LAFAYETTE

3738 LANDMARK DR
LAFAYETTE, IN 47905
PHONE (765) 807-2780
FAX (317) 706-3417

INDIANAPOLIS

CENTER FOR PAIN MANAGEMENT

8805 N MERIDIAN ST
INDIANAPOLIS, IN 46260
PHONE (317) 706-7246
FAX (317) 706-3417

GREENWOOD

533 COUNTY LINE RD #201
GREENWOOD, IN 46143
PHONE (317) 706-7246
FAX (317) 706-3417

Dear New Patient:

Thank you for choosing the Center for Pain Management for your care. We look forward to meeting you. Enclosed you will find a new patient packet.

It is essential that you bring the following to your scheduled appointment:

- **Completed forms in this packet**
- **Insurance card(s)**
- **Photo identification**
- **All bottles of medication you take except refrigerated (includes over-the-counter and herbal supplements).**
- **Any MRI, CT scans, or X-ray images you can bring with you**

Also enclosed is a Health History form. Our office may reach out to you prior to your appointment to obtain additional health information.

To expedite the best plan of care, we ask that you contact your previous physicians to obtain any records in regards to your current condition. Please have their office send any recent office visit notes, any imaging (MRIs/CT Scans/X-rays), and list of current medications.

***Please use the enclosed release of information form if your prior/other physician offices require a signed release before they will send us your medical records.**

Please understand that your first appointment may take longer than expected due to the extensiveness of care.

Again, thank you for choosing the Center for Pain Management.

317-706-7246
(fax) 317-706-3417
www.IndyPain.com
8805 N Meridian St
Indianapolis, IN 46260

New Patient Registration Form

Center for Pain Management, Center for Special Surgery and Center for Southside Surgery

PATIENT INFORMATION

Name:_____ **Today's Date:**_____

SSN:_____-_____-_____ **Sex: F / M D.O.B:**_____/_____/_____ **Marital Status:**_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Primary Phone:(_____)_____-_____ **Best Time to Call:**_____

Email Address:_____

Spouse Name:_____ **Daytime Ph#:**(_____)_____-_____

Emergency Contact:_____ **Daytime Ph#:**(_____)_____-_____

Referring Physician:_____ **Phone#:**(_____)_____-_____

Primary Care Physician:_____ **Phone#:**(_____)_____-_____

Employer Information **Employment Status:** ***Employed*** ***Unemployed*** ***Disabled*** ***Retired***

Occupation:_____ **Employer:**_____

Employer Address:_____ **Ph#**(_____)_____-_____

Are you retired? (please circle) Y / N **If yes, date retired:**_____

Are you disabled or unemployed? Y / N **If yes, exact date last worked:**_____

Are you currently in school? Y / N **Full-time / Part-time** **School Name:**_____

GUARANTOR INFORMATION (the person responsible for the patient's account)

What is the patient's relationship to the guarantor? Self Spouse Child Other:_____

Guarantor Name:_____ **D.O.B.:**_____/_____/_____ **SSN:**_____-_____-_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Home Phone:(_____)_____-_____ **Work:**(_____)_____-_____ **Cell:**(_____)_____-_____

eMail Address:_____

Occupation:_____ **Employer:**_____

Employer Address:_____

INSURANCE INFORMATION

Do you have MEDICARE Part A? Y / N Part B? Y / N Medicare Policy Number:_____

If you have Medicare, do you also have a Medigap policy or other supplemental coverage? Y / N

Do you have MEDICAID? Y / N Medicaid Policy Number:_____

PRIMARY INSURANCE INFORMATION- Insurance card must be provided to front desk

Insurance Company Name:_____

Claims Mailing Address:_____

Contact Name:_____ Ph#(_____)_____-_____

Policy Holder's Name:_____ SSN:_____-_____-_____

Policy Holder's D.O.B.:_____/_____/_____ Relationship:_____

Policy Number/ID#:_____ Group#:_____

Group Name/Employer Name:_____

SECONDARY INSURANCE INFORMATION- Insurance card must be provided to front desk

Insurance Company Name:_____

Claims Mailing Address:_____

Contact Name:_____ Ph#(_____)_____-_____

Policy Holder's Name:_____ SSN:_____-_____-_____

Policy Holder's D.O.B.:_____/_____/_____ Relationship:_____

Policy Number/ID#:_____ Group#:_____

Group Name/Employer Name:_____

OTHER INSURANCE INFORMATION- Information must be provided to front desk, if applicable

