NC PAIN MANAGEMENT SERVICES

Francisco Naveira, MD
Board-Certified in Anesthesiology (DABA)
Board-Certified in Pain Medicine (DABPM)
Board-Certified in Interventional Pain Management (DABIPP)

Dear New 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.** (4 pages)

☐ 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.

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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:_____

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FORM 2: MEDICAL QUESTIONNAIRE **PATIENT'S NAME: _____**

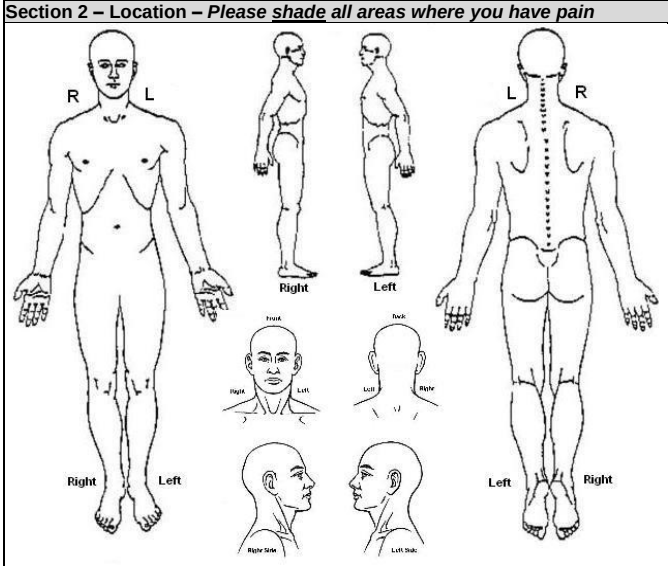
Part I – History of Present Illness

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:**_____
___Is this under "**Workers Compensation**"? Yes_____ NO_____
___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 – Timing –*When does the character of the pain get worse?*

___Not influenced by the time of the day.
___Mornings
___Afternoons
___Night
___**During** activity or exercise
___**After** activity or exercise
___After immobility

Section 6 – Aggravating Factors – *What makes your pain worse?*

___Bending
___Bowel Movements
___Climbing
___Eating
___Intercourse (Sex)
___Kneeling
___Lifting
___Motion
___Nerve Blocks
___**Sitting** (prolonged?)
___Standing (prolonged?)
___Squatting
___Stooping
___Surgery made it worse
___Twisting
___Walking
___Walking uphill
___Walking downhill
___Working

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

___Acupuncture
___Bending
___Biofeedback
___Stretching
___Cold packs
___Hot packs
___Hypnosis
___Lying down
___Medications
___Nerve Blocks
___Resting
___Sitting
___Sleeping
___Standing
___TENS
___Using a Brace
___Relaxation Therapy
___Physical Therapy
___Warm showers or baths
___Chiropractic manipulations
___Walking

Section 8 – Associated Problems – *Which of these do you have?*

___Color changes
___Constipation
___Day-time Cramps
___**Night-time Cramps**
___Depression
___Dizziness
___Erectile dysfunction
___Fatigue
___Impotence
___Inability to concentrate
___**Inability to control bladder**
___**Inability to control bowel**
___Nausea
___Numbness
___Personality changes
___Sadness
___Spasms
___Suicidal Ideations
___**Sweating**
___**Swelling**
___**Temperature changes**
___Tingling
___Vomiting
___Weakness
___Pain Wakes me up
___Pain does not let me sleep

Section 9 – Quality – *Which of the following describes your pain?*

___Aching
___Agonizing
___Annoying
___**Burning**
___**Constant**
___Intermittent
___Cramping
___Cruel
___Deep
___Disabling
___Distressing
___Dreadful
___Dull
___Exhausting
___Fearful
___Feeling of constriction
___Feeling of Weight
___Getting longer
___Getting shorter
___Heavy
___Horrible
___Hot
___Itching
___Lancinating
___Nagging
___Pressure-like
___Pulsating
___Punishing
___Sharp
___Shooting
___Sickening
___Splitting
___Stabbing
___Superficial
___Tender
___Throbbing
___Tingling
___Tiring
___Toothache-like
___Uncomfortable
___Work-related

Section 10 – Previous Examinations or Tests

___Biopsy
___**Bone Scan**
___CPT
___**CT Scan**
___**CT-Myelogram**
___**Discogram**
___**EMG/PNCV**
___Endoscopy
___Epidurogram
___**MRI Scan**
___Myelogram
___Nerve Blocks
___Spinal Taps
___X-rays
___**Nerve Conduction Test**
___Neurological Evaluation
___Neurosurgical Evaluation
___Orthopedic Evaluation
___Chiropractic Evaluation
___Psychiatric Evaluation

Section 11 – Previous Treatments – *Please draw a star (✱)next to those that helped.*

___Biofeedback
___Chiropractic manipulations
___Cryoanalgesia
___Epidural steroid injections
___Facet blocks
___Hypnotherapy
___Morphine pump
___Narcotic medications
___Physical therapy
___Pool exercises
___Radiofrequency
___Relaxation therapy
___Spinal Cord Stimulator
___Steroid Treatments (by mouth)
___Strengthening exercises
___Stretching exercises
___TENS
___Traction
___Trigger point injections

