

Patient Health History - Intake Form

Patient Information

Name: (Last, First, Middle):			Date:		
Date of Birth:		Soc. Sec #:		Home Phone:	
E-mail Address:			Cell Phone:		
Address:			May We Text You? <input type="checkbox"/> Yes <input type="checkbox"/> No		
City:		State:	Zip Code:		Sex M F
Marital Status:	Single	Married	Divorced	Widow	Separated

MVA / Worker's Compensation

Insurance Company					
Claim #:			Date of Loss:		
Adjuster's Name:			Phone #:		
Employer:			Occupation:		
Address:					
City:		State:		Zip Code:	
Full Time		Part Time		Unemployed	
Lawyer:		Phone:		City:	

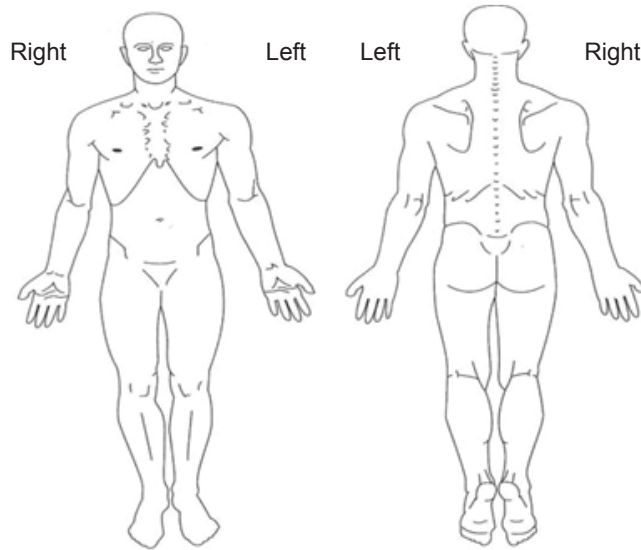
Health Insurance

Insurance Company:			Effective Date:		
Insurance ID #:			Group #:		
<i>Please enter the policyholder's information below. If you are the policy holder, check here <input type="checkbox"/> and continue to the next section.</i>					
Policyholder's Name (Last, First, Middle)					
Relationship to Patient:		Soc. Sec #		Date of Birth:	

Contact

Emergency Contact:					
Relationship:			Phone:		
Who Referred You to Pain Management Associates?:					
Primary Care Physician:				Phone:	

Please Draw the Location of Your Pain Using the Symbols Shown Below



D = Dull B = Burning N = Numb S = Stabbing T = Tingling C = Cramping

What is your Pain Right Now?

What is your pain level at its best?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

What is your typical or Average Pain?

What is your pain at its worst?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

Injury / Pain Information

What caused your pain?: Work Related Date: _____ Car Accident Date: _____

Describe Accident:

Have you had any injuries to your area of pain prior to the accident? Yes No

Have you ever been treated for the area of injury prior to the accident? Yes No

Where is your 1st problem? _____

How often does the pain occur? Continuously Daily Several Times a Week

What makes it worse? Sitting Standing Walking Other: _____

What makes it better?

Does the pain interrupt your sleep: Yes No

Where is your 2nd problem? _____

How often does the pain occur? Continuously Daily Several Times a Week

What makes it worse? Sitting Standing Walking Other: _____

What makes it better?

Does the pain interrupt your sleep: Yes No

Past Treatment

Have you tried other treatments for this condition? Yes No

*Please indicate below the improvement seen with any other treatments you have received.
Improvement Rating: 1 = Better 2 = Little to No Improvement 3 = No Change 4 = Worse*

Treatment	Start Date	Duration / # of Times	Area	Rating
Chiropractor				1 2 3 4
Physical Therapy				1 2 3 4
Pain Management Injections		<input type="checkbox"/> Yes <input type="checkbox"/> No When _____ Where _____ Type _____ Area _____		
Back Surgery		<input type="checkbox"/> Yes <input type="checkbox"/> No When _____ Where _____		
Diagnostic Testing		Yes	No	Area
MRI				
Nerve Testing				

