DOCTORS® PAIN CLINIC

PATIENT DEMOGRAPHIC FORM

LAST NAME:		FIRST NAME:	M.I.
D.O.B:	GENDER: ☐ Male ☐ Female ☐ Transgender	MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
SOCIALSECURITY NO.		PREFERRED LANGUAGE: ☐ English ☐ Other ☐ Indian ☐ Spanish ☐ Russian	
RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific ☐ Black or African American ☐ White ☐ Hispanic ☐ Other Race		ETHNICITY: ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Refuse to Report	
HOME ADDRESS:		CITY	STATE / ZIP
HOME PHONE:	CELL:	EMAIL:	
EMPLOYER:		WORK PHONE:	
ALLERGIES (Medical Alert):			
PRIMARY CARE PHYSICIAN:	PHONE:	REFERRING PHYSICIAN:	
PHARMACY NAME:		ADDRESS:	
CITY:	STATE:	ZIP:	
IN CASE OF EMERGENCY CONTACT			
FIRST NAME:	LAST NAME:	RELATION:	PHONE:
INSURANCE INFORMATION: PRIMARY			
Insured Name:	Relationship to Patient:	DOB:	
Insurance Company:			
Insurance Company Address:			
City:	State:	ZIP:	Phone:
Policy No:	Group No:		Employer:
INSURANCE INFORMATION: SECONDARY			
Insured Name:	Relationship to Patient:	DOB:	
Insurance Company:			
Insurance Company Address:			
City:	State:	ZIP:	Phone:
Policy No:	Group No:		Employer:
I give permission to leave phone message(s):		☐ YES	☐ NO

Revised 6/2020

INSTRUCTIONS: If this is a Workers Compensation Injury, complete entire form. If this is not a work-related injury, simply sign and date In the last section of the form.

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Patient Information:

Name: _____ SSN: ____/___/_____

Address: _____ Telephone:_____

Employer Information:

Name of Company:_____ Contact Person:_____

Address: _____Telephone: _____

Accident Information:

Date of Injury: ____/_____/____ Location: _____

Nature of injury/illness: _____

Managed Care Organization Handling Claim:

MCO Name: _____Telephone: _____

Address: _____Case Manager: _____

Workers Compensation Claim Information:

Claim number: _____

Attorney Information:

Name: _____Telephone: _____

Address: _____

Patient Signature: _____ Date: _____

IF INJURY IS NOT RELATED to a workplace injury please sign and date below.
Please be advised that by signing below you will be responsible for payment of denied claims if this is indeed a work-related injury and you fail to inform our office.

Patient Signature: _____ Date: _____

Rev 1/2013

INITIAL PAIN ASSESSMENT FORM

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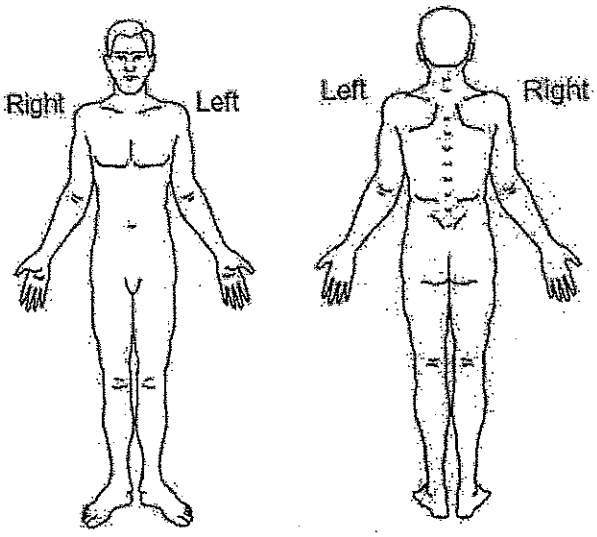
Patient Name: _____Today's Date: _____

Referring Physician: _____

Have you ever been seen in ANY Pain Clinic before? ____YES ____NO If YES, WHERE_____

CHIEF COMPLAINT OF PAIN: MARK on picture below where pain is (including where it radiates to):

On the pictures mark #1 on the area of your body where you have the most pain. Mark #2 on the area you have secondary pain. Do not write on back. PLEASE DO NOT CIRCLE MORE THAN 2 AREAS.



