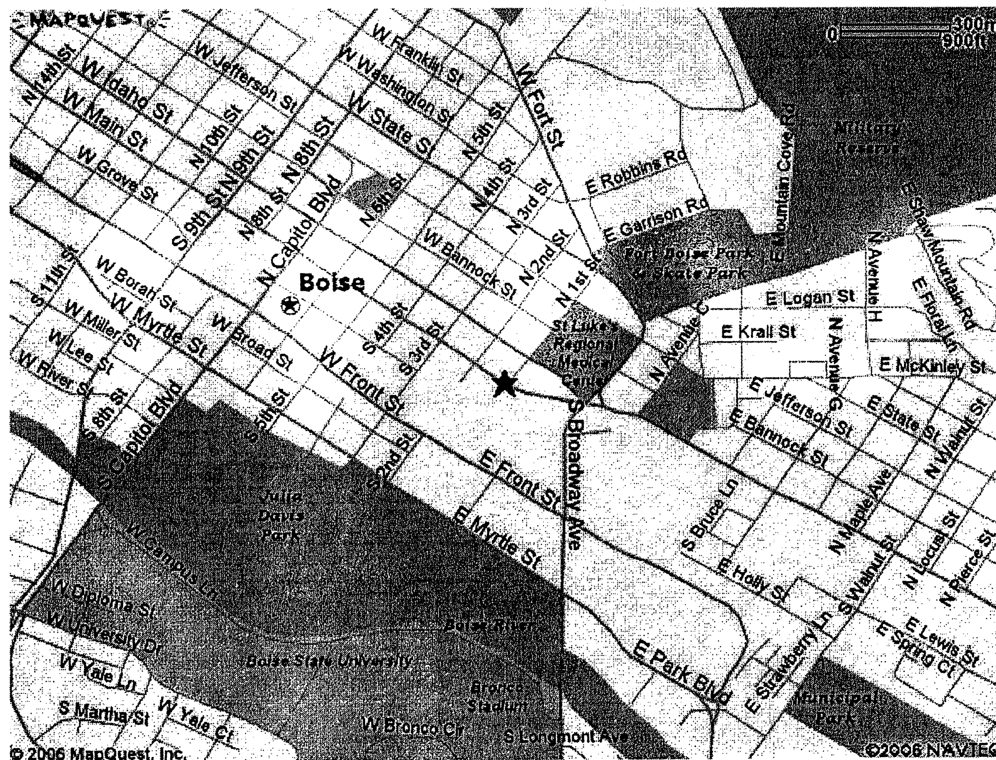
THE CENTER FOR PAIN CARE

115 W. Main Street Suite 102
Boise, ID 83702
Phone (208)342-4700
Fax (208)342-4710

Our office is located between 1st and 2nd on Main Street in the Main Street Professional Building

Parking is around the back of the building. Entrance to parking lot is between The Ronald McDonald House and Les Bois Building



PLEASE CIRCLE YOUR PAIN LEVEL TODAY ON A SCALE OF 1-10
(1 IS NO PAIN AND 10 IS THE WORST PAIN IMAGINABLE)

