Pain Source Solutions, LLC.

Phone - (816) 221-4114
Fax – (816) 471-1247

We would like to take this opportunity to welcome you to Pain Source Solutions Pain Clinic. We understand pain is not easy to deal with and that everyone's pain is unique to them. Our primary goal is to provide you with the utmost professional care. Below are some important details about our clinic:

Our scheduling hours our Monday – Friday 7:30am to 2:30pm. We are closed all major holidays. Our clinic scheduling office number is (816) 221-4114. Our nursing staff number is (816) 691-1779. **We see patients by appointment only. We do not accept walk-in patients.** Also, you must have a primary referring physician to be seen in the Pain Clinic. If you can't make it to your appointment, please call us as soon as possible. Calling in advance to cancel your appointment, allows us time to schedule someone on the waiting list.

Each time you visit our clinic please check in with the receptionist. We sometimes experience delays so your patience is appreciated. At each visit you will be asked to complete a two sided follow-up Pain Assessment Form. It's very important for you to bring a complete list of the medications and the dosages that you're taking to each visit. **Please do not write "same" in the medication remarks; you must list your medications and the dosages each time you visit. If you are on any medications to thin your blood (anticoagulants) such as: Coumadin, Lovenox, Plavix, Aggrenox, Pletal, Ticlid, or Heparin please notify the physician and nurse during your visit prior to any procedure**.

Prescription refills are handled at the time of your visit and at the discretion of your physician. If for some reason a change needs to be made in your prescription you may call Monday – Thursday. Changes are only made at the discretion of your physician and a clinic visit may be required. **Please do not call the day your prescription runs out, it is your responsibility to monitor your medication supply and call a few days BEFORE your medications run out. NO REFILLS WILL BE ISSUED ON FRIDAYS.**

Return calls are made at the end of the day to assure that scheduled patients do not experience a delay in their appointments. A nurse, who has talked directly with your physician about your concerns, may make the return phone call**. If you feel that your call requires immediate attention please contact the North Kansas City Hospital Pain Clinic at (816) 691-1779 and inform the receptionist.** Most importantly, when leaving a message, please provide a number where you can be reached. This may require that you leave a home and a work phone number. If you are having a medical emergency call 911.

If you should have any questions after being seen in the Pain Clinic, please refer to your physician discharge instructions or feel free to give us a call. (nkc)

NO-SHOW CANCELLATION FEE POLICY

When you schedule an appointment for a procedure or an office visit, we are committing the doctor to be available for you and we are also committing that professional personnel and specialized equipment and facility is available for your appointment as well.

Too frequently patients have failed to show up for a scheduled appointment, or have rescheduled their appointments with very short notice. This creates a significant waste of available resources. It also causes longer waiting times for appointments.

Our no-show cancellation policy exists to help eliminate this waste.

When you schedule an appointment for an office visit or procedure you agree to notify our office in a timely manner if you choose to cancel or reschedule your appointment.

FAILURE TO GIVE NOTICE OF CANCELLATION / RESCHEDULING OF APPOINTMENT OR FAILURE TO SHOW FOR A SCHEDULED APPOINTMENT WILL RESULT IN YOU BEING CHARGED A FEE OF $75.00.

We expect you to call us during regular business hours at least 48 hours prior to your scheduled appointment. Weekends and holidays are not part of “notice time”.

WHEN THE NO-SHOW CANCELLATION FEE IS CHARGED OUR OFFICE WILL NOT SCHEDULE ANY OTHER APPOINTMENTS UNTIL THE FEE IS PAID.

ADDITIONALLY, EXCESSIVE NO-SHOWS OR CANCEL / RESCHEDULED APPOINTMENTS MAY RESULT IN DISMISSAL FROM OUR PRACTICE.

Thank you for understanding.