How long have you had this pain: _____

What caused this pain to begin (*be specific*): _____

_____

_____

Is your pain continuous? _____or intermittent? _____

Circle below the words that best describe your pain:

Aching Throbbing Sharp Shooting Stabbing Tender Burning Dull

Please rate the pain using the scale below at its WORST:

No pain 1 2 3 4 5 6 7 8 9 10 Severe pain

Rate the pain using the scale below at its BEST:

No pain 1 2 3 4 5 6 7 8 9 10 Severe pain

Pain scale:	0 – 1 no pain barely noticeable	2 – 3 has to stop to think about pain
	4 – 5 interferes with activities and rest	6 - 7 distracting grits teeth tot carry out activities
	8 – 9 severe enough to stop your activity	10 worst pain imaginable

What other symptoms are associated with your pain: Circle one:

Numbness Tingling Weakness Headaches

*Other:*_____

INITIAL PAIN ASSESSMENT FORM (page 2)

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What makes your pain better?_____

Worse?_____

How does the pain impact your Sleep?_____

How does the pain impact your Mood?_____

What other Treatments and/ or Medications have you received and were they effective? (these are important for Prior Authorizations of Any Medications- use Back if needed)

_____

_____

What tests or studies have been done regarding this pain? (MRI, X-ray, CT Scan, EMG, etc). What medications are you currently on for pain? What % of pain relief do you get from your current medications?

Tests: _____

Medications:_____

_____

List any other healthcare providers you have seen for this pain _____

_____

_____

Tell us what your expectations/ goals are from the Doctors Pain Clinic: (Goals are things like walking more, sleeping better, going back to work, doing housework)

_____

_____

Domestic Situation:

With whom do you live? _____

Are there any Substance Abuse or Domestic Violence issues in the household? _____YES _____NO

If YES, explain_____

Are you able to care for yourself?_____ Do you have a care giver?_____

Please fill in:

Height: _____Weight:_____

Patient Signature:_____Date:_____

Rev:7/2014

HEALTH QUESTIONNAIRE

PATIENT NAME	DOB:	TODAY'S DATE:

MEDICATIONS: List all Medications you are currently taking (include over the counter medications) If you need more space use back of this form.

BLOOD THINNERS: Please list all blood thinner medications and the Dr. that prescribed them(Include Aspirin here):	**Medical Marijuana:** ____yes _____no

ALLERGIES: List all Allergies to Medications. Write **"NONE"** if no known allergies.

MEDICAL HISTORY: Do you have or had any of the following?

	AIDS/HIV		COPD		Herpes/Shingles		Myocardial Infarction
	Alcoholism		Diabetes		High Blood Pressure		Osteoporosis
	Anemia		Diverticulitis		___Kidney disease ___ Kidney stones		Pacemaker
	Asthma		Fibromyalgia		Liver disease		Pneumonia/Pleurisy
	____Arthritis ____ Rheumatoid		Gastric ulcers		Lupus		Psoriasis
	Bronchitis		Glaucoma		Mental Illness: ___Anxiety ___Bipolar ___Depression __PTSD ___Schizophrenia		Seizures
	Cancer type:		Heart disease Type:		Migraine		STD type:_____
	Chronic Pain		Heart murmur		MRSA		Stroke
	Colitis		Hepatitis		Multiple Sclerosis (MS)		Thyroid disease
							Tuberculosis

SURGERIES/ HOSPITALIZATIONS: List all and include date if known. Use the back of this form if more space is needed

FAMILY HISTORY: If any "blood" relative(s) have suffered any of the following. Match the NUMBER(S) of the medical condition with corresponding relative.

