PATIENT INFORMATION

Please Print

Patient Name: _____ Date: _____
Last First M

Home Address: _____ DOB: _____

_____ _____ _____
City State Zip

SS# _____ Marital Status _____ Gender: Female ☐ Other ☐ Male ☐

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Provide

Driver's License #: _____ State: _____

Home Phone #: _____ Cell #: _____ Work# _____

Email Address: _____

Employer Name: _____ Occupation: _____

Employer Address: _____

Work Phone: _____

In Case of Emergency: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

_____

Insurance Information:

PRIMARY INSURANCE: _____

Address: _____ Phone#: _____

ID # _____ Group # _____ Insured Name: _____

Relation: _____ SS# _____

PATIENT INFORMATION

Please Print

SECONDARY INSURANCE: _____

Address: _____ Phone #_____

ID #_____ Group #_____ Insured Name: _____

Relation: _____ SS#_____

WORKERS COMPENSATION INFORMATION /AUTO INFORMATION

Insurance Carrier Name: _____ Phone: _____

Address: _____ Claim#_____

Date of Injury/Accident: _____ City /State: _____

Approved Injury: _____

Adjuster: _____ Phone: _____

Fax#: _____ Email: _____

Attorney: _____ Phone#_____

Firm Name: _____

Address: _____

***Please Note: You are responsible to provide updated information if changes are made. Failure to do so could result in your being responsible for payment. ***

I certify that the information I have reported is correct.

_____ _____

Patient Signature Date

Revised 8/2021

Delaware Valley Pain and Spine Institute

Release of Information and Financial Policy

Financial Policy:

Thank you for choosing Delaware Valley Pain and Spine Institute. We are dedicated to you, and our goal is to provide exceptional medical care. We realize the financial aspect of medicine is overwhelming, and we are committed to work with you and your insurance company to make the process as easy as possible.

Due to the increased number of patients who no-show and or cancel less than 24 hours, a $30.00 cancellation and or no-show fee will be enforced as a courtesy to those who are inconvenienced.

- You are responsible for supplying us with current, correct insurance information, adjuster information, and or attorney information at each visit.
- You are responsible to notify us of any changes in your address or phone number.
- You are ultimately responsible for payment of all charges whether or not such charges are covered and paid. (either fully or partially) by your insurance company.
- All referrals for (HMO patients) are your responsibility and must be current for each visit.
- All Co-payments, co insurance and deductibles will be expected at the time of service.
- You may not self pay, then ask us to submit to your insurance at a later time.
- Please be aware some if not all services you may receive may not be covered or considered "reasonable or necessary "by Medicare and other insurers. Payment is expected at time of service unless other arrangements are made with our billing department. You will be asked to sign an ABN (Advanced Beneficiary Notice) for coverage of these services
- If you account is over 60 days past due, you will receive a letter stating you have 20 days to pay your account in full. Partial payment will not be accepted unless otherwise negotiated.
- A $25.00 fee will be charges for all returned checks.

Our billing office is open from 8:00A to 4:00P, Monday thru Friday to assist you in answering your questions.

I hereby guarantee payment of all charges for medical treatment and services provided to me (or my dependent) by Fox Chase Pain Management Associates DBA Delaware Valley Pain and Spine Institute. I understand and agree that if the office places my account with an agency or attorney for collection, the offices shall be paid by me for all collections costs to the extent allowed by applicable law.

I authorize the release of medical information to my primary care of referring physician and to the consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician. I have read and agree to this financial policy.

Patient Signature _____ Date _____

Release of Information Please indicate with whom we can leave a message regarding appointment and test results.

Name: _____ Relationship _____ Phone # _____

Name: _____ Relationship _____ Phone # _____

Patient Signature _____ Date: _____

HIPPA POLICY: I acknowledge I have received or declined a copy of Delaware Valle Pain and Spine Institutes Notice of Privacy Policy. This is available from our receptionist and is also located in our waiting areas.

Patient Signature _____ Date _____

Revised 8-2021

OSWESTRY PAIN QUESTIONAIRE

(Please print) Name: _____ Date : _____

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1 – Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2 – Personal care (washing, dressing etc)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

Section 4 – Walking*

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than PLOH
- ☐ Pain prevents me from walking more than 1 PLOH
- ☐ Pain prevents me from walking more than \DUGV
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

OSWESTRY PAIN QUESTIONAIRE

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9 – Social life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10 – Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

