

# New Patient Information Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Dear Patient:**

Please help us the help you by taking the time to complete this questionnaire PRIOR to your appointment. This form helps us in working to identify the cause and effects of your pain. Thank you.

Give the date the current pain problems or flair-up began (for each area of pain): \_\_\_\_\_

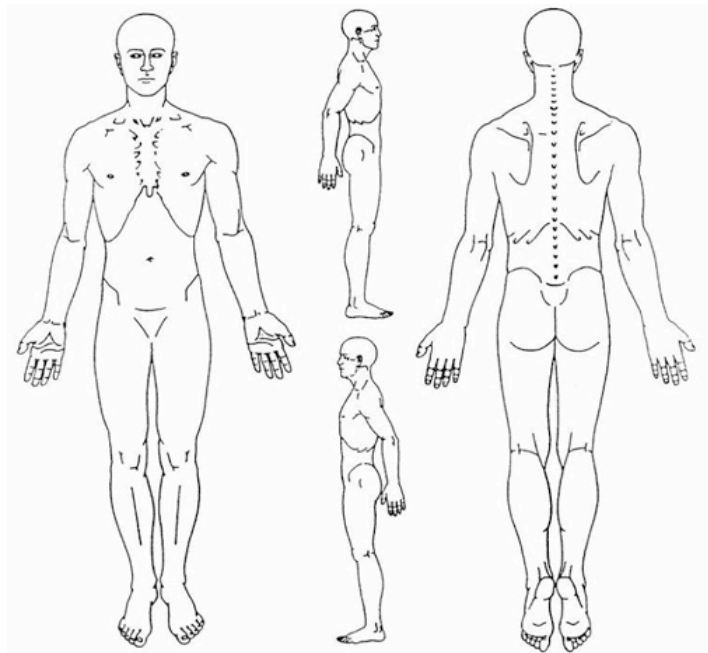
Give the date the original pain began: \_\_\_\_/\_\_\_\_/\_\_\_\_

Where did the injury occur? Please provide details of how the injury occurred: \_\_\_\_\_

**Where is your pain located?**

Use this diagram to show where you have your pain. Mark the area with the symbol that best describes your pain:

Aching Pain	*****
Burning Pain	xxxxxxx
Numbness	=====
Pins & Needles	ooooooo
Stabbing Pain	////////



**What best describes your pain?**

- \_\_\_ always present, always the same intensity
- \_\_\_ always present, intensity changes
- \_\_\_ usually present, but short periods without pain
- \_\_\_ often present, with pain-free periods for one to several hours
- \_\_\_ often present, but mostly pain free
- \_\_\_ occasionally present, once to several times a day for a few minutes to one hour
- \_\_\_ occasionally present for brief periods, lasting a few seconds to a few minutes
- \_\_\_ rarely present - every few days or weeks

**What is the relation of the pain to the time of day:**

\_\_\_ no relation to time of day \_\_\_ worse in morning \_\_\_ worse in afternoon \_\_\_ worse in evening  
 \_\_\_ worse at night \_\_\_ related to certain month(s) \_\_\_ related to certain season(s)

**Describe the quality of you pain:**

\_\_\_ sharp \_\_\_ aching \_\_\_ throbbing \_\_\_ burning \_\_\_ tinging \_\_\_ other: \_\_\_\_\_

**Does pain interfere with:** \_\_\_ sleep habits \_\_\_ social activities \_\_\_ sexual ability/desire

\_\_\_ daily activities (bathing, grooming, eating, dressing, etc.) \_\_\_ bowel / bladder function

**An episode of pain is usually accompanied by:**

- |                                 |                            |                         |
|---------------------------------|----------------------------|-------------------------|
| ___ muscle tension or tightness | ___ chills                 | ___ dizziness           |
| ___ swelling in painful area    | ___ general sweating       | ___ anxiety             |
| ___ weakness                    | ___ headache               | ___ irritability        |
| ___ numbness                    | ___ nausea                 | ___ depression          |
| ___ color change                | ___ vision disturbances    | ___ disturbing thoughts |
| ___ coldness in painful area    | ___ changes in taste/smell | ___ other _____         |
| ___ heat in painful area        | ___ nasal stuffiness       |                         |
| ___ sweating in one area        | ___ fatigue                |                         |

