Prime Regenerative and Pain Management
2765 Jefferson Davis Highway, Suite 201
Stafford, VA 22554
(540) 659-5414

Pain Questionnaire

The purpose of this questionnaire is to obtain a complete assessment of you and your pain problems. This is a long questionnaire because pain is a very complex problem that affects all aspect of your life. We are trying to evaluate how the pain has affected your life so that we can make the best recommendation possible to assist you in your recovery. This record is confidential and no one can see it without your permission.

Patient's Name:_____ D.O.B.:_____ Age:_____

Date: _____

Signature/Relationship of person completing this form: _____

Patient Address: _____ Phone: (Home): _____

_____ (Cell) _____

_____

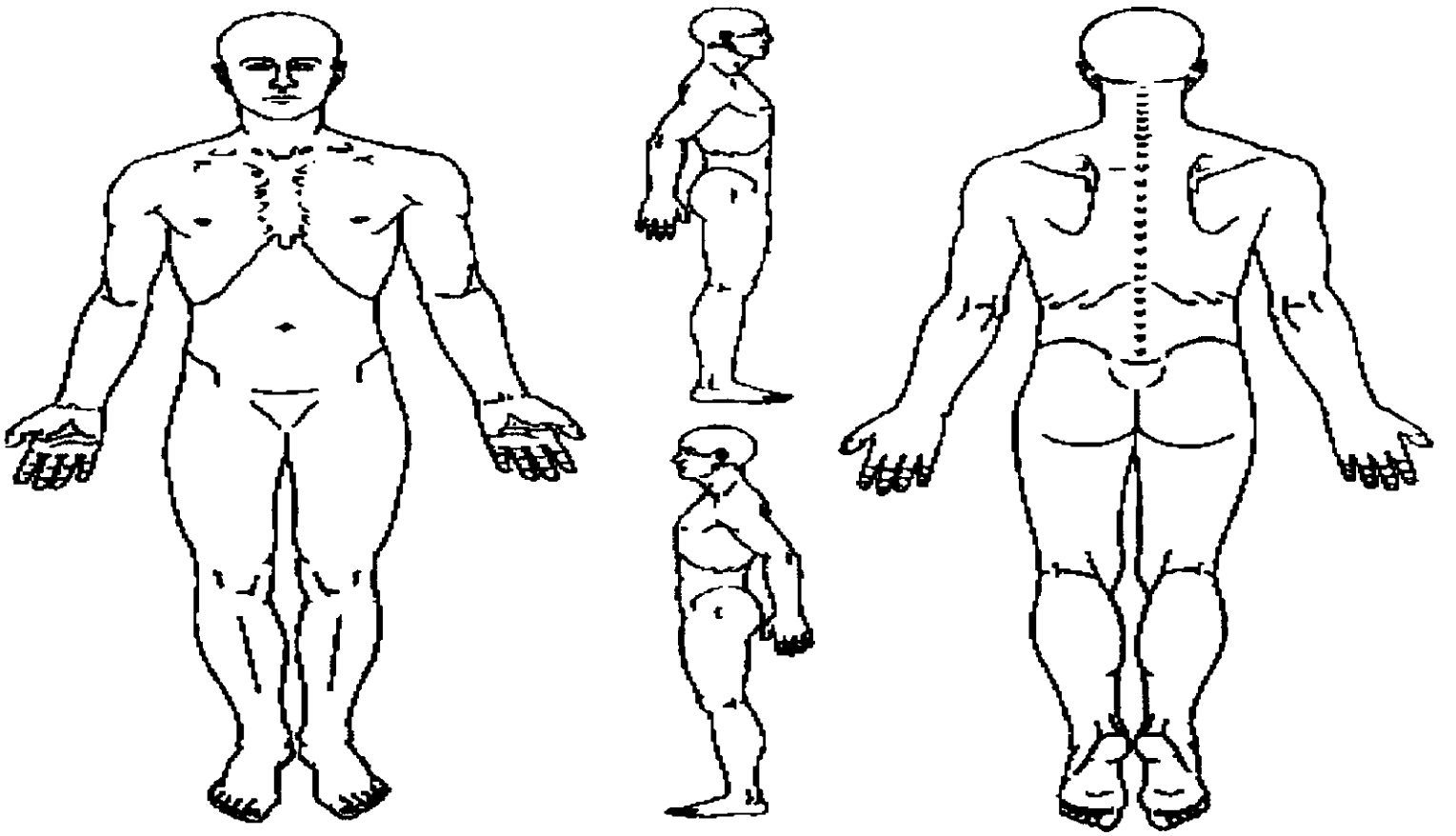
Referring Physician's name and address: _____

