

Welcome!

We are pleased you have chosen Einstein Pain Institute for your care. We understand how traumatic and isolating chronic pain can be. Finding the right treatment plan is a step that brings you closer to relief. Our multidisciplinary team will help you feel better, improve your functionality and help you live a more satisfying life. We certainly want your appointments to be informative and productive.

In order to accommodate you, we ask that you complete the following required forms in their entirety:

- New Patient Intake form
- Medical History checklist

**Please pay close attention to these required forms, as your appointment may need to be rescheduled if either of them is missing. Keystone Mercy in particular has specific guidelines for their patients.**

#### **What to expect at your first visit:**

Your first visit will consist of a thorough history and physical examination. You will be seen by a nurse first, then a physician assistant and the physician. This initial evaluation may take up to an hour from start to finish, but this time is important for an assessment and treatment plan to be formulated. Due to the length of this examination, and various other factors such as insurance authorizations, **please do not expect medications or injections during your first visit.** Out of fairness to all our patients we ask that you try to arrive 15 minutes early for your visit, and please call at least 24 hours in advance if you must cancel. If you are more than 15 minutes late for your appointment it may need to be rescheduled. In addition, appointments canceled less than 24 hours in advance will be considered a no show, and after 3 no shows you will not be rescheduled.

#### **Please bring the following to your first appointment:**

- Completed intake form including medical history checklist
- Insurance card and two forms of photo ID
- All relevant past medical records including MRI, CT scans, bone scans and/or EMG reports (you need to bring both the films and written reports)\*
- Worker's compensation/auto insurance phone number, adjuster's name and mailing address
- Referral or prescription slip, if required by your insurance
- Physical/occupational/aquatic therapy discharge summaries\*
- Co-pay, if required by insurance

\* Special note to Keystone Mercy patients: your insurance requires you to have had an MRI and completed physical therapy within the last year before they will authorize fluoroscopic injection therapy. You may want to discuss these requirements with your referring physician and have them completed before your visit in order to expedite your care.

Einstein Pain Institute is committed to success and safety. Thank you for taking the time to provide this information that is important for the level of care we can provide. Your answers will help us individualize your treatment and optimize your success and safety.

Sincerely,

S. Nadeem Ahsan, MD  
Sandra Brice, PA-C

Deepak Mehrotra, MD  
Kenneth Cohen, CRNP

Jasmeet S. Oberoi, MD  
Charon Gant, PA-C

Date: \_\_\_\_\_

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle: \_\_\_\_\_

Date of birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work: \_\_\_\_\_

Marital status: \_\_\_\_\_ Religious preference: \_\_\_\_\_

Referring physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary care physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Healthcare Insurance Carrier:

1 \_\_\_\_\_ ID# \_\_\_\_\_

2 \_\_\_\_\_ ID# \_\_\_\_\_

Claim adjustor (if applicable): \_\_\_\_\_ Phone: \_\_\_\_\_ Claim number: \_\_\_\_\_

Nearest relative: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

Are you employed?  Yes  No Occupation: \_\_\_\_\_

If unemployed, how long? \_\_\_\_\_ Is this due to pain?  Yes  No

Do you plan to go on disability?  Yes  No

Please list your medical problems, other than pain (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illness, etc.):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please list all of your current medications with dosages:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please list all medications and dosages taken for pain management in the past:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Please list any allergies to medications:** \_\_\_\_\_

Please list any intolerance to medications: \_\_\_\_\_

Please list any prior surgeries not related to pain, and dates performed:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please list any prior surgeries related to pain (such as laminectomy) and dates performed:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Family medical history:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

With whom do you live? \_\_\_\_\_

Are there any substance abuse issues in your household?  Yes  No If yes, please explain \_\_\_\_\_

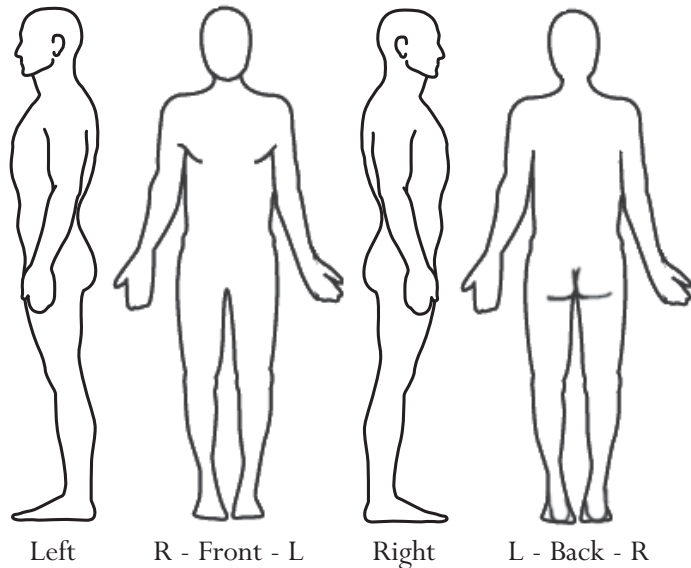
Are you able to care for yourself?  Yes  No

