TCPC
TRI-COUNTY PAIN CONSULTANTS, PC

Dear Patient,

Welcome to Tri-County Pain Consultants. Please arrive 30 minutes early to your upcoming appointment to complete the registration process.

You will receive a reminder call prior to your appointment. If you have any questions or concerns, please call us between 8:30AM-5:00PM at (800) 319-3118 and select option 1.

In order for us to address your needs at the time of your appointment we ask that you please;

1. Bring your License/ID and Insurance card to each appointment. *A digital picture will also be taken at this initial appointment* for your electronic medical chart.
2. Plan to update or verify your personal information at each appointment.
3. Complete the enclosed Patient Information Forms and bring them to your appointment. This information will be used by the provider during your evaluation. Failure to have the forms completed prior to your arrival may result in your appointment being delayed or rescheduled.
4. Please arrange for a driver to arrive with you for your appointment. Some procedures may require the use of light sedation. Please be aware that you must have a driver present in the waiting room in order to receive sedation.
5. Anticipate being at our office for your initial appointment for approximately two or three (2-3) hours.

FINANCIAL POLICY

Our office participates with a variety of insurance plans including but not limited to:

Medicare Priority Health Blue Cross HAP Aetna Cofinity United Healthcare

If you have questions regarding your insurance, we will try to help. However, questions relating to specific coverage issues must be directed to your insurance company's member services department. Their telephone number should be listed on the back of your insurance card.

Referrals: Many insurance plans require a referral from your primary care physician to be seen by a specialist. We will contact your insurance carrier to arrange for a referral but ask that you follow up with them too. If a referral is required but not secured, your visit may be rescheduled or you may be financially responsible.

All applicable co-payments, deductibles, co-insurance and personal balances, both current and prior, are due at the time of service unless other payment arrangements have been made. In some cases, you may be asked to pay the balance of your account or make payment arrangements prior to making your next appointment.

For your convenience, we accept cash, checks, VISA, MasterCard, Discover, American Express and money orders. You may also pay your bill online through our website (shown below). *Please note that there is a $25.00 service charge for all returned checks.*

We understand that there may be times and circumstances that come up where you are unable to pay your entire bill. In these situations it is very important that you contact our Billing Office (800-319-3118) so a financial representative can assist you in setting up a reasonable payment plan and to keep your account from being sent to a collection agency.

If you fail to meet the financial obligations agreed upon in this financial policy or have other payment arrangements made, your outstanding balance will be sent to a collection agency. You will be required to pay your entire balance and any collection agency fees, up to 25% of your account balance, before being scheduled for any further appointments.

If you have billing related questions, please contact our billing office at (800) 319-3118 and select option 2.

www.tricountypain.com

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History Form

Patient Name: ______________________________ Date of Consultation: ______________

Age: ________________ ❐ Male ❐ Female Social Security No.: ______________

REFERRING PHYSICIAN
Full Name: ______________________________
Address: ______________________________
City: ______________________________
State, Zip: ______________________________
Phone No.: ______________________________

FAMILY PHYSICIAN
Full Name: ______________________________
Address: ______________________________
City: ______________________________
State, Zip: ______________________________
Phone No.: ______________________________

CHIEF COMPLAINT: (Explain what brought you into the office today.) ______________________________

