Greater St. Louis Pain Management
11716 Studt Ave
St. Louis, MO 63141
Phone: 314-997-1888
Fax: 314-838-2788

Please complete the following forms and bring them with you when you come for your appointment with Dr. Chen at the Pain Management Center. Filling out the forms prior to your arrival will expedite your visit.

After consultation with the physician, you may or may not receive a treatment. Please expect a 30-minute stay after treatment is given. Regarding transportation back to your residence, for your safety you are advised to arrange for someone else to drive you home.

Please arrive 10 minutes before your appointment to fill out paperwork.

Thank you.

If you have had any x-rays, CT scans and/or MRI, please bring the results with you the day of your appointment.

Greater St. Louis
Pain Management Center

Patient Name _____

Date Completed _____

Patient Intake Summary

The information requested on this form will be very helpful to us in working out with you the best treatment program for your pain. Please answer each question and add additional comments if you feel they would be helpful. If you cannot answer some questions, a staff member will be available to assist you in completing this form. This information you give will be confidential and will not be released to anyone, but the Doctor who referred you, without your consent.

I. Name _____ Date of Birth _____
Age _____ Sex _____

Street Address _____
City _____ State _____ Zip _____

Home Phone Number _____
Cell Phone Number_____
Business Phone Number _____
Employer_____

Marital Status: Married _____ Divorced _____ Single _____ Widowed _____

Children (names and ages): _____
_____
_

Who referred you to the Pain Management Center? _____

Why did they refer you? _____

List all the physicians whose care you are under: _____
_____
_
_____

II. Occupation:

A. What work do you do? What does your work involve?

B. How many hours per week? _____

C. How much work, if any, have you missed in the past month due to pain? _____

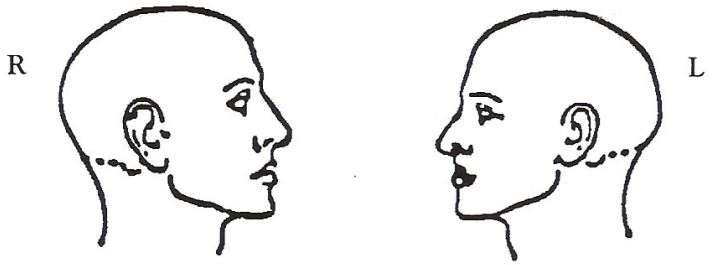
D. How has pain affected your work (check those that apply)?

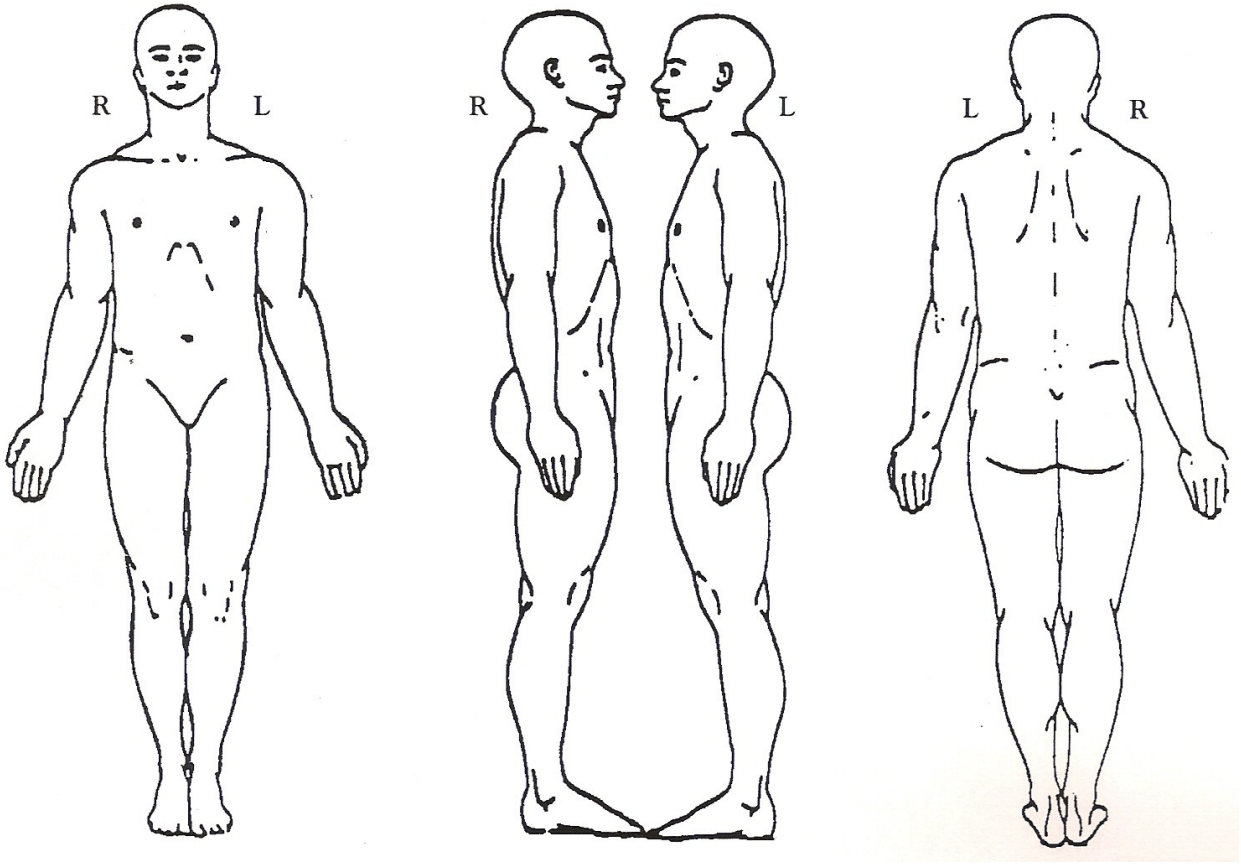
Missing work ____ Problems with co-workers ____

