Please fill out the enclosed questionnaire and the accompanying forms.

There are 3 ways you can get the forms to us.

1. Fax to us (and bring originals to your appointment):
   781-662-7241
   (This will be the fastest way to schedule you, and it will shorten the time you spend in the waiting room before your appointment.)

OR

2. Mail to us:
   Boston Pain Specialist, PC
   50 Tremont Street Suite 103
   Melrose, MA 02176

OR

3. Bring the forms with you on your appointment date

Dr. Sasa Periskic Date: _____

Boston Pain Specialist

Initial Patient History/Assessment

Name: _____ DOB: _____

Nickname: _____

Who referred you: _____

Primary care physician: _____

Pharmacy name and address: _____

Where is the worst pain in your body: □ BACK □ NECK □ OTHER: _____

When did your pain begin: _____

How did your pain begin:
□ Accident at work
□ Auto accident
□ Pain just began
□ Other reason

Briefly describe the circumstances you checked: _____

_____

Please mark what your pain level is AT THE PRESENT TIME:

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

No Pain Moderate Pain Worst Possible Pain

_____

Please mark what your pain level is WHEN IT'S AT IT'S WORST:

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

No Pain Moderate Pain Worst Possible Pain

Please check what makes your pain feel:

Worse	Better
□ Walking	□ Medication: _____
□ Lifting	□ Heat
□ Bending	□ Ice
□ Lying	□ Rest
□ Sitting	□ Lying
□ Standing	□ Standing
□ Weather/Temperature change	□ Sitting
□ Other: _____	□ Weather/Temperature change
	□ Other: _____

Please describe your pain (check all that apply):

□ Pricking □ Ache □ Burning

□ Throbbing □ Sharp/Stabbing □ Shooting

□ Dull □ Pulling

□ Other: _____

Does your pain radiate (i.e. travel down leg or down arm)? □ YES □ NO

If yes, please describe: _____

Have you had any acute loss of bowel/bladder control: □ YES □ NO

If yes, please describe: _____

Do you have numbness? □ YES □ NO

If yes, is it constant or occasional? □ CONSTANT □ OCCASIONAL

