Pain Management Center of Long Island

PATIENT COMMERCIAL INSURANCE DEMOGRAPHIC

Mark One:
☐ New Patient ☐ Change Name ☐ Change Address ☐ New Insurance Effective: ____________

Is this related to: Motor Vehicle Accident? ☐ YES ☐ NO
Work Related Accident? ☐ YES ☐ NO
If YES, DO not complete this form use WC or NF Demographic Form

Patient Last Name	**First Name**	**MI**	**Date of Birth**	**Age**	**Sex**

Patient Address	**City**	**State**	**Zip Code**	**Social Security #**

Marital Status	Primary Language	Race	Ethnicity:
☐ S ☐ M ☐ D ☐ W	☐ ENGLISH ☐ ____________	☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ Unknown ☐ White ☐ Decline Info	☐ Hispanic ☐ Non-Hispanic ☐ Type Unknown

Patient Telephone#	Patient Cell Phone #	Patient Work#	Email:

Emergency Contact	Relationship	Telephone #	Family Doctor Name & Phone:

Primary Reason for Visit	Referred to us by:	Pharmacy Name and Address:

1st Insurance	**Policy #**	Group #	Policy Holder Date of Birth

Policy Holder Name	Relationship to Pt.	Insurance Billing Address

2nd Insurance	**Policy #**	Group #	Policy Holder Date of Birth

Policy Holder Name	Relationship to Pt.	Insurance Billing Address

3rd Insurance	**Policy #**	Group #	Policy Holder Date of Birth

Policy Holder Name	Relationship to Pt.	Insurance Billing Address

PLEASE HAVE PHOTO I.D. AND ALL INSURANCE CARDS AVAILABLE

☆ **We can share you health information with your:**

Spouse ________ **Significant Other** ________ **Parent** ________ **Children** ________ **PCP** ______ **Attorney** ______

Other: ______________________________________

☆ I understand that copayments are due at time of service
☆ I understand that referrals are my responsibility
☆ I have received a copy of my HIPAA Privacy Policy

____
Patient Signature

BC5

Name:
DOB:
Date:

Comprehensive Pain Evaluation and History

Date:____________________ Height: ____________ Weight: __________ lbs. Blood Pressure: _______________ Right / Left Handed

ALLERGIES: ☐ **No Known Drug Allergies**

Allergic to:	Severity
____________________	☐ mild ☐ moderate ☐ severe ☐ anaphylactic
____________________	☐ mild ☐ moderate ☐ severe ☐ anaphylactic
____________________	☐ mild ☐ moderate ☐ severe ☐ anaphylactic
____________________	☐ mild ☐ moderate ☐ severe ☐ anaphylactic
____________________	☐ mild ☐ moderate ☐ severe ☐ anaphylactic

Do you have a care plan / healthcare proxy?
☐ Yes Name of person: ____________________
☐ No
☐ No answer, due to cultural/spiritual beliefs

Please list all previous **SURGERIES** : ____

____

Is there a family history of addiction or chronic pain? (specify) ________________________________

Have you had pneumonia vaccine ? ____________________

LIFESTYLE (Current Smoking Status:)

☐ Never Smoker
☐ Former smoker ....
Year Started _________
Year Stopped _________

☐ Current Every Day Smoker..... Year started smoking _______ #Packs per day _______
☐ Current Some Day Smoker..... Year started smoking _______ #Packs per day _______
☐ Tobacco smoker __Heavy __ Light...Year started smoking ____ # Packs / Day ____

☯ **MEDICAL HISTORY: Do you or have you had: (check all that apply)**

☐ Asthma
☐ Arrhythmia
☐ Bipolar Disorder
☐ Blood Disorder
☐ Cancer: ___________
☐ Cardiovascular Disease
☐ Cardiac Stents

☐ Depression
☐ Diabetes
☐ Heart Attack
☐ Hypertension
☐ Kidney Disease
☐ Liver Disease
☐ Migraines

☐ Peptic Ulcer Disease
☐ Seizures
☐ Sleep Apnea
☐ Stroke
☐ Thyroid Disease

Mother's Medical History ☐ No relevant history

____

Father's Medical History ☐ No relevant history

____

Please list all other **medical conditions** you have or are under treatment for? (Liste todas sus condiciones medicas)

☯ **What is the complaint which you are seeking help for**? (Cual es su dolor?)

☯ Is the pain related to an injury, cancer, surgery or other disease? (Es relacionado a un tipo de accidente, cirugia o enfermedad?)

☯ When did the pain begin? How long has it been present? (Cuando empezo su dolor y cuanto tiempo lo tiene?)

