PAIN & WELLNESS INSTITUTE, P.A.
YAMILET NENINGER MD
THIS FORM MUST BE COMPLETED PRIOR TO THE APPOINTMENT DATE

PATIENT INFORMATION

Date of First Visit _____

Patient Name_____

Address_____

_____

Phone #:

Home (_____)_____

Work (_____)_____

Cell (_____)_____

Sex: ☐ M ☐ F D.O.B_____ Age_____

Height: _____ Weight: _____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

E-Mail address_____

Patient SS #_____

Patient License ID #_____

Occupation_____

Employer _____

Employer Address_____

_____

Pharmacy _____

Address_____

_____

Phone (_____)_____

Referring Physician_____

Primary Care Physician_____

IN CASE OF EMERGENCY, CONTACT TO:

Name _____

Relationship_____

Phone (_____)_____

INSURANCE

Ins. Co. _____

Subscriber Name_____

Relationship to patient _____

D.O.B_____ SS# _____

ID# _____Group # _____

Is patient covered by additional insurance ☐ **Yes** ☐ **No**

Ins. Co. _____

Subscriber Name_____

D.O.B _____ SS# _____

Ins. Co. _____

ID# _____Group # _____

Is this a work related injury ☐ **Yes** ☐ **No**

Date of Accident _____

Case Manager _____

Address_____

_____

Phone _____ Ext _____

Claim Number _____

Is this injury related to a car accident ☐ **Yes** ☐ **No**

Date of Accident _____

Case Manager _____

Address_____

_____

Phone _____ Ext _____

Claim Number _____

Do you have legal representation ☐ **Yes** ☐ **No**

Name_____

Phone_____

NEW PATIENT HISTORY / ASSESSMENT FORM

Name: _____ Date of Birth: _____

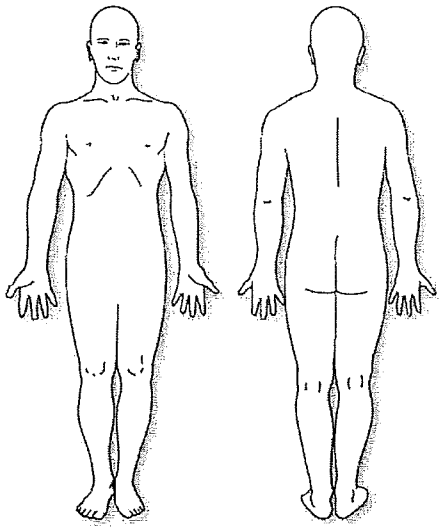
PRESENT ILLNESS

When did your pain start? _____

Under what circumstances did your pain begin? _____

Where is the location of your pain? _____

Please shade the painful areas on the diagram below



NUMERIC PAIN SCALE

Please circle the number that best describes the amount of pain you feel right now.

No pain 0 1 2 3 4 5 6 7 8 9 10 *Worst pain imaginable*

What is the highest number that your pain goes to? _____
What is the lowest number that your pain goes to? _____

Check the words that describe your pain:

___ Aching ___ Tender
___ Throbbing ___ Burning
___ Shooting ___ Sharp
___ Numb ___ Radiating

What makes your pain worse? **(Describe)** _____
What relieves your pain? **(Describe)** _____
Have you ever been treated at another pain management center or program? **YES / NO**. Procedure Before: **Yes/ NO Which?** _____
_____ Where? _____ And when? _____
Does your pain interfere with your sleep? **Yes/No** Explain: _____
How many work days did you miss in the last month due to pain? _____

MEDICATIONS

LIST ALL MEDICATIONS THAT YOU ARE TAKING NOW. (INCLUDING OVER THE COUNTER, HERBAL, AND VITAMIN)

NAME OF MEDICATION	DOSE (MG OR # OF PILLS)	HOW OFTEN? (# TIMES PER DAY)	WHAT IS THIS MEDICATION FOR?	DATE STARTED	PRESCRIBING DOCTOR

Do you take any blood thinning medication? _____ Which? _____

List all other pain medications that you have tried in the past and why you stopped: _____

_____

ALLERGIES

Please list any known drug, food or environmental allergies and indicate what the adverse effect/reaction is: _____

_____

MEDICAL HISTORY
PLEASE CHECK ALL THAT APPLY

____ Heart Disease
____ Hypertension, Date: ____
____ Migraine
____ Open wound
____ Poor blood clotting
____ Lung disease
____ Kidney Problems

____ Thyroid Disease
____ Current Infection
____ Bleeding Disorder
____ Diabetes , Date:_____
____ Liver Disease
____ Depression/Anxiety
___ Previous Psychiatric care

____Seizures
____ Stroke
____ GERD/Ulcer
____ Shingles
____ HIV/AIDS
____ Hepatitis Type__
____ Other
____ Falls in last year.
How many: _____

Cancer
Site _____
Diagnosis Date_____
Chemotherapy_____
Radiation_____
Other _____

SURGICAL HISTORY
PLEASE LIST ALL SURGERIES

DATE	SURGERY	DOCTOR

SOCIAL HISTORY:

Marital Status: __ Married __Divorced __ Single
Do your currently work? __ Yes __ No What is/was occupation? _____
Smoker __ Yes __ No If you quit when? _____
How many cigarettes did you/do smoke per day? _____ Number of years _____
Alcohol Use? __ Yes ___ No If yes how many? _____
History of street drug use? __ Yes __ No If yes, what type? _____
Do you have a history of alcoholism? __ Yes __ No
Have you received treatment for alcohol or substance (Legal/illegal) abuse? __ Yes __ No
Family history of drug or alcohol abuse? ___ Yes __ No
Is there a possibility that you are pregnant? __ Yes __ No

FAMILY MEDICAL HISTORY

		Living: Y / N	Any Disease/Conditions Past or Present	If Deceased, Cause of death
Father		_____	_____	_____
Mother		_____	_____	_____
Sibling(s)	(Sisters):	_____	_____	_____

(Brothers):_____ _____ _____

Children(s) (Daughters): _____ _____ _____

(Sons): _____ _____ _____

MISCELLANEOUS

ARE YOU, OR HAVE YOU EVER BEEN, INVOLVED WITH ANY OF THE FOLLOWING?

