Account # _____ Date_____

MEDICAL HISTORY INFORMATION

Name:_____Birthdate:_____Age:_____

Address: _____

Home Telephone:_____Cell Telephone:_____Work Telephone:_____

Social Security Number:_____ Marital Status: Single Married Divorced Widowed

Spouse's Name:_____Birthdate:_____ Social Security Number:_____

Spouse's Employer:_____ Work Telephone:_____

Referring Physician:_____Telephone:_____

Primary Care Physician:_____ Telephone:_____

Please list who you want our office notes sent to:

1. _____ 2. _____

_____ _____

Primary Insurance:	Secondary Insurance:
Name:_____	Name:_____
Address: _____	Address:_____
_____	_____
Insured's Name:_____	Insured's Name:_____
Group#: _____	Group #:_____
ID: _____	ID: _____
Telephone: _____	Telephone:_____
Employer: _____	Employer: _____

ASSIGNMENT OF BENEFITS

I request that payment of authorized benefits be made to Pain Consultants of East Tennessee on my behalf for any services rendered to me. I understand that I am financially responsible for all charges incurred regardless of insurance coverage.

_____ _____

PATIENT SIGNATURE DATE

MEDICARE PATIENTS ONLY

PATIENT NAME: _____ **MEDICARE NUMBER:**_____

I request that payment of authorized Medicare benefits be made on my behalf to PAIN CONSULTANTS OF EAST TENNESSEE, PLLC for any services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services.

_____ _____

PATIENT SIGNATURE DATE

Account # _____ Date_____

REVIEW OF SYSTEMS: (please circle any health problems you have now)

GEN:	fever	chills	weight changes	fatigue
CV:	chest pain swelling of feet/legs	palpitations	cyanosis	
RESP:	bloody sputum shortness of breath	cough	wheezing	
HEENT:	eye pain ringing in ears toothache	double vision change in smell	sinus pain mouth pain	
GI:	abdominal pain Constipation	vomiting bloody stools	diarrhea rectal bleeding	
MS:	muscle pain neck pain joint swelling	muscle weakness back pain stiffness	muscle cramps joint pain	
ALLERGY:	latex allergy	tape allergy	environmental allergies	
ABUSE:	physical	sexual	emotional	
GU:	painful urination urination at night	incontinence flank pain	frequent urination sexual problems	
HEM/ LYMPH:	blood thinners sickle cell anemia extremity swelling	HIV lymph node tenderness	hepatitis lymph node swelling	
NEURO:	headaches tremors numbness/tingling	dizziness paralysis coordination problems	seizures difficulty walking	
PSYCH:	nervous breakdown anxiety/nervousness suicidal plan	hallucinations insomnia	depression/mood changes suicidal thoughts	
ENDO:	heat intolerance excessive sweating	cold intolerance	abnormal hair growth	
SKIN:	rash	redness	itching	bruising

IF YOU ARE AGE 65 OR OLDER: Have you ever received the pneumonia vaccine (shot)? Yes No

Account # _____ Date_____

PAST MEDICAL HISTORY: (please circle any health problems you have ever had)

SKIN:	eczema	psoriasis	hives
		other:_____	
HEAD:	migraines	head injury	headaches
	trigeminal neuralgia	other: _____	
EYES:	glaucoma	cataracts	other:_____
ENT:	hearing loss	hearing aids	other:_____
RESP:	asthma	emphysema	bronchitis
	pneumonia	tuberculosis	COPD
	sleep apnea	other:_____	
CV:	heart attack	murmur	varicose veins
	high blood pressure	coronary artery disease	lower extremity edema
	blood clots	other:_____	
GI:	ulcers	colitis	crohn disease
	pancreatitis	constipation	GI bleed
	hiatal hernia	irritable bowel syndrome	hemorrhoids
	cirrhosis	GERD	other: _____
GU:	kidney disease	urinary tract infections	kidney stones
	prostate problems	STD	interstitial cystitis
	erectile dysfunction	low testosterone	other:_____
MS:	rheumatoid arthritis	osteoarthritis	osteoporosis
	multiple sclerosis	fibromyalgia	myofascial pain
		other:_____	
NEURO:	parkinson disease	CRPS	head injury seizures
	stroke/TIA	shingles	other:_____
PSYCH:	depression	anxiety	panic attacks
	suicidal attempts	nervous breakdown	bipolar disease
		other:_____	
BLOOD:	transfusions	anemia	leukemia
	sickle cell	HIV	hepatitis
	blood thinners	other:_____	
ENDO:	diabetes	thyroid problems	other:_____
ABUSE:	alcohol abuse	drug abuse type:_____	

Account # _____ Date_____

CONSERVATIVE TREAMENTS TRIED: (Please circle)

