NEBRASKA PAIN INSTITUTE

Getting you back to the good life

New Patient Intake Form

Last Name: _____ First Name: _____ Middle Init: _____

Preferred Name: _____ Sex: ☐M ☐F DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Preferred #?: Home/Cell

May we leave a voice message to remind you about appointments on your home and/or cell phone number? ☐ Yes ☐ No

Email address: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐ Separated ☐Widowed Primary Language: ☐ English ☐ Spanish ☐ Other

Race: ☐ African/American ☐ Caucasian ☐ Hispanic ☐ Other _____ Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino

Occupation: _____ Work Phone: _____

Address _____

Referring Physician: _____

Primary Care Physician: _____ Location: _____

Pharmacy Name: _____ Location: _____

Do you take Blood Thinners? ☐ Yes ☐ No If so which one? _____

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

INSURANCE (If due to an auto accident, please obtain additional form from receptionist)

INFORMATION PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
Insurance Company Name: _____	Insurance Company Name: _____
Policy #: _____	Policy #: _____
Group ID#: _____	Group ID#: _____
Whose name is insurance in? ☐ Self ☐ Spouse ☐ Other _____	Whose name is insurance in? ☐ Self ☐ Spouse ☐ Other _____
Insured Name: _____	Insured Name: _____
DOB: _____ SSN: _____	DOB: _____ SSN: _____
Address: ☐ same as above _____	Address: ☐ same as above _____
_____	_____

The above information is true to the best of my knowledge. I authorize Nebraska Pain Institute, LLC to furnish information to insurance carriers required to process my claims. I authorize my insurance benefits be paid directly to the physician. I understand fully that I am responsible for any amount not covered by the insurance, or any collection fees, or interest acquired.

_____ _____

Signature Printed Name

TURN OVER

NEBRASKA
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Communication Form

I _____ give permission to Nebraska Pain Institute to share my health information with the following individuals who are involved in my care:

Name	Relationship	Contact Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature _____ Date _____

Print Name _____ Date of Birth _____

Last Name _____ First Name _____ DOB _____

PRIMARY PAIN

Is this the result of an auto accident or work injury? ☐ No ☐ Yes (If yes, please ask receptionist for additional form)

How did your pain begin?

_____

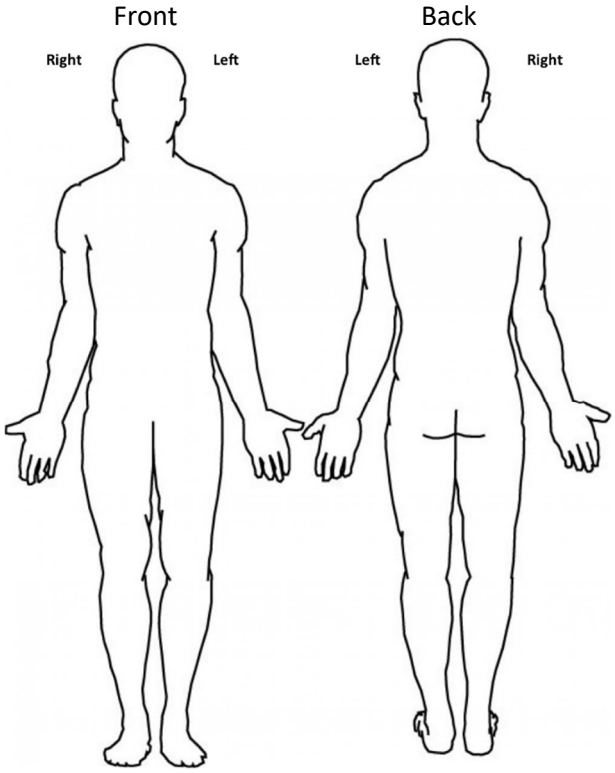
_____

_____

Circle the words that describe your pain

☐Burning	☐ Aching	☐Sharp	☐ Constant
☐Electric	☐ Throbbing	☐Stabbing	☐Occasional
☐Prickling	☐ Dull	☐Shooting	☐ Frequent
☐Numbing	☐ Cramping	☐Stinging	☐ Rare
☐Other _____			

Please designate your pain location; mark W for worst pain



How would you rate your pain on a scale from 0-10 with 0 being no pain and 10 being the worst pain

0 1 2 3 4 5 6 7 8 9 10

When is your pain worst?

