



PATIENT INFORMATION FORM

Please Complete All Questions.

Account # _____

We welcome you as a patient and value our ongoing relationship during your course of treatment at Dunes Pain Specialists.

Patient **Legal** Name: Last _____ First _____ Middle _____

Preferred Name: _____

Social Security #: _____ Date of Birth: _____ Marital Status: _____ Sex: M F

Address: (Box/Street) _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ **This WILL NOT BE USED to send or receive patient information.**

E-Mails will include information pertaining to Dunes Pain Specialists.

Race: (Please Circle): American Indian/ Native Alaskan, Asian, Black/African American, More than 1 race, Native Hawaiian, Other Pacific Island, White, Refused

Ethnicity (Please Circle): Are you Latino or Hispanic. Yes No Refused

Primary Phone: Cell Home Work (_____) _____

How would you like to be contacted? *Mark all that apply.*

Secondary Phone: Cell Home Work (_____) _____

Call Text Email

Employer/School: _____ Retired: Yes No Disabled: Yes No

Name of Spouse/Closest Relative: (**Minors list both parents**) _____

Relationship: _____ Phone: _____

Referring Physician: _____ Primary Care Physician: _____

Primary Insurance: _____ ID #: _____ Group #: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

I authorize payment of benefits to Dunes Pain Specialists, including insurance payments, settlements from any lawsuit or workers' compensation proceedings, special case or lump sum settlements of which my attorney will pay upon receipt of any funds for services rendered by Dunes Pain Specialists. I authorize Dunes Pain Specialists to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Signature: _____

Patient or Legal Guardian if patient under 18 years old

_____ Date

Disclosure of Physician Ownership Form

A majority of Dunes Pain Specialists physicians, including your treating physician, may be owners of Dunes Surgical Hospital Limited Partnership ("Surgery Center"). You have the right to choose the provider of your healthcare services. Therefore, you have the option to use a healthcare facility other than the Dunes Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternate providers.

By signing this Disclosure of Physician Ownership Form, you acknowledge that you have read and understand the disclosure.

Signature: _____

Patient or Legal Guardian if patient under 18 years old

_____ Date

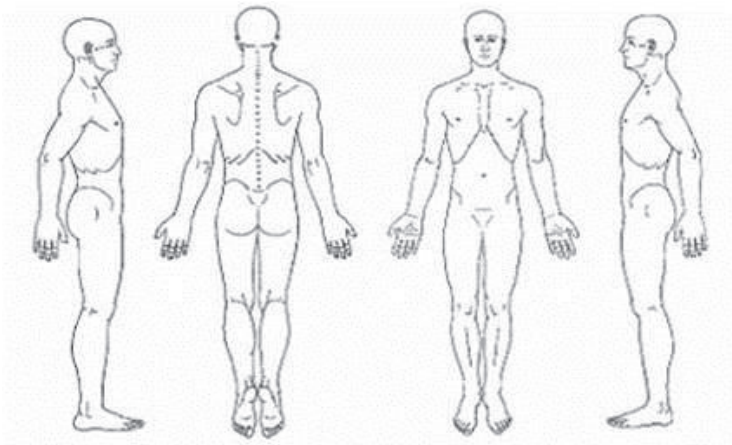
Notice of Privacy Practices Receipt Form

A copy of the Dunes Pain Specialists Notice of Privacy Practices was made available to me. Updated copies are available upon request at each visit.

