New Patient Registration

PHONE: 563-344-1050 FAX: 563-424-4579

PLEASE READ THESE INSTRUCTIONS: *We want your visit with your healthcare provider to be as productive and beneficial as possible. When filling out this form, please keep in mind the importance of the information you are providing. Although this form is time consuming, a lot of information is needed to obtain a complete picture of your pain problem. We appreciate your time and help!*

HOW DID YOU HEAR ABOUT OUR CLINIC:

- ☐ Family Member
- ☐ Facebook
- ☐ TV
- ☐ Insurance Company
- ☐ Friend
- ☐ Twitter
- ☐ Radio
- ☐ Other
- ☐ Physician/Provider
- ☐ Website
- ☐ Employer

	Yes	No	If yes, please describe briefly
Were you referred to our clinic by another provider?			
Are you on disability for pain?			If yes, since when:
Is the pain the result of an accident?			If yes, describe:
Is the pain the result of your work, or did it occur on the job?			Worker Comp carrier Case worker

NOTE: *If you have recent images (less than 18 months) such as MRI's, X-rays or CT's of the affected area, please obtain a copy of the images on disk to bring to your appointment.*

GOAL:

Why are you here today? _____

What is your goal for this appointment? _____

_____

SOCIAL HISTORY:

Please answer the following; if you respond yes to any, please give brief explanation.
Have you ever, or do you do any of the following?

	Yes	No	If yes, please answer questions
Smoke			How many per day?
			For how many years?
			If previously smoked, when did you quit?
Drink alcohol			How many per day? Per week?
Use illegal substances			Which ones?
Had a felony conviction			What kind?
Been in a motor vehicle accident			When? How many?

SOCIAL HISTORY, continued:

	Yes	No	If yes, please answer questions
Been in drug rehab or had a DUI			When?
Been in alcohol rehab or had a DUI			When?
Work at heights			
Been discharged from another pain clinic			Reasons:
Marital status: ☐ married ☐ single ☐ divorced ☐ widowed			
Highest level of education: ☐ grade school ☐ high school ☐ college ☐ graduate school			

FAMILY HISTORY:

	Yes	No	Family Member
Back pain			
Hip fracture (broken hip)			
Depression			
Psychiatric illness			
Suicide (or attempted)			
Alcoholism			
Drug Abuse			
Other			

MEDICAL HISTORY:

Have you ever had any of the following?

	Yes	No	Comments
Sleep apnea			
Stroke			
High Blood Pressure			
Diabetes			
Thyroid disease			
Heart attack or heart valve malfunction			
Irregular heartbeat			
Heart failure			
COPD			
Asthma			
Arthritis (if yes, please select at right)			☐ rheumatoid ☐ degenerative ☐ psoriatic
Fibromyalgia			

MEDICAL HISTORY, continued:

	Yes	No	Comments
Osteoporosis			
Gastrointestinal disease (bleeding ulcers, irritable bowel, inflammatory bowel)			
Liver disease			
Kidney problems (stones, failure)			
HIV or Hepatitis (list type)			
Cancer (if yes, list where and type)			
Blood clotting problems (clot in leg, clot in lung)			
Neurological disease (if yes, please select at right)			☐ Parkinson ☐ MS ☐ CP ☐ seizures ☐ neuropathy ☐ migraines
Psychiatric disease (if yes, please select at right)			☐ depression ☐ anxiety ☐ bipolar disorder ☐ schizophrenia
If psychiatric problems, who is your provider for this?			
**If female, menstrual problems			
History of pre-adolescent sexual assault			
Other			

SURGICAL HISTORY:

Please list all surgeries you have had in spaces below. Use separate sheet if needed.

Type of Surgery	Year	Surgeon	Where (town)

MEDICATION HISTORY:

Please list all medications you are currently taking. Please list any side effects of the medication. Include "over the counter drugs", vitamins, supplements, herbs, and birth control pills. Use separate sheet if needed.

Name	Strength	How Often	Side Effects

Please list any medications you have taken in the past for pain, any side effects and if it relieved your pain.

Name	Strength	How long took	Side effects	Did it relieve your pain?

Please list all allergies you have. Please include the reaction to any medications listed.

