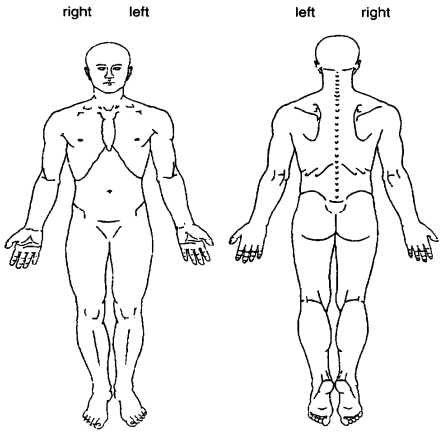
PATIENT INFORMATION QUESTIONNAIRE

_____ _____ _____
Last First Middle Male/Female Age

Referring Physician
Practice Name:_____
Physician's Name:_____
Address: _____
_____

Primary Care Physician
Practice Name: _____
Physician's Name: _____
Address:_____
_____

Describe your most disabling/severe pain:
_____
_____



How and when did your pain begin? _____ (month/year)

☐ Work accident ☐ Following surgery/illness
☐ Home accident ☐ Other accident
☐ Auto accident ☐ Unknown
☐ Other:_____

Describe the circumstances around the onset of your pain:

_____

_____

Please mark the area(s) on the diagram above in which you are in pain.

Circle the number that best describes how severe your pain is

|----------|----------|

0 no pain 1 2 mild 3 4 discomfort 5 6 distress 7 8 horrible 9 10 worst pain imaginable

Duration of pain
☐ < 1 week ☐ 1-4 wks ☐ 1-3 months
☐ 3-6 months ☐ 6-12 months ☐ > 1 year

How often does the pain occur?
☐ Continuously ☐ Several times per day
☐ Intermittent ☐ Occassionally ☐ Less than daily

How has the pain intensity changed since it began?
☐ Increased ☐ Decreased ☐ No change

Select one or more items below to describe the nature of your pain:
☐ Throbbing ☐ Shooting ☐ Sharp ☐ Cramping ☐ Hot/burning ☐ Aching ☐ Stabbing

How do the following factors affect your pain? (check one blank per number)

	Better	Worse	No effect		Better	Worse	No effect
1. Heat	☐	☐	☐	6. Climate	☐	☐	☐
2. Cold	☐	☐	☐	7. Fatigue	☐	☐	☐
3. Lying down	☐	☐	☐	8. Coughing	☐	☐	☐
4. Sitting	☐	☐	☐	9. Massage	☐	☐	☐
5. Walking	☐	☐	☐	10. Alcohol	☐	☐	☐

Which of the following activities are affected by your pain?
☐ Falling asleep ☐ Social interaction ☐ Household chores
☐ Staying asleep ☐ Sexual activity ☐ Work/School ☐ Leisure

Give the dates of the tests you have had to diagnose your pain:

X-rays _____ Myelogram _____
CT scan _____ Nerve conduction/EMG _____
MRI _____ Other _____

List the name(s) of other specialists including previous pain clinics/specialists you have seen for you pain:

Name	Specialty	Dates seen

Give the dates of treatments you have had for your pain

Acupuncture	_____	Exercise	_____	Physical therapy	_____
Biofeedback	_____	Facet block	_____	Psychotherapy	_____
Brace	_____	Hypnosis	_____	Surgery	_____
Chiropractor	_____	Massage	_____	TENS unit	_____
Epidural	_____	Nerve block	_____	Trigger point	_____

Other_____

Do you have any drug allergies?

☐ ***No*** known drug allergies ☐ ***Yes*** (please list drug and reaction):

_____

List all medications you are currently taking:

	Medication	Dose		Medication	Dose
1.			9.		
2.			10.		
3.			11.		
4.			12.		
5.			13.		
6.			14.		
7.			15.		
8.			16.		

Past pain medications tried:

_____
_____
_____

Past Surgical History

Surgery	Year	Surgery	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History

Please check any of the conditions below that run in your family:

☐ Arthritis ☐ Cancer ☐ Depression ☐ Diabetes ☐ Heart disease
☐ Lupus ☐ Stroke ☐ Other:_____

Past Medical History

Review of Systems

Constitutional

☐ Obesity
☐ Weight loss

☐ Chills ☐ Fever
☐ Fatigue

Musculoskeletal

☐ Arthritis ☐ Fibromyalgia ☐ Numbness ☐ Weakness

Neurological

☐ Headache ☐ Seizures ☐ Confusion ☐ Light sensitivity
☐ Migraines ☐ Stroke ☐ Dizziness ☐ Loss of consciousness

Psychiatric

☐ Depression ☐ Substance abuse ☐ Anxiety ☐ Suicidal thoughts
☐ Difficulty sleeping

