



# Patient History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: Male  Female

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

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

Referring Doctor: \_\_\_\_\_ City: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ City: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

How many different physicians have you seen regarding your pain? \_\_\_\_\_

Were you injured in a work-related accident?  Yes  No

Are you receiving Workman's Compensation?  Yes  No

Are you receiving Disability?  Yes  No

Do you have a lawsuit in litigation?  Yes  No

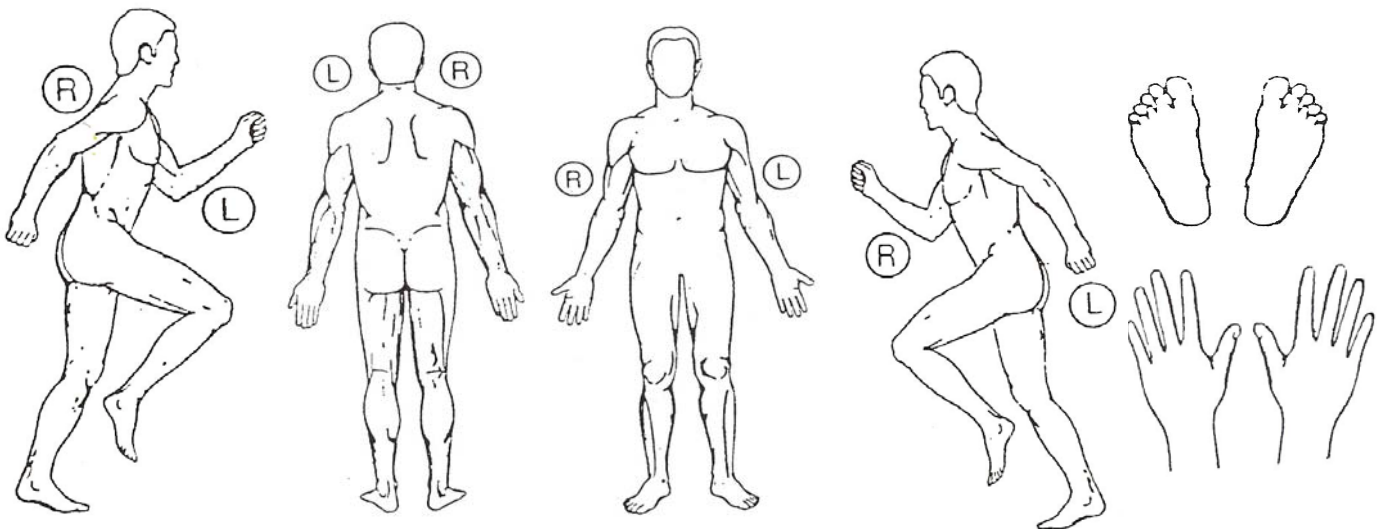
Are you presently working?  Yes  No

What part of the day is your pain most severe?  Morning  Afternoon  Evening  Nighttime

Are you able to be physically active?  Yes  No - Explain: \_\_\_\_\_

When/how did your pain start? \_\_\_\_\_

**Please mark on the pictures below where your pain is located:**



CIRCLE THE NUMBERS BELOW TO RATE THE LEVEL OF YOUR PAIN (ON A SCALE OF 0 TO 10).



**What increases your pain?** Please mark a check (√) next to all that apply:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> physical activity        | <input type="checkbox"/> warm/hot weather | <input type="checkbox"/> noise              |
| <input type="checkbox"/> sitting                  | <input type="checkbox"/> cold weather     | <input type="checkbox"/> financial concerns |
| <input type="checkbox"/> standing                 | <input type="checkbox"/> damp weather     | <input type="checkbox"/> riding in a car    |
| <input type="checkbox"/> walking                  | <input type="checkbox"/> stress           | <input type="checkbox"/> family             |
| <input type="checkbox"/> lying down – flat in bed | <input type="checkbox"/> anger            | <input type="checkbox"/> sneezing           |
| <input type="checkbox"/> lying on side            | <input type="checkbox"/> climbing stairs  | <input type="checkbox"/> coughing           |
| <input type="checkbox"/> bending over             | <input type="checkbox"/> other: _____     |   |

**What decreases your pain?** Please mark a check (√) next to all that apply:

- |  |                                       |  |
|--|---------------------------------------|--|
| <input type="checkbox"/> physical activity | <input type="checkbox"/> watching TV  | <input type="checkbox"/> socializing with family/friends |
| <input type="checkbox"/> lying down        | <input type="checkbox"/> music        | <input type="checkbox"/> massage                         |
| <input type="checkbox"/> lying on side     | <input type="checkbox"/> work         | <input type="checkbox"/> deep breathing                  |
| <input type="checkbox"/> bath/shower       | <input type="checkbox"/> walking      | <input type="checkbox"/> pain pills                      |
| <input type="checkbox"/> heating pad       | <input type="checkbox"/> smoking      | <input type="checkbox"/> alcohol                         |
| <input type="checkbox"/> ice/cold compress | <input type="checkbox"/> other: _____ |  |

