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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Delmarva%20Logo%20on%20Top%20(No%20Motto)%20copy%20black.png | **NEW PATIENT****INFORMATION****FORM** |

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|  | **Phone** | **(302) 355-0900** |
|  | **Fax** | **(302) 355-0901** |
|  | **Web** | delmarvapain.com |

 |
| **PATIENT INFORMATION & REGISTRATION** |  |
| Name:       | Date of Visit:       |
| Referring Physician:       | Date of Birth:       | Age:       |
| Primary Care Physician:       | Sex: [ ]  Male [ ]  Female |
| Preferred Phone #       | [ ]  Home [ ]  Mobile [ ]  Work |
| Emergency Contact Name:       | Relationship:       |
| Emergency Contact Phone #       |  |  |
| Employer & Occupation:       |
| In compliance with the HITECH Act (EHR) to attain Meaningful Use, we are required to capture demographic data including your preferred language, race, and ethnicity. This is an important part of your medical history and will assist us during our clinical quality improvement process. Please complete the information below: |
| **Primary Language:**[ ]  Arabic[ ]  Chinese[ ]  English[ ]  French[ ]  Korean[ ]  Spanish[ ]  Other:       | **Race:**[ ]  African-American[ ]  Arabic[ ]  Asian[ ]  Caucasian[ ]  Filipino[ ]  Hispanic[ ]  Other:       | **Ethnicity:**[ ]  Hispanic[ ]  Non-Hispanic |
| **Contact Preference:** |
| By providing my email address or cell phone number below, I hereby consent and state my preference to have my physician and other staff at Delmarva Pain and Spine Center, LLC communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments and billing. I understand that email and standard SMS may be insecure and could potentially be intercepted by a third-party.**Note:** Messages will be related directly to your care only and will not include any marketing material or solicitation. |
| **Email Address:       Cell Phone #:** |
| **ADVANCE DIRECTIVES INFORMATION** |
| Advance Directives are legal documents that allow you to spell out your decisions about end-of-life care ahead of time. Although advance directives, by anesthesia standards, will NOT be honored at this facility, we will keep them on file at your request. In the event of an emergency, advanced cardiac life support will be instituted in every instance and you will be transported to higher level of care. The directives will be recognized by the receiving hospital in the case that a transfer is required from our facility due to emergency. |
| Do you have any advanced directives to share with us? [ ]  Yes [ ]  No |
| **If yes, please provide all relevant advance directives documentation to our front office staff to keep on record.** |  |
| **PRIMARY COMPLAINT** |
| **Reason for visit:**  | **How long have you had pain?**  |
| **Onset of Pain** *(please select the appropriate indicator listed below):* |
| [ ]  Pain Began With No Known Cause [ ]  Injury Outside Of Work [ ]  Injury at Work [ ]  Illness (Not Injury) [ ]  Motor Vehicle Accident (PIP) [ ]  Other**Explain how pain started:**      |
| **How did your current pain episode begin?**  | [ ]  Gradually [ ]  Suddenly |
| **Since your pain began, has your pain** | [ ]  Increased [ ]  Decreased [ ]  Stayed the Same |
|  |  |
| **Mark the location of your pain on the diagram below:** | **Please circle the number that best describes the amount of pain you feel right now:** |
| *Mark ‘X’ for severe pain**Mark ‘O’ for less severe pain**Mark ‘\*’ for tingling or burning* |

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| *No Pain* | 0 1 2 3 4 5 6 7 8 9 10 | *Severe**Pain* |

