Updated Patient Information

General Information

Date: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Employer: _____

Employer Address: _____

Spouse Name: _____

Phone Numbers

Home: _____

Work: _____

Cell: _____

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

Updated Subjective Complaint Form

1. Present Complaint(s) - Please be specific: _____

2. Explain how it happened and whether it is work, non-work related, auto accident, or other:

_____

3. Symptoms have persisted for: ☐ hours ☐ 1 day ☐ days ☐ weeks ☐ months ☐ years

4. Complaint(s)/Symptoms: ☐ come and go ☐ came on gradually ☐ came on suddenly

5. What makes your condition worse? ☐ nothing ☐ lifting ☐ trying to stand ☐ standing ☐ walking ☐ sitting ☐ movement ☐ exercise ☐ inactivity ☐ work activities ☐ home activities ☐ other

6. What makes your condition better? ☐ nothing ☐ lifting ☐ trying to stand ☐ standing ☐ walking ☐ sitting ☐ movement ☐ exercise ☐ inactivity ☐ work activities ☐ home activities ☐ other

7. Quality of your pain: ☐ deep/dull ☐ tight ☐ spasm ☐ sharp ☐ numbness ☐ stabbing ☐ other

8. Does this pain radiate? ☐ yes ☐ no If yes, from where to where: _____

9. Pain Level: On a scale of 0-10, with 0 being you're pain free and can function quite well, and 10 being you're in excruciating pain all of the time, where would you rate your intensity of pain?

0	1	2	3	4	5	6	7	8	9	10
No Pain			Low Pain			Moderate Pain			Intense Pain	

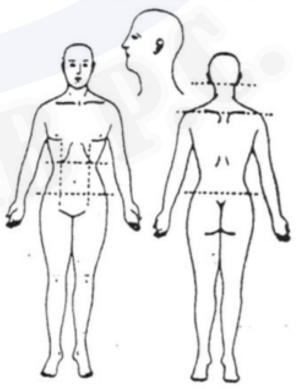
10. When did your complaint(s)/symptoms start? _____

11. Have you ever had this problem before? ☐ yes ☐ no If yes, when? _____

12. Symptoms are **BETTER** in: ☐ AM ☐ Midday ☐ PM

Symptoms are **WORSE** in: ☐ AM ☐ Midday ☐ PM

13. Shade area(s) of your complaint(s):



14. What have you done to relieve your condition? _____

Patient Signature: _____ Date: _____

Patient's Name _____

Neuropathy Pain Scale

The following scales have been designed to find out about your complaint and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Please use the scale below to tell us how intense your pain is:

No Pain — Most Intense Pain Possible

0 1 2 3 4 5 6 7 8 9 10

2. Please use the scale below to tell us how sharp your pain feels. Words used to describe "sharp" feelings include "like a knife," "like a spike," "jabbing" or like "jolts."

Not Sharp — The most sharp pain imaginable

0 1 2 3 4 5 6 7 8 9 10

3. Please use the scale below to tell us how hot your pain feels. Words used to described very hot pain include "burning and "on fire."

Not Hot — The most hot sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

4. Please use the scale below to tell us how dull your pain is. Words used to describe very dull pain include "like a dull toothache," "dull pain," "aching," and "like a bruise."

Not Dull — The most dull sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

5. Please use the scale below to tell us how cold your pain feels. Words used to describe very cold pain include "like ice" and "freezing."

Not Cold — The most cold sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

6. Please use the scale below to tell us how sensitive your skin is to light touch or clothing. Words used to describe sensitive skin include "like sunburned skin" and "raw skin."

Not sensitive — The most sensitive sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

7. Please use the scale below to tell us how itchy your pain feels. Words used to describe itchy pain include "like poison oak" and "like a mosquito bite."

Not Itchy — The most itchy sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

8. Now that you have told us the different physical aspects of your pain, the different types of sensations, we want you to tell us overall how unpleasant your pain is to you. Words used to describe very unpleasant pain include "miserable" and "intolerable." Remember, pain can have a low intensity, but still feel extremely unpleasant, and some kinds of pain can have a high intensity but be very tolerable. With this scale, please tell us how unpleasant your pain feels.

Not Unpleasant at All — The most unpleasant sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

9. We want you to give us an estimate of the severity of your deep versus surface pain. We want you to rate each location of pain separately. We realize that it can be difficult to make these estimations, and most likely it will be a "best guess," but please give us your best estimate.

How intsense is your deep pain?

No Deep Pain — The most intense deep pain sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

How intense is your surface pain?

No Surface Pain — The most intense surface pain sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

10. Which of the following best describes the time quality of your pain? Please check only one answer.

☐ I feel a back ground pain all of the time and occasional flare-ups (break-through pain) some of the time.
Describe the background pain: _____
Describe the flare-up (break-through pain): _____

☐ I feel a single type of pain all the time - Describe this pain: _____

☐ I feel a single type of pain only sometimes- Other times, I am pain free.
Describe this occasional pain: _____

Print Patient Name: _____ Patient Signature: _____ Date: _____

Neuropathy Pain scale: From Galer BS, Jensen MP. Development and preliminary validation of pain measure specific to Neuropathic pain: The Neuropathic pain scale. Neurology. 1997;48(1):332-338. Reprinted with permission from Lippincott Williams & Wilkins.

Authorization to Release Medical Information

I am authorizing the following person(s) to have access to my medical records

_____ _____ (relationship)

_____ _____ (relationship)

_____ _____ (relationship)

☐ None: _____

Patient Signature: _____ Date: _____

Authorization to Contact Patient

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of to the individual's home

I wish to be contacted in the following manner (check all that apply)

____ Home Telephone _____
- ____ Okay to leave message with detailed information
- ____ Leave message with call-back number only
- ____ Leave appointment reminder information

____ Work Telephone _____
- ____ Okay to leave message with detailed information
- ____ Leave message with call-back number only
- ____ Leave appointment reminder information

____ Written Communication
- ____ Okay to mail to my home address
- ____ Okay to mail to my home or work address
- ____ Okay to fax to this number

_____

____ Other
- ____ Okay to to leave a message on this cell number

_____

The Practice's Privacy Notice has been provided to me prior to my signing below. I have had a chance to ask questions and/or have concerns addressed. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that a copy of the Privacy Notice prior to signing this Consent, and had encouraged me to read the Privacy Notice carefully prior to my signing this consent. I understand that this consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me. I have read and understand the above statements, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Your Physician is not required to agree to a restriction that you may request. If your physician believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If this is a conflict for you, you have the right to use another Healthcare Professional.

Patient Signature: _____ Date: _____

Permission to receive information regarding your services.
Please check all that apply.

☐ Home Phone: _____

☐ Cell Phone Number: _____

☐ Work Phone: _____

Carrier: _____

****Message and data rates may apply****

☐ Email: _____

Signature: _____ Date _____