Medications

Have you tried any pain/sleep medication treatments for this condition? Yes No

*Please indicate below the improvement seen with any other treatments you have received.
Effectiveness Rating: 1 = Great Help 2 = Some Help 3 = No Help*

Pain/Sleep Medication	Are You Currently Taking This Medication?	How Long Did You Take the Medication?	Effectiveness Rating
	Yes <input type="checkbox"/> No <input type="checkbox"/>		1 2 3
	Yes <input type="checkbox"/> No <input type="checkbox"/>		1 2 3
	Yes <input type="checkbox"/> No <input type="checkbox"/>		1 2 3
	Yes <input type="checkbox"/> No <input type="checkbox"/>		1 2 3
	Yes <input type="checkbox"/> No <input type="checkbox"/>		1 2 3

Please List All Other Medications You Are Currently Taking:

Medication	Dosage	Medication	Dosage

Occupational History

Are you currently working? Yes No If No when was your last day of work? _____

Occupation: _____ Job Title: _____

Does your pain affect you ability to perform your job duties? Yes No

Are you unable to work because of your pain? Yes No

If yes, please describe: _____

What are your usual activities? _____

History and Physical

Patient Name: _____

Age: _____ Sex: Female Male Height: _____ Weight: _____

Allergies: None Yes NKDA Latex Dye Contrast Other _____

Reaction to Allergies: _____

Medications: None Yes Please List _____

Are you on blood thinners: None Yes Coumadin Plavix Other _____

Patient Medical History

Condition					Other
Endocrine	<input type="checkbox"/> None	<input type="checkbox"/> Diabetes: Insulin	<input type="checkbox"/> Diabetes: Non-Insulin	<input type="checkbox"/> Thyroid	_____
Eyes	<input type="checkbox"/> None	<input type="checkbox"/> Glaucoma: Narrow Angle	<input type="checkbox"/> Glaucoma: Wide Angle		_____
Cardio	<input type="checkbox"/> None	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Valve Problem	_____
		<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Angina		_____
Circulation	<input type="checkbox"/> None	<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Chronic Edema	<input type="checkbox"/> Varicose Veins	_____
				<input type="checkbox"/> Spider Veins	_____
Neurological	<input type="checkbox"/> None	<input type="checkbox"/> CVA/Stroke	<input type="checkbox"/> Seizures		_____
Respiratory	<input type="checkbox"/> None	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Asthma	<input type="checkbox"/> COPD	_____
Gastrointestinal	<input type="checkbox"/> None	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Heartburn/Reflux	<input type="checkbox"/> Liver Problems	_____
Genitourinary	<input type="checkbox"/> None	<input type="checkbox"/> Urination Problems	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Erectile Dysfunction	_____
Musculoskeletal	<input type="checkbox"/> None	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Joint Replacement		_____
Psychiatric	<input type="checkbox"/> None	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Claustrophobia	_____
Hematologic	<input type="checkbox"/> None	<input type="checkbox"/> Low Platelets	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Poor Clotting	_____
Venous Disease	<input type="checkbox"/> None	<input type="checkbox"/> Varicose	<input type="checkbox"/> Spider Veins		_____

Surgical History: None Yes Type: _____

If Yes - Any difficulty with Anesthesia? _____

Social History: Smoking: No Yes How Much: _____

Alcohol: No Yes How Much: _____

Drugs: No Yes

Family History: _____

Office Use Only --- Do Not Write Below

Physical Exam

	Normal	Abnormal	If Abnormal, please specify:
HEENT			
Chest/Lung			
Heart			
Neurological			
Mental Status			

Physician Signature: _____ **Date:** _____

If the History and Physical Examination was performed more than seven(7) days prior to surgery

The above was reviewed by me. No change has occurred since the H&P was completed.

