Interventional Pain
Management Specialists LLC

Dear Valued Patient: You have an appointment to be seen in the Outpatient Pain Clinic:

At:_____

On:_____

At:_____ AM/PM We look forward to seeing you.

Enclosed you will find a questionnaire. It is **VERY IMPORTANT** that you take the time to fill out this questionnaire as completely as possible in an effort to help us better evaluate your pain problem. Also, it will streamline your first visit to the clinic. Please bring the completed questionnaire with you to the clinic on your first visit. Those who have not completed this paperwork prior to their appointment will be asked to reschedule.

A few reminders:

- Please be on time. In fairness to other patients, those people who are 20 minutes or more late, will be asked to reschedule.
- You should check in at the registration desk 15 minutes prior to your scheduled appointment so you have time to complete your registration.
- Bring your driver's license, insurance cards and any referrals or authorizations that are required by your insurance carrier.
- Remember to allow time for parking.
- Bring a list of your current medications with you to each clinic visit.
- Please bring pertinent medical records including reports from X-rays, MRIs or CT scans with you.
- Please be prepared to pay your insurance co-pay.
- Coinsurance and or deductible balances after treatments * you will be responsible to pay 50 percent of your outstanding balance at each visit before any additional appointments will be made.

Insurance: Patients with insurance will be asked to pay any deductible or co-payment at each visit. Please make certain that your insurance company will cover the Pain Clinic service and obtain any referral letters or authorizations that may be necessary.

Private Pay Patients: Our policy is that your first visit will be for evaluation only. Payment in cash, money order or by cashier's check in the amount of $500.00 will need to be paid at your initial visit. Payments for any treatments will be discussed after your initial consult.

PMGS

Menorah Medical Center
5701 W 119th St. Suite 102
Overland Park, KS 66209

Interventional Pain Management Specialists Questionnaire

Date: _____

Name: _____ Date of Birth: _____ Age: _____

Sex: _____ Height: _____ Weight: _____ Disabled ? ____Yes ____No

Phone Numbers: Home _____ Work _____ Cell _____

Address: _____

City : _____ State : _____ Zip: _____

Emergency Contact : _____

Referring Physician: _____ Primary Care Physician: _____

Is this injury related to a Motor Vehicle Accident? Yes No If yes, Date of Accident: _____
Date pain began: _____ Insurance Company Name: _____

Is this a Worker's Comp injury? ____Yes ____No If yes, Date of Injury: _____ Date pain began: _____

Employer: _____ Occupation: _____

Are you currently working? _____ If no, last date worked? _____

Current Work Restrictions: _____

List all previous Workers' Comp Injuries _____

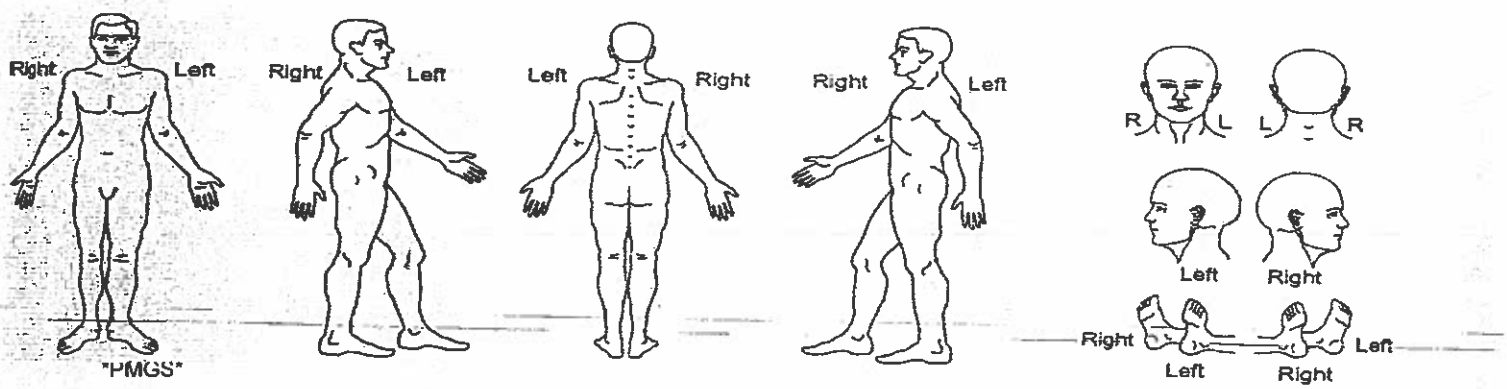
Workers' Comp Case Worker : _____ Number: _____

Date Pain Began: _____ Describe Event/Onset: _____

Have you seen a Pain Physician in the past ? ____Yes ____ No When? _____ Where ? _____

Where you Discharged/Dismissed from there practice? ____ Yes ____ No If yes, Why? _____

On the diagram shade in the area(s) where your pain is located:



What makes your pain Better? (Example: Heat, Ice, Rest, Medicine, Etc ....)

