317-706-7246
(fax) 317-706-3417
www.IndyPain.com
8805 N Meridian St
Indianapolis, IN 46260

Returning Patient Registration Form

Center for Pain Management, Center for Special Surgery and Center for Southside Surgery

PATIENT INFORMATION

Name:____ **Today's Date:**___________________

SSN:________-________-________ **Sex: F / M D.O.B:**______/______/______ **Marital Status:**____________________

Address:____

City:________________________________ **State:**________________ **Zip Code:**__________________

Primary Phone:(_______**)**_______**-**___________ **Best Time to Call:**______________________________________

Email Address:____

Spouse Name:______________________________________ **Daytime Ph#:(**_______**)**_______**-**______________

Emergency Contact:__________________________________ **Daytime Ph#:(**_______**)**_______**-**______________

Referring Physician:_________________________________ **Phone#:(**_______**)**_______**-**______________

Primary Care Physician:______________________________ **Phone#:(**_______**)**_______**-**______________

Employer Information

Employment Status: ***Employed Unemployed Disabled Retired***

Occupation:______________________________ **Employer:**_____________________________________

Employer Address:____ **Ph#(**_______**)**_______**-**_____________

Are you retired? (please circle) Y / N **If yes, date retired:**___________________________________

Are you disabled or unemployed? Y / N **If yes, exact date last worked:**____________________________

Are you currently in school? Y / N **Full-time / Part-time** **School Name:**_________________________

GUARANTOR INFORMATION (the person responsible for the patient's account)

What is the patient's relationship to the guarantor? Self Spouse Child Other:_________________________

Guarantor Name:_________________________ **D.O.B.:**______/______/______ **SSN:**________-________-___________

Address:____

City:________________________________ **State:**________________ **Zip Code:**__________________

Home Phone:(_______**)**_______**-**___________ **Work:(**_______**)**_______**-**___________ **Cell:(**_______**)**_______**-**______________

eMail Address:____

Occupation:______________________________ **Employer:**_____________________________________

Employer Address:____

INSURANCE INFORMATION

Do you have MEDICAID? Y / N Medicaid Policy Number:____________________________

PRIMARY INSURANCE INFORMATION- Insurance card must be provided to front desk

Insurance Company Name:____

Policy Holder's Name:____ SSN:________-________-_________

Policy Holder's D.O.B.:_______/_______/_________ Relationship:____

Policy Number/ID#:_______________________________________

SECONDARY INSURANCE INFORMATION- Insurance card must be provided to front desk

Insurance Company Name:____

Policy Holder's Name:____ SSN:________-________-_________

Policy Holder's D.O.B.:_______/_______/________ Relationship:____

Policy Number/ID#:_______________________________________ Group#:__________________________________

OTHER INSURANCE INFORMATION- Information must be provided to front desk, if applicable

Is this an Accident / Injury? Y / N If yes, date of Accident / Injury:___________________________________

Worker's Compensation, *Auto Accident,* *Other Accident / Injury* (circle if applicable)

Are you currently involved in or pursuing litigation over these injuries? Y / N

If yes, Attorney Name:___________________________________ Law Firm:__________________________________

Attorney Phone#:(_______)_______-___________ Claim/Case#:____

Insurance Company or Worker's Compensation Carrier Name:____

Claims Mailing Address:____

Contact Name:____ Ph#(_______)_______-___________

Policy Holder's Name:____ SSN:________-________-_________

Policy Holder's D.O.B.:_______/_______/_________ Relationship:____

Claim/Case#:_________________________________ Employer Phone #:____________________________________

Employer Name:____

317-706-7246
(fax) 317-706-3417
www.IndyPain.com

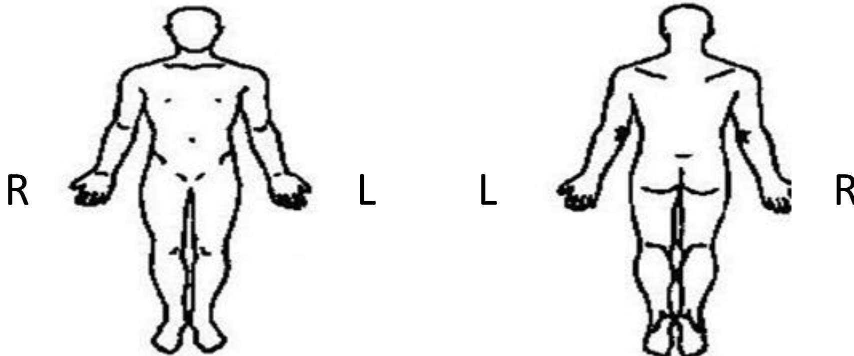
Returning Patient Pain History

Center for Pain Management, Center for Special Surgery and Center for Southside Surgery

HISTORY of PRESENT ILLNESS

Patient Name (please print): ____ M/F Age ______
Last name, First Name, Middle Initial
Have you ever been to another Pain Center? Yes / No If Yes, where/when: ______________________
What is the chief complaint that brings you to the doctor today? _________________________________
____
How did these symptoms begin? ____
When did you first start experiencing these symptoms? MM/DD/YY ______________________________
When did the symptoms progress to the current level of severity? ________________________________
Have you had Physical Therapy before? Yes/No If Yes, where: ____________________
When was your last Physical Therapy Appointment? ______________
How many visits have you had this year? ________