____

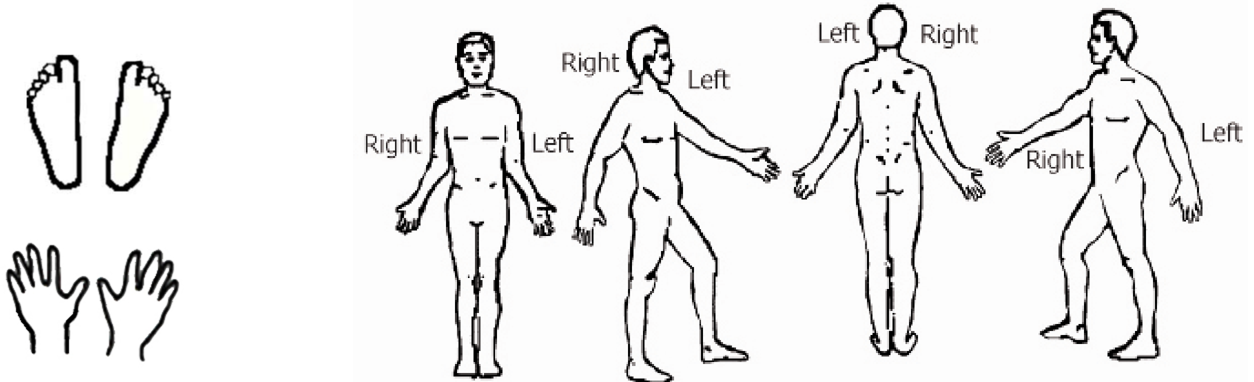
____

Do you have pain or another symptom? ______________________________

A particular condition or diagnosis? ______________________________

Did a physician ask you to come to our office for a particular type of treatment? ______________________

HISTORY OF PRESENT ILLNESS:
Please indicate on the drawings below where your pain is located.



Please circle any of the following symptoms that you are experiencing.

Is your problem: constant, intermittent, frequent, occasional, infrequent

Is the pain: sharp, dull, aching, throbbing, burning, tingling, shooting, stabbing, electrical

Is your problem: mild, moderate, severe, excruciating

How would you rate your average pain on a scale of 0 to 10, where 0 is no pain and 10 is unbearable? __________

How long have you been experiencing this problem? ______________________________

Do any of the following make the problem worse: time of day, sitting, standing, bending, lifting, twisting, crawling, stair climbing, coughing, sneezing, heat, cold, eating, weather changes, light touch, stress, other, ______________

Do any of the following make the problem better: rest, heat, cold, massage, medication, other ___________________

Are there any factors or symptoms that occur with your problem, such as, numbness, muscle weakness, bowel or bladder problems, or others? ____

____

What doctors have you seen for this problem? (Name and Specialty) ___________________________

____

What tests have you had for this problem and what were the results, if known?

- MRI ___________________________
- CT Scan ___________________________
- X-Rays ___________________________
- EMG ___________________________

What treatments have you had for this problem and what were the results?

- Surgery ___________________________
- Physical Therapy/Occupational Therapy ___________________________
- Injections/Nerve Blocks ___________________________
- TENS ___________________________
- Psychological/Behavioral Pain Management ___________________________
- Osteopathic/Chiropractic Manipulation ___________________________
- Acupuncture ___________________________

What medication are you currently taking for this problem and how much? ___________________________

____

What medication have you used in the past for this problem? ___________________________

____

PAST MEDICAL HISTORY: Do you have any of the following conditions? Please check all that apply.

- ❒ High Blood Pressure
- ❒ High Cholesterol
- ❒ Irregular Heart Beat
- ❒ Congestive Heart Failure
- ❒ Coronary Artery Disease
- ❒ Heart Attack/MI
- ❒ Peripheral Vascular Disease
- ❒ Sleep Apnea
- ❒ Asthma
- ❒ Bronchitis/Emphysema/COPD
- ❒ Pneumonia
- ❒ Tuberculosis
- ❒ Diabetes
- ❒ Hepatitis
- ❒ Pancreatitis
- ❒ Stomach Ulcers
- ❒ GERD
- ❒ Thyroid Disorder
- ❒ Kidney Disease
- ❒ Gynecological Problems
- ❒ Pregnancy / LMP __________
- ❒ Osteoarthritis
- ❒ Rheumatoid Arthritis
- ❒ Lupus
- ❒ Scleroderma
- ❒ Carpal Tunnel Syndrome
- ❒ Glaucoma
- ❒ Strokes
- ❒ TIAs
- ❒ Seizure Disorder
- ❒ Headaches
- ❒ Depression
- ❒ Anxiety/Panic Disorder
- ❒ Bleeding Disorder
- ❒ HIV/AIDS
- ❒ Cancer, type ______________
- ❒ Other, ___________________________

PAST SURGICAL HISTORY: (Please list all surgeries you have had and the approximate dates.) _________________

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____

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HOSPITALIZATIONS: (If you have been hospitalized, when was it and for what reason.) ______________________________
____
____

Accidents/Injuries: (Please list any significant accidents or injuries and when they occurred.) ____________________
____
____
____

Medications: (Please list all medications you are currently taking, including aspirin.)