Score : _____

Name:_____ Date of Birth:_____

Email:_____ Best Phone Number:_____

Height:_____ Weight_____ Age:_____

Referring Physician: _____ Ph: _____

Primary Care Physicians:_____ Ph: _____

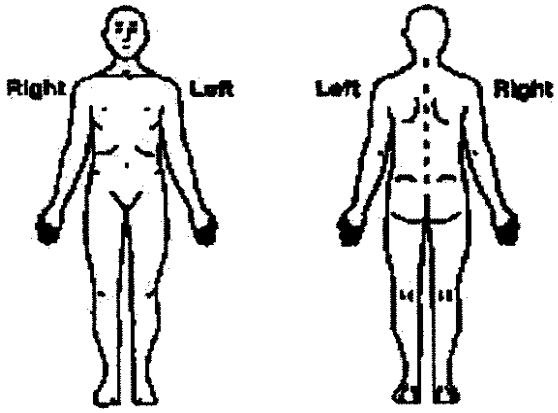
Who referred you to the practice:_____

Pain History

What is your primary complaint? _____

How long have you had your current pain symptoms? _____ weeks _____months _____years

Please shade areas where you are hurting:



Pain Symptom/Quality:

How would you describe your pain?

(Please check all that apply)

☐Burning	☐Sharp	☐Cutting
☐Throbbing	☐Cramping	☐Dull/Aching
☐Shooting	☐Pressure	☐Constant
☐Occasionally	☐Numbness	☐Tingling

Circle the Average Pain Intensity:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (mauled by bear)

What is the **lowest** pain score this week? _____

What is the **highest** pain score this week?_____

What makes the pain **better**?_____

What makes the pain **worse**?_____

Numbness: Yes / No Where: _____

Weakness: Yes / No Where: _____

History of Prior Treatments:

☐ OTC Medications (Tylenol Advil)

☐ Prescription Medications (non-opioids) - please circle medications below

Gabapentin (Neurontin) *Lyrica* *Cymbalta* *NSAIDS* *Other Antidepressants*

☐ Opioids/Narcotics

Please list previous opioids tried: _____

☐Physical Therapy ☐Chiropractic Therapy ☐Acupuncture ☐TENS unit
☐Topical Cream ☐Home Exercise Program ☐Back/Neck/Other Brace ☐Massage
☐Other: _____

Past Medical History:

Have you had any of the following health problems (Please check all that apply)?

☐ Heart attack ☐Coronary Artery Disease ☐Chest Pain
☐Atrial Fibrillation ☐Heart Valve placement ☐Deep Vein Thrombosis
☐Diabetes ☐Stroke ☐Hypertension
☐Asthma or Wheezing ☐COPD (Emphysema /Bronchitis)
☐Kidney Disease ☐Liver Disease ☐Seizure or Epilepsy
☐Bleeding Problem ☐Depression ☐Anxiety
☐Thyroid Disease
☐Arthritis (specify location) _____
☐Cancer (what type) _____
☐Other conditions/diseases _____

Past Surgical History

Please list all surgeries and provide approximate dates:

_____

_____

_____

_____

Current Medications

Name	Dose	Frequency	Name	Dose	Frequency

Please list any DRUG ALLERGIES:

_____

SOCIAL HISTORY

FAMILY LIFE: Please specify living arrangements:
☐Living alone ☐Living with friends ☐Living with spouse/ partner
☐Living with spouse/ partner and children ☐Living with children ☐ Living with other

CURRENT EMPLOYMENT STATUS: Please check one:
☐Employed Full-time ☐ Employed Part-time ☐Student
☐Disability ☐Retired ☐Unemployed ☐Full time Parent/Homemaker

SUBSTANCE ABUSE
Do you currently use tobacco products? ☐Yes ☐No
Did you previous use tobacco products? ☐Yes ☐No
Do you currently or have you previously been treated for illicit drug or alcohol abuse? ☐yes ☐no

FAMILY HISTORY: Please specify any medical or psychiatric conditions common in your family and who suffers with these ailments:
Condition: _____ Specific family member(s): _____
Condition: _____ Specific family member(s): _____
Condition: _____ Specific family member(s): _____

COVID VACCINATED ☐Yes ☐No

REVIEW OF SYSTEMS: Please check all items you feel apply to you:

☐Recent gain of weight: _____ pounds over _____ weeks/months/years
☐Recent loss of weight: _____ pounds over _____ weeks/months/years
☐Fever
☐Dizziness
☐Difficulty swallowing
☐Double or blurry vision
☐Nausea
☐Diarrhea
☐Easy or excessive bruising
☐Rash
☐Genital pain
☐Hypothyroidism
☐Chest pain
☐Joint stiffness
☐Pain in extremity (specify):
☐Loss of Consciousness
☐Seizures
☐Vomiting
☐Heart burn
☐Easy or excessive bleeding
☐Diabetes
☐Difficulty urinating
☐Hyperthyroidism
☐Heart palpitations
☐Decreased Range of Motion
☐Swelling (specify):
☐Difficulty walking
☐Muscle weakness
☐Constipation
☐Adrenal Disease
☐Shortness of Breath

PHARMACY INFORMATION _____ **PHONE**_____

ADDRESS_____