Are you currently receiving or in the process of receiving worker's compensation related to your problem? YES NO

Are you involved in litigation related to your pain problem? YES NO

Pain Diagram

Pain: + + + **Numbness: - - -** **Tingling: x x x**



Pain History (Circle ones that apply)	Pain Intensity (Circle the one that applies)
Throbbing, Shooting, Stabbing, Sharp, Cramping, Gnawing, Hot burning, Aching, Numbness, Tingling, Dull, Pulling	0 1 2 3 4 5 6 7 8 9 10 **0**= No Pain **5**= Moderate Pain **10**= Worst Pain Number your pain when it is worst: _____ Number your pain when it is least: _____ Number your pain on average: _____

When did the pain begin?: _____

How did your pain begin?: _____

In general, when is your pain the worst?
Morning _____ Afternoon _____ Evening_____ Night_____ No pattern to the pain_____

How often do you have the pain?
Constantly (100% of time)_____ Nearly constantly(60-95% of time)_____
Intermittent (30-60% of time)_____ Occasionally(less than 30% of time)_____

Please circle what makes your pain feel:
Worse: Walking Lifting Bending Lying Weather changes Standing Other:_____
Better: Heat Ice Rest Lying Weather changes Standing Medication:_____

Prior Treatments (Check all that apply)

	Helpful	Not Helpful
Surgery	☐	☐
Nerve Block	☐	☐
TENS	☐	☐
Physical Therapy	☐	☐
Occupational Therapy	☐	☐
Biofeedback	☐	☐
Psychology support	☐	☐

Diagnostic procedure done

Diagnostic Test	Body part evaluated	Date
Plain X-Rays		
MRI		
CT Scan		
EMG		
Bone Scan		
Discogram		
Myelogram		

Past Medical History

- ☐ Heart Problems_____
- ☐ Hypertension_____
- ☐ Circulation Problems_____
- ☐ Diabetes_____
- ☐ Kidney/Bladder Problems_____
- ☐ Liver Problems_____
- ☐ Cancer_____
- ☐ Blood Disorders_____
- ☐ Lung Problems/Asthma_____
- ☐ Intestinal Problems/Ulcers_____
- ☐ Blackouts/Falls_____
- ☐ Other_____
- ☐ Any medical Devices implanted in your body?_____
  (i.e., pacemaker, portacath, pump, rods, prosthesis, etc.)

Past Surgical History

Name of Surgery	Date

Please list <u>all medication</u> and dosages you are currently taking. PLEASE DO NOT OMIT any blood thinners you may be taking; i.e., Coumadin, Lovenox, Heparin, Plavix, Aggranox, etc.

_____
_____
_____
_____
_____
_____

Please list all drug allergies

_____
_____
_____

Social History

Are you married: Yes/No

Do you take care of other family members: Yes/No If yes, then who?_____

_____

Previous/Current Occupation: _____

Are you currently working? Yes/No If not, why?_____

Do you have any legal issues that are current or pending related to your current medical problem? Yes/No
If yes, please specify_____

Do you smoke? Yes/No If yes, how many per day?_____

Recreational drug use? Yes/No

Alcohol use? Yes/No If yes, how many per day/week_____

Patient's review of systems (Circle the ones that apply to YOU only)

Constitutional: Wt. _____ Ht. _____ Fever/Chills Night sweats Wt. Loss Wt. Gain

HEENT: Hearing loss Hearing aid R/L Sinus problem Loose teeth Dentures partial/full Glaucoma/Cataracts Glasses/Contacts

Endocrine: Diabetes Insulin dependent/oral diabetic medications Thyroid problems Addison's disease Excessive thirst or urination

