CAROLINA PAIN CENTER

New Patient Intake Paperwork

Your completed intake paperwork helps our providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call (252) 222-3340 if you have any questions or are unsure how to complete any section of this form.

Today's Date _____

Patient Information

Your Name: _____ Social Security Number: _____

Street Address: _____ Date of Birth: _____ Age: _____

City/State/Zip: _____ Height: _____ Weight: _____ lbs

Email: _____ Gender: ❑ Male ❑ Female

Physical Address Same as Mailing? ❑ Yes ❑ No If not, _____

Preferred Phone: _____ ❑ Home ❑ Mobile ❑ Work

Secondary Phone: _____ ❑ Home ❑ Mobile ❑ Work

Email: _____ Driver's License # / State: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other _____

Race: ❑ American Indian or Alaskan Native ❑ Asian or Pacific Islander ❑ Black ❑ White ❑ Refuse to Report

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Refuse to Report Primary Language: ❑ English ❑ Spanish ❑ Other

Referral

Were you referred to our clinic by another physician? If so, whom? _____

↳ If not, how did you hear about us? ❑ Insurance Company ❑ Family ❑ Friend ❑ PCP
❑ www.CarolinaPainCenter.net ❑ Other Website _____

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City/State/Zip: _____

Primary Insurance Plan

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

Complete this box if you are *not* the policy holder for your primary insurance

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

Complete this box if you are *not* the policy holder for your secondary insurance

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim

Workers Comp Company: _____ Agent Name: _____

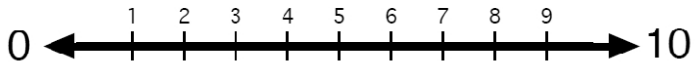
Phone number: _____ Fax number: _____

Claim Number: _____ Date of initial injury: _____

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 social 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



_____ What number on the pain scale (0-10) best describes your pain **right now**?

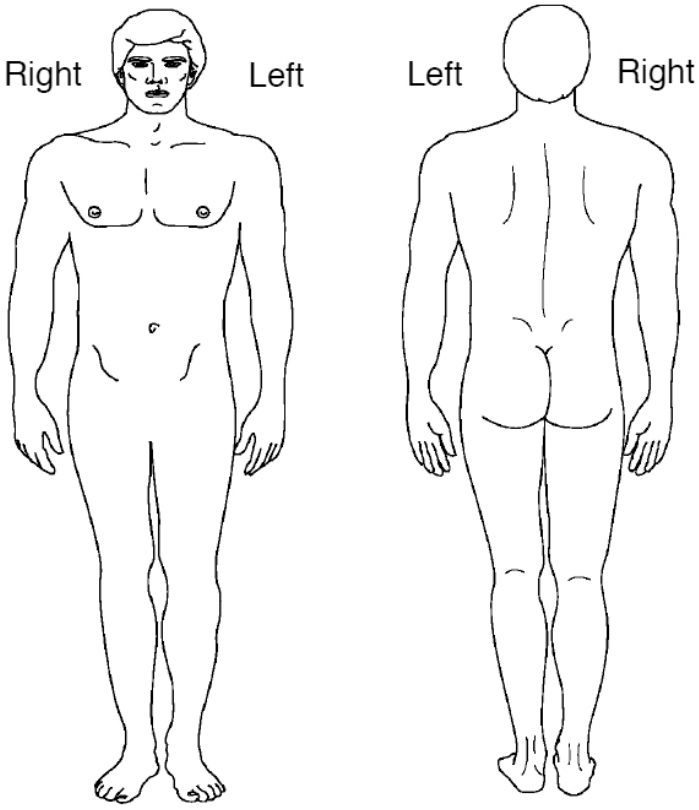
_____ What number on the pain scale (0-10) best describes your **worst pain**?

_____ What number on the pain scale (0-10) best describes your **least pain**?

_____ What number on the pain scale (0-10) best describes your **average pain over the last month**?

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

"N" = numbness
"S" = stabbing
"B" = burning
"P" = pins and needles
"A" = aching



Where is your worst area of pain located? _____

Does this pain radiate? If so, where? _____

Please list any additional areas of pain: _____

Onset of Symptoms

Approximately when did this pain begin? _____

What caused your current pain episode? _____

Is your pain the result of a Motor Vehicle Accident or Personal Injury (legal term describing injury sustained to your person by negligence of another) ❑ Yes ❑No

How did your current pain episode begin? ❑ Gradually ❑ Suddenly

Since your pain began, how has it changed? ❑ Decreased ❑ Increased ❑ Stayed the same

Pain Description

Check all of the following that describe of your pain:

❑ Aching	❑ Hot/Burning	❑ Shooting	❑ Stabbing/Sharp
❑ Cramping	❑ Numbness	❑ Spasming	❑ Throbbing
❑ Dull	❑ Shock-like	❑ Squeezing	❑ Tiring/Exhausting
❑ Tingling/Pins and Needles			

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

When is your pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings Middle of the night

In the past three months have you developed any new:

❑ Balance Problems ❑ Bladder incontinence ❑ Bowel incontinence ❑ Chills
❑ Difficulty Walking ❑ Fevers ❑ Nausea ❑ Vomiting
❑ Numbness/Tingling – Where?_____ ❑ Weakness – Where? _____

❑ I HAVE NOT RECENTLY DEVELOPED ANY OF THE ABOVE CONDITIONS.

Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints :

❑ MRI of the _____ Date: _____ Facility: _____

❑ X-ray of the _____ Date: _____ Facility: _____

❑ CT scan of the _____ Date: _____ Facility: _____

❑ EMG/NCV study of the _____ Date: _____ Facility: _____

❑ Other diagnostic testing: _____

❑ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

Pain Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:

❑ Chiropractic ❑ Physical Therapy ❑ Spine Surgery ❑ Psychological Therapy ❑ Podiatrist Treatment

❑ Discogram – (circle all levels that apply) Cervical / Thoracic / Lumbar

❑ Epidural Steroid Injection – (circle all levels that apply) Cervical / Thoracic / Lumbar

❑ Joint Injection – Joint(s) _____

❑ Medial Branch Blocks or Facet Injections – (circle all levels that apply) Cervical / Thoracic / Lumbar

❑ Nerve Blocks – Area/Nerve(s) _____

❑ Radiofrequency Ablation – (circle all levels that apply) Cervical / Thoracic / Lumbar

❑ Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant

❑ Trigger Point Injection – Where? _____

❑ Vertebroplasty / Kyphoplasty – Level(s) _____

❑ Other: _____

❑ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS.

Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? ❑ Yes ❑No

If so, have you ever had any adverse reaction to anesthesia? ❑ Yes ❑No

Which type of anesthesia did you react adversely to? Please check all that apply.

❑ Local anesthesia ❑ Epidural ❑ General anesthesia ❑ IV Sedation

Do you have a family history of adverse reactions to anesthesia? If so, to which of the following?

❑ Local anesthesia ❑ Epidural ❑ General anesthesia ❑ IV Sedation

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Abdominal Surgery

❑ Gallbladder removal _____

❑ Appendectomy _____

❑ Other _____

Female Surgeries

❑ Caesarean section _____

❑ Hysterectomy _____

❑ Laparoscopy _____

❑ Ovarian _____

❑ Other _____

Heart Surgery

❑ Valve replacement _____

❑ Aneurysm repair _____

❑ Stent placement _____

❑ Other _____

Joint Surgery

❑ Shoulder _____

❑ Hip _____

❑ Knee _____

Spine / Back Surgery

❑ Discectomy (levels)_____

❑ Laminectomy _____

❑ Spinal fusion (levels) _____

Other Common Surgeries

❑ Hemorrhoid surgery _____

❑ Hernia repair _____

❑ Thyroidectomy _____

❑ Tonsillectomy _____

❑ Vascular surgery _____

Please list any other surgeries and dates (attach an additional sheet if necessary)

❑ I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE.

Current Medications

Please indicate which (if any) of the following blood-thinners you are taking:
❑Aggrenox ❑ Coumadin / Warfarin ❑ Effient ❑Lovenox ❑ Plavix ❑ Pletal ❑ Pradaxa ❑ Prasugrel
❑ Ticlid ❑ Other _____

Please list *all* medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Allergies

Do you have any known drug allergies? ❑Yes ❑No

If so, please list all medications you are allergic to.

Medication Name	**Allergic Reaction Type**

Topical Allergies: ❑ Iodine ❑ Latex ❑ Tape Are you allergic to shellfish? ❑ Yes ❑ No

Family History

Mark all appropriate diagnoses as they pertain to your biological *MOTHER AND FATHER* only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother													
Father													

Other medical problems: _____

❑ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY. ❑ I AM ADOPTED (No Medical History Available).

Social History

Are you capable of becoming pregnant? ❑ Yes ❑No *If so*, are you currently pregnant? ❑ Yes ❑No

Highest level of education obtained: ❑ Grammar school ❑ High School ❑ College ❑ Post-graduate

Alcohol Use: ❑ Daily Limited Use ❑ History of Alcoholism ❑ Current Alcoholism
❑ Never Drinks Alcohol ❑ Drinks Alcohol Socially

Tobacco Use: ❑ Current Tobacco User Packs Per Day_____ How many years smoker _____
❑ Former Tobacco User ❑ Has Never Used Tobacco

Illegal Drug Use: ❑ Denies Any Illegal Drug Use ❑ Currently Using Illegal Drugs (Which: _____)
❑ Currently Uses Marijuana ❑ Currently Using Someone Else's Prescription Medications
❑ Formerly Used Illegal Drugs (not currently using) (Which: _____)

