

York Pain Consultants, LLC, PA – Intake Sheet

SSN: _____

Home Phone: _____

Last Name: _____

Other Phone: _____

First Name: _____ MI _____

Male/Female

Address 1 _____

Date of Birth: ____ / ____ / ____

City _____ State _____ Zip _____

Employer: _____

Referring Doctor: _____

Marital Status: _____ Employment Status: _____

Primary Care Doctor: _____

Student: Part-time Full-Time

Pharmacy Name/Location _____

Responsible Party Information – Please Complete if Patient is Under 18

Last Name: _____

Home Phone: _____ Work Phone: _____

First Name: _____ MI _____

Male/Female

Address 1 _____

Date of Birth: ____ / ____ / ____

Address 2 _____

SSN: _____

City _____ State _____ Zip _____

Employer: _____

Primary Insurance Information

Secondary Insurance Information

Insurance Name: _____

Insurance Name: _____

Subscriber Name: _____

Subscriber Name: _____

Certificate Number: _____

Certificate Number: _____

Group Number or Name: _____

Group Number or Name: _____

Effective Date _____

Effective Date: _____

Worker's Compensation Information

Emergency Contact Information

Date of Injury: _____

Name _____

Claim Number: _____

Relationship to patient _____

Adjuster _____

Telephone _____

Name/Phone _____

I hereby authorize payment to go directly to York Pain Consultants, LLC, PA. I also authorize York Pain Consultants, LLC, PA to release information necessary to process my medical claim. I agree to allow York Pain Consultants, LLC, PA to release medical information to other medical practices (I.e. Primary Care Physician) that is necessary for my treatment. My personal history information will not be released to any outside facility not directly involved in my care and treatment.

I understand that I am financially responsible for all charges whether or not paid by insurance and for all services rendered on my behalf or my dependants.

I understand that in the case that my insurance requires a referral for treatment that it is my responsibility to acquire one. If I do not acquire one, I understand that I am responsible for all charges incurred at York Pain Consultants, LLC, PA.

Signature: _____ Date: _____

PAIN HISTORY

Name _____ DOB _____

Reason you are seeing the Doctor today: _____

Where is the pain located? _____

Date of injury/onset of pain: _____

Briefly describe the history of the problem: _____

What is the quality (description) of the pain?

- aching throbbing shock-like sharp pins and needles
 burning crushing pressure stabbing other _____

On a severity scale of 1-10 (1 being little pain and 10 being intolerable) my pain is a _____

Is there referred (radiating) pain, numbness, or tingling? no yes

Referred pain to _____

Referred numbness to _____

Referred tingling to _____

Pending Litigation/Compensation: no yes

List any factors that aggravate the pain:

- all exercise climbing stairs coughing
 driving sneezing walking standing sitting lying down
 weather changes other aggravating factors _____

List any factors that relieve the pain:

- applying cold applying heat lying down sitting down
 massaging area walking/moving other relieving factors _____

Please note any factors that go along with the pain:

- bladder dysfunction bowel dysfunction
 dizziness fever weakness other _____

List any previous tests related to this problem (in the last 12 months)

- CT scan EMG Myelogram Discogram Labs MRI Xray
 Other _____

List any previous treatments in the past 12 months (and their effectiveness on the pain):

Medications: (name)

- | | | |
|-------------------|--|---|
| _____ | <input type="checkbox"/> effective | <input type="checkbox"/> non-effective |
| _____ | <input type="checkbox"/> effective | <input type="checkbox"/> non-effective |
| _____ | <input type="checkbox"/> effective | <input type="checkbox"/> non-effective |
| Physical Therapy | <input type="checkbox"/> resolved <input type="checkbox"/> better <input type="checkbox"/> worse | <input type="checkbox"/> no change/unimproved |
| Injection Therapy | <input type="checkbox"/> resolved <input type="checkbox"/> better <input type="checkbox"/> worse | <input type="checkbox"/> no change/unimproved |
| Chiropractic | <input type="checkbox"/> resolved <input type="checkbox"/> better <input type="checkbox"/> worse | <input type="checkbox"/> no change/unimproved |
| Massage | <input type="checkbox"/> resolved <input type="checkbox"/> better <input type="checkbox"/> worse | <input type="checkbox"/> no change/unimproved |
| Acupuncture | <input type="checkbox"/> resolved <input type="checkbox"/> better <input type="checkbox"/> worse | <input type="checkbox"/> no change/unimproved |
| Biofeedback | <input type="checkbox"/> resolved <input type="checkbox"/> better <input type="checkbox"/> worse | <input type="checkbox"/> no change/unimproved |
| Tens Unit | <input type="checkbox"/> resolved <input type="checkbox"/> better <input type="checkbox"/> worse | <input type="checkbox"/> no change/unimproved |
| Psychologist | <input type="checkbox"/> resolved <input type="checkbox"/> better <input type="checkbox"/> worse | <input type="checkbox"/> no change/unimproved |
| Other _____ | | |

**YORK PAIN CONSULTANTS, LLC, PA
PATIENT HEALTH HISTORY**

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Social Security Number (SSN) _____ Appointment Date _____

Full Name _____ Male Female Date of Birth _____

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications)
 No Yes If yes, please list below..

Medication Name	Dosage	How often taken

ARE YOU ALLERGIC TO ANY MEDICATIONS? No Yes If yes, please list below.

Name of Medication	Type of Reaction

Are you allergic to seafood? No Yes If yes, what reaction do you have? _____
 Are you allergic to anything that touches your skin (such as latex, tape or metal)? No Yes latex tape metal

Have you ever been *DIAGNOSED* with any of the following problems?