Signature: _____

Patient or Legal Guardian if patient under 18 years old

_____ Date



Current Pain Level

1 2 3 4 5 6 7 8 9 10

Best Pain in last 7 Days

1 2 3 4 5 6 7 8 9 10

Worst Pain in last 7 Days

1 2 3 4 5 6 7 8 9 10

Mark affected areas: P=pain, T=Tingling, N=Numbness, B=Burning, S= Stiffness

Date of Injury/ Surgery

_____ Date of Injury (if applicable)

_____ Date of Surgery

Injured at work

Pain onset after Motor Vehicle Accident

Attorney Involved

Workman’s Comp

Pending lawsuit

Onset of Pain

Chronic (> 3 months) Sudden (< 3 months) Gradual

_____ Date of onset of pain

_____ How long have you experienced this pain

Quality of Pain

Burning Shooting

Cramping Dull/Aching

Tingling Sharp

Throbbing Numbness

Duration of Pain

Constant

Frequent

Intermittent

Occasional

Pain Modifiers

| | Relieved by | Worse With |
|---------------------|--------------------------|--------------------------|
| Laying Down | <input type="checkbox"/> | <input type="checkbox"/> |
| Heat | <input type="checkbox"/> | <input type="checkbox"/> |
| Ice | <input type="checkbox"/> | <input type="checkbox"/> |
| Movement | <input type="checkbox"/> | <input type="checkbox"/> |
| Position changes | <input type="checkbox"/> | <input type="checkbox"/> |
| Coughing / sneezing | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting | <input type="checkbox"/> | <input type="checkbox"/> |
| Standing | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending | <input type="checkbox"/> | <input type="checkbox"/> |
| Lifting | <input type="checkbox"/> | <input type="checkbox"/> |
| Turning | <input type="checkbox"/> | <input type="checkbox"/> |
| Sit to Stand | <input type="checkbox"/> | <input type="checkbox"/> |
| Upright activity | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | | |

Miscellaneous Symptoms

| | |
|------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Numbness of the Limbs | <input type="checkbox"/> Clumsiness |
| <input type="checkbox"/> Limb weakness | <input type="checkbox"/> Urinary retention |
| <input type="checkbox"/> Abnormality of walk | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Fecal incontinence |

Daily Activities Impaired by Pain

| | |
|----------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Work | <input type="checkbox"/> Socializing |
| <input type="checkbox"/> Yard Work, shopping | <input type="checkbox"/> Sexual activity |
| <input type="checkbox"/> Recreation | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Self Care |
| <input type="checkbox"/> House work | |

Previous Treatments:

| | Have Not Tried | If tried, mark relief | | |
|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | | None | Moderate | Excellent |
| Back Brace | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Physical therapy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chiropractic | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Medication | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Injections (types) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | | | |
| Other Therapy (types) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| _____ | | | | |

Past Medical History

| | |
|---------------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Chronic Bronchitis |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Clotting Disorder |
| <input type="checkbox"/> Chest Pain / Coronary Artery Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Obstructive Sleep Apnea |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Acid Reflex/Heart Burn | <input type="checkbox"/> Headaches |
| | <input type="checkbox"/> Recent Infection |
| | <input type="checkbox"/> Other |
| | <input type="checkbox"/> NONE |

Previous Imaging

| | |
|------------------------------------------------|-------------|
| <input type="checkbox"/> MRI – cervical spine | Date: _____ |
| <input type="checkbox"/> MRI- thoracic spine | Date: _____ |
| <input type="checkbox"/> MRI – lumbar spine | Date: _____ |
| <input type="checkbox"/> CT- cervical spine | Date: _____ |
| <input type="checkbox"/> CT-thoracic spine | Date: _____ |
| <input type="checkbox"/> CT-lumbar spine | Date: _____ |
| <input type="checkbox"/> EMG | Date: _____ |
| <input type="checkbox"/> Xray – cervical spine | Date: _____ |
| <input type="checkbox"/> Xray – lumbar spine | Date: _____ |
| <input type="checkbox"/> Xray – thoracic spine | Date: _____ |
| <input type="checkbox"/> Bone Scan | Date: _____ |

Allergies

| | Reaction |
|---------------------------------------------|----------|
| <input type="checkbox"/> NONE | |
| <input type="checkbox"/> Shellfish | _____ |
| <input type="checkbox"/> Codeine | _____ |
| <input type="checkbox"/> Penicillin | _____ |
| <input type="checkbox"/> Contrast dye | _____ |
| <input type="checkbox"/> Sulfa drugs | _____ |
| <input type="checkbox"/> Seasonal allergies | _____ |
| <input type="checkbox"/> Iodine | _____ |
| <input type="checkbox"/> Latex | _____ |
| Other _____ | |
| _____ | |

