INTEGRATIVE
PAIN & SPINE

WELCOME PACKET

YOUR APPOINTMENT HAS BEEN SCHEDULED ON: DATE: _____ TIME: _____

Should you need to cancel, please call the office at: 972-219-8400

PLEASE READ THE BELOW LISTED INFORMATION

It is very important that you bring your MRI or CT reports to your appointment
The physician needs this information to best help you at the time of your visit

If you are relying on the facility or another office to send these directly to our practice we ask that you call 2 days in advance of your scheduled appointment to confirm that the office has received them.

Thank you for your cooperation

Thank you for choosing us to serve your health care needs

Every effort will be made to honor your appointment time.
Please note, however, that due to the nature of our practice, occasionally there are delays with appointments.
We apologize in advance for any inconvenience this may cause you.

INTEGRATIVE PAIN & SPINE
S. BADIYAN, MD
BOARD CERTIFIED ANESTHESIOLOGY & PAIN MANAGEMENT
FELLOWSHIP TRAINED – PAIN MEDICINE
DIPLOMATE - THE AMERICAN BOARD OF ANESTHESIOLOGY

DEMOGRAPHIC INFORMATION

Name: _____ **DOB:** ___/ ___ /_____ **AGE:** _____ **Social Security:** _____
Last First Middle Initial

Address: _____
Number Street City State Zip

Cell Phone: _____ Home Phone: _____ EMAIL: _____

Who referred you to our office? _____ Phone Number: _____

Who is your primary care doctor? _____ Phone Number: _____ Location: _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

ADDITIONAL INFORMATION

□ **Male** □ **Female** **Marital Status:** □ Married □ Single □ Other: _____

Languages Spoken: □ English □ Spanish □ Other: _____

Occupation: _____

Employer: _____

PLEASE TELL US THE REASON FOR YOUR VISIT: _____

_____

_____

PHARMACY INFORMATION

PREFERRED PHARMACY: _____ PHONE #: _____

PHARMACY ADDRESS**:** _____

MEDICATION ALLERGIES

□ **No Known Drug Allergies**

□ **No Other Allergies (latex, contrast or adhesives..)**

□ **Yes I have known Drug Allergies (Please list name and symptoms)**

1._____ _____

2._____ _____

□ **Yes I have Other Allergies to things like latex, contrast or adhesives (Please list name and symptoms)**

1._____ _____

2._____ _____

CURRENT MEDICATIONS

LIST ALL THE CURRENT MEDICATIONS YOU ARE TAKING

NAME:	**DOSE**	**FREQUENCY**	**REASON PRESCRIBED:**
Example: Benadryl	*40 mg*	*one tab a day*	*Allergies*
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____

_____ _____

Signature of Patient/Guardian Date

PATIENT NAME: _____ DATE: _____

REVIEW OF SYSTEMS

ROS. Does the patient currently have any of these issues? *Please circle yes or no*

Constitutional	Fatigue	No	Yes	Fever	No	Yes	Weight Loss	No	Yes
Neurologic	Seizures	No	Yes	Dizziness	No	Yes	Headaches	No	Yes
Musculoskeletal	Muscle Pain	No	Yes	Back Pain	No	Yes	Weight Gain	No	Yes
	Joint Pain	No	Yes	Neck Pain	No	Yes	Morning Stiffness	No	Yes
Skin	Rash	No	Yes	Ulcers	No	Yes			
Pulmonary	Short of Breath	No	Yes	Wheezing	No	Yes	Cough	No	Yes
	Difficulty Breathing	No	Yes						
Cardiology	Chest Pain	No	Yes	Palpitations	No	Yes	Irregular Heart Beat	No	Yes
Gastrointestinal	Diarrhea	No	Yes	Vomiting	No	Yes			
	Constipation	No	Yes	Nausea	No	Yes	Abdominal Pain	No	Yes
Genitourinary	Freq Urine	No	Yes	Pain Urinating	No	Yes	Burning with Urination	No	Yes
Eyes/Ears/Nose	Nasal Drainage	No	Yes	Change of Vision	No	Yes	Loss Of Hearing	No	Yes
Mouth and Throat	Sore Throat	No	Yes	Tooth Ache	No	Yes			
Hematologic	Easy Bleeding	No	Yes	Easy Bruising	No	Yes			
Psychiatric	Anxiety	No	Yes	Depression	No	Yes			

Has the patient or family member ever been diagnosed with any of the following medical conditions?

	FAMILY MEMBERS	PATIENT	IF YES FOR PATIENT, PLEASE COMMENT
Heart Disease (CAD)	No Yes	No Yes	
High Blood Pressure	No Yes	No Yes	
Stroke	No Yes	No Yes	
Cancer	No Yes	No Yes	
Osteoarthritis	No Yes	No Yes	
COPD	No Yes	No Yes	
Depression	No Yes	No Yes	
Coagulation Defects	No Yes	No Yes	
DVT (Blood Clots)	No Yes	No Yes	
Anemia	No Yes	No Yes	
Hepatitis	No Yes	No Yes	
Diabetes	No Yes	No Yes	
Kidney Disease	No Yes	No Yes	
Asthma	No Yes	No Yes	
Sleep Apnea	No Yes	No Yes	
Stomach Ulcers	No Yes	No Yes	
High Cholesterol	No Yes	No Yes	
Rheumatoid arthritis	No Yes	No Yes	
Lupus	No Yes	No Yes	
Seizures	No Yes	No Yes	
Anxiety	No Yes	No Yes	
Other Health Issues: _____	No Yes	No Yes	

If you checked yes to any of the above, are you under treatment for this issue with a physician? No Yes
If so, who is the physician treating you? _____

PATIENT NAME: _____ DATE: _____

PRIOR SURGERIES

Please list any surgeries you have ever had

□ _____

□ _____

□ _____

□ _____

□ _____

PRIOR SURGERIES

□ _____

□ _____

□ _____

□ _____

□ _____

SOCIAL HISTORY

Height_____ Weight_____

Alcohol Intake: Please circle the one that applies to you: Never Drink Drink Socially Drink Daily: wine beer liquor

Do you have a history of alcohol abuse? □ Yes □ No

Smoking History: Have you ever smoked? □ Yes □ No If yes, How long? _____ How Many ____packs/day

Have you quit smoking? □ Yes □ No If yes, When? _____ How Many ____packs/day

Illicit Drug Use: Do you currently use any illicit substances? □ Yes □ No

Have you ever used any illicit substances? □ Yes □ No

If yes, which one(s)? _____

OTHER HEALTH RELATED ISSUES NOT COVERED ABOVE

_____

_____

_____

_____

_____

_____