If not, caregiver's name and phone number \_\_\_\_\_

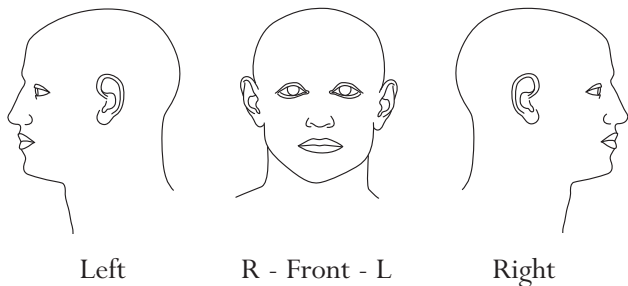
Are you currently involved in a lawsuit?  Yes  No If yes, please explain \_\_\_\_\_

Where is your pain? Be specific and list **in order of most severe pain** to least severe pain:

1. \_\_\_\_\_ **Most severe**
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_ **Least pain**



Please mark where your pain is located.



When did your pain start? \_\_\_\_\_

Was there a particular event that caused your pain?  Yes  No Please explain: \_\_\_\_\_

How often does your pain occur and for how long? \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

Please indicate most recent diagnostic test you have had regarding your pain:

	Date	Facility	Results
___ X-rays	_____	_____	_____
___ CAT Scan	_____	_____	_____
___ MRI	_____	_____	_____
___ EMT	_____	_____	_____
___ Myelogram	_____	_____	_____
___ Other	_____	_____	_____

Please list any other doctors you have consulted regarding this problem:

	Name	Specialty	Date	Phone
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Please check off any treatments you have undergone for this problem, and if they have helped or not helped your problem:

	Helped			Helped	
	Yes	No		Yes	No
___ Surgery	___	___	___ Chiropractor	___	___
___ Medications	___	___	___ Ultrasound	___	___
___ _____	___	___	___ Acupuncture	___	___
___ _____	___	___	___ Biofeedback	___	___
___ Nerve block, steroid or trigger pt. injections	___	___	___ Hypnosis	___	___
___ Bedrest	___	___	___ Relation	___	___
___ TENS	___	___	___ Exercise	___	___
___ Heat	___	___	___ Traction	___	___
			___ Other _____	___	___

Pain can be very difficult to describe. It is helpful to compare the intensity of your pain at different intervals. Please rate the intensity of your pain on a scale from 0 to 10. **0 = no pain 10 = the worst pain you can imagine**

What is your pain now? **1 2 3 4 5 6 7 8 9 10**

What is your level of pain when it is most severe? **1 2 3 4 5 6 7 8 9 10**

What is your level of pain when it is least painful? **1 2 3 4 5 6 7 8 9 10**

On subsequent visits, we will refer to the 0 to 10 pain scale and ask you to rate your pain.

Please mark an "X" on the line to represent the intensity of your pain.

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>No Pain</b>										<b>Worst Pain</b>

**MEDICAL HISTORY** (check answer(s) that apply)

- 1. Constitutional Symptoms**  No Problems
  - weight loss \_\_\_\_\_ lbs., period of time \_\_\_\_\_
  - weight gain \_\_\_\_\_ lbs., period of time \_\_\_\_\_
  - recurrent fever
  - general weakness
  - fatigue – persistent
- 2. Skin**  No Problems
  - dry skin
  - recurrent rashes
  - eczema
  - itching
  - changes in skin color
  - changes in hair or nails
- 3. HEMATOLOGIC / LYMPATHIC**  No Problems
  - swollen glands
  - low blood count (anemia)
  - easy bruising
  - easy bleeding
  - slow to heal after cuts
  - history of blood transfusion(s)
  - enlarged glands
  - phlebitis
  - HIV positive
  - on blood thinners
- 4. Head / Face**  No Problems
  - headaches / migraines
  - history head injury no residual problems
  - history head injury with residual problems of \_\_\_\_\_
  - facial pain
  - TMJ R L
  - Tic douloureux R L \_\_\_\_\_
- 5. Eyes**  No Problems
  - nearsighted
  - farsighted
  - wear glasses
  - wear contact lenses
  - cataracts at present time R L
  - conjunctivitis R L
  - glaucoma R L
  - double vision
  - blurred vision
- 6. Ear / Nose / Mouth**
  - Ears  No problems
    - hard of hearing R L
    - hearing aids R L
    - frequent earaches R L
    - chronic ear discharge R L
    - vertigo
    - ringing in ears R L
  - Nose / Sinuses  No Problems
    - sinus discharge
    - nasal discharge
    - repeated nosebleeds