MEDICAL CONDITION #		Alive	Deceased (circle Alive or Deceased for each family member)			
Mother:		Alive	Deceased	1. Diabetes	6. Cancer	11. Asthma
Father:		Alive	Deceased	2. Hypertension	7. Unknown	12. Hepatitis
Sister/Brother:		Alive	Deceased	3. Heart Disease	8. Alcoholism	13. Osteoarthritis
Grandparents:		Alive	Deceased	4. Stroke	9. Thyroid	
Aunt/Uncles:		Alive	Deceased	5. Mental Illness	10. Arthritis	

SYMPTOMS: Please mark a "C" for current problem, or your age at the time of the problem. Leave unmarked if no problem (s).

⇩	SOCIAL HISTORY	⇩	EYE | EAR | NOSE | THROAT	⇩	GASTROINTESTINAL	⇩	CARDIOVASCULAR
	Smoke: ___yes ___no		Decreased hearing		Loss of appetite		Chest pain/Angina
	Former smoker: ____		Ringing in Ears		Difficulty swallowing		Irregular pulse
	Quit date:_____		Frequent Ear infections		Heartburn		Palpitations
	STREET DRUG USE		___Dizzy spells _____Fainting		Persistent nausea		Swollen Ankles
	____yes ___no		Failing Vision		Abdominal pain		Calf pain
	Type: _____		Nose Bleeds (recurrent)		Jaundice		Phlebitis
	CBD oil: ____yes ____no		Sinus Trouble		_____Diarrhea __Constipation		Varicose veins
	ALCOHOL USE		Sore Throats (frequent)		Diverticulitis/Colitis		**DERMATOLOGY/ENDOCRINE**
	Daily: _____yes____no		Prolonged hoarseness		Bloody or Tarry stool		Eczema
	_____oz. per day		**RESPIRATORY**		**NEUROLOGICAL**		Psoriasis
	COFFEE/CAFFEINE		Allergies/Hay Fever		Headaches (frequent)		____Rashes _____Hives
	_____cups per day		Shortness of breath		Numbness/tingling		Tattoos
	SLEEPING AT NIGHT		Chronic cough		Tremors/hand shaking		Body Piercings
	____yes _____no		**URINARY/GYNECOLOGICAL**		Weakness		**PSYCHOLOGICAL**
	EXERCISE		Urinate more than 2x per night		Seizures/stroke		Sleeping/concentration
	_____x per week		Urgency/Frequency		**MUSCULOSKELETAL**		Nervousness/anxiety
	PHYSICAL THERAPY		Decreased stream		Back pain (recurrent)		Suicidal
	Done at: _____		Frequent urinary infections		Bone fractures/joint injury		Memory loss
	FEMALES ONLY		Blood in Urine		Joint pain		Feeling of worthlessness
	Date of last Menses:		Pain Urinating		Leg pain when walking		Phobia
	Current birth control:						

ZUNG SELF-RATING SCALE

Depression and chronic pain often times go hand in hand.
This survey is a tool designed to help us with your individualized treatment plan.

Name _____ **Date** _____
Age _____ **Sex** _____ **Marital Status** _____
Occupation _____ **Education** _____

Reply to questions using one of the four replies below (A-D)
A – Little or none of the time
B – Some of the time
C – A large part of the time
D – Most or all of the time

	A Little or none of the time	B Some of the time	C A large part of the time	D Most of the time	
1. I feel downhearted and blue	1	2	3	4	
2. Morning is when I feel the best	4	3	2	1	
3. I have crying spells or feel like it	1	2	3	4	
4. I have trouble sleeping at night	1	2	3	4	
5. I eat as much as I used to	4	3	2	1	
6. I still enjoy sex	4	3	2	1	
7. I notice that I am losing weight	1	2	3	4	
8. I have trouble with constipation	1	2	3	4	
9. My heart beats faster than usual	1	2	3	4	
10. I get tired for no reason	1	2	3	4	
11. My mind is as clear as it used to be	4	3	2	1	
12. I find it easy to do the things I used to do	4	3	2	1	
13. I am restless and can't keep still	1	2	3	4	
14. I feel hopeful about the future	4	3	2	1	
15. I am more irritable than usual	1	2	3	4	
16. I find it easy to make decisions	4	3	2	1	
17. I feel that I am useful and needed	4	3	2	1	
18. My life is pretty full	4	3	2	1	
19. I feel that others would be better off if I were dead	1	2	3	4	
20. I still enjoy the things that I used to	4	3	2	1	
				TOTAL RAW SCORE	

