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| Delmarva%20Logo%20on%20Top%20(No%20Motto)%20copy%20black.png | **NEW PATIENT**  **INFORMATION**  **FORM** | | | | | | | | |  |  |  | | --- | --- | --- | |  | **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* | | | | | | |  |  |  | | --- | --- | --- | | *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 Bowel  Syndrome  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** |
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| **I HAVE NOT HAD ANY SURGICAL PROCEDURES DONE** | |

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| **PAST HOSPITALIZATION** | |
| **Reason For Hospitalization** | **Date** |
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| **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