NC Pain Management Services PA

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Burlington, NC 27215
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ncpainmanagement.com

Dear New Fast-Track Patient:

We would like to welcome you to our practice. We realize that you have a choice when it comes to selecting a Pain Specialist. Thank you for choosing us. We are dedicated to providing you with the best possible medical care. Excellence is our commitment.

To help you with your upcoming visit, we need some important information. We appreciate you taking the time to fill out these forms. Simply follow these three easy steps:

☐ STEP 1:

Please check off each completed item. When finished, **do not mail these back**, instead bring them personally with you to your appointment.

☐ Completed **Form 1: Patient Demographics.** (2 pages)

☐ Completed **Form 2: Medical Questionnaire.** (1 page)

☐ STEP 2:

Call us at **(336) 538-7180**. Let us know when you have completed your forms to setup your appointment. Write below your appointment date and time.

Date:_____ Time:_____

☐ STEP 3:

Please bring the following items with you, to your initial evaluation:

☐ Bring the completed Forms.

☐ Bring all of your current medications.

Thank you for choosing our practice. We look forward to assisting you with your healthcare.

NC Pain Management Services PA

Reminders:

- If you are **unable to keep your appointment**, we would appreciate your call to cancel it.
- Please come in 15 to 20 minutes prior to your appointment time.
- Do not schedule any other appointments on the day of your evaluation.
- Your **initial visit** is an **evaluation only**; **do not expect** to receive any **controlled substances** on your first appointment.

NC PAIN MANAGEMENT SERVICES, PA
Francisco A. Naveira, MD

FORM 1: PATIENT DEMOGRAPHICS (DATA QUESTIONNAIRE)

If there is any information that does not apply to your case, please leave the space blank.

Patient Information: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Last name:_____ First:_____ Middle initial:_____

Address:_____ City:_____ State:____ Zip:_____

Home phone:_____ Work phone:_____ Cell phone:_____

E-mail:_____

Date of birth:_____ Employer:_____ SS#:_____

Sex: ☐ Male ☐ Female

Spouse/Parent/Guardian Information:

Last name:_____ First:_____ Middle initial:_____

Date of birth:_____ Employer:_____ SS#:_____

Home phone:_____ Work phone:_____ Cell phone:_____

Policy Holder: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐Other:_____

Policy Holder Information (only if different from above):

Last name:_____ First:_____ Middle initial:_____

Date of birth:_____ Employer:_____ SS#:_____

Home phone:_____ Work phone:_____ Cell phone:_____

Emergency Contact:

Last name:_____ First:_____ Middle initial:_____

Home phone:_____ Work phone:_____ Cell phone:_____

Referred by: ☐ Doctor:_____ ☐ Friend/Family:_____

☐ Nurse:_____ ☐ Other:_____

Primary Insurance:

Insurance carrier:_____ Patient ID#:_____

Group#:_____ Phone#:_____

Secondary Insurance:

Insurance carrier:_____ Patient ID#:_____

Group#:_____ Phone#:_____

Tertiary Insurance:

Insurance carrier:_____ Patient ID#:_____

Group#:_____ Phone#:_____

Liability Injury Case:

Lawyer's name:_____

Office phone:_____ Fax number:_____

Date of Injury:_____ Liability Claim#:_____

Worker's Compensation Case:

Case Worker's name:_____

Office phone:_____ Fax number:_____

Date of Injury:_____ W.C. Claim#:_____

Assignment of benefits: I hereby authorize insurance carrier(s) to assign any benefits directly to "NC Pain Management Services, PA".

Patient's Signature:_____ Date:_____

Medical Records Release: I authorize the release of any and all medical or other information necessary to process my claims.

