Welcome!

Thank you for choosing New England Advanced Spine & Pain Center (NEAS&P) to manage your chronic pain medical care. Please complete the following forms and bring them to the office with you the day of your appointment.

Please take your time to complete these forms as it is necessary to have very detailed information concerning your medical condition(s). This will help Dr. Abraham and his staff to give you the best care possible.

Listed below are reminders to make your appointment and treatment a success:

You must bring your insurance card(s). All applicable co-pays and/or deductibles are collected at the time of your appointment. **Personal checks are not accepted.** Cash, Mastercard/Visa, and Money Orders will be accepted.
Check with your insurance prior to your appointment to verify your benefits. Call the toll free number listed on the back of your insurance card.

You must bring a valid form of **PHOTO ID**.

NEAS&P looks forward to treating and taking care of you. Please call if you have any questions prior to your appointment.

Patient Information:

Last Name _____ First Name_____ Middle Initial _____

Date of Birth _____ Social Security # _____

Home Address _____ City_____ State_____ Zip_____

Cell Phone_____ Home Phone _____ Work Phone_____

Email Address _____

Emergency Contact: _____ Phone _____

Emergency Contact Relation to Patient _____

Primary Medical Insurance _____ ID _____

Secondary Medical Insurance _____ID_____

Referring Physician _____

Primary Care Physician _____

Patient Information

Today's date: _____

Your name: _____ Date of Birth: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

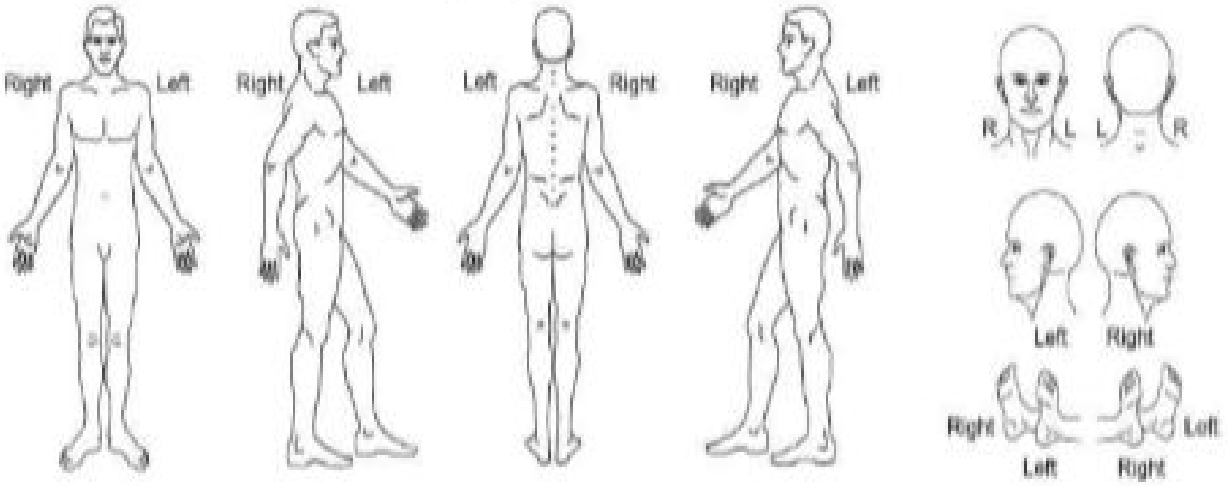
Pain History

Chief Complaint (Reason for your visit today)? _____

Does this pain radiate? If so where? _____

Please list any additional areas of pain: _____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



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? ☐ Improved ☐ Worsened ☐ Stayed the same

Pain Description

Describe the character of your pain (eg: dull, stabbing, throbbing, etc):

_____

What time of day is your pain at its worst? _____

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present ☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now_____ The Best It Gets_____ The Worst It Gets_____

What other factors worsen or affect your pain?