Physical Therapy	yes	no	Relief:	Good	Temporary	None	Worse
Home Exercise Program	yes	no	Relief:	Good	Temporary	None	Worse
Occupational Therapy	yes	no	Relief:	Good	Temporary	None	Worse
Chiropractic Treatments	yes	no	Relief:	Good	Temporary	None	Worse
Bracing	yes	no	Relief:	Good	Temporary	None	Worse
TENS Unit	yes	no	Relief:	Good	Temporary	None	Worse
Ice	yes	no	Relief:	Good	Temporary	None	Worse
Heat	yes	no	Relief:	Good	Temporary	None	Worse
Massage Therapy	yes	no	Relief:	Good	Temporary	None	Worse

Injection Therapy (if yes, by whom and when)_____

PAST SURGICAL HISTORY: (please list any surgeries that you have had in the past) _____
_____
_____
_____

FAMILY HISTORY: (Has anyone in your family (blood relatives only), besides yourself, had problems with any of the following)

heart disease lung disease cancer diabetes arthritis
nervousness chronic pain disability alcoholism
drug abuse or addiction emotional/psychiatric illness

SOCIAL HISTORY:

Employment: unemployed disabled full time part time odd jobs
retired worker's compensation working/on medical leave

Occupation: _____

Military Service: yes: past service current service no

Marital Status: single married separated divorced widowed

Tobacco use: none cigars quit _____years ago
cigarettes snuff/chew ____packs per day

Alcohol use: none ____drinks per day ____drinks per week
____drinks per month recovering alcoholic
Beer Wine Liquor

Account # _____ Date_____

Street drugs currently used: _____ □ none
Used in the past: _____
Used to help with pain? Yes No

How often do you use recreational drugs?
Frequently Sometimes Rarely Never

Have you ever been in rehab or treatment for drug or alcohol abuse? Yes No
When? _____

Have you ever been discharged from any **PAIN CENTER OR MEDICAL PRACTICE**? Yes No

MEDICATION ALLERGIES: (rash, swelling, itching): _____
_____

PAIN RELATED HISTORY:

Where do you hurt? _____

Rate your pain 0-10 (10 = worst imaginable) at times: _____

How would you describe your pain: (Circle all items that apply)

dull	aching	sharp	burning	stabbing	throbbing
cramping	stinging	shooting	squeezing	pounding	electrical shock

Is your pain? constant comes and goes

What things make your pain <u>better</u>? (Circle all items that apply)

bedrest	standing	sitting	walking	physical activity
coughing/sneezing	bending	heat	cold	position changes
lying flat on back / stomach		lying on right / left side		distraction (TV, etc)
alcohol	eating	weather changes		

What things make your pain <u>worse</u>? (Circle all items that apply)

bedrest	standing	sitting	walking	physical activity
coughing/sneezing	bending	heat	cold	position changes
lying flat on back / stomach		lying on right / left side		distraction (TV, etc)
alcohol	eating	weather changes	worry/stress	sex
lifting	driving			

What activities of daily living do you have difficulty performing? (Circle all items that apply)

bathing	dressing	eating	sleeping	cooking
cleaning	walking	transferring	driving	

Account # _____ Date_____

ORT ASSESSMENT INSTRUMENT:

PATIENT NAME: _____

ORT ASSESSMENT INSTRUMENT:

		MARK EACH BOX THAT APPLIES
1. Family History of Substance Abuse	• Alcohol • Illegal Drugs • Prescription Drugs	□ □ □
2. Personal History of Substance Abuse	• Alcohol • Illegal Drugs • Prescription Drugs	□ □ □
3. Age	Mark box if age 16-45 years)	□
4. Personal history of Preadolescent Sexual Abuse	Mark box if yes	□
5. Psychological Disease	• ADHD, OCD, Bipolar disorder, Schizophrenia • Depression	□ □

□ None of the above apply to me

ORT SCORE: _____ LOW MOD HIGH

PCET PROVIDER INITIALS: _____

DATE: _____

This assessment is a screening tool only. Patients have or will have a 45 minute face to face interview with one of our Behavioral Medicine Institute psychologist for their formal risk assessment given finding of the following publication.

Jones T and Passik SD (2011). "A Comparison of Methods of Administering the Opioid Risk Tool." *Journal of Opioid Management*. 7(5): 347-352.

Account # _____ Date_____

COMMUNICATION SHEET

NAME: _____

DOB: _____

HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

E-MAIL: _____

How do you prefer we contact you? _____

May we leave private information on your answering machine? _____

May we give private information to your spouse/family? _____

(Please specify name, relationship, and phone number)_____

May we e-mail private information to you? _____

Signature: _____ **Date:** _____

You must advise PCET in writing if the above information changes in any way.