**Check the words that best describe your pain:**

- |  |                                       |                                      |
|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> sharp                         | <input type="checkbox"/> shooting     | <input type="checkbox"/> itching     |
| <input type="checkbox"/> dull                          | <input type="checkbox"/> tingling     | <input type="checkbox"/> pulling     |
| <input type="checkbox"/> aching                        | <input type="checkbox"/> hot          | <input type="checkbox"/> heavy       |
| <input type="checkbox"/> burning                       | <input type="checkbox"/> cold         | <input type="checkbox"/> numbness    |
| <input type="checkbox"/> stabbing                      | <input type="checkbox"/> radiating    | <input type="checkbox"/> aggravating |
| <input type="checkbox"/> cramping                      | <input type="checkbox"/> constant     | <input type="checkbox"/> throbbing   |
| <input type="checkbox"/> intermittent (comes and goes) | <input type="checkbox"/> other: _____ |                                      |

**Please list any medication allergies:** \_\_\_\_\_

**Please list any food allergies:** \_\_\_\_\_

**Are you allergic to LATEX?**  Yes  No

**Are you allergic to IVP (x-ray) Dye?**  Yes  No

**Have you been treated for any of the following problems?** Please check (√) all that apply:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> high blood pressure   | <input type="checkbox"/> shortness of breath    | <input type="checkbox"/> diabetes             |
| <input type="checkbox"/> heart disease (_____) | <input type="checkbox"/> ulcers                 | <input type="checkbox"/> thyroid disease      |
| <input type="checkbox"/> chest pain            | <input type="checkbox"/> liver disease          | <input type="checkbox"/> depression           |
| <input type="checkbox"/> palpitations          | <input type="checkbox"/> abdominal pain         | <input type="checkbox"/> anxiety              |
| <input type="checkbox"/> tachycardia           | <input type="checkbox"/> change in bowel habits | <input type="checkbox"/> nervous disorder     |
| <input type="checkbox"/> asthma                | <input type="checkbox"/> arthritis              | <input type="checkbox"/> drug abuse           |
| <input type="checkbox"/> emphysema             | <input type="checkbox"/> pregnant               | <input type="checkbox"/> alcohol abuse        |
| <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> epilepsy               | <input type="checkbox"/> hepatitis            |
| <input type="checkbox"/> cancer                | <input type="checkbox"/> bleeding problems      | <input type="checkbox"/> difficulty urinating |
| <input type="checkbox"/> TIA or stroke         | <input type="checkbox"/> other: _____           |   |

Please mark a check (√) next to all that apply to your sleeping habits:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> I have trouble sleeping | <input type="checkbox"/> My pain wakes me up | <input type="checkbox"/> I have restless sleep |
|--|--|--|

**Please list all surgeries performed on you, and the year they were performed:**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Please list all pain medications you are now taking.** How long have you been taking each one?

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

**Please list all other medications you are now taking.**

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

Are you:  Married  Single  Divorced  Widowed      How many children do you have? \_\_\_\_\_

Please list the highest level of education that you have completed: \_\_\_\_\_

**What is your occupation?** \_\_\_\_\_ **What is your height?** \_\_\_\_\_ **Your weight?** \_\_\_\_\_

**Does your job involve:**

- lifting    operating heavy machinery    twisting/turning    repetitive motion    vibration

**Do you...**

...smoke?  Yes  No

... drink alcohol?  Yes  No

...use recreational drugs?

If "yes", how much? \_\_\_\_\_

If "yes"...  Daily  Socially

Yes  No

Please use the lines below to note any special concerns or questions related to this visit:

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

\_\_\_\_\_  
**Today's Date**

\_\_\_\_\_  
**Signature of person completing this form**

**THIS SECTION IS FOR OFFICE USE ONLY**

BP:

P:

Resp:

O<sub>2</sub> Saturation:

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

Insurance cards copied

**PATIENT REGISTRATION**

Co-Payment: \$ \_\_\_\_\_

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

**INFORMATION**

Is your condition work related?  YES  NO

An auto accident? YES  NO

Date of injury: \_\_\_\_\_

Marital Status:  Single  Married  Widow

Sex:  Male  Female

Name: \_\_\_\_\_  
last name first name middle name/initial

Street address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Date of birth: \_\_\_ / \_\_\_ / \_\_\_ Social Security # \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Spouse's name: \_\_\_\_\_  
last name first name middle name/initial

Responsible Party: \_\_\_\_\_ Date of birth: \_\_\_ / \_\_\_ / \_\_\_

Relationship to patient:  Self  Spouse  Other Social Security # \_\_\_\_\_

Street address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

**Please present insurance cards to receptionist**

PRIMARY insurance name: \_\_\_\_\_ Is insurance HMO?  YES  NO

Insurance address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of insured: \_\_\_\_\_ Date of birth: \_\_\_ / \_\_\_ / \_\_\_ Relationship to insured: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Group number: \_\_\_\_\_

SECONDARY insurance name: \_\_\_\_\_ Is insurance HMO?  YES  NO

Insurance address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of insured: \_\_\_\_\_ Date of birth: \_\_\_ / \_\_\_ / \_\_\_ Relationship to insured: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Group number: \_\_\_\_\_

Referred by: \_\_\_\_\_

Primary Care physician name & address: \_\_\_\_\_

Name(s) of other physician(s) who care for you: \_\_\_\_\_

Name of person not living with you: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number: ( ) \_\_\_\_\_

**Assignment of Benefits Financial Agreement**

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Ramesh P Kanuru, M.D. Inc. D/B/A Advanced Pain Consultants, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. If I do not pay the entire balance within 30 days of the statement date, a late charge of 1.5% will be assessed each month. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: \_\_\_\_\_ Your signature: \_\_\_\_\_