What makes your pain Worst? (Example: Walking, Standing, Lifting, Etc.....)

On a scale from 0 (no pain) to 10 (excruciating) rate your pain:
At its WORST: _____ At its LEAST: _____ At its USUAL: _____
What is your pain level Today? _____

Circle all that apply:

Burning _ Weakness _ Aching _ Tingling _ Throbbing _ Coldness _ Sharp _ Skin Discoloration _ Dull _ Muscle Spasms _ Tiring_ Muscle Tightness _ Numbness _ Increased Swelling _ Bowel and/or Bladder problems _ Nagging_ Miserable_ Unbearable_ Penetrating_ Tender_ Continuous_ Intermittent_ Other: _____

Circle any form of treatment received for pain:

Injections/Blocks When? _____ Where: _____ _ Physical/Occupational Therapy _ Chiropractor/Manipulation_ Acupuncture _ Hypnosis _ TENS Unit _ Psychotherapy/Psychiatric Therapy_ Pain Medications

Check any tests performed for evaluation of pain:

___	Lumbar MRI	Where? _____	Date (if known) _____
___	Cervical MRI	Where? _____	Date (if known) _____
___	CT Scan	Where? _____	Date (if known) _____
___	Myelogram	Where? _____	Date (if known) _____
___	X-Rays	Where? _____	Date (if known) _____
___	Bone Scan	Where? _____	Date (if known) _____
___	EMG	Where? _____	Date (if known) _____
___	Discogram	Where? _____	Date (if known) _____

List ALL current medications: (continue on back if needed or attach list)

ALLERGIES TO MEDICATIONS: _____

Side Effects From Previous Medications: _____

Medical History - Circle all that apply

Arthritis	Bone Disease	Anxiety	High Blood Pressure
Glaucoma/cataracts	Muscular Disorder	Epilepsy or Seizure	High Cholesterol
Hepatitis	Blood Transfusion	Muscular Disorder	Any Type of Infection
Kidney Disease	Bone Disease	Jaundice	Describe: _____
Blood Disease/Anemia	Paralysis	Diabetes	
Heart Attack/CAD/CHF	GI/Stomach Disorder	Thyroid Disease	COPD/Emphysema
Positive HIV/AIDS Test	Psychiatric or Mental Disorder	Heart Murmur	Cancer Type: _____
Anticoagulant Therapy	Depression	Abnormal EKG	
Asthma	Abnormal Bleeding Tendencies	Fracture of Neck/Back	

Family Medical History:

Heredity Defects: ____**Yes** ____**No** **If Yes, Please list,** _____

Past Surgical History

Surgery: _____ Year: _____
Surgery: _____ Year: _____
Surgery: _____ Year: _____
Surgery: _____ Year: _____
Surgery: _____ Year: _____

Social History – Check all that apply

___ **Drink Alcohol: (Circle One) Occasionally Frequently Daily**

___ **Use street drugs or have a history of substance addiction/abuse**

(Heroin_ Barbiturates_ Cocaine_ Marijuana_ Amphetamines_)

___ **Use Tobacco** ____ **Pack per day** _____ **How long?**

Are you pregnant or trying to become pregnant? ____ Yes ____ No

Marital Status: (Circle) Married Single Divorced Widowed Number of Children: ____

Level of Education: _____ Occupation: _____ Employer: _____

Currently Working? Yes No Full time_____ Part time_____

Circle any of the following symptoms you currently have:

Paralysis	Irregular Heartbeat	Vomiting	Blood in Urine
Fever	Wheezing	Shortness of Breath	Diarrhea/Constipation
Coughing	Muscle Aches	Unexpected Weight Loss	Weakness
Numbness	Sore Throat	Abdominal Pain	Urinary Pain/Discomfort
Fatigue	Heartburn		Skin rashes
Headaches	Chest Pain	Joint Pain/Swelling	Other : _____

The Attached information was reviewed with the patient by:

_____ on _____
(Physician) (Date)

_____ on _____
(Physician) (Date)

_____ on _____
(Physician) (Date)

Crimson | Pain Management

WELCOME TO OUR PRACTICE

Thank you for choosing **Crimson Pain Management** as part of your healthcare team. We are committed to providing you with the best possible care and are dedicated to working toward a positive treatment outcome. Your clear understanding of our financial policy is important to our professional relationship.