Have you ever abused narcotic or prescription medications? ❑ Yes ❑No (Which: _____)

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical
- ❑ Cancer – Type _____
- ❑ Diabetes – Type _____
- ❑ HIV / AIDS

Head/Eyes/Ears/Nose/Throat
- ❑ Headaches
- ❑ Migraines
- ❑ Head Injury
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Glaucoma

Cardiovascular / Hematologic
- ❑ Anemia
- ❑ Bleeding Disorders
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Mitral Valve Prolapse
- ❑ Murmur
- ❑ Phlebitis
- ❑ Poor Circulation
- ❑ Stroke
- ❑ Coronary Artery Disease
- ❑ Pacemaker/Defibrillator

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema / COPD
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Valley Fever

Gastrointestinal
- ❑ Bowel Incontinence
- ❑ GERD (Acid Reflux)
- ❑ Gastrointestinal Bleeding
- ❑ Constipation

Musculoskeletal
- ❑ Amputation
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Chronic Low Back Pain
- ❑ Chronic Neck Pain
- ❑ Chronic Joint Pain
- ❑ Fibromyalgia
- ❑ Joint Injury
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Phantom Limb Pain
- ❑ Rheumatoid arthritis
- ❑ Tennis Elbow
- ❑ Vertebral Compression Fracture

Genitourinary/Nephrology
- ❑ Bladder Infection(s)
- ❑ Dialysis
- ❑ Kidney Infection(s)
- ❑ Kidney Stones
- ❑ Urinary Incontinence

Hepatic
- ❑ Hepatitis A (active / inactive / unsure)
- ❑ Hepatitis B (active / inactive / unsure)
- ❑ Hepatitis C (active / inactive / unsure)

Neuropsychological
- ❑ Alcohol Abuse
- ❑ Alzheimer Disease
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Epilepsy
- ❑ Prescription Drug Abuse
- ❑ Multiple Sclerosis
- ❑ Paralysis
- ❑ Peripheral Neuropathy
- ❑ Schizophrenia
- ❑ Seizures
- ❑ Reflex Sympathetic Dystrophy/CRPS
- ❑ Other Diagnosed Conditions

_____

Review of Systems

Mark the following symptoms that you currently suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.*

Constitutional:
- ❑ Excessive Sweating
- ❑ Insomnia
- ❑ Unexplained Weight Gain
- ❑ Chills
- ❑ Excessive Thirst
- ❑ Low Sex Drive
- ❑ Unexplained Weight Loss
- ❑ Difficulty Sleeping
- ❑ Fatigue
- ❑ Night Sweats
- ❑ Weakness
- ❑ Easy Bruising
- ❑ Fevers
- ❑ Tremors

Eyes:
- ❑ Recent Visual Changes

Ears/Nose/Throat/Neck:
- ❑ Nosebleeds
- ❑ Dental Problems
- ❑ Recurrent Sore Throats
- ❑ Earaches
- ❑ Ringing in the Ears
- ❑ Hearing Problems
- ❑ Sinus Problems

Cardiovascular: ❑ Bleeding Disorder ❑ Chest Pain ❑ Deep Vein Thrombosis
❑ Fainting ❑ High Blood Pressure ❑ Irregular Heartbeat ❑ Lightheadedness
❑ Shortness of Breath During Sleep ❑ Swelling in the Feet

Respiratory: ❑ Cough ❑ Wheezing ❑ Pulmonary Embolism
❑ Shortness of Breath on Exertion/Effort ❑ Shortness of Breath at Rest

Gastrointestinal: ❑ Abdominal Cramps ❑ Acid Reflux ❑ Constipation
❑ Coffee Ground Appearance in Vomit ❑ Dark and Tarry Stools ❑ Diarrhea
❑ Hernia ❑ Vomiting

Musculoskeletal: ❑ Back Pain ❑ Joint Pain ❑ Joint Stiffness
❑ Joint Swelling ❑ Muscle Spasms ❑ Neck Pain

Genitourinary/Nephrology: ❑ Blood in Urine
❑ Decreased Urine Flow/Frequency/Volume ❑ Flank Pain ❑ Painful Urination

Neurological: ❑ Carpal Tunnel Syndrome ❑ Dizziness
❑ Headaches ❑ Numbness/Tingling ❑ Instability When Walking ❑ Tremors ❑ Seizures

Psychiatric: ❑ Depressed Mood ❑ Feeling Anxious ❑ Stress Problems
❑ Suicidal Thoughts ❑ Suicidal Planning

Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize Carolina Pain Center and any 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 my consent for Carolina Pain Center 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 Carolina Pain Center Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize the Carolina Pain Center to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Carolina Pain Center to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Carolina Pain Center will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

Signed:_____ Date: _____