



Welcome to Shawnee Mission Center for Pain Medicine!

In order to provide the highest quality of care, we would like you to complete the enclosed questionnaire before your next visit. It will provide specific information that will help us determine the best course of treatment for you. Please answer each question yourself and bring this assessment with you to your appointment.

We value your privacy, so the information you provide is strictly confidential and will be used only by Shawnee Mission Center For Pain Medicine. We will not release your personal health information to anyone without your specific written permission. If you have any questions about the Assessment Form please call 913.676.2370.

Please make sure to read the “Insurance Information” also because it contains very important information regarding your coverage. We are considered an “outpatient” facility and this may affect the way your visit is reimbursed by your insurance company.

Please bring the following to this appointment:

- A list of your current medications
- A driver to take you home
- A completed History & Physical form

We are located in the Woodland Hills building. 7315 East Frontage Road, Suite 140, Shawnee Mission, KS 66204. Please do not hesitate to call if you have any concerns.

If you will be visiting us at our Prairie Star location, our address is 23351 Prairie Star Parkway, Building A, Suite A145, Lenexa, KS 66227.

Thank you again, and we look forward to meeting you at your appointment.



**IMPORTANT INSURANCE INFORMATION
PLEASE READ**

Scott Ashcraft, MD

Jonathan Ferns, MD

Timothy Lair, MD

Brian Mills, MD

Daniel Mitchell, MD

Don Richter, MD

Gregory Trempy, MD

Daphne Fry, MSN, ARNP

Melanie Yunger, MSN, ARNP

Jamie Boatman, MSN, ARNP

Stacy Forrestt, PA-C

Ravindran Sabapathy, PsyD

Interventional Pain Management

Behavioral Pain Management

Pain Evaluation Services for:

Back and Neck Pain

Disc Disorders

Compression Fractures

Radiculopathy

Sympathetic Dystrophy

Myofascial Pain

Neurogenic Pain

Cancer Pain

Dear Patient:

We are pleased that you have chosen the Center for Pain Medicine at Shawnee Mission Medical Center for your needs. The following is important information you need to know about your visit with us. As part of your visit today, you may be charged for an evaluation visit and/or a procedure. There will be an **“outpatient facility”** charge generated on behalf of Shawnee Mission Medical Center, and in addition, the physician will charge you separately. **Midwest Anesthesia Associates, PA** will send the physician’s bill. Please note that your insurance may charge you a co-pay/coinsurance for each service individually.

All procedures, including all injections, are considered **“outpatient surgery”** by your insurance company. ***Any co-pay/coinsurance/deductible for these services will be due at the time of service.*** Please call your insurance company to verify your plan’s benefits for these services. We will contact your insurance company for any necessary authorizations.

If you have questions before your visit, please contact us at 913-676-2370 opt. 5. If you have questions about your bill, please contact customer service at Shawnee Mission Medical Center at 913-676-2238.

Thank you,
Patient Financial Services
Shawnee Mission Medical Center

Patient Signature _____ **Date** _____

Clinic: 913-676-2370
Physician Billing Office: 913-642-4900
Fax: 913-676-7692

7315 East Frontage Road, Suite 140
Shawnee Mission, KS 66204
A Seventh-day Adventist Community Service
ShawneeMission.org
CenterforPainMedicine.com

(Please fill out this form and bring it with you to your appointment.)

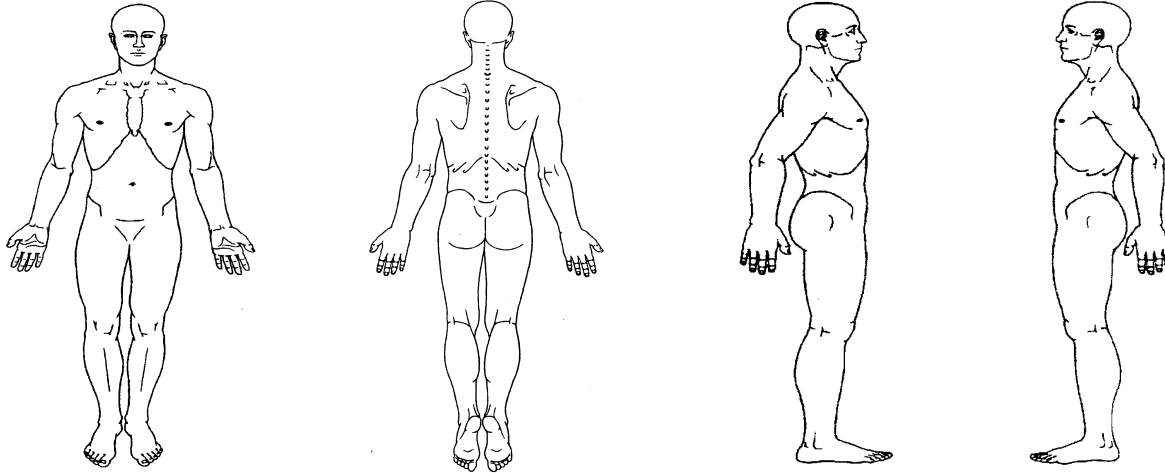
Name _____ Date _____ Date of Birth _____

