Northeast Georgia PHYSICIANS GROUP

Interventional Pain Medicine

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Dear Valued Patient,

We are so grateful you have entrusted us for your healthcare needs. We look forward to serving you.

Based upon the information obtained from your referring physician, as well as Dr. Slack's assessment of you, a treatment plan will be formulated. Example treatment plans consist of site specific injections targeting the underlying cause of pain.

Please note: Opioid therapy (common Opioids include: Lortab, Percocet, Fentanyl, etc.) may or MAY **NOT** be used. Please do not expect to receive a prescription for an opioid medication at your visit. If you would like to discuss the above treatment approach prior to your visit, please contact our office.

Please arrive 20 minutes prior to your scheduled appointment. Please bring your Photo ID and Insurance Card(s) along with any imaging discs. Please complete the following paperwork prior to your appointment with Interventional Pain Medicine and bring it with you to your appointment.

If you wish to change your appointment date or time, please call our office at 770-219-6520.

Best Regards,

The Scheduling Department
neurosciences.scheduling@nghs.com

Northeast Georgia Physicians Group- Interventional Pain Medicine

DATE:_____ NAME:_____ AGE:_____

Weight:_____ Height:_____ BP:____/____ Pulse:_____ Resp:_____ O2:_____ Temp:_____

What problem are we seeing you for? _____

Have you had CT, MRI, X-Rays or EMG Study done? ☐ Yes ☐ No If so, where and when: _____

PAST MEDICAL HISTORY: Have you ever been diagnosed with any of these conditions?

☐ Migraine Headaches	☐ Low Blood Pressure	☐ Stomach Ulcers	☐ Prostate Enlargement
☐ Implanted Devices	☐ High Cholesterol	☐ Diabetes	☐ Epilepsy
☐ Stroke	☐ Thyroid Disease	☐ Low Blood Sugar	☐ Arthritis
☐ Carotid Artery Disease	☐ Asthma	☐ Liver Disease	☐ Fibromyalgia
☐ Coronary Artery Disease	☐ Emphysema	☐ Hepatitis	☐ Psychiatric Disorder
☐ Heart Attack	☐ COPD	☐ Kidney Stones	☐ Anxiety
☐ Abnormal Heart Rhythm	☐ Congestive Heart Failure	☐ Kidney Disease	☐ Claustrophobia
☐ High Blood Pressure	☐ Tuberculosis	☐ Anemia	☐

Have you ever had cancer? ☐ Yes ☐ No Where?

PAST SURGICAL HISTORY: Have you ever had any of the following surgeries?

☐ Back Surgery	☐ Cardiac Stent When:
☐ Neck Surgery	☐ Joint Replacement Which Joint(s)? _____
☐ Carotid Surgery	☐ Other Joint Related Surgeries
☐ Brain Surgery	☐ Carpal Tunnel Repair
☐ Pacemaker	☐ Spinal Cord Stimulator Trial

SOCIAL HISTORY:

Alcohol Use: ☐ Yes ☐ No How Often?

Tobacco Products: ☐ Yes ☐ No Packs per day? _____

Are you currently working? ☐ Yes ☐ No Occupation?

Disability? ☐ Yes ☐ No ☐ Pending ☐ Seeking

History of Substance Abuse: ☐ Yes ☐ No

Are you Pending Litigation? ☐ Yes ☐ No

☐ Married ☐ Divorced ☐ Widowed ☐ Single

FAMILY HISTORY: Do any of your blood relatives have or have they ever had any of these conditions?

