ASCENT
PAIN SOLUTIONS

New Patient Intake Form

We are committed to compassionate care; we must exercise proper due diligence when prescribing opioid analgesic for chronic pain. Prescription drug abuse has reached epidemic proportions in our society. Therefore, our clinic policy is that an appropriate workup must be completed prior to the dispensing of an opioid prescription. This workup will include review of previous pharmacy/clinic records, evaluation by diagnostic and laboratory tests, and acceptable completion of a urine drug screen yielding expected results. Common examples of opioid analgesics include hydrocodone, morphine, oxycodone, fentanyl, opana, and methadone. Prescriptions for these medications will not be given at an initial visit.

- Please bring your driver's license and insurance cards along with your completed new patient intake forms to your scheduled appointment. Payment for services is expected at the time of service (co-pays, co-insurance, private pay). We accept cash, check, money order, and credit cards (Visa, American Express, MasterCard, and Discover).

- If you have been instructed to obtain imaging reports by our staff, please bring them to your appointment. Our office requires these as part of your consultation. If we do not have your films at the time of your appointment, you may be rescheduled.

- Your initial visit at the Practice is a consultation. If a doctor referred you for an injection, you must be seen for an office visit first. Procedures are scheduled after the initial consultation.

- If English is your second language, please make arrangements for someone to accompany you to your visit who can translate in order to provide you with the best healthcare service. We want you to fully understand your diagnosis and prognosis and have any questions you may have answered.

Patient Signature: _____

Printed Name: _____

Date: _____

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's notice of privacy practices, which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document.

Acknowledgement of External Rx History

I understand that the Practice reserves the right to obtain an external Rx history and randomly verify past medications through the Prescription Drug Monitoring Database in order to be prescribed any medications.

*Please list the name of any person(s) you wish to have access to your medical information, including portal access: *

Name:_____ Relationship: _____

Permission to Leave Messages

I give permission for the Practice to leave appointment information, test results, and/or pre-operative instructions on voice message for the following phone numbers or with the following individuals:

Name:_____ Relationship: _____

Communication Consent

We want to stay connected with our patients. Patients in our Practice and all our affiliated clinics may be contacted via email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If you provide an email or phone number to the Practice, you understand that you may receive these communications from the Practice. The Practice does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan.

Select below to **opt-out** of communication via text and/or email regarding various aspects of your medical care, which may include, but shall not be limited to, reminders, feedback, and general health reminders/information, test results, prescriptions, appointments, and billing.

Opt-out: ☐ Text ☐ E-Mail

Acknowledgement of Cancellation/No Show Policy

If you are unable to make an appointment, please call within 24 hours prior to your appointment time to reschedule. If you fail to notify our office prior to missing your scheduled appointment, you may be subject to a NO SHOW fee. Frequent NO SHOWS may result in a release from the Practice.

Patient Signature & Date: _____

Patient Acknowledgement/Financial Statements

I understand that services or items that I have requested to be provided to me by Ascent Pain Solutions may not be covered under my insurance as being reasonable or medically necessary for my care. I understand my health plan determines the medical necessity of the services or items I request and receive. I also understand I am responsible for payment if these services or items are determined not to be reasonable or medically necessary and or process towards my out of network benefits.

I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf. I further understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required.

I understand that any portion of my medical bills not covered by insurance will be billed to me at the address I have provided. Non-Compliance or defaulting on payments may result in denial of services and/or a legal claim against me for non-payment.

Patient Name: _____

Patient Signature: _____

DOB: _____

Date: _____

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PATIENT'S PERSONAL INFORMATION

Name: _____ Preferred Name: _____
Last Name First Name M.I.

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SSN: _____ Driver's License Number & State: _____

Employer: _____ Employer Phone: _____

E-Mail Address: _____

Preferred Method of Communication? * ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ E-mail/Patient Portal

If you provide an email or phone number, you understand that you may receive these communications from the Practice. To opt-out, Communication Consent

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify

Preferred Language: _____

Race: ☐ Indigenous Tribes ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other: _____

Referring Physician: _____ Primary Care Provider: _____

Other Providers: _____

Emergency Contact: _____ Relationship: _____

Emergency Phone: _____ Phone Type: _____

PATIENT'S RESPONSIBLE PARTY INFORMATION

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ SSN: _____ Relationship: _____

HOW DID YOU HEAR ABOUT US?