Age _____ Sex: M ___ F ___ Height: _____ft. _____in. Weight _____ lbs

Primary Physician _____ -- _____ Referring Physician (If Different) _____

CURRENT PROBLEM

Please draw where your primary pain is located using the diagrams below:



When did the pain begin? _____

Did it begin gradually or suddenly? _____ If suddenly, is it the result of an injury? ___ Yes ___ No

If result of an injury, describe the injury _____

If not a result of injury, what do you think caused your pain? _____

Since your pain started is it (circle one) **Worse** **Unchanged** **Intermittent** **Better** **NA**

Please describe your pain in as much detail as possible _____

Do you have any other symptoms such as numbness, weakness, or pins and needles sensation? Please describe.

CURRENT PROBLEM CONTINUED...

What makes your pain worse? Standing _____ Sitting _____ Walking _____ Lying Down _____

Other _____

What have you found that makes your pain better? _____

Does your pain affect your sleeping? Yes ___ No ___ If so, how? _____

Do you have difficulty controlling your bowels? Yes ___ No ___ Difficulty controlling your bladder Yes ___ No ___

Please mark your average (A) and maximum (M) pain level on the line below.

0 1 2 3 4 5 6 7 8 9 10
No Pain _____ Worst Pain Imaginable

Was the injury work-related? Yes ___ No ___ Are you involved in a lawsuit? Yes ___ No ___

Does the pain interfere with your ability to work? Yes ___ No ___

If so, how? _____

Does the pain interfere with your daily activities? Yes ___ No ___

If so, how? _____

Do you need assistance with walking? Yes ___ No ___ Assistive Device? _____

If yes, is this assistive device preventing falls?

Have you had any recent falls? ___ Yes ___ No

SUBJECTIVE ASSESSMENT OF THE HOME ACTIVITY LEVEL

Please indicate which activities of daily living cause the greatest difficulty

PERSONAL	HOUSEHOLD CHORES	GENERAL MOBILITY
Dressing upper body _____	Meal preparation _____	Sitting _____
Dressing lower body _____	Shopping _____	Bending _____
Bathing _____	Home Repairs _____	Getting in/out of bed _____
Hair Care _____	House cleaning _____	Standing _____
Sleeping _____	Shoveling snow _____	Walking _____
Yard work/gardening _____	Twisting _____	Lifting _____
Child Care _____	Up and down stairs _____	Getting in/out of car _____

HISTORY OF TREATMENTS

Please indicate whether or not you have had any of these tests for your present problem:

	YES	NO	WHEN	WHERE
REGULAR X-RAYS				
CT SCAN				
MYLEOGRAM				
MRI				
BONE SCAN				
BLOOD TESTS				
EMG (nerve test)				
DISCOGRAM				

Please indicate the following treatments you have tried in the past.

TREATMENTS	DATE	BETTER		OUTCOME	NA
		yes	no		
Exercise					
Physical Therapy					
Occupational Therapy					
Chiropractic					
Counseling					
Biofeedback					
Injections/Nerve Block					
TENS Unit					
Medications					

HISTORY OF PAST PROVIDERS

Please list the names of all physicians, chiropractors, psychiatrist, psychologist, osteopaths, or other pain facilities whom you have seen for your present problem. List them in the order in which you saw them from first to last.

NAME OF PHYSICIAN	SPECIALTY	DATE FIRST SEEN	DATE LAST SEEN

PAST MEDICAL HISTORY

Do you have or have you had any of the following conditions? (Please Check All That Apply)

ENDOCRINE

- Diabetes
 Hypo/Hyperthyroid

HEMATOLOGY

- Bleeding disorder
 Anemia

RHEUMATOLOGY

- Arthritis, Type _____
 Fibromyalgia

CARDIAC

- Heart Attack
 Congestive Heart failure
 Coronary Artery Disease
 Valvular heart Disease
 High Blood Pressure

GENITOURINARY

- Incontinence
 Bladder control problems
 Kidney disease
 Kidney infections

GASTROINTESTINAL

- Ulcers
 Gallstones
 Liver Disease
 Hepatitis
 Pancreatitis
 GERD/reflux disease

OTHER

- Cancer, Type _____

RESPIRATORY

- Asthma
 Bronchitis
 Emphysema/COPD

NEUROLOGICAL

- Stroke/TIA
 Migraines

PSYCHIATRIC

- Bipolar disease
 Depression
 History of Drug/Alcohol problems
 Other mental illness _____
 Anxiety

Please provide any additional about the above conditions below, or list other conditions not covered on the above list:

PAST SURGICAL HISTORY

Please list any surgeries you have had including procedure and date:

Surgery	Year	Facility/Physician

CURRENT MEDICATIONS

ARE YOU TAKING ANY BLOOD-THINNING MEDICATIONS? (e.g. ASPIRIN, COUMADIN, HEPARIN, TICLID, PLAVIX (CLOPEDIGREL) PLETAL, LOVENOX, ARISTA, JANTOVEN, WARFARIN, OTHER _____ YES _____ NO _____

Please list any medications you are currently taking. Include vitamins, over-the-counter medications, herbal preparations, laxatives, or inhalers.