☐ Heart Disease	☐ Kidney Disease	☐ Psychiatric History
☐ Hypertension	☐ Neurological Illness / Disorder	☐ Drug Abuse
☐ Stroke	☐ Seizure Disorder	☐ Parkinson's Disease
☐ Back Surgery	☐ Diabetes	☐ Arthritis
☐ Migraines	☐ Brain Aneurysm	☐ Trembling

Family Member(s) currently on narcotics? ☐ Yes ☐ No _____

Family History of Cancer? ☐ Yes ☐ No If Yes, What type(s)? _____

REVIEW OF SYSTEMS (Check Current or Present Symptoms):

GENERAL:

☐ Weight Loss	☐ Weight Gain	☐ Fatigue	☐ Weakness
☐ Fever	☐ Chills		

SKIN:

☐ Rashes ☐ Lesions ☐ Lumps ☐ Slow Healing Wounds

EYES:

☐ Pain ☐ Double Vision ☐ Blurry Vision ☐ Loss of Vision

EARS, NOSE & THROAT:

☐ Hearing Loss ☐ Ringing in Ears ☐ Vertigo ☐ Nose Bleed

☐ Sore Throat

RESPIRATORY:

☐ Cough ☐ Wheezing ☐ Shortness of Breath ☐ Painful Breathing

CARDIOVASCULAR:

☐ Chest Pain or Discomfort ☐ Swelling ☐ Shortness of Breath with Activity ☐ Tightness

GASTROINTESTINAL:

☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea

VASCULAR:

☐ Leg Cramping ☐ Leg Swelling ☐ Calf Pain when Walking

MUSCULOSKELETAL:

☐ Muscle or Joint Pain ☐ Muscle Weakness ☐ Stiffness

NEUROLOGIC:

☐ Weakness ☐ Numbness ☐ Tingling ☐ Tremor

☐ Memory Loss ☐ Difficulty Walking ☐ Headache ☐ Off-Balance

☐ Dizziness

PSYCHIATRIC

☐ Loss of Concentration ☐ Anxiety ☐ Irritability ☐Depression

HEMATOLOGIC: **URINARY:**

☐ Ease of Bleeding ☐ Ease of Bruising ☐ Frequency ☐ Painful Urination

☐ **All other systems reviewed and negative**

Allergies? ☐ Yes ☐ No If yes, please list allergies and reactions: _____

Please note: As NGPG Interventional Pain Medicine utilizes alternative treatment options for pain, opioid medications (example: Lortab, Percocet, Fentanyl, etc.) will not be prescribed unless deemed clinically appropriate by your provider. Your signature below represents your acknowledgement of this policy.

Patient Signature_____ Date:_____

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Pain Survey

Please Thoroughly Complete Both Sides of This Survey

Name:_____ **Date:**_____

Location: In what part of your body is your pain the worst?_____

_____

Radiation/Referral Pattern: Does your pain travel to other locations? (Please be as specific as possible.)

_____

_____

Quality: How would you describe your pain (aching, burning, etc.)? _____

_____

Severity: Rate your pain on a scale of 1-10: _____

Duration: For how long have you experienced your current pain? _____

Is the pain constant?_____

Timing: At what time of day (or night) is the pain at its worst?_____

_____

Aggravating Factors: What activities worsen the pain?_____

_____

Alleviating Factors: What makes the pain better?_____

_____

Functionality: Are you exercising, walking, stretching, etc?_____

_____

Work: Are you working full-time? Part-time?_____

Sleep: How many hours of sleep do you get per night? _____ Would you consider this quality sleep?____