Circle the # that best describes your current level of pain **AT ITS LEAST**, on average during a usual day:

0 1 2 3 4 5 6 7 8 9 10  
 (No Pain) (Most Severe Imaginable)

Circle the # that best describes your current level of pain **AT ITS TYPICAL LEVEL**, during a usual day:

0 1 2 3 4 5 6 7 8 9 10  
 (No Pain) (Most Severe Imaginable)

Circle the # that best describes your current level of pain **AT ITS WORST**, during a usual day:

0 1 2 3 4 5 6 7 8 9 10  
 (No Pain) (Most Severe Imaginable)

**To what extent does your job involve the following activities?**

Activity	Not at all	Minimal	Great deal
Sitting			
Standing			
Walking			
Light lifting			
Heavy lifting			
Bending			
Pushing			
Driving			
Repeat Activity			

**Describe your occupational duties (list if retired or disabled):**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Describe your recreational activities/hobbies:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Check the items that INCREASE your pain:**

heat    cold    sex    stress    drugs  
 sitting    weather    standing/walking    bending    driving    lifting    exercise  
 being around people    bedsheets    cough or sneeze    being alone

**List any other activities that either cause or INCREASE your pain:** \_\_\_\_\_

**How soon after beginning the activity does that pain occur?** \_\_\_\_\_

**Items that DECREASE your pain:**    TENS    medication    alcohol    socializing    heat  
 cold    activity    exercise    lying on back    lying on side    massage    nothing  
 being alone    other \_\_\_\_\_

**How long after beginning these activities does the pain DECREASE?** \_\_\_\_\_

**Is this related to an active claim?**   **Work Comp:** Yes / No   **Auto:** Yes / No   **Other:** \_\_\_\_\_

**If disabled, have you tried to return to work?**   Yes / No

**Do you have a lawsuit in litigation?**   Yes / No

**Do you plan to initiate a lawsuit?**   Yes / No

**If yes, please list attorney's name, address, and phone:** \_\_\_\_\_

**List all recent diagnostic tests (x-ray, CAT scan, EMG, MRI, etc.)**

Test	Date	Results

**Since the onset of your pain, who have you consulted for treatment or pain relief?**

<input type="checkbox"/> acupuncturist	<input type="checkbox"/> orthopedist (bones)	<input type="checkbox"/> family practitioner
<input type="checkbox"/> anesthesiologist	<input type="checkbox"/> rheumatologist	<input type="checkbox"/> neurosurgeon
<input type="checkbox"/> biofeedback	<input type="checkbox"/> chiropractor	<input type="checkbox"/> clergy
<input type="checkbox"/> physical therapist	<input type="checkbox"/> psychologist	<input type="checkbox"/> oncologist
<input type="checkbox"/> podiatrist	<input type="checkbox"/> psychiatrist	<input type="checkbox"/> internist
<input type="checkbox"/> dentist/oral surgeon	<input type="checkbox"/> pain center	<input type="checkbox"/> radiologist
<input type="checkbox"/> transcendental meditation / relaxation therapy	<input type="checkbox"/> other _____	

**List all physicians, chiropractors, therapists, etc. you have seen for your present problem:**

Name	Date last seen	Treatment / Results

Please select the level of relief for each previous treatment:

Treatment	Very Helpful	Somewhat	Little If Any	No Benefit	Haven't Tried
Physical Therapy					
Exercise					
Chiropractic					
Massage					
Electrical Stimulation					
Surgery					
Trigger point/muscle injections					
Nerve Blocks					
Epidural Injections					
Psychology/Counseling					
Over the Counter Medication					
Prescription Anti-inflammatory					
Prescription Pain Medication					
Muscle Relaxers					