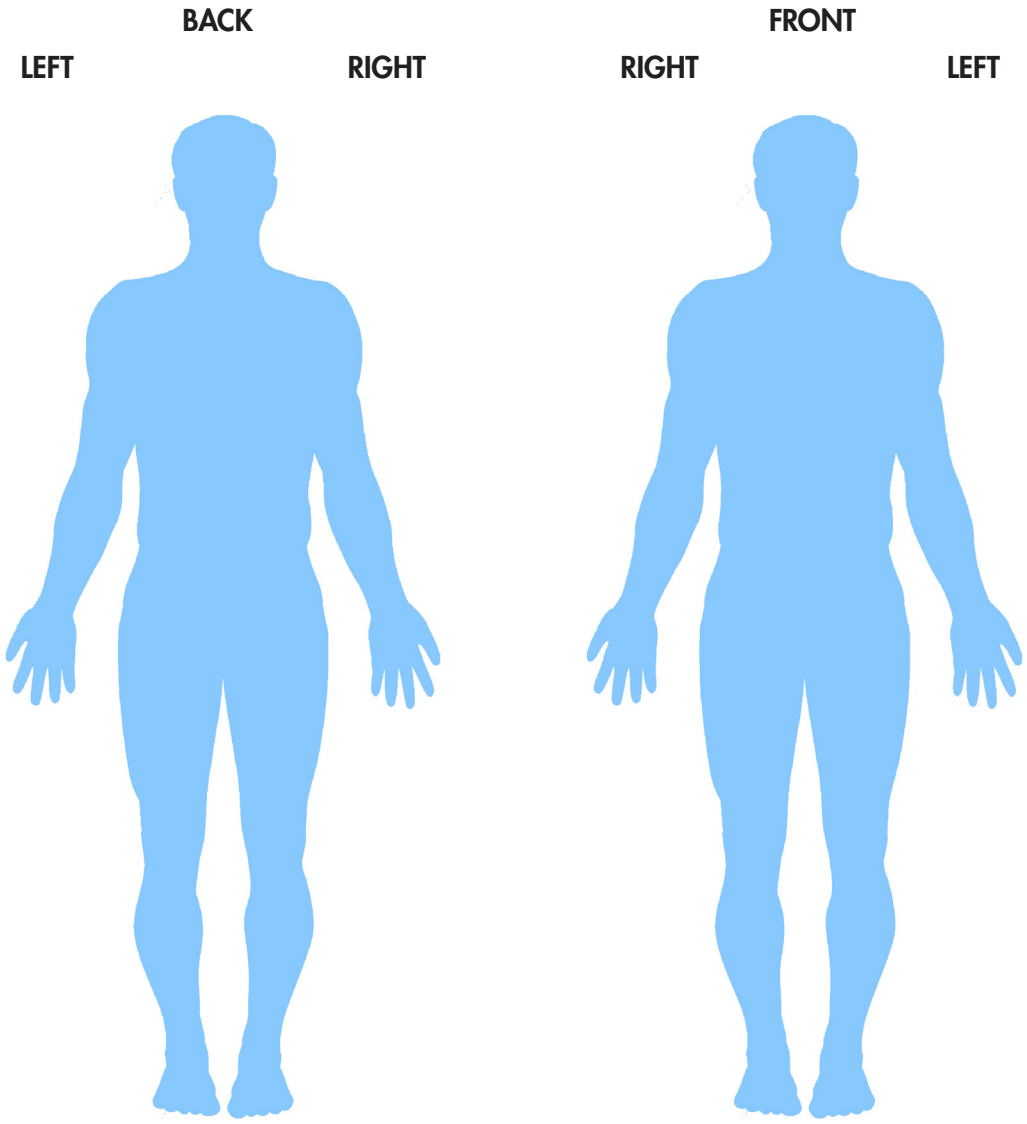
Allergy	Reaction

RATE YOUR PAIN FROM 0 – 10:

(0–10) ____ Best ____ Worst ____ Average ____ Today

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

On the diagram, shade in the areas where you feel pain. Put an X (only up to 2) on the two areas that hurt the most. Please write a #1 near the worst painful area; a #2 by the second painful area.



PAIN HISTORY:

Describe the pain: ☐ achy ☐ sharp ☐ burning ☐ throbbing ☐ squeezing
When did the pain start? (enter number) weeks ago months ago years ago

	Yes	No	If yes, please answer:
Has the pain been there for more than 6 months?			If so, is it getting worse?
Is there numbness?			Where?
Is there tingling?			Where?
Is the pain constant?			
If so, does it change in strength?			
Is the pain intermittent?			
If so, when does it occur?			
If so, what causes it to start?			
Is it happening more often?			
Does pain interfere with sleep?			
If yes, how long do you sleep at night?			
Do you take medication to help you sleep?			
If yes, what?			
Who prescribed it?			
What specific position makes it worse? (check all that apply)	☐ sitting ☐ standing ☐ lying on side ☐ lying on back ☐ lying on stomach		
How would you describe your emotional health? (check all that apply)	☐ happy/cheerful ☐ optimistic ☐ anxious ☐ angry ☐ worried ☐ depressed ☐ indifferent ☐ hopeless		
What have you tried to relieve your pain? (check all that apply)	☐ ice ☐ heat ☐ chiropractic ☐ acupuncture ☐ braces ☐ surgery ☐ injections		

TESTING	When	Where	Results
Plain X-rays			
MRI			
CT scan			
EMG/NCV studies			

PAIN HISTORY, continued:

This is a list of symptoms that you may have. If you had these in the last 6 months, mark yes. If these are older symptoms that have now resolved, then mark no. We are only interested in those symptoms that are a persistent problem, occur frequently, and are especially bothersome for you.