Cardiovascular

☐ Angina ☐ Heart stent ☐ Chest pain ☐ Palpitations
☐ Heart attack ☐ Pacemaker

Respiratory

☐ Asthma ☐ Emphysema ☐ Shortness of breath

Gastrointestinal

☐ Reflux ☐ Hepatitis ☐ Abdominal pain ☐ Diarrhea
☐ Incontinence ☐ Ulcers ☐ Bloating ☐ Heartburn
☐ Irritable bowel syndrome ☐ Constipation ☐ Nausea

Genitourinary

☐ Impotence ☐ Kidney stones ☐ Decreased libido ☐ Urinary frequency
☐ Urinary Incontinence ☐ Urinary tract infection ☐ Prostate problems ☐ Urinary hesitancy

Integumentary

☐ Herpes Zoster ☐ Skin Cancer ☐ Rash ☐ Swelling

Endocrine, Hematologic, Allergy/Immunologic, HEENT

☐ Cancer:_____ ☐ HIV ☐ Bruise easily ☐ Visual changes
☐ Diabetes ☐ Thyroid problems ☐ Ringing in ears

Rheumatologic

☐ Lupus ☐ Polymyalgia Rheumatica ☐ Other:_____

Social History

Please list everyone with whom you live:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Which of the following describes your marital status?
☐ Single ☐ Married
☐ Separated ☐ Divorced
☐ Widow(er) ☐ Other:_____

What is your employment status? (Current or former profession:_____)
☐ Full time ☐ Part time ☐ On disability ☐ Retired ☐ Workman's Comp ☐ Unemployed

How much education have you completed? ☐ Grade-yrs___; ☐ high school; ☐ college; ☐ other:_____

After your pain began, was your employer understanding of your pain problems? ☐ Y ☐ N

Do you having pending settlement for disability, workman's comp or a legal matter? ☐ Y ☐ N

Do you use or have used at any time any of the following?

Alcohol	Tobacco products	Illegal drugs (including narcotics)
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Present ☐ Past	☐ Present ☐ Past	☐ Present ☐ Past
		Please list: _____

Services and Treatment Policy

We are pleased that your physician has requested a consultation for you at the Duke Health Raleigh Hospital Pain Center. Our goal is to provide you with a proper diagnosis and plan for the most effective treatment of your pain.

We expect that you may have had previous attempts to treat your pain prior to your consultation with us. In many instances, the use of pain medications on a long-term basis is appropriate. However, the Duke Health Raleigh Hospital Pain Center is not obligated to prescribe narcotic drugs or provide any treatment procedures during your first consultation with us. We firmly believe it is in your best interest to have a complete evaluation in order to determine the most effective method to reduce pain and restore function. Continuing a therapy that does not achieve those goals would defeat the purpose of a new evaluation. Additionally, please do not terminate care with another physician because you have an appointment in the Duke Health Raleigh Hospital Pain Center. Based on the outcome of your evaluation, we may make recommendations to your current physicians without arranging further follow-up in the Duke Health Raleigh Hospital Pain Center.

Unfortunately, many conditions which cause chronic pain also cause disability. The process of disability evaluation and filing of claims is quite extensive. At the current time, the Duke Health Raleigh Hospital Pain Center does not perform disability evaluations. Your referring physician should be able to assist you in coordinating disability evaluations when appropriate.

Appointment Policy

If you are unable to make your scheduled appointment, you must call to cancel the appointment no later than 24 hours before the scheduled time. If you fail to cancel your appointment, you will be charged a “no show” fee. For most insurance plans and Worker’s Compensation carriers “no show” charges are non-covered services. You will be solely responsible for payment of this charge. Repeated “no shows” and cancellations of your scheduled appointments may result in your being discharged from care at the Duke Health Raleigh Hospital Pain Center. You will be referred back to your primary care physician or to another chronic pain management facility.

Billing Statement and Financial Policy

At the Duke Health Raleigh Hospital Pain Center, you will be treated by physicians from Carolina Pain Consultants. There will be ***two bills*** for each visit to the Duke Health Raleigh Hospital Pain Center. One bill from Duke Health Raleigh Hospital will be for technical and facility fees (nursing staff, office staff and supplies). The second bill from Carolina Pain Consultants will be for the physician’s professional services.

It is the policy of Duke Health Raleigh Hospital Pain Center and Carolina Pain Consultants to file claims to your insurance plan and / or Workman’s Compensation carrier. If you are not covered by an insurance plan or Workman’s Compensation carrier you are expected to pay in full. If you are pursuing a liability claim for injuries related to an accident or occurrence, you are expected to pay in full. If your insurance requires a co-pay, that payment will be collected by Duke Health Raleigh Hospital at the date of service. You may also be responsible for a co-pay as determined by your insurance for the provider charge, in addition to the facility co-pay. Your provider co-pay will be billed by Carolina Pain Consultants.

If you have questions about a Duke Health Raleigh Hospital Pain Center bill call Patient Accounting at 919.954.3488. If you have questions about a Carolina Pain Consultants bill call Customer Service at 919.873.9533.

My signature below confirms that I have read and agree to abide by the above policies.

Patient Signature Date

_____ _____

Witness Signature Date

_____ _____