New Patient Information

NORTHERN ANESTHESIA & PAIN MEDICINE, LLC

Please complete these pages in their entirety. You may inquire at our front desk or call **907-622-7246** if you have any questions or are unsure how to complete any section of this form.

Last Name:_____ **First Name:**_____ Date of Birth: _____

Any Previous names: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Street Address: _____ City/State/Zip_____

Mailing Address (if different) _____ City/State/Zip_____

Gender: ❑ Male ❑ Female Marital Status:_____

Email _____

Social Security Number: _____

Emergency Contact Name:_____ Phone:_____ Relationship: _____

Referral Information

Primary Care Provider_____ Clinic Name_____

Referring Physician _____ Clinic Name_____

Previous Pain Clinic(s)

Please list all pain management practices ("pain clinics") you have been to previously, and dates:

_____

_____

Demographic Information

Race **(required for Medicare)** ❑ American Indian or Alaskan Native ❑ Asian or Pacific Islander ❑ Black ❑ White ❑ Refuse to Report

Ethnicity **(required for Medicare)** ❑ Hispanic ❑ Non-Hispanic ❑ Refuse to Report

Primary Language: ❑ English ❑ Korean ❑ Russian ❑ Spanish ❑ Tagalog

❑ Other _____

Disabilities requiring special assistance: _____

Case Manager Name:_____ Phone number:_____

Primary Insurance Plan

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

Complete this box if you are *not* the policy holder for your primary insurance

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): _____ **Plan:** _____

Policy/I.D. Number: _____ Group Number: _____

Complete this box if you are *not* the policy holder for your secondary insurance

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim

Workers Comp Company: _____ Agent Name: _____

Phone number: _____ Fax number: _____

Claim Number: _____ Date of initial injury: _____

Preferred Pharmacy

Pharmacy Name: _____

Street/ City: _____

Name: _____

FOR NURSING

Height:_____ Weight:_____lbs T _____ BP _____ HR _____ RR _____

Current Medications

Please list *all* medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Please indicate which of the following blood-thinners you are taking: ❑None for the past month

❑Aggrenox ❑Coumadin (Warfarin) ❑Eliquis ❑Lovenox ❑Plavix

❑Pletal ❑Pradaxa ❑Prasugrel ❑Ticlid ❑Other _____

Allergies

Please list all medication allergies below, or check "None" if none known. ❑None

Medication	Reaction	Medication	Reaction

Topical Allergies: ❑Iodine ❑Latex ❑Tape Are you allergic to shellfish? ❑Yes ❑No

Past Medical History

I have been diagnosed with the following conditions:

❑ AIDS/HIV infection
❑ Alcoholism
❑ Anemia
❑ Angina
❑ Anxiety
❑ Asthma
❑ Atrial fibrillation
❑ Bipolar mood disorder
❑ Cancer (type) _____
❑ Chronic kidney disease
❑ Cirrhosis
❑ Congestive heart failure
❑ COPD
❑ Coronary disease
❑ Depression

- ❑ Diabetes (active / inactive / unsure)
- ❑ Diverticulitis
- ❑ DVT
- ❑ Emphysema
- ❑ Epilepsy (seizures)
- ❑ Esophageal reflux (GERD)
- ❑ Fibromyalgia
- ❑ Gallbladder disease
- ❑ Gastric ulcer
- ❑ Glaucoma
- ❑ Gout
- ❑ Headaches (chronic)
- ❑ Hearing loss
- ❑ Heart attack
- ❑ Hemorrhoids
- ❑ Hepatitis A, B, C (circle)
- ❑ High blood pressure
- ❑ Hyperlipidemia (high cholesterol or triglycerides)
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Kidney Stones
- ❑ Lupus
- ❑ Lyme disease
- ❑ Migraines
- ❑ Mitral Valve Prolapse
- ❑ Multiple Sclerosis
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Pacemaker/Defibrillator
- ❑ Psoriasis
- ❑ Pulmonary embolism
- ❑ Rheumatoid arthritis
- ❑ Schizophrenia
- ❑ Seizures
- ❑ Sleep apnea, use CPAP?____
- ❑ Spinal cord injury
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Urinary Incontinence
- ❑ Vertebral Compression Fracture
- ❑ Other Diagnosed Conditions:

_____

_____

_____

_____

Past Surgical History

❑ I HAVE NEVER HAD ANY SURGICAL PROCEDURES.