Constitutional:	Yes	No
Fatigue		
Night sweats		
Weight loss		
Excessive sweating		
Inability to sleep		

Constitutional, con't.:	Yes	No
Chills		
Weight gain		
Change in appetite		
Recent illness		
Fever		

Eyes:	Yes	No
Double vision		
Light hurts eyes		
Blurry vision		
Watery eye(s)		

Dermatologic:	Yes	No
Rash		
Skin growth		
Sores		
Swelling		

Ears, Nose, Throat, Neck:	Yes	No
Sore throat		
Runny nose		
Dry mouth		
Lump on neck		

Ears, Nose, Throat, Neck, con't.:	Yes	No
Neck stiffness		
Sinus congestion		
Snoring		

Musculoskeletal:	Yes	No
Joint swelling		
Joint redness		
Joint pain		
Muscle pain		
Any broken bone		

Musculoskeletal, con't.:	Yes	No
Joint warmth		
Joint stiffness		
Muscle weakness		
Any bone disease		

Cardiovascular:	Yes	No
Chest pain, pressure, tightness		
Lightheaded		
Swelling in legs		

Cardiovascular, con't.:	Yes	No
Heart beating fast or irregular		
Short of breath when lying flat		

Respiratory:	Yes	No
Shortness of breath		
Wheeze		
Cough		
Bloody sputum		

Endocrine:	Yes	No
Heat intolerance		
Always thirsty		
Low sex drive		
Cold intolerance		
Menopause		

Gastrointestinal:	Yes	No
Pain or difficulty swallowing		
Nausea		
Weight loss		
Vomiting blood		
Constipation		
Reflux		

Gastrointestinal, con't.:	Yes	No
Heartburn		
Vomiting		
Diarrhea		
Abdominal pain		

Hematologic:	Yes	No
Prolonged bleeding after cut		
Bleeding gums		
Chemotherapy		

Hematologic, con't.:	Yes	No
Lumps in armpit or groin		
Low blood counts		
Radiation		

Genitourinary:	Yes	No
Blood in urine		
Trouble emptying bladder or starting urine flow		
Erectile dysfunction		

Genitourinary, con't.:	Yes	No
Menstrual irregularity		
Loss of control or holding urine		
Lumps		

Neurologic:	Yes	No
Walking incoordination		
Shaky hands		
Spasms		

Neurologic, con't.:	Yes	No
Hand incoordination		
Drowsiness		
Room spinning		

Emotional/Psychiatric:	Yes	No
Depressed or down feelings		
Lack of appetite		
Suicidal thoughts		

Emotional/Psychiatric, con't.:	Yes	No
Lack of interest		
Anxiety		
Hallucination		

CONTACT INFORMATION:

Best phone number for us to leave appointment reminders and detailed messages: _____

CERTIFICATION AND WRITTEN PERMISSION FOR TREATMENT:

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

b. *I authorize Pain Centers of Iowa, P.C. (PCI), and any associate, assistants, and other health care providers it may deem necessary to treat my condition. I understand that no warranty or guarantee has been made regarding a specific result or cure. I agree to abide by the treatment plan and participate in the care rendered under it to maximize its effectiveness.*

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b. I authorize Pain Centers of Iowa, P.C. (PCI), and any associate, assistants, and other health care providers it may deem necessary to treat my condition. I understand that no warranty or guarantee has been made regarding a specific result or cure. I agree to abide by the treatment plan and participate in the care rendered under it to maximize its effectiveness.

c. I give my written permission to PCI to retrieve and review my medication history. I understand this will become part of my medical record. I give my permission for PCI to submit comments to Prescription Monitoring Programs sanctioned by Iowa and surrounding states as PCI deems reasonable.

d. I acknowledge that I have had an opportunity to review PCI Notice of Privacy Practices which is available at its various office locations for public inspection and on its website. The notice describes how my protected health information may be used and disclosed to other parties, and how I can access my medical records.

e. I authorize PCI 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 health care provider, primary care provider, any health care provider to which I am referred, and to my pharmacy. I also authorize PCI to release any information required in obtaining procedure authorization or the processing of any insurance claim.

f. I understand that PCI will not release my Protected Health Information to any other (including family members) without my completion of a written "Patient Authorization for Use and Disclosure of Protected Health Information" form available at each office location and the website.

PATIENT DEMOGRAPHICS

Patient Full Legal Name:			
Male Female	Date of birth:	Social Security #	
Patient mailing address:			
Race: American Indian or Alaska native Asian Black or African American Native Hawaiian or Other Pacific Islander White			
Ethnicity: Hispanic or Latino Not Hispanic or Latino			
Primary Language:			
Primary Physician's Name:			
Referring Physician's Name:			
Primary Insurance:	ID#	Group or Plan #	
Name of the subscriber if not self:			
Subscriber DOB:	Relationship to subscriber:		
Secondary Insurance:	ID#	Group or Plan #	
Name of the subscriber if not self:			
Subscriber DOB:	Relationship to subscriber:		
Current Pharmacy:			
Address:		Phone:	

Please note that if this consult is the result of an auto accident you will be considered a cash pay patient and will be given the proper documentation to self-bill your carrier.

Signature: _____ Date: _____