M.D. Pain Specialists
Transformation through evidence based care

James B. Shaw, M.D.
Board Certified Pain Specialist

New Patient Comprehensive Questionnaire

Name:_____ □ M □ F Birth date:_____SS#:_____
E-mail address:_____
Is English your first language? □Yes□No If no, what language?_____
Primary Care Physician:_____ Phone:_____
Referred by: _____ Phone:_____

Other physicians or health care providers that you have seen or are currently seeing, including chiropractors, therapists, etc.
Name:_____ Specialty: _____
Address:_____ Phone:_____
Name:_____ Specialty: _____
Address:_____ Phone:_____

EMPLOYMENT INFORMATION
Current Employer:_____ Phone: _____
Address:_____ Date of Hire:_____
Occupation & Job Title: _____
Current Work Status: □working□full-time □part-time □regular work □modified work □not working
Hours worked per week:_____ Hours worked per day:_____
Describe your job duties: _____
I am : □ right handed □ left handed □ambidextrous

WORK INJURIES
Is your pain related to a work injury: □Yes□ No Date of Injury:_____
Job title at time of injury:_____
Have you filed a Worker's Compensation claim with this employer for this injury? □Yes □No
If yes, please list separately all work injuries and body parts injured:_____
List any other jobs or income source at the time of your injury:_____
Are you currently in litigation (lawsuit)? □Yes □No

EMERGENCY CONTACT
Name:_____Relation:_____Phone:_____

I authorize the release of any medical information necessary to process this claim to the insurance company, attorney,or other physicians. I understand that I am responsible for all charges incurred. I further authorize my insurance to make direct payment to Dr. James B. Shaw, MD, PC for all medical benefits.

PAYMENT OF FEES IS YOUR RESPONSIBILITY AND IS EXPECTED AT THE TIME OF SERVICE

Private Insurance Patients: Many insurance companies are now requiring prior authorization before procedures and/or second opinions for surgery. Please know if your insurance requires this. In the event you need surgery or hospitalization, you will need to let us know if this is required.

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION

My signature below authorizes the doctor to release all or part of my medical records to hospitals, other doctors, medical service companies, insurance companies, worker's compensation carrier or welfare agencies. I hereby authorize my insurance company/fund to pay benefits directly to James B Shaw, MD, PC, Dr. James B. Shaw, M.D. Pain Specialists, and/or associates. I understand that I am financially responsible for any amounts not covered by the insurance.

DISCLOSURE: All patients will be charged a $15 REBILLING FEE for balances over 90 days

_____ _____

Patient Signature Date

Pain History:

Describe the purpose of your visit:

_____

_____

Describe any other problems or symptoms that accompany your pain:

_____

_____

_____

How your pain first started: □Suddenly □Gradually □Lifting □Fall
□Twisting □Bending □Pulling □Injured at work □Sports
□ Accident □No apparent cause □other:_____

Please explain:

_____

_____

Describe specifically how your injury(ies) occurred:

_____

_____

Where is your pain located?_____

What makes your pain worse?

_____

What makes your pain less?

_____

_____

If zero (0) is no pain and ten (10) is the worst pain imaginable, how would you rate your pain?

_____

During the day, how much time do you spend laying down or resting?

_____

Is your pain: □ Constant or □Intermittent
How many times in the past 12 months have you been to the ER for treatment for your pain?

_____

_____

Past Pain Treatments
(nerve block, TENS, physical therapy, medicine, acupuncture, counseling, biofeedback, surgery, Epidural or Trigger Point Injections)

TREATMENT	DID IT HELP?
	□ Yes □No
	□ Yes □No
	□ Yes □No
	□ Yes □No
	□ Yes □No
	□ Yes □No
	□ Yes □No

Tests you've had for your pain problem

TEST NAME	□ Yes □No	DATE PERFORMED
X-Rays	□ Yes □No	
CAT Scan	□ Yes □No	
MRI	□ Yes □No	
EMG/Nerve Conduction Study	□ Yes □No	
Myelogram	□ Yes □No	
Bone Scan	□ Yes □No	
Discogram	□ Yes □No	
Other	□ Yes □No	

What can you do now?

Walk 1 block	□ Yes □No	Housework	□ Yes □No
Climb stairs	□ Yes □No	Work at home	□ Yes □No
Drive	□ Yes □No	Other:	□ Yes □No
Other:	□ Yes □No	Other:	□ Yes □No

Do you have trouble with:

Bowels	□ Yes □No	Sleep	□ Yes □No	Physical Activity	□ Yes □No
Relationships	□ Yes □No	Mood	□ Yes □No	Enjoyment of Life	□ Yes □No
Concentration/Thinking	□ Yes □No	Appetite	□ Yes □No	Sexual Relationships	□ Yes □No
Energy Level	□ Yes □No	Other			

Describe your average day:

_____

_____

_____

Review of Systems & Family History

	You	Family		You	Family		You	Family
Diabetes			High Blood Pressure			Heart/Lung		
Alcohol or Drug Problem			Neurological Problems			Neck or Back Problems		
Cancer			Stomach Problems			Bowel Problems		
Stroke			Psychological Problems			Nervousness		
Gout			Hereditary Disease			Hearing Loss		
Anemia			Past Work Injuries			Sport Injuries		
Skin Problems			Depression/Anxiety			Broken Bones		
Thyroid Disease			Suicide Attempts			Auto Accidents		
Migraines			Bleeding Disorder			Epilepsy		
Mental Disorder			Kidney/Bladder			Disability		
Arthritis			Sever Injuries			Seizures		

Have you had any weight changes in the past year? □Yes □No
Please explain:

_____
_____
_____

Personal & Social History

Marital History
□Single
□Married How many times?_____
When?_____
□Widowed When?_____
□Divorced When?_____
□Separated When?_____

With whom do you live:_____
Children & their ages:_____
Last grade completed in school:_____College:_____
What type of student were you?_____
If you did not complete high school, please explain why:

_____
Were you ever thought to have a learning disability? □Yes □No
Did you ever see a school psychologist? □Yes □No
How would you characterized your childhood?_____
Have you ever served in the military? □Yes □No
Have you ever been convicted of a felony? □Yes □No

Family & Social History

Do you use?		Please explain
Tobacco	□ Yes □No	
Alcohol	□ Yes □No	
Coffee	□ Yes □No	
Recreation Drugs	□ Yes □No	

Have you ever used alcohol or drugs excessively in the past? □ Yes □No
if yes, please explain:

_____

Does anyone in your house use drugs? □ Yes □No
Are you currently (or have you ever) participated in a drug or alcohol rehabilitation program ? □ Yes □NoIf yes, please explain:

_____

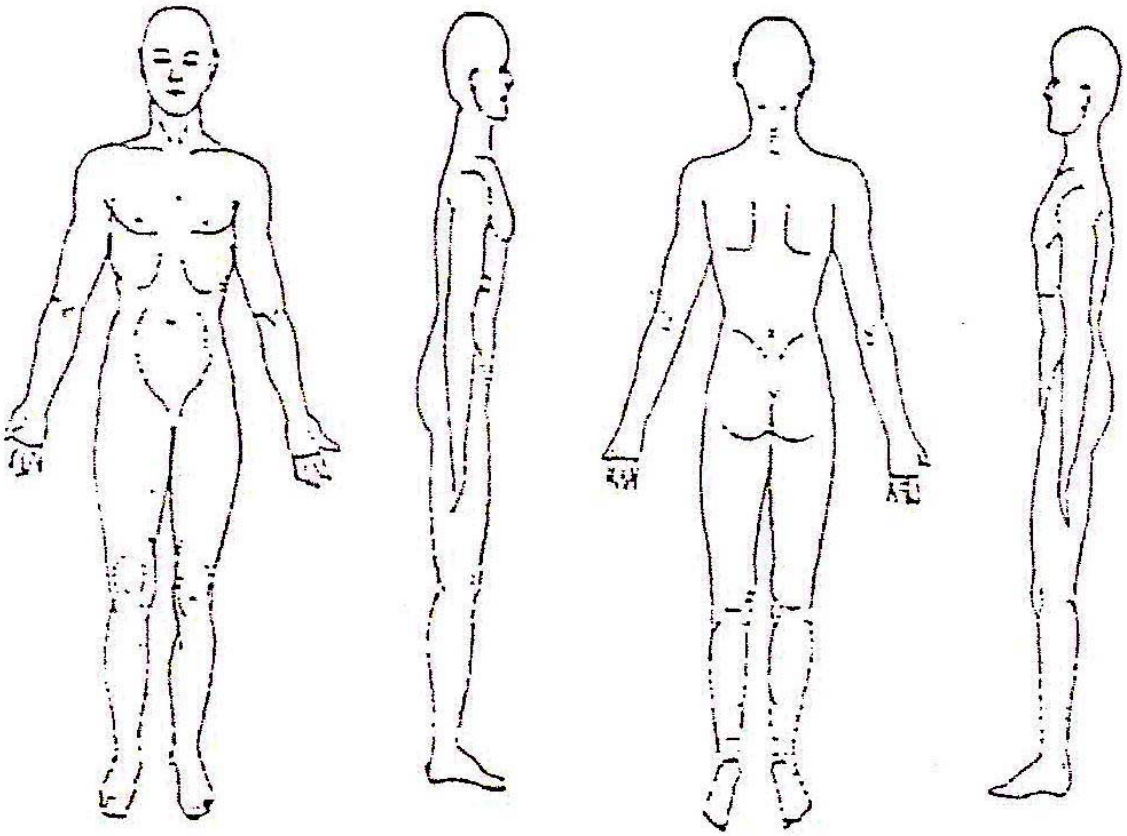
Where is your pain?

● **= severe**

✖ **= moderate**

○ **= mild**

Use arrowsto show where pain radiates or travel to.



Please add any other important information that you think would help us understand your situation:

_____

_____

_____

Has anyone else assisted you with completing this form? □ Yes □No

If yes, who? _____

PHARMACY INFORMATION

Pharmacy Name:

_____

Phone:_____Fax:_____

Address:

_____

City, State Zip:

_____

Medicine that you take NOW, including non-prescription or vitamins:

Name of Medication	Date Started	Doctor giving prescription	Strength per pill	# per day	Does it help?
					□ Yes □No
					□ Yes □No
					□ Yes □No
					□ Yes □No
					□ Yes □No
					□ Yes □No
					□ Yes □No
					□ Yes □No
					□ Yes □No

Are there any side effects?

_____

_____

Allergies: (Please include medicine,food and dye allergies)

_____

_____

_____

_____