

New Patient

Today's Date: _____ Referring Provider: _____

Your Name: _____ Gender: Male Female

Marital Status: Married Single Divorced Widowed Other: _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____ Age: _____

Street Address: _____

City/State/Zip: _____

Physical Address Same as Mailing? Yes No

If not, please list mailing address: _____

Employer: _____ Occupation: _____

Email Address: _____ @ _____

DAY TIME Phone #: _____ Home Mobile Work

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____ Phone Type (circle one): Home Work Cell

How did you hear about us? Insurance Co Employer Facebook Internet search Print Ad Family/Friend

Please check if: This is an INJURY CLAIM or This is a WORKMAN'S Compensation Claim

Primary Insurance: _____ **HOLDER Name:** _____

HOLDER DOB: _____ Relationship to you: _____

Secondary Insurance: _____ **HOLDER Name:** _____

HOLDER DOB: _____ Relationship to you: _____

Assignment of Benefits

I hereby authorize my insurance benefits be paid directly to Adam Wuollet, MD. I am financially responsible for non-covered services and/or balances not paid by my insurance carrier. I also authorize release of any of my information required to process these claims. I authorize Adam Wuollet, MD to provide my medical care, including diagnosis and treatment. I certify that the information on this form is accurate, complete and true.

Signature of Patient or Legal Representative _____ Date _____

Legal Representative Name _____ Date _____

Clinical Information

Today's Date: _____ Today's Provider: _____

Your Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____

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

Pain Description

Use the pain scale described below to rate your pain for the questions below:

- 0 - Pain-free
- 1 - Very minor annoyance, occasional minor twinges
- 2 - Minor annoyance, occasional strong twinges
- 3 - Annoying enough to be distracting
- 4 - Can be ignored if you are involved in your work/task, but still distracting
- 5 - Cannot be ignored for more than 30 minutes
- 6 - Cannot be ignored for any length of time but can still go to work and participate in social activities
- 7 - Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
- 8 - Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
- 9 - Unable to speak, crying out or moaning uncontrollably, near delirium
- 10 - Unconscious, pain makes you pass out

_____ What number on the pain scale (0-10) best describes your **right now**?

_____ What number on the pain scale (0-10) best describes your **worst pain**?

_____ What number on the pain scale (0-10) best describes your **least pain**?

Where is your worst area of pain located?

Does this pain radiate? If so, where?

Please list any additional areas of pain: _____

Onset of Symptoms

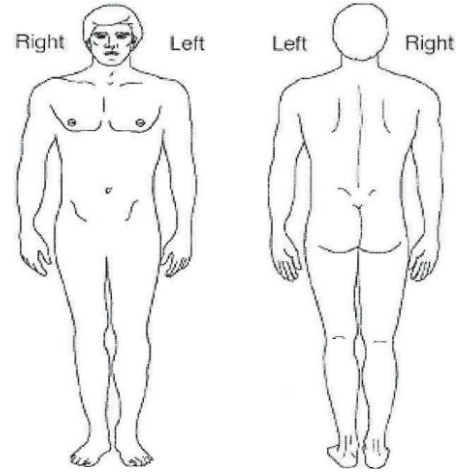
Approximately when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? Gradually Suddenly

Since your pain began, how has it changed? Decreased Increased Stayed the same

Use this diagram to indicate the location and type of your pain.
 Mark the drawing with the following letters that best describe your symptoms:



"N" = numbness

"S" = stabbing

"B" = burning

"P" = pins and needles

"A" = aching

Pain Description - Check all the following that describe of your pain

- | | | | |
|--------------------------------------|-------------------------------------|---|--|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Numbness | <input type="checkbox"/> Spasms | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Shock-like | <input type="checkbox"/> Squeezing | <input type="checkbox"/> Tingling/Pins & Needles |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Shooting | <input type="checkbox"/> Stabbing/Sharp | <input type="checkbox"/> Tiring/Exhausting |
| <input type="checkbox"/> Hot/Burning | | | |

Factors that Affect your Pain

	Increases Pain	Decreases Pain	No Change
<input type="checkbox"/> Bending Backward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Changes in Weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing / Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting Objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Looking Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Looking Downward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Looking Side to Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rising from a Seated Position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What other factors worsen or affect you pain that is not listed above? _____

Diagnostic Tests and Imaging

What imaging/tests have you had done for your pain complaint?

