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Patient: ____________________

Appointment Date and Time: ____________________

Office Location: ____________________

Thank you for choosing InterveneMD. Our mission is to uphold high principles while providing safe, compassionate, high quality, cost-effective interventional pain management techniques for the diagnosis and treatment of pain and related disorders. We believe in educating you about your pain so that you can become an active participant in our treatment.

Included in this packet you will find directions to our office and our general office policies. You will also find a medical history and insurance form. Filling this form out completely prior to your visit will enable our physicians to spend more time answering your questions and discussing your treatment plan. Please bring this completed questionnaire with you to your initial appointment.

Please also bring your insurance card, a photo ID, and any recent office notes from you referring doctor (including any Xray or MRI reports).

If you are taking blood thinning medication, please let us know. If possible, contact the prescribing physician to see if you can safely stop these medications prior to any injections we may give.

We will do everything we can to accommodate your request to have an injection at this first visit. But, please remember that our first priority is to ensure that we have an adequate assessment of your pain, given you the opportunity to ask questions, and explained any procedures to your satisfaction.

If you have any questions, please feel free to call our office at 843-216-4844. We look forward to meeting you.

PATIENT INFORMATION

Last Name: ______________________________ First Name: ___________________ M.I.: ___________

Address: ________________________________ City: _____________________ State: ____ Zip:______

Phone (____) ____-_______ Cell: (____) ____-_______ Email: __________________________________

Birthdate: _____/_____/_______ Sex: M___ F___ Marital Status: S___ M___ D___ Sep ___

Social Security #: _______-_____-________ Occupation: _______________________________________

Employer: ___________________________________ Address: __________________________________

City: _____________________ State: ____ Zip: _________ Phone: (____) ____-_________

In Case of Emergency, notify: _______________________________________ Phone (____) ____-_____

INSURANCE INFORMATION

Insurance's Name or Responsible Party: ____

Relationship: _____________________________ Occupation: ___________________________________

Insured's Birthdate: _____/_____/_______ Social Security #: _______-_____-________

Address (if different from patient): ____

City: _____________________ State: ____ Zip: _________ Phone (____) ____-_______

Insurance Company: _____________________________________ ID #: __________________________

Group #: ____________________________________ Name on Card: ____________________________

Secondary Insurance: _____________________________________ ID #: _________________________

Group #: ____________________________________ Name on Card: ____________________________

I, the undersigned, certify that I (or my dependent) have insurance with ____________________________.
I assign directly to InterveneMD, Jeff Folk MD, Todd Joye MD, all insurance benefits otherwise payable to me for all services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure payment for these services.

I, the undersigned (or other responsible party), also voluntarily give my consent to InterveneMD, Jeff Folk MD, Todd Joye MD, and staff, to provide medical care, including examination, diagnostic testing, procedures and treatment to me, or to my dependent, as judged to be necessary and appropriate. I acknowledge that no guarantees of effectiveness are expressed or implied, that I have the right to decide the extent of my health care, including referrals to other health care facilities or professionals, and that I may refuse treatment.

____

Patient (or responsible party) signature Relationship Date

Pre Visit Questionnaire

Full Name: ____DOB: ____________________

Location of your Pain: ____

Who referred you to us: ____

Primary Care Physician: ____

HISTORY OF PRESENT ILLNESS

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain imaginable

Pain level today: ___________Worst pain: _________Least pain: _________Usual pain: _________

When and how did your pain start? ____

____

____

What activities increase your pain?

☐Coughing and Sneezing ☐Sitting ☐Standing ☐Lying Down ☐Bending

☐Rest ☐Walking, how far? _________________________ ☐Physical Activity

☐Sexual Activity ☐Posture ☐Time of Day or Night

Other, please describe: ____

What relieves your pain? ____

____

Have you had any of the following for your pain?

☐Chiropractor ☐Physical Therapy: # times per week _______ when was your last visit? ___________

☐Massage: # times per week _______ when was your last visit? ______________________________

☐Interventional Procedures (Injections like epidural, facet joint, SI joint, trigger point, etc). If so, please list them below:

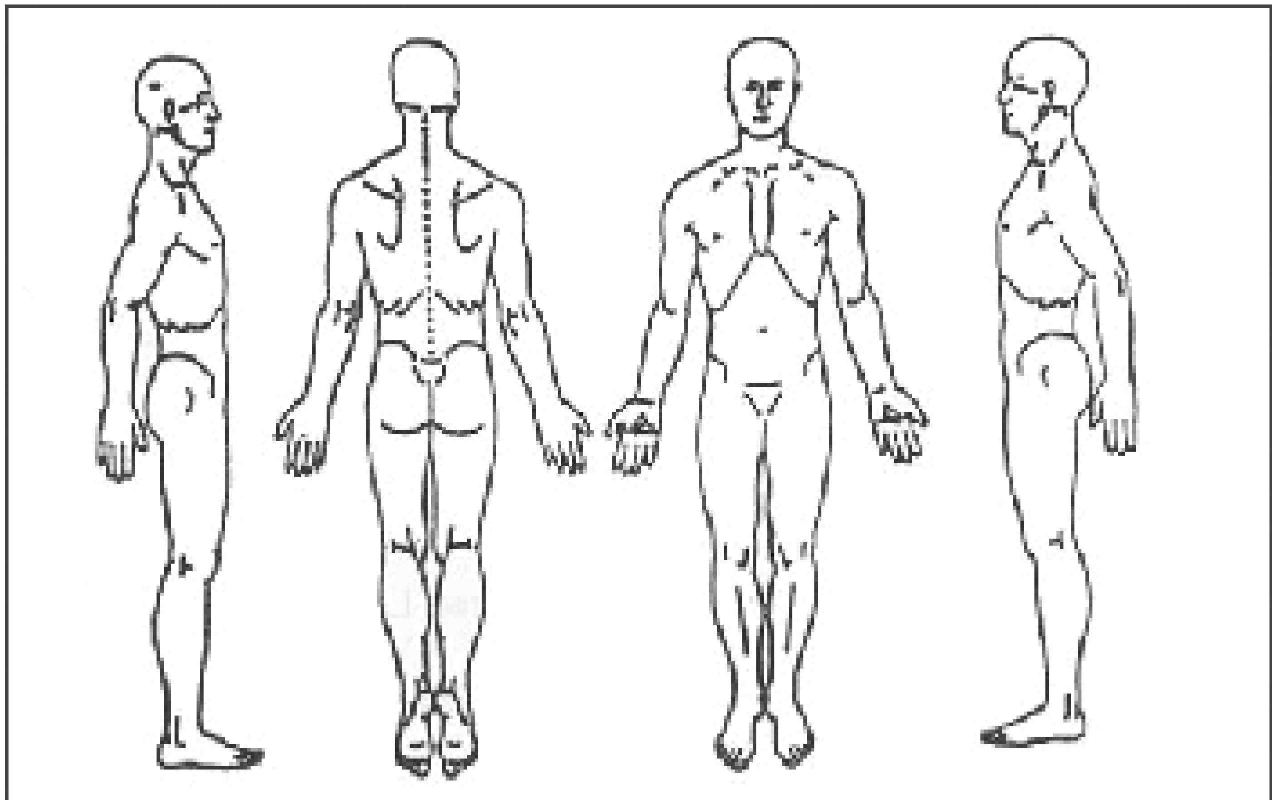
LAST?	RELIEF?	HOW LONG RELIEVED?
________________________________	☐Yes ☐No	____________________
________________________________	☐Yes ☐No	____________________
________________________________	☐Yes ☐No	____________________
________________________________	☐Yes ☐No	____________________

Patient Name ____ Date of Birth ____________________

PAIN DRAWING

Please fill this out carefully. Mark the area on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation of pain and include all affected areas.

Numbness - **N** Burning - **B** Aching - **A** Pins & Needles - **P** Stabbing - **S**



FAMILY HISTORY
Do any of these problems run in your family? (mom, dad, brother, sister, aunt, uncle)

☐No Problems

☐Arthritis ☐High Blood Pressure ☐HIV ☐Lupus ☐Fibromyalgia ☐Heart Attack

☐Heart Disease ☐Multiple Sclerosis ☐Diabetes ☐Epilepsy ☐Asthma

☐Depression ☐Bleeding Disorder ☐Schizophrenia ☐Hepatitis

☐Alcoholism ☐Thyroid Disorders ☐Chronic Pain

☐Cancer, please specify what kind and in which relative: ____

Patient Name ____ Date of Birth ____________________

SOCIAL HISTORY

Smoking ☐Yes ☐Never ☐Former Smoker - when did you quit? ______________________________
How many cigarettes per day _________ Cigars per day _________ Pipe ________

Do you drink alcohol? ☐No ☐Yes -how much? ____

Have you ever had a problem with alcohol? ☐No ☐Yes - explain ______________________________

Do you consume drinks with caffeine? ☐No ☐Yes

Do you use any street drugs? ☐No ☐Yes - explain ____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed # of Children ____________________