*Write ‘L’ above number to indicate least pain**Write ‘W’ above number to indicate worst pain* |
| **What pain level is a realistic goal for you?** |       |
|  |  |
| **What best describes your pain?** *(select all that apply)* |
| [ ]  Aching / Cramping[ ]  Hot / Burning[ ]  Dull[ ]  Electrical | [ ]  Numb[ ]  Stabbing / Sharp[ ]  Shooting[ ]  Tingling |
| **Frequency and duration of pain?**[ ]  Constant [ ]  Intermittent [ ]  Daily |
| **Do you experience any of the following?** *(select all that apply)*[ ]  Weakness [ ]  Numbness [ ]  Tingling [ ]  Loss of Bowel/Bladder Control [ ]  Trouble with Balance |
| **What makes your pain worse?** *(select all that apply)* |
| [ ]  Bending Backwards[ ]  Bending Forward[ ]  Climbing Stairs[ ]  Cold[ ]  Coughing / Sneezing[ ]  Driving | [ ]  Exercise[ ]  Heat[ ]  Lifting[ ]  Light Touch[ ]  Sexual Activity | [ ]  Sitting[ ]  Standing[ ]  Stress[ ]  Walking[ ]  Work |
| [ ]  Other:       |
| **What helps to relieve your pain?** *(select all that apply)* |
| [ ]  Bath/Shower[ ]  Exercise[ ]  Heat[ ]  Ice | [ ]  Lying Down[ ]  Medications[ ]  Meditation[ ]  Physical Therapy | [ ]  Relaxation[ ]  Sitting[ ]  Standing[ ]  Walking |
| [ ]  Other:       |  |  |
| **Pain interferes with** *(select all that apply):* |  |  |
| [ ]  Appetite[ ]  Cooking[ ]  Driving[ ]  Exercise[ ]  Hobbies | [ ]  House Chores[ ]  Job Performance[ ]  Self-Care[ ]  Sex | [ ]  Shopping[ ]  Sleep[ ]  Social Life[ ]  Traveling |
| **Does your pain limit your ability to walk?** [ ]  YES [ ]  NO |  |
| **How long can you sit?**  | [ ]  Minimal [ ]  30 Minutes [ ]  >1 Hour | **How long can you stand?**  | [ ]  Minimal [ ]  30 Minutes [ ]  >1 Hour |
| **To assist with walking, I use a:**  [ ]  Cane [ ]  Walker [ ]  Wheelchair [ ]  No Assistance Device |  |

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| **PRIOR WORKUP & TREATMENT** |
| **Have you ever had any of the following imaging studies?** |
| [ ]  X-Ray of the  | Date:       | Facility:       |
| [ ]  CT scan of the  | Date:       | Facility:       |
| [ ]  MRI of the  | Date:       | Facility:       |
| [ ]  EMG of the  | Date:       | Facility:       |
| [ ]  Other:       |
| [ ]  **I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS** |
| **PRIOR PAIN MEDICATIONS** *(check all medications you have used in the past for treatment of pain)* |
| **NSAIDS / Tylenol** | [ ]  Aspirin[ ]  Celebrex[ ]  Daypro[ ]  Feldene[ ]  Ibuprofen | [ ]  Indocin[ ]  Lodine[ ]  Mobic[ ]  Motrin[ ]  Naproxen | [ ]  Relafen[ ]  Salsalate / Trilisate[ ]  Toradol[ ]  Tylenol |
| **Opioids** | [ ]  Codeine[ ]  Demerol[ ]  Dilaudid[ ]  Fentanyl | [ ]  Hydrocodone[ ]  Levorphanol[ ]  Methadone[ ]  Morphine / MSContin | [ ]  Nucynta[ ]  Oxycodone (Percocet)[ ]  Oxycontin[ ]  Tramadol |
| **Anti-Depressants** | [ ]  Bupropion (Wellbutrin)[ ]  Citalopram (Celexa)[ ]  Desioramine[ ]  Desvenlafaxine (Pristiq) | [ ]  Duloxetine (Cymbalta)[ ]  Escitalopram (Lexapro)[ ]  Fluoxetine (Prozac)[ ]  Imipramine (Tofranil) | [ ]  Paroxetine (Paxil)[ ]  Sertraline (Zoloft)[ ]  Venlafaxine (Effexor) |
| **Anti-Anxiety** | [ ]  Ativan[ ]  Klonopin | [ ]  Valium[ ]  Xanax |  |
| **Muscle Relaxants** | [ ]  Baclofen[ ]  Flexeril[ ]  Parafon Forte | [ ]  Robaxin[ ]  Skelaxin[ ]  Soma | [ ]  Valium (Diazepam)[ ]  Zanaflex |
| **Nerve Pain** | [ ]  Amitriptyline[ ]  Cymbalta[ ]  Lyrica | [ ]  Neurontin[ ]  Nortriptyline[ ]  Savella | [ ]  Tegretol |

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| **Have you been treated at another pain management center or program?**  | [ ]  YES *(answer below)* [ ]  NO |
| Where?       | When?       |
| **PREVIOUS TREATMENTS** *(select all that apply)*: |
| [ ]  Acupuncture[ ]  Biofeedback[ ]  Blocks or Injections[ ]  Bracing – Type:      [ ]  Chiropractic Manipulation | [ ]  Home Exercise Program[ ]  Nerve blocks[ ]  Physical Therapy - Date Completed:      [ ]  Surgery[ ]  Other:       |
| [ ]  **I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS** |

