

North Shore Pain Services Patient Questionnaire

Today's Date: ____/____/____

Your Information:

Last Name: _____ First: _____ Middle: _____

Date of Birth: ____/____/____ Age: _____ SS#: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Work Phone: (____) _____

Emergency Contact:

Name: _____ Relation: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Work: (____) _____

Referring Physician:

Name: _____ Specialty: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Phone: (____) _____ Fax: (____) _____

Primary Care Physician (PCP):

Name: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Phone: (____) _____ Fax: (____) _____

Pharmacy:

Name: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Phone: (____) _____

We can share information with you:

Spouse: ____ Significant Other: ____ Parent: ____ Children: ____ PCP: ____

Signature: _____

Marital status: _____ Number of children: _____

With whom do you live? _____

Do you practice any religion or have a personal faith system which helps you to cope with the pain?

Please describe your pain complaint and location:

How and when did the pain start, and how has it changed since that time?

Please indicate on the following what makes the pain better (+) or worse (-):

<input type="checkbox"/> Heat	<input type="checkbox"/> Cold	<input type="checkbox"/> Humidity
<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Lying Down
<input type="checkbox"/> Coughing	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Walking
<input type="checkbox"/> Noise	<input type="checkbox"/> Anxiety/Emotions	<input type="checkbox"/> Massage
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Caffeine	<input type="checkbox"/> Body position
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Stairs	<input type="checkbox"/> Bowel movements
<input type="checkbox"/> Driving	<input type="checkbox"/> Vibrations	<input type="checkbox"/> Housework

0	1	2	3	4	5	6	7	8	9	10
no pain		mild		discomforting		distressing		horrible		excruciating

Using this pain scale, please describe your pain:

- at it's worst? _____
- at it's least? _____
- right now? _____

Circle any of the following that you currently use:

cane	wheelchair	crutches	brace
scooter	walker	prosthesis	collar

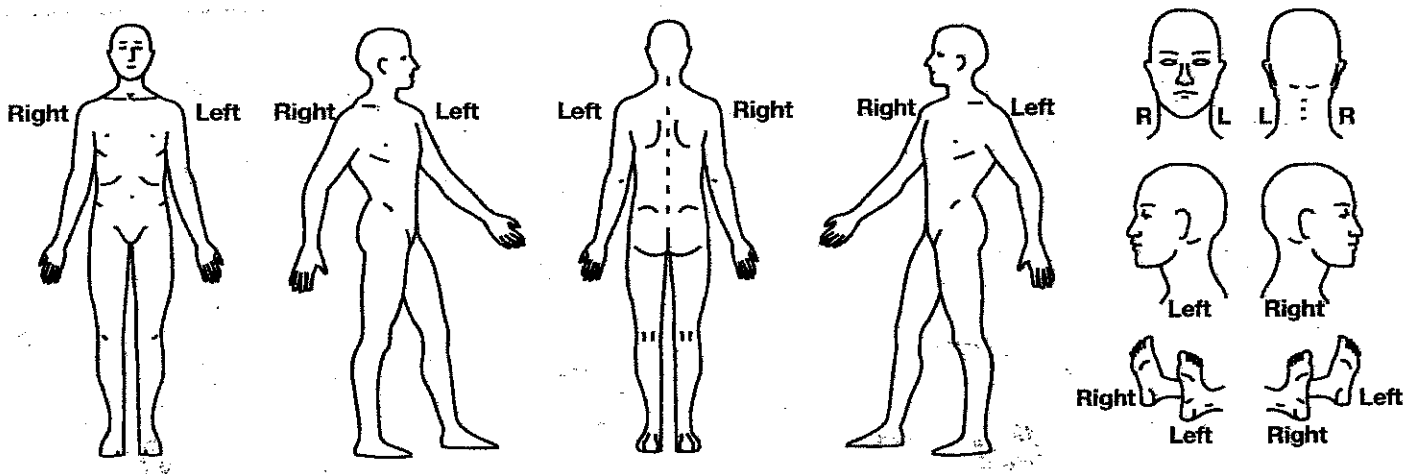
Please circle any treatments you have undergone for your pain problem. Place a (+) next to those that were effective and a (-) next to those that were not:

Acupuncture	Hypnosis	TENS unit
Bed Rest	Massage Therapy	Traction
Biofeedback	Physical Therapy	Trigger Point Injections
Chiropractor	Psychotherapy	Ultrasound
Exercise	Relaxation Training	Other:

Have you had any previous pain procedures like epidurals or nerve blocks? YES NO
When and with whom?

What is your height? _____ current weight? _____
 Do you smoke? _____ If yes, how many packs/ years? _____
 Do you drink alcohol? _____ If yes, how much? _____
 Do you use recreational drugs? _____ If yes, what? _____
 Are you currently employed? _____ Occupation: _____
 If unemployed, for how long? _____ Is this due to a pain condition? _____
 Do you receive disability benefits? _____
 If so, what type? _____
 Do you have a pending settlement about disability, workmen's compensation or a legal matter? ____Yes ____No
 If yes, explain briefly: _____

Please mark the area(s) of the body where your pain is on the figures below:



RELEASE AND ASSIGNMENT

I hereby assign all medical and/ or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Blue Shield, HMOs and commercial insurance to North Shore Pain Services, LLP.

North Shore Pain Services, LLP, bills only for the professional component of these services.

I understand that I am financially responsible for all charges for the hospital and for anesthesia if these services are used.

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

I authorize release of any information required to secure payment on my behalf.

I the undersigned am aware that there is a \$30.00 late cancellation fee for any appointment or procedure that is not cancelled at least twenty-four hours in advance.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to North Shore Pain Services, LLP, for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agencies any information needed to determine these benefits or the benefits payable for related services.

Print patient name

Patient signature

Social Security number

Date