**Past Medical History** (Check any of the following that you have had):

- |   |  |  |                                      |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> chemotherapy                                 | <input type="checkbox"/> bleeding disorder     | <input type="checkbox"/> cerebral aneurysm | <input type="checkbox"/> stroke      |
| <input type="checkbox"/> seizures                                     | <input type="checkbox"/> diabetes              | <input type="checkbox"/> neuropathy        | <input type="checkbox"/> arthritis   |
| <input type="checkbox"/> meningitis                                   | <input type="checkbox"/> high blood pressure   | <input type="checkbox"/> heart attack      | <input type="checkbox"/> sickle cell |
| <input type="checkbox"/> cancer (location: _____)                     | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> dysrhythmia       | <input type="checkbox"/> asthma      |
| <input type="checkbox"/> kidney stone                                 | <input type="checkbox"/> kidney disease        | <input type="checkbox"/> pneumonia         | <input type="checkbox"/> GERD        |
| <input type="checkbox"/> tuberculosis (TB)                            | <input type="checkbox"/> glaucoma              | <input type="checkbox"/> chest pain        | <input type="checkbox"/> ulcer       |
| <input type="checkbox"/> rheumatic fever                              | <input type="checkbox"/> heart murmur          | <input type="checkbox"/> pacemaker         | <input type="checkbox"/> colitis     |
| <input type="checkbox"/> hiatus hernia                                | <input type="checkbox"/> liver disease         | <input type="checkbox"/> fibromyalgia      | <input type="checkbox"/> AIDS        |
| <input type="checkbox"/> hepatitis B                                  | <input type="checkbox"/> hepatitis C           | <input type="checkbox"/> hyperthyroid      | <input type="checkbox"/> Bipolar dz  |
| <input type="checkbox"/> anxiety                                      | <input type="checkbox"/> depression            | <input type="checkbox"/> hypothyroid       |                                      |
| <input type="checkbox"/> chronic obstructive pulmonary disease (COPD) |  | <input type="checkbox"/> other _____       |                                      |

**Past Surgical History** (please list all previous surgeries)

Type of Surgery	Date	Performing Surgeon

What specifically do you want from treatment? \_\_\_\_\_  
 \_\_\_\_\_

What specifically do you expect from treatment? \_\_\_\_\_

**PSYCHOLOGICAL AND SOCIAL HISTORY:**

Have you ever received psychological/psychiatric treatment? Yes / No  
Have you ever seriously considered suicide? Yes / No  
Have you ever had a drug abuse problem? Yes / No  
Have you ever been treated for drug abuse or addiction? Yes / No  
Have you ever been terminated from another pain practice? Yes / No  
Have you ever failed a drug test for any reason? Yes / No

If yes, please explain: \_\_\_\_\_

How often do you see a Doctor? \_\_\_\_\_ rarely \_\_\_\_\_ 1-2 times/month \_\_\_\_\_ 3 or more times/month

Do you smoke? \_\_\_\_\_ not at all \_\_\_\_\_ former smoker \_\_\_\_\_ less than 1/2 pack/day \_\_\_\_\_ 1-2 packs/day  
\_\_\_\_\_ 2 or more packs/day \_\_\_\_\_ cigar \_\_\_\_\_ pipe \_\_\_\_\_ # of years

Do you drink alcohol? \_\_\_\_\_ not at all \_\_\_\_\_ occasionally \_\_\_\_\_ drink to relieve the pain \_\_\_\_\_ 1-3 drinks/day  
\_\_\_\_\_ more than 4 drinks/day \_\_\_\_\_ have attended Alcoholics Anonymous

Sleep: How many hours per night do you usually sleep? \_\_\_\_\_ Does pain interrupt your sleep? \_\_\_\_\_

If YES, how many nights per week does pain interrupt your sleep? \_\_\_\_\_

Race: \_\_\_\_\_ White \_\_\_\_\_ African American \_\_\_\_\_ Hispanic \_\_\_\_\_ Asian \_\_\_\_\_ American Indian \_\_\_\_\_ Other

Highest level of education completed: \_\_\_\_\_ Occupation: \_\_\_\_\_

Are you presently working? If no, give last date worked \_\_\_\_\_

\_\_\_\_\_ yes, full-time \_\_\_\_\_ yes, part-time \_\_\_\_\_ no, due to pain \_\_\_\_\_ no, but not due to pain  
\_\_\_\_\_ full-time with restrictions \_\_\_\_\_ part-time with restrictions \_\_\_\_\_ on sick leave