_____

Mood: How is your mood (irritable, sad, happy most of the time, etc.)?_____

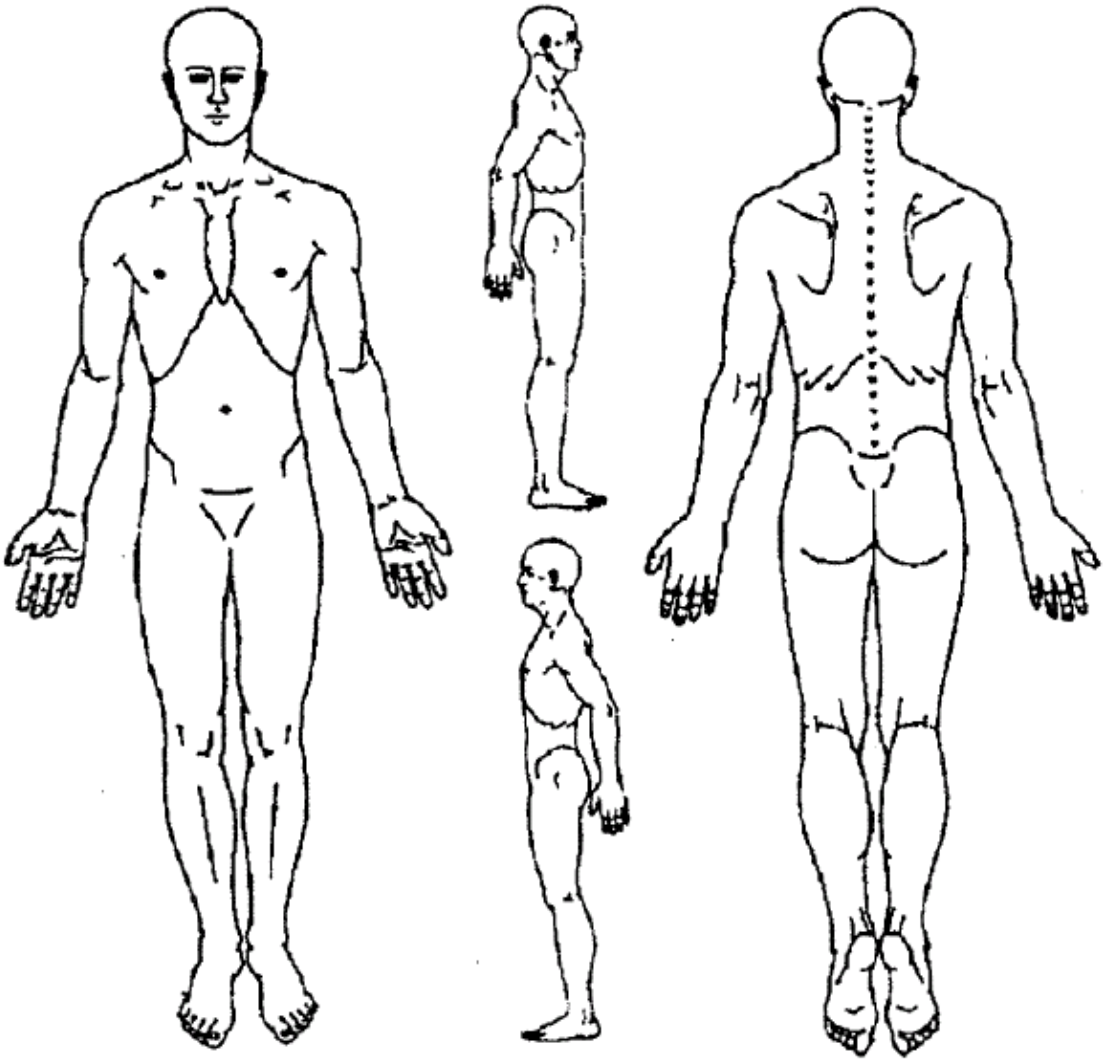
_____

Pain Diagram

Name:_____ **Date:**_____

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - - - - -	O O O O O	^^^^^	xxxxx	⊗⊗⊗⊗
- - - - - - - - -	O O O O O	^^^^^	xxxxx	⊗⊗⊗⊗



Please make a slash through the line below to indicate your current pain level.

No Pain |_____**| Worst Possible Pain**

Patient Signature:_____ **Date:**_____

MEDICATION LIST

NAME:_____ **DOB:**_____

PHARMACY:_____ **PHONE:**_____

PLEASE PROVIDE US WITH COMPLETE LIST OF MEDICATIONS BELOW, INCLUDING DOSE AND HOW MANY TIMES PER DAY YOU TAKE EACH MEDICATION.

MEDICATION	DOSE	TIMES PER DAY