Shawnee Mission Health
CENTER FOR PAIN MEDICINE

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.

Shawnee Mission Health
CENTER FOR PAIN MEDICINE

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

Shawnee Mission Health
CENTER FOR PAIN MEDICINE

Patient Assessment Form

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

Name_____ Date _____ Date of Birth _____

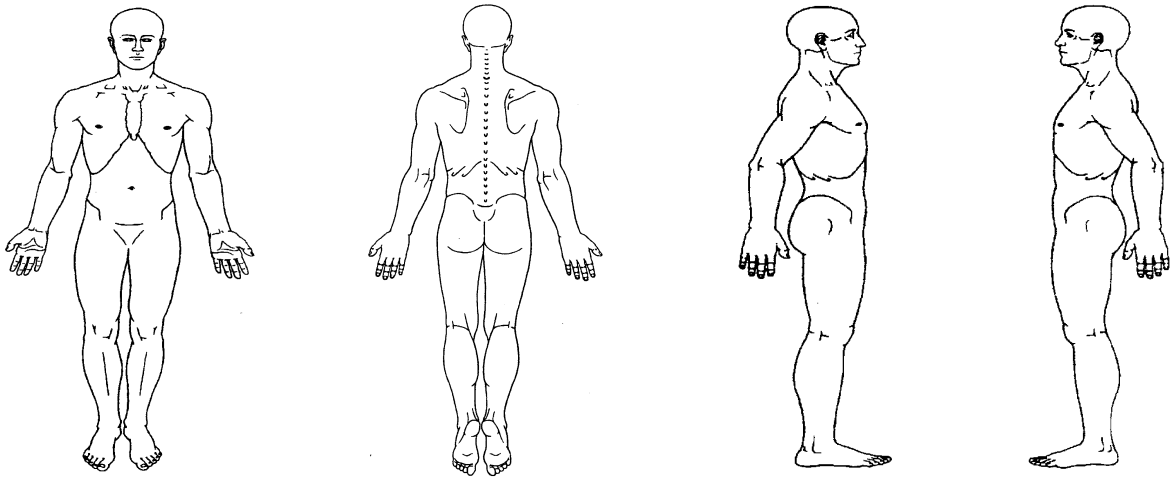
Age_____ Sex: M ____ F ____ Height: _____ft. _____ in. Weight _____ lbs

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____I_____I_____I____I____I____I____I____I____I____I____I____ 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.**
- ***MUSCULOSKELETA*L: 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

_____-

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Patient Assessment Form

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**_____