If you have been given work restrictions, please list them in detail: \_\_\_\_\_

Do you consider yourself disabled by this pain? Yes / No

If yes, why? \_\_\_\_\_

**ACTIVITY:**

What do you do for exercise? \_\_\_\_\_

How often do you exercise? \_\_\_\_\_

How far are you able to walk (please estimate in feet, yards or miles)? \_\_\_\_\_

**FAMILY HISTORY:**

**Current marital status:**

Never married     Married     Separated     Divorced     Widowed

Ages of children \_\_\_\_\_ Who shares your home? \_\_\_\_\_

**If you are married or have a spouse equivalent, circle the number on the rating scale that best describes your relationship:**

<b>Before Pain</b>	<b>Now</b>
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
(poor) (excellent)	(poor) (excellent)

**Check causes of marital conflict:**     finances     sex     personality differences     parents  
 children     alcohol/drugs     religion     illness     none     other \_\_\_\_\_

**Has any member of your family had the same pain problem or one similar to yours? Describe the similarity and who (i.e. any disability, headache, etc.)** \_\_\_\_\_

**Check any of the following that any family member (not you) has or had:**

- |   |  |  |                                   |
|---|--|--|-----------------------------------|
| <input type="checkbox"/> ulcerative colitis/ulcer | <input type="checkbox"/> arthritis         | <input type="checkbox"/> disability due to accident or illness | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> high blood pressure      | <input type="checkbox"/> drinking problem  | <input type="checkbox"/> attempted or completed suicide        | <input type="checkbox"/> stroke   |
| <input type="checkbox"/> drug abuse               | <input type="checkbox"/> thyroid problem   | <input type="checkbox"/> heart trouble/surgery                 | <input type="checkbox"/> gout     |
| <input type="checkbox"/> psychiatric treatment    | <input type="checkbox"/> tuberculosis (TB) | <input type="checkbox"/> headaches/migraines                   | <input type="checkbox"/> asthma   |
| <input type="checkbox"/> cancer                   | <input type="checkbox"/> depression        | <input type="checkbox"/> glaucoma/cataracts                    | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> chronic pain             | <input type="checkbox"/> allergies         | <input type="checkbox"/> illness occurred in 2 or more members | <input type="checkbox"/> other    |

**ALLERGIES:**

*Please select which best describes*

I am not aware of any allergies that I might have

**I am allergic to...**

IV Contrast Dye     Shellfish     Tape     Latex     Other: \_\_\_\_\_

**I am allergic to the following medications:**

Medication	Reaction



## REVIEW OF SYMPTOMS:

Have you had any of the following symptoms?

### Constitutional

- Recent weight gain? ( \_\_\_\_\_ pounds)
- Recent weights loss? ( \_\_\_\_\_ pounds)
- Fever/chills or soaking sweats at night?
- Fatigue?

### HEENT

- Headaches more than once or twice a week?
- Difficulty walking?
- Problem with vision not corrected with glasses?
- Impaired Hearing?
- Dizziness?
- Frequent or severe nosebleeds?
- Trouble chewing or swallowing?
- Sore tongue or mouth?

### Respiratory

- Daily Cough?
- Wheezing?
- Sleep Apnea?
- Home Oxygen

### CVS

- Short of breath after two flights of stairs?
- Short of breath just sitting or lying down?
- Discomfort in the chest?
- Swelling of the ankles every day?
- Palpitations?
- Pain in the legs when walking?
- High blood pressure?

### Skin

- Change in hair growth anywhere?
- Change in a mole?
- Sore which is not healing?

### GI

- Frequent heartburn or indigestion?
- Change in bowel habits?
- Black or blood in bowel movements?
- Abdominal pain?
- Loss of bowel control?
- Nausea/vomiting?

### GU/Renal

- Difficulty urinating?
- Do you lose control of urine at times?
- Awaken at night more than once to urinate?
- Bloody or unusual appearing urine?

### Musculoskeletal

- Back Pain?
- Persistent pain in joints?