Problems with supervisors ____ Limiting job activities ____

III. Pain Description and Factors Influencing Pain

A. Please shade in with a pencil, on the drawings below, the areas where you feel pain.





B. Describe in your own words what your pain is like (where it is, how it feels, etc.):
_____
_____
_____

C. How long have you had this problem? _____

D. How did your pain problem first start? (accident, etc.). Please describe:
_____
_____
_____

E. How frequently do you have pain (check those which apply)?
constant ____ comes and goes ____
Always there, sometimes worse than others ____ other ____

F. Check any of the following symptoms you have:
numbness ____ tingling ____ burning sensation ____ change in vision ____
ringing in ears ____ fatigue ____ sweating ____ nausea ____ vomiting ____
dizziness ____ constipation ____ diarrhea ____
waking up early in the morning ____
weight loss ____ weight gain ____ loss of appetite ____ weakness ____
cough ____ difficult menstrual periods ____
other:

G. People agree that the following five words represent pain of increasing intensity:

1.	2.	3.	4.	5.
mild	discomforting	distressing	horrible	excruciating

To answer each question below, write the <u>number</u> of the most appropriate word in the space beside the questions.
1. Which word describes your pain right now? _____
2. Which word describes it at its worst? _____
3. Which word describes it when it is least? _____

H. Which of the following helps reduce your pain? (check all that apply):
heat ____ rest ____ standing ____ cold ____ pacing ____ sitting ____
involving myself in some activity ____ thinking about other things ____
other (please specify) _____
_____
_

I. What <u>increases</u> your pain? (check all that apply):
sitting ____ activity (moving around) ____ cold ____ standing ____
lifting ____ pushing ____ damp weather ____ lying down ____ tension ____

J. What do you think causes your pain and what will help relieve it?

IV. Previous Treatments for Pain

Which, if any, of the following treatments have you had for your pain problem and how helpful were these treatments in relieving your pain (check all that apply and check how helpful they were)?

TREATMENT	check if you've had this	How helpful was this?		
		very	some	not at all
Nerve Blocks				
Surgery				
TENS Unit				
Occupational/Physical Therapy				
Biofeedback				
Hypnosis				
Psychological Therapy				
Other				

V. PAIN EFFECTS

Please be specific in answering the following questions.

