



New Patient Packet (Initials: _____ DOB: ____/____/____)

Legal First Name: _____ Legal Middle Name: _____ Legal Last Name: _____

Former legal last name (if applicable): _____ DOB: ____/____/____ Age: ____ Gender: Male Female

Race: American Indian Asian Black/African American Hispanic/Latino White Other: _____

SSN#: _____ - _____ - _____ Street address: _____ City: _____ State: _____ Zip: _____

Please list two **confidential** phone numbers we can leave messages at and contact you by:

Home Phone #: (____) _____ Cell Phone #*: (____) _____

**By providing your Cell Phone number you authorize us to send you appointment reminders and other communications. Please see front desk if you would like to Opt Out.*

E-Mail: _____ (this will be your medical portal log-in)

Referring Physician: _____

Primary Care Physician: _____

Preferred Pharmacy (name and address): _____

INSURANCE INFORMATION

Please provide your insurance card(s) to the receptionist

Primary Insurance: _____ Patient's Relationship to Subscriber: Self Spouse Child Other: _____

Policy #: _____ Group #: _____

Subscriber's Name: _____

Subscriber's SSN#: _____ - _____ - _____ DOB: ____/____/____

Secondary Insurance: _____ Patient's Relationship to Subscriber: Self Spouse Child Other: _____

Policy #: _____ Group #: _____

Subscriber's Name: _____

Subscriber's SSN#: _____ - _____ - _____ DOB: ____/____/____

Is this a Worker's Compensation Injury? NO YES Phone # of your WC adjuster: (____) _____

If yes, what is the Date of Injury? ____/____/____ If yes, what is your WC Claim Number? _____

Do you have a pending lawsuit related to your pain? NO YES Which areas of your body are included in the lawsuit?: _____. Contact information of your attorney? _____

Is there a possibility that you are pregnant (female patients)? NO YES

EMERGENCY CONTACT INFORMATION/AUTHORIZED CALLER

List anyone below whom you wish to list as your Emergency Contact and authorize to discuss with us your medical condition and diagnosis (including treatments, payments, appointments, and health concerns). If the name is not listed on this form, we are legally unable to release any information to that person.

Name: _____ Relationship to patient: _____ Contact Phone #: (____) _____

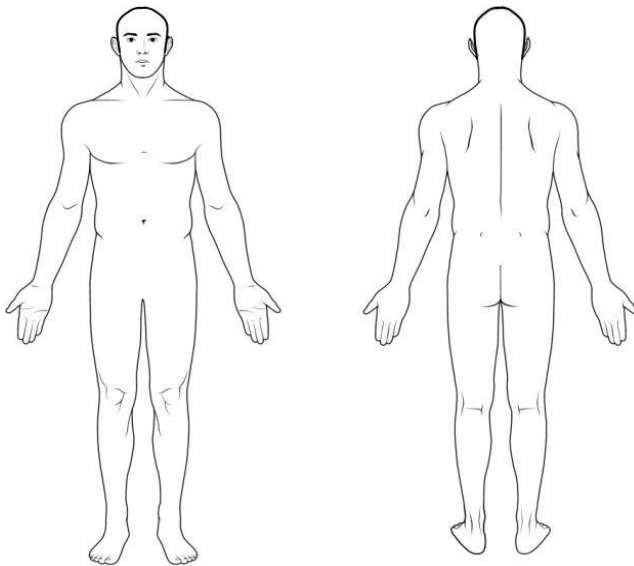
Name: _____ Relationship to patient: _____ Contact Phone #: (____) _____

Name: _____ Relationship to patient: _____ Contact Phone #: (____) _____

ADVANCED DIRECTIVE (please mark any applicable choices)

<input type="checkbox"/> I do not have an Advanced Directive	<input type="checkbox"/> I have a Living Will (provide a copy)
<input type="checkbox"/> I have a DNR/DNI (provide a copy)	<input type="checkbox"/> I have a Power of Attorney (provide a copy)
<input type="checkbox"/> I am an Organ Donor (provide a copy)	<input type="checkbox"/> I am a Surrogate Decision Maker (provide a copy)

Where is your pain located? (please mark the diagram below):



Describe your pain in your own words (please include the location and quality of the pain):

When did the pain start? (please provide date): _____

Since your pain began it has: Increased Decreased Remained the same Other: _____

What caused your pain? _____

Your pain is mostly: Constant Off and On Other: _____

How does your pain feel? Aching Burning Throbbing Shooting Sharp Dull Other: _____

Do you experience? Numbness Tingling Weakness Coldness Spasms Where? _____

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What makes your pain WORSE? (please list) _____

What makes your pain BETTER? (please list) _____

Indicate your pain level (please circle one number on each line):

Current pain level: (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

Least pain level last week: (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

Highest pain level last week: (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