Some questions ask the information positively but in all cases the symptom severity is scored form 1-4.
The total score is often converted to a 100 point scale (SDS Index)
SDS Index = (score / 80 total points) x 100 or SDS Index = score x 1.25

Total SDS raw score _____
SDS Index (score x 1.25) _____

0 -- 20	No Depression	No interventions required
21 – 40	Mild Depression	No Intervention required/Reevaluate as needed
41 – 60	Moderate Depression	Offer psych support/ Reevaluate q 6 months
61 – 80	Severe Depression	Strongly recommended psych support/ Reevaluate 3 months

Are you being treated for depression now *or* have you been treated in the past? ____yes ____no

If you are being seen, by whom? _____

Please complete this survey and bring it with you to your scheduled appointment. Thank you.

Rev 12/05, 4/06/ 6/12 1/13

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Quality of Life/Functional Study
(Evaluate once a year)

Patient name _____ Date _____

In the past month have you done any of the following?

(Please check)	Yes	No
Worked?		
Participated in volunteer activities?		
Participated in a hobby?		
Spent time feeding or caring for a pet?		
Performed childcare/family care/eldercare activities?		
Talked with family or friends?		
Took a walk or exercised?		
Spent time on line on the computer?		
Wrote a letter or email?		
Took time for yourself?		
Visited with friends and or relatives?		
Attended church or social function?		
Shopped?		
Performed other outside activities?		
Read (newspaper, book magazine, bible, internet)?		
Played cards/board games/video games?		
Worked crossword puzzles/jigsaw puzzles/sudoku etc.?		
Made something?		
Worked outdoors in a garden/yard/care for plants?		
Watched a movie?		
Prepared meals?		
Baked?		
Cleaned house/laundry?		
Completed household repairs?		
Listen to music?		
For staff use. Total YES answers =	**Total**	**Total**

Legend: 0-5 poor 6-10 fair 11-15 good 16-20 very good 21-25 excellent

Patient signature _____

Staff signature _____

02/13
10/09

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PAIN CLINIC

PATIENT RESPONSIBILITY FORM

PAYMENT POLICY

It is our policy to collect the appropriate payment due from the patient at the time service is rendered. This includes co-payment or "co-pay," deductible and/or co-insurance according to your health insurance benefit plan. *These amounts will be collected when you check in for your appointment.*

All patients with no medical insurance or "self-pay patients" must *pay for services before being seen.*

*****IF PAYMENT IS NOT MADE AT THE TIME OF SERVICE, YOU MAY NOT BE SCHEDULED ANOTHER APPOINTMENT UNTIL PAYMENT IS RECEIVED*****

Patient medical billing process

The billing staff, as a courtesy to you, will submit a medical bill to your primary health insurance for processing. **It is important to give your updated information to the front office staff.** Your complete and current information is needed to submit an accurate claim form to your health insurance company. The remaining amount on the claim will be sent to your secondary health insurance company, if provided, after payment is received from the primary health insurance company.

You are responsible for any outstanding balance, such as non-covered charges as outlined in your health insurance policy. The billing staff will mail you a statement that contains the remaining cost of your service and/or procedure received during your visit after any/all insurances are billed and payments are processed.

Payment is due within 20 days of the date on the statement. We accept cash, check, Mastercard, Visa and Discover. If you prefer, you may pay your bill by credit card on-line 24 hours a day at doctorspainclinic.com.

For questions about your bill, please call billing at 330-629-2888 ext 140 Monday through Friday between the hours of 8am and 4pm.

I acknowledge receipt of this notice and I am aware that if my copay, deductible, co-insurance amount or self-pay charge is not paid at the time of service I may not receive a follow up visit until my payment is received.

