CAROLINA PAIN CENTER

518 Beaman Street, Clinton, NC
Phone 910.596.4288 Fax 910.592.3384
www.SampsonRMC.org

Patient Registration

Patient Name: _____ DOB: _____
First Middle Last

Address: _____ _____
Street Address City State Zip Code Email Address

Phone: _____|_____|_____
Home Work Cell

Employer: _____

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Native American ☐ Other

Social Security Number: _____

Marital Status: _____ Spouse's Name: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: _____

Insurance Company: _____

Subscriber Name: _____ Subscriber Social Security Number:_____

Subscriber Employer: _____ Subscriber Birthdate: _____

Preferred Pharmacy: _____

Financial Agreement & Authorization of Treatment

I authorize treatment and agree to pay all fees and charges for such treatment at the time services are rendered. I understand that additional charges could apply as well as charges from other medical facilities if additional testing is required. I request that my insurance company pay directly to Carolina Pain Center and authorize the release of medical information to my insurance company.

_____ _____ _____
Patient (Parent/Guardian/Power of Attorney) Signature Relationship Date

_____ _____
Witness Date

**As a witness, I am witnessing the signature and not the contents of this document.*

CAROLINA PAIN CENTER
518 Beaman Street, Clinton, NC
Phone 910.596.4288 Fax 910.592.3384
www.SampsonRMC.org

New Patient Questionnaire

Patient Name: _____ **Today's Date** _____
First MI Last

Male __
Female __

Date of Birth _____ Height _____ Weight _____

Referring Physician _____ Primary Care Physician _____

CHIEF COMPLAINT:

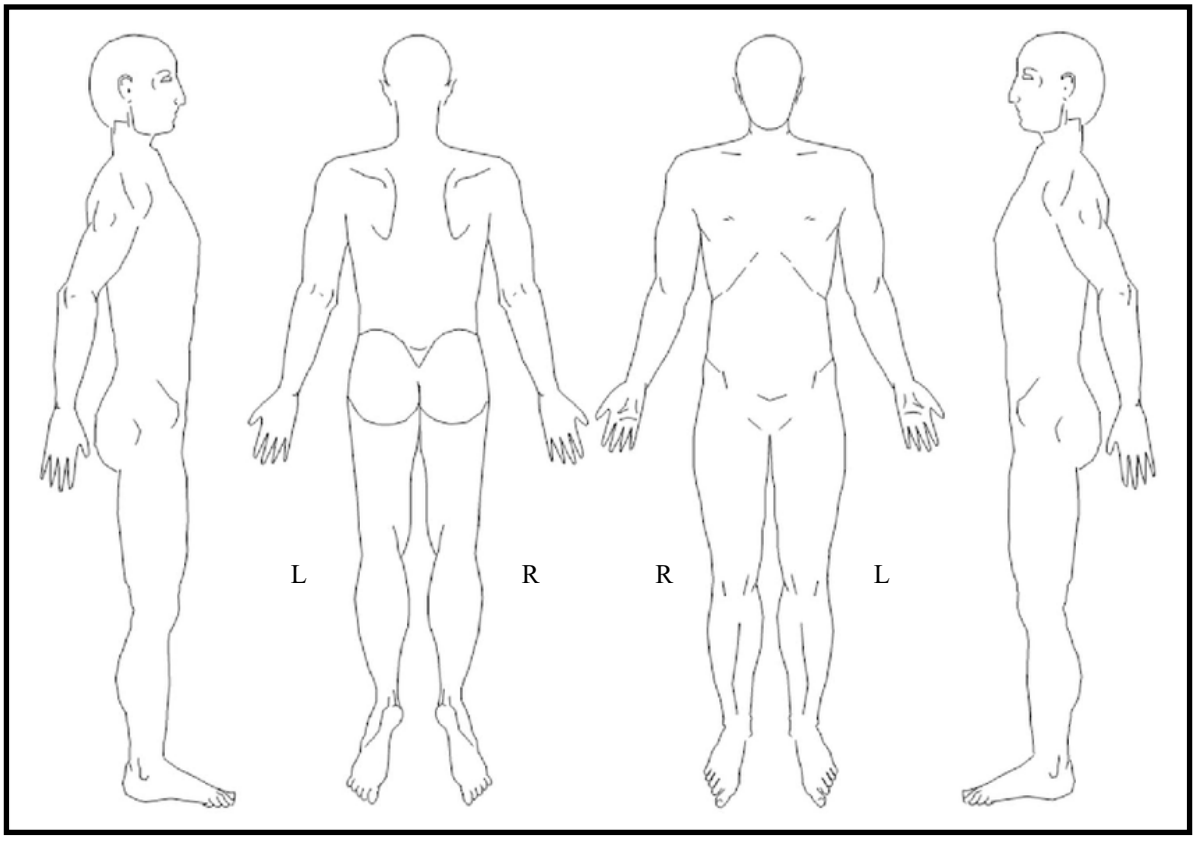
Why are you visiting the Carolina Pain Center?_____

Describe your pain:_____

When did the pain begin? _____(month/year)

MARK THE PICTURE WHERE YOU ARE HAVING PAIN.

