INTAKE ASSEMENT FORM PAGE 1 OF 3

Today's Date_____ Patient Name_____ Acct #_____

Date Of Birth_____Age _____ Referring Dr_____ Family Dr_____

Reason for Visit_____

HISTORY OF PRESENT ILLNESS:(Details of Injury/Illness)

1. Where is the pain?_____

2. When did the pain first start? _____

3. Describe your Pain: Electrical☐ Burning☐Throbbing☐Constant☐Other: _____

4. Pain Scale(10 being the worst possible, 5 moderate severe, 1 minimal)

1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8 ◯9◯ 10◯

5. When is the pain most severe? MORNING◯ MID-DAY◯ EVENING◯

6. When is the pain least severe? MORNING◯ MID-DAY◯ EVENING◯

7. What make your pain/symptoms worse? _____

8. What makes your pain/ symptoms better? _____

9. Do HOT Compresses Help? YES◯ NO◯ Do COLD Compresses Help? YES◯ NO◯

10. Walking Ability (1 Being Normal 10 not able to walk)

1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯

11. Mood Scale  (1Very Good 10 Very Bad)

1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯

12. Sleep Pattern: Good◯ Wake up Multiple Times◯ Not Able to Sleep◯

13. Enjoyments of Life: _____

14. Relationship with other People: Good◯ Normal◯ Difficult◯ Other:_____

15. Working Ability: Can/Cannot Work◯ Can/ Cannot do Housework◯

16. Have you ever had/used: PHYSICAL THERAPY☐ CHIROPRACTOR☐ TENS UNIT☐ EPIDURALS☐ INJECTIONS☐

17. Have you ever been to a pain clinic? YES◯ NO◯ IF YES, NAME OF CLINIC_____

18. Allergies: _____

19. Please List all medications you are taking:

20. Are you Pregnant? YES◯ NO◯ N/A◯

21. Have you had injections? YES◯ NO◯

Check which apply: Epidural☐ Facet Injection☐ RF procedure☐ Other:_____

Do you have any other Symptoms: (**Check all that Apply**) Nausea☐ Vomiting☐ Constipation☐ Diarrhea☐ Lack of Appetite☐ Indigestion☐ Difficulty Sleeping☐ felling drowsy☐ Nightmares☐ Dizziness☐ Tiredness☐ Itching☐ Urinary Problems☐ Sweating☐ Weakness☐ Headaches☐ Suicidal Thoughts☐

ANY OTHER INFORMATION:_____

INTAKE ASSESSMENT FOR PAGE 2 OF 3

Family History: (Check all that Apply) Migraines☐ Stroke☐ Heart Attack☐ Diabetes☐ Cancer☐ Bleeding Disorder☐ Aneurysms☐ Polycystic Kidney/ Marfan's disease☐

Past Medical History:

Do you have any metal in your body? YES◯ NO◯

Past Medical History of: (Check all that Apply) Heart Attack☐ Stroke☐ High Blood Pressure☐ Diabetes☐ Cancer☐ Other:_____

Social History: Single☐ Married☐ Separated☐ Divorced☐ Live Alone☐

Household #_____

Do you currently drive? YES◯ NO◯

1. Pregnant? YES◯ NO◯

2.Breast Feeding? YES◯ NO◯ 3. Level of Education _____

4. Disabled? YES◯ NO◯

5.Smoking? YES◯ NO◯ _____ # of packs per day for _____ years

6. Alcohol? YES◯ NO◯ _____ drinks per day/week/month for _____years

List All Surgeries you have had Present/Past:

REVIEW OF SYMPTOMS (CHECK ALL THAT APPLY):

Sleep-Apnea☐ Fever☐ Weight Loss☐ Weight Gain☐ Fatigue☐ Sleep difficulty☐

Blurred vision☐ Cataracts☐ Glasses☐ Glaucoma☐ Pain☐ Sensitivity to Light☐

Loss of vision in one Eye☐ Nose Bleeds☐ Sinus Problems☐ Hearing, Smelling☐ Swallowing☐