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

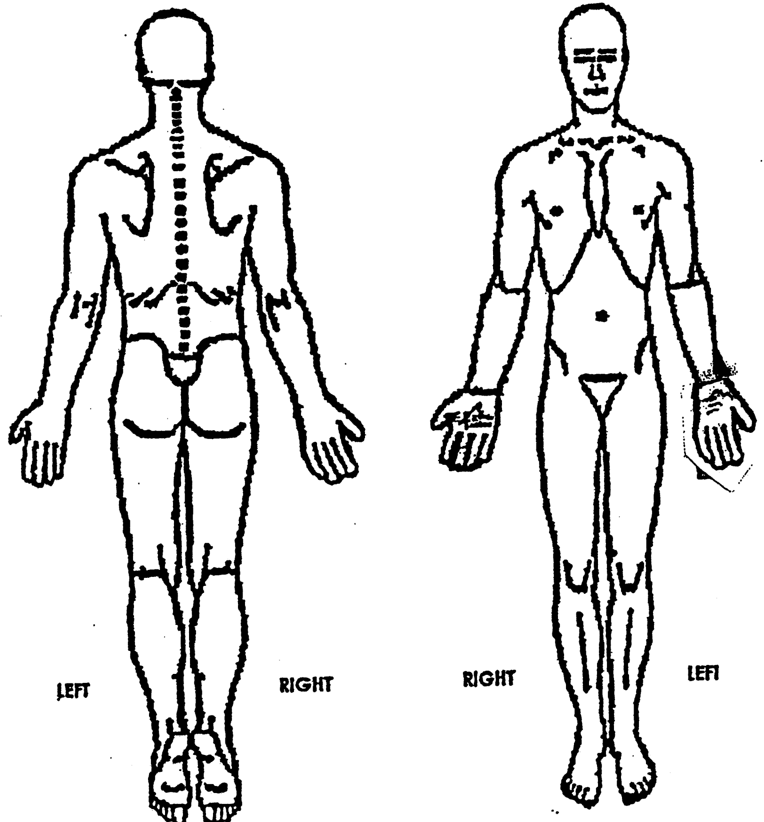
- Is your pain constant______ periodic_____ or a result of activities_______?
- Is your discomfort the same_____ better_____ worse____ than your last visit?
- How many hours of uninterrupted sleep do you get per night? ________.
- How many hours do you nap per day? _______.
- Are you currently working your normal job? Yes___ No___ Please detail: Date last worked__________ Reason off work (disability, terminated, etc) ______________________________, if on disability list authorizing physician.______________________________________, if working list restrictions, _________________________________.
- Are you performing normal daily activities? Yes_____ No_____.
- Are you currently in a physical therapy program Yes____ No____.
- Do you feel that you are progressing? Yes____ No____.
- Have you been instructed in relaxation techniques? Yes____ No____.
- Have you had any procedures? Yes____ No____ How many____ Date of last Procedure__/__/__ Response_____________________________________.

- Please list all medications/dosage/frequency (including over the counter medications) that you are currently taking: (*if more room is needed continue on the back.*)

1. ____________________ 4.____________________ 7.____________________
2. ____________________ 5.____________________ 8.____________________
3. ____________________ 6.____________________ 9.____________________

On the diagram, please use colored markers to Indicate the type and location of pain.

- Aches..................Yellow
- Burning...............Blue
- Stabbing..............Red
- Numbness............Black
- Pins & Needles.......Green



Name: ______________________________

Date: ______________________________

THE CENTER FOR PAIN CARE P.A.

208.342.4700
fax: 208.342.4710

115 W. Main St. Ste. 102
Boise, ID 83702

☐ New ☐ Change Effective Date _____ / _____ / _____

Account #: ________________

PATIENT DEMOGRAPHIC INFORMATION

PERSONAL INFORMATION

Legal Name: ____ Nickname: ____________
(Last Name) (First Name) (Middle)

Address: ____ Male: ______ Female: ______

City: ____________________ State: ____________ Zip: ____________

Phone Number: _____ - _____ - _____ (Home) _____ - _____ - _____ (Work) _____ - _____ - _____ (Cell)

Date of Birth: _____ / _____ / _____ Marital Status: ______ SSN: ____________

Employer: ____
(Name) (Address)

Emergency Notification (other than person living in household): ____________________ Phone: _____ - _____ - _____

REFERRAL INFORMATION

Referring Physician: ________________________________ Phone: _____ - _____ - _____

Family Physician: ________________________________ Phone: _____ - _____ - _____

Reason for Visit: ____

PAYOR SOURCE Is this a work-related (workman's comp claim) injury? Yes ☐ No ☐ Auto Injury? Yes ☐ No ☐

This section must be completed if you answered Yes to the above questions:

Company Name: ____________________ Claim Number: ____________________

Address: ____

Contact Person: ____________________ Phone Number: _____ - _____ - _____

Date of Injury: _____ / _____ / _____ Have you contacted an attorney? Yes ☐ No ☐

Health insurance coverage? ☐ Primary ____________ ☐ Secondary ____________ ☐ None

Are there any imaging studies available? Yes ☐ No ☐ Diagnosis: ____________________

____

According to HIPAA regulations, The Center For Pain Care may provide my spouse and/or primary home caregiver access to my health information. In addition to my spouse and/or primary home caregiver, I also authorize The Center For Pain Care to disclose my protected health information to the following individual(s):

By signing below, I ***DO NOT*** authorize The Center For Pain Care to grant access to my health information to my spouse and/or home caregiver.