Respiratory: Blood in sputum Shortness of breath Chronic cough Snoring Home oxygen Home breathing treatment Airway obstruction History of TB Sleep apnea Nasal septal deviation

Cardiovascular: Angina Chest pain Palpitations Heart murmur (if yes, do you take antibiotics for dental work?) Heart attack Chronic heart failure Shunts/Stents Rheumatic fever Pacemaker Artificial valve

Gastrointestinal: Change in appetite Hepatitis Liver disease Ulcer Heartburn Diarrhea Constipation Nausea/vomiting Gastrointestinal bleeding (blood in stool, dark/tarry stool, vomiting blood) Bowel incontinence

Gynecological: Last period _____ Menopausal Hysterectomy

Genitourinary: Kidney problems Burning while urinating Blood in urine Frequency Bladder or Kidney infections Ostomy Dialysis Catheter Difficulty urinating Urinary incontinence

Neurological: Dizziness Headache Seizures Stroke Weakness of extremities Fainting Numbness Paralysis Multiple sclerosis Other: _____

Hematological: Easy bruising Low platelets On Asprin/Non steroid anti-inflammatory History of cancer History of radiation therapy History of chemotherapy

Musculoskeletal: Back pain Neck pain Joint pain Arthritis Cast Osteoporosis Amputation Joint replacement Artificial limb Rheumatoid arthritis

Skin: Sores Rashes Bruises Cuts Burns Incision Itching

Psychological: During the past month have you been- Tense Anxious Depressed Discouraged Irritable Upset

Family History

Do you have a family history of the following. Please circle the ones that apply.

Pain Arthritis Cancer Psychological problems Bleeding disorders Other_____

Signature_____ Date_____

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& PAIN MANAGEMENT

Patient Demographics

Name_____

Date of Birth___/___/___

Address_____

_____

Home Ph_____ Cell Ph_____

Sex_____ Race_____

S.S # _____-_____-_____

Email _____

Best Contact (circle) Email, Home #, Cell #, By Mail

Marital Status(circle) Married , Single, Divorced, Widow

Primary Care Physician_____

Primary Pharmacy_____

Emergency Contact:

Name_____ Relationship_____

Address _____

Phone Number_____

Insurance information

Name of Insurance:_Primary_____(Please Confirm)_____

Secondary_____

Subscriber Name_____

Subscriber Birthdate_____

Subscriber S.S #_____-_____-_____

PRIME REGENERATIVE
& PAIN MANAGEMENT

Patient Name: _____ DOB: _____

Last 4 of SSN: _____

By signing the form, I hereby authorize _____ to disclose the health information described below to the office of Prime Regenerative and Pain Management

CHECK ALL THAT APPLY.

- ❑ All health information
- ❑ Last (3) office visits, MRI, or X-Ray notes, injection procedure notes
- ❑ Health information relating to the following treatment or condition

_____

- ❑ Health information for the dates:

_____

- ❑ Other specific health information or dates:

_____

REASONS FOR THIS AUTHORIZATION:

❑ At my request ❑ Other (specify)

This authorization expires upon: _____ (date or description of event)

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health services are provided solely for the purpose of creating health information for a third party and that if I refuse to sign an authorization those services may be denied.

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt requested, to the Privacy Office at the health care provided listed above. Once health information is disclosed pursuant to the authorization, it may be re-disclosed and may no longer be protected by privacy laws.

_____ _____

Patient/Responsible Party Signature Date

Please forward records to:

Prime Regenerative and Pain Management
2765 Jefferson Davis Highway, Suite 201
Stafford, VA 22554
Office (540) 659-5414

PRIME REGENERATIVE
& PAIN MANAGEMENT

PRIVACY FORM/RELEASE OF INFORMATION

I, _____, give permission to MAPRC, LLC, known as Prime Regenerative & Pain Management to discuss my medical information and healthcare concerns with:

_____ _____

Name and Relationship Phone Number

_____ _____

Name and Relationship Phone Number

_____ _____

Name and Relationship Phone Number

_____ _____

Name and Relationship Phone Number

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Printed Name Relationship to Patient