Jared Ennis, MD
Jason Holt, MD

4019 N. Remington Dr. Fayetteville, AR 72703 • ipsnwa.com • Phone: (479) 595-8192 • Fax: (479) 442-1748

Date:_____/_____/_____

Last Name:_____First Name:_____
Middle:_____

Sex:_____ Marital Status: M W D S Date of Birth:_____/_____/_____

Address:_____ City:_____ State:_____
Zip:_____

Home phone:_____ Cell Phone:_____
Other:_____

Insurance:_____(primary) _____(secondary)

Social Security#_____ Patient's employer_____

Spouse:_____Spouse Date of Birth: _____/_____/_____

Spouse SS#_____ Name of MD who referred you to us:_____

In case of emergency:

Contact #1:_____ Contact #2:_____
Relationship:_____ Relationship:_____
Home Phone:_____ Home Phone:_____

Is this a worker's compensation claim injury? YES NO Date of Injury:_____/_____/_____
Employers Name:_____
Workers Comp Nurse or Rep:_____
Is this visit as a result of a Motor Vehicle Crash? YES NO Date of Accident:_____/_____/_____

I hereby authorize IPS of NWA to release any information pertaining to my medical services to my insurance company or governmental agency (VA, TriCare, Medicare, Medicaid, etc.) and their intermediaries /carriers as provided within federal/state law, so that payment of insurance benefits can be made directly to Interventional Pain Specialists (IPS) and its providers for rendered services. I understand all services provided at IPS are charged to me pending payment by my insurance, and that I am responsible for these facts fees regardless of insurance coverage. I understand it is required by law that I notify this clinic of all parties who may be responsible for paying for my treatment. Co-pays (or payment for non-covered services) are due prior to being seen and evaluated.

INSURANCE AUTHORIZATION AND ASSIGNMENT
I request that payment of authorized insurance benefits or Medicare benefits be made on my behalf to IPS for services rendered. Regulations pertaining to Medicare assignment of benefits apply.

SIGNATURE OF INSURED/AUTHORIZED PERSON:_____
DATE:_____/_____/_____

Interventional Pain Specialists of Northwest Arkansas

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Date:_____

Last Name:_____ First Name:_____ MI: _____

Sex: Male Female DOB:_____/_____/_____ Age:_____

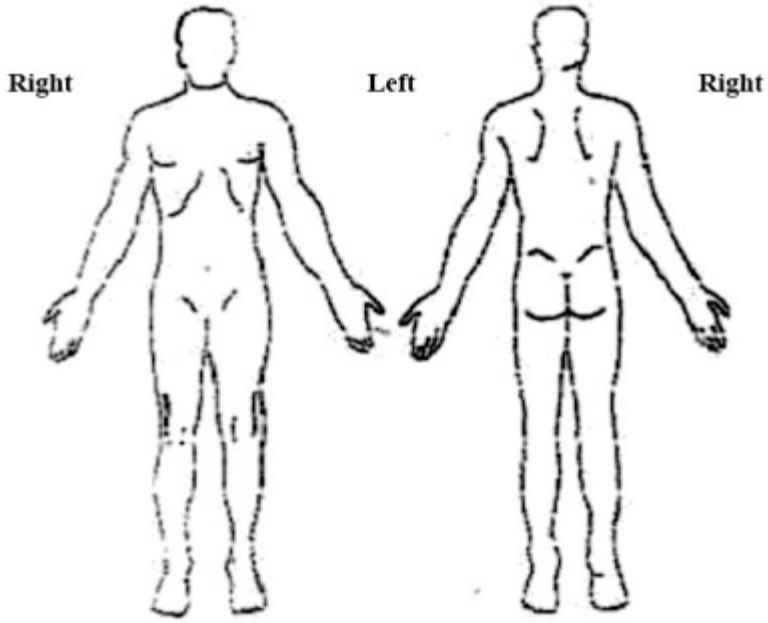
Referring Physician:_____ Primary Care Physician:_____

Height:_____ Weight:_____

Description of Pain

Please indicate on the diagram and circle the words that best describe your pain.

Head	Abdomen
Scalp	Pelvis
Ear	Back
Cheek	Genitals
Jaw	Groin
Chest	Hip
Rib	Buttock
Breast	Thigh
Neck	Knee
Shoulder	Leg
Elbow	Ankle
Arm	Foot
Hand	
Wrist	Other:_____



Which side is your pain the worst?

Left Right Both sides about the same

Please indicate the character of your pain. (Circle all that apply)

Aching	Burning	Throbbing	Dull	Sharp/Stabbing
Shooting	Gnawing	Shocking	Pressure	Numbness/Tingling

Please indicate any associated symptoms with your pain. (Circle all that apply)

Numbness	Cramping	Weakness	Limping
Tightness	Headaches	Spasms	

How long have you had this pain?

1-2 weeks	3-6 weeks	2-3 months	3-6 months	6-12 months
1-2 years	3-5 years	More than 5 years		

OR

Specific date that pain began _____

Under what circumstances did your pain begin?

Accident at work	Accident at home	Following surgery
Auto accident	After a fall	Repetitive motion
Arthritis	Unknown reason	Other_____

Pain Intensity

Please use the scale 0 = no pain and 10 = worst pain in your life

Indicate the average level of pain over the past few weeks:

0 1 2 3 4 5 6 7 8 9 10

Indicate the WORST your pain has been over the past few weeks:

0 1 2 3 4 5 6 7 8 9 10

Indicate the BEST your pain has been over the past few weeks:

0 1 2 3 4 5 6 7 8 9 10

Which describes your usual level of pain?

Mild	Uncomfortable	Distressing/Severe
Very Severe (cannot perform daily activities)	Unbearable (unable to get out of bed)	

When is your pain present?

