1031 West Williams Street, Suite 102, Apex, NC 27502
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NEW PATIENT INFORMATION FORM

All patients (new and returning) are subject to the following no-show/broken appointment policy. Your completion of this form indicates that you acknowledge and fully understand this policy.

When an appointment is made for a patient to be seen in our office, a specific time is reserved for that patient. This allows the provider to meet the patient's needs. Broken or missed appointments result in the loss of valuable time that could be spent with patients in need of treatment. For this reason, if a patient fails to keep a **NEW PATIENT VISIT**, he or she will be charged a fee of **$250**. If a patient fails to keep a **FOLLOW-UP VISIT**, he or she will be charged a fee of **$100**. If a patient fails to keep an appointment for a **PROCEDURE**, he or she will be charged a fee of **$150**. If a no-show fee is not paid within **60 (sixty) days**, the patient will be charged an additional **$10** late payment fee. If an appointment needs to be cancelled or rescheduled for any reason, please notify our office at least **24 hours** in advance, and no fee will be charged. If a patient misses more than **3 (three)** appointments without prior notice, that patient may be dismissed from the practice.

We ask that all NEW PATIENTS bring recent imaging reports (MRI's, CT, X-Ray, EMG, etc.) to their first visit. Also, please bring ALL CURRENT MEDICATIONS within their ORIGINAL PILL BOTTLES. Failure to do so will mean that we cannot prescribe medications on the first visit and treatment will be delayed.

Name:

E-Mail Address:

Today's date:

Date of birth:

Sex:

How did you hear about Atlantic Spine & Pain?

Referring physician:

Primary care physician (if different):

Please indicate your primary pharmacy (name & location):

What approximate date did your pain start?

Did your pain start suddenly or gradually?

List your PRIMARY and SECONDARY areas of pain:

	PRIMARY	SECONDARY
☐ Neck Pain	☐	☐
☐ Upper Back	☐	☐
☐ Low Back Pain	☐	☐
☐ Shoulder Pain	☐	☐
☐ Elbow Pain	☐	☐
☐ Wrist Pain	☐	☐
☐ Hand Pain	☐	☐
☐ Hip Pain	☐	☐
☐ Knee Pain	☐	☐
☐ Ankle Pain	☐	☐
☐ Foot Pain	☐	☐
☐ Abdominal Pain	☐	☐
☐ Pelvic Pain	☐	☐
☐ Chronic Pain	☐	☐
☐ Headaches	☐	☐
☐ Peripheral Neuropathy	☐	☐

List OTHER areas of pain:

Which SIDE is your Primary pain?

☐ Right ☐ Left ☐ Both

Which SIDE is your SECONDARY pain?

☐ Right ☐ Left ☐ Both

What evaluation and treatments are you interested in?

☐ Pain Management by Medication

☐ Injections

☐ Botox for Migraine

☐ Prolotherapy

☐ Platelet Rich Plasma

☐ PT referral

☐ Diagnostic Testing **(EMG/NCV, X-Ray, MRI)**

My pain is due to:

☐ **Car accident**

☐ **Surgery**

☐ **Lifting Injury**

☐ **Sports injury**

☐ **Work injury**

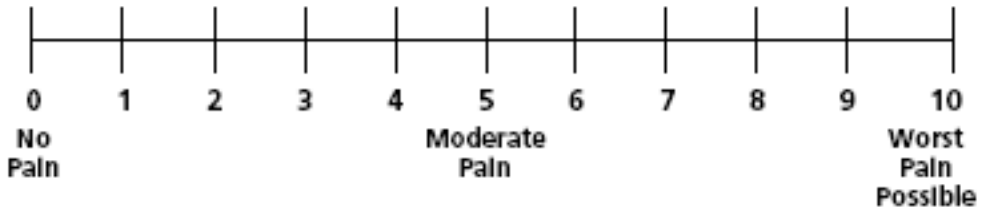
☐ **A Fall**

☐ **Other _____**

Which of the following best describes your pain?

☐Constant ☐Frequent ☐Intermittent ☐Occasional

How severe is your pain right now:

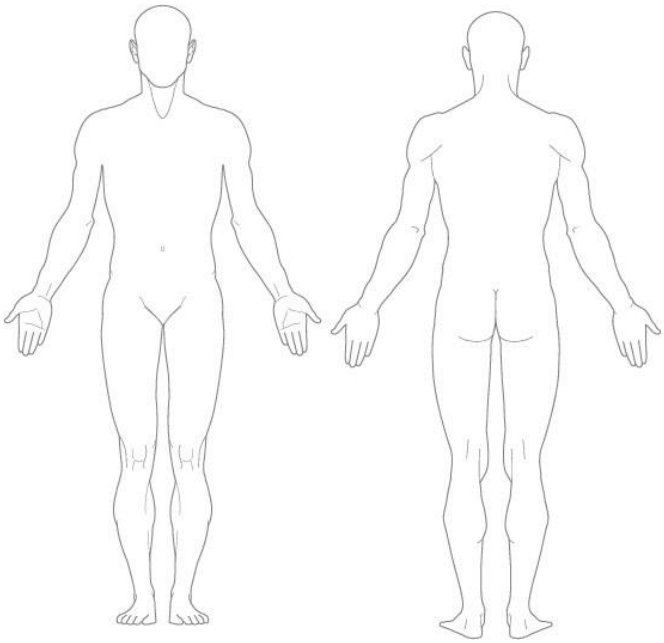


Select all that describes you current pain.

☐Burning	☐Throbbing	☐Dull/Aching	☐Shooting	☐Sharp
☐Cramping	☐Pressure	☐Lightening Like	☐Electric	☐Cutting
☐Numbness	☐Tingling	☐Insomnia	☐Other _____	

If your pain is radiating, where does it travel? _____

Please shade in the location(s) of your pain:



Is your pain associated with?

- ☐ **Numbness. Where? _____**
- ☐ **Tingling. Where? _____**
- ☐ **Weakness. Where? _____**
- ☐ **Bladder or bowel dysfunction? _____**

Known reactions to anesthetics?	☐ Yes ☐ No
History of cardio-defibrillator?	☐ Yes ☐ No
History of pacemaker?	☐ Yes ☐ No
Is sleep affected by your pain?	☐ Yes ☐ No
Are you currently taking any blood thinners?	☐ Yes ☐ No
Do you have an allergy to shellfish?	☐ Yes ☐ No
Do you have known reactions to radiographic contrast?	☐ Yes ☐ No
Do you have diabetes?	☐ Yes ☐ No

How do each of the following affect your pain?

	Relieves Pain	Worsens Pain	No Effect
Lying down			
Standing			
Sitting			
Walking			
Exercise			
Medications			
Relaxation			
Thinking about something else			
Coughing/Sneezing			
Urination			
Bowel Movement			

Have you ever been treated by a pain specialist before? _____

If "yes", where and when? _____

Why did you leave? _____

What treatments have been attempted in the past?

	Excellent Relief	Moderate Relief	Minimal Relief	No Relief
Bedrest	☐	☐	☐	☐
Traction	☐	☐	☐	☐
Back Brace	☐	☐	☐	☐
TENS Unit	☐	☐	☐	☐
Physical Therapy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Ice	☐	☐	☐	☐
Heat	☐	☐	☐	☐
Corticosteroid Injection	☐	☐	☐	☐
Cervical Facet Injection	☐	☐	☐	☐
Epidural Injection	☐	☐	☐	☐
Lumbar Facet Injection	☐	☐	☐	☐
Nerve Block	☐	☐	☐	☐
Surgery	☐	☐	☐	☐
Chiropractic	☐	☐	☐	☐
Acupunture	☐	☐	☐	☐
Psychotherapy	☐	☐	☐	☐
Biofeedback	☐	☐	☐	☐
Hypnosis	☐	☐	☐	☐
Prolotherapy	☐	☐	☐	☐
Platelet Rich Plasma	☐	☐	☐	☐
Other:	☐	☐	☐	☐

What medications have been taken to relieve pain in the past?

	Excellent Relief	Moderate Relief	Minimal Relief	No Relief
Cymbalta (Duloxetine)	☐	☐	☐	☐
Effexor (Venlafaxine)	☐	☐	☐	☐
Savella (Milnacipran)	☐	☐	☐	☐
Amitriptyline	☐	☐	☐	☐
Nortriptyline	☐	☐	☐	☐
Desipramine	☐	☐	☐	☐
Neurontin (Gabapentin)	☐	☐	☐	☐
Lyrica (Pregabalin)	☐	☐	☐	☐
Topiramate	☐	☐	☐	☐
Lamotrigine	☐	☐	☐	☐
Carbamazepine	☐	☐	☐	☐
Oxcarbazepine	☐	☐	☐	☐
Zonisamide	☐	☐	☐	☐
Keppra (Levitracetam)	☐	☐	☐	☐
Beta Blockers (Propranolol)	☐	☐	☐	☐

Calcium Channel Blockers	☐	☐	☐	☐
ACE Inhibitors	☐	☐	☐	☐
Ergotamines	☐	☐	☐	☐
Triptans	☐	☐	☐	☐
Ibuprofen	☐	☐	☐	☐
Naproxen	☐	☐	☐	☐
Diclofenac	☐	☐	☐	☐
Celecoxib (Celebrex)	☐	☐	☐	☐
Meloxicam (Mobic)	☐	☐	☐	☐
Nabumetone (Relafen)	☐	☐	☐	☐
Indomethacin	☐	☐	☐	☐
Ketorolac (Toradol)	☐	☐	☐	☐
Voltaren Gel	☐	☐	☐	☐
Flector Patch	☐	☐	☐	☐
Aspirin	☐	☐	☐	☐
Baclofen	☐	☐	☐	☐
Cyclobenzaprine (Flexeril)	☐	☐	☐	☐
Carisoprodol (Soma)	☐	☐	☐	☐
Methocarbamol (Robaxin)	☐	☐	☐	☐
Metaxalone (Skelaxin)	☐	☐	☐	☐
Tizanidine (Zanaflex)	☐	☐	☐	☐
Diazepam (Valium)	☐	☐	☐	☐
Tramadol (Ultram)	☐	☐	☐	☐
Hydrocodone (Vicodin, Lortab, Norco)	☐	☐	☐	☐
Oxycodone (Lorcet, Roxicet)	☐	☐	☐	☐
Oxycontin	☐	☐	☐	☐
Percocet	☐	☐	☐	☐
Fentanyl (Duragesic)	☐	☐	☐	☐
Hydromorphone (Dilaudid)	☐	☐	☐	☐
Exalgo	☐	☐	☐	☐
Tapentadol	☐	☐	☐	☐
Propoxyphene (Darvon)	☐	☐	☐	☐
Methadone	☐	☐	☐	☐
Acetaminophen	☐	☐	☐	☐
Licoderm	☐	☐	☐	☐

Past medical history: Please indicate all chronic medical conditions (e.g. diabetes, hypertension, depression).

☐ Hypertension	☐ Chronic Renal Fail	☐ Osteoarthritis
☐ CHF	☐ Hepatitis	☐ HIV
☐ Coronary Artery Disease	☐ Cirrhosis	☐ Depression
☐ Prior MI	☐ GERD	☐ Anxiety
☐ Stroke	☐ IBS	☐ Panic Attacks
☐ COPD	☐ Obesity	☐ Hypercholesterolemia
☐ Sleep apnea	☐ Diabetes	☐ Migraines

☐ Nicotine Dependence ☐ Cancer ☐ Insomnia
☐ Asthma ☐ Hypothyroidism ☐ Denial of Past Medical History
☐ Other: _____

Past surgical history: Please list all operations, and the date performed.

☐ Neck Surgery ☐ Hemorrhoidectomy ☐ Osteoarthritis
☐ Back Surgery ☐ Hysterectomy ☐ Tubal Ligation
☐ Cervical Fusion ☐ Cardiac Cath ☐ Pacemaker
☐ Lumbar Laminectomy ☐ Cholecystectomy ☐ Tonsillectomy
☐ Lumbar Fusion ☐ Lung surgery ☐ Heart Valve Replacement
☐ Gastric Bypass ☐ C-Section ☐ Hip Replacement
☐ CABG ☐ Thyroid Surgery ☐ Knee Replacement
☐ Appendectomy ☐ Carotid Surgery ☐ Knee Arthroscopy
☐ Inguinal Hernia Repair ☐ Cataract ☐ Denial of Past Medical History

Other Surgical History:

_____
_____
_____
_____
_____

Past imaging history: Please indicate all MRIs, X-Rays, EMGs and CTs related to your current pain.

Please list type and facility	Date

Medications: Please list ALL medicines you currently take, including vitamins, supplements, and over-the-counter drugs. Please bring your bottles with you.

Medicine	Dose

Allergies: Please list all allergies to medicines, animals, or environmental factors.

_____

_____

Family History: Please list the conditions or illnesses that run in your family.

Condition	Relative
_____	_____
_____	_____
_____	_____
_____	_____

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Do you have children? What are their ages?

Living Situation? ☐ Significant Other ☐ Spouse ☐ Adult Children ☐ Alone

☐ Assisted-Living Facility ☐ Friend

Education level: ☐ Diploma/GED ☐ Associates ☐ Bachelor's ☐ Master's ☐ Doctorate

Do you work? ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Unemployed

If not currently working, when was the last time you worked?

What are your hobbies/interests?

Do you now (or have you ever) used tobacco? ☐ Yes ☐ No

Type: ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chewing tobacco ☐ Dip/snuff

Amount:

Start date: **Quit date:**

Do you now (or have you ever) used alcohol? ☐ Yes ☐ No

Type:

Amount (drinks/week):

Do you now (or have you ever) used recreational drugs? ☐ Yes ☐ No

Type:

Frequency:

Have you ever been treated for substance abuse/dependence? ☐ Yes ☐ No

Have you ever been arrested for DUI? ☐ Yes ☐ No

Have you ever been arrested on drug-related charges? ☐ Yes ☐ No

Have you ever undergone psychiatric or psychological counseling? ☐ Yes ☐ No

REVIEW OF SYSTEMS (check all that apply)

Constitutional: ☐ No problems

☐Fever ☐Abnormal Appetite ☐Trouble Sleeping ☐Fatigue

☐Other _____

Eyes: ☐ No problems

☐Blurry vision ☐Double vision ☐Glasses ☐Other _____

ENT: ☐ No problems

☐Sore throat ☐Hearing Changes ☐Nose bleeds ☐Other _____

Cardiovascular: ☐ No problems

☐Chest pain ☐Palpitations ☐Leg/Feet swelling ☐Other _____

Respiratory: ☐ No problems

☐Wheezing ☐Coughing ☐Short of breath ☐Other _____

Hematologic/Lymphatic: ☐ No problems

☐Easy bruising ☐Easy bleeding ☐Other _____

Gastrointestinal: ☐ No problems

☐Dysphagia ☐Heartburn ☐Nausea ☐Vomiting

☐Abdominal pain ☐Diarrhea ☐Other _____

Genitourinary: ☐ No problems

☐Pain w/ urination ☐higher frequency ☐Blood in urine ☐Pain w/ sex

☐Impotence ☐Other _____

Skin: ☐ No problems

☐Rashes ☐Skin lesions ☐Other _____

Musculoskeletal: ☐ No problems

☐Joint pain ☐Joint swelling ☐Muscle aches ☐Other _____

Neurological: ☐ No problems

☐Weakness ☐Numbness ☐Balance problems ☐Tremor

☐Dizziness ☐Memory problems ☐Headaches ☐Seizures

☐Other _____

Psychiatric: ☐ No problems

☐Depression ☐Anxiety ☐Mood changes ☐Suicidal Thoughts

☐Other _____