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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:

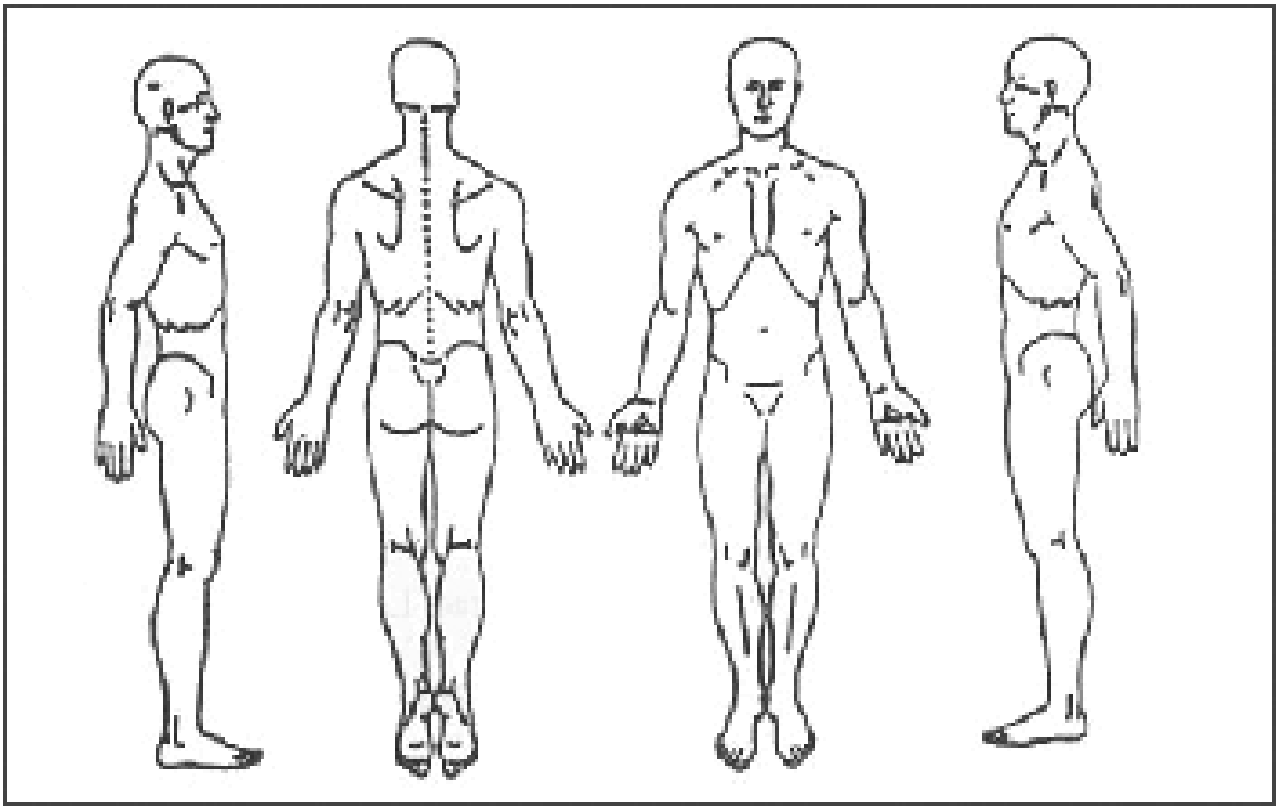
LAST?	**RELIEF?**	**HOW LONG RELIEVED?**
_____	☐Yes ☐No	_____
_____	☐Yes ☐No	_____
_____	☐Yes ☐No	_____
_____	☐Yes ☐No	_____

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

Currently at Work: ☐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?_____

Currently Not At Work: ☐Unemployed ☐Retired ☐Disability
Other, explain _____
Last date of employment: _____

Litigation History

☐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:

_____

_____

_____

_____

_____

_____

_____