Have you ever been convicted of a crime? ☐No ☐Yes - what was the date and nature of the offense leading to conviction? ____

WORK HISTORY

<u>Currently at Work</u>: ☐Employed . ☐Full Time . ☐Part Time . ☐Self Employed

Occupation: ___________________________________ What shift do you work? ___________________
How many hours/day? ____________ How many hours/week? _______________
Describe job duties: ____

How many hours at work do you: ☐Stand - # hours ______ ☐Sit - # of hours _____

☐Walk - # of hours _____ ☐Bend - # of hours _____ ☐Computer work - # of hours ______

Do you lift at work? ☐No ☐Yes - how much weight? ______ lbs., how many times per day?_________

<u>Currently Not At Work</u>: ☐Unemployed ☐Retired ☐Disability
Other, explain ____
Last date of employment: ____

<u>Litigation History</u>

☐Open Case ☐Work Related ☐Personal Injury ☐Auto Accident

Claim # __________________________ Date of Injury: _______________________________________
Name of Adjuster/Case Worker: ____

☐Working with an Attorney, please tell us who ____

Patient Name ____ Date of Birth ____________________

SLEEP HISTORY

What time do you go to bed? ________ How long does it take you to fall asleep? ____________________

How many times do you wake up at night? ____

How many hours of sleep do you get per night? ____

How many hours of sleep would you like to get per night? ____

Have you taken sleep medications or natural supplements to help you fall asleep? ☐Yes ☐No
If yes, please list: ____

Does your pain wake you up at night? ☐Yes ☐No

FUNCTIONAL HISTORY

Do you require assistance: ☐Driving ☐Walking ☐Standing ☐Climbing Stairs

☐Lifting ☐Cooking ☐Bathing ☐Using the Toilet ☐Dressing ☐Shopping

☐Household Chores ☐Outdoor Yard Work

PAST MEDICAL HISTORY

Please check all conditions that you have been diagnosed with:

☐Heart Attack ☐Stroke ☐Blood Clots ☐Diabetes ☐Liver Disease

☐Asthma ☐Thyroid Disease ☐Kidney Disease ☐Depression ☐Alcohol/Drug Abuse

☐Ulcers ☐Seizures

ALLERGIES ☐No Known Allergies

☐Latex Allergy ☐IVP Dye Allergy ☐Iodine Allergy ☐Shellfish Allergy ☐Sulfa Allergy

☐Penicillin ☐Other - explain ____

PAST SURGICAL HISTORY - Please list surgeries and the year they were done

____

____

____

____

____

____

Patient Name ____ Date of Birth ___________________

MEDICATIONS

List all medications you currently take (prescription & non prescription). Use reverse side of this paper if necessary.

	Medication	Dose	Frequency	Date Started	Prescribing Doctor
1)					
2)					
3)					
4)					
5)					
6)					
7)					
8)					
9)					

List all medications you have previously taken for your pain problem **EFFECTIVE?**

1)____ ☐Yes ☐No

2)____ ☐Yes ☐No

3)____ ☐Yes ☐No

4)____ ☐Yes ☐No

5)____ ☐Yes ☐No

REVIEW OF SYSTEMS

Constitutional Symptoms ☐No Problems

☐Weight loss _________lbs, during the past ______________________

☐Weight gain _________lbs, during the past ______________________

☐Recurrent fever ☐General weakness ☐Fatigue ☐Chills

☐Insomnia ☐Excessive sleeping

Ear/Eyes/Nose/Throat . ☐No Problems

☐Hearing loss ☐Ringing in Ears ☐Blurred Vision ☐Difficulty Swallowing ☐Hoarseness

Patient Name ____ Date of Birth ___________________

Neurological ☐No Problems

☐Incontinence of urine or stool ☐Frequent or recurrent headaches ☐ Fainting

☐Blackouts ☐Stroke ☐Gait difficulties ☐Paralysis ☐Frequent Falls

☐Tremors ☐Neuropathy ☐Weakness, where?_________________________________

☐Seizures ☐Epilepsy ☐Polio Dizzy Spells ☐Vertigo

☐Ataxia ☐Paresthesia ☐Confusion ☐Problems with concentration

☐Hyperesthesia ☐Speech Disorder ☐Problems with thinking or thought process

☐Problems with memory

Psychiatric ☐No Problems

☐Suicidal thoughts ☐Depressed ☐Anxious ☐Shaky ☐Agitated

☐Obsessive Compulsive Disorder ☐Post Traumatic Stress Disorder

☐Sexual Abuse History ☐Domestic Violence ☐Previous Suicide Attempts

☐Panic Episode ☐Paranoia ☐Hallucinations ☐Crying Spells

☐Mood Swings ☐Nervousness

Have you had any previous hospitalizations for psychiatric care or treatment? ☐Yes ☐No