- ❑ ACDF (neck fusion) _____
- ❑ Aneurysm repair _____
- ❑ Appendectomy _____
- ❑ Bowel resection _____
- ❑ Caesarean section _____
- ❑ Coronary bypass _____
- ❑ Craniotomy _____
- ❑ Gallbladder removal _____
- ❑ Gastric bypass _____
- ❑ Hernia repair _____
- ❑ Hip replacement _____
- ❑ Hip surgery (other) _____
- ❑ Hysterectomy _____
- ❑ Knee replacement _____
- ❑ Knee surgery (other) _____
- ❑ Laminectomy _____
- ❑ Laparoscopy _____
- ❑ Ovarian surgery _____
- ❑ Prostate surgery _____
- ❑ Shoulder surgery _____
- ❑ Stent placement _____
- ❑ Spinal fusion (levels) _____
- ❑ Thyroidectomy _____
- ❑ Tonsillectomy _____
- ❑ Valve replacement _____
- ❑ Vascular surgery _____

❑ OTHER _____

Family History (biological parents only)

MOTHER alive / deceased/ unknown (circle one)

- ❑ Alcoholism
- ❑ Cancer
- ❑ Diabetes
- ❑ Genetic condition _____
- ❑ Heart disease_____
- ❑ High blood pressure
- ❑ Rheumatoid arthritis
- ❑ Stroke
- ❑ Other _____

FATHER alive / deceased/unknown (circle one)

- ❑ Alcoholism
- ❑ Cancer
- ❑ Diabetes
- ❑ Genetic condition _____
- ❑ Heart disease_____
- ❑ High blood pressure
- ❑ Rheumatoid arthritis
- ❑ Stroke
- ❑ Other _____

Social History

Smoking Status: ❑Never Smoked ❑Current smoker ❑Former Smoker ❑Other tobacco use

Packs Per Day_____ How many years did/have you smoked? _____

Alcohol Use: ❑None ❑Occasional ❑Daily/ drinks per day _____

❑History of Alcoholism ❑Current Alcoholism

Illegal Drug Use: ❑None ❑ Currently Using Illegal Drugs: _____

❑Currently Using Marijuana ❑Currently Using Someone Else's Prescription Medications

❑Formerly Used Illegal Drugs: _____

Have you ever abused narcotic or prescription medications? ❑No ❑Yes _____

Are you capable of becoming pregnant? ❑ Yes ❑No *If so*, are you currently pregnant? ❑ Yes ❑No

Occupation: _____

Regular Exercise: ❑No ❑Yes: activity and frequency _____

_____

Others who live in your home: ❑Spouse ❑Children ❑Other _____

REVIEW OF SYSTEMS

Mark the following symptoms that you **currently** suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.*

Constitutional: ❑ Difficulty sleeping/Insomnia ❑ Chills ❑ Fatigue ❑ Fever ❑ Headache
❑ Lightheadedness ❑ Night Sweats ❑ Unexplained Weight gain ❑ Unexplained Weight loss

Eyes: ❑ Diminished visual acuity (worsening vision) ❑ Eye pain

Ears/Nose/Throat/Neck: ❑ Dental Problems ❑ Ear pain ❑ Hearing Problems
❑ Nosebleeds ❑ Ringing in the Ears ❑ Sinus problems ❑ Recurrent Sore Throats

Endocrine: ❑ Change in cold / heat tolerance ❑ Dizziness ❑ Excess sweating ❑ Excess thirst
❑ Weakness of muscles

Respiratory: ❑ Recent upper respiratory infection ❑ Cough ❑ Coughing up blood
❑ Shortness of Breath on exertion ❑ Wheezing

Cardiovascular: ❑ Chest Pain ❑ Shortness of Breathing lying flat ❑ Fainting
❑ Irregular heartbeat ❑ Palpitations ❑ Shortness of Breath at Rest ❑ Swelling in the hands/feet

Gastrointestinal: ❑ Abdominal Cramps ❑ Bloody or Dark, Tarry Stools ❑ Constipation
❑ Loss of appetite ❑ Diarrhea ❑ Difficulty swallowing ❑ Heartburn ❑ Blood in Vomit
❑ Nausea ❑ Vomiting