1. ______________________________ 4. ______________________________ 7. ______________________________

2. ______________________________ 5. ______________________________ 8. ______________________________

3. ______________________________ 6. ______________________________ 9. ______________________________

Allergies: Please list all medication and other allergies. ____
____

Family History: Please list any illnesses that are present in your family or the cause of their death: ______________
____
____

SOCIAL HISTORY:

❒ Married ❒ Single ❒ Divorced ❒ Separated ❒ Widow/Widower

Do you live with your spouse or significant other? ❒ Yes ❒ No

How many children and grandchildren do you have? Children ______________ Grandchildren ______________

If you smoke, how many packs per day and for how many years? _______________________________________

How many alcoholic beverages do you drink a day? ____

Do you now or have you ever used illegal drugs? ____

Have you ever been the victim of abuse or violence? ____

What is your highest level of education? ______ Do you have vocational training and in what area? ______________

OCCUPATIONAL HISTORY

❒ Working full-time ❒ Working part-time ❒ On medical leave ❒ Disabled ❒ Unemployed ❒ Retired

What is your current occupation? ____

Where do you work and how long have you been there? ____

REVIEW OF SYSTEMS: Please circle of any of the following symptoms that you are experiencing.

General: Weight gain/loss, Fatigue, Fever, Chills, Night Sweats

Skin: Hair changes, Nail changes, Itching, Rashes

Head: Trauma, Headaches

Eyes: Vision loss, Blurriness, Tearing, Glasses, Contact lenses

Ears: Hearing loss, Ringing, Dizziness, Ear ache

Nose/Sinuses: Allergies, Nose bleed

Mouth/Throat/Neck: Bleeding gums, Hoarseness, Sore throat, Difficulty swallowing, Swollen neck, Masses

Breasts: Skin changes, Lumps/masses, Discharge

Respiratory: Shortness of breath, Wheezing, Productive cough, Coughing up blood

Cardiovascular: Palpitations, Heart murmur, Chest pain, Shortness of breath lying down, during sleep, Leg swelling, Leg pain, Leg pain when walking

GI: Loss of appetite, Nausea, Vomiting, Indigestion, Irregular bowel movements, Constipation, Diarrhea, Vomiting blood, Bloody stools, Black/tarry stools, Hemorrhoids, Abdominal pain, Jaundice

Urinary: Frequency, Urgency, Hesitancy, Painful urination, Blood in urine, Incontinence, Stones, Infections

Male: Testicular pain or masses, Hernias, Discharge, STD's, Loss of sex interest/function

Female: Pregnant, Irregular periods, Painful periods, Hot flashes/sweats, STD's, Loss of sex interest/function

Musculoskeletal: Joint stiffness, Joint instability, Reduced range of motion, Swelling/redness of joints

Neurological: Numbness, Tingling, Loss of sensation, Muscle weakness, Paralysis, Tremors, Seizures Fainting/blackouts

Hematologic: Anemia, Easy bruising/bleeding, Bleeding disorder, Transfusions

Endocrine: Heat/cold intolerance, Excessive sweating, Excessive thirst, Excessive Hunger

Psychiatric: Changes in mood, Stress/tension, Anxiety, Depression, Thoughts of suicide, Memory problems

FUNCTIONAL STATUS:

How long can you:

Sit ____________________
Stand ________________
Walk __________________
Climb Stairs ___________
Drive __________________

Does the pain interfere with:

❒ Daily activities
❒ Eating
❒ Dressing
❒ Bathing
❒ Using the toilet
❒ Getting out of Bed/Chair
❒ Recreational activities
❒ Housework
❒ Yard work
❒ Work Duties

PATIENT GOALS

What are your goals for treatment? ____

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____

____

____

____

____ _____________________________

Signature: Date:

Thank you for completing this questionnaire. It will help us serve you better.