History of substance abuse or rehab? ☐Yes ☐No

Hematologic ☐No Problems

☐Blood Transfusion ☐Bleeding Disorders (Hemophilia) ☐Anemia

☐Easy Bruising ☐IV Drug Use ☐Enlarged Lymph Nodes

Musculoskeletal ☐No Problems

☐Muscle Cramps ☐Stiff Joints ☐Swelling of Joints ☐Generalized Arthritis

☐Rheumatoid Arthritis ☐Fibromyalgia Syndrome ☐Osteoporosis

☐Neck Pain ☐Upper Back Pain ☐Low Back Pain ☐Heel spur ☐Joint Pain

☐Hardware ☐Deformity ☐Limited Range of Motion

☐Gout ☐Difficulty with Walking ☐Pain in Feet ☐Cold Upper Extremity ☐R ☐L

☐Cold Lower Extremity ☐R ☐L

Patient Name ____ Date of Birth ___________________

Cardiac ☐No Problems

☐Heart Disease ☐Swelling of Feet ☐High Blood Pressure ☐Chest Pain

☐Heart Murmur ☐Heart Failure ☐Stents ☐Shortness of Breath with Walking

☐Pacemaker ☐Shortness of Breath When Lying Flat ☐Palpitations

☐Rheumatic Fever

Peripheral Vascular ☐No Problems

☐Thrombophlebitis ☐Poor Circulation

☐Blood Clots ☐Varicose Veins ☐Vascular Surgery

Infectious Disease ☐No Problems

☐Hepatitis ☐A ☐B ☐C

☐HIV ☐Herpes ☐Shingles ☐Tuberculosis

Gastrointestinal ☐No Problems

☐Irritable Bowel Syndrome ☐Crohn's Disease (Ulcerative Colitis)

☐Constipation ☐Diarrhea ☐Chronic Laxative Use

☐Eating Disorder ☐Heartburn ☐Jaundice Blood in Stool

Urinary ☐No Problems

☐Kidney infections ☐Blood in Urine ☐Difficulty with Urination ☐Painful Urination

Endocrine ☐No Problems

☐Diabetes ☐Use Insulin ☐Goiter ☐Excessive Sweating ☐Infertility

☐Thyroid Disorder ☐Excessive Thirst ☐Excessive Eating ☐ Decreased Sex Drive

Respiratory ☐No Problems

☐Cough ☐Wheezing ☐Asthma ☐Bronchitis

☐Emphysema ☐Pneumonia ☐Sleep Apnea ☐CPAP at Night

Other ☐No Problems

☐Cancer – Specify ____

☐Rashes, Scars

Patient Name ____ Date of Birth ____________________

SCHOOL HISTORY

Circle your highest completed level of education:

Post Graduate (PhD/Masters/Professional) College High School Elementary

Do you have any difficulty

☐Reading ☐Writing ☐Speaking ☐Understanding English

RADIOLOGICAL TESTS

Which of the following tests have been performed? Mark only applicable tests and dates if known.

☐Regular X-rays of ____

☐CT scan of ____

☐Myelogram of ____

☐MRI of ____

☐Discogram of ____

☐Bone Scan of ____

☐Nerve Conduction Study of ____

☐Other, specify ____

Patient Name ____ Date of Birth ____________________

TREATMENT GOALS

What do you expect to accomplish at interveneMD? (Please check all that apply)

☐Ability to return to work ☐Complete pain relief ☐Partial pain relief

☐Decreased medication use ☐Increase in activity ☐Better mood or behavior

☐Other, please explain ____

When do you expect these changes in your pain to occur?

☐Overnight ☐A couple of weeks ☐One month ☐Six months

☐Other, please explain ____

____

Treatment Expectation Pain Scale: 0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain imaginable

If you are currently not working, what pain score is needed to get you back to work? ____________________

If your pain is currently limiting leisure activities or hobbies, what pain score is needed to get you back into these activities? ____

THANK YOU!

Thank you for completing this rather lengthy questionnaire. We realize it can be exhausting to fill out this information. Please know that your answers will be most useful in helping us to understand you and your pain, as well as how different you are from other people who have similar types of problems. If there is anything else you think we should know at this time, please feel free to use the lines below.

Any additional information, comments or questions:

____

____

____

____

____

____

____