Shoreline Interventional Pain Center
T:860-771-4960 | F: 860-771-4953 | Shorelinepain.com

APPOINTMENT:_____

- Please complete the enclosed packet and bring to your appointment.
- Please arrive 30 minutes before your appointment to create or update your medical records.
- Please bring your insurance card and identification card.
- Please bring your MRI or CT SCAN DISC if it was performed anywhere OTHER than L&M Hospital.

Directions to our office:

Upon arrival at Lawrence and Memorial Hospital:

- Enter through the MAIN ENTRANCE
- Take PEACH ELEVATOR to FLOOR 2
- TAKE LEFT out of the elevator and pain clinic is the first office on the left. Suite 2.006

For office use only:

☐ BMI ☐ SMOKING

☐ DEPRESSION ☐ FALL RISK

SUDHIR KADIAN, MD
50 FAIR HARBOUR PL STE 2D
NEW LONDON, CT 06320
Phone: 860-771-4960
Fax: 860-771-4953

PATIENT NAME: _____ **GENDER:** _____
FIRST MIDDLE INITIAL LAST

DATE OF BIRTH: _____ **AGE:** _____ HEIGHT: _____ WEIGHT: _____**MARITAL STATUS**: _____
MONTH/DAY/YEAR

STREET ADDRESS: _____ C**ITY**: _____ **STATE**: _____ **ZIP**: _____

TELEPHONE (Home) _____ **(Work)** _____ **(Cell)**_____

SOCIAL SECURITY #: _____ **OCCUPATION:** _____

EMAIL:_____

NAME OF EMPLOYER:_____

REFERRING DOCTOR:_____

PRIMARY CARE DOCTOR :_____

PHARMACY YOU USE: (name, city, state):_____

EMERGENCY CONTACT:

NAME_____RELATIONSHIP TO PATIENT_____ PHONE #_____

DID INJURY OCCUR AT WORK? YES/NO **INJURY DATE**: ____/____/____

How did the injury happen? _____

IF LIABILITY CASE, NAME & ADDRESS OF ATTORNEY: _____

_____

IS INJURY RELATED TO MOTOR VEHICLE ACCIDENT: YES/NO **ACCIDENT DATE**: ___/___/___

INSURANCE CARRIER & CLAIM #: _____

CONTACT PERSON: _____

PRESENT PAIN HISTORY

Where is the primary location of your pain? _____

How long has your pain been present? _____

What activities, if any, increase your pain? _____

What activities decrease your pain? _____

Have you had any physical therapy or chiropractic manipulation for your present problem? YES/ NO

If Yes, Whom did you see? _____
Was it beneficial? YES/NO/SOMEWHAT

List the medications have you tried to treat this pain:

Medication	Has it helped?	Was there any negative reaction?
_____	YES/ NO	_____
_____	YES/ NO	_____
_____	YES/ NO	_____

Please rate your pain that you are experiencing **NOW**, at this very moment:

0 1 2 3 4 5 6 7 8 9 10

Please rate your **AVERAGE** pain over the last 2 weeks

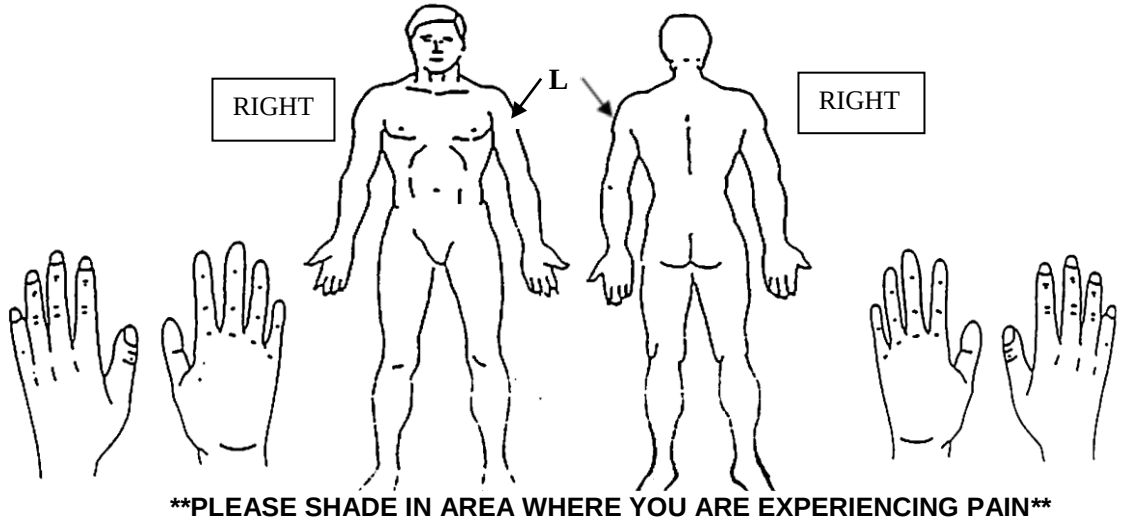
0 1 2 3 4 5 6 7 8 9 10

In the past week, what number describes **HOW PAIN HAS INTERFERED WITH YOUR ENJOYMENT OF LIFE:**