Average pain level last week: (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

PREVIOUS IMAGING/DIAGNOSTIC TESTS RELATED TO YOUR PAIN

Please circle all that apply

X-ray (when/where? _____)	CT Scan (when/where? _____)	MRI (when/where? _____)
Myelogram (when/where? _____)	EMG/NCS (when/where? _____)	Other: _____

PREVIOUS TREATMENTS RELATED TO YOUR PAIN

Please circle all that apply

Bedrest	TENS unit/braces	Home exercises	Acupuncture
Chiropractor	Muscle relaxants	NSAIDs	Opioid medications
Trigger point injections	Epidural steroid injections	Joint injections	Nerve blocks
Facet joint injections	Radiofrequency ablations <small>(i.e. "Nerve Burning")</small>	Spinal cord stimulator	Pain pump
Physical Therapy: What body area(s): _____, Where done: _____, Dates done: _____			

ALLERGIES AND MEDICATIONS

Allergies: List ALL medications/drugs to which you are allergic: I am NOT allergic to anything

Medications you are allergic to?	Type of reaction

Medications you are allergic to?	Type of reaction

Please attach an additional sheet of paper if needed

PAST MEDICAL & SURGICAL HISTORY

Have you ever been diagnosed with or treated for any of the following conditions?

Cardiac

- Aortic regurgitation/stenosis
- Coronary artery disease (CAD)
- Heart attack (MI)
- Heart stent (angioplasty)
- Congestive heart failure (CHF)
- Irregular pulse (arrhythmia)
- Pacemaker/defibrillator (AICD)
- High blood pressure
- Deep vein thrombosis (DVT)
- Other: _____

Respiratory

- COPD
- Asthma
- Sarcoidosis
- Pneumonia
- Pulmonary embolism (PE)
- Sleep apnea
- Other: _____

Gastrointestinal

- Heartburn (GERD)

- Constipation
- Peptic ulcer disease
- Inflammatory bowel disease
- Crohn's disease
- Bulimia/anorexia
- Other: _____

Musculoskeletal

- Osteoporosis
- Arthritis (type: _____)
- Joint degeneration (DJD)
- Gout
- Fibromyalgia
- Scoliosis
- Psoriasis or lupus
- Spinal Stenosis
- Connective tissue disease
- Carpal tunnel syndrome
- Other: _____

Neurologic

- Headaches or migraines
- Diabetic neuropathy

- Myasthenia gravis
- Seizures or epilepsy
- Multiple sclerosis
- Alzheimer's/Parkinson's disease
- Stroke or TIA ("mini stroke")
- Other: _____

Psychiatric

- Anxiety or panic attacks
- Depression
- Bipolar disorder
- Schizophrenia
- Insomnia
- PTSD
- ADHD/ADD
- Other: _____

Other

- Diabetes (type: _____)
- Easy bleeding
- HIV/AIDS
- Hepatitis (type: _____)
- Cancer (type: _____)
- Kidney or liver disease
- Other: _____

Please list all surgeries that you have had:

Surgery type	Date (month and year)	Location (which hospital)

Please attach an additional sheet of paper if needed

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OPIOID RISK TOOL (ORT): mark each question as either “Yes” or “No”. Use “✓” to indicate your answer.

	Yes	No
Age 16 - 45?		
Has there been a history of preadolescent sexual abuse?		
Has there been a family history of alcohol abuse?		
Has there been a family history of illegal drug abuse?		
Has there been a family history of prescription drug abuse?		
Has there been a personal history of alcohol abuse?		
Has there been a personal history of illegal drug abuse?		
Has there been a personal history of prescription drug abuse?		
Has there been a personal history of ADHD, OCD, bipolar or schizophrenia?		
Has there been a personal history of depression?		

PHQ-2

Over the last 2 weeks, how often have you been bothered by any of the following?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, hopeless	0	1	2	3

Would you like a referral for a mental health professional? NO YES Comment: _____

FALL ASSESSMENT

Have you had 2 or more falls in the past year? NO YES

Have any falls in the past year resulted in injury? NO YES

TOBACCO USE (including e-cigarettes and vapes)

I never smoked I used to smoke I currently smoke. When did you start? _____

If smoker: How often do you smoke?	
Daily	
4 or more times per week	
2-3 times per week	
1 or less time per week	

If smoker: How many cigarettes do you smoke per day?	
5 or less	
6-10	
11-20	
21-30	
Over 31	

If smoker: How soon after you wake up do you smoke?	
Within 5 minutes	
Within 6-30 minutes	
Within 31-60 minutes	
After 60 minutes	

If smoker: Are you interested in quitting?	
Ready to quit	
Thinking about quitting	
Not ready to quit	

_____/_____/_____
Patient’s or Authorized Representative’s Name and Signature

_____/_____/_____
Date