THE PAIN CENTER

VIRGINIA WEST VIRGINIA

COMPREHENSIVE PAIN CARE

Name: (Last) _____(First)_____(M.I.)_____ **Date:**_____/_____/_____

Address: _____

City: _____ **State:**_____ **Zip:**_____

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

Email Address: _____ ☐ Do not have email ☐Do not wish to provide

Date of Birth: _____/_____/_____ Gender: ☐Male ☐Female

Social Security Number _____/_____/_____

Emergency Contact:_____ Relationship:_____

Home Phone:_____/_____/_____ Cell Phone:_____/_____/_____

PCP Physician: _____Referring Physician: _____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Employment: ☐Employed ☐Unemployed ☐Disabled ☐Retired

Employer:_____Occupation:_____

Employer Address:_____

Guarantor (if patient is under 18 _____

Relationship:_____Home Phone:_____/_____/_____ Cell Phone:_____/_____/_____

Is this a: ☐Workers Compensation Injury ☐Accident Related Injury ☐Neither

Primary Insurance Carrier:_____

Policy #: _____ Group #: _____

Subscribers Name:_____

Subscribers Date of Birth: _____/_____/_____ Relationship to Patient:_____

Secondary Insurance Carrier:_____

Policy #: _____ Group #: _____

Subscribers Name:_____

Subscribers Date of Birth: _____/_____/_____ Relationship to Patient:_____

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Name of Pharmacy: _____

Address: _____ City: _____ State_____ Zip_____

Phone #: _____/_____/_____

Language: ☐ English ☐ Spanish ☐ Other ☐ Refuse to Report

Race: ☐ Black or African American ☐ White ☐ Hispanic ☐ Other Race ☐ Refuse to Report

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refuse to Report

PLEASE READ THE FOLLOWING DOCUMENTS AND INITIAL BELOW:

_____ **(initial)** **I have reviewed the Statement of Financial Policy**

_____ **(initial)** **I have reviewed the Patient Rights and Responsibilities**

_____ **(initial)** **I have reviewed the HIPAA Information and Consent Form**

RELEASE OF INFORMATION

It is The Pain Center's policy not to release information regarding your treatment to family or friends, except for (1) parent/legal guardian of a minor, (2) other persons authorized by the patient, (3) as we may reasonably infer from the circumstances (e.g., patient brings a family member/friend into the exam room), (4) in emergency situations, or (5) as otherwise permitted by federal and state law.

If you do not have anyone listed below they will not be able to call into our office for information regarding your care including your appointment date or time.

Please indicate below any individuals you authorize The Pain Center to release your medical information to:

NAME _____ Relationship _____ Phone #: _____

NAME _____ Relationship _____ Phone #: _____

NAME _____ Relationship _____ Phone #: _____

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Chief Complaint

_____

_____

_____

Smoking Status (circle)

☐Current every day smoker ☐Current some day smoker ☐Former smoker ☐Never smoked

What is your usage per day? _____

Alcohol Use (circle)

☐Non-drinker ☐Drink socially ☐Drink daily ☐History of alcohol abuse

How much do you drink per week? _____

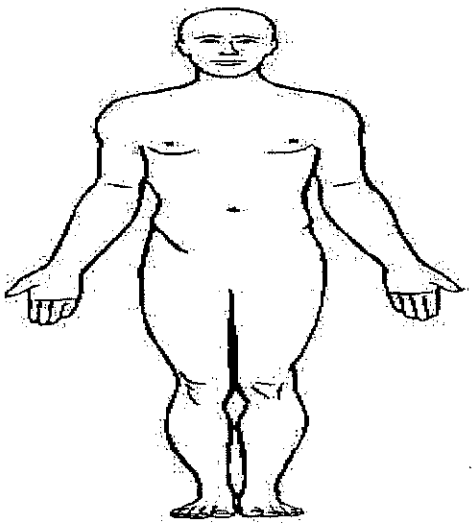
Illicit Drug Use

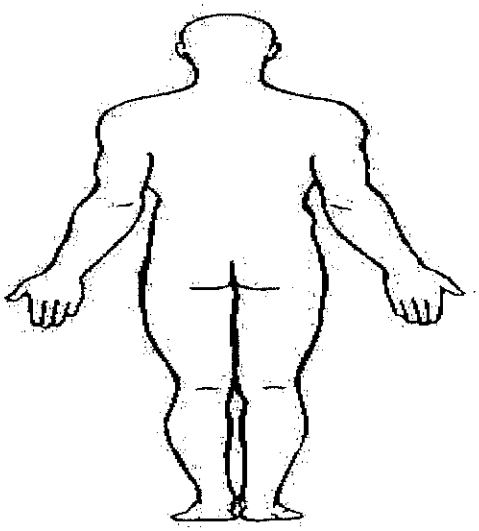
Do you use any illicit drug? ☐Yes ☐No

If yes, please specify ☐Marijuana ☐Cocaine ☐Heroin ☐Methamphetamines

☐Opioids ☐Inhalants ☐Other: _____

Location of pain. Draw X to indicate areas of deep pain. Draw Z to indicate areas of tingling and numbness. Use arrows to show areas that pain or tingling radiates/travels.





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Frequency of pain

☐Constant ☐Intermittent (comes and goes)

Description of pain

☐Aching ☐Burning ☐Radiating Pain ☐Sharp ☐Shooting

☐Electric Like ☐Stabbing ☐Dull ☐Deep ☐Tingling

Severity

☐Minor ☐Moderate ☐Severe

Pain Intensity

Rate your pain on a scale of 0 to 10 (0 is no pain and 10 is the worst pain possible) _____

Duration and Onset of Pain

How long have you had this pain? Specify days, months or years (example 6 months or 1 year)

_____

Describe how your pain started

☐Gradual ☐Sudden ☐Triggered

If triggered please explain (example if pain was caused by a fall or car accident, etc.)