Medication & Dose	How often	Medication & Dose	How often
1)		10)	
2)		11)	
3)		12)	
4)		13)	
5)		14)	
6)		15)	
7)		16)	
8)		17)	
9)		18)	

DRUG ALLERGIES

DO YOU HAVE ANY ALLERGIES? YES NO If yes, please list the medication and the reaction:

This includes: medications, food, latex, iodine, environmental agents or irritants

REVIEW OF SYSTEMS

Do you have any of the following symptoms? Please circle all that apply.

- **GENERAL**: Weight loss, rashes, itching, color changes, headaches, dizziness, fever or chills, night sweats
- **EYES**: Blurred vision, light sensitivity, deficits in your vision, changes in your vision.
- **EAR,NOSE,THROAT**: Sinus problems, trouble swallowing, ringing in your ears, dental problems.
- **CARDIAC**: Chest pain, palpitations, poor circulations, swelling in extremities, poor exercise tolerance
- **REPIRATORY**: Shortness of breath, difficulty breathing, wheezing, coughing, sputum production.
- **URINARY**: Painful urination, difficulty urinating, bladder control problems, frequent urinary infections.
- **GASTROINTESTINAL**: Heartburn, nausea, vomiting, diarrhea, bloody stools, constipation.
- **MUSCULOSKELETAL**: Achy swollen joints, stiff joints, muscle spasms, sore/ tender muscles.
- **SKIN**: Rashes, skin irritations, skin ulcers.
- **NEUROLOGICAL**: Poor memory, headaches, poor balance, loss of consciousness, fainting, muscle weakness, numbness, or changes in sensation.
- **PSYCHOLOGICAL**: Anxiety, depression, increased emotional stress, hallucinations, paranoia, suicidal ideations (thoughts of harming yourself difficultly with concentration.
- **ENDOCRINE**: Always thirsty, always hot, always cold, hair and nail changes.
- **HEMATOLOGY**: Easy bruising, cuts take a long time to stop bleeding, painful lymph nodes, frequent leg swelling, fatigue.
- **ALLERGIC/IMMUNE**: are you prone to infections, sensitive to many foods, medicines

FAMILY HISTORY

Please list any significant medical problems for any blood relatives(parents, grandparents, brothers or sisters) also list any medical problems that tends to run in your family.

SOCIAL HISTORY

Marital Status: Single___ Married___ Divorced___ Widowed___

Indicate current household members: Self___ Spouse___ Children___ Other___

What kind of support do you have to help you cope with this problem? (e.g. family, friends, church, etc.)

EXERCISE: Type of exercise: _____

Days/Week: _____

TOBACCO USE: Do you currently use tobacco products? ___ Yes ___ NO

IF YES, how many packs a day? _____ How many years? _____

IF FORMER SMOKER, when did you quit? _____ before you quit, how many packs a day ___ and how many years _____

Do you drink caffeinated beverages? YES NO If yes, how many cups/cans per day? _____

Do you drink alcoholic beverages? YES NO If yes, how many beverages per week? _____

Have you ever had, or do you have a substance abuse problem? Yes ___ No ___

Are you currently employed? ___ Yes ___ No. If yes please complete the following questions:

Your current employer _____

Your current occupation _____

Your usual duties include: _____

Are you involved with Workman's compensation? ___ Yes ___ No

If so, what is the name and phone number of your case worker? _____

OTHER

Is there any chance you could be pregnant? YES NO If yes, when is your due date?

Primary Language: English Spanish Other _____ Do you need an interpreter? YES NO

Are you hard of hearing? YES NO Do you need glasses to read? YES NO

Would you like to have a consult with a dietician to discuss any dietary concerns? YES NO

Are there any religious or cultural factors which may impact your care while in the clinic? YES NO

If yes, please explain _____

Do you, or anyone you know, need information regarding problems of abuse and/or neglect? Yes ___ No ___

What are your realistic goals for treatment of your pain? (check all that apply)

To be pain free ___ Help living with pain ___ Other _____

Reduced pain ___ Increased activity _____

Thank you for your time in completing this form.

Patient signature

_____ -

Assessment reviewed with Patient by:

_____ R.N. _____ M.D.

Date _____ Time _____ Date _____ Time _____

Assessment reviewed with Patient by:

_____ R.N. _____ M.D.

Date _____ Time _____ Date _____ Time _____

Assessment reviewed with Patient by:

_____ R.N. _____ M.D.

_____ Date _____ Date

Assessment reviewed with Patient by:

_____ R.N. _____ M.D.

_____ Date _____ Date

Assessment reviewed with Patient by:

_____ R.N. _____ M.D.

Date _____ Time _____ Date _____ Time _____