Section 12 – Additional information

1) Number of **visits** to the **Emergency Room** in the past 2 month: _____
2) Number of **Physicians** that you have seen for this problem: _____
3) Have you ever been seen by another pain management specialist or in another Pain Clinic? Yes_____ NO____
4) Is there, or will there ever be any **litigation** related to your condition? Yes_____ NO____
5) Are you considering pursuing **disability**? Yes____ NO____

Section 13 – Physician Notes

Reviewing Doctor's Signature:

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Part II - Review of Systems

Section 14 – 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 15 – 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 16 – Neurological History
___Seizure disorders
___Convulsions
___Epilepsy **Date** of last attack: _____
___Stroke Residual deficits or weakness:
___Peripheral Neuropathy
___Spina Bifida
___Scoliosis (Crooked Spine)
___Incontinence (Urinary or Fecal)
___Tethered Cord Syndrome

Section 17 – Psychological-Psychiatric History
___Psychiatric Disorder
___Bipolar Disorder
___Anxiety
___Depression
___Panic Attacks
___Personality Disorder
___Suicidal Ideations
___Attempted Suicide
___History of having been abused
___Insomnia

Section 18 – Gastrointestinal History
___Ulcers
___Hiatal Hernia
___Reflux or Heartburn
___Irritable Bowel Syndrome (IBS)
___Hepatitis
___Cirrhosis
___Pancreatitis
___Constipation

Section 19 – Genitourinary History
___Kidney disease
___Renal Failure (Dialysis?)
___Kidney Stones
___Blood in urine
___Recurrent urinary tract infections

Section 20 – Hematological History
___Anemia
___Bruise easily
___Easy Bleeder
___Hemophilia
___Sickle Cell Disease or Trait
___Coagulation Disorder
___Low platelet count

Section 21 – Endocrine History
___Diabetes (IDDM, NIDDM)
___Thyroid Disease (Low, High)

Section 22 – Rheumatologic History
___Lupus
___Osteoarthritis
___Rheumatoid arthritis
___Fibromyalgia
___Myositis / Polymyositis
___Chronic Fatigue Syndrome

Section 23 – Musculoskeletal History
___Myasthenia Gravis
___Muscular Dystrophy
___Multiple Sclerosis
___Malignant Hyperthermia

Section 24 – Other Significant History
___Weight loss
___Exposure to AIDS
___Cancer: (What kind/location?) _____
___Other:
___Problems with Anesthesia

Section 25 – Social History
___Married ___Single ___Divorced ___Widower ___Separated
Number of Children: _____ ___No Children
___**Smoking**: I have smoked as many as ___Packs of cigarette per day
I started smoking when I was _____years old. (Pack-year hx)
___I quit smoking ____ (years, months, days) ago.
___Never smoked
___Alcohol abuse
___Alcoholism
___Drug Addiction
___illegal drug use
___I have been told that I **snore**
___Convicted of "Driving Under the influence"
___Accused or convicted of **any** crimes

Section 26 – Work History
___Working (Part-time, Full-time) ___Retired
___Type of work:_____
___Disabled since_____(Date), due to:_____
___Out of work due to pain since_____(Date)
___I quit going to work on my own.
___I was given a "work excuse" by my Doctor (indicate name below)

Section 27 – Surgical History
___Heart Surgery ___Neck Surgery ___Knee Surgery
___Lung Surgery ___Back Surgery ___Hip Surgery
___Other:

Section 28 – Family History – Please indicate affected family member
___Alcoholism
___Chronic Pain
___Drug Addiction
___Alcohol or Drug-related Deaths
___Cancer (indicate what part of the body?)
___Diabetes
___High Blood Pressure
___Sudden Death (Unexplained)

Section 29 – Physician Notes (DO NOT WRITE IN THIS AREA)
VAS Goal: _____/10

____**PCP**

Functional Goals:

Time-line:

Expectations: R U

Reviewing Physician's Signature:

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ALLERGIES:

Agent/Medication that you are allergic to.	Type of reaction (What happens when exposed to it.)

PRIMARY CARE PHYSICIAN:

Name	Telephone Number	Fax Number

PHYSICIANS INVOLVED IN YOUR CARE: (IN THE PAST 2 YEARS)

Specialty	Name	Telephone Number
Neurosurgeon (Current**)**		
Neurosurgeon (Past**)**		
Neurologist		
Orthopedic Surgeon (Current**)**		
Orthopedic Surgeon (Past**)**		
Rheumatologist		
Pain Specialist (Previous**)**		
Psychiatrist		
Other:		

MEDICATIONS CURRENTLY TAKEN:

Name of medication	Dosage	How you take it.	Reason for medicine.	Prescriber.

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STATEMENT OF ACCURACY:

I hereby certify that I have personally filled out all 4 pages of this ***Form 2: Medical Questionnaire***, to the best of my abilities. I also recognize that the accuracy of this document is essential to safely establish a correct diagnosis and effective treatment.

Name of person filling out Form: _____

Patient/Guardian's Signature:_____ Date:_____