CWPC Follow-up Intake

1. Please enter your information.

First Name: _____ Last Name: _____ Date of Birth: _____ Email: _____

Has your address changed since your last visit?
○ Yes ○ No

If yes, please provide: _____

Has your pharmacy changed since your last visit?
○ Yes ○ No

If yes, please provide: _____

Has your insurance changed since your last visit?
○ Yes ○ No

If yes, please provide Payer and Member ID: _____

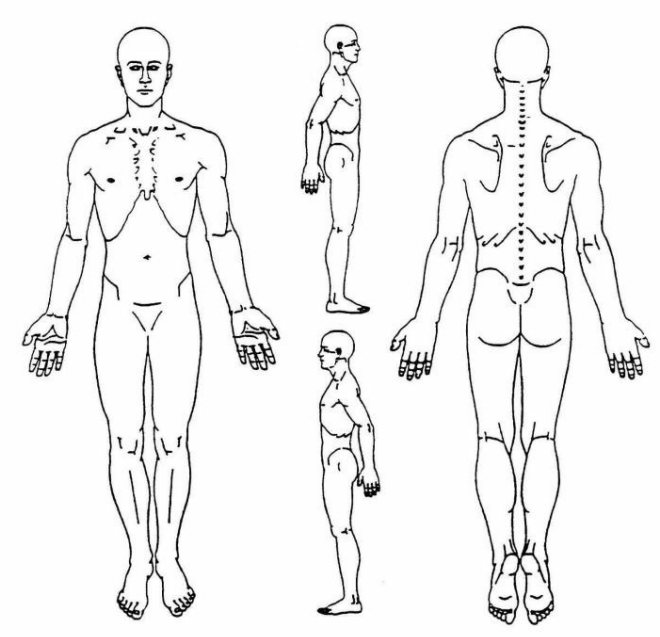
What is the reason for your visit today?
☐ Medication Refill ☐ Medication Change ☐ Post-Procedure Assessment ☐ Image Review
☐ Test Result Review ☐ Other

Explain Other: _____

Patient Information

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

0 - Numbness 1 - Pins and Needles 2 - Aching 3 - Stabbing 4 - Burning



3. Pain Description

Height: _____ Weight: _____ Do you smoke? ○ Yes ○ No

Your pain right now:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Your worst pain:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Your least pain:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Your average pain over the last month?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Where is the worst area of your pain located? _____ Does the pain radiate? If so, where? _____

Check all that describe your pain today:
☐ Aching ☐ Cramping ☐ Dull ☐ Hot/Burning ☐ Numb ☐ Shock-Like ☐ Tingling/Pins and Needles
☐ Shooting ☐ Spasming ☐ Squeezing ☐ Tiring/Exhausting ☐ Stabbing/Sharp ☐ Throbbing

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

When is your pain at its worst?
○ Morning ○ During the day ○ Evenings ○ Middle of night

Mark all of the following activities that are adversely or negatively affected by your pain:
☐ Enjoyment of life ☐ General Activity ☐ Mood ☐ Normal Work ☐ Recreational Activities
☐ Relationships with people ☐ Sleep ☐ Walking ☐ Other

Other:

_____

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

Since your last visit has your pain changed?
○ Increased ○ Decreased ○ Stayed the same

4. Post-Procedure Relief/Patient Update:

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 ☐ Difficulty Walking ☐ Fevers
☐ Nausea ☐ Chills ☐ Vomiting

Weakness- Where? _____

Numbness or Tingling- Where? _____

☐ I have not recently developed problems with any of the above conditions since my last visit.

5. Current Medication: Please list any CHANGES since your last visit in the medication you are currently taking

	Medication	Date first use	Dosage
1			
2			
3			

6. Are you currently taking blood thinners or anti-coagulants?

○ Yes ○ No

I authorize the Center for Wellness and Pain Care to access my electronic medication, history and formulary information.

_____

Signature

7. Mark the following medication side-effects you are experiencing:

☐ Confusion
☐ Drowsiness
☐ Vomiting
☐ I am stable on my current medication regimen
☐ Constipation (Less than 3 Bowel movements a week)
☐ Nausea
☐ Weight Gain
☐ My medications help to improve my functioning and quality of life.
☐ Dizziness
☐ Dry Mouth
☐ I do not have and adverse side-effect from current medications.

8. Review of Symptoms

Constitutional

☐ Chills ☐ Difficulty sleeping ☐ Easy Bruising ☐ Excessive Sweating ☐ Excessive Thirst ☐ Fatigue
☐ Fever ☐ Low Sex Drive ☐ Night Sweats ☐ Tremors ☐ Unexplained Weight Gain
☐ Unexplained Weight Loss ☐ Weakness

Eyes

☐ Visual Changes ☐ Blurry Vision ☐ Vision Loss

Ears/Nose/Throat/Neck

☐ Dental Problems ☐ Difficulty Hearing ☐ Earaches ☐ Nosebleeds ☐ Sore Throat ☐ Ringing in Ears
☐ Sinus Problems

Cardiovascular

☐ Bleeding Disorder ☐ Chest Pain ☐ Deep Vein Thrombosis ☐ Fainting ☐ High Blood Pressure
☐ Irregular Heartbeat ☐ Lightheadedness ☐ Shortness of Breath ☐ Swelling in feet

Respiratory

☐ Cough ☐ Wheezing ☐ Shortness of breath (Exertion/Effort) ☐ Shortness of breath at rest

Gastrointestinal

☐ Abdominal Reflux ☐ Acid Reflux ☐ Constipation (Less than 3 bowel movements a week)
☐ Epigastric Pain ☐ Dark and Tarry Stools ☐ Diarrhea

Musculoskeletal

☐ Back Pain ☐ Joint Pain ☐ Joint Stiffness ☐ Neck Pain ☐ Myalgia ☐ Muscle Weakness ☐ Shoulder Pain

Neurologic

☐ Headache ☐ Dizziness ☐ Numbness/Tingling ☐ Instability when walking ☐ Tremors ☐ Seizures

Psychiatric

☐ Depressed Mood ☐ Feeling Anxious ☐ Stress Problems ☐ Suicidal thoughts ☐ Suicidal planning

Genitourinary/Nephtology

☐ Blood in Urine ☐ Decreased Urine (Flow, Frequency, Volume) ☐ Flank Pain ☐ Painful Urination

I certify that the above information is accurate, complete, and true. I authorize CWPC and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for CWPC to retrieve my medication history. I understand that this will become part of my medical record. I acknowledge that I have had the opportunity to review CWPCâ€™s Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records. I authorize the CWPC to release my Protected Health Information (medical records) in accordance with itâ€™s Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also Authorize CWPC to release any information required in obtaining procedure authorization or the processing of any insurance claims. I understand that CWPC will not release my Protected Health Information to any other party (including family) without my completing a written â€œPatient Authorization for Use and Disclosure of Protected Health Informationâ€ form, available at its facility and on its website. 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 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 a 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 agency fees and attorney fees will increase the balance you owe.

_____

Signature

9. Opioid Risk Tool

Do you have a family history of substance abuse with alcohol

_____

Do you have a family history of substance abuse with illegal drugs?

_____

Do you have a family history of substance abuse with RX drugs?

_____

Do you have a personal history of substance abuse with alcohol?

_____

Do you have a personal history of substance abuse with illegal drugs?

_____

Do you have a personal history of substance abuse with RX drugs?

_____

Are you between the age of 16-45?

History of pre-adolecent sexual abuse?

ADD, OCD, Bipolar, Schizophrenia?

Depression?

Total Score

10.