Surgical History

- | | |
|-------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Lung Surgery |
| <input type="checkbox"/> Hip replacement | <input type="checkbox"/> Tonsillectomy / Adenoidectomy |
| <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Nephrectomy |
| <input type="checkbox"/> Rotator Cuff Repair | <input type="checkbox"/> Laparoscopy |
| <input type="checkbox"/> Knee Arthroscopy | <input type="checkbox"/> Temporal Artery Biopsy |
| <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Carotid Endarterectomy |
| <input type="checkbox"/> Coronary Artery Bypass Graft | <input type="checkbox"/> Cataract Surgery |
| <input type="checkbox"/> Cardiac Catheterization | <input type="checkbox"/> History of Tubal Ligation |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> History of Cesarean Section |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> History of Prostate Surgery |
| <input type="checkbox"/> Gallbladder Surgery | <input type="checkbox"/> Radiation of the Thyroid |
| <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Thyroid Surgery |
| <input type="checkbox"/> Thoracotomy – Chest Surgery | <input type="checkbox"/> No Prior Surgeries |
| <input type="checkbox"/> Neck Surgery | |
| <input type="checkbox"/> Brain Surgery | |

Social History

Alcohol Use:

- Yes No Do you Drink, Drinks per Day _____
 Yes No Possible problem with alcohol

Tobacco Use:

- Yes No Smoking
_____ Cigarettes per day
 Yes No Previous History of Smoking
 Yes No Illicit Drug Use
 Yes No History of Alcoholics Anonymous (AA)
 Yes No History of Narcotics Anonymous (NA)

Marital Status:

- Yes Currently Married
 Yes Single
 Yes Divorced
 Yes Widowed

Employment Status

- Yes No
Occupation _____
 Yes Physical disability affecting ability to work
 Yes Occupation Student
 Yes Occupation Homemaker
 Yes Unemployed
 Yes Retired

Family History

- Suicide
- Mental Illness
- Alcoholism
- Drug/ Substance Abuse
- Cancer
- Acute Heart Attack
- Heart Disease
- Hypertension
- Early Death (non-natural cause)
- Other Family History

Please specify family member for each marked item:

Medications

Current Prescriptions: (Include ALL RX's)

| Medication | Dose | Frequency |
|------------|-------|-----------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |
| 6. _____ | _____ | _____ |
| 7. _____ | _____ | _____ |
| 8. _____ | _____ | _____ |
| 9. _____ | _____ | _____ |

Are you taking blood thinners? Yes No

Previously Tried Pain Medications:

(explain why the medication was discontinued)

| | |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |

Preferred Pharmacy: _____

Review of Systems

Head/Neck/Eyes

Headache
 Neck Pain
 Swollen Glands in the neck
 Pain in or around the eyes
 Vision Problems
 No Head Neck or Eye Problems

Musculoskeletal

Back Pain
 Shoulder Pain
 Shoulder Swelling
 Stiffness in the Morning
 Generalized Arthritis
 No Musculoskeletal Problems

Cardiovascular

Chest Pain or Discomfort
 High Blood Pressure
 Palpitations
 No Cardiovascular Problems

Gastrointestinal

Change in bowel habit
 Vomiting
 Nausea
 Diarrhea
 Constipation
 Heartburn
 Blood in Stool
 No Gastrointestinal Problems

Systemic

Recent Weight Gain
 Recent Weight Loss
 Feeling tired (fatigue)
 Fever
 No Constitutional Problems

Psychiatric

Anxiety
 Insomnia
 Nightmares
 Depression
 Suicidal Ideation
 No Psychiatric Problems

Pulmonary

Cough
 Wheezing
 Shortness of breath
 No Respiratory Problems

Neurologic

Difficulty with balance / walking
 Dizziness
 Numbness or Tingling
 Frequent Headaches
 No Neurologic Problem

Hematological

Easy Bruising
 Easy Bleeding
 No Hematological Problems

Skin

Itching
 Skin Rash
 Skin Swelling, mass, or lump
 No Skin Problems

Other

Other

PATIENT SIGNATURE: _____ DATE: _____

(Or Legal Guardian if patient is under 18 years old)

REVIEW OF THE ABOVE INFORMATION HAS BEEN COMPLETED WITH PATIENT.

PHYSICIAN SIGNATURE: _____ DATE: _____