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.

Demographic Information

Your Name: _____ Date of Birth: _____

Any Previous Names you have gone by: _____

Social Security Number: _____ Driver's License # / State: _____

Preferred Phone: _____ Secondary Phone: _____

Street Address: _____ City/State/Zip_____

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

Email **(required for Medicare)** _____

Emergency Contact Name: _____ Phone:_____ Relationship: _____

Gender: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

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: _____

Referral Information / Primary Care Provider

Were you referred to our clinic by another physician? If so, whom? _____

Who is your primary care provider? _____

Previous Pain Clinic(s)

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

_____

_____

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: _____

Worker's Compensation Claim Information

(Complete this section only if your visit today is related to a Worker's Compensation claim)

Workers Comp Company: _____ Agent Name: _____

Phone number: _____ Fax number: _____

Claim Number: _____ Date of initial injury: _____

Preferred Pharmacy

Pharmacy Name: _____ City: _____

FOR NURSING

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

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

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
❑Apixaban (Eliquis) ❑Aspirin ❑Clopidogrel (Plavix) ❑Coumadin ❑Dabigatran (Pradaxa)
❑Edoxaban (Savaysa) ❑Prasugrel (Effient) ❑Rivaroxaban (Xarelto) ❑Ticagrelor (Brilinta) ❑Other _____

Past Medical History

I have been diagnosed with the following conditions:

❑ AIDS/HIV infection	❑ Bipolar mood disorder	❑ Depression
❑ Alcoholism	❑ Cancer _____	❑ Diabetes
❑ Anemia	❑ Chronic kidney disease	❑ Diverticulitis
❑ Angina	❑ Cirrhosis	❑ DVT
❑ Anxiety	❑ Congestive heart failure	❑ Emphysema
❑ Asthma	❑ COPD	❑ Epilepsy (seizures)
❑ Atrial fibrillation	❑ Coronary disease	❑ Esophageal reflux (GERD)

- ❑ Fibromyalgia
- ❑ Gastric ulcer
- ❑ Glaucoma
- ❑ Gout
- ❑ Headaches (chronic)
- ❑ Hearing loss
- ❑ Heart attack
- ❑ Hemorrhoids
- ❑ Hepatitis A (active / inactive / unsure)
- ❑ Hepatitis B (active / inactive / unsure)
- ❑ Hepatitis C (active / inactive / unsure)
- ❑ 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
- ❑ Tuberculosis
- ❑ Urinary Incontinence
- ❑ Vertebral Compression Fracture
- ❑ Other Diagnosed Conditions:

_____

_____

_____

_____

Past Surgical History

- ❑ ACDF (neck fusion) _____
- ❑ Aneurysm repair _____
- ❑ Appendectomy _____
- ❑ Bowel resection _____
- ❑ Caesarean section _____
- ❑ Cholecystectomy (gallbladder removal)_____
- ❑ Coronary bypass _____
- ❑ Coronary stent placement _____
- ❑ Craniotomy _____
- ❑ Gastric bypass_____
- ❑ Hernia repair _____
- ❑ Hip replacement_____
- ❑ Hip surgery (other)_____
- ❑ Hysterectomy _____
- ❑ Knee replacement_____
- ❑ Knee surgery (other)_____
- ❑ Laparoscopy_____
- ❑ Ovarian surgery_____
- ❑ Prostate surgery_____
- ❑ Shoulder surgery _____
- ❑ Spinal decompression (discectomy,laminectomy) *Level(s)?*_____
- ❑ Spinal fusion *Level(s)?*_____
- ❑ Thyroidectomy _____
- ❑ Tonsillectomy _____
- ❑ Valve replacement _____
- ❑ Vascular surgery _____

❑ OTHER _____

_____

Social History

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

(Current) 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

Highest level of education obtained: ❑Grade school ❑High School ❑College ❑Post-graduate

Occupation: _____

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

_____

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

Family History (biological parents only)