**PATIENT NAME:** \_\_\_\_\_

- deviated nasal septum
  - chronic sinus problems
  - chronic stuffy nose
  - hay fever
  - nasal polyps
- Mouth / Throat  No Problems
- teeth \_\_\_loose \_\_\_none
  - dentures \_\_\_full \_\_\_partial
  - bleeding gums
  - dry mouth
  - sore throat
  - hoarseness
  - vocal cords polyps
  - trouble swallowing
- 7. Chest / Breasts**  No Problems
  - breast masses
  - breast surgery
  - chest surgery
  - other explain \_\_\_\_\_
- 8. Respiratory**  No Problems
  - smoker \_\_\_\_\_ pack(s) per day since \_\_\_\_\_
  - recurrent cough
  - chronic bronchitis
    - sarcoidosis
  - emphysema
  - chronic obstructive pulmonary disease
  - bronchial asthma
  - tuberculosis
  - wheezing
- 9. Cardiac / Peripheral –Vascular**
  - Cardiac  No Problems
    - heart trouble
    - swelling of feet
    - high blood pressure
    - chest pain
    - heart attack
    - bypass surgery
    - angioplasty
    - mitral valve prolapse
    - heart murmur
    - valvular surgery
    - heart failure
    - shortness of breath with walking
  - Peripheral –Vascular  No Problems
    - poor circulation in arm R L
    - blood clots in arm R L
    - varicose veins R L
    - poor circulations in legs R L
    - blood clots in leg R L
    - vascular surgery \_\_\_\_\_
- 10. Hepatic-Biliary/Gastrointestinal/Abdominal**
  - any liver disease
  - history hepatitis Active \_\_\_\_\_ Inactive \_\_\_\_\_

**MEDICAL HISTORY** (check answer(s) that apply)

- history jaundice due to gallbladder disease
- gallbladder problems
- Gastrointestinal  No Problems
- loss of appetite
- abdominal pain
- problems with gas
- heartburn
- recurrent nausea
- recurrent diarrhea
- recurrent constipation
- ulcer
- hiatal hernia
- regurgitation
- reflux
- indigestion
- history of vomiting blood
- blood in stools
- loss of control of bowels
- bleeding ulcers
- diverticular disease
- Crohn's disease
- 11. Urinary**  No Problems
- frequent urination
- difficulty with urination
- burning on urination
- inability to control urination
- loss of control
- blood in urine
- kidney stones
- 12. Genital / Reproductive**
- Male  No Problems
- discharge
- painful testicles
- lumps in testicles
- hydrocele
- sexually transmitted disease(s)
- sexual dysfunction
- Female  No Problems
- menstruation Regular\_\_\_\_\_ Irregular\_\_\_\_\_
- first day last menstrual period:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
- premenstrual syndrome, since\_\_\_\_\_
- recurrent vaginal discharge
- number pregnancies\_\_\_\_\_ miscarriages\_\_\_\_\_
- abortions\_\_\_\_\_
- Cesarean sections(s), number\_\_\_\_\_
- on hormones
- history cancer of uterus – ovaries
- sexual dysfunction
- sexually transmitted disease(s)
- 13. Endocrine**  No Problems
- Excessive thirst or urination
- heat intolerance
- cold intolerance
- change in hat or glove size
- thyroid trouble Underactive\_\_\_\_\_ Overactive\_\_\_\_\_
- sugar diabetes-since\_\_\_\_\_
- insulin dependent yes / no
- disease of pituitary gland
- disease of adrenal gland
- Cushing's disease

**PATIENT NAME:** \_\_\_\_\_

- 14. Musculoskeletal**  No problems
- muscle cramps
- stiff joints
- swelling of joints
- generalized arthritis
- rheumatoid arthritis
- fibromyalgia syndrome
- osteoporosis
- neck pain
- upper back pain
- low back pain
- heel spurs
- gout
- difficulty with walking
- cold upper extremities R L
- cold lower extremities R L
- pain in feet
- 15. Neurological / Psychiatric**
- Neurological  No Problems
- frequent or recurrent headaches
- fainting
- migraines
- blackouts
- stroke
- dizzy spells
- gait difficulties
- seizures
- epilepsy
- tremors
- neuropathy
- weakness
- paralysis
- Psychiatric
- problems with concentration
- confusion
- problems with thinking or thought process
- problems with memory
- depressed
- anxious
- shaky
- agitated
- 16. Allergies / Immunologic**
- Allergies  No Problems
- drug allergies\_\_\_\_\_
- food allergies\_\_\_\_\_
- environmental allergies\_\_\_\_\_
- Immunologic  No Problems
- immunologic disorders\_\_\_\_\_
- AIDS
- lupus