☐ Postcard ☐ Commercial ☐ Website ☐ Leading Reach ☐ Walk-In

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Diagnostic Tests & Imaging: Mark all of the following tests you have had related to your current pain:		
MRI of the _____	Date: _____	Facility: _____
X-Ray of the _____	Date: _____	Facility: _____
CT scan of the _____	Date: _____	Facility: _____
EMG/NCV Study _____	Date: _____	Facility: _____

PAIN TREATMENT HISTORY: Mark the following pain treatments you have undergone **PRIOR** to today's visit:			
Treatment ☐ **NO PREVIOUS TREATMENTS**	**No Relief**	**Moderate Relief**	**Excellent Relief**
Chiropractic Therapy, # of sessions _____ Date Range: _____	☐	☐	☐
Home Exercise Program, # of sessions _____ Date Range: _____	☐	☐	☐
Physical Therapy, # of sessions _____ Date Range: _____	☐	☐	☐
Spinal Column Stimulator: ☐ Trial ☐ Permanent Implant	☐	☐	☐
Spine Surgery: _____	☐	☐	☐
Medication ☐ **NO PREVIOUS TREATMENTS** Anti-Inflammatories, type _____ Date Completed: _____	☐	☐	☐
Injections ☐ **NO PREVIOUS TREATMENTS** Joint Injection, type _____ Date Completed: _____	☐	☐	☐
Joint Injection, type _____ Date Completed: _____	☐	☐	☐
Epidural Steroid Injection, Date Completed: _____ SI Joint Injections, Date Completed: _____ Radiofrequency Ablation, DateCompleted: _____	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐

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Current Medications:

Are you taking a **PRESCRIBED BLOOD-THINNER**? If so, which one? _____

Name/phone of the doctor that prescribed your blood thinner: _____

Please list **ALL** medications you are currently taking including OTC medications, ibuprofen, aspirin, and fish oil. Add an additional sheet if necessary.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Allergies: Please list all allergies that you have:

Medication Name that I'm Allergic to:	The Allergic Reaction I have is:
1.	
2.	
3.	
4.	

Are you allergic to any of the following?

Iodine ☐ No ☐ Yes **Tape** ☐ No ☐ Yes **Latex** ☐ No ☐ Yes

Do you require special rescue measures for your latex allergy? ☐ No ☐ Yes

☐ **I HAVE NO KNOWN ALLERGIES**

Post Medical History/Problem List:

Are you currently pregnant? ☐ No ☐ Yes Are you post-menopausal? ☐ No ☐ Yes

Do you plan on becoming pregnant? ☐ No ☐ Yes

Have you had two or more falls in the last year? ☐ No ☐ Yes

Have you received a pneumonia vaccination? ☐ No ☐ Yes Date: _____

Have you been diagnosed with hypertension? ☐ No ☐ Yes Date: _____

Mark all conditions/diseases that you have been **DIAGNOSED** with:

☐ Asthma	☐ Epilepsy	☐ HIV/AIDS	☐ Migraines
☐ Cancer, Type _____	☐ Fibromyalgia	☐ High Blood Pressure	☐ Osteoarthritis/Osteoporosis
☐ Diabetes, Type_____	☐ Heart Disease	☐ Kidney Disease	☐ Peripheral Vascular Disease
☐ Emphysema/COPD	☐ Hepatitis, type_____	☐ Lupus	☐ Shingles
☐ Sleep Apnea	☐ Stroke	☐ Other: _____	

☐ **I HAVE NO SIGNIFICANT MEDICAL HISTORY**

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Past Surgical History:

Do you currently have an implanted ICD, pacemaker, or defibrillator? ☐ No ☐ Yes

Please list prior surgeries or procedures in the table below. Attach an additional sheet if required.

Date	Surgery/Procedure	Physician

☐ **I HAVE NO SIGNIFICANT SURGERY HISTORY**

Family History: Mark all appropriate diagnoses as they pertain to your BIOLOGICAL familymembers only :

- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Headaches
- ☐ Heart Disease/Stroke
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Substance Abuse

☐ **I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY**

☐ **I AM ADOPTED (No Medical History Available)**

Social History:

Smoking: ☐ Current everyday ☐ Current some days ☐ Former smoker ☐ Never smoker

Alcohol: ☐ Current alcoholism ☐ History of alcoholism ☐ Social alcohol use ☐ No alcohol use

Marijuana: ☐ Current use ☐ Former use ☐ Medical Marijuana Card Holder ☐ Never used

Illegal Drugs: ☐ Current use, list which ones _____

☐ Former use, list which ones _____

☐ Never used

Narcotic and Prescription Medications:

I have abused narcotic and/or prescription medications ☐ No ☐ Yes

If yes, please list which ones _____

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Review of Systems: Mark all of the following symptoms that you **CURRENTLY** suffer from:

Constitutional:
- ☐ Chills
- ☐ Difficulty Sleeping
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweat

Cardiovascular/Respiratory:
- ☐ Chest Pain
- ☐ Cough
- ☐ Difficulty Breathing
- ☐ Fainting
- ☐ High Blood Pressure
- ☐ Swelling in Feet