Daytime	Nighttime	Intermittent
Constantly present	With Activity	Other_____

What makes your pain better? (Circle all that apply)

Heat	Ice	Rest	Lying	Standing
Sitting	Walking	Bending	Pain meds	Arthritis meds
Traction	TENS unit	Injections	Physical therapy	Nothing

What makes your pain worse? (Circle all that apply)

Heat	Ice	Rest	Lying	Standing
Sitting	Walking	Bending	Pain meds	Arthritis meds
Traction	TENS unit	Injections	Physical therapy	Nothing

What therapies have been tried previously to treat your pain? (Circle all that apply)

Arthritis meds	Pain meds	Physical therapy	Chiropracty	Massage
Acupuncture	Injections	Biofeedback	Cognitive behavioral therapy	

How is your sleep pattern?

Normal	Poor	Severely Disrupted

What limitations have resulted from your pain? (Circle all that apply)

Missed work	Unable to work	Unable to participate in hobbies
Unable to travel	Unable to enjoy sex	Unable to exercise

Other_____

What are your expectations/goals from treatment of your pain? (Circle all that apply)

Return to work	Enjoy my hobbies	Spend time with friends/family
Resume exercise	Reduce reliance on medication	Other_____

Review of Systems: Please mark the box of any <u>persistent</u> symptoms you have had in the <u>last few months</u>.

Constitutional
___inability to do daily activities
___fever
___chills
___weight loss
___loss of appetite
___fatigue
___loss of strength

Eyes
___corrective lenses/contacts
___changes in vision

Respiratory
___shortness of breath
___asthma
___COPD/emphysema
___sleep apnea
___respiratory infections

Gastrointestinal
___heartburn
___frequent constipation
___abdominal pain
___nausea/vomiting

Musculoskeletal
___muscle pain
___muscle cramps
___neck pain
___back pain
___joint pain
___arthritis
___muscle weakness

Genitourinary
___incontinence
___difficulty of urination

Hematologic
___bleeding disorder
___anemia

Cardiovascular
___chest pain

___irregular heart beat
___high blood pressure
___edema in legs
___heart attack

Neurologic
___headache
___numbness
___weakness
___seizures
___gait disturbance

Psychiatric
___anxiety
___depression
___sleeping difficulty

Skin
___itching
___rashes

Endocrine
___Thyroid problems
___Diabetes

Infectious
___HIV
___Hepatitis

Personal Medical History: Do you have now (current) or have you had (past) any of the following conditions?

☐None

Condition	Current	Past	Comments	Code
Anxiety				300.00
Arthritis (Rheumatoid)				714.0
Arthritis (Osteoarthritis)				715.90
Asthma				493.90
Bladder / Kidney Problems				
Blood Clot (leg)				453.40
Blood Clot (lung)				415.11
Cancer Breast				174.9
Cancer Colon				153.9
Cancer Other Type				
Cancer Ovarian				183.0
Cancer Prostate				185
Coronary Artery Disease				414.00
Depression				311
Diabetes				250.00
Drug abuse				305.90
Emphysema				492.8
Heartburn/Reflux/GERD				530.81
Gout				274.9
Gynecological Conditions (Endometriosis)				617.9
Heart Attack				410.90
Hepatitis				
High Blood Pressure				401.9
Kidney Disease / Failure				586
Kidney Stones				592.0
Liver Disease				573.9
Migraine Headaches				346.90
Osteoporosis				733.00
Seizure / Epilepsy				780.39
Sleep Apnea				780.57
Stomach Ulcer				531.90
Stroke				434.91
Hyperthyroidism				242.90
Hypothyroidism				244.9
Other (list)				

Please list allergies to medications:_____

Do you take any blood thinners?

Yes _____ No

Do you have a pacemaker?

Yes No

Surgical History: Please check off any procedure or surgeries. List any abnormal finding or complications

☐ None

Surgical Procedure	Yes	Year	Comments
Abdominal Surgery			
Appendectomy (appendix removal)			
Back Surgery (lumbar)			
Breast Surgery			Circle: Right Left Both
Coronary Bypass			
Coronary Stent			
Cataract			
Gallbladder Removal			
Heart Surgery			
Hip Surgery			Circle: Right Left Both
Hysterectomy			
Knee Surgery			Circle: Right Left Both
Neck Surgery			
Sinus Surgery			
Other (list)			

Family History: Please mark yes/no if family members have had the following diseases.

☐ None

Disease	Yes	No	Comments
Alcoholism/Drug Abuse			
Alzheimers			
Asthma			
Bleeding or Clotting Disorder			
Cancer			
Coronary Artery Disease (heart attack, angina)			
Depression/Suicide/Anxiety			
Diabetes			
Genetic Disorder			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Thyroid Disease			
Other (list)			

Social History:

Marital Status (circle one):

Single Married Divorced Widowed Separated

Do you have any pending lawsuits related to your pain complaints? (circle one)

Yes No

Any possibility of being pregnant?

Yes No Not Applicable

What is your current employment status? (please circle one)

Employed (list occupation)_____ Unemployed Retired
Disabled Student House Wife
Medical Leave

Have you previously applied or are currently applying for disability?

Yes No

Do you drink alcohol? (please circle one)

No Used to drink Occasionally
1-2 times a week Weekends only Daily
History of abuse

Do you use tobacco? (please circle one)

No Currently smoking Used to smoke Use smokeless tobacco

Do you use illicit drugs? (please circle one)

No Current use (describe)_____ Former use (describe)_____

By signing below, I acknowledge that I have received a copy of Interventional Pain Specialists' Notice of Privacy Practices.

_____ _____

Patient Signature **Date**

Patient Name_____ **Date**_____

Medication	Dosage	How Often