Pain Specialty Consultants, P.A.

1200 Brooklyn, Suite 140, San Antonio, Texas 78212
Phone: (210) 527-1166 • Fax: (210)527-1163

Patient History Form

Personal Data (please print)

Date: ____

Name: ____

Social Security #: ______________________________

Drivers License #: ____________________________

What is your current employment status?:

❒ Full Time ❒ Part Time ❒ Retired ❒ Homemaker

❒ Unemployed due to pain

Date last worked: ______________________________

Occupation: __________________________________

Have you changed your job for health reasons?

❒Yes ❒ No

What is your level of physical activity at work?

❒ Highly active ❒ Slightly Active

❒ Moderately Active ❒ Inactive

Birth Date: ______ Age: ______ Ht: ______ Wt: ______

If you consider yourself disabled, please indicate the date of onset of your disability : _________________________

Marital Status: ❒ Married ❒ Single

❒ Divorced ❒ Widowed # of times married: _______

Highest level of Education: ❒ Grade School

❒ High School - Grad. Date: _______ ❒ Voc/Tech/Bus

❒ College Degree ____________________________________

Have you ever felt like you had to cut down on medication?

❒ Yes ❒ No

Have people annoyed you by criticizing your medication use?

❒ Yes ❒ No

Name of person to contact in case of emergency:

Relationship: _________________________________

Address: ____________________________________

City: _________________ State: _____ Zip: _____

Phone: (bus.) ______________ (home) ________________

Have you ever felt guilty about your medication use?

❒ Yes ❒ No

Have you ever needed an eye opener or needed medication to feel normal? ❒ Yes ❒ No

Are you pregnant or is there a chance that you could be pregnant? ❒ Yes ❒ No

Have you or anyone in your family had a problem with an Anesthetic? ❒ Yes ❒ No

Are there any medical problems that run in your family? ____

Do you smoke? ❒ Yes ❒ No

Do you consume alcohol? ❒ Yes ❒ No

Sleep Pattern: ____

Do you exercise? ❒ Never ❒ Rarely ❒ Frequently Type _____________________________________

Do you have any emotional or psychological problems that concern you? ❒ Yes ❒ No

Have you ever seen a psychologist or a psychiatrist? ❒ Yes ❒ No

How many times have you been to the emergency room, because of the present pain? __________ Times

What do you want from your treatment? ____

What do you expect from your treatment? ____

If your pain cannot be helped what do you plan to do? ____

List any hobbies or special interests: ____

Health Questionnaire

Drug allergies: ❒ No ❒ Yes, Please List: ____

Current medications: what, if any, medications are you taking now. Please list all medications.

Medication	Why prescribed	Dosage	How Often	Effectiveness: Very/Not at all
1				
2				
3				
4				
5				
6				
7				
8				

Personal Medical History: (Please check and explain)

❒ High Blood Pressure	❒ Diabetes	❒ Glaucoma
❒ Mental Illness	❒ Abnormal Pap Smear	❒ Sexually Transmitted Disease
❒ Heart Disease	❒ Cancer	❒ Seizures
❒ Migraine Headaches	❒ Shortness of Breath	❒ Tuberculosis
❒ Kidney Disease	❒ Asthma	❒ Alcoholism
❒ Ulcers	❒ Fatigue	❒ Gout
❒ Bladder Infection	❒ Stroke	❒ Anemia
❒ Abnormal Bleeding	❒ Dizziness, Fainting	❒ Allergies
❒ Liver Disease	❒ Arthritis	❒ Fibromyalgia
❒ Thyroid Disease	❒ Sexual Dysfunction	❒ Other
❒ Mononucleosis	❒ COPD	❒

Explanation: ____
____

Check the box that applies to your work experience:

	Almost always	Some of the time	Hardly ever
I am satisfied that I can turn to a fellow worker for help when something is troubling me.			
I am satisfied with the way my fellow workers talk things over with me and share problems with me.			
I am satisfied that my fellow workers accept and support my new ideas or thoughts			
I am satisfied with the way my fellow workers respond to my emotions, such as anger, sorrow or laughter.			
I enjoy the tasks involved in my job.			
Please check the column that indicates how well you get along with your closest or immediate supervisor.			

List any surgeries you have had or hospital admissions:
Type of Surgery or Admission.

1.
2.
3.
4.
5.

CURRENT MEDICAL PROBLEM
Pain History:
Describe in your own words what your pain is like (location, how it feels, is it constant, does it come and go, do you have numbness, etc.) ____
____
____

How and when did your pain problem first start? (accident, disease, after surgery, date of onset, etc.)
____
____
____

How much work have you missed since pain onset ______________________________

Do you always have pain at rest? ______________________________

Physician's Comments
(for office use only)
Review of systems:
Constitutional: fever, chills, night sweat, weight gain, weight loss, anorexia, fatigue
Psych: depression, aggression, anxiety, suicidal ideation
GIT: nausea, vomit, diarrhea, constipation, heartburn, melena, hematochezia, abdominal pain
GU: nocturia, polyuria, polydipsia, hematuria, pyuria, incontinence
CVS: chest pain, palpitation, failure
Resp: cough, sputum, hemoptysis, SOB
Blood: bleeding dyscrasias, pallor
Skin: rash, lumps
Metabolic: polyphagia, hot, cold, obesity
Neuro: dizziness, tingling, numbness, syncope, headaches
Eyes: discharge, redness, vision

Alert Oriented: x3 HR BP RR

Mood: depressed, anxious
GPE: well developed, well nourished, well groomed
Scalp: normocehalic, nontraumatic
Eyes: Anemia, Icterus, PERRLA
Ears: no tragal tender, no discharge
Nose: septum central, mucosa pink, no polyps
Tongue: central moist, pink
Neck: supple, trachea central, no thy romegaly, no JVD
Chest: hyperresonant, CTA
Heart: S1S2, no murmur, no gallop
Abdomen: soft, nontender, no organomegaly
Extremeties: no calf tenderness, no edema, no clubbing, no cyanosis, pulses +

Type of pain:

❐ Sharp	❐ Dull Ache	❐ Burning	❐ Throbbing	❐ Tiring
❐ Constant	❐ Intermittent	❐ Tingling	❐ Cutting	❐ Sickening
❐ Pressing, Pulling	❐ Numb	❐ Cramping	❐ Other	❐ Punishing
❐ Stinging	❐ Stabbing	❐ Spasms	❐	❐ Fearful

Made worse by: ❐ Sitting ❐ Standing ❐ Walking ❐ Sneezing
❐ Coughing ❐ Straining ❐ Flexing ❐ Extension
❐ Light Stroking of Skin ❐ Other

Made better by: ❐ Rest ❐ Sitting ❐ Medication
❐ Other: ____

Time of day your pain is worse: ❐ Morning, on arising ❐ Later in morning
❐ Afternoon ❐ Evening
❐ Bedtime ❐ Night - sleeping hrs.
❐ Pain is always the same
❐ Pain varies - no particular time is worse

Have you had bowel changes: ❐ Yes ❐ No
Bladder changes: ❐ Yes ❐ No
Paralysis: ❐ Yes ❐ No

Have you noticed any of the following changes in the painful area:
❐ Increased nail growth ❐ Skin change ❐ Swelling
❐ Hair growth ❐ Sweating ❐ Goose bumps
❐ Temperature change, if so: ❐ Cold ❐ Hot

Physician's Comments
(for office use only)

Previous Treatment for Pain:	**Yes**	**No**	**Helpful**	**Not Helpful**	**Problem**
Nerve Blocks					
Surgery					
TENS Unit					
Occupational/Physical Therapy					
Biofeedback					
Hypnosis					
Counseling					
Chiropractic					

Which of the following tests have you had to evaluate your pain within the past six months to year?

Test	**Date**	**Results**
X-Ray		
Laboratory/Blood/Urine		
CT Scan		
MRI		
Epidurogram		
Myelogram		
Thermogram		
Bone Scan		
Rectal/Hemoccult		
Other		

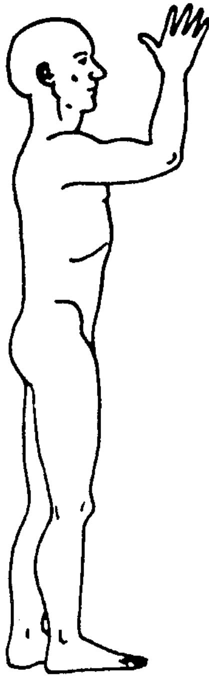
Name of Physicians involved in your medical care:

