NEW CONSULTATION APPOINTMENT INFORMATION

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Board Certified Pain Management
Board Certified Anesthesiology
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Steven Humansky, PA-C
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Certified Nurse Pracitioner

OHIO
Boardman/Main Office
1011 Boardman-Canfield Road
Youngstown, Ohio 44512
330.629.2888
1.888.784.4312 (toll-free)

Howland
8740 East Market St. Suite 2
Warren, Ohio 44484
330.647.6404

Date_____

Dear _____:

Your physician, Dr. _____has requested for you to be seen by one of our pain management specialists. We appreciate the opportunity to work with you and your physician to help manage your chronic pain. Enclosed is a brochure to familiarize yourself with our practice and the many treatments offered.

To better serve you and to help your visit with the specialists be as efficient as possible, we ask for the following information before your appointment:

- **Packet of Information:** Please complete all enclosed forms **before** your appointment.

Please bring the following information to your appointment.

- **Photo ID:** Without a photo I.D. your appointment will need to be rescheduled.

- **Insurance Card:** Any co-pay if applicable will be due at the time of visit. If you do not have insurance, please call our Billing Department: 330.629.2888, ext. 140

- **List of current medications or current prescription bottles:** Please include over-the-counter medications and vitamins.

  ****Please be advised that a prescription for pain medication is not guaranteed at the initial consultation****

  ****Failure to provide any of the above information may result in the rescheduling of your appointment*****

Your Appointment is Scheduled:

Date:_____Time:_____am/pm

Office Location: OHIO: Boardman
1011 Boardman Canfield Rd, Youngstown, OH 44512

Office Location: OHIO: Howland
8740 E. Market Street, Suite 2, Warren, OH 44484

We look forward to seeing you for your appointment. If for any reason, you need to reschedule, please give a minimum 48-hour notice, and call our Main Office at 330.629.2888 or toll-free: 1.888.784.4312.

Sincerely,
Doctors Pain Clinic

DOCTORS© PAIN CLINIC

INITIAL PAIN ASSESSMENT FORM

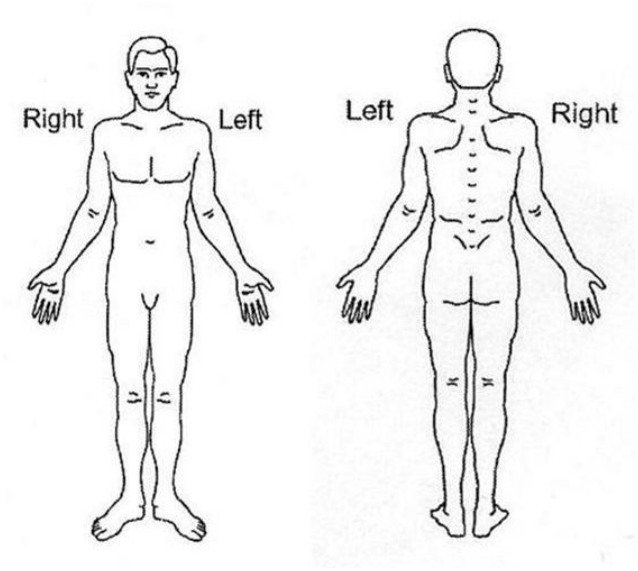
Patient Name: _____**Today's Date**: _____

Referring Physician: _____

Have you ever been seen in ANY Pain Clinic before? ____YES _____NO If YES, WHERE_____

CHIEF COMPLAINT OF PAIN: MARK on picture below where pain is (including where it radiates to):

On the pictures mark #1 on the area of your body where you have the most pain. Mark #2 on the area you have secondary pain. Do not write on back. PLEASE DO NOT CIRCLE MORE THAN 2 AREAS.