☐In the morning	☐ During the day	☐In the evening
☐Middle of the night	☐ With weather changes	☐All the time
☐Other _____		

What makes your pain better?

☐Lying down ☐Sitting ☐Standing ☐Resting ☐ Walking ☐Exercising ☐Medications ☐Leaning Forward

☐Other _____

What makes your pain worse?

☐Lying down ☐Sitting ☐Standing ☐Resting ☐ Walking ☐Exercising ☐Medications ☐Leaning Forward

☐Other _____

Previous Treatments (circle all that apply):

☐Physical therapy	☐Surgery	☐Medications Injections	☐TENS	☐Acupuncture
☐Chiropractic	☐Massage	☐Other _____		

Previous Medications (circle all that apply):

☐Tylenol	☐Oxycodone	☐Methadone	☐Morphine	☐Dilaudid	☐Celebrex
☐NSAIDS	☐Fentanyl	☐Neurontin	☐Tapentadol	☐MS contin	☐Butrans
☐Oral Steroids	☐Hydrocodone	☐Cymbalta	☐Lyrica	☐Opana	☐Belbuca
☐Tramadol	☐Oxycontin	☐Percocet	☐Mobic	☐Topamax	☐Nucynta

TURN OVER

Past Medical History:

List all Medical Problems:

_____
_____
_____
_____
_____

List all surgeries:

_____
_____
_____
_____
_____

MEDICATIONS (please list all medications or attach a list):

_____
_____
_____
_____
_____
_____

ALLERGIES: Please list all known drug allergies.

If you are unaware of any drug Allergies check here ☐

_____
_____
_____
_____
_____

Family History:

Mother: ☐ Diabetes ☐ Heart Disease ☐ Lung Disease ☐ Hypertension ☐ High Cholesterol ☐ Deceased

Father: ☐ Diabetes ☐ Heart Disease ☐ Lung Disease ☐ Hypertension ☐ High Cholesterol ☐ Deceased

List any immediate biological relatives who suffer from chronic pain (list only relation and type of pain).

_____
_____

Social History:

Married: ☐ YES ☐ NO Children: ☐ YES ☐ NO If so, how many: _____

Do you drink any alcohol? ☐ YES ☐ NO ☐ Heavily ☐ Daily ☐ Occasionally ☐ Socially ☐ Rarely

How much/often? _____

Have you ever smoked cigarettes or used tobacco? ☐ YES ☐ NO Do you currently? ☐ YES ☐ NO

Packs Per Day? Years of use? _____

Do you use Illicit drugs? ☐ YES ☐ NO ☐ Heavily ☐ Daily ☐ Occasionally ☐ Rarely

Drug name(s):_____

REVIEW OF SYSTEMS: (Please circle any symptoms you have experienced within the last month.)

GENERAL:	☐Appetite Change	☐Chills	☐Sweating	☐Fever	☐Fatigue	☐Weight Change
HENT:	☐Neck Pain	☐Neck Stiffness	☐Ear Pain	☐Sore Throat	☐Congestion	☐Sinus Pressure
EYES:	☐Vision changes	☐Eye Pain	☐Eye Redness	☐Eye Discharge		
RESPIRATORY:	☐Apnea	☐Shortness of breath	☐Wheezing	☐Cough		
CARDIOVASCULAR:	☐Chest pain	☐Swelling	☐Palpitations	☐Chest Pressure		
GASTROINTESTINAL:	☐Nausea /Vomiting	☐Constipation	☐Diarrhea	☐Heartburn		
ENDOCRINE:	☐Thyroid Problems	☐Elevated Glucose	☐ Sexual Difficulties			
GENITOURINARY:	☐Incontinence	☐Hesitancy	☐ Urgency			
MUSCULOSKELETAL:	☐Arthralgia	☐Back Pain	☐Gait Disturbance	Joint Swelling	☐Myalgia	Fibromyalgia
SKIN:	☐Color Changes	☐Rash	☐Wounds	☐Pain to Light Touch		
NEUROLOGICAL:	☐Headache	☐Dizziness	☐Numbness	☐Weakness	☐Confusion	☐Seizures
HEMATOLOGIC:	☐Anticoagulation	☐HIV	☐Bleeding disorder			
PSYCHIATRIC:	☐Depression/anxiety	☐Substance abuse	☐Suicidal Thoughts			