Patient's Signature:_____ Date:_____

Alamance Regional Medical Center

1240 Huffman Mill Road
Burlington, NC 27216
Pain Management Centers
Medication Assessment Form

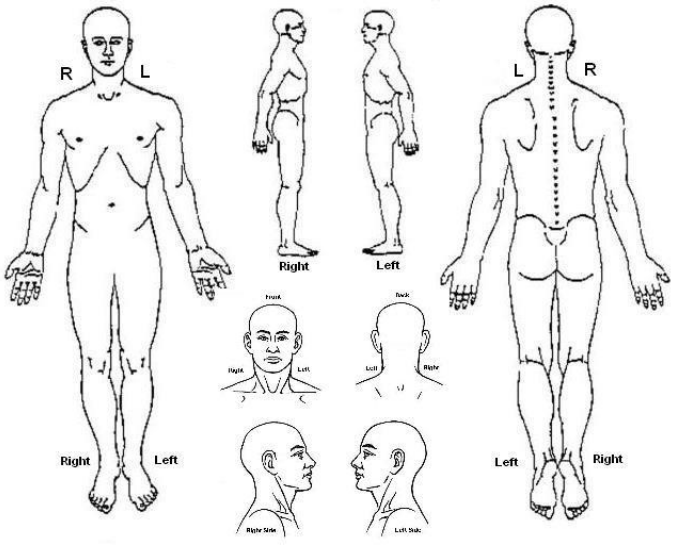
Fast Track – History

Section 1 - Onset and Duration

___**Sudden** onset
___**Gradual** onset
___ **Date** of onset: _____

How long have you had Pain?
_____
(Days, Months, Years)

Section 2 – Location – *Please shade all areas where you have pain*



Section 3 – Cause of your pain – *What started your pain?*

___Work-related accident or event **Date:**_____
___Motor vehicle accident **Date:**_____
___Unknown
___Other (Briefly **explain**):

Section 4 - Severity

___Getting Better
___Getting Worse
___No change since its onset

Please indicate using a scale from **0** to **10**, how bad your pain is:
1) At its **worse**:_____**/10**
2) At its **best**:_____**/10**
3) **Now**:_____**/10**
4) Most of the time:_____**/10 (Average)**

Section 5 – Associated Problems – *Which of these do you have?*

___**Inability to control bladder**
___**Inability to control bowel**
___Numbness
___Weakness
___**Sweating**
___**Swelling**
___**Temperature changes**
___Tingling

Section 6 – Quality – *Which of the following describes your pain?*

___**Constant**
___Intermittent
___**Burning**
___Cramping
___Sharp
___Dull
___Deep
___Superficial
___Pulsating
___Tender
___Throbbing
___Tingling
___Shooting
___Stabbing
___Toothache-like
___Uncomfortable
___Work-related

Section 7 - Alleviating Factors – *What makes your pain better?*

___Cold packs
___Hot packs
___Lying down
___Medications
___Resting
___Sitting
___Sleeping
___Standing
___Walking
___Using a Brace

Section 8 – Previous Examinations or Tests

___**Bone Scan**
___**CT- Myelogram**
___**Discogram**
___**CT Scan**
___Nerve Blocks
___**MRI Scan**
___Myelogram
___X-rays
___**Nerve Conduction Test**
___Neurosurgical Evaluation
___Orthopedic Evaluation
___**EMG/PNCV**

Section 9 – Previous Treatments – *Please draw a star (✱)next to those that helped.*

___Chiropractic manipulations
___Epidural steroid injections
___Facet blocks
___Narcotic medications
___Physical therapy
___Steroid Treatments (by mouth)
___TENS
___Traction
___Trigger point injections

Section 10 – Cardiovascular History

___Heart Trouble
___Abnormal Heart Rhythm
___Daily Aspirin intake
___High Blood Pressure
___Chest Pain
___Heart Attack **Date:**_____
___Heart Surgery
___Pacemaker or defibrillator
___Heart Failure
___Congestive Heart Failure
___Heart Murmur
___Heart Valve Problems
___Heart Catheterization
___Blood Thinners (Coumadin, Ticlid, Aspirin, etc.)
___Need antibiotics prior to dental work

Section 11 – Neurological History

___Seizure disorders
___Convulsions
___Stroke
___Incontinence (Urinary or Fecal)
___Epilepsy

Section 12 – Pulmonary or Respiratory History

___Lung Problems
___Asthma
___Emphysema
___Shortness of breath
___I have been told that I **snore**
___Smoker
___Bronchitis
___Sarcoidosis
___Exposure to Tuberculosis
___**Sleep apnea**

Section 13 – Hematological History

___Bruise easily
___Easy Bleeder
___Hemophilia
___Coagulation Disorder
___Low platelet count

Section 14 – Endocrine History

___Diabetes (IDDM, NIDDM)
___Thyroid Disease (Low, High)

Section 15 – Physician Notes

___NPO x ____hrs.
___Informed consent obtained

Reviewing Doctor's Signature:

I hereby certify that I have personally filled out this Form, both, Part I and Part II, to the best of my abilities. I also recognize that this document is essential for the correct diagnosis and treatment of my condition. I also understand that if any of this information is found to have been omitted or manipulated, this alone would be grounds for my dismissal from this program.

Name: _____

Patient's Signature: