CENTER FOR WELLNESS & PAIN CARE OF LAS VEGAS
"where healing begins..."

Follow-up Visit Intake Paperwork

Please carefully complete all sections of this form, even if nothing has changed since your last visit.

Your Name: _____ Date of Birth: _____ Today's Date: _____

Has your medical coverage changed from your last visit? ❑ Yes ❑ No

Reason For Today's Visit

❑ Medication Refill ❑ Medication Change ❑ Post-Procedure Assessment ❑ Review MRI Results

❑ Review Test Results ❑ Other: _____

Pain Description

Height: _____ Weight: _____

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain using a 0 – 10 scale:

_____ Your pain **right now**?

_____ Your **worst pain**?

_____ Your **least pain**?

_____ Your **average pain over the last month**?

Where is your worst area of pain located?

_____

Does this pain radiate? If so, where?

_____

Check all that describe your pain today:

❑ Aching ❑ Shooting

❑ Cramping ❑ Spasming

❑ Dull ❑ Squeezing

❑ Tingling/Pins and Needles

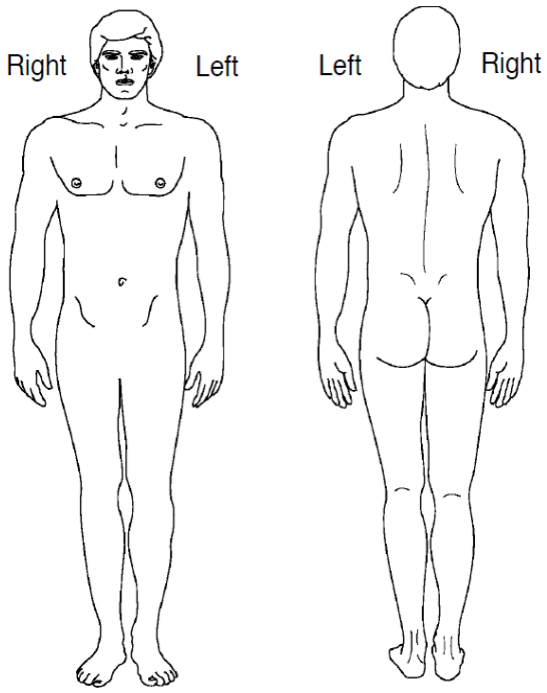
❑ Hot/Burning ❑ Tiring/Exhausting

❑ Numb ❑ Stabbing/Sharp

❑ Shock-like ❑ Throbbing

Use the diagram to indicate the location and type of your pain.

Mark the drawing with the following letters that best describe your symptoms:
"**N**" = numbness "**P**" = pins and needles
"**A**" = aching "**S**" = stabbing "**B**" = burning



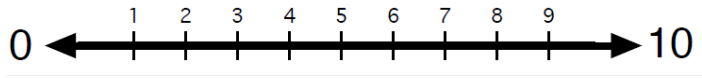
What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

When is your pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings ❑ Middle of the night

Mark all of the following activities that are adversely/negatively affected by your pain

☐ Enjoyment of Life ☐ Normal Work ☐ Sleep
☐ General Activity ☐ Recreational Activities ☐ Walking
☐ Mood ☐ Relationships with People ☐ Other: _____

Pain Scale



Changes Since your Last Visit

Have you developed any new pain complaints since your last visit you would like to discuss today? ☐ Yes ☐ No

Since your last appointment, how as your pain changed? ☐ Decreased ☐ Increased ☐ Stayed the same

If you had a procedure, how much pain relief did you obtain?
☐ None ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Were there any problems? ☐ Yes ☐ No If yes, please explain:_____

Since your last visit, have you developed any new:

☐ Balance Problems ☐ Bladder incontinence ☐ Bowel incontinence ☐ Chills
☐ Difficulty Walking ☐ Fevers ☐ Nausea ☐ Vomiting
☐ Numbness/Tingling – Where?_____ ☐ Weakness – Where? _____

☐ I HAVE NOT RECENTLY DEVELOPED PROBLEMS WITH ANY OF THE ABOVE CONDITIONS SINCE MY LAST VISIT.

Current Medications

Please list any *changes* since your last visit in the medications you are currently taking.

Medication Name **Dose** **Change**

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

☐ **I authorize The Center for Wellness and Pain Care of Las Vegas to access my electronic Medication History and Formulary Information**

Are you currently taking any blood-thinners or anticoagulants? ☐ Yes ☐ No

Medications Effects

Mark the following medication side-effects you are experiencing, if any:

❑ Confusion	❑ Constipation	❑ Dizziness	❑ Drowsiness
❑ Dry Mouth	❑ Nausea	❑ Vomiting	❑ Weight Gain

❑ I do not have any adverse side effects from current medications.
❑ I am stable on my current medication regimen.
❑ My medications help to improve my functioning and quality of life.

Review of Systems

Mark the following symptoms that you currently suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.*

Constitutional:	❑ Chills	❑ Difficulty Sleeping	❑ Easy Bruising
❑ Excessive Sweating	❑ Excessive Thirst	❑ Fatigue	❑ Fevers
❑ Insomnia	❑ Low Sex Drive	❑ Night Sweats	❑ Tremors
❑ Unexplained Weight Gain	❑ Unexplained Weight Loss		❑ Weakness
Eyes:	❑ Recent Visual Changes		
Ears/Nose/Throat/Neck:	❑ Dental Problems	❑ Earaches	❑ Hearing Problems
❑ Nosebleeds	❑ Recurrent Sore Throats	❑ Ringing in the Ears	❑ Sinus Problems
Cardiovascular:	❑ Bleeding Disorder	❑ Chest Pain	❑ Deep Vein Thrombosis
❑ Fainting	❑ High Blood Pressure	❑ Irregular Heartbeat	❑ Lightheadedness
❑ Shortness of Breath During Sleep		❑ Swelling in the Feet	
Respiratory:	❑ Cough	❑ Wheezing	❑ Pulmonary Embolism
❑ Shortness of Breath on Exertion/Effort		❑ Shortness of Breath at Rest	
Gastrointestinal:	❑ Abdominal Cramps	❑ Acid Reflux	❑ Constipation
❑ Coffee Ground Appearance in Vomit		❑ Dark and Tarry Stools	❑ Diarrhea
❑ Hernia	❑ Vomiting		
Musculoskeletal:	❑ Back Pain	❑ Joint Pain	❑ Joint Stiffness
❑ Joint Swelling	❑ Muscle Spasms	❑ Neck Pain	
Genitourinary/Nephrology:		❑ Blood in Urine	
❑ Decreased Urine Flow/Frequency/Volume		❑ Flank Pain	❑ Painful Urination
Neurological:	❑ Carpal Tunnel Syndrome		❑ Dizziness
❑ Headaches	❑ Numbness/Tingling	❑ Instability When Walking	❑ Tremors ❑ Seizures
Psychiatric:	❑ Depressed Mood	❑ Feeling Anxious	❑ Stress Problems
❑ Suicidal Thoughts	❑ Suicidal Planning		

Signature and Date

In the event that I am asked to provide a urine and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested. I have the right to refuse specific tests, but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected 30 days of being notified of any balance due. Please note that in the event that you fail to make payment when due, this account will be referred to a collection agency for collections. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

Signed:_____ Date: _____