

NEW PATIENTS' INFORMATION SHEET

Please print clearly. Please complete all information so that your claim can be processed quickly and efficiently. Thank you!

PATIENT INFORMATION

(First) (MI) (Last)

Name _____

Date of Birth: _____ Sex: Male / Female Marital Status: S M W D

(Street) (City) (State) (ZIP)

Address: _____

Phone #: _____ Social Security #: _____

Employer: _____ Work #: _____

Employer's Address: _____

If Student, School Name: _____ Full / Part Time _____

WORKER'S COMP/ACCIDENT INFORMATION

Insurance Name: _____

Address: _____ Phone #: () - _____

Adjuster Name: _____ Adjuster Phone #: () - _____

Date of Injury or Accident: _____ Claim #: _____

Type of Injury: Back Leg Hip Neck Shoulder Arm Head Other: _____

Place of work during time of accident: _____ Phone #: () - _____

In Litigation: Yes NO Amount of Medical Benefits: _____ Notice of Compensation Payable: Yes NO

INSURANCE INFORMATION

Insurance Co.: _____ Phone #: _____

Insurance Address: _____

Identification #: _____ Group #: _____

Insured's Name: _____ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer: _____ Phone #: _____

Employer's Address: _____

Insured's Social Security #: _____ Date of Birth: _____ Sex: Male / Female

If the patient is covered by another insurance policy, please complete the following information for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank you!

INSURANCE INFORMATION

Insurance Co.: _____ Phone #: _____

Insurance Address: _____

Identification #: _____ Group #: _____

Insured's Name: _____ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer: _____ Phone #: _____

Employer's Address: _____

Insured's Social Security #: _____ Date of Birth: _____ Sex: Male / Female

I hereby assign, transfer, and set over to Center for Pain Control all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature _____ Date _____

Center for Pain Control, PC

1235 Penn Avenue, Suite 302
Wyomissing, PA 19610
TEL. (610) 374-2927
FAX (610) 374-2909



James P. Barrett, M.D. PhD.
James H. Hsu, M.D.
Jason T. Bundy, M.D.

DATE: _____ REFERRING PHYSICIAN: _____

NAME: _____ FAMILY DOCTOR: _____

DOB: _____

PLEASE COMPLETE THESE FORMS PRIOR TO YOUR APPOINTMENT AND BRING THEM WITH YOU THE DAY OF YOUR SCHEDULED APPOINTMENT. If you are unable to fill them out yourself, please have your family doctor give you a list of your medical history and current medication. You will need to arrive at our clinic 30 min prior to your appointment so we can assist you with this form.

- **What is your chief complaint?** (example: 30% low back pain and 70% right leg pain)

- **When did it start?** (example: 2months ago, or "7-26-03")

- **Did you sustain any trauma immediately prior to the onset?** YES NO

- **Is this work related or motor vehicle accident related?** YES NO

- **Do you have an attorney?** (Please provide their contact information) YES NO

- **Please describe the trauma.**

- **Is the pain there constantly, intermittently, or both?** (example: constant back pain with intermittent left leg pain)

- **Please describe the characteristics of your pain.** (sharp vs. dull, burning, squeezing, throbbing, tingling, etc.)

- **What makes the pain worse?** (Please circle)

Sitting Standing Walking Lying flat Bending over Lifting Others _____

- **What makes the pain better?** (Please circle)

Sitting Standing Walking Lying flat Lifting Change Positions Other _____

Taking medications (please list _____)

- **What have you tried?**

	Dosage?	How long?	Helpful?	Reason stopped
Ibuprofen (Advil, Motrin)				
Acetaminophen (Tylenol)				
Aspirin				
Naproxen (Aleve, Naprosyn)				
Diclofenac (Voltaren)				
Etodolac (Lodine)				
Ketorolac (Toradol)				
Nabumetone (Relafen)				
Meloxicam (Mobic)				
Celecoxib (celebrex)				
Carisoprodol (Soma)				
Cyclobenzaprine (Flexeril, Amrix)				
Diazepam (Valium)				
Metaxalone (Skelaxin)				
Methocarbamol (Robaxin)				
Tizanidine (Zanaflex)				
Gabapentin (Neurontin)				
Pregabalin (Lyrica)				
Topiramate (Topamax)				
Amitriptyline (Elavil)				
Duloxetine (Cymbalta)				
Venlafaxine (Effexor)				
Nortriptyline (Pamelor)				
Hydrocodone/APAP (Vicodin, Lortab, Norco)				
Oxycodone/APAP (Percocet, Endocet, Tylox, Roxicet)				
Methadone				
Morphine				
Fentanyl patch				
Oxycontin				
Lidoderm Patches				
Flector Patches				
Voltaren Gel				
Other medications				