No-Show Cancellation Policy Pain Source Solutions

07-26-2012 PSSNSNCPOLICY

PAIN CLINIC – PATIENT INTAKE FORM

Name ____ Date of Birth ____/____/____ **Room #** _____

Address ______________________________________ Sex ____________ Age ____

____ Primary Care Physician ________________

Home Phone (________) _________-___________ Referring Physician ________________

Cell Phone (________) _________-___________

CHIEF COMPLAINT:

Describe in your own words why you came to the Pain Clinic today: ______________________

____

What are you expecting from your visit to the Pain Clinic today? ______________________

____

HISTORY OF PRESENT ILLNESS:

When did you first notice your pain/problem? ______________________________

What do you think caused your pain/problem? ______________________________

____

Where is your pain? (Please draw on figure on page 5) _______

Is your pain worse on one side than the other, if so, which side? ______________________

Describe your pain (for example, dull, sharp, burning, achy, etc.) ______________________

____

Does your pain migrate or radiate to other parts of your body, if so, where? ______________

____

Please use the following scale to rate your pain below: **0-10**

0 meaning no pain and **10** meaning the worst pain you've ever had or can imagine.

My pain at BEST is ____. My pain NOW is ____. My pain at its WORST is ____.

List the things that make your pain better ______________________________

____

List the things that make your pain worse ______________________________

____

How is your sleeping? ______________________________

Have there been any changes in your mood? (for example, irritable, sad, not eating, etc.)

If so, please explain ______________________________

____

What have other physicians told you is causing your pain? ______________________

____

____

____

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PAIN CLINIC – PATIENT INTAKE FORM

Has your physician prescribed or have you tried any of the following forms of treatments for pain relief? If so, please note the date(s) you tried or began treatment, the effectiveness (for example, good, bad, very, etc.) and the percentage of pain relief, if any.

	DATE(S)	EFFECTIVENESS	% PAIN DECREASED
Restricting Activity			0% - 100% - _______%
Medication(s)			0% - 100% - _______%
Ice / Heat			0% - 100% - _______%
Physical/Occupational Therapy			0% - 100% - _______%
Tens Unit			0% - 100% - _______%
Chiropractic			0% - 100% - _______%
Biofeedback / Counseling			0% - 100% - _______%
Nerve Blocks / Injections			0% - 100% - _______%
Surgery			0% - 100% - _______%

Is this pain the result of a work related accident? ____________________

If yes, is legal action or an insurance settlement pending? ____________________

If yes, describe the current status of such action ____________________

If no, do you plan to pursue legal action or insurance settlement in the future? ____________________

Have you had any of the following pain related evaluations and if so please give the date(s) and the facility in which you had the evaluations.

	DATE(S)	**FACILITY**
X-rays		
Cat Scans		
MRI		
Myelogram		
Bone Scan		
Nerve and Muscle Tests (EMGs)		

Previous Medical History:

Have you ever been diagnosed with any of the following medical conditions, and if so, when?

	Date Diagnosed		**Date Diagnosed**
Asthma / COPD		High BP	
Heart Disease		Ulcers / GERD	
Kidney Problems		Hepatitis	
Bleeding Tendencies		Cancer	
Diabetes		Other	

Previous Surgical History:

Please list any surgeries that you've had, and the dates of those surgeries below:

Surgery	**Date of Surgery**

Height ____________________ Weight ____________________

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PAIN CLINIC – PATIENT INTAKE FORM

Drug Allergies **Reaction**

____

____

____

____

Medications **Dose**

____

____

____

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____

____

If you are currently taking a blood thinner, please CIRCLE which one you are taking:

LOVENOX PLAVIX COUMADIN REFLUDAN HEPARIN TICLID PLETAL AGGRENOX

Social History:

I work at ____________________________________.

I am retired from ______________________________.