_____ _____

Signature Date

_____

Print Name

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent the practice may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the NOTICE OF PRIVACY PRACTICES for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. (The practice reserves the right to revise its Notice of Privacy Practices at anytime.)

With my consent the practice may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent the practice may release information to (spouse, family member, other)

_____. *Please print name and relationship.*

With my consent the practice may mail to my home or to other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that the practice limit and or restrict how it uses or discloses my PHI to carry out TPO. However, I have been informed the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

**** *A request for limitations and restrictions of PHI form must be submitted.* ****

By signing this form, I am consenting to the practice use and disclosure of my PHI to carry our TPO. I am also acknowledging that no recording devices will be used on the premises in order to protect any PHI throughout the Doctors Pain Clinic.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the practice may decline to provide treatment to me.

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES.

_____

Signature of Patient *or* Legal Guardian (relationship) Date _____

_____

Print Name of Patient *or* Legal Guardian (relationship)

Rev. 9.2013
Rev: 02/19/2018
Rev: 02/02/2021

Directions

DOCTORS© PAIN CLINIC

From all areas to Main Office/Boardman/Youngstown, Ohio

1011 Boardman-Canfield Road
Youngstown, Ohio 44512
330.629.2888

Need more directions to our other locations? Visit us online at: www.doctorspainclinic.com

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From Salem/Lisbon, OH:
Take Route 14 to Route 46. Turn on to Route 46 North to Route 11 North. Take Route 11 North and Exit at US Route 224/Canfield/Boardman. Make a right on to US Route 224. Proceed several miles past Raccoon Road, Tippecanoe Road. Doctors Pain Clinic is located on the right, approximately one half mile from Tippecanoe Road in the Parkside Professional Center.

From Greater Warren, OH area:
Take Ohio Route 11 South toward Youngstown. Merge on to I-80/Ohio-11 S toward Girard/Cleveland. Merge onto OH-11 South via Exit 224A on the LEFT toward Canfield. Follow Route 11 South. Exit on to US Route 224/Poland/Canfield. Turn Left onto US Route 224 East, passing Raccoon Road, Tippecanoe Road. Doctors Pain Clinic is about ½ mile on the right and located in the back building of the Parkside Professional Center.

From Cleveland and areas Northwest:
Follow Ohio Turnpike East to Exit 218 toward Youngstown/Niles. Continue on I-80 east and Merge on to Route 11 South, Exit 224A toward Canfield. Follow Route 11 South to US Route 224. Make a left onto Route 224. Follow Route 224 past Raccoon Road, Tippecanoe Road. Doctors Pain Clinic is about ½ mile on the right and located in the back building of the Parkside Professional Center.

From Akron and areas West:
Follow Interstate 76 East which turns into Interstate 80 East. Continue on I-80 East toward Youngstown. Merge onto Ohio Route 11 South via Exit 224A. Follow Route 11 South and Exit on to US Route 224. Make a left on to Route 224. Follow Route 224 past Raccoon Road, Tippecanoe Road. Doctors Pain Clinic is about ½ mile on the right and located in the back building of the Parkside Professional Center.

From Pittsburgh and areas Southwest:
Follow the Pennsylvania Turnpike West to the Ohio Turnpike. Continue west and take Exit 234 to Youngstown, I-680. Take I-680 North and Exit on to US Route 224. Make a left on to US Route 224. Follow Route 224 for several miles passing South Avenue, Market Street, Glenwood Avenue. Doctors Pain Clinic will be approximately approximately 1 mile from Glenwood Avenue and located on the left in Parkside Professional Center.

From Sharon/Greenville, PA:
Take Interstate 80 West. Merge onto Ohio-11 S toward Girard/Cleveland. Merge onto OH-11 S via Exit 224A on the LEFT toward Canfield. Follow Route 11 South. Exit on to US Route 224/Poland/Canfield. Turn Left onto US Route 224, passing Raccoon Road, Tippecanoe Road. Doctors Pain Clinic is about ½ mile on the right and located in the back building of the Parkside Professional Center.

Note: These directions are for planning purposes. You may find construction, traffic or other events that may cause road conditions and routes to differ.