I Have Not Had Any Diagnostic Tests Performed for My Current Pain Complaints

Date	Facility	Type of Imaging
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

I Have Not had any Surgical Procedures Performed

Abdominal Surgery

Gallbladder removal _____

Appendectomy _____

Other _____

Joint Surgery

Shoulder _____

Hip _____

Knee _____

Female Surgeries

Caesarean section _____

Hysterectomy _____

Laparoscopy _____

Ovarian _____

Other _____

Spine / Back Surgery

Discectomy (levels) _____

Laminectomy _____

Spinal fusion (levels) _____

Other Common Surgeries

Hemorrhoid surgery _____

Hernia repair _____

Thyroidectomy _____

Tonsillectomy _____

Vascular surgery _____

Heart Surgery

Valve replacement _____

Aneurysm repair _____

Other _____

Please list any other surgeries and dates (attach an additional sheet if necessary):

Current Medications

Are you taking a prescribed **blood-thinner** medication? Yes No If yes, please check which one:

- Aggrenox Coumadin Effient Eliquis Lovenox Plavix Pleta Pradaxa
 Ticlid Warfarin Xarelto Other _____

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Who and approximately when was the last provider to prescribe you pain medications or other controlled substances?
 Attach an additional sheet, if required.

Allergies

Do you have any known drug allergies? Yes No

If so, please list all medications you are allergic to.

Medication Name:	Allergic Reaction Type:
_____	_____
_____	_____
_____	_____
_____	_____

Please check if you are allergic to: Iodine or Tape

*Are you allergic to latex? Yes No

Family History

Mark all appropriate diagnoses as they pertain to your biological **MOTHER AND FATHER** only.

	<i>Headaches</i>	<i>Heart Disease</i>	<i>High Blood Pressure</i>	<i>High Cholesterol</i>	<i>Kidney Problems</i>	<i>Liver Problems</i>	<i>Osteoporosis</i>	<i>Rheumatoid Arthritis</i>	<i>Seizures</i>
Mother:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Medical Problems: _____

- Have No Significant Family Medical History**
 I Am Adopted (No Medical History Available)

Social History

Are you capable of becoming pregnant? Yes No
 If so, are you currently pregnant? Yes No

Highest level of education obtained: Grammar High School College Post-Graduate

Alcohol Use: Current Alcoholism Daily Limited Alcohol Use History of Alcoholism
 Never Drinks Alcohol Social Alcohol Use

Tobacco Use: Current Tobacco Use Former Tobacco User Never Used Tobacco

Drug Use: Denies Any Illegal Drug Use Currently Using Illegal Drugs (Which: _____)
 Currently Using Someone Else's Prescription Medication
 Formerly Used Illegal Drugs (not currently using) (Which: _____)

Have you ever abused narcotic or prescription medications? Yes No (Which: _____)

Have you ever been discharged from a pain management practice in the past? Yes No

If so, please explain: _____

Which practice were you discharged from? _____

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical

- Cancer - Type
- Diabetes - Type
- HIV/AIDS

Head/Eyes/Ears/Nose/Throat

- Glaucoma
- Headaches
- Head Injury
- Hyperthyroidism
- Hypothyroidism
- Migraines

Cardiovascular/Hematologic

- Anemia
- Bleeding Disorders
- Coronary Heart Disease
- Heart Attack
- High Blood Pressure
- High Cholesterol
- Mitral Valve Prolapse
- Murmur
- Pacemaker/Defibrillator
- Phlebitis
- Poor Circulation
- Stroke

Respiratory

- Asthma
- Bronchitis
- Emphysema/COPD
- Pneumonia
- Tuberculosis
- Valley Fever

Gastrointestinal

- Bowel Incontinence
- Acid Reflux/GERD
- Gastrointestinal Bleeding
- Constipation

Musculoskeletal

- Amputation
- Bursitis
- Carpel Tunnel Syndrome
- Chronic Low Back Pain
- Chronic Neck Pain
- Chronic Joint Pain
- Fibromyalgia
- Joint Injury
- Osteoarthritis
- Osteoporosis
- Phantom Limb Pain
- Rheumatoid Arthritis
- Tennis Elbow
- Vertebral Compression Fracture