_____

What other factors relieve your pain?

_____

Are there any associated symptoms? (eg: numbness/tingling/weakness/incontinence, etc)

_____

What are the goals you wish to achieve with Pain Management? _____

_____

Diagnostic Tests and Imaging

Mark all of the following tests that you have had related to your current pain complaints:

☐MRI of the: _____ Date: _____

☐X-Ray of the: _____ Date: _____

☐CT Scan of the: _____ Date: _____

☐EMG/NCV study of the: _____ Date: _____

☐Other Diagnostic Testing: _____ Date: _____

☐ I have not had ANY diagnostic tests for my current pain complaint

Please mark all of the following treatments you have had for pain relief: ☑

	No Change	Worsened Pain	Helped Pain
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
TENS Unit	☐	☐	☐

Interventional Pain Treatment History

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar

☐ Joint Injection – Joint(s) _____

☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar

☐ Nerve Blocks – Area/Nerve(s) - _____

☐ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar

☐ Spinal Cord Stimulator – Trial Only/Permanent Implant _____

☐ Trigger Point Injections – Where? _____

☐ Vertebroplasty/Kyphoplasty – Level(s) _____

☐ Other - _____

Which of these procedures listed above have helped with your pain? _____

_____

Please list the names of other Pain Physicians you have seen in the past?

_____

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist	☐ Neurosurgeon	☐ Psychiatrist/Psychologist
☐ Chiropractor	☐ Orthopedic Surgeon	☐ Rheumatologist
☐ Internist	☐ Physical Therapist	☐ Neurologist

☐ Other _____

Past Medical History

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

Cancer/Oncology
- ☐ Cancer – Type _____
- ☐ Cancer – Type_____
- ☐ Cancer – Type_____

Cardiovascular/Hematologic
- ☐ Anemia
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stoke/TIA
- ☐ Heart Valve Disorders
- ☐ Presence of stent/pacemaker/ defibrillator

Gastrointestinal
- ☐ GERD (Acid Reflux)
- ☐ Gastrointestinal Bleeding
- ☐ Stomach Ulcers
- ☐ IBS/Crohns Disease

Urological
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Dialysis

Neurological
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Balance Disorder
- ☐ Head Injury
- ☐ Headaches
- ☐ Migraines

ENT
- ☐ Glaucoma
- ☐ Vertigo
- ☐ Hearing Problems
- ☐ Nosebleeds

Respiratory
- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD

Musculoskeletal/Rheumatologic
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Chronic Joint Pains

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ ADD/ADHD
- ☐ PTSD

Endocrinology
- ☐ Diabetes – Type_____
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Other Diagnosed Conditions
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Past Surgical History

Please list any surgical procedures you have had done in the past including date:

1) _____ Date? _____
2) _____ Date? _____
3) _____ Date? _____
4) _____ Date? _____
5) _____ Date? _____

☐ I have **NEVER** had any surgical procedures performed.

Family History

Mark all appropriate diagnoses as they pertain to your parents and siblings:

☐ Arthritis ☐ Cancer ☐ Diabetes

☐ Headaches/Migraines ☐ High Blood Pressure ☐ Kidney Problems

☐ Liver Problems ☐ Osteoporosis ☐ Rheumatoid arthritis

☐ Seizures ☐ Stroke

☐ Other Medical Problems: _____

☐ I have no significant family medical history

Social History

Occupation: _____ When was the last time you worked? _____

Who is in your current household? _____

Are there any stairs in your current home? _____ If so how many? _____

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

Are you currently under worker's compensation? ☐ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

Alcohol Use:

☐ Social Use ☐ Daily use of alcohol ☐ Never ☐ History of alcoholism ☐ Current alcoholism

Tobacco Use:

☐ Current user ☐ Former user ☐ Never used

☐ Packs per day? _____ ☐ How many years? _____ ☐ Quit Date: _____

Illegal Drug Use:

☐ Denies any illegal drug use ☐ Currently uses illegal drugs ☐ Formerly used illegal drugs (not currently

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

Current Medications

Are you currently taking any blood thinners or anti-coagulants? ☐ YES ☐ No

If YES, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other _____

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

	Medication Name	Dose	Frequency
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Please list all past pain medications that you have been on at any point for your current pain complaints?

	Medication Name	Dose	Frequency
1)			
2)			
3)			
4)			
5)			

Only if any of your medications cause constipation, please answer these questions. If not, skip this section.

On average, how often do you have a bowel movement?
(Please check one)

- ☐ More than 3 times per day
- ☐ Once per day
- ☐ Less than once per week
- ☐ 2 to 3 times per day
- ☐ 2 to 3 times per week

Think back to when you started pain medicine. Did your bowel habits change? If so how?

Allergies

Do you have any drug/medication allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to

Medication Name	Allergic Reaction
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

Review of Systems

Mark the following symptoms that you currently suffer from:

Constitutional: ☐Fevers ☐Chills ☐Sweats ☐Weakness ☐Fatigue ☐Decreased Activity ☐Malaise ☐Unexplained weight gain ☐Unexplained weight loss ☐Low sex drive ☐Difficulty sleeping

Eyes: ☐Blurriness ☐Double vision ☐Visual disturbance ☐Pain

Ears/Nose/Throat/Neck: ☐Hearing problems ☐Ear pain ☐Sinus problems ☐Sore throat ☐Nosebleeds

Respiratory: ☐Shortness of breath ☐Cough ☐Sputum production ☐Wheezing

Cardiovascular: ☐Chest pain ☐Palpitations ☐Swelling in feet ☐Shortness of breath during sleep ☐Bleeding disorder ☐Blood clots ☐Fainting

Gastrointestinal: ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Heartburn ☐Abdominal pain

Genitourinary/Nephrology: ☐Painful urination ☐Blood in urine ☐Change in urine stream ☐Unusual discharge ☐Flank pain ☐Urinary incontinence

Musculoskeletal: ☐Back pain ☐Neck pain ☐Joint pain ☐Muscle pain ☐Muscle cramp ☐ Muscle spasm ☐Gait disturbances ☐Joint stiffness ☐Joint swelling ☐Trauma

Integumentary: ☐Rash ☐Itching ☐Lesions ☐Bruising

Neurological: ☐Abnormal balance ☐Confusion ☐Numbness ☐Tingling ☐Dizziness ☐Headaches ☐Loss of coordination ☐Memory loss ☐Seizures ☐Tinnitus ☐Tremors ☐Vertigo

Psychiatric: ☐Feeling anxious ☐Depressed mood ☐Suicidal thoughts ☐Hallucinations ☐Stress problems ☐Suicidal planning ☐Thoughts of harming others

FINANCIAL RESPONSIBILITY

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

PATIENT'S AUTHORIZATION

In order to submit a claim for payment for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

MEDICARE & MEDICAID

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or any related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize
such physician or organization to submit a claim to Medicare or Medicaid for payment to me.

I request that payment under the medical insurance program be made to me or New England Advanced Spine & Pain Center , LLC (Dr. Bassem O. Abraham) on any bills for services furnished by Dr. Abraham.

ALL OTHER INSURANCE

I hereby authorize Dr. Abraham to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician and authorize and direct my insurance carrier to issue payment check(s) directly to me or to the physician rendering the covered services.

I authorize Dr. Abraham to furnish complete information to my insurance carriers or its intermediaries regarding services rendered.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original**. I understand that I am financially responsible for all charges whether or not paid by said insurance.** I hereby authorize said assignee to release all information necessary to secure the payment.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR FULL PAYMENT OF MY BILL OR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER IN A TIMELY FASHION.

PATIENT/RESPONSIBLE PARTY SIGNATURE _____

DATE _____