Please mark on the drawings below all areas where you are feeling pain:



Location: _________________________________ Severity: mild moderate severe

Quality: aching stabbing cramping shooting burning throbbing gnawing

sharp numbness tingling unbearable

Duration: Intermittent (stops & starts) or Persistent (all the time)

Modifying Factors
What makes it better: ____
What makes it worse: ____

HEALTH HISTORY INTAKE QUESTIONS
Center for Pain Management, Center for Special Surgery and Center for Southside Surgery

*Please note any changes in the past 6 months

Name: _______________________________________ **Date:** ________________

ALLERGIES: Do you have a Latex allergy? Yes / No

Please list all **allergies to medications** and reactions you have: ___________________________

____

FAMILY HISTORY: Please circle any of the following that are present in your family members

Alzheimers	Diabetes	Mental Illness
Anesthesia Reaction	Fibromyalgia	Rheumatoid Arthritis
Cancer	Heart Disease	Seizure
Chronic Pain	Lung Disease	Stroke
	Migraines	

PAST MEDICAL: Please circle any of the following for which **you have ever** received treatment

Alcohol Abuse	Drug Dependence	Obstructive Sleep Apnea
Anemia	Gastric Ulcer	Osteoperosis
Anesthesia Complications	Head Injury	Psoriasis
Anxiety Disorder	Hepatitis B	Psychological Trauma
Arthritis	Hepatitis C	Seizure Disorder
Asthma	Hiatal Hernia	STD
Bleeding Disorders	HIV / Aids	Spinal Surgery
Cancer[type:__________]	Hypercoagulopathy	Thrombophlebitis
Congestive Heart Failure	Hypertension	Tuberculosis
COPD	Hyperthyroidism	Urinary Tract Infection
Coronary Artery Disease	Hypothryoidism	
CVA(stroke)	Kidney Disease	
Depression	Liver Disease	
Diabetes	Other Medical Problems___________________________	

Currently on a blood thinner? Yes / No
If so, which medication: ____

Also any medications containing NSAIDS or aspirin.

I have had (or a family member has had) a problem (e.g. prolonged paralysis, or malignant-hyperthermia) under anesthesia: Yes / No

My last pneumonia vaccination was __/__/__ N/A My Last flu vaccination was __/__/__ N/A
My last mammogram was __/__/__ N/A My last colonoscopy was __/__/__ N/A

*Please note in changes in the past 6 months

MEDICATION HISTORY: Please list all **current pain** medication with **mg doses** and **frequency** (times taken per day):

1. ________________________________ 2. ____________________________________
3. ________________________________ 4. ____________________________________
5. ________________________________ 6. ____________________________________

Please list **all** other medication taken **including over the counter**, **weight loss, CBD and nutraceuticals**:

1. ________________________________ 2. ____________________________________
3. ________________________________ 4. ____________________________________
5. ________________________________ 6. ____________________________________

PAST MEDICAL: **Hospitalizations**: (please list all major illnesses with diagnosis and year)

1.____ 2.____
3. ____ 4.____
5.____ **6.** ____

Surgeries: (please list all surgeries and type along with year performed) (include spinal injections)

1.____ 2.____
3. ____ 4.____
5.____ **6.** ____

When and **where** have you had any of the following?:

MRI(s): ____

CT(s): ____

X-ray(s): ____

EMG: ____

REVIEW OF SYSTEMS: Please indicate if you have any of the following conditions or symptoms. Circle all that apply.

General Health:
Chills
Fatigue
Fever
Night Sweats
Weight Gain >10lbs
Weight Loss >10lbs

Skin:
Dryness
Excessive Sweating
Hair Loss
Nail Changes
Rash
Skin Color Changes

HEENT:
Bleeding Gums
Blurred Vision
Double Vision
Head Injury
Hearing Loss
Hoarseness
Vertigo
Visual Loss

Respiratory:
Cough
Decreased Exercise Tolerance
Difficulty Breathing
Hemaptysis
Snoring
Wheezing

Breast:
Breast Mass
Breast Pain
Nipple Discharge
Skin Changes

Cardiovascular:
Calf Cramps
Chest Pain
Difficulty Breathing Lying Down
Fainting/Blacking Out
Irregular Heart Beat
Shortness of Breath
Swelling of Extremities

Gastrointestinal:
Abdominal Pain
Black Tarry Stool
Constipation
Diarrhea
Difficulty Swallowing
Heartburn
Jaundice
Nausea
Rectal Bleeding
Vomiting

Musculoskeletal:
Joint pain
Joint Stiffness
Joint swelling
Muscle atrophy
Muscle weakness

Neck:
Neck Mass
Neck Stiffness
Swollen Glands

Neurological:
Decreased Memory
Difficulty Speaking
Headaches
Incontinence Stool
Incoordination
Loss of Consciousness
Seizures
Stroke

P*sychiatric:*
Anxiety
Change in Sleep Pattern
Depression
Hallucinations
History of abuse
Mood Changes
Panic Attacks
Suicidal Ideation

Endocrine:
Cold Intolerance
Excessive Thirst
Excessive Urination
Hair Changes
Heat Intolerance
Sexual Dysfunction
Thyroid Problems

Hematology:
Abnormal Bleeding
Anemia
Blood Clots
Easy Bruising

Information Provided by: ______________________________ Date: _________________________