Name:
DOB:
Date:

☯ Since it began how has the quality changed? e.g. Increased, decreased, unchanged. (Como ha cambiado su dolor? Tiene mas, menos, sin cambios desde el inicio del dolor)

☯ How often does the pain occur? **Circle ONE** (Con que frecuencia le ocurre su dolor? Marque Uno)

Nonstop-continuous,	Several times a day,	Once a day	Several times a week	Several times a month
Seguido y constante	Varias veces diario	Ocurre diario una vez	Varias veces semanal	Varias veces semanal

☯ **For the following please use 0-10** (Del # 0 al 10, con diez siendo el dolor mas grave anote como le afecta su dolor?)

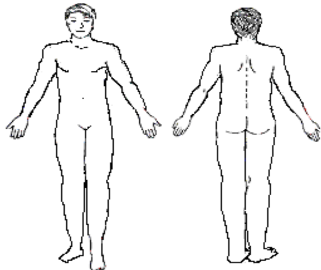
0 = no pain disruption, 10 worst pain imaginable extremely disruptive

Pain at its worst ? Maximo Dolor ________________

Pain at its best ever? Minimo Dolor ________________

Pain Score today (0 - 10) : ________________

☯ Please shade in the affected areas (Marque las areas de su dolor)



☯ Which characteristics describe your pain? **Check all that apply**. (Marque las descripciones de su dolor)

☐ Aching (agotado)	☐ Pins/Needles (hormigiante)	☐ Soreness/Stiff (tiezo)	☐ Other:
☐ Burning (arde)	☐ Radiates (dolor se extiende)	☐ Stabbing (apunalado)	____________________
☐ Cramping (calambres)	☐ Sharp (dolor que pica)	☐ Tender (tierno)	
☐ Dull (dolor leve)	☐ Shooting (dolor se dispara)	☐ Throbbing (palpitante)	
☐ Numbness (entumecido)	☐ Spasm (calambre)	☐ Tingling (dolor hormigiante)	

☯ What makes the pain better? (Que le alivia su dolor?)

☯ What makes the pain worse? (Que le empeora su dolor?)

☯ What specialist have you seen for the pain? Chiropractor, Neurologist, Orthopedist, Physical Therapist, Surgeon ?
Que especialistas ha consultado para su dolor? Quiropractico, Neurologo, Ortopedista, Terapia Fisica, Cirujano ?

Date seen Physical therapist (Fechas que tuvo terapia fisica?) ________________________

Date seen Chiropractor (Fechas que tuvo tratamientos quiropracticos) ________________________

Date seen Other (Fechas de otros especialistas?) ________________________

Name:
DOB:
Date:

☯ What therapies have you tried for the pain? Circle & write in others. Surgery , nerve blocks, brace, physical therapy, biofeedback, relaxation, TENS and Heat, injections, acupuncture, chiropractic, massage, hypnosis, ultrasound, etc.
(Que terapias le han hecho para su dolor? Marque todas y escriba si no estan listadas: Cirugia, inyecciones, terapia fisica, relajacion, maquina TENS, acupuntura, quiropractico, masajes, ultrasonido)

☯ What medicine do you currently take for your pain? Specify next to each who prescribes them to you and whether:
Helps, No-help or Not sure. Include over the counter, herbal and alternative preparations. (Que medicina esta tomando para su dolor? Especifique a lado de cada una si le ayuda. Incluya todas medicinas farmaceuticas y naturales)

☯ What other medication have you taken for pain? Why were they stopped? (Que otras medicinas ha tomado para su dolor? Porque las dejo de tomar?)

☯ Please list **all other medications** you are currently taking. Including over the counter herbal and alternative supplements.
(Liste todo tipo de medicamentos que esta tomando incluyendo vitaminas y hiebras naturales)

☯ Do you or have you used **illicit or un-prescribed drugs? If so, which ones**. (Usted usa drogas ilegales? Cuales)

☯ Do you share **drugs**? (Comparte o usa usted drogas?)

☯ How much **alcohol** do you consume in a week? (Cuantas bebidas alcolicas toma semanal?) ________________
Females: In the past year, how many times have you had 4 or more drinks in a day ? _______
Males: In the past year, how many times have you had 5 or more drinks in a day ? _______

☯ What is you **current employment status?** What type of work do/did you do? (Esta trabajando? Que tipo de trabajo hace?)

☯ Are you involved in any lawsuits ? (Tiene un caso legal ahorra contra alguien?)

Physician Signature ______________________ **Date** ______________