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| **MEDICATION THERAPY** |
| **Please list all of the medications you are taking now. Include all over-the-counter, herbal, and other supplemental medications and vitamins.** |
| **[ ]  I HAVE PROVIDED MY PHYSICIAN WITH A PRINTED MEDICATION LIST** |
| **Medication** | **Dose****(mg)** | **How Often?****(# times/day)** | **What is this medication for?** | **Date Started?** | **Prescribing Doctor** |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
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|       |       |       |       |       |       |
| **Do you take any blood thinning medications?** [ ]  YES [ ]  NO ; If Yes, which one?       |

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| **PAST MEDICAL HISTORY** |
| **Please check all that apply.** |
| **Cardiovascular** | **Respiratory** | **Gastrointestinal** | **Endocrine** | **Hematologic** |
| [ ]  Chest Pain[ ]  Heart Attack[ ]  Heart Disease[ ]  Heart Rhythm [ ]  Disturbances[ ]  Diabetes[ ]  Insulin[ ]  High Blood Pressure[ ]  Colitis[ ]  Irritable BowelSyndrome[ ]  High Cholesterol | [ ]  Asthma[ ]  COPD/Emphysema[ ]  Chronic Bronchitis[ ]  Anticoagulation[ ]  Venous Insufficiency[ ]  Low Blood Pressure[ ]  Hiatal Hernia | [ ]  Acid Reflux/GERD[ ]  Ulcers[ ]  Polyps[ ]  Easy Bruising[ ]  Arterial Insufficiency[ ]  Bowel Problems[ ]  Blood Thinners[ ]  Embolism[ ]  Liver Disease | [ ]  Obesity[ ]  Hypothyroid[ ]  Hyperthyroid[ ]  Frequent Pneumonia[ ]  Positive TB Test[ ]  Frequent Colds/Sore Throat[ ]  Blood Clots[ ]  Gallbladder Problems[ ]  Special Diet | [ ]  Bleeding Disorders[ ]  Anemia[ ]  Hepatitis A, B, C[ ]  Pancreatitis[ ]  Abnormal Chest X-Ray[ ]  Crohn’s Disease[ ]  Other |
|  |  |  |  |  |
| **Neurological** | **Psychological** | **Genitourinary** | **Musculoskeletal** |  |
| [ ]  Memory Problems[ ]  Seizures[ ]  Stroke[ ]  Movement Disorder[ ]  Muscular Dystrophy[ ]  Neuropathy[ ]  Migraine[ ]  Epilepsy[ ]  Headaches | [ ]  Nervous Breakdown[ ]  Depression[ ]  Anxiety[ ]  Panic Disorder[ ]  Psychosis[ ]  Alcohol or Drug Abuse[ ]  Other | [ ]  Sexual Dysfunction[ ]  Sexually Transmitted Disease[ ]  Prostate Disease[ ]  Kidney Problems[ ]  Chronic Infection[ ]  Bladder Problems | [ ]  Fibromyalgia[ ]  Rheumatoid Arthritis[ ]  Osteoarthritis[ ]  Osteoporosis[ ]  Back Problems[ ]  Neck Problems |  |
| **Miscellaneous** | **General** | **Allergic/****Immunological** | **Cancer** |  |
| [ ]  Glaucoma[ ]  Cataracts[ ]  Visual Problems[ ]  Hearing Loss[ ]  Chronic Skin Disorder[ ]  Pregnancy | [ ]  Medical Equipment[ ]  Cane[ ]  Walker[ ]  Wheel Chair[ ]  Hospital Bed[ ]  Oxygen | [ ]  Autoimmune Disorder[ ]  Lupus, Sjogren’s[ ]  Raynaud’s Syndrome[ ]  Immune Deficiency[ ]  HIV | [ ]  Site[ ]  Diagnosis Date:[ ]  Chemotherapy[ ]  Radiation[ ]  Other |  |

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| **ALLERGIES** |
| **Please list any known drug, food, or environmental allergies and indicate the adverse effect/reaction:** |
| **Medications Allergic To** | **Reaction To Medication** |
|       |       |
|       |       |
|       |       |

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| [ ]  Contrast/IV Dye[ ]  Iodine[ ]  Latex | [ ]  Shellfish[ ]  Other (specify):      **[ ]  I HAVE NO KNOWN ALLERGIES** |
| **PAST SURGICAL HISTORY** |
| **Type of Surgery** | **Date** |
|       |       |
|       |       |
|       |       |
|       |       |
| [ ]  **I HAVE NOT HAD ANY SURGICAL PROCEDURES DONE** |