Is this an Accident / Injury? Y / N If yes, date of Accident / Injury:_____

Worker's Compensation, Auto Accident, Other Accident / Injury **(circle if applicable)**

Are you currently involved in or pursuing litigation over these injuries? Y / N

If yes, Attorney Name:_____ Law Firm:_____

Attorney Phone#:(_____)_____-_____ Claim/Case#:_____

Insurance Company or Worker's Compensation Carrier Name:_____

Claims Mailing Address:_____

Contact Name:_____ Ph#(_____)_____-_____

Policy Holder's Name:_____ SSN:_____-_____-_____

Policy Holder's D.O.B.:_____/_____/_____ Relationship:_____

Policy Number/ID#/Case#:_____ Group#:_____

Group Name/Employer Name:_____

CENTER FOR PAIN MANAGEMENT
www.IndyPain.com

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3738 Landmark Dr.
Lafayette, IN 47905

Edward J. Kowlowitz, M.D. John J. Fitzgerald, M.D. Jocelyn Bush, M.D.
Scott Kim, M.D. David Gordon, M.D. Amanda Wakefield, Psy.D., HSPP

RELEASE OF INFORMATION

I, _____, with Date of Birth (month/day/year): _____

authorize and release the disclosure of my health information from: _____

_____

to the Center for Pain Management and/or Innovations Pain Management Group (a division of Center for Pain Management) for the purpose of: _____

The information to be released includes: _____

_____

I understand that I may revoke this authorization at any time except to the extent that information has already been released in response to this authorization. I understand that I may revoke this authorization by making the request in writing and giving it to an office staff member of the Center for Pain Management and/or Innovations Pain Management Group. I understand that information disclosed in response to this authorization may be re-disclosed by the recipient and therefore is no longer protected. I understand that my treatment may not be conditioned upon the signing of this authorization.

AUTHORIZATION

Signature: _____

Relationship if other than patient: _____

Date: _____

Expiration Date or Event: _____

Fax form back to 317-706-3417

www.indypain.com

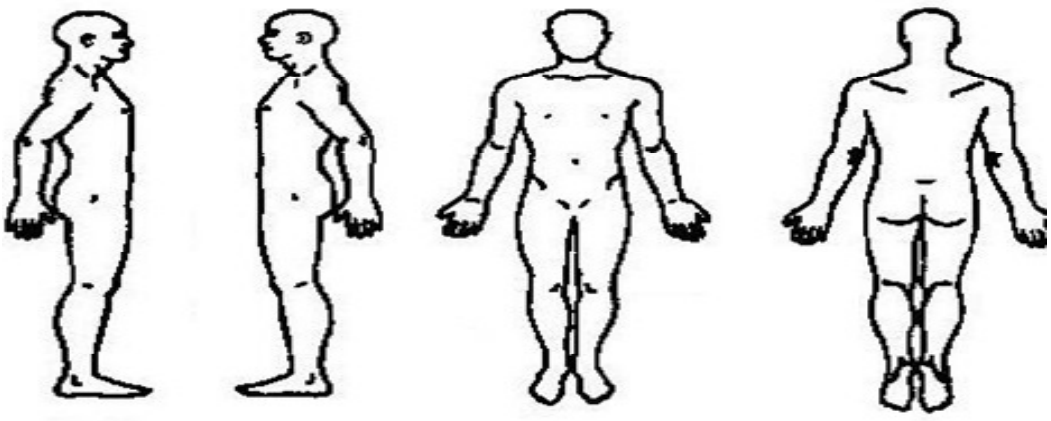
317-706-7246
(fax) 317-706-3417
www.IndyPain.com

New Patient Pain History

Center for Pain Management, Center for Special Surgery and Center for Southside Surgery

HISTORY of PRESENT ILLNESS

Patient Name (please print): _____ M/F Age _____
Last name, First Name, Middle Initial
Have you ever been to another Pain Center? Yes / No If Yes, where/when: _____
Have you had Physical Therapy before? Yes/No If Yes, where: _____
When was your last Physical Therapy Appointment? _____
How many visits have you had this year? _____
What is the chief complaint that brings you to the doctor today? _____
_____
How did these symptoms begin? _____
When did you first start experiencing these symptoms? MM/DD/YY _____
When did the symptoms progress to the current level of severity? _____
Please mark on the drawings below all areas where you are feeling pain:



Location: _____ Severity: mild moderate severe

Quality: dull aching stabbing cramping shooting burning throbbing

Duration: Intermittent (stops & starts) or Persistent (all the time)

Pain worse in: morning afternoon evening Context: _____

Modifying Factors

What makes it better: _____
What makes it worse: _____
Associated Symptoms: _____

Please circle the number that reflects your current level of pain:
None 0 1 2 3 4 5 6 7 8 9 10 unbearable

On the average over the past 4 weeks my pain at the best was a:
None 0 1 2 3 4 5 6 7 8 9 10 unbearable

On the average over the past 4 weeks my pain at the worst was a:
None 0 1 2 3 4 5 6 7 8 9 10 unbearable

Please list 3 specific things you are unable to do because of your pain:

_____ _____ _____

Please identify which of the following medications have been tried in the past by checking the appropriate box. (Do not check any drug never taken)

	Helpful?			Helpful?			Helpful?	
NSAID	Y	N	**Muscle Relaxant**	Y	N	**Anticonvulsant**	Y	N
Motrin			Skelaxin			Neurontin / Gabapenitn		
Lodine			Norflex			Lyrica		
Naprosyn			Soma			Topamax		
Relafen			Robaxin			Depakote		
Indocin			Flexeril			Tegretol		
Celebrex			Zanaflex / Tizanidine			Dilantin		
Mobic			Valium			Lamictal		
			Baclofen					
Opioid (narcotic)						**Antidepressant**		
Tramadol / Ultram			**Others**			Elavil		
Percocet/ Oxycodone			Pennsaid Cream			Pamelor		
Lortab / Vicodin/ Norco / Hydrocodone			Ketamine Gel			Doxepin		
Duragesic / Fentanyl			Lidoderm Patch			Tofranil		
Dilaudid			Imitrex			Desyrel		
Oxycontin			Amerge			Wellbutrin		
Suboxone			Hector Patch			Anafranil		
Butrans / Belbuca						Luvox		
Hysingla			**Constipation Meds**			Zoloft		
Zohydro						Remeron		
Levorphanol			Relistor			Paxil		
Methadone			Amitiza			Prozac		
Morphine IR/ER			Symproic			Serzone		
			Movantik			Effexor		
						Respiradol		

HEALTH HISTORY INTAKE QUESTIONS
Center for Pain Management, Center for Special Surgery and Center for Southside Surgery

Name: _____ **Date:** _____

ALLERGIES: Do you have a Latex allergy? Yes / No

Please list all allergies and reactions you have: _____
_____

FAMILY HISTORY: Please circle any of the following that are present in your family members

Anesthesia Reaction	Chronic Pain	Cancer
Diabetes	Fibromyalgia	Heart Disease
Migraines	Mental Illness	Rheumatoid Arthritis

PAST MEDICAL: Please circle any of the following for which you have ever received treatment

Alcohol Abuse	Drug Dependence	Obstructive Sleep Apnea
Anemia	Gastric Ulcer	Osteoporosis
Anesthesia Complications	Head Injury	Psoriasis
Anxiety Disorder	Hepatitis B	Psychological Trauma
Arthritis	Hepatitis C	Seizure Disorder
Asthma	Hiatal Hernia	STD
Bleeding Disorders	HIV / AIDS	Spinal Surgery
Cancer[type:_____]	Hypercoagulopathy	Thrombophlebitis
Congestive Heart Failure	Hypertension	Tuberculosis
COPD	Hyperthyroidism	Urinary Tract Infection
Coronary Artery Disease	Hypothyroidism	
CVA(stroke)	Kidney Disease	
Depression	Liver Disease	
Diabetes		

Currently on a blood thinner? Yes / No

If so, which medication: _____

Also any medications containing NSAIDS or aspirin.

I have had (or a family member has had) a problem (e.g. prolonged paralysis,
Or malignant hyperthermia) under anesthesia: Yes / No

Immunizations: (date received) Tetanus:_____
Hepatitis: _____
TB test:_____

Females: Last menstrual period _____

Are you or could you be pregnant? Yes / No
Are your periods regular? Yes / No / N/A
Hysterectomy? Yes / No

Tobacco Use: Do you smoke cigarettes or e-cigs? Yes / No

If so, how many packs or mg (eLiquid/) per day?_____

Did you ever smoke? Yes / No Do any immediate relatives smoke? Yes / No

Do you chew tobacco?