Genitourinary/Nephrology

- Bladder Infection(s)
- Dialysis
- Kidney Infection(s)
- Kidney Stones
- Urinary Incontinence

Hepatic

- Hepatitis A
(active/inactive/unsure)
- Hepatitis B
(active/inactive/unsure)
- Hepatitis C
(active/inactive/unsure)

Neuropsychological

- Alcohol Abuse
- Alzheimer Disease
- Bipolar Disorder
- Depression
- Epilepsy
- Prescription Drug Abuse
- Multiple Sclerosis
- Paralysis
- Peripheral Neuropathy
- Schizophrenia
- Seizures
- Reflex Sympathetic Dystrophy/CRPS

Other Diagnosed Condition:

Global Pain Scale Please answer all questions

INSTRUCTIONS: For each question, please indicate your response by circling a number from 0 to 10

YOUR PAIN: 0 = No Pain 10 = Extreme Pain

- For the *past week*, the **best** my pain has been.... 0 1 2 3 4 5 6 7 8 9 10
- For the *past week*, the **worst** my pain has been 0 1 2 3 4 5 6 7 8 9 10
- For the *past week*, my **average** pain has been 0 1 2 3 4 5 6 7 8 9 10
- For the *past 3 months*, my **average** pain has been 0 1 2 3 4 5 6 7 8 9 10

YOUR FEELINGS:

During the past week, I have felt: 0 = Strongly Disagree 10 = Strongly Agree

- Afraid 0 1 2 3 4 5 6 7 8 9 10
- Depressed 0 1 2 3 4 5 6 7 8 9 10
- Tired 0 1 2 3 4 5 6 7 8 9 10
- Anxious 0 1 2 3 4 5 6 7 8 9 10
- Stressed 0 1 2 3 4 5 6 7 8 9 10

YOUR CLINICAL OUTCOMES:

During the past week: 0 = Strongly Disagree 10 = Strongly Agree

- I had trouble sleeping 0 1 2 3 4 5 6 7 8 9 10
- I had trouble feeling comfortable 0 1 2 3 4 5 6 7 8 9 10
- I was less independent 0 1 2 3 4 5 6 7 8 9 10
- I was unable to work (or perform normal tasks) 0 1 2 3 4 5 6 7 8 9 10
- I needed to take more medication 0 1 2 3 4 5 6 7 8 9 10

YOUR ACTIVITIES:

During the past week, I was NOT able to: 0 = Strongly Disagree 10 = Strongly Agree

- Go to the store 0 1 2 3 4 5 6 7 8 9 10
- Do chores in my home. 0 1 2 3 4 5 6 7 8 9 10
- Enjoy my friends and family 0 1 2 3 4 5 6 7 8 9 10
- Exercise (including walking) 0 1 2 3 4 5 6 7 8 9 10
- Participate in my favorite hobbies... 0 1 2 3 4 5 6 7 8 9 10

Review of Symptoms

Mark the following conditions/diseases that you **currently suffer from**:

Constitutional:

- | | | | |
|--|--|--|-----------------------------------|
| <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Unexplained Weight Loss | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Low Sex Drive | <input type="checkbox"/> Unexplained Weight Gain | |

Eyes:

- Recent Visual Changes

Ears/Nose/Throat/Neck:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Earaches | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Recurrent Sore Throat |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Dental Problems | |

Cardiovascular:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Fainting | <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Swelling in the Feet |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath During Sleep | |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Irregular Heartbeat | | |

Respiratory:

- | | | | |
|---|---|--|-----------------------------------|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Shortness of Breath on Exertion/Effort | <input type="checkbox"/> Shortness of Breath at Rest | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Pulmonary Embolism | | | |

Gastrointestinal:

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> Abdominal Cramps | <input type="checkbox"/> Coffee Ground Appearance in Vomit | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Dark Tarry Stools | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Constipation | | <input type="checkbox"/> Vomiting |

Musculoskeletal:

- | | | |
|--|--|---|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Joint Swelling |
| <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Neck Pain |

Genitourinary/Nephrology:

- | | | |
|--|---|--|
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Pelvic Pressure |
| <input type="checkbox"/> Decreased Urine Flow/
Frequency/Volume | <input type="checkbox"/> Flank Pain | |
| | <input type="checkbox"/> Painful Urination | |

Neurological:

- | | | |
|---|---|--|
| <input type="checkbox"/> Carpel Tunnel Syndrome | <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Instability When Walking | <input type="checkbox"/> Seizures |

Psychiatric:

- | | | |
|--|--|--|
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Stress Problems | <input type="checkbox"/> Suicidal Planning |
| <input type="checkbox"/> Feeling Anxious | <input type="checkbox"/> Suicidal Thoughts | |

	Mark Each that Applies	OFFICE USE ONLY	
		Item Score If Female	Item Score if Male
Family History of Substance Abuse: Alcohol <input type="checkbox"/> Illegal <input type="checkbox"/> Drugs <input type="checkbox"/> Prescription Drugs		1 2 4	3 3 4
Personal History of Substance Abuse: Alcohol <input type="checkbox"/> Illegal <input type="checkbox"/> Drugs <input type="checkbox"/> Prescription Drugs		3 4 5	3 4 5
Your Age (Mark box if 16-45) <input type="checkbox"/>		1	1
Personal History of Preadolescent Sexual Abuse: <input type="checkbox"/>		3	0
Personal History of Psychological Disease: Attention Deficit Disorder, <i>OR</i> Obsessive Compulsive Disorder, <i>OR</i> Bipolar, <i>OR</i> Schizophrenia <input type="checkbox"/> Depression <input type="checkbox"/>		2 1	2 1
<input type="checkbox"/> None of the above apply to me	TOTAL		

Urine Drug Testing Information

At Adam Wuollet, MD, the safety and wellbeing of our patients is a top priority. When our patients warrant narcotic (opioid) therapy, there are many factors that go into the decision-making process of medication management. As part of our safety and compliance program one of those factors is Urine Drug Testing or “UDT”.

As many of you know, we are undergoing a significant cultural shift at the state and federal level with respect to narcotic (opioid) therapy. In addition to a governmental shift in thinking, there exists a significant change in the medical community in what we call the “local standard of care”. These changes are part of a concerted effort to decrease the associated adverse effects of narcotic (opiate) therapy, and protect you, the patient.

At Adam Wuollet, MD, we adhere to these federal, state, and local guidelines with respect to narcotic (opiate) therapy. Performing urine drug testing on patients is part of those guidelines. To simplify this process for providers, **CMS (Center for Medicare and Medicaid Services)** has published guidelines for appropriate UDT. These guidelines mandate a certain number of screening tests, as well as confirmatory tests, each year for each patient undergoing narcotic (opiate) therapy. For each patient, the number of tests may be different based on differences in treatment and medical history.

In finding various labs to work with, Adam Wuollet, MD has made every effort to assure that our patients’ UDT process, as well as laboratory billing process, will be in their best interest. We must use third party laboratories for our urine specimens. If you should have questions or comments regarding your UDT billing, explanation of benefits, or bills received, please contact the laboratory directly. Adam Wuollet, MD does not financially benefit from UDT and will be unable to answer billing questions about UDT.

By signing this document, you are stating that you have read, and understand its content. As always, we appreciate your understanding in this manner, and the trust you put into us for your pain management needs. Thank you.

Print Name

DOB

Date

Signature

Patient Name: _____
(Please print)

Acknowledgement of Notice of Privacy Practices:

I have been offered a copy of the Notice of Privacy Practices. I understand that Adam Wuollet, MD has the right to change its Notice of Privacy Practices from time to time and that I may contact Adam Wuollet, MD at any time to obtain a current copy.

****Signature:** _____ **Date:** _____

Acceptance of Patient Financial Agreement:

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Policy.

****Signature:** _____ **Date:** _____

Notice of Electronic Access to Prescription History:

By signing below, I authorize Adam Wuollet, MD to obtain my medication history from my pharmacy electronically.

****Signature:** _____ **Date:** _____

Notice of Diagnostic Release:

By signing below, I authorize Adam Wuollet, MD to release my current diagnosis to my pharmacy to validate my need for pain management prescriptions and to secure such as needed.

****Signature:** _____ **Date:** _____

Authorization of Release of Health Information:

I hereby authorize Adam Wuollet, MD and its Employees permission to discuss, send and/or receive my personal health information **to/with the following individual(s):**

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I further authorize Adam Wuollet, MD to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care. I also authorize the release of information that may be necessary in the processing of any insurance claims.

****Signature:** _____ **Date:** _____