I have missed work in the last month ______________ (Y / N)

If yes, how many days? ________________________

Tobacco use Y / N ____ ppd ______ # of years ______ Quit? ____________ (Date)

Alcohol use Y / N ____ amount/day ___________ History of abuse? _______ (Y / N)

Illicit Drug use Y / N ____ History of use Y / N ____

I am: Single, Married, Divorced, Widowed? __________________

I am: Pregnant, or Planning to become Pregnant ________ (Y / N / NA) Last menstrual period __________

Does anyone live with you? _______ If so, who? _________________________

Education Background: (circle all that applies)

GED High School College Technical School Other ______________

Family History: Do any of your immediate family members have a history of a major disease? (For example: heart disease, lung disease, bone disease) if so, please list here:

Mother ____

Father ____

Sister ____

Brother ____

PAIN CLINIC – PATIENT INTAKE FORM

Review of Systems:

Do you have any of the following symptoms? Please list all symptoms that apply.

CONSTITUNTIONAL

Fever/chills/sweats/weight change ______________________________

EYES, EARS, NOSE

Headaches/eye, ear or nose problems ______________________________

CARDIOVASCULAR

Chest pains/murmur/fluttering in chest ______________________________

RESPIRATORY

Short of breath/productive cough ______________________________

GASTROINTESTIONAL

Diarrhea/constipation/incontinence ______________________________

NEUROLOGIC

Weakness/loss of balance/falls ______________________________

SKIN

Skin rash/hives/ulcers ______________________________

PSYCHIATRIC

Depression/anxiety ______________________________

ENDOCRINE

Diabetes/thyroid ______________________________

HEMATOLOGIC

Bleeding problems/anemia/swollen nodes ______________________________

ALLERGY/IMMUNOLOGIC

Seasonal allergies/asthma/hay fever ______________________________

LATEX ALLERGY

Have you ever been tested for a Latex Allergy? (Y / N) ____________

If so, what were the results? (Negative / Positive) ____________

Do you have eczema or problems with rashes? (Y / N) ____________

Do you have swelling, itching, hives, or other symptoms after contact with:

- Balloons (Y / N) ________________
- Dental Examination or Procedure (Y/ N) ______
- Vaginal or Rectal Exam (Y / N) ____________
- Using a Diaphragm or Condom (Y / N) _______
- Wearing Rubber Gloves (Y / N) ____________

Have you experienced an unexplained anaphylactic episode? (For example: rapid heart, swelling of your throat and respiratory distress all at the same time) (Y / N) _________

If yes, which one? ______________________________

FOOD ALLERGY

Are you allergic to any of the following? If so, indicate which ones and the reaction.

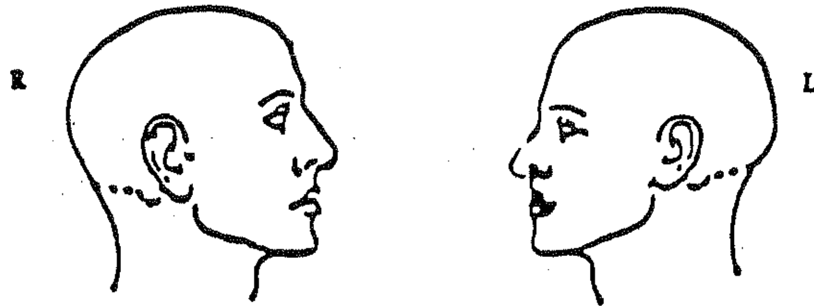
Bananas / Avocados ______________________________

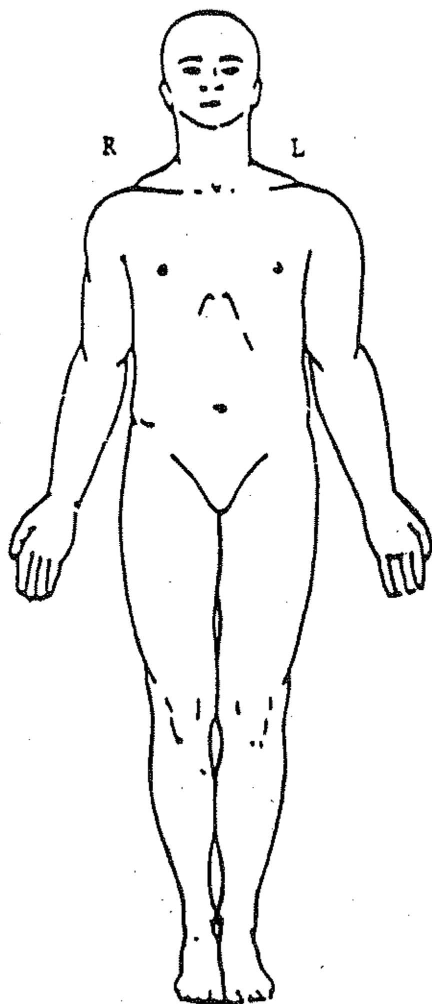
Kiwi Fruit / Chestnuts ______________________________

