

Highest level of education: ☐ Grade School ☐ High School ☐ College ☐ Post-Graduate

Alcohol Use: ☐ No ☐ Occasional ☐ Daily

Tobacco Use: ☐ No ☐ Occasional ☐ Daily Packs/Day? _____, Years? _____

Substance Abuse: ☐ Never ☐ Occasional ☐ Daily ☐ History of Drug use, What Drug? _____

Have you ever abused a narcotic or prescription medication? ☐ No ☐ Yes, which? _____

Are you now or is there a possibility of you being pregnant? ☐ No ☐ Yes

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated Spouse

Name_____Phone Number_____

Are you currently working ☐ No ☐ Yes, Occupation _____

Review of Systems

Please check the following boxes of symptoms you currently have:

☐ Fatigue
☐ Fever
☐ Headache
☐ Ear Pain
☐ Ear Discharge
☐ Sore Throat
☐ Vision Problems
☐ Eye Discharge
☐ Eye Redness
☐ Nasal Bleeding
☐ Nasal Discharge
☐ Shortness of Breath
☐ Sputum Production

☐ Cough
☐ Chest Pain
☐ Palpitations
☐ Leg Swelling
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Blood in Stool
☐ Pain with Urination
☐ Frequent Urination
☐ Flank Pain
☐ Skin Rashes

☐ Jaundice
☐ Skin Lesions
☐ Dizziness
☐ Tremors
☐ Seizures
☐ Excessive Thirst
☐ Weight Changes
☐ Heat or Cold intolerance
☐ Bruising
☐ Bleeding Easily
☐ Depression
☐ Anxiety
☐ Substance Abuse

Patient Initials:_____

I certify that all information is accurate, complete and true. I authorize Oklahoma Pain Physicians, associates, assistants, and other health care providers it may deem necessary to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give consent for Oklahoma Pain Physicians to retrieve and review my medication history. I understand that this will become part of my medical record. I acknowledge that I have had the opportunity to review Oklahoma Pain Physicians notice of privacy practices, which is displayed for public inspection at its facility. This notice describes how my protected health information may be used and disclosed, and how I may access my health records. I authorize Oklahoma Pain Physicians to release my protected health information (medical records) in accordance with its notice of privacy practices. This includes, but not limited to my referring physician, primary care physician, and any physician(s) may be referred to. I also authorize Oklahoma Pain Physicians to release any information required in obtaining procedure authorization or the processing of any insurance claims. I understand that Oklahoma Pain Physicians will not release my protected health information to any other party (including family) without completing a written patient authorization for use and disclosure of protected health information form available at the facility or in the new patient packet.

Authorization for Release of Information

In the event that a patient wishes another individual to receive medical information such as test results, etc., or in the event that the patient is unable to receive those results, that patient may choose to designate persons who are authorized to receive that information.

I hereby authorize the release of my medical information to the following designated persons: Check one or all

☐ Spouse Name _____

☐ Child/Children's Name(s) _____

☐ Other _____

☐ May leave voicemail or email

My signature indicates that I have read the above and granted the request. I understand that if I do not sign, or list any person, the information will not be given to anyone but the patient. I also understand that I am able to revoke this authorization at any time; the request must be in writing to your physician.

Acknowledgement of receipt of privacy notice for oklahoma pain physicians: I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices which describes how my protected health information may be used and disclosed, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

Patient Initials:_____