	How long?	Helpful?	Reason stopped
Chiropractors			
Massage therapy			
Physical therapy / Aquatic therapy			
Tens Unit			
Heat Compress			
Cold compress			
Acupuncture therapy			
Psychotherapy / Biofeedback			
Behavior modification therapy			

- **Images** (X-Ray, CT Scan, Bone Scan, etc.)

Study	Date	Where

- **Spine Injections**

	Doctor	Date	Helpful?	How long did it last?
Epidural steroid inj				
Facet injections				
Radiofrequency ablations				
SI joint injections				

- **Spine surgery**

	Doctor	Date	Helpful?	How long did it last?

- **Current Medication** (Please list all meds including vitamins and OTC meds)

Medication	Why prescribed	Dosage

- **Are you allergic to any medications?** (Please list and describe reaction)

Medication	Reaction

IV contrast allergy? YES NO

Shellfish allergy? YES NO

• **Past Medical History** (Please circle all)

AIDS / HIV Alcoholism Asthma Cancer Diabetes Emphysema Epilepsy Heart Disease
 Hepatitis Herpes High Blood Pressure Multiple Sclerosis Pacemaker Seizures Stroke
 Thyroid Disorders Tuberculosis Fibromyalgia Depression Bipolar Disorder Schizophrenia
 Anxiety Disorder Other Psychiatric Issues Irritable Bowel Syndrome Chronic Pelvic Pain Migraine
 Other: _____

• **Past Surgical History**

Surgery	Year

• **Family History** (Please list all significant family medical history such as bleeding problems (hemophilia), psychiatric disorders, chronic pain, or any substance abuse)

• **Social history**

Who do you live with now? _____

Do you have any children? ___ How many? ___ How is their health? _____

Are you currently working? ___ If not, why not? _____ Why did you stop? _____

What do/did you do for a living? _____

Do you smoke? ___ If yes, how much? _____ (per day on average)

Do you drink? ___ If yes, how much? _____ (per day on average)

Do/did you use any illicit drugs? ___ What kind and how much? _____

Have you ever gone through rehab for drug or alcohol abuse? ____.