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

REVIEW OF SYSTEMS

Circle any of the following you have experienced **THIS MONTH:**

Constitutional

Fatigue

Fever / Chills

Night Sweats

Weight Loss / Gain

Insomnia

Eyes

Recent Visual Changes

Head/ENT

Headache

Sinus problems

Hearing Problems

Ringing in the Ears

Recurrent Sore Throats

Dizziness (Vertigo)

Dental Problems

Respiratory

Shortness of breath

Cough

Coughing up blood

Wheezing

Cardiovascular

Chest Pain

Palpitations

Shortness of Breath

***Nighttime** Shortness of Breath*

Can't Sleep Laying Flat

Fainting/Lightheadedness

Feet or Leg Swelling

Gastrointestinal

Loss of appetite

Difficulty swallowing

Heartburn

Nausea / Vomiting

Vomiting Blood

Bloody or Dark, Tarry Stools

Abdominal Pain / Cramps

Diarrhea

Constipation

Genitourinary

Blood in Urine

Change in Urine Flow/Frequency

Flank Pain

Painful Urination

Urinary incontinence

Endocrine

Excessive thirst

Cold tolerance decrease

Heat tolerance decrease

Excessive sweating

Weakness of muscles

Hematologic

Easy bleeding

Easy bruising

Musculoskeletal

Neck Pain / Back Pain

Muscle Aches / Spasms

Joint Pain

Joint Swelling / Stiffness

Neurological

Dizziness / Fainting

Confusion / Memory Loss

Speech disturbance

Limb weakness / Paralysis

Involuntary movements

Instability When Walking

Numbness / Tingling

Seizures

Tremors

Psychiatric

Feeling Anxious

Depressed Mood

Suicidal Thoughts

Suicidal Planning

Skin

New skin discoloration

New rash

Open sores

Medical History and Consent for Treatment, Including TeleHealth Consent

Initial next to each paragraph to indicate that you have read, understood and agree with its content.

___ I authorize Northern Anesthesia & Pain Medicine (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 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 acknowledge that I have had the opportunity to review NAPM's Price Transparency Fee Schedule, which is displayed for public inspection at its facility and on its website.

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

___I authorize NAPM to release my Protected Health Information (medical records) 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.

___ If, during or after the COVID19 National Public Health Emergency my NAPM Provider advises the use of telehealth services, I consent/agree to receive telehealth services including assessment, treatment, diagnosis, and education, using interactive audio, video, and data communications. During my visit, my NAPM Provider and I will be able to see and speak with each other from remote locations. I consent to forwarding my information to a third party as needed to receive telehealth services, and I understand that existing confidentiality protections apply. I acknowledge that while telehealth can be used to provide improved access to medical care, as with any medical procedure, there are potential risks and no results can be guaranteed or assured.

I understand and agree that potential risks of telehealth include: (i) limited or no availability of diagnostic laboratory, x-ray, EKG, and other testing, and some prescriptions, to assist my medical provider in diagnosis and treatment; (ii) my provider's inability to conduct a hands-on physical examination of me and my condition; and (iii) delays in evaluation and treatment due to technical difficulties or interruptions, distortion of diagnostic images or specimens resulting from electronic transmission issues, unauthorized access to my information, or loss of information due to technical failures. I will not hold NAPM responsible for lost information due to technological failures.

I further understand that my NAPM Provider's advice, recommendations, and/or decisions may be based on factors not within his/her control, including incomplete or inaccurate data provided by me. I understand that my NAPM Provider relies on information provided by me before and during our telehealth encounter and that I must provide information about my medical history, condition(s), and current or previous medical care that is complete and accurate to the best of my ability.

___*I may discuss these risks and benefits with my NAPM Provider and will be given an opportunity to ask questions about telehealth services. I have the right to withdraw this consent to telehealth services or end the telehealth session at any time without affecting my right to future treatment by NAPM.*

I understand that reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation. All existing confidentiality protections under federal and Alaska State law apply to information disclosed during this telehealth consultation.