_____

_____

What makes your pain worse?

☐Twisting ☐Sneezing ☐Coughing ☐Touch of Skin

☐Standing ☐Sitting ☐Bending Forward ☐Bending Backward

☐Walking ☐Exercise ☐Cold ☐Heat ☐Stress

☐Other:_____

_____

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What makes your pain better?

☐Standing ☐Sitting ☐Bending Forward ☐Bending Backwards

☐Walking ☐Medications ☐Exercise ☐Injections

☐Cold ☐Heat ☐Rest ☐Change Positions Frequently

☐Other:_____

_____

What treatments have you tried for your pain?

☐Medications ☐Physical Therapy ☐Acupuncture ☐Injections ☐TENS Unit

☐Chiropractic Care ☐Pain Management Service Elsewhere ☐Psychology/Counseling

Please specify your response (examples list names of medications tried, name of previous pain management, type of injections, etc.)

_____

_____

_____

Are any of the following symptoms associated with your pain?

☐Numbness ☐Swelling ☐Joint Pain ☐Muscle Pain ☐Tingling ☐Nausea

☐Palpitations ☐Dizziness ☐Vomiting ☐Seizures ☐Fainting

☐Shortness of Breath ☐Radiating Pain

Are you allergic to any medications, food, etc. Please specify (example Penicillin causes rash)

_____

_____

_____

Are you currently taking a blood thinner medication for a blood clotting disorder?

☐Yes ☐No If yes, specify the name of medication: _____

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Please list ALL the MEDICATIONS you are CURRENTLY taking. Specify the name, dose and frequency (example Ibuprofen 800mg two times daily). You may also attach CURRENT MEDICATION LIST.

Medication Name	Dose	Frequency

Family Medical History. Please list any family medical problems (example diabetes, heart attack, stroke, type of cancer, etc.)

Father: _____

_____

Mother:

_____

_____

Sister(s): _____

_____

Brother(s): _____

_____

Past Surgical History:

☐Angioplasty ☐Coronary Artery Stent ☐Coronary Artery Bypass Graft

☐Pacemaker ☐Carotid Endarterectomy ☐Appendectomy ☐Gastric Bypass

☐Cataract Extraction ☐Tonsillectomy ☐Adenoidectomy ☐Hysterectomy

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Patient Name: _____

Please check all CURRENT symptoms

General Health — All Normal
- ☐ Fever
- ☐ Chills
- ☐ Change in appetite
- ☐ Lack of energy
- ☐ Unexplained weight loss/weight gain

Ophthalmologic — All Normal
- ☐ Vision changes
- ☐ Blurred vision

ENT — All Normal
- ☐ Sore throat
- ☐ Sinus pain
- ☐ Hoarseness
- ☐ Swollen glands
- ☐ Difficulty swallowing

Endocrinology (Glands) — All Normal
- ☐ Intolerance to heat or cold
- ☐ Weakness

RESP (LUNGS & BREATHING) — All Normal
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Cardiovascular — All Normal
- ☐ Chest pain
- ☐ Palpitations

GI (Stomach and Intestines) — All Normal
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Abdominal pain

(MUSCLES BONES & JOINTS) — All Normal
- ☐ Radiating leg pain
- ☐ Loss of bowel/bladder control
- ☐ Radiating arm pain
- ☐ Numbness/tingling
- ☐ Lower extremity weakness
- ☐ Upper extremity weakness
- ☐ Shoulder pain
- ☐ Neck pain
- ☐ Low back pain

Peripheral Vascular — All Normal
- ☐ Cold extremities
- ☐ Decrease sensation in extremities

Integ (Skin Hair Breast) — All Normal
- ☐ Discoloration
- ☐ Rash
- ☐ Nail changes

Neurologic (brain and nerves) — All Normal
- ☐ Dizziness
- ☐ Balance difficulty
- ☐ Headache
- ☐ Loss of strength
- ☐ Loss of use of extremity

Psychiatric (Mood & Thinking) — All Normal
- ☐ Depressed mood
- ☐ Feelings of depression
- ☐ Anxiety
- ☐ Difficulty sleeping2

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MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to the providers at The Pain Center. When you schedule an appointment with The Pain Center we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective immediately, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hour notice** will be considered a No Show and charged a **$50.00 fee** (office visit) / **$100 fee** (procedure).
- Any established patient who fails to show or cancels/reschedule an appointment with no 24 hour notice a **second time** will be charged a **$75.00 fee** (office visit) / **$150 fee** (procedure).
- If a **third,** No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be **dismissed** from The Pain Center.
- Any new patient who fails to show for their Initial Visit will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **must be paid in full before any further appointments can be made.**

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office.

You may contact The Pain Center at the numbers below. Should it be after regular business hours Monday through Friday or a weekend, you may leave a message. Messages left at either location are acceptable.

The Pain Center of West Virginia 304-263-6165 located in Martinsburg, WV
The Pain Center of Virginia 540-773-2689 located in Winchester, VA
The Pain Center of Maryland 240-850-3210 located in Hagerstown, MD

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

I hereby consent to and authorize The Pain Center to apply the benefits on my behalf for the services rendered by Dr. Waheed Baksh, Kristen Williams PA-C, and Staff. I request payment from my insurance or responsible party be made to The Pain Center. I certify that all information I have provided is correct to the best of my knowledge. I authorize the release of any medical information for this claim or any related claim. I permit a copy of this authorization be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay the medical services proved to me. I understand that payment is due when the statement is rendered.

_____ _____

Signature Relationship to Patient

_____ _____

Printed Name Date