Alcohol Use: How many drinks do you have per week? _____

What do you drink?_____

How many times in a year do you have more than four drinks in one day? _____

Have you ever been treated for alcohol dependency? Yes / No

Do any of your immediate relatives have or had an alcohol problem? Yes / No

Substance Abuse: Do you currently use: marijuana / CBD? Yes / No

Do you currently use any other street drugs, such as : cocaine, crack, ecstasy, heroin, methamphetamines etc…?. Yes / No

Have you in the past used any of the above street drugs? Yes / No

Do any of your first degree relatives have a substance abuse problem? Yes / No

Have you ever been treated for substance abuse? Yes / No

MEDICATION HISTORY: Please list all current pain medication with mg doses and frequency (times taken per day):

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Please list all other medication taken including over the counter, weight loss and nutraceuticals:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

PAST MEDICAL: (continued) Hospitalizations: (please list all major illnesses with diagnosis and year)

1._____ 2._____

3. _____ 4._____

5._____ 6. _____

Surgeries: (please list all surgeries and type along with year performed) (include spinal injections)

1._____ 2._____

3. _____ 4._____

5**.**_____ **6.** _____

When and where have you had any of the following: (list results, if known)

MRI(s): _____

CT(s): _____

X-ray(s): _____

Colonoscopy: _____

Mammogram: _____

SOCIAL HISTORY:
(please circle)

Race:
White
African American
Asian
Hispanic
Indian
Other_____

Language:
English
Spanish
Other:_____

Marital Status:
Single
Married
Divorced
Widowed

I currently live in a:
House
Apartment
Mobile Home
Retirement Center

Education:
Some High School (Grade_____)
High School Graduate
Some College
College Graduate
Masters
Doctorate

Annual Household Income:
less than $10,000
$10,0001 to $20,000
$20,001 to $40,000
$40,001 to $100,000
$100,001+

Job History:
do not work
less than 20 hrs/week
20-40 hrs/wk
40hrs or more/week
retired
disability
applying for disability
missed work due to pain
no missed work due to pain

JOB HISTORY:

Job Title:_____ Years in current position:_____

Prior Job:_____ Years in that position: _____

If you are currently NOT WORKING what was the exact date you last worked:_____

If you are disabled, what year were you declared disabled? _____ By whom? _____

How much do you lift on your job?_____ How often? _____

REVIEW OF SYSTEMS: Please indicate if you have any of the following conditions or symptoms. Circle all that apply.

General Health:
Chills
Fatigue
Fever
Night Sweats
Weight Gain >10lbs
Weight Loss >10lbs

Skin:
Dryness
Excessive Sweating
Hair Loss
Nail Changes
Rash
Skin Color Changes

HEENT:
Bleeding Gums
Blurred Vision
Double Vision
Head Injury
Hearing Loss
Hoarseness
Vertigo
Visual Loss

Neck:
Neck Mass
Neck Stiffness
Swollen Glands

Breast:
Breast Mass
Breast Pain
Nipple Discharge
Skin Changes

Cardiovascular:
Calf Cramps
Chest Pain
Difficulty Breathing Lying Down
Fainting/Blacking Out
Irregular Heart Beat
Shortness of Breath
Swelling of Extremities

Gastrointestinal:
Abdominal Pain
Black Tarry Stool
Constipation
Diarrhea
Difficulty Swallowing
Heartburn
Jaundice
Nausea
Rectal Bleeding
Vomiting

Musculoskeletal:
Joint pain
Joint Stiffness
Joint swelling
Muscle atrophy
Muscle weakness

Neurological:
Decreased Memory
Difficulty Speaking
Headaches
Incontinence Stool
Incoordination
Loss of Consciousness
Seizures
Stroke

Psychiatric:
Anxiety
Change in Sleep Pattern
Depression
Hallucinations
History of abuse
Mood Changes
Panic Attacks
Suicidal Ideation

Endocrine:
Cold Intolerance
Excessive Thirst
Excessive Urination
Hair Changes
Heat Intolerance
Sexual Dysfunction
Thyroid Problems

Hematology:
Abnormal Bleeding
Anemia
Blood Clots
Easy Bruising

Other Medical Problems: _____

Information Provided by:_____ Date:_____