Speech Problems☐ Headaches☐ Numbness/Tingling hands/feet☐ Dizziness☐ Seizures☐

Stroke☐ Trouble walking☐ Joint Swelling☐ Stiffness☐ back Pain☐ Neck Pain☐ Dry Skin☐

Irritation☐ Rash☐ Skin Cancer☐ Asthma☐ Congestion☐ Dry cough☐ Heart Burn☐

Shortness of Breath☐ Coughing☐ Wheezing☐ Dizziness☐ Heart Murmur☐ Numbness☐

Palpitations☐ Chest Pain☐ Abdominal Pain☐ Abdominal Swelling☐ Tumor☐ Blood in Stool☐

Diarrhea☐ Constipation☐ Change in Bowel Habits☐ Hemorrhoids☐ nausea☐ vomiting☐

Blood in Urine☐ Trouble Urinating☐ Frequent urination☐ painful urination☐ kidney stones☐

Breast discharge☐ Breast Lump☐ Pelvic Discharge☐ Pelvic Itching☐ Pelvic Pain☐

Abnormal Hair Growth☐ Diabetes☐ Anxiety☐ Depression☐ eating Disorder ☐

Intake Assessment Form Page 3 of 3

Please Check YES or NO:

1. YES○ NO○ Do you have any prior or pending charges and/or convictions?
2. YES○ NO○ Ever attempted suicide?
3. YES○ NO○ Suicidal or planning suicide?
4. YES○ NO○ Any thoughts of suicide past or present?
5. YES○ NO○ Ever made plans for suicide?
6. YES○ NO○ Ever Overdosed?
7. YES○ NO○ Ever Addicted?
8. YES○ NO○ Drug Treatment, Rehab, Detox
9. YES○ NO○ Drug Conviction, Indictment, or investigation?
10. YES○ NO○ Ever bought, sold, or abused drugs?
11. YES○ NO○ Any recreational drug use?
12. YES○ NO○ Ever felt you should cut down on substance use?
13. YES○ NO○ Ever felt annoyed by others criticism of your substance use?
14. YES○ NO○ Ever felt guilty about your substance abuse?
15. YES○ NO○ Ever had a morning eye opener to start your day?
16. YES○ NO○ Have you ever sued or are planning to sue any healthcare provider?
17. YES○ NO○ Have you ever received medications over the internet?
18. YES○ NO○ Have you ever abused illegal substances?
19. YES○ NO○ Have you ever abused any legal substances?
20. YES○ NO○ Have you ever been diagnosed with schizophrenia, psychosis, hallucinations, major depression, bipolar, antisocial, borderline personality disorder, hepatitis C/B, HIV, liver disease?
21. YES○ NO○ Do you have or have you had any needle track marks in your skin?

22. YES○ NO○ Has anyone in your family or household had any type of substance abuse or drug problems?
23. YES○ NO○ History of Preadolescent sexual Abuse

Explain any of the YES answers above:

_____

By Signing I certify the above information is truthful, if something has not been marked nothing has changed since my initial or last office visit. I also Authorize that I received, read, and understand a copy of Medical Pain Managements Notice of Privacy Practice.

Patient Signature_____ Date_____

Medical Pain Management

Shailesh P. Upadhyay, M.D.
Board Certified Pain Management

NCV Patient Questionnaire

Please circle YES or NO to the following questions. This will aid us in completing your medical history.