How long have you had this pain: _____

What caused this pain to begin (*be specific*): _____

_____

_____

Is your pain continuous? _____or intermittent? _____

Circle below the words that best describe your pain:

Aching Throbbing Sharp Shooting Stabbing Tender Burning Dull

Please rate the pain using the scale below at its WORST:

No pain 1 2 3 4 5 6 7 8 9 10 Severe pain

Rate the pain using the scale below at its BEST:

No pain 1 2 3 4 5 6 7 8 9 10 Severe pain

Pain scale:	0 – 1 no pain barely noticeable	2 – 3 has to stop to think about pain
	4 – 5 interferes with activities and rest	6 - 7 distracting grits teeth tot carry out activities
	8 – 9 severe enough to stop your activity	10 worst pain imaginable

What other symptoms are associated with your pain: Circle one:

Numbness Tingling Weakness Headaches

Other:_____

INITIAL PAIN ASSESSMENT FORM (page 2)

DOCTORS© PAIN CLINIC

What makes your pain better?_____

Worse?_____

How does the pain impact your Sleep?_____

How does the pain impact your Mood?_____

What other Treatments and/ or Medications have you received and were they effective? (these are important for Prior Authorizations of Any Medications- use Back if needed)

_____

_____

What tests or studies have been done regarding this pain? (MRI, X-ray, CT Scan, EMG, etc). What medications are you currently on for pain? What % of pain relief do you get from your current medications?
Tests: _____

Medications:_____

_____

List any other healthcare providers you have seen for this pain _____

_____

_____

Tell us what your expectations/ goals are from the Doctors Pain Clinic: (Goals are things like walking more, sleeping better, going back to work, doing housework)

_____

_____

Domestic Situation:
With whom do you live? _____

Are there any Substance Abuse or Domestic Violence issues in the household? _____YES _____NO

If YES, explain_____

Are you able to care for yourself?_____ **Do you have a care giver?**_____

Please fill in:
Height: _____**Weight:**_____

Patient Signature:_____**Date:**_____

Rev:7/2014

HEALTH QUESTIONNAIRE

PATIENT NAME:	**DOB:**	**TODAY'S DATE:**
BLOOD THINNERS: Please list all blood thinner medications and the Dr. that prescribed them. (Include Aspirin here):		

MEDICATIONS: List all Medications you are currently taking (include over the counter medications) If you need more space use back of this form

MEDICAL HISTORY: Do you have or had any of the following? (Please **CHECK** the box of all that pertain to your history.)

	AIDS/HIV		COPD		Herpes/Shingles		Myocardial Infarction
	Alcoholism		Diabetes		High Blood Pressure		Osteoporosis
	Anemia		Diverticulitis		____Kidney disease ___ Kidney stones		Pacemaker
	Asthma		Fibromyalgia		Liver disease		Pneumonia/Pleurisy
	____Arthritis ____ Rheumatoid		Gastric ulcers		Lupus		Psoriasis
	Bronchitis		Glaucoma		Mental Illness: ___Anxiety ___Bipolar ___Depression __PTSD ___Schizophrenia		Seizures
	Cancer- Type: _____		Heart disease Type:		Migraine		STD- Type: _____
	Chronic Pain		Heart murmur		MRSA		Stroke
	Colitis		Hepatitis		Multiple Sclerosis (MS)		Thyroid disease
							Tuberculosis

ALLERGIES: List all allergies to medications. Write "**NONE"** if no known allergies.

SURGERIES/ HOSPITALIZATIONS: List all and include date if known. Use the back of this form if more space is needed.

FAMILY HISTORY: If any "blood" relative(s) have suffered any of the following, **CIRCLE** the family member(s) with the corresponding medical condition.

MEDICAL CONDITION:						
Alcoholism	Mother	Father	Sister/Brother	Grandparents	Aunt/Uncles	Children
Arthritis	Mother	Father	Sister/Brother	Grandparents	Aunt/Uncles	Children
Asthma	Mother	Father	Sister/Brother	Grandparents	Aunt/Uncles	Children
Cancer	Mother	Father	Sister/Brother	Grandparents	Aunt/Uncles	Children
Diabetes	Mother	Father	Sister/Brother	Grandparents	Aunt/Uncles	Children
Heart Disease	Mother	Father	Sister/Brother	Grandparents	Aunt/Uncles	Children
Hepatitis	Mother	Father	Sister/Brother	Grandparents	Aunt/Uncles	Children
Hypertension	Mother	Father	Sister/Brother	Grandparents	Aunt/Uncles	Children
Mental Illness	Mother	Father	Sister/Brother	Grandparents	Aunt/Uncles	Children
Osteoarthritis	Mother	Father	Sister/Brother	Grandparents	Aunt/Uncles	Children
Stroke	Mother	Father	Sister/Brother	Grandparents	Aunt/Uncles	Children
Thyroid	Mother	Father	Sister/Brother	Grandparents	Aunt/Uncles	Children
DECEASED: (Please CHECK √)						