Gastrointestinal:
- ☐ Constipation
- ☐ Dark and Tarry Stool
- ☐ Diarrhea
- ☐ Nausea/Vomiting

Genitourinary/Nephrology:
- ☐ Blood in Urine
- ☐ Involuntary Urination
- ☐ Loss of Bowel Control
- ☐ Painful Urination
- ☐ Pelvic Pressure

Ear/Nose/Throat/Neck:
- ☐ Difficulty Hearing
- ☐ Earaches
- ☐ Hay Fever/Allergies
- ☐ Nosebleeds
- ☐ Recurrent Sore Throats
- ☐ Sinus Problems

Eyes:
- ☐ Recent Visual Changes

Neurological:
- ☐ Dizziness
- ☐ Headaches
- ☐ Instability When Walking
- ☐ Numbness/Tingling
- ☐ Weakness

Psychiatric:
- ☐ Anxiety/Stress
- ☐ Depressed Mood
- ☐ Suicidal Thoughts
- ☐ Suicidal Planning

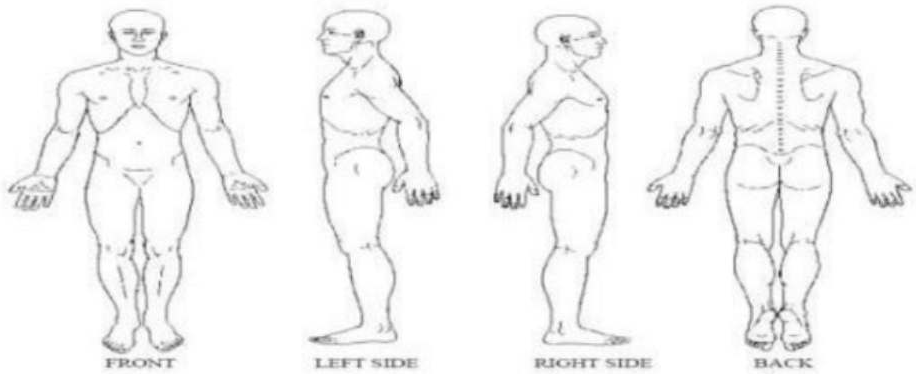
Musculoskeletal:
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Neck Pain

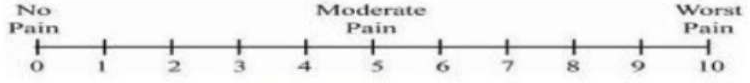
Onset of Symptoms and Reason for Visit Today:

When did this pain begin? _____

What caused your current pain or injury? _____

Was the pain or injury due to a motor vehicle accident or person injury? ☐ No ☐ Yes





What is your current pain level **right now**? _____ What is your **worst** level of pain level? _____

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Activity:

How many days per week do you exercise?_____Types of Exercise _____

Does your pain interfere with any of the following? ☐ Work ☐ School ☐ Home Duties ☐ Daily Living ☐ Recreational Activities

Where is your worst area of pain located? _____

Does the pain radiate? If yes, where? _____

Please list additional areas of pain _____

What word best describes the frequency of your pain? ☐ Constant ☐ Intermittent

Since your pain began, has your pain: ☐ Increased ☐ Decreased ☐ Stayed the Same

When is your pain at its worst? ☐ Mornings ☐ During the Day ☐ Evenings ☐ Middle of the Night

Check all that describe your pain **today:**

☐ Aching	☐ Hot/Burning	☐ Spasms	☐ Throbbing
☐ Cold	☐ Numb	☐ Squeezing	☐ Tingling/Pins and Needles
☐ Cramping	☐ Shock-like	☐ Stabbing/Sharp	☐ Tiring/Exhausting
☐ Dull	☐ Shooting		

Factors that Affect your Pain:

Do you have significant back/buttock/leg pain with prolonged standing and/or prolonged walking that is relieved with sitting and/or lying down? ☐ No ☐ Yes

If yes to the above question, is your pain also alleviated with bending forward (using a shopping cart, leaning on kitchen counter, etc.)? ☐ No ☐ Yes

What makes your pain better? _____

What makes your pain worse? _____

Please indicate any factors that affect your pain in the list below:

	Increases Pain	Decreases Pain	No Change
Bending Backward	☐	☐	☐
Bending Forward	☐	☐	☐
Changes in Weather	☐	☐	☐
Climbing Stairs	☐	☐	☐
Cold	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Heat	☐	☐	☐
Lifting Objects	☐	☐	☐
Looking Forward	☐	☐	☐
Looking Downward	☐	☐	☐
Looking Side to Side	☐	☐	☐
Lying Down	☐	☐	☐
Rising from a Seated Position	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