Hematologic: ❑ Easy bleeding ❑ Easy bruising ❑ Frequent infections

Genitourinary/Nephrology: ❑ Change in Urine Flow/Frequency/Volume_____ ❑ Flank (Side) Pain
❑ Blood in urine ❑ Urinary incontinence ❑ Painful urination

Musculoskeletal: ❑ Neck Pain ❑ Back Pain ❑ Joint Stiffness
❑ Muscle cramps ❑ Muscle aches ❑ Joint Pain ❑ Joint Swelling

Skin: ❑ New skin discoloration ❑ New rash ❑ Open lesions/sores

Neurological: ❑ Limb weakness ❑ Involuntary movements

❑ Instability When Walking ❑ Difficulty speaking ❑ Confusion ❑ Memory Loss

❑ Paralysis ❑ Seizures ❑ Numbness/Tingling ❑ Tremors

Psychiatric: ❑ Feeling Anxious ❑ Depressed Mood ❑ Stress ❑ Suicidal Planning

❑ Suicidal Thoughts

Medical History and Consent for Treatment

I certify that the information herein is accurate, complete and true.

I authorize Northern Anesthesia & Pain Medicine (hereafter "NAPM") and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for NAPM to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review NAPM's Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize the NAPM to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize NAPM to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that NAPM will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

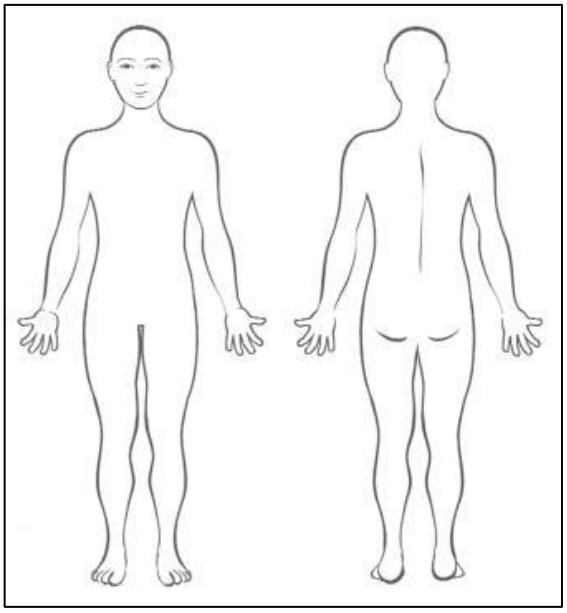
I understand that NAPM, as a Christian faith-based organization may offer prayer to me, which I have the right to refuse. I understand that NAPM may request offsite prayer on my behalf for my physical, mental/emotional and spiritual health condition, disclosing only my first name, and I have the right to forbid this by signing here: _____

Signed:_____ Date: _____

PAIN HISTORY

Where is your **ONE WORST** area of pain located? _____

Does **THIS** pain radiate? If so, where? _____



Please rate the descriptors below to describe your overall pain, if applicable. If different areas of pain have different qualities, please draw arrows to (or label) the diagram on the left.

PAIN QUALITY	NONE	MILD	MODERATE	SEVERE
1. Throbbing	(0)____	(1)____	(2)____	(3)____
2. Shooting	(0)____	(1)____	(2)____	(3)____
3. Stabbing	(0)____	(1)____	(2)____	(3)____
4. Sharp	(0)____	(1)____	(2)____	(3)____
5. Cramping	(0)____	(1)____	(2)____	(3)____
6. Gnawing	(0)____	(1)____	(2)____	(3)____
7. Hot-burning	(0)____	(1)____	(2)____	(3)____
8. Aching	(0)____	(1)____	(2)____	(3)____
9. Heavy	(0)____	(1)____	(2)____	(3)____
10. Tender	(0)____	(1)____	(2)____	(3)____
11. Splitting	(0)____	(1)____	(2)____	(3)____
12. Tiring-exhausting	(0)____	(1)____	(2)____	(3)____
13. Sickening	(0)____	(1)____	(2)____	(3)____
14. Fearful	(0)____	(1)____	(2)____	(3)____
15. Punishing-cruel	(0)____	(1)____	(2)____	(3)____

Please mark an "X" on the line below indicating your AVERAGE pain level this month, and minimum/maximum pain levels by "MIN" and "MAX"