Disability:

____Not receiving or seeking disability
____Not receiving but seeking or planning to seek disability
____Receiving disability
____Past litigation/lawsuit or legal

Litigation/lawsuit(s):

_____No (and not intending) pain related lawsuit
_____Currently in pain related litigation/lawsuit or pain related legal involvements
_____Involvements related to pain condition

Motor Vehicle Accidents:

_____ Pain not related to motor vehicle accident
_____ Pain related to motor vehicle accident and settlement pending
_____ Pain related to motor vehicle accident but No settlement pending or necessary.

REVIEW OF SYSTEMS

PLEASE CIRCLE ANY OF THE LISTED SYMPTOMS THAT ARE CURRENT PROBLEMS FOR YOU

Constitutional:	fever/chills	Visual change	weight loss or gain	hearing	
Cardiovascular:	palpitations	leg swelling	heart attack	chest pain	high blood pressure
Respiratory:	shortness of breath	asthma	chronic coughs	Sputum production	wheezing
Gastrointestinal:	Heartburn.	nausea	constipation	rectal bleeding	diarrhea
Genitourinary:	change in bowel control	change in bladder control	Blood in urine		
Musculoskeletal:	joint pain or stiffness	swelling in joints	back or neck problems	Redness in joints	
	Arthritis/ joint disease	frequent muscles spasm			
Neurological:	weakness	fainting	numbness	headaches	dizziness	seizures
Psychological:	depression	anxiety	stress		
Endocrine:	frequent urination	change in appetite	heat/cold tolerance	sweating	
Hematologic:	bleeding or bruising				

Preventive Care

PLEASE CIRCLE IF APLICABLE.

Breast Cancer Screening (Mammogram): Yes/No Date: _____ Where: _____ Result: Positive/Negative
Colorectal Cancer Screening: Yes/No Test: Occult Blood stool/Colonoscopy/Sigmoidoscopy. Date: _____ Result: Positive/Negative
Pneumonia vaccine: Yes/No/Refuse Date: _____ Where: _____
Influenza Vaccine: Yes/No/Refuse Date: _____ Where: _____

If the patient is unable to sign, complete the following: ☐ **MINOR** ☐ **UNABLE**

PATIENT SIGNATURE _____ **DATE** _____

(OR PARTY RESPONSIBLE SIGNATURE)

PRESCRIPTION RENEWAL POLICY

Prescriptions and refills will only be processed or issued during regular office hours. Some prescriptions/refills can be authorized without the Doctor seeing the patient; other prescriptions/refills will not be renewed without an office visit due to the necessity for the doctor to examine the state of the patient.

Our daily office hours for prescriptions renewal or refills are from **8.30 A.M. to 5.00 P.M.** Please have your pharmacy call our offices not later than **5.00 P.M.** In the same way you or your pharmacy MUST call our offices **72 HOURS** prior the authorization of any prescriptions or refills.

During the evening, **after 5.00 P.M.**, or during weekends, no prescription or refill will be authorized. **NO EXCEPTION.**

PLEASE REMEMBER:

1. Prescriptions or refills would not be authorized on evenings, after 5.00 p.m, or on weekends.
2. Please call our offices at least 72 hrs before any prescription could be authorize.
3. Patient must be seen by the Doctor at least every two months to ensure prescriptions authorizations.

IMPORTANT NOTE:

WE ARE NOT RESPONSIBLE FOR ANY PRESCRIBE NARCOTICS WHICH HAVE BEEN MISPLACED OR STOLEN.

PRESCRIBE NARCOTICS WILL NOT BE REFILLED UNTIL THE RENEWAL DATE. **NO EXCEPTION.**

If the patient is unable to sign, complete the following: ☐ **MINOR** ☐ **UNABLE**
I UNDERSTAND AND ACCEPT ON BEHALF OF THE PATIENT ALL THE ABOVE.

PATIENT SIGNATURE _____ **DATE** _____
(OR PARTY RESPONSIBLE SIGNATURE)

RELATIONSHIP _____

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	o	o	o	o	o
2. How often have you felt a need for higher doses of medication to treat your pain?	o	o	o	o	o
3. How often have you felt impatient with your doctors?	o	o	o	o	o
4. How often have you felt that things are just too overwhelming that you can't handle them?	o	o	o	o	o
5. How often is there tension in the home?	o	o	o	o	o
6. How often have you counted pain pills to see how many are remaining?	o	o	o	o	o
7. How often have you been concerned that people will judge you for taking pain medication?	o	o	o	o	o
8. How often do you feel bored?	o	o	o	o	o
9. How often have you taken more pain medication than you were supposed to?	o	o	o	o	o
10. How often have you worried about being left alone?	o	o	o	o	o
11. How often have you felt a craving for medication?	o	o	o	o	o
12. How often have others expressed concern over your use of medication?	o	o	o	o	o

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	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.

The SOAPP®-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

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Improving Pain Treatment Through Education