SOCIAL HISTORY:		
SMOKE	____yes ____no	
FORMER SMOKER	____yes ____no	Quit date:
URINARY INCONTINENCE	____yes ____no	
STREET DRUG USE	____yes ____no	Type:
CBD OIL	____yes ____no	
MEDICAL MARIJUANA	____yes ____no	
ALCOHOL USE	____yes ____no	____oz. per day
COFFEE/CAFFEINE	____yes ____no	____cups per day
SLEEPING AT NIGHT	____yes ____no	
PHYSICAL THERAPY	____yes ____no	Facility:
EXERCISE:	____yes ____no	____ X per week

SYMPTOMS: Please **CIRCLE** all current. Leave unmarked if no problem(s).

EYE | EAR | NOSE | THROAT	GASTROINTESTINAL	CARDIOVASCULAR
Decreased hearing	Loss of appetite	Chest pain/Angina
Ringing in Ears	Difficulty swallowing	Swollen ankles
Frequent Ear infections	Heartburn	Irregular pulse
Dizzy spells	Ulcer	Leg pain when walking
Eye Pain	Persistent nausea	Palpitation
Nose Bleeds (recurrent)	Abdominal pain	Varicose veins/phlebitis
Sinus Trouble	Jaundice/Hepatitis	High blood pressure
Sore Throats (frequent)	Diarrhea	
Prolonged hoarseness	Constipation	**DERMATOLOGY/ENDOCRINE**
Failing vision	Diverticulosis/Colitis	Rashes
Fainting	Blood or tarry stool	Hives
	Hemorrhoids	Psoriasis/Eczema
RESPIRATORY	Hernia	Tattoos/body piercing
Allergies	Blood transfusion	Thyroid
Hay Fever		Diabetes
Pneumonia/Pleurisy	**NEUROLOGICAL**	
Bronchitis/chronic cough	Tremors/Hand shaking	**PSYCHOLOGICAL**
Asthma	Numbness/Tingling	Sleeping/concentration
Shortness of breath	Headaches (frequent)	Nervousness/Anxiety
	Weakness	Depression
URINARY/GYNECOLOGICAL	Seizures	Suicidal
Urinate more than 2x per night		Memory loss
Urgency/leaking	**MUSCULOSKELETAL**	Feeling of worthlessness
Decreased stream	Back pain (recurrent)	Phobia
Frequent urinary infections	Bone fracture	
Blood in Urine	Joint injury	**INFECTIOUS DISEASE**
	Joint pain	AIDS/HIV
FEMALE ONLY	Arthritis	Herpes
Current birth control	Osteoporosis	Tuberculosis
Dale of last menses	Leg pain when walking	STD
Menopause		Hepatitis A, B, C
Hysterectomy		

DOCTORS PAIN CLINIC

Quality of Life/Functional Study
(Evaluate once a year)

Patient name _____ Date _____

In the past month have you done any of the following?

(Please check)	Yes	No
Worked?		
Participated in volunteer activities?		
Participated in a hobby?		
Spent time feeding or caring for a pet?		
Performed childcare/family care/eldercare activities?		
Talked with family or friends?		
Took a walk or exercised?		
Spent time on line on the computer?		
Wrote a letter or email?		
Took time for yourself?		
Visited with friends and or relatives?		
Attended church or social function?		
Shopped?		
Performed other outside activities?		
Read (newspaper, book magazine, bible, internet)?		
Played cards/board games/video games?		
Worked crossword puzzles/jigsaw puzzles/sudoku etc.?		
Made something?		
Worked outdoors in a garden/yard/care for plants?		
Watched a movie?		
Prepared meals?		
Baked?		
Cleaned house/laundry?		
Completed household repairs?		
Listen to music?		
For staff use. Total YES answers =	**Total**	**Total**

Legend: 0-5 poor 6-10 fair 11-15 good 16-20 very good 21-25 excellent

Patient signature _____

Staff signature _____

ZUNG SELF-RATING SCALE

Depression and chronic pain often times go hand in hand.
This survey is a tool designed to help us with your individualized treatment plan.