1.Do you suffer from neck pain, with pain in your arms or hands? …….. YES NO

2. Do you have weakness, numbness, or burning in either of your arms or hands?……YES NO

3. Do your hands or arms fall asleep?..... YES NO

4. Do you have reduced feeling (sensation) in your hands or arms?…… YES NO

5. Do you suffer from a loss of hand grip strength?..... YES NO

6. Do you suffer from back pain with pain in your buttocks, legs, or feet?....YES NO

7. Do you have weakness, numbness, or burning in your buttocks, legs, or feet?.....YES NO

8. Do your legs or feet fall asleep?.....YES NO

9. Do you have reduced felling(sensation) in your buttocks, legs, or feet?...YES NO

_____ _____
Patient Signature Date

701 Leighton Ave., Anniston, AL 36207 256-231-1231 256-231-1232 Fax

Medical Pain Management

Shailesh P. Upadhyay, M.D.
Board Certified Pain Management

Card Protocol

Instructions to Patients
When Seeing any other Physicians

1. Make sure you get one of my business cards
2. List your current RX's (the ones I currently prescribe for you) on the sheet below.
3. Give this sheet to any doctor, dentist, ER doctor, etc., who treats you- tell them to put it in your chart so they will know the medications I have prescribed you.
4. Any and all additional pain medications including cough medicines prescribed for you any other doctor are required to be disclosed to me, physicians may give you additional narcotics when needed for acute pain (i.e. dental extractions, surgery, auto accidents, trauma, acute injuries) BUT THEY HAVE TO FAX ME SOMETHING that tells me why you were seen, that they know what medications you are on and that they wrote you a prescription for additional medication. FAILURE TO DO THIS IS A VIOLATION OF OUR NARCOTIC AGREEMENT. They can fax this information on their letter head to 256-231-1232

701 Leighton Ave., Anniston, AL 36207 256-231-1231 256-231-1232 Fax

Medical Pain Management

Shailesh P. Upadhyay, M.D.
Board Certified Pain Management

Permission to Release Medical Records to Medical Pain Management

Date:_____

I,_____ _____, authorize to release fax copies of my medical records to Medical Pain Management at 256-231-1232.

Records Needed:
History and Physical H&P
Last Chart Notes
MRI/CT-scan Reports

_____ _____
Signature Date

_____ _____
Signature of Guardian if applicable Date

Relationship to Patient:_____

Medical Pain Management

Shailesh P. Upadhyay, M.D.

Board Certified Pain Management

Notice for Release of Medical Records

Patient Information(please print):

Last Name	First Name	Middle	Maiden (if applicable)

Address	City	State	Zip

Date of Birth	SSN	Home Phone#	Cell #	Work #

I, the undersigned, hereby authorize: Medical Pain Management
701 Leighton Ave
Anniston AL 36207
To RELEASE information from my medical record. This authorization includes release fo information concerning HIV testing or treatment of AIDS, Aids related condition, drugs or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/physiological conditions.

Name of person above information is to be released to:_____
How is the above person related to you:_____
Street Address_____
City, State, and Zip Code_____

The following information (but not limited to) may be released or reviewed
CHECK EACH BOX THAT APPLIES
Office Notes ☐ History/Physical☐ Procedures☐ XRay Reports☐ Lab☐ Other☐
Test (specify):_____ Date of Treatment_____

Records May be: Mailed☐ Picked Up☐ Faxed☐ Reviewed Only ☐

Purpose of release of information: Medical Care☐ Insurance☐ Attorney/Legal☐ Disability☐
Personal☐ Other(specify)_____☐

All information obtained during evaluation and/or treatment will be provided to referring physician. I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to obtain treatment. I understand that this information may be subject to redisclosure by the recipient and will no longer protect by Federal Privacy Regulations. This statement must be signed and dated, and may be revoked at anytime except to the extent action has been taken prior to revocation. Please send a written notice of revocation to Medical Pain Management 701 Leighton Ave Anniston AL 36207. This authorization will expire 60 days after the date below,or sooner by choice, in which case, this consent will expire on _____.

I hereby consent to the disclosure of the treatment records to the purpose and extent stated above

Signature of Patient/Legal Guardian	Relationship to Patient	Date

701 Leighton Ave., Anniston, AL 36207 256-231-1231 256-231-1232 Fax

HOW TO SEND THE FORM
- Save the form to your computer
- Open it with Adobe Reader DC (www.adobe.com/reader/)
- Complete the form fields
- To send, click the SUBMIT button.

SUBMIT