To help you better understand the billing practice, you are being seen in an OUT PATIENT FACILITY.
Please be prepared to pay an outpatient surgical Co-Pay / Co- Insurance for a SURGICAL FACIITY.
You will also receive a specialist billing charge Co-Pay/ Co- Insurance for the SPECIALIST VIST.
PLEASE UNDERSTAND THESE CHARGES ARE FOR EACH AND EVERY VISIT.

INSURANCE

As your physician, our relationship is with you—our patient, not with your insurance company. We cannot accept responsibility of negotiating claims for our professional services with hundreds of insurance companies. **While we do file insurance claims as a courtesy to our patients, all charges are your responsibility from the date the services are rendered.**

It is important that you understand the provisions of your policy coverage. We cannot guarantee payment of all claims. A reduction in payment or a rejection of your claim by your insurance company does not relieve you of your financial obligation. In the event of insurance denials, errors, or non-covered services, each patient is responsible for all services rendered.

We charge what is usual and customary for our services in our area. You are responsible for payment of your account, including your co-payments. Nonpayment of your account is justification for your dismissal from our practice.

To ensure your claims are paid accurately and in a timely manner, it is important that your billing information be reviewed and verified at each clinic visit. Please bring your personal identification (i.e. driver's license, social security card), insurance cards, Medicare cards and secondary insurance information with to each visit.

You will be billed for missed appointments. We dedicate individual time for each scheduled patient in our clinic. Appointments must be cancelled 24 hours in advance, and Monday appointments must be cancelled on the preceding Friday. THE STANDING FEE IS $ 25.00 and this is billed to you and not your Insurance company.

PRIVATE PAY PATIENTS:
Our policy for Private Pay Patients: Payment is due at the time of service for both the Facility and the Physician there are no EXCEPTIONS..... Interventional Pain Management Specialist accepts payment in CASH, MONEY ORDER, or CASHIERS CHECK ONLY..... The facility accepts all forms of payment.

Crimson | Pain Management

If your account is delinquent, you will be asked to reschedule your appointment until arrangements have been made with our billing office. Delinquent accounts may be referred to a collection agency and a surcharge may be added in order to cover the costs incurred to contract for recovery services. Once your account has been forwarded to an Outside Collection Agency you will no longer be able to been seen in the clinic until the account is paid in full and removed from collections.

Assignment of Benefits

Name of Insured (print):_____

Social Security Number:_____

I request that payment of authorized insurance benefits, including Medicare beneficiary, be made on my behalf to the organization listed below for any services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to the organization, the CMS (Centers for Medicare & Medicaid Services), my insurance carrier or other medical entity. A copy of this authorization will be sent to CMS or my insurance carrier if requested. The original will be kept on file.

CRIMSON PAIN MANAGEMENT

Signature: _____

Date:_____

INTERVENTIONAL PAIN MANAGEMENT SPECIALISTS

Worker's Compensation Questionnaire

Patient Agreement

Patient's Name_____ SS# _____

Address_____ Tel. No._____

W/C Insurance Carrier_____ Address_____

Tel. No. _____

Case Worker _____ Tel. No. _____

Date of Injury/Illness _____Date of First Visit _____

Claim Adjuster_____ Claim number_____

Is this condition related to employment? Yes _____ No_____

If accident: Auto_____ Other_____

Where did the Injury occur? _____

How did it happen? _____

Employee/employer who verified this information_____

Employer's Name _____ Address _____

Employer Telephone Number _____

In the event the claim for worker's compensation is declared fraudulent for this illness or condition, or it is determined by the Worker's Compensation Board that the illness or injury is not a compensable worker's compensation case, I,_____, Hereby agree to pay all physician's fees for services rendered. I have been informed that I am responsible to pay any services rendered by Interventional Pain Management Specialists with regard to this Workers' Compensation injury or illness. I agree to pay all services not covered by Workers' Compensation and all charges for treatments and personal items unrelated to my workers' compensation illness or injury.

(I attest that all the above information is true and accurate)

Signed_____ Date_____

Your health history is important in your treatment plan here at Menorah Medical Center. Because we are committed to providing the very best care possible for you, we ask that you give us some additional information about your health history. Please complete as accurately as possible, and if you have any questions, please let us know.

Allergies: Medication, contrast, food, tape, latex, environmental substances ☐ **None**

Medication / Item	Describe Reaction	Medication / Item	Describe Reaction

Medications: Prescription, Over-the-counter, Herbal, Vitamins, Inhaler, Eye drops, etc. Please complete for each medication being taken at this time.

