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: _____

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: _____ Phone Number: _____

Pharmacy Name: _____ Phone Number: _____

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

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

INSURANCE

INFORMATION PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____

Policy #: _____

Group ID#: _____

Whose name is insurance in? ☐ Self ☐ Spouse ☐ Other _____

Insured Name: _____

DOB: _____ SSN: _____

Address: ☐ same as above _____

_____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____

Policy #: _____

Group ID#: _____

Whose name is insurance in? ☐ Self ☐ Spouse ☐ Other _____

Insured Name: _____

DOB: _____ SSN: _____

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

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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

How did your pain begin?

_____

_____

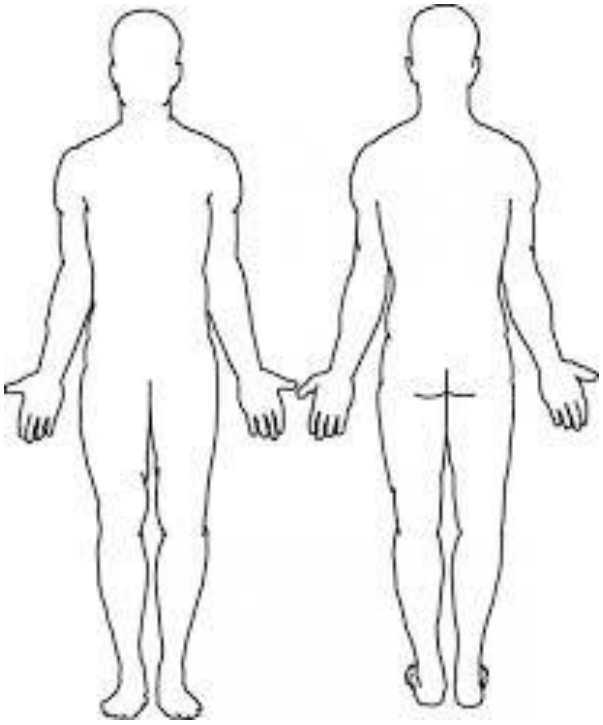
_____

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

Front Back



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

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			