Please mark: **(X)** for Numbness, **(T)** for Tingling, **(B)** for Burning



PAIN:

How did your pain begin?

Work Accident ____ Auto Accident ____ Other Injury ____ Gradual Onset ____

Home Accident ____ Following Surgery or Injury ____ No Trauma ____ Unknown ____

Circle the number that best describes how severe your pain is:

0 1 2 2 3 4 5 6 7 8 9 10

No Pain Mild Discomfort Distress Horrible Worst Pain

Duration of pain:

Less than 1 month ____ 1 to 3 months ____ 3 to 6 months ____

6 to 12 months ____ More than 1 year ____ How many years? ____

How often do you have pain?

Constantly (76-100% of the day) ____ Frequently (51-75% of the day) ____ Occasionally (26-50% of the day) ____

Intermittently (0-25% of the day) ____ Weekly (Less than daily) ____ Monthly ____

How has the pain intensity changed since it began?

Increased ____ Decreased ____ No Change ____

Select one or more of the items below to describe the nature of your pain:

Throbbing ____ Shooting ____ Sharp ____ Cramping ____ Hot/Burning ____

Stabbing ____ Aching ____ Tingling ____ Numbing ____ Dull Ache ____

How do the following factors affect your pain?

	Worse	Better	No Effect		Worse	Better	No Effect		Worse	Better	No Effect
Walking	____	____	____	Heat	____	____	____	Lying Down	____	____	____
Standing	____	____	____	Bending	____	____	____	Cold	____	____	____
Sitting	____	____	____	Sitting	____	____	____				

Which of the following activities are affected by your pain?

Sleep ____ Work/School ____ Social Interaction ____

Leisure ____ Household chores ____ Sexual Activity ____

Which of the following tests have you had in regard to your pain?

X-ray ____ Bone Scan ____ CAT Scan (CT) ____ Myelogram ____ MRI ___ Electromyogram (EMG) ____

For each treatment listed below, indicate the amount and duration of pain relief that resulted.

TREATMENT	% RELIEF	TIME LASTED	NEVER TRIED
Acupuncture			
Biofeedback			
Chiropractic			
Cold Therapy			
Heat Therapy			
Hypnosis			
TENS			

TREATMENT	% RELIEF	TIME LASTED	NEVER TRIED
Non-narcotic pills			
Narcotics			
Physical Therapy			
Psycotherapy			
Relaxation Therapy			
Surgery			
Epidural Steroid			

MEDICAL HISTORY—Have you ever had any of these conditions?

Hypertension ____ Diabetes ____ Heart attack ____ Angina ____

Heart Stent ____ Pacemaker ____ Asthma ____ COPD ____

Lupus ____ Stroke ____ Seizures ____ Fybromyalgia ____

Kidney Stones ____ Cancer ____ Gastric Ulcers ____ Reflux ____

Thyroid Problems ____ Hepatitis ____ Irritable Bowel Syndrome ____

PAST SURGICAL HISTORY

Please list the surgical operations you have had: _____

_____

Do you have any drug allergies?

NO known drug allergies ____ YES ____ Drug:_____

Reaction:_____

List all medications you are taking, including non-prescription, vitamins & herbal supplements:

_____

_____

_____

Are you taking blood thinners? _____NO _____YES, if yes, which one_____

Please list any past pain medicines you have tried:_____

FAMILY HISTORY—Please check any of the following diseases that occur in your family:

Arthritis ____ Cancer ____ Depression ____ Diabetes ____ Heart ____

Lupus ____ Stroke ____ Fibromyalgia ____ Other ____ _____

SOCIAL HISTORY

Marital Status: Single ___ Married ___ Widowed ___ Divorced ___ Separated ___

Number of children:_____ Number of people living in household:_____

SOCIAL HISTORY continued

Do you: SMOKE? Yes ____ No ____ How much? _____

DRINK? Yes ____ No ____ How much? _____

RECREATIONAL DRUGS? Yes ____ No ____ How much? _____

Have you ever had any psychiatric or psychological treatment? ___No ___Yes

If yes, for what problem?_____

What is your usual occupation?_____

Current work status: Full-time ___ Part-time ___ Retired ___ Disabled ___ Unemployed ___

If not currently working, how long has it been since you last worked?_____

Is your spouse employed? ___Yes ___No

Is there currently a question of lawsuit or disability claim concerning your pain condition? ___Yes ___No

REVIEW OF SYMPTOMS—Please check any of the following symptoms that you have.