- | | |
|--|--|
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Mental Health/Psychiatric |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease | |
| <input type="checkbox"/> Kidney Disease | |

SURGERIES AND HOSPITALIZATIONS

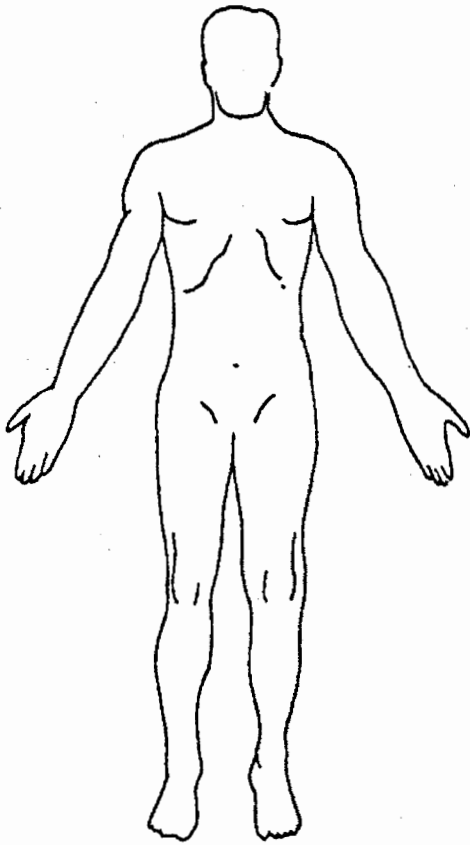
Please list all surgeries that you have had in the past (include dates): _____

FAMILY HISTORY

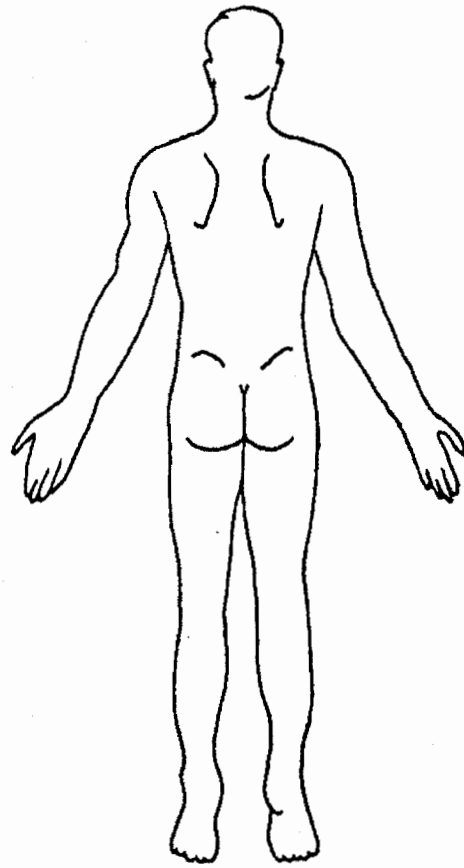
- No family history of significant or pertinent health problems.
 Other: _____

SOCIAL HISTORY

- Non-smoker Smoker: _____ Packs per day
 Alcohol: _____ times per week
 Recreational drug use



Front



Back

Please mark the location(s) of your pain on the diagrams above with an "X." If whole areas are painful, please shade in the painful area.

Office Policies

- 1. Appointments:** Please be on time. We will make every effort to keep your waiting time to a minimum. We do ask that you notify us if you are running late or will not make an appointment. We reserve the right to reschedule any appointment if you are 10 minutes late. We are *not* an emergency pain center and our role is not to schedule appointments on an “emergency basis”. We will always try to schedule patients as soon as possible for their given condition.
- 2. Phone Calls:** Our office hours are generally Monday through Thursday, 9 am to 5 pm. If you need to speak to the nurse for any issues, you will likely need to leave a message and we will get back to you by the end of the day. Medication refills require 24 to 48 hours notice and are not addressed off-hours or on an “emergency” basis. If there is a serious medical issue or emergency after hours, please go to the emergency room.
- 3. Medications:** At York Pain Consultants we specialize in advanced *interventional pain management* techniques to treat a variety of chronic pain conditions. Other treatment options include: medications (anti-inflammatory or NSAIDs, muscle relaxants, anti-seizure or antidepressants, narcotic and non-narcotic analgesics), physical therapy, manual therapy, chiropractic treatment, acupuncture, surgery, behavioral and psychotherapy, and many other alternative options. We make every effort to work with your primary care provider to make these referrals as appropriate. Our office does **not** typically “take over” writing prescriptions for pain medications. We are **not** a “narcotic management” center. Pain medications are specifically prescribed through our office in small amounts for post-procedure related pain while you are under our care, otherwise at our discretion. We will always work with your PCP to find a treatment plan that is appropriate for you; ultimately it is **your** responsibility along with your primary care provider to manage these prescriptions.
- 4. Urinalysis:** All new patients are asked to undergo a urine toxicology screening. This allows us to quantify the amount of any medications you might be taking, and also screens for illicit or illegal substances. You are not required to have this test.

____ **YES;** I consent to urine toxicology analysis. I understand that my insurance may be billed for these services, and I may be responsible for some of the cost as well. Repeat testing may be done randomly at any time. I also understand that any abnormal test results will preclude me from obtaining **any** prescriptions from this office, regardless of whether or not they are “controlled substances”.

____ **NO,** I do not consent to urine toxicology analysis. I understand that no prescriptions for any medications will be provided by York Pain Consultants.

Name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____
Christopher J. Delorie, DO