______________________________ Patient Signature

______________ Date

CENTER FOR PAIN CARE P.A.

Effective Date: ___/___/___

PATIENT INSURANCE INFORMATION

WE WILL NEED TO MAKE A COPY OF YOUR INSURANCE CARD(S)

Personal Information

Legal Name: ______________________________ Nickname: ______________
(Last Name) (First Name) (Middle)

Account #: ______________

Insurance Information Is this a work-related (workman's comp claim) injury? Yes ☐ No ☐ Auto Injury? Yes ☐ No ☐

(This section must be completed if you answered Yes to the above questions:)

Company Name: ______________________ Claim Number: ______________

Address: ____

Contact Person: ______________________ Phone Number: _____ - _____ - _____

Date of Injury: _____ / _____ / _____ Have you contacted an attorney? Yes ☐ No ☐

Primary Insurance Company: ______________________ Phone Number: _____ - _____ - _____

Address: ____
(Street Number & Name) (City) (State) (Zip)

Contract Number: ______________________ Group Number: ______________

Subscriber Legal Name: ______________________ Effective Dates: _____ / _____ / _____

Subscriber SSN: ______________________ Subscriber Date of Birth: _____ / _____ / _____

Subscriber Employer: ______________________ Phone Number: _____ - _____ - _____

Subscriber Relationship: ______________________

Secondary Insurance Company: ______________________ Phone Number: _____ - _____ - _____

Address: ____
(Street Number & Name) (City) (State) (Zip)

Contract Number: ______________________ Group Number: ______________

Subscriber Legal Name: ______________________ Effective Dates: _____ / _____ / _____

Subscriber SSN: ______________________ Subscriber Date of Birth: _____ / _____ / _____

Subscriber Employer: ______________________ Phone Number: _____ - _____ - _____

Subscriber Relationship: ______________________

AGREEMENT TO PAY:
I agree to pay my physician all charges for services rendered. I agree to be responsible for all un-reimbursed expenses not covered by insurance. I further understand that my agreement with my insurance company is independent of my agreement with my physician and agree to be responsible for all charges for services rendered. I FURTHER AGREE THAT IN THE EVENT ANY CHARGES MADE BY MY PHYSICIAN ARE NOT PAID AND THIS MATTER IS REFERRED TO AN ATTORNEY FOR COLLECTION, I AGREE TO BE RESPONSIBLE FOR ALL COSTS OF COLLECTION, INCLUDING REASONABLE ATTORNEY FEES.

______________________________ ______________
Signature *Date*

ZUNG SELF-RATING DEPRESSION SCALE

Patient's Initials

Date of Assessment

Please read each statement and decide how much of the time the statement describes how you have been feeling during the past several days.

Make check mark (✓) in appropriate column.	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted and blue				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping at night				
5. I eat as much as I used to				
6. I still enjoy sex				
7. I notice that I am losing weight				
8. I have trouble with constipation				
9. My heart beats faster than usual				
10. I get tired for no reason				
11. My mind is as clear as it used to be				
12. I find it easy to do the things I used to				
13. I am restless and can't keep still				
14. I feel hopeful about the future				
15. I am more irritable than usual				
16. I find it easy to make decisions				
17. I feel that I am useful and needed				
18. My life is pretty full				
19. I feel that others would be better off if I were dead				
20. I still enjoy the things I used to do				

Adapted from Zung, A self-rating depression scale, *Arch Gen Psychiatry*, 1965;12:63-70.

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