CONSTITUTIONAL	___Obesity	___Weight loss	___Fatigue	___Fever	___Chills	
MUSCULOSKELETAL	___Arthritis	___Numbness	___Weakness	___Back Pain	___Neck Pain	
PSYCHIATRIC	___Depression	___Difficulty sleeping	___Anxiety	___Suicidal thoughts		
GENITOURINARY	___Impotence	___Decreased libido	___Incontinence	___Urinary tract infection		
GASTROINTESTINAL	___Abdominal pain	___Bloating	___Constipation	___Diarrhea	___Heartburn	___Nausea
ENDOCRINE, HEMATO-LOGIC, ALLERGY/ IMMUNOLOGIC/HEENT	___HIV	___Bruise easily	___Visual changes	___Ringing in ears		
INTEGUMENTARY	___Herpes Zoster	___Skin cancer	___Rash	___Swelling		
CARDIOVASCULAR	___Chest pain	___Palpitations				
RESPIRATORY	___Shortness of breath					
RHEUMATOLOGIC	___Polymyalgia rheumatica					
NEUROLOGICAL	___Headache	___Migraines	___Seizures	___Confusion	___Dizziness	___Light sensitivity
	___Loss of consciousness					

___Other, if any other symptoms, please list_____

USE OF OPIOIDS

I, _____, understand that Carolina Pain Center (Dr. Morkos) does not use opioids as a first line treatment for pain. I understand that I will not receive opioid medication or prescriptions on my first visit to the pain center.

Signature_____Date_____

Witness_____Date_____

Financial Agreement & Authorization of Treatment

I authorize treatment and agree to pay all fees and charges for such treatment at the time services are rendered. I understand that additional charges could apply as well as charges from other medical facilities if additional testing is required. I request that my insurance company pay directly to Carolina Pain Center and authorize the release of medical information to my insurance company.

_____ _____ _____

Patient (Parent/Guardian/Power of Attorney) Signature Relationship Date

_____ _____

Witness Date

**As a witness, I am witnessing the signature and not the contents of this document.*

CAROLINA PAIN CENTER
518 Beaman Street, Clinton, NC
910.596.4288
www.SampsonRMC.org

Health History

Date:_____

Name:_____ Date of Birth:_____

Known Medical Allergies:_____

Right Now what are your **Current Symptoms**, check if any:

Fever/Chills			Painful or Bloody Urination			Memory Loss			Difficulty Sleeping		
Unexplained Weight Loss			Leaking Urine			Fainting/Dizziness			Anxiety		
Excessive Tiredness			Difficulty Urinating			Numbness			Heartburn		
Blurry Vision			Cough			Difficulty Walking			Nausea/Vomiting		
Eye Pain			Wheezing			Muscle Weakness			Diarrhea/Constipation		
Itchy, Watery Eyes			Shortness of Breath			Joint Pain			Abdominal Pain		
Ear Pain			Chest Pain or Discomfort			Rash			Breast Mass		
Hearing Loss			Palpitations			Itching			Nipple Discharge		
Trouble Swallowing			Leg Pain			Non-Healing Ulcers			Breast Pain		
Allergies or Nasal Congestion			Headaches			Excessive Sadness					

Please check if you ever have been diagnosed with any of the following medical problems:

Asthma			Depression			Hepatitis			Irregular Heart Rate		
Cancer			Diabetes			High Blood Pressure			Kidney Disease		
COPD			Heart Disease			High Cholesterol			Thyroid Problems		

If diabetic, is your diabetes controlled by ☐ Insulin ☐ Pills

Please list any **current** surgeries & approximate dates.