The patient's current medical status has changed since the last H&P was performed in that: _____

Physician Signature: _____ Date: _____

Physical Exam

Vitals	HT:	WT:	HR:	BP:	R:
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	Range of Motion	
	C-Spine	L-Spine
F. Flexion	_____ / 45	_____ / 80
Extension	_____ / 45	_____ / 30
R. Lateral	_____ / 45	_____ / 40
L. Lateral	_____ / 45	_____ / 40
R. Rotation	_____ / 60	_____ / 45
L. Rotation	_____ / 60	_____ / 45
R. SLR		_____ / 60
L. SLR		_____ / 60

DTR's		
Bicep	_____ / 2	_____ / 2
Patella	_____ / 2	_____ / 2
Achilles	_____ / 2	_____ / 2
Strength		
UE	_____ / 5	_____ / 5
LE	_____ / 5	_____ / 5
Sensory		
UE		
LE		

Orthopedic Exam

Elbow	Shoulder
Medial Epicondylitis	+ - Neer Impingement Sign/Rotator Cuff
+ - Pain Resisted Wrist Flexion	+ - Pain or Resisted Abduction/Supraspinatus
Lateral Epicondylitis	+ - Pain or Resisted Lateral Rotation (infraspinatus)
+ - Firm Hand Grasping	+ - Medial Rotation (subscapularis)
+ - Pain Resisted Wrist Extension	+ - Elbow Flexion (Biceps)
	+ - Supination (Biceps)
Knee	
+ - Valgus Stress Test (Medial Collateral Ligament)	+ - Varus Stress Test (Lateral Collateral Ligament)
+ - McMurray Test (Medial Meniscus)	(Extension = Lateral Movement)

Notes:

Physician Signature: _____ Date: _____

Pain Management Associates

Assignment of Benefits and LTD Power of Attorney

I hereby assign benefits and authorize payment directly to Pain Management Associates and/or its staff (hereinafter collectively "You") of any insurance benefits made as payment to me (or a minor for whom I am guardian) as reimbursement for services provided to me (or a minor for whom I am the guardian) for their services. I agree to immediately forward to this office any insurance payments which are made directly to me.

I, _____, irrevocably assign to you, Pain Management Associates, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically included filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize you to act on my behalf. I consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" set forth in the NJ Administrative Code. I request that the insurance carrier consent to my assignment of benefits Within 10 days of receipt otherwise it is deemed consented to.

As a medical provider I agree to attempt to reasonably comply with the PIP carrier's decision point review/pre-certification plan and to hold the patient harmless if I fail to comply with same, in consideration for the carrier's consent to this assignment.

In the even the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case in my name including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against the carrier in my name or in your name as a medical provider rendering services to me and designate your collection agency as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me.

I authorize you and your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release call such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

I understand that I am responsible for all fees charged, whether they are covered by insurance or not. Also, I am aware it is my personal responsibility to monitor insurance payments and maximums. If I receive any payment from an insurance carrier relating to the services rendered, I agree that I will hold such payment in trust for _____ and I also agree to send such payment to _____ within one week after receipt of same. I also agree to pay attorney's fees equal to 33 1/3% of the outstanding balance, plus court costs, in the event the account is turned over to an attorney for collection.

Patient's Signature: _____ Date: _____

Patient's Name (printed): _____

Pain Management Associates

305 West Grand Avenue Suite 500
Montvale, NJ 07645
Tel: 201-326-4777 • Fax: 201-391-1196

Acknowledgement of Patient Rights and Privacy Practices

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by our practice listed at the beginning of this notice, and how I may obtain access to and control this information.

Signature(Patient)

Date

Print Name

Pain Management Associates

305 West Grand Avenue Suite 500
Montvale, NJ 07645
Tel: 201-326-4777 Fax: 201-391-1196

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

_____ Complete record

_____ Records of care from _____ to _____ only

_____ Records of care concerning the following condition(s)

_____ Other. Specify: _____

_____ Confer with other person orally about information in my medical record

to the following person(s):

Name

Street

City State ZIP

The reasons or purposes for this release of information are:

I understand that you will provide this information within 15 business days from receipt of request, and you may charge a fee for preparing and furnishing this information.

The fee is waived because the records are to be used for supporting an application for disability or other benefits or assistance under Aid to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, and Federal Old-Age and Survivors Insurance. I have attached a statement which confirms that such an application or appeal has been filed or is pending.

Signed: _____ Date: _____
(Patient or person legally authorized to consent on patient's behalf)