

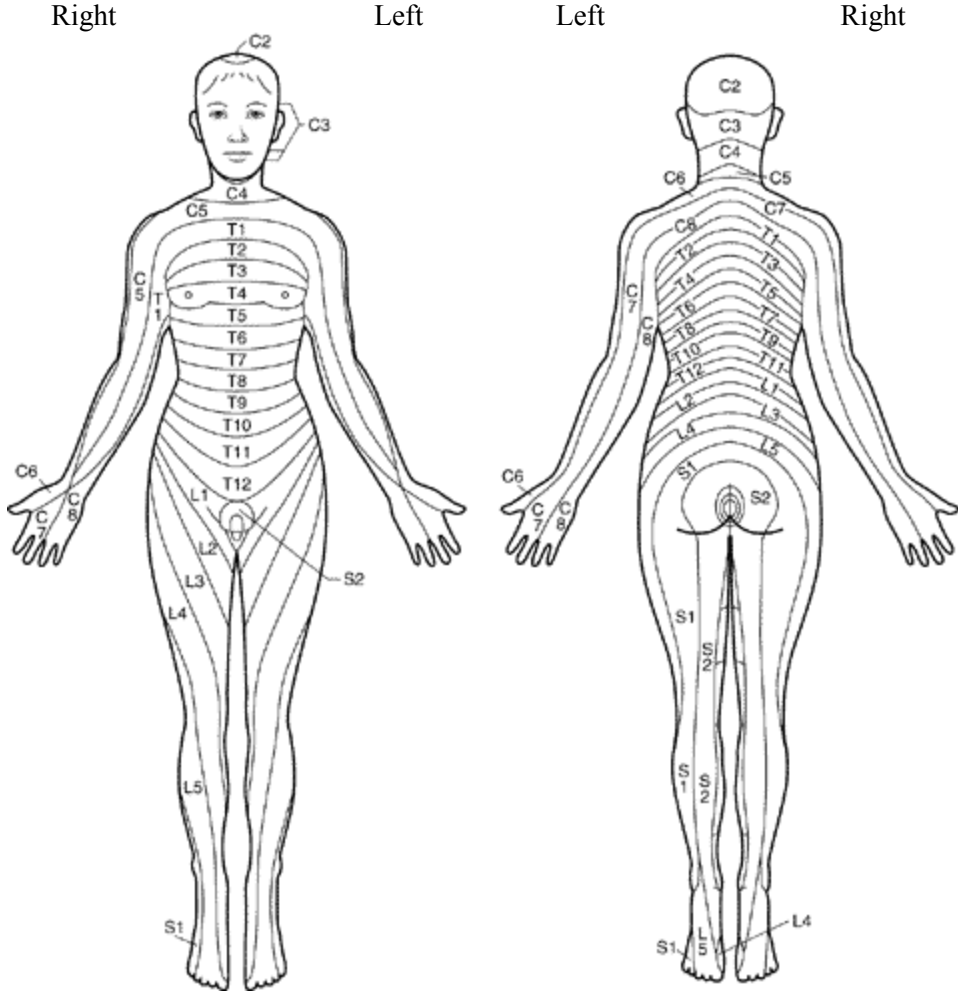


New Patient Intake Form

Name _____
Primary Care M.D. _____

Date _____
Referring Provider _____

1) Pain Location



2) Onset

- a) when started _____
- b) how started, initiating trauma, motor vehicle accident etc _____

3) Intensity (put a cross where your pain level is)

a) Now 0 ___ 1- ___ 2- ___ 3- ___ 4- ___ 5- ___ 6- ___ 7- ___ 8- ___ 9- ___ 10
no pain worst pain imaginable

b) average 0 ___ 1- ___ 2- ___ 3- ___ 4- ___ 5- ___ 6- ___ 7- ___ 8- ___ 9- ___ 10

c) at the best 0 ___ 1- ___ 2- ___ 3- ___ 4- ___ 5- ___ 6- ___ 7- ___ 8- ___ 9- ___ 10
no pain worst pain imaginable

d) worst pain 0 ___ 1- ___ 2- ___ 3- ___ 4- ___ 5- ___ 6- ___ 7- ___ 8- ___ 9- ___ 10



- 4) Description of pain (circle)
 aching throbbing sharp burning dull
 pins and needles shooting stabbing pressure sore discomfort
 cramping electric shocks
- 5) Weakness (circle) yes no
- 6) Numbness (circle) yes no
- 7) Bladder or bowel changes – incontinence (circle) yes no
- 8) What makes pain worse _____

9) What makes pain better _____

10) Interference with activities of daily life (no interference 0 -- max interference 10)

- a) sleep _____
- b) activity _____
- c) work _____
- d) mood _____
- e) interaction with family, friends, co-workers _____

11) Previous treatments and did they help?