Surgery:_____ Date:_____

Surgery:_____ Date:_____

Surgery:_____ Date:_____

Social History

Tobacco Use: ☐ Never ☐ Current Smoker ☐ Previous Smoker ☐ Uses Oral Tobacco

Alcohol Use: ☐ None ☐ Occasional ☐ Daily Use

Family History

Please indicate any immediate family members (Mother, Father, Sibling or Child) that have had any of the following:

	Who			Who			Who
Heart Disease			Diabetes			Breast Cancer	
Thyroid Disease			Kidney Disease			Colon Cancer	
High Blood Pressure			Bleeding Disorder			Prostate Cancer	

Preventive Health

Please indicate the date of your most preventive health immunizations:

Flu Shot_____ Tetanus_____ Pneumonia Vaccine_____

Bone Density_____ Eye Exam_____

Men: Prostate Exam_____

Women: Mammogram_____ Pap Smear_____

Medication List

Please list all current medications.

_____

_____

_____

_____

_____

CAROLINA PAIN CENTER
518 Beaman Street, Clinton, NC
Phone 910.596.4288 Fax 910.592.3384
www.SampsonRMC.org

Authorization for Release of Medical Records

Medical records requested from:

_____ _____
Name of Facility or Provider Phone Number

_____ _____
Address Fax Number

Patient Name:_____ Date of Birth:_____

Covering Health Care from:_____ to _____
Date Date

Information to be disclosed:

☐ Complete Medical Record
(Please provide the last 2 years of office notes, consults, diagnostic studies, immunizations, patient health summary, etc.)

☐ Other:_____

I hereby authorize the release of my health information to Carolina Pain Center. I understand that this may include information relating to AIDS (Acquired Immunodeficiency), or HIV (Human Immunodeficiency Virus), behavioral health services or psychiatric care, and/or treatment of alcohol and/or drug abuse. I am transferring care to Carolina Pain Center.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in (90) days or on the following date/condition:_____

_____ _____ _____
Patient (Parent/Guardian/Power of Attorney) Signature Relationship Date

_____ _____
Witness Date

**As a witness, I am witnessing the signature and not the contents of this document.*

CAROLINA PAIN CENTER

518 Beaman Street, Clinton, NC
910.596.4288
www.SampsonRMC.org/CPC

Medical Record/Information Release

I give permission to Carolina Pain Center to contact me regarding my healthcare needs (may include diagnoses, test results, appointments) in the following ways:

Leave a message on my answering machine at home or cell phone. ☐ Yes ☐ No

Leave a message at my work for me to return your call. ☐ Yes ☐ No

Mail lab/x-ray results to my home address. ☐ Yes ☐ No

I also agree to allow Carolina Pain Center staff to discuss my healthcare needs (may include diagnoses, test results, appointments) with the following people listed below. I understand that I can add or remove people included on this list as needed:

Name:_____ Relationship:_____

Phone Number:_____

Name:_____ Relationship:_____

Phone Number:_____

Disclosure to Health Information Exchanges

Carolina Pain Center participates in the North Carolina Health Information Exchange Network, called NC HealthConnex, which is operated by the North Carolina Health Information Exchange Authority (NCHIEA). We will share your protected health information, or PHI, with the NC HIEA and may use NC HealthConnex to access your PHI to assist us in providing health care to you. We are required by law to submit clinical and demographic data pertaining to services paid for with funds from North Carolina programs like Medicaid and State Health Plan. We may also share other patient data with NC HealthConnex not paid for with State funds. If you do not want NC HealthConnex to share your PHI with other health care providers who are participating in NC HealthConnex, you must opt out by submitting a form directly to the NC HIEA. Forms and brochures about NC HealthConnex are available in our offices and online at NCHealthConnex.gov. You may also contact our Privacy Officer at Sampson Regional Medical Center, 607 Beaman Street, Clinton, NC 28328. Again, even if you opt out of NC HealthConnex, we still will submit your PHI if your health care services are funded by State programs. Your patient data may also be exchanged or used by the NC HIEA for public health or research purposes as permitted or required by law. For more information on NC HealthConnex, please visit NCHealthConnex.gov/patients.

_____ _____ _____

Patient (Parent/Guardian/Power of Attorney) Signature Relationship Date

_____ _____

Witness Date

**As a witness, I am witnessing the signature and not the contents of this document.*

CAROLINA PAIN CENTER

518 Beaman Street, Clinton, NC
Phone 910.596.4288 Fax 910.592.3384
www.SampsonRMC.org

Privacy Practice Acknowledgement

I _____, have received a copy of the Notice of Privacy Practices from Carolina Pain Center.

_____ _____ _____
Patient (Parent/Guardian/Power of Attorney) Signature Relationship Date

_____ _____
Witness Date

**As a witness, I am witnessing the signature and not the contents of this document.*

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed and a signature was not possible at the time.
- ☐ The patient refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:_____

  _____
- ☐ Other:_____

_____ _____ _____
CPC Staff Signature Date