Name _____ **Date** _____
Age _____ **Sex** _____ **Marital Status** _____
Occupation _____ **Education** _____

Reply to questions using one of the four replies below (A-D)
A – Little or none of the time
B – Some of the time
C – A large part of the time
D – Most or all of the time

	A Little or none of the time	**B** Some of the time	**C** A large part of the time	**D** Most of the time	
1. I feel downhearted and blue	1	2	3	4	
2. Morning is when I feel the best	4	3	2	1	
3. I have crying spells or feel like it	1	2	3	4	
4. I have trouble sleeping at night	1	2	3	4	
5. I eat as much as I used to	4	3	2	1	
6. I still enjoy sex	4	3	2	1	
7. I notice that I am losing weight	1	2	3	4	
8. I have trouble with constipation	1	2	3	4	
9. My heart beats faster than usual	1	2	3	4	
10. I get tired for no reason	1	2	3	4	
11. My mind is as clear as it used to be	4	3	2	1	
12. I find it easy to do the things I used to do	4	3	2	1	
13. I am restless and can't keep still	1	2	3	4	
14. I feel hopeful about the future	4	3	2	1	
15. I am more irritable than usual	1	2	3	4	
16. I find it easy to make decisions	4	3	2	1	
17. I feel that I am useful and needed	4	3	2	1	
18. My life is pretty full	4	3	2	1	
19. I feel that others would be better off if I were dead	1	2	3	4	
20. I still enjoy the things that I used to	4	3	2	1	
				TOTAL RAW SCORE	

Some questions ask the information positively but in all cases the symptom severity is scored form 1-4.
The total score is often converted to a 100 point scale (SDS Index)
SDS Index = (score / 80 total points) x 100 or SDS Index = score x 1.25

Total SDS raw score _____
SDS Index (score x 1.25) _____

0 -- 20	No Depression	No interventions required
21 – 40	Mild Depression	No Intervention required/Reevaluate as needed
41 – 60	Moderate Depression	Offer psych support/ Reevaluate q 6 months
61 – 80	Severe Depression	Strongly recommended psych support/ Reevaluate 3 months

Are you being treated for depression now *or* have you been treated in the past? ____yes ____no

If you are being seen, by whom? _____

Please complete this survey and bring it with you to your scheduled appointment. Thank you.

Rev 12/05, 4/06/ 6/12 1/13

INSTRUCTIONS: If this is a Workers Compensation Injury, complete the entire form. If this is <u>not</u> a work-related injury, simply sign and date the last section of the form.

<u>Patient Information:</u>

Name: _____ SSN: ____/___/_____

Address: _____ Telephone:_____

<u>Employer Information:</u>

Name of Company:_____ Contact Person:_____

Address: _____Telephone: _____

<u>Accident Information:</u>

Date of Injury: ____/_____/____ Location: _____

Nature of injury/illness: _____

<u>Managed Care Organization Handling Claim:</u>

MCO Name: _____Telephone: _____

Address: _____Case Manager: _____

<u>Workers Compensation Claim Information</u>:

Claim number: _____

<u>Attorney Information</u>:

Name: _____Telephone: _____

Address: _____

Patient Signature: _____ Date: _____

IF INJURY IS <u>NOT</u> RELATED to a workplace injury please sign and date below.
Please be advised that by signing below you will be responsible for payment of denied claims if this is indeed a work-related injury and you fail to inform our office.