☐ **No Medications being taken at this time.**

Medication Name (Please Print)	Dose (mg. unit)	Route	Frequency	Last Dose Taken (Date and Time)	Indication

Source of Information:

- ☐ Medication List
- ☐ Medication Container
- ☐ Patient/Family
- ☐ Other: _____

The above information is accurate as to the best of my knowledge.

Patient Signature: _____ Date/Time: _____

Nurse Signature: _____ Date/Time: _____

Physician Signature: _____ Date/Time: _____

MENORAH MEDICAL CENTER

Home Medication Reconciliation Form

Patient Information / Label

Oswestry Neck Disability Index

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday life activities. Please check the box for *the one statement* in each section that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that *most closely* describes your present-day situation. Thank you.

Patient name _____ Date _____

Please check one box in each section.

Section 1–Pain Intensity

- ☐ 0 I have no pain at the moment.
- ☐ 1 The pain is very mild at the moment.
- ☐ 2 The pain is moderate at the moment.
- ☐ 3 The pain is fairly severe at the moment.
- ☐ 4 The pain is very severe at the moment.
- ☐ 5 The pain is the worst imaginable at the moment.

Section 2–Personal Care (washing, dressing, etc.)

- ☐ 0 I can look after myself normally without causing extra pain.
- ☐ 1 I can look after myself normally, but it causes extra pain.
- ☐ 2 It is painful to look after myself; I am slow and careful.
- ☐ 3 I need some help but manage most of my personal care.
- ☐ 4 I need help every day in most aspects of self-care.
- ☐ 5 I do not get dressed; I wash with difficulty and stay in bed.

Section 3–Lifting

- ☐ 0 I can lift heavy weights without extra pain.
- ☐ 1 I can lift heavy weights, but it gives me extra pain.
- ☐ 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned—for example on a table.
- ☐ 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ 4 I can lift only very light weights.
- ☐ 5 I cannot lift or carry anything at all.

Section 4–Reading

- ☐ 0 I can read as much as I want to with no pain in my neck.
- ☐ 1 I can read as much as I want to with slight pain in my neck.
- ☐ 2 I can read as much as I want with moderate neck pain.
- ☐ 3 I can't read as much as I want because of moderate neck pain.
- ☐ 4 I can hardly read at all because of severe pain in my neck.
- ☐ 5 I cannot read at all.

Section 5–Headaches

- ☐ 0 I have no headaches at all.
- ☐ 1 I have slight headaches that come infrequently.
- ☐ 2 I have moderate headaches that come infrequently.
- ☐ 3 I have moderate headaches that come frequently.
- ☐ 4 I have severe headaches that come frequently.
- ☐ 5 I have headaches almost all the time.

Section 6–Concentration

- ☐ 0 I can concentrate fully when I want to with no difficulty.
- ☐ 1 I can concentrate fully when I want to with slight difficulty.
- ☐ 2 I have a fair degree of difficulty in concentrating when I want to.
- ☐ 3 I have a lot of difficulty in concentrating when I want to.
- ☐ 4 I have a great deal of difficulty in concentrating when I want to.
- ☐ 5 I cannot concentrate at all.

Section 7–Work

- ☐ 0 I can do as much work as I want to.
- ☐ 1 I can only do my usual work, but no more.
- ☐ 2 I can do most of my usual work, but no more.
- ☐ 3 I cannot do my usual work.
- ☐ 4 I can hardly do any work at all.
- ☐ 5 I can't do any work at all.

Section 8–Driving

- ☐ 0 I can drive my car without any neck pain.
- ☐ 1 I can drive my car as long as I want with slight pain in my neck.
- ☐ 2 I can drive my car as long as I want with moderate pain in my neck.
- ☐ 3 I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ 4 I can hardly drive at all because of severe pain in my neck.
- ☐ 5 I can't drive my car at all.

Section 9–Sleeping

- ☐ 0 I have no trouble sleeping.
- ☐ 1 My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ 2 My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ 3 My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ 4 My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ 5 My sleep is completely disturbed (5-7 hours sleepless).

Section 10–Recreation

- ☐ 0 I am able to engage in all my recreation activities with no neck pain at all.
- ☐ 1 I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ 2 I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ 3 I am able to engage in a few of my recreation activities because of pain in my neck.
- ☐ 4 I can hardly do any recreation activities because of pain in my neck
- ☐ 5 I can't do any recreation activities at all.

Score: _____ (50) Benchmark -5= _____

Oswestry Back Disability Index

This questionnaire is designed to help us better understand how your back pain affects your ability to manage everyday life activities. Please check the box for *the one statement* in each section that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that *most closely* describes your present-day situation. Thank you.

