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

Enclosed you will also find a Health History Intake Questions form. Someone from our office will contact you within the week before your appointment to obtain this information. The form is provided for your convenience, so you can be prepared to review the information with our staff. To minimize your wait when you arrive for your appointment, it is important that we speak to you and complete this pre-registration prior to your appointment. If you prefer to speak with someone at your convenience, please call 317-706-7246 ext 2011. Please expect the call to take approximately 15 minutes.

To expedite the best plan of care, we ask that you contact your previous physicians to obtain any records regarding 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.
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:________________________________________________

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**INSURANCE INFORMATION**

Do you have MEDICAID?  Y / N

Medicaid Policy Number:__________________________

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

Insurance Company Name:__________________________________________

Policy Holder’s Name:_________________________________________ SSN:_______-_______-_______

Policy Holder’s D.O.B.:_______/_______/_______ Relationship:_________________________________________________________

Policy Number/ID#:____________________________________________

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

Insurance Company Name:__________________________________________

Policy Holder’s Name:_________________________________________ SSN:_______-_______-_______

Policy Holder’s D.O.B.:_______/_______/_______ Relationship:_________________________________________________________

Policy Number/ID#:____________________________________________ Group#:________________________________

**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:_________________________________________________________

Claim/Case#:__________________________________________ Employer Phone #:____________________________________

Employer Name:_________________________________________________
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
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: ____________________________
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? ________________________________

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? ________

Please mark on the drawings below all areas where you are feeling pain:

Front  Rear

<table>
<thead>
<tr>
<th>L</th>
<th>R</th>
<th>L</th>
<th>R</th>
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</table>

Location: ___________________________  Severity: mild  moderate  severe

Quality:  aching  stabbing  cramping  shooting  burning  throbbing  gnawing
sharp  numbness  tingling  unbearable

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

Modifying Factors
What makes it better: ____________________________________________________________
What makes it worse: ____________________________________________________________

www.indypain.com
Please circle the number that reflects your current level of pain:
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)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Helpful?</th>
<th>Helpful?</th>
<th>Helpful?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid</td>
<td>Y N</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td>Ultram (Tramadol)</td>
<td>Motrin (Ibuprofen)</td>
<td>Valium (Diazepam)</td>
<td></td>
</tr>
<tr>
<td>Percocet (Oxycodone)</td>
<td>Lodine</td>
<td>Xanax (Alprazolam)</td>
<td></td>
</tr>
<tr>
<td>Loritab / Vicodin / Noroc (Hydrocodone)</td>
<td>Naprosyn</td>
<td>Larazepam</td>
<td></td>
</tr>
<tr>
<td>Duragesic (Fentanyl)</td>
<td>Relafen</td>
<td>Lexapro (Escitalopram)</td>
<td></td>
</tr>
<tr>
<td>Dilaudid</td>
<td>Indocin</td>
<td>Cymbalta (Duloxetine)</td>
<td></td>
</tr>
<tr>
<td>Oxycontin</td>
<td>Mobic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suboxone</td>
<td></td>
<td>Anti-Convulsant</td>
<td></td>
</tr>
<tr>
<td>Ultram (Tramadol)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Motrin (Ibuprofen)</td>
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<tr>
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</tr>
<tr>
<td>Motrin (Ibuprofen)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valium (Diazepam)</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>NSAID</th>
<th>Helpful?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y N</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anti-Anxiety</th>
<th>Helpful?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y N</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tricylic Antidepressant</th>
<th>Helpful?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurontin (Gabapentin)</td>
<td></td>
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</table>

<table>
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<tr>
<th>Sleep</th>
<th>Helpful?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y N</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Muscle Relaxant</th>
<th>Helpful?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y N</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Others</th>
<th>Helpful?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y N</td>
<td></td>
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</tbody>
</table>

www.indypain.com
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 to medications** and reactions you have: ________________________________

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

- [ ] Alzheimer's
- [ ] Diabetes
- [ ] Mental Illness
- [ ] Anesthesia Reaction
- [ ] Fibromyalgia
- [ ] Rheumatoid Arthritis
- [ ] Cancer
- [ ] Heart Disease
- [ ] Seizure
- [ ] Chronic Pain
- [ ] Lung Disease
- [ ] Stroke
- [ ] Migraines

**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
- [ ] Other Medical Problems__________________________________

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

My last pneumonia vaccination was __/__/__  N/A  My Last flu vaccination was __/__/__  N/A

My last mammogram was __/__/__  N/A  My last colonoscopy was __/__/__  N/A
**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? 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
If yes, which ones? ________________________________________________
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, CBD and nutraceuticals:
1. ___________________________  2. ___________________________
3. ___________________________  4. ___________________________
5. ___________________________  6. ___________________________
**PAST MEDICAL:** (continued)  
**Hospitalizations:** (please list all major illnesses with diagnosis and year)

<table>
<thead>
<tr>
<th>1.</th>
<th>2.</th>
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<tbody>
<tr>
<td>3.</td>
<td>4.</td>
</tr>
<tr>
<td>5.</td>
<td>6.</td>
</tr>
</tbody>
</table>

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

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<tr>
<th>1.</th>
<th>2.</th>
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</thead>
<tbody>
<tr>
<td>3.</td>
<td>4.</td>
</tr>
<tr>
<td>5.</td>
<td>6.</td>
</tr>
</tbody>
</table>

**When and where** have you had any of the following?:

- MRI(s):
- CT(s):
- X-ray(s):
- EMG:

**SOCIAL HISTORY:**  
(please circle)

<table>
<thead>
<tr>
<th>Race:</th>
<th>I currently live in a:</th>
<th>Annual Household Income:</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>House</td>
<td>less than $10,000</td>
</tr>
<tr>
<td>African American</td>
<td>Apartment</td>
<td>$10,001 to $20,000</td>
</tr>
<tr>
<td>Asian</td>
<td>Mobile Home</td>
<td>$20,001 to $40,000</td>
</tr>
<tr>
<td>Hispanic</td>
<td>Retirement Center</td>
<td>$40,001 to $100,000</td>
</tr>
<tr>
<td>Indian</td>
<td></td>
<td>$100,001+</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Language:</th>
<th>Education:</th>
<th>Job History:</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>Some High School (Grade _____)</td>
<td>do not work</td>
</tr>
<tr>
<td>Spanish</td>
<td>High School Graduate</td>
<td>less than 20 hrs/week</td>
</tr>
<tr>
<td>Other</td>
<td>Some College</td>
<td>20-40 hrs/wk</td>
</tr>
<tr>
<td></td>
<td>College Graduate</td>
<td>40hrs or more/week</td>
</tr>
<tr>
<td></td>
<td>Masters</td>
<td>retired</td>
</tr>
<tr>
<td></td>
<td>Doctorate</td>
<td>disability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>applying for disability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>missed work due to pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>no missed work due to pain</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status:</th>
<th>Job Title:</th>
<th>Years in current position:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td></td>
<td></td>
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</tbody>
</table>

**JOB HISTORY:**

<table>
<thead>
<tr>
<th>Job Title:</th>
<th>Years in current position:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Prior Job:</th>
<th>Years in that position:</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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</table>

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? __________________________

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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

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

**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

**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

**Respiratory:**
- Cough
- Decreased Exercise Tolerance
- Difficulty Breathing
- Hemaptysis
- Snoring
- Wheezing

**Hematology:**
- Abnormal Bleeding
- Anemia
- Blood Clots
- Easy Bruising

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

**Neck:**
- Neck Mass
- Neck Stiffness
- Swollen Glands

Information Provided by: ______________________________ Date: _________________________