0 1 2 3 4 5 6 7 8 9 10

In the past week, what number describes **HOW PAIN HAS INTERFERED WITH YOUR GENERAL ACTIVITY?**

0 1 2 3 4 5 6 7 8 9 10



****PLEASE SHADE IN AREA WHERE YOU ARE EXPERIENCING PAIN****

MEDICATIONS AND ALLERGIES

Are you on any of the following medications? Please circle all that apply.

Aspirin Coumadin Plavix Lovenox Xarelto

Prescriber:_____

Please list all of your current prescriptions, including any "over the counter" medications or herbal substances that you are currently taking: **(A copy of your personal list can be used.)**

MEDICATION	DOSE (MG)	TIMES A DAY	PRESCRIBER

Do you have any allergies to any medications? YES / NO
Please list the medications and the associated reaction below.

MEDICATION	REACTION

Please circle if you have any allergies to:

Iodine Shellfish IV/CAT Scan Dye

If applicable, what was the reaction: _____

PERSONAL MEDICAL HISTORY

Please check all conditions/illnesses that pertain to you:
WOMEN:

Are you trying to conceive? YES / NO

Is there a possibility that you could be pregnant? YES / NO

General

__Aids
__HIV
__SHINGLES

Eyes

__Cataracts
__Glaucoma
__Detached retina
__Diabetic retinopathy

Neurologic

__Seizure Disorder/Epilepsy
__Multiple Sclerosis
__Stroke/TIA
__Weakness of extremities

Respiratory

__Asthma
__Tuberculosis
__Chronic Obstructive Pulmonary Disease
__Sarcoidosis
__Asbestos Exposure

Gastrointestinal

__ Liver disease
__ Hepatitis
__ Jaundice
__ Ulcers
__ Gastritis
__ Reflux
__ GI Bleed

Musculoskeletal

__Fractures
__Arthritis
__Osteoporosis
__Osteopenia
__Fibromyalgia
__Scoliosis

Cardiovascular

__Heart Attack
__High Blood Pressure
__High Cholesterol
__Pacemaker/Defibrillator
__Irregular/Rapid Heartbeat

Hematologic

__Anemia
__Lymphoma
__Blood Clots
__Hemophilia
__Leukemia

Endocrine

__Diabetes
__Thyroid Disease
__Parathyroid Disease

History of Cancer

Cancer Type_____

Date Diagnosed_____

Treatment Rendered_____

Oncologist _____

Psychiatric History

__Psychosis
__ Anxiety
__Suicidal attempt
__ Depression
__ Drug Overdose
__Borderline Personality Disorder
__ Other _____

COMPLETE SURGICAL HISTORY

List Any Previous Surgeries or Illnesses (including psychiatric) for which you have been hospitalized:

SURGERY/HOSPITALIZATION	HOSPITAL	YEAR

FAMILY MEDICAL HISTORY

Mother : **State of Health:** ___good ___poor ____ deceased
Father : **State of Health**: ___good ___poor ____ deceased

Please notate medical conditions of your immediate family member using:
F=father, M=mother, B=brother, S=sister, A=aunt, U=uncle, GF=grandfather, GM=grandmother. Please indicate if family member is maternal or paternal.

____Diabetes ____Stroke
____Hypertension ____Alcoholism
____Thyroid Disorder ____Rheumatoid Arthritis
____Heart Disease ____Lupus
____Mental History ____Bleeding Disorder
____Cancer (type(s) and family member(s) affected _____

____Other _____

SOCIAL HISTORY

SMOKING HISTORY

Do you presently smoke cigarettes or use tobacco in any form? YES / NO

If NO, did you ever smoke cigarettes or use tobacco in any form? YES / NO

How many cigarettes do you smoke a day? _____

How soon after you wake up do you smoke?____

Are you ready to quit? YES / NO

ALCOHOL

Did you have a drink containing alcohol in the past year? YES / NO

How often? _____

How much? _____

How often did you have 6 or more drinks on one occasion?_____

Have you ever had a problem with alcohol abuse presently or in the past? YES / NO

Have you been through a rehab program? YES / NO

Have you used any illicit drugs other than those for medical reasons in the last 12 months? YES / NO

If YES, please indicate below which of the following drugs or substances

Amphetamines____ Barbiturates____ Cocaine___ Heroin____ Marijuana____ Other_____

REVIEW OF SYSTEMS

Are you experiencing any of the following at this time? (Please check all that apply.)