Physician	**Address**	**Phone**

Please complete Pain Chart on next page

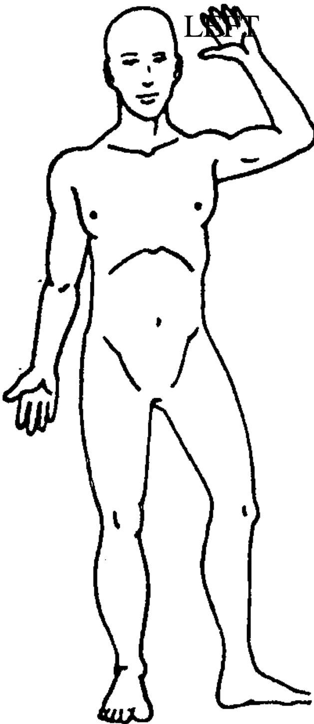
Mark the areas of your pain: (Please complete this page)

RIGHT



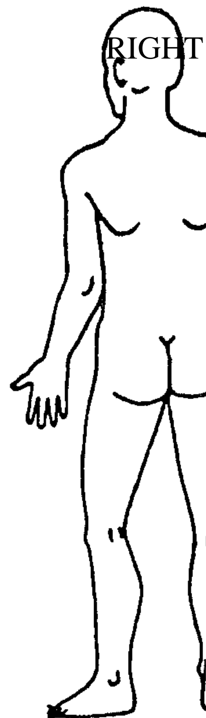
LEFT

RIGHT



LEFT

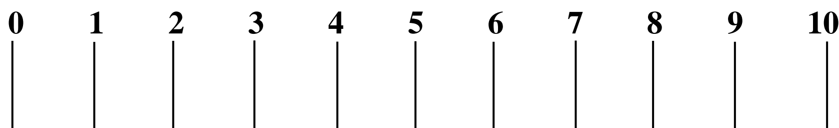
LEFT



RIGHT

On a scale of 0 to 10 rate your pain:

0 1 2 3 4 5 6 7 8 9 10



No Pain

Worst Pain Imaginable

Physician's Comments
(for office use only)

Physical Exam:
Gait: anantalgic/limp/slow/waddling/cane/walker/wheelchair
Coordination: heel knee/shin finger/nose
Cervical Spine: tender/spasm/ROM/spurling/distraction/valsalva
Thoracic Spine:

Lumbar Spine: paravertebral spasm/tender/S.I. joint/scar/gluteal tender/greater trochanter/ROM
Extremities: well built/atrophy/nontender/tender/length equal/unequal/spasticity pulses
FROM/Limited ROM/Phalen's (press)
Tinel's (tap)
- hips
- knee
- ankle
- foot
- shoulder
- elbow
- wrist

Sensory: loss of sensation, allodynia, nail change, temp change, hair change, skin change, color, pulses, trigger points
Motor: mass, power, tone, fasciculations, involuntary movement, reflexes

C:5 motor: shoulder abduct
sensory: lateral arm
reflex: biceps
C:6 wrist extension
sensory: lateral forearm
reflex: brachioradialis
C:7 motor: wrist flexion/finger extension
sensory: middle finger
reflex: triceps
C:8 motor: finger flexion
sensory; medial forearm

T:1 motor: finger abd/add
sensory: medial arm

L:4 motor: foot inver
sensory: medial leg
reflex: patellar
L:5 motor: toe exten
sensory: dorsal foot

S:1 motor: foot inver
sensory: lat foot
reflex: achilles

Misc: SLR/Patricks/Hoover/Freiburg (pirifomis)

Head:
supraorbital/infraorbital/occipital/auriculo temporal

NEW PATIENT INFORMATION

Pain Specialty Consultants, P.A.
1200 Brooklyn Ave, # 140
San Antonio, Texas 78212
Phone (210) 527 1166

Patient's Name______________________________________Date of Birth____________________________

Male ( ) Female ( ) Social Sec #___________________________ Phone #: Home____________________
Work Phone________________________
Cell Phone_________________________
Email _____________________________
Full Mailing Address:____

Primary Insured's Name________________________________Primary Insured's Date of birth______________

Primary Insured's Social Sec #__________________________Primary Insured's Employer__________________

Primary Insured's Employer's Address____

In case of emergency contact Name_____________________________Phone #___________________________
Emergency contact address____

Treating Physician (Primary Care)___________________________Phone #________________________________

Referring Physician________________________Phone#___________________________UPIN______________

Lawsuit Pending ( ) yes ( ) no Attorney's Name ________________________________Phone_____________
Insurance Information:
Private( ) PPO( ) HMO( ) Medicare A ( ) B ( ) Medicaid ( )
Carrier 1:____

Carrier2:____

The undersigned hereby authorizes the release of any information relating to all claims for the benefits submitted on behalf of myself and /or dependants. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for service to be rendered without obtaining my signature on each and every claim to be submitted for myself and /or dependants and that I will be bound by this signature as though the undersigned had personally signed the particular claim and understand that I am financially responsible for all charges incurred. As a insurance will be billed but any charge not paid by my insurance on each visit will be my responsibility. I understand I will get a statement mail for the unpaid charges. If these charges are not paid within 30 days then this may be sent to a collection agency which can impair my c have also reviewed the Notice of Privacy Practices of Pain Specialty Consultants dated effective 4-14-03, which explains how my health infor be used and disclosed. I authorize that my records may be released to my treating physician, referring physician or physicians or entities inv care. I understand that I am entitled to receive a copy of the Notice of Privacy Practices. I also hereby consent to the use and disclosure of m information for purposes of treatment, payment and other health care operations as set forth in the Notice of Privacy Practices. I will make aware of any insurance change prior to each visit or else be responsible for the charges.

Signature:____ Date__________________________________

Pain Specialty Consultants, P.A.
1200 Brooklyn Ave, Suite 140
San Antonio, TX 78212

Acknowledgement of Review of
Notice of Privacy Practices

I have reviewed the Notice of Privacy Practices of Pain Specialty Consultants, P.A. ("Pain Specialty Consultants") dated effective April 14, 2003, which explains how my health information will be used and disclosed. I understand that I am entitled to receive a copy of the Notice of Privacy Practices. I also hereby consent to the use and disclosure of my health information by Pain Specialty Consultants for purposes of treatment, payment and health care operations as set forth in the Notice of Privacy Practices.

____

Signature of Patient or Personal Representative Date______________________

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

Acknowledgement of Financial Policy

The undersigned hereby authorizes the release of any information relating to all claims for the benefits submitted on behalf of myself and / or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for service to be rendered without obtaining my signature on each and every claim to be submitted for myself and / or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim and understand that I am financially responsible for all charges incurred. As a courtesy my insurance will be billed but any charge not paid by my insurance will be my responsibility. If these charges are not paid within 30 days, then this may be sent to a outside collection agency which can impair my credit rating. I will make the office aware of any change in insurance, phone number and address prior to each visit or else be responsible for the charges.

Please call us during normal business hours and give us at least 24 hours to reschedule or cancel an appointment.

Payment of fees, co-pays and deductibles are due at the time of service and cannot be waived. Returned checks will accrue $30.00 returned check fee and any other bank fees payable only in cash.

I have read and understand the financial policy of the practice and agree to be bound by its terms. I also understand and agree that the practice may alter the terms at its discretion.

Signature of patient: ____________________________________ DOB:______________________

Name of Patient (printed):________________________________ Date:______________________

1200 Brooklyn Ave, Suite 140
San Antonio, TX 78212
Praful Singh, M.D.
(210) 527 1166

Discharge instructions for Epidural steroid Block/ Facet joint block:

1. Before you leave please make sure that you have a follow up appointment with Dr. Singh.

2. No driving for the next 24 hours. Do not sign any legal documents for the next 24 hours.

3. You may use cold packs at the injection site for the next 24 hours. Keep injection site clean and dry
.

4. Do not take any blood thinners like aspirin, coumadin, plavix etc till further orders.

5. You may eat your regular diet today.

6. Limit your walking. **Walk only with assistance for the next 10-12 hours**. Do not walk if you have any weakness in your legs.

7. You may shower tomorrow if you are able to stand alone.

8. You may remove any Band-Aids tomorrow. Apply an ice pack or heating pad to injection site if you have pain.

9. Limit your activity today. Bed rest may be necessary today

10. If you have leg weakness and/or numbness walk only with assistance.

11. If you should have any questions or concerns please call Dr. Singh's office at 210 527 1166

12. If you develop fever >100 degrees F, neck stiffness and/or new onset of leg weakness, severe headaches, call Dr. Singh's office.

13. You may take plain Tylenol for pain.(if you are not allergic to it.)

14. You may resume most of your normal medications. But do not take any blood thinners like aspirin, coumadin, plavix, ticlid etc for the next 24 hours. Avoid anti inflammatory medications for next 24 hours. If you are on Metformin (Glucophage) then check with us or your MD if need to hold it for a day or so.

15. Do not leave the office unless you understand all these instructions.

Patients Signature ____ Date _____________________