Patient Signature: _____ Date: _____

DOCTORS© PAIN CLINIC

PATIENT DEMOGRAPHIC FORM

LAST NAME:		**FIRST NAME:**	**M.I.**
D.O.B:	**GENDER:** ❑ Male ❑ Female ❑ Transgender	**MARITAL STATUS:** ❑ Single ❑ Married ❑ Divorced ❑ Widowed	
SOCIALSECURITY NO.		**PREFERRED LANGUAGE**: ❑ English ❑ Other ❑ Indian ❑ Spanish ❑ Russian	
RACE: ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian/Other Pacific ❑ Black or African American ❑ White ❑ Hispanic ❑ Other Race		**ETHNICITY:** ❑ Hispanic or Latin ❑ Not Hispanic or Latin ❑ Refuse to Report	
HOME ADDRESS:		**CITY**	**STATE** / **ZIP**
HOME PHONE:	**CELL:**	**EMAIL:**	
EMPLOYER:		**WORK PHONE:**	
ALLERGIES (Medical Alert):			
PRIMARY CARE PHYSICIAN:	**PHONE:**	**REFERRING PHYSICIAN:**	
PHARMACY NAME:		**ADDRESS:**	
CITY:	**STATE:**	**ZIP:**	

IN CASE OF EMERGENCY CONTACT

FIRST NAME:	**LAST NAME:**	**RELATION:**	**PHONE:**

INSURANCE INFORMATION: PRIMARY

Insured Name:	**Relationship to Patient:**	**DOB:**	
Insurance Company:			
Insurance Company Address:			
City:	**State:** / **ZIP:**	**Phone:**	
Policy No:	**Group No:**	**Employer:**	

INSURANCE INFORMATION: SECONDARY

Insured Name:	**Relationship to Patient:**	**DOB:**	
Insurance Company:			
Insurance Company Address:			
City:	**State:** / **ZIP:**	**Phone:**	
Policy No:	**Group No:**	**Employer:**	

I give permission to leave phone message(s):	☐ **YES**	☐ **NO**

Revised 6/2020

DOCTORS© PAIN CLINIC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent the practice may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the NOTICE OF PRIVACY PRACTICES for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. (The practice reserves the right to revise its Notice of Privacy Practices at anytime.)

With my consent the practice may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent the practice may release information to (spouse, family member, other)

_____. *Please print name and relationship.*

With my consent the practice may mail to my home or to other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that the practice limit and or restrict how it uses or discloses my PHI to carry out TPO. However, I have been informed the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

**** *A request for limitations and restrictions of PHI form must be submitted.*****

By signing this form, I am consenting to the practice use and disclosure of my PHI to carry our TPO. I am also acknowledging that no recording devices will be used on the premises in order to protect any PHI throughout the Doctors Pain Clinic.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the practice may decline to provide treatment to me.

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES.

_____

Signature of Patient *or* Legal Guardian (relationship) Date _____

_____

Print Name of Patient *or* Legal Guardian (relationship)

Rev. 9.2013
Rev: 02/19/2018
Rev: 02/02/2021

PATIENT RESPONSIBILITY FORM

PAYMENT POLICY
It is our policy to collect the appropriate payment due from the patient at the time service is rendered. This includes co-payment or "co-pay," deductible and/or co-insurance according to your health insurance benefit plan. *These amounts will be collected when you check in for your appointment.*
All patients with no medical insurance or "self-pay patients" must *pay for services before being seen.*

*****IF PAYMENT IS NOT MADE AT THE TIME OF SERVICE, YOU MAY NOT BE SCHEDULED ANOTHER APPOINTMENT UNTIL PAYMENT IS RECEIVED*****

Patient medical billing process
The billing staff, as a courtesy to you, will submit a medical bill to your primary health insurance for processing. **It is important to give your updated information to the front office staff.** Your complete and current information is needed to submit an accurate claim form to your health insurance company. The remaining amount on the claim will be sent to your secondary health insurance company, if provided, after payment is received from the primary health insurance company.

You are responsible for any outstanding balance, such as non-covered charges as outlined in your health insurance policy. The billing staff will mail you a statement that contains the remaining cost of your service and/or procedure received during your visit after any/all insurances are billed and payments are processed.
Payment is due within 20 days of the date on the statement. We accept cash, check, Mastercard, Visa and Discover. If you prefer, you may pay your bill by credit card on-line 24 hours a day at doctorspainclinic.com.

For questions about your bill, please call billing at 330-629-2888 ext 206 Monday through Friday between the hours of 7:00am-3:00pm.

I acknowledge receipt of this notice and I am aware that if my copay, deductible, co-insurance amount or self-pay charge is not paid at the time of service I may not receive a follow up visit until my payment is received.

_____ _____
Signature Date

_____
Print Name