0 1 2 3 4 5 6 7 8 9 10

When did **THIS** pain begin, and what started it? _____

_____

_____

Is **THIS** pain the result of a Motor Vehicle Accident or Personal Injury (legal term describing injury sustained to your person by negligence of another) ❑ No ❑Yes _____

What word best describes the frequency of **THIS** pain? ❑ Constant ❑ Intermittent

How did your current pain episode begin? ❑ Gradually ❑ Suddenly

Since **THIS** pain began, how has it changed? ❑ Decreased ❑ Increased ❑ Stayed the same

When is **THIS** pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings ❑ Middle of the night

What makes **THIS** pain worse? _____

What makes **THIS** pain better? _____

Are there any associated symptoms with **THIS** pain? (e.g., nausea, dizziness, imbalance, urinary incontinence)

_____

_____

Have you had any of the following studies done for **THIS** pain?

❑ Laboratory studies (blood drawn) _____ Date: _____

❑ X-rays_____ Facility: _____ Date: _____

❑ CT ("CAT scan")_____ Facility: _____ Date: _____

❑ MRI _____ Facility: _____ Date: _____

❑ EMG/NCV (nerve studies) _____Facility: _____Date: _____

❑ Other studies: _____

Please check ALL the pain treatments you have undergone previously:

❑Physical therapy ❑Chiropractic care ❑Acupuncture ❑Other alternative treatments

❑Joint injections _____ ❑Epidural steroid injections (circle: cervical / lumbar)

❑Facet blocks or medial branch blocks (circle: cervical/lumbar)

❑Radiofrequency ablation/"rhizotomy" (circle: cervical/lumbar) ❑ Trigger Point Injection

❑Pain psychology/counseling

❑ Discogram (circle: cervical/lumbar) ❑ Spinal Column Stimulator (circle: cervical/lumbar)

❑ Vertebroplasty / Kyphoplasty – Level(s) _____

❑ Other _____

Using the following scale: 0 = **NEVER**, 1 = **RARELY**, 2 = **SOMETIMES**, 3 = **OFTEN**, 4 = **VERY OFTEN**

How often do you have mood swings? 0 1 2 3 4

How often do you smoke a cigarette within one hour of waking up? 0 1 2 3 4

How often have you taken medication other than how it was prescribed? 0 1 2 3 4

In the past 5 years, how often have you used illegal drugs (including marijuana?) 0 1 2 3 4

How often have you had legal problems or been arrested? 0 1 2 3 4

- I don't get tired more than usual
- I get tired more easily than I used to
- I get tired from doing anything
- I am too tired to do anything

- I don't feel "like a failure"
- I feel I have failed more than most people
- Looking back, all I see is a string of failures
- I feel like a complete failure.

- I don't feel ashamed of myself
- I feel ashamed of myself often
- I am constantly ashamed of myself
- I feel that I am worthless

- I make decisions as well as I ever have
- I procrastinate/put off decisions
- I HATE making decisions
- I can't make decisions any more

- I don't ever think about harming myself
- I feel I would be better off dead
- I have made plans to commit suicide
- I am going to kill myself

- I am not pessimistic or discouraged
- I am discouraged about the future
- I feel I have nothing to look forward to
- I feel the future is totally hopeless

- I don't feel sad or unhappy this week
- I feel sad/unhappy this week
- I feel sad/unhappy all the time
- I feel so sad/unhappy I can't stand it

- I have NOT lost interest in other people
- I am less interested in others than usual
- I am disinterested in others and their feelings
- I don't care about others at all

- I am not particularly dissatisfied
- I don't enjoy things like I used to
- I don't get any satisfaction from anything
- I am dissatisfied/unhappy with everything

- I don't feel I look any worse than I used to
- I am worried that I look unattractive lately
- I am afraid I have "let myself go" for good
- I feel completely ugly

- My appetite is no worse than usual
- My appetite is worse than it used to be
- My appetite is much worse than usual
- I have no appetite at all

- I don't feel disappointed in myself
- I am disappointed with myself
- I am disgusted with myself
- I hate myself

- I can work about as well as before
- It takes extra effort to get anything started
- I have to push myself very hard to do anything
- I can't do any work at all

How has your pain affected your:

ENERGY _____ MOOD _____

SLEEP _____ WORK _____

EXERCISE _____ RECREATION _____

RELATIONSHIPS _____

Please list any **ADDITIONAL** areas of pain and relevant information: _____