Are you currently pregnant or plan to become pregnant? YES NO

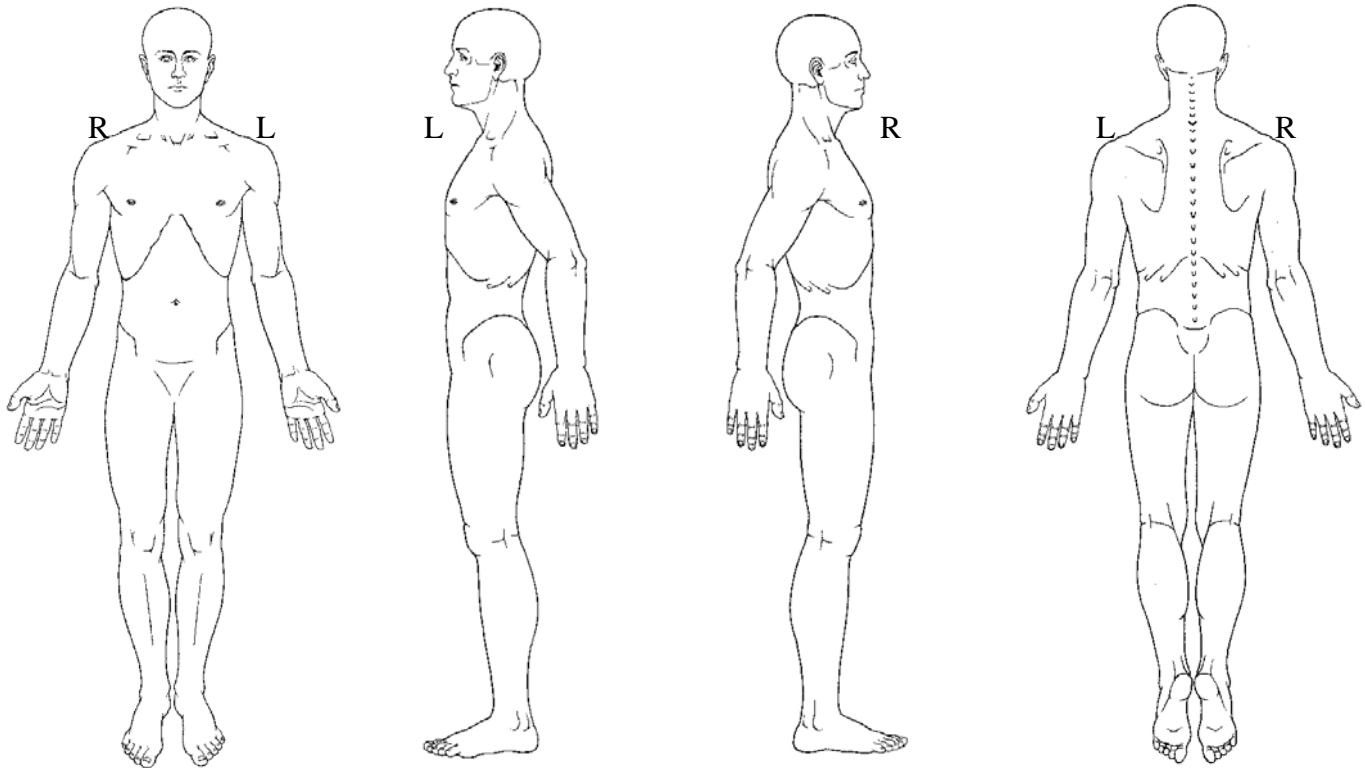
Have you ever been discharged from a doctor's office because of noncompliance not following their directions?

• **Review of system**

In the past month, have you experience any significant (Please circle all)

Weight loss/gain Fever/chills Changes in hearing/vision Dizziness Pass out Shortness of breath
 Productive cough Chest pain Abdominal pain Diarrhea/constipation Weakness in the extremities
 Lost control of bowel/urinary functions Bleeding problems Rashes Depression Suicidal thoughts
 Homicidal thoughts Others _____

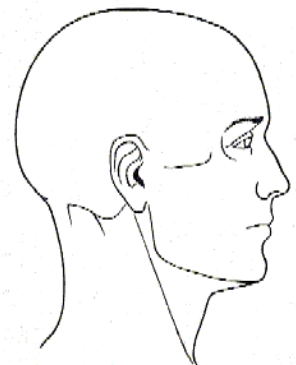
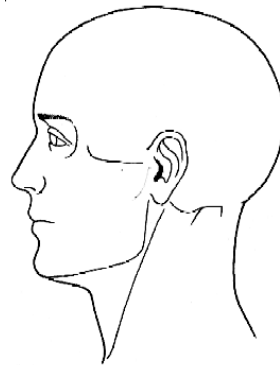
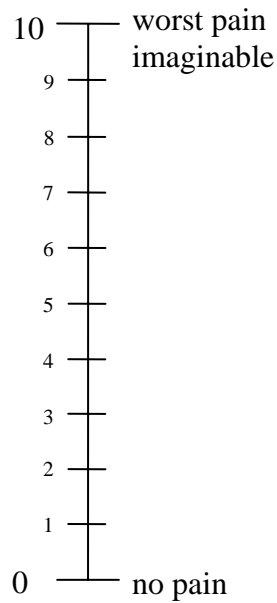
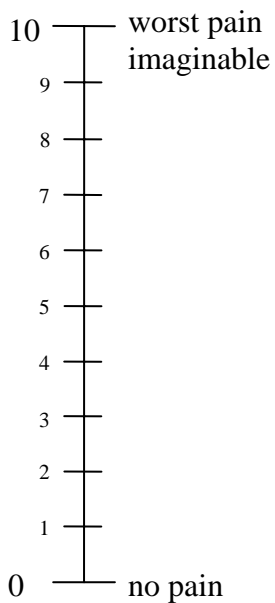
- Please shade in on the drawings the areas where you feel pain.



Please rate the severity of your pain (mark “baseline” and “with exacerbation”)

BASELINE

WITH ACTIVITY



- Who has treated you since the onset of the chief complaint?

Patient's Signature

Date