- a) Physical therapy _____
- b) Chiropractic _____
- c) Massage _____
- d) Acupuncture _____
- e) Heat/Cold _____

f)	Pain Medication	Dose	Duration	Side Effects	Benefit
1)					
2)					
3)					
4)					
5)					

- g) Procedures (epidural, facet, etc) _____
- h) TENS _____
- i) Pyschologist (including biofeedback, cognitive therapy) _____

12) Surgical evaluation (orthopedic/ neurosurgeon) yes no

13) Neurologist yes no

14) Diagnostic radiological (x-ray, MRI) yes no

Where done _____

Past Medical History

Past Surgical History

Allergies and Effects

Do you take any antibiotics for medical/dental procedures? Yes No



Policies and Procedures

The mission of the Spine & Pain Institute of New England is to provide high quality, safe, and accessible care. The aim is to decrease pain and increase function through consultation, coordination of care, and diagnostic and therapeutic interventions.

The purpose of this form is to give patients information to assist in the success of their treatment and outline expectations:

1. Please set up appointments for visits in advance. Due to the physician's full schedule, he/she may not be able to see walk-ins.
2. Please call at least 48 hours in advance if you cannot keep your scheduled appointment.
3. If you miss 2 scheduled appointments without prior advance notification, we will consider you discharged from treatment. If you are late for your appointment (15 minutes or more), you will be considered discharged from treatment. The physician will evaluate your individual case prior to making the decision to end treatment due to missed appointments and tardiness.
4. Please understand that chronic pain is different from acute pain. There is not always "immediate" relief from chronic pain. It may require several treatments to provide adequate pain relief.
5. This clinic does not write prescriptions for opioids (narcotics). If opioid pain medication is clearly indicated, the physician will make appropriate recommendations to your referring physician.
6. Please comply with all treatment plans set up for you by your physician. Pain management is multidisciplinary and pain relief is often due to a combination of treatments.
7. Arrangement for payment of services must be made prior to your appointment.
8. Emergency—Please go to the emergency room if you are unable to contact your doctor here or your primary care physician.

I have read and understand the above policies.

Please sign: _____

Date: _____



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Spine & Pain Institute of New England reserves the right to modify the privacy practices outline in the notice.

I have been made aware of and have been given the opportunity to review the Notice of Privacy Practices for Spine & Pain Institute of New England.

Name of Patient (PRINT)

Signature of Patient

Date

Patient refused to sign acknowledgment

Staff Member

Date



Patient Registration

Last Name _____ First Name _____ Middle _____
 Address _____ City _____ State _____ Zip _____
 Telephone (home) _____ (cell) _____ Date of Birth _____
 Sex _____ Age _____ Social Security # _____ Marital Status _____
 E-mail Address: _____

Your email address will remain confidential and will only be used if we cannot reach you at the contact information given above. You will also receive our patient focused newsletter which includes educational information about pain conditions and treatment alternatives

Next of kin (for emergency use ONLY):

Name: _____
 Relationship: _____
 Phone #: _____

Primary Care MD: _____
 Telephone: (office) _____ (fax) _____
 Address: _____

Referring MD: _____
 Telephone: (office) _____ (fax) _____
 Address: _____

Insurance Type (check one):

Private Workman's Comp Motor Vehicle Accident

Primary Insurance:

Insurance Company: _____ Cardholder's Name _____
 Policy # _____ Group # _____
 Telephone: (office) _____ (fax) _____
 Case Manager: _____

Secondary Insurance:

Insurance Company: _____ Cardholder's Name _____
 Policy # _____ Group # _____
 Telephone: (office) _____ (fax) _____
 Case Manager: _____

If Workman's Comp or Motor Vehicle Accident

Insurance Company: _____ phone _____
 Claim # _____ Date of Injury: _____
 Adjuster Name: _____ phone _____ fax _____
 Attorney Name: _____ phone _____ fax _____

Employer:

Address _____ City _____ State _____ Zip _____
 Telephone: _____



Name: _____
Address: _____

Date of Birth: _____
Telephone#: _____

1. Assignment of health insurance benefits

I authorize Spine & Pain Institute of New England, PC to release medical information about me to my insurance carrier and its agents any information needed to determine benefits or the benefits payable for related services. I request that the payment under my current health insurance be made on my behalf to Spine & Pain Institute of New England, PC on any bill for services furnished me by the provider.

Signature of Patient

Date

2. Other Party Liability

Is this condition/injury/illness the result of a motor vehicle accident, Workers' Compensation or Personal Injury Claim? No Yes
If the answer is "yes", is the claim still open? No Yes
Is the claim in litigation? No Yes

If yes, please supply the name and address of your attorney:

Signature of Patient

Date

3. Release of Medical Records

At the time of your first visit to Spine & Pain Institute of New England, you will be asked to sign an acknowledgment of receipt of our notice of privacy practices in compliance with the Health Insurance Portability and Accountability Act of 1996.

Copies of your medical notes are sent to your referring physician, primary care physician and insurance carrier. Any and all other requests for medical records need to be requested in writing.

I consent to the disclosure of my medical records. I also hereby release Spine & Pain Institute of New England and their personnel from any liability concerning such disclosure. This consent is subject to revocation at any time, except to the extent that action has been taken by Spine & Pain Institute of New England, PC and their personnel in good faith.

Signature of Patient

Date