A. How do family/friends know when you're experiencing pain? _____
_____

B. Has the pain affected your mood (e.g. sadness, nervousness)? _____
_____

C. How do you act toward your family/friends when you're experiencing pain? ____
_____

D. How do family/friends act toward you when you experience pain? _____
_____

E. If you didn't have pain, how might your life be different (what could you do that you cannot do now)? _____

VI. Medical History Weight _____ Height _____

A. Circle any of the following conditions you have had or presently have and note when this was diagnosed. Please add comments you feel would be helpful:

Condition	Date Diagnosed	Comments
Diabetes		
Asthma		
Cancer		
Arthritis		
High Blood Pressure		
Heart Problems		
Emphysema		
Allergies		
Ulcer		
Kidney Problems		
Bleeding Problems		
Others:		

B. List any surgeries you have had:

Type of Surgery	Date

C. Which of the following tests have you had to evaluate your pain problem?

Test	Date	Result
X-ray		
Laboratory tests (blood, urine)		
CT scan		

EMG (Nerve Conduction)		
Myelogram		
Thermogram		
Other		

D. Do you smoke? Yes ____ No ____ How much? _____
E. Do you drink alcoholic beverages? Yes ____ No ____ How much? _____

VII. Medications

A. Are your allergies to any medications? If yes, which ones?

B. Current Medications

What, if any, medication(s) are you taking now? Please list all medications, both prescription and over-the-counter. Check how effective any of the following have been for pain relief.

Name of Medication	Why was this prescribed?	How much do you take and how often?	How Effective? (check one) very	somewhat	not at all

C. Past Medications

Name of Medication	How much did you take and how often?	How effective? (check one) very	somewhat	not at all

VI. Litigation

A. If your pain is due to an accident, is litigation (legal suit) or an insurance settlement pending? If yes, describe the current state of litigation or settlement:

_____

_____

_____

B. Do you have plans to pursue a legal or insurance settlement in the future? If yes, describe what you may do: _____

_____

VII. Goals of Therapy

Please list below the goals you would most like to achieve by participating in this treatment program. Select goals that you think you can personally attain. Define your goals in terms of specific behaviors as in the example below and describe what you can do now:

	Behavioral Goal	What can you do now?
EXAMPLE	a. Sitting in a chair for one hour at a time.	Able to sit for 10 minutes
	b.	
	c.	
	d.	
	e.	

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and authorize payment of the covered insurance and health care benefits, including all major medical benefits, otherwise payable to me to be made directly to the physician and/or clinical furnishing services to me including, but not limited to, T. Z. Chen, MD. I understand that health insurance providers, and commercial insurance companies, may not cover part of the medical services rendered and I fully understand that I am financially responsible for and agree to pay all charges not paid by my health care coverage.

I authorize the release of medical information as may be required to process the claims for payment of the medical services rendered and it is expressly understood that the right of such information to be privileged is hereby waived.

I have had the opportunity to discuss with the physician or his staff to my satisfaction the nature of the treatment administered and I acknowledge that no guarantees have been made to me as to the results of such treatment. This form has been fully explained to me and I have had the opportunity to ask any questions concerning the charges for the treatment. I am satisfied that I fully understand this assignment and its significance.

A copy of this assignment shall be considered as valid as the original.

x _____
Signature of Patient

Social Security # _____
Employer-Firm _____
Insurance
Company _____
(primary)
Address _____
_____
Certificate or Policy # _____
Group Individual

x _____
Signature of Insured

Social Security # _____
Employer-Firm _____
Insurance
Company _____
(primary)
Address _____
_____
Certificate or Policy # _____
Group Individual

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FINANCIAL STATEMENT

To Our Patients:

We strongly feel that patients deserve the best possible medical care. In an effort to maintain this high quality of care, I would like to share with you some facts about Health Care Benefits.

Understanding your Health Care Benefits has become increasingly complex. Health insurance groups each have specific rules and limitations attached to their policies. You may find that your specific policy does not cover part of the health care services that I provide. It is unfortunate that health insurance companies sometimes place limitations on the kind or amount of care they will cover.

You will be asked to provide insurance information at the time of your first visit. If your insurance requires preauthorization, which applies to most HMO's, please make the necessary arrangements prior to each visit. The Billing/Insurance Department is familiar with many insurance plans and will be happy to assist you.

I am not involved in any way with the decision-making policies of the health insurance providers. Since the professional care is rendered to the patient, you will be responsible for any portion of your care not covered by your health insurance provider.

All co-payments will be due and collected the day medical services are rendered.

Deductibles will be billed and expected to be paid promptly.

After payment has been received from your insurance company, any remaining balance will be billed to your from the Patient Billing Department. Should you have any questions regarding our billing procedures, please contact the Patient Billing Department at 314-997-1888.

To summarize, it is my goal to provide quality and compassionate care for all of my patients despite the increasing limitation of the insurance industry. My office will continue to accommodate you by filing your insurance claims on your behalf.

Thank you for choosing Greater St. Louis Pain Management Center as your healthcare provider.

x _____
Signature of Patient

I am satisfied that I fully understand this statement.