AABP PAIN MANAGEMENT
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AABP
INTEGRATIVE PAIN CARE

Name:_____ **DOB:**_____ **DOS:**_____

New Outpatient/Office Visit

MEDICAL HISTORY: Referred for Consultation? ( )YES ( )NO

Name:_____ Age:_____
Referring Physician's Name:_____
Primary Care Doctor's Name (if different)_____
Address:_____ Telephone:_____
Occupation:_____ Disability?_____ Height: _____ Weight: _____
What hurts?_____
What side?_____ **When** did the problem start?_____
Type of pain (circle all that apply): *Dull Sharp Burning Constant Radiating Numbness Pins & Needles*
Is the pain (circle all that apply): *Constant Intermittant Nightly Upon Waking Related to Bowel Movements or Urination*
What makes the **pain better**?_____
What makes the **pain worse**?_____
Rate your pain from 1-10: slight 1—2—3—4—5—6—7—8—9—10 very bad
Does the pain **wake you** up at night? Yes ☐ No ☐
Have you had this problem in the **past**? Yes ☐ No ☐
What **treatments** have you undergone for this problem:_____
List all Pain Medications_____

PREVIOUS TREATMENTS (this condition):

( ) Chiropractic ( ) Physical Therapy
( ) Psychotherapy ( ) Counseling ( ) Surgery (Provide details) ( ) Nerve blocks (Provide Details)
( ) Medication ( ) Other:
( ) MRI/CT (recent) Outcome of these modalities:

List all Interventions (injections & surgeries)_____

SOCIAL HISTORY: Level 3: 1-2 history areas / 4: All 3

Marital status: Single Married Divorced Widowed Separated
With whom do you live?_____ Are you in Litigation?_____
Cigarettes per day: _____ Alcoholic drinks per day: _____ Recreational Drug use _____

FAMILY HISTORY: Level 3: 1-2 history areas/4: All 3

Do your parents or any other first degree relatives suffer from any medical conditions? (please list)

PAST MEDICAL HISTORY: Level 3: 1-2 history areas / 4: All 3

Do **you** suffer from any of the below conditions? Condition	Yes	No	Severity/Treatment	If Mother/Father/Sibling has disease (Put M/F/S)
Heart Disease				
Diabetes				
Asthma				
High Blood Pressure				
Hepatitis				
Liver Disease				
Kidney Disease				

Rheumatoid Arthritis				
Glaucoma				
Seizures or Epilepsy				
AIDS				
Anemia or Blood Disorder				
Are you pregnant?				
OTHER:				

List all previous surgeries:_____

_____

Are you taking PLAVIX, COUMADIN, LOVENOX or any other ANTICOAGULANTS?

List **all medications** you currently take:_____

_____

_____

____See Provided Medication List

Allergies to medications, Shellfish, Iodine Contrast:_____

Do you suffer from (circle all that apply):

Constitutional: *None Fatigue fevers unexplained weight gain unexplained weight loss poor appetite*

Eyes: *None Blurry vision Double vision loss of vision Pain on looking at light*

ENT: *None Bloody nose sore throat dry mouth loss of hearing*

CV: *None Chest pain leg swelling palpitations Difficulty breathing on exertion*

Pulm: *None Shortness of breath wheezing persistent cough asthma*

GI: *None Diarrhea Blood in stool abdominal pain constipation*

GU: *None Frequent urination blood in urine painful urination urinary incontinence*

Musculoskeletal: *None Muscle pain Joint pain arthritis inflamed joints Back Pain*

Skin: *None Rash Change in skin lesions Erythema Blisters Itching*

Neurological: *None Loss of sensation weakness numbness tingling tremors paralysis seizure bowel/bladder incontinence*

Psychiatric: *None Anxiety depression hallucinations mood instability personality changes panic attacks sleep disturbances*

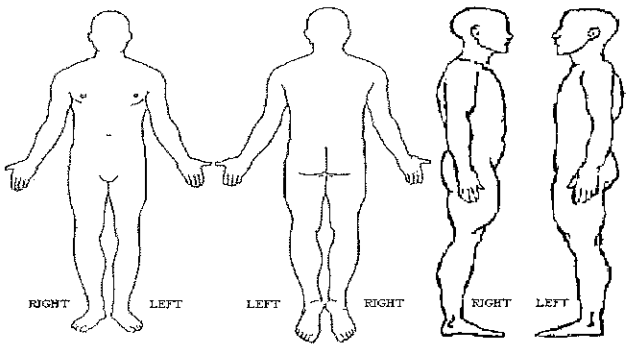
Hematologic: *None Easy bruising bleeding swollen lymph nodes Anticoagulant use*

Endocrine: *None Hot flashes Diabetes Hair loss Hypothyroid Hyperthyroid Heat intolerance Cold intolerance*

Integumentary: *None Denies problems Breast tenderness/swelling Color changes Hair/Nail growth changes Scaling of skin Sensitivity to light touch Sweating Temperature changes*

____All Other Review of systems Negative

Please Mark the Location of your Pain:



AABP PAIN MANAGEMENT

Patient Name/Nombre Del Paciente	Date of Service/ Fecha de Servicio

PATIENT INFORMATION

Social Security Number/ Numero Social	Marital Status/Estado Civil: _ Single/Soltero _ Married/Casado _Widow/Vuido		
Home Address/Direccion de casa	City/Cuidad	State/Estado	Zip Code/Codigo postal
Home Phone/Numero de Telefono	Cell phone/Numero de Celular	Date of Birth/Fecha de Nacimiento	Sex/Sexo
Name of Employer(School)/Empleador(Escuela)			
Emergency Contact/Emergencia	Name/Nombre	Relationship/Relacion	Telephone/Telefono

INSURANCE INFORMATION

GET THIS INFORMATION FROM YOUR INSURANCE ID CARD (S)			
Name of Primary Insurance/Nombre del Seguro Primario			
Insurance Address/Direccion del Seguro	City/Cuidad	State/Estado	Zip Code/Codigo Postal
Insurance ID#/Numero de Identificacion	Group#/Numero de Grupo	Policy Holder Name/Nombre del asegurado	
Name of Secondary Insurance/Nombre de Seguro Secundario			
Insurance Address/Direccion del Seguro	City/Cuidad	State/Estado	Zip Code/Codigo Postal
Insurance ID#/Numero de Identificacion	Group#/Numero de Grupo	Policy Holder Name/Nombre del asegurado	

Referring Doctor/Medico de Referencia	Referring Doctor Telephone/Numero del Medico de Referencia
Address of Referring Doctor/Direccion del Medico de Referencia	
Pharmacy Name, Address & Telephone / Nombre de Farmacia, Direccione y Numero de Telefono	

In consideration of services rendered, or to be rendered, to the patient, I hereby authorize insurance payments to Anesthesiology Associates of Boro Park. I understand that if the group does not receive payment from the insurer

I am personally responsible for the payment of all fees.

Signature/Firma _____

Relationship to Patient/Relacion al Paciente _____

Date/Fecha _____