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| **PAST HOSPITALIZATION** |
| **Reason For Hospitalization** | **Date** |
|       |       |
|       |       |
|       |       |
| **[ ]  I HAVE NO HISTORY OF HOSPITALIZATION** |
| **FAMILY HISTORY** |
| **Please specify any medical or psychiatric conditions common among BIOLOGICAL family members only:** |
| [ ]  Anxiety / Depression[ ]  Arthritis[ ]  Cancer[ ]  Diabetes[ ]  Headaches[ ]  Heart Disease / Stroke[ ]  High Blood Pressure | [ ]  Kidney Problems[ ]  Liver Problems[ ]  Rheumatoid Arthritis[ ]  Seizures[ ]  Substance Abuse[ ]  Other:       |
| [ ]  **I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY** |

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| **SOCIAL HISTORY** |
| **Are you a smoker?** [ ]  CURRENT, How Many?      [ ]  FORMER [ ]  NEVER | **Do you drink alcohol?** [ ]  YES, How Much?      [ ]  NO |
| **Do you use illicit street drugs?** [ ]  YES, Which Ones?      [ ]  NO | **What is your marital status?**[ ]  Single [ ]  Married [ ]  Cohabitating [ ]  Separated [ ]  Divorced [ ]  Widowed |
| **Who do you live with?** [ ]  Alone [ ]  Spouse [ ]  Children [ ]  Parents | **Are you pregnant, or planning a pregnancy?** [ ]  YES [ ]  NO |

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| **PAST PSYCHOLOGICAL HISTORY** |
| **Have you ever had psychiatric or psychological evaluation or treatment for any problem, including pain?**[ ]  YES, Treated For: [ ]  ADD [ ]  OCD [ ]  Bipolar [ ]  Schizophrenia [ ]  Other:      [ ]  NO |
|  |
| **Have you ever been treated for symptoms of depression?**[ ]  YES, When?      [ ]  NO |
|  |
| **Have you ever considered/planned/attempted suicide?**[ ]  YES, When?      [ ]  NO |

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| **REVIEW OF SYSTEMS** |
| **Do you have any of the following?** |
| **General** | [ ]  Fatigue [ ]  Fever  | [ ]  Weight Loss/Gain [ ]  Other:       |
| **HEENT** | [ ]  Cataract [ ]  Glaucoma  | [ ]  Hearing Loss [ ]  Other:       |
| **Cardiovascular** | [ ]  AICD/Pacemaker [ ]  Chest Pain [ ]  Claudication | [ ]  Heart Attack [ ]  Heart Failure [ ]  Heart Murmur | [ ]  Hypertension [ ]  Irregular Heartbeat [ ]  Other:       |
| **Respiratory** | [ ]  Asthma [ ]  Bronchitis [ ]  Cough  | [ ]  Emphysema [ ]  Pulmonary Embolus [ ]  Sleep Apnea  | [ ]  SOB [ ]  TB [ ]  Other:       |
| **Gastrointestinal** | [ ]  Cirrhosis [ ]  Diverticulitis [ ]  Gall Bladder Disease  | [ ]  GERD [ ]  Hepatitis[ ]  Hyperlipidemia  | [ ]  Irritable Bowel [ ]  Peptic Ulcer Disease [ ]  Other:       |
| **Genitourinary** | [ ]  Dialysis [ ]  Renal Failure  | [ ]  Transplant [ ]  Other:       |
| **Musculoskeletal** | [ ]  Back Pain[ ]  Joint Pain | [ ]  Neck Pain[ ]  Rheumatoid Arthritis  | [ ]  Other:       |
| **Neurological** | [ ]  Dizziness [ ]  Seizures  | [ ]  Stroke [ ]  Other:       |
| **Psychiatric** | [ ]  Anxiety / Stress [ ]  Bipolar  | [ ]  Depression [ ] Suicidal Thoughts/Planning | [ ]  Other:       |
| **Endocrine / Metabolic** | [ ]  Diabetes [ ]  Lupus  | [ ]  Thyroid Disease [ ]  Other:       |
| **Hematologic / Lymphatic** | [ ]  Anemia[ ]  Bleeding/Clotting Problems  | [ ]  DVT [ ]  Other:       |
| **Cancer:** [ ]  YES [ ]  NO ; If Yes, Type:      **Chemo:** [ ]  YES [ ]  NO **Radiation:** [ ]  YES [ ]  NO  |

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| **CERTIFICATION** |
| **I certify that the above information is accurate, complete, and true. I understand that this will become part of my medical record.** |
| **X**  |
| Patient Signature (Patient, Guardian, or Representative) | Date |

 Printed Name