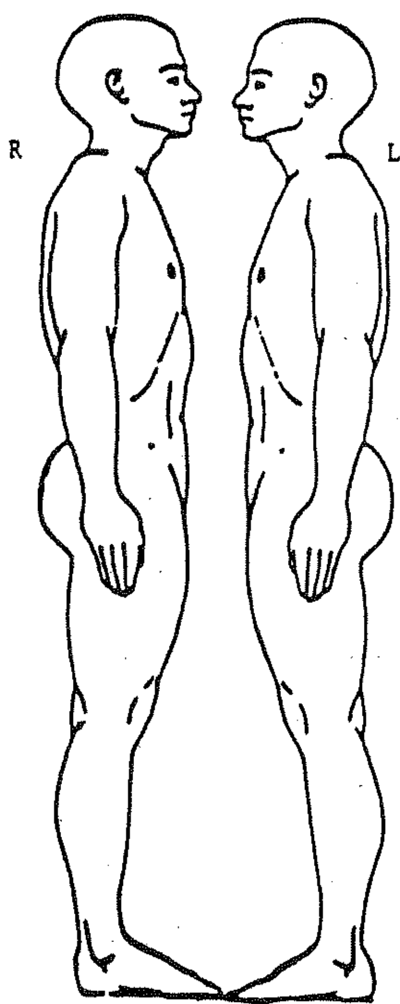
****Nursing**** If patient answers yes to BOTH a **LATEX ALLERGY** and **ANY** of the above questions were answered yes, NOTE **LATEX ALLERGY** on the front of the chart.

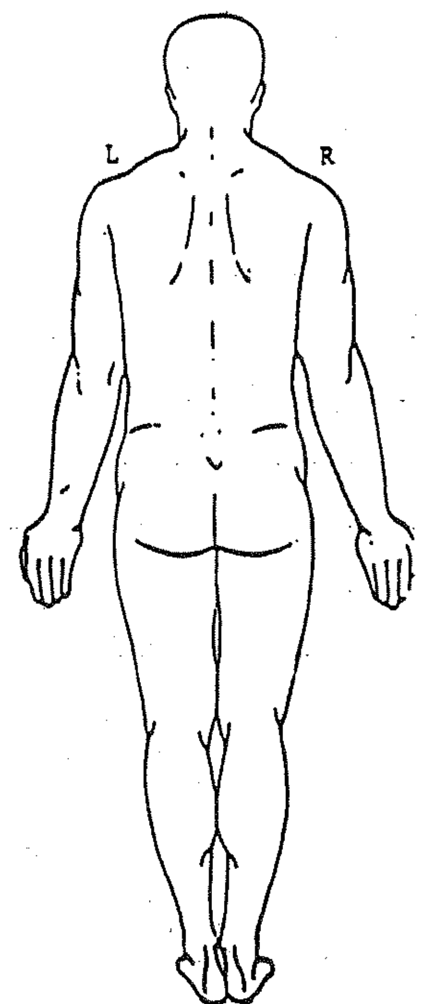
PAIN CLINIC – PATIENT INTAKE FORM

Please SHADE in, on the drawings below, the areas where you feel pain.









Intake form completed per patient responses.

Date ____________________ RN Signature ____

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PMS-1 3/12

PAIN CLINIC – PATIENT INTAKE FORM

DIAGNOSIS: ____

____

____

____

PLAN: ____

____

____

____

______________________ ______________

PHYSICIAN SIGNATURE **DATE**

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