I understand that telehealth visits are currently covered by all major forms of health insurance however as with all medical services I am ultimately responsible for payment of services rendered by NAPM.

___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: _____

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

By my signature below, I certify that I have read, understood and agree with all provisions of NAPM's consent for treatment.

Signed:_____ Date: _____

Please check **ONLY ONE BOX** per row

Lately…

	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
Are you able to do chores such as vacuuming or yard work?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Are you able to go up and down stairs at a normal pace?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Are you able to go for a walk of at least 15 minutes?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Are you able to run errands and shop?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

	Never	Rarely	Sometimes	Usually	Always
I have trouble doing all of my regular leisure activities with others	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
I have trouble doing all of the family activities that I want to do	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
I have trouble doing all of my usual work (include work at home)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
I have trouble doing all of the activities with friends that I want to do	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

In the past 7 days…

	Not at all	A little bit	Somewhat	Quite a bit	Very much
How much did pain interfere with your day to day activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How much did pain interfere with work around the home?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How much did pain interfere with your ability to participate in social activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How much did pain interfere with your household chores?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

	Very poor	Poor	Fair	Good	Very good
My sleep quality was	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

	Not at all	A little bit	Somewhat	Quite a bit	Very much
My sleep was refreshing	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
I had a problem with my sleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I had difficulty falling asleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

	Never	Rarely	Sometimes	Often	Always
I felt fearful	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I found it hard to focus on anything other than my anxiety	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My worries overwhelmed me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I felt uneasy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

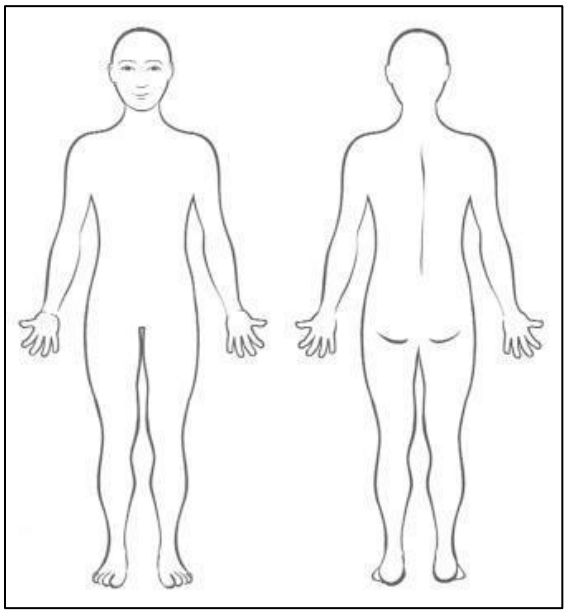
	Not at all	A little bit	Somewhat	Quite a bit	Very much
I feel fatigued	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I have trouble starting things because I am tired	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How run-down did you feel on average?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How fatigued were you on average?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

	Never	Rarely	Sometimes	Often	Always
I felt worthless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I felt helpless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I felt depressed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I felt hopeless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

In the past 7 days…

How would you rate your pain on average?

☐ 0 **No pain** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Worst pain imaginable**



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

_____

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

_____

*Please circle the **THREE** most relevant descriptors for this issue from this list:*

ACHING	CRAMPING	GNAWING	THROBBING
SHARP	SHOOTING	STABBING	BURNING
HEAVY	TENDER	SPLITTING	EXHAUSTING
SICKENING	FEARFUL	PUNISHING-CRUEL	

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 _____

Please check the box next to the word that best fits your pain condition:

Since it began, my pain has: ❑ Decreased ❑ Stayed the Same ❑ Increased

My pain is: ❑ Constant ❑ Intermittent

My pain is worst in the: ❑ Mornings ❑ Daytime ❑ 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:

❑Medication _____

_____

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

❑Pain psychology/counseling ❑Joint injections _____

❑Spinal injections _____

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

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