### Psychological

- Frequent conflicts at home?
- History of hospitalization for an emotional problem?
- Do you often feel anxious or depressed?

### Neurological

- Loss of consciousness or convulsions?
- Weakness or numbness of arms or legs?

### Immune

- Hay fever?
- OTHER \_\_\_\_\_

### Additional information for the Physician:

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**Interventional Medical Associates, LLC**

Robert G. Valentine, MD & Prathima Reddy, MD

6821 NW 11th Place

Gainesville, Florida 32605

Phone: (352) 331-3353

Fax: (352) 333-9035

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

I hereby authorize **Interventional Medical Associates, LLC** to release or obtain any information from my medical record to coordinate my healthcare.

The following items are needed:

- |  |   |
|--|---|
| <input type="radio"/> Face Sheet (Patient information) | <input type="radio"/> Radiology / Imaging Reports   |
| <input type="radio"/> Insurance Information            | <input type="radio"/> Lab Results                   |
| <input type="radio"/> Progress Notes                   | <input type="radio"/> Operative / Procedure Reports |
| <input type="radio"/> Entire Record                    |   |
| <input type="radio"/> Other: _____                     |   |

I acknowledge and hereby consent to such that the released or obtained information may contain:

- ◆ Alcohol and drug abuse information
- ◆ Psychiatric information
- ◆ HIV testing, HIV results, and / or AIDS information

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that disclosure of this information to a party other than one directly involved with my healthcare is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information".

A photocopy of this "Authorization for Release of Medical Information" shall be considered as effective and valid as the original.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Married? Yes No Other \_\_\_\_\_

Spouses Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Nearest relative not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

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**Primary Insurance:** \_\_\_\_\_ ID#: \_\_\_\_\_

Responsible party if different from patient: \_\_\_\_\_ DOB: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ ID#: \_\_\_\_\_

Responsible party if different from patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Auto Accident?: Yes / No DOA: \_\_\_\_\_ Name of insured: \_\_\_\_\_

Workers' Comp?: Yes / No DOI: \_\_\_\_\_ Employer at time of injury: \_\_\_\_\_

Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

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## ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I hereby assign all insurance benefits to which I am entitled, including Medicare private insurance, major medical benefits, auto benefits, workers' compensation and any other health plans to Interventional Medical Associates, LLC. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including HIV, substance abuse or psychiatric information which may be found in the record and is necessary to secure payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## FINANCIAL POLICY

### **ABOUT FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE**

As your physician, we are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

#### **Payment for service is due at the time services are rendered.**

We accept cash, checks, debit, and credit cards. Returned checks are subject to a service charge of \$25.00 and you may lose your privilege to write checks in our office.

#### **Cancelled Appointments**

Patients who fail to keep appointments or cancel without 24 hours advanced notice may be charged a \$25.00 to \$50.00 fee. After a second occurrence you may be discharged from the practice.

#### **Medicare**

Your deductible and 20% of the allowable charges are due at the time of service. If we do not know the Medicare allowable charge for a specific service, we will bill you after Medicare pays. Please bring a copy of the Medicare Explanation of Benefits (EOB) showing you have met your yearly deductible.

#### **Blue Cross Blue Shield**

Coinsurance, deductible, and co-pays must be paid at the time of service. Because we are under contract with this insurance company, we will file your insurance.

#### **Auto**

Most auto policies cover 80% of your accident-related healthcare costs. The 20% balance must be paid at the time services are rendered unless prior arrangements have been made. Representation by an attorney does not mean that you are not responsible for your coinsurance.

#### **Financial Agreement**

We will gladly discuss your proposed treatment and do our best to answer any questions relative to your insurance. You must realize, however that: 1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. 2. Not all services are a covered benefit in all contracts. Some insurance companies may arbitrarily select certain services that they will not cover.

We must emphasize that, as your medical care provider, our relationship and concern is with you and your health, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, **all charges are your responsibility from the date the services are rendered.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If it becomes necessary to collect any sum through an attorney or collections agency, then the patient agrees to pay all reasonable costs of collection, including attorney's fees, whether a suit is filed or not.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_