____Chronic headache _____Blood in stool
____Unexplained weight loss _____Black tarry stools
____Loss of appetite _____Abdominal pain
____Blurred vision or loss of vision _____Bruise easily
____Shortness of breath _____History of bleeding problems
____Chest pain _____Loss of Control of Bladder/Bowel

AGREEMENTS OF CARE

I hereby authorize any physician, health care practitioner or other medically related service, to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to my health insurer.

I also authorize my health insurer to disclose to a hospital, provider or health care service plan, self-insurer, or an insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a Group Contract held by an employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review of an audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with any health insurer including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, and our heirs, executors and administrators.

I hereby authorize payment of benefits to be made to the clinician rendering the service. I will be held responsible for any costs which are not covered by my insurance carried, and will be billed directly for such costs.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

The Notice of Privacy Practices has been made available to me and is understood.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

If Parent/Guardian, Relationship to Patient: _____

Providers Signature: _____ Date:_____

NO SHOW AND CANCELLATION POLICY

Thank you for choosing our practice to assist you with your care. We appreciate your trust and are committed to providing you with high quality, compassionate care.

We value our patients and tailor their treatment plans according to their unique needs, in doing so, we allocate time for each appointment accordingly. We realize that circumstances may occur beyond your control that may not allow you to provide 24-hour notification. **Failure of a patient to notify the office to cancel or change their appointments without 24-hour notice is considered a "No Show"**. To help remind patients of their appointments we have implemented an automated reminder system. Please ensure we have your correct and most-up-to date phone numbers or email address at all times throughout the course of your treatment to allow us to better serve you.

The "no show" appointments will be documents in the patient record.

Charges for "no show" appointments are as follows:

- **Office visit: $50.00**
- **Procedure/surgical center visit: $100.00**

This letter will serve as notice about the office "no show" policy and fees.

I acknowledge that I have read and understand the policy.

Patient Name: _____

Patient Signature: _____ Date: _____

Authorization to disclose protected health information (PHI)

Patient Name:_____ DOB:_____ Date:_____

Number To Leave Messages At:

By signing blow, I hereby authorize the practice to leave my protected health information including, but no limited to, results, prescriptions and appointments at the following number:

_____

Patient's signature:_____ Date:_____

People To Leave Messages With:

By signing below, I hereby authorize the practice to leave my protected health information including, but not limited to, results, prescriptions and appointments with:

(Name):_____ Relationship:_____

(Name)_____ Relationship:_____

Release to fax:

By signing below, I hereby authorize the practice to fax my protected health information to the following number:_____.

Patient's signature:_____ Date:_____

Oswestry Low Back Pain Disability Index 2.1

Directions: This questionnaire has been designed to give us information as to how your **BACK (or LEG)** trouble has affected your ability to manage in everyday life. Please answer every section. Mark one letter only in each section that most closely describes you today.

Section 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 - Personal Care (washing, dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than a quarter mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 4 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 5 - Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than half an hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 - Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than half an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 - Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain, I have less than 6 hours sleep.
- Because of pain, I have less than 4 hours sleep.
- Because of pain, I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

Section 8 - Sex Life (if affected by pain)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

Section 9 - Social Life

- My social life is normal and causes me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sports, etc.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

Section 10 - Traveling

- I can travel everywhere without pain.
- I can travel everywhere but it gives me extra pain.
- Pain is bad but I manage journeys over two hours.
- Pain restricts me to journeys of less than one hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to receive treatment.

2018 Annual MIPS Questionnaire General

Patient Name: _____ Date: _____

1. Do you have little or no interest in doing things? ____ No

____ Yes, please check one: ____ Several Days ____ More than half the days ____ Everyday

2. Are you feeling down, depressed or hopeless? ____ No

____ Yes, please check one: ____ Several Days ____ More than half the days ____ Everyday

If you answered YES to question 1 or 2, then complete the following table. If you answered No to both question 1 and 2 then you DO NOT have to complete the table, skip to Immunizations below.

	Not at all (O)	Several days (1)	More than half the days (2)	Everyday (3)
3. Do you have trouble falling or staying asleep or sleeping too much?				
4. Do you feel tired or have little energy?				
5. Do you have poor appetite or overeating?				
6. Do you feel bad about yourself, feel like a failure, or feel you have let yourself or your family down?				
7. Do you have trouble concentrating on things, such as reading the newspaper or watching television?				
8. Do you move or speak so slowly that other people could have noticed? Or the opposite? Are you fidgety or restless and move around more than usual?				
9. Do you have thoughts that you would be better off dead and/or have thoughts of hurting yourself in some way?				

Have you fallen in the past year? (Answer only if 65 years and older.)

____ NO ____ Yes : ___ 1 fall with injury ___ 2 or more falls with injury

___ 1 fall without injury ___ 2 or more falls without injury