Patient name _____ Date _____

Please check one box in each section.

Section 1–Pain Intensity

- ☐ 0 My pain is mild to moderate. I do not need pain killers.
- ☐ 1 The pain is bad, but I manage without taking pain killers.
- ☐ 2 Pain killers give complete relief from pain.
- ☐ 3 Pain killers give moderate relief from pain.
- ☐ 4 Pain killers give very little relief from pain.
- ☐ 5 Pain killers have no effect on the pain.

Section 2–Personal Care (washing, dressing, etc.)

- ☐ 0 I can look after myself normally without causing extra pain.
- ☐ 1 I can look after myself normally, but it causes extra pain.
- ☐ 2 It is painful to look after myself; I am slow and careful.
- ☐ 3 I need some help but manage most of my personal care.
- ☐ 4 I need help every day in most aspects of self-care.
- ☐ 5 I do not get dressed; I wash with difficulty and stay in bed.

Section 3–Lifting

- ☐ 0 I can lift heavy weights without extra pain.
- ☐ 1 I can lift heavy weights, but it gives me extra pain.
- ☐ 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e., on a table.
- ☐ 3 Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ☐ 4 I can lift only very light weights.
- ☐ 5 I cannot lift or carry anything at all.

Section 4–Walking

- ☐ 0 I can walk as far as I wish.
- ☐ 1 Pain prevents me from walking more than 1 mile.
- ☐ 2 Pain prevents me from walking more than ½ mile.
- ☐ 3 Pain prevents me from walking more than ¼ mile.
- ☐ 4 I can walk only if I use a cane or crutches.
- ☐ 5 I am in bed or in a chair for most of every day.

Section 5–Sitting

- ☐ 0 I can sit in any chair for as long as I like.
- ☐ 1 I can sit in my favorite chair only, but for as long as I like.
- ☐ 2 Pain prevents me from sitting for more than 1 hour.
- ☐ 3 Pain prevents me from sitting for more than ½ hour.
- ☐ 4 Pain prevents me from sitting for more than 10 minutes.
- ☐ 5 Pain prevents me from sitting at all.

Section 6–Standing

- ☐ 0 I can stand as long as I want without extra pain.
- ☐ 1 I can stand as long as I want, but it gives me extra pain.
- ☐ 2 Pain prevents me from standing for more than 1 hour.
- ☐ 3 Pain prevents me from standing more than ½ hour.
- ☐ 4 Pain prevents me from standing more than 10 minutes.
- ☐ 5 Pain prevents me from standing at all.

Section 7–Sleeping

- ☐ 0 Pain does not prevent me from sleeping well.
- ☐ 1 I sleep well but only when taking medication.
- ☐ 2 Even when I take medication, I sleep less than 6 hours.
- ☐ 3 Even when I take medication, I sleep less than 4 hours.
- ☐ 4 Even when I take medication, I sleep less than 2 hours.
- ☐ 5 Pain prevents me from sleeping at all.

Section 8–Social Life

- ☐ 0 Social life is normal and causes me no extra pain.
- ☐ 1 Social life is normal, but increases the degree of pain.
- ☐ 2 Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
- ☐ 3 Pain has restricted my social life, and I do not go out as often.
- ☐ 4 Pain has restricted my social life to my home.
- ☐ 5 I have no social life because of pain.

Section 9–Changing Degree of Pain

- ☐ 0 My pain is rapidly getting better.
- ☐ 1 My pain fluctuates, but overall is definitely getting better.
- ☐ 2 My pain seems to be getting better, but improvement is slow at present.
- ☐ 3 My pain is neither getting better nor worse.
- ☐ 4 My pain is gradually worsening.

Section 10–Traveling

- ☐ 0 I can travel anywhere without extra pain.
- ☐ 1 I can travel anywhere, but it gives me extra pain.
- ☐ 2 Pain is bad, but I manage journeys over 2 hours.
- ☐ 3 Pain restricts me to journeys of less than 1 hour.
- ☐ 4 Pain restricts me to necessary journeys under ½ hour.
- ☐ 5 Pain prevents travelling except to the doctor/hospital.

Score: _____ (50) Benchmark -5= _____

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 15—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1

PAD risk evaluation	Score
Have Diabetes?	7
Have any wounds or ulcers on foot or lower leg	6
Over 65 years?	6
Over 50 years?	4
EVER smoke?	5
Ever had lower extremity revascularization?	5
Have history of hypertension/high blood pressure	4
Ever feel resting leg pain or foot pain	4
One foot colder than the other?	4
Have neuropathy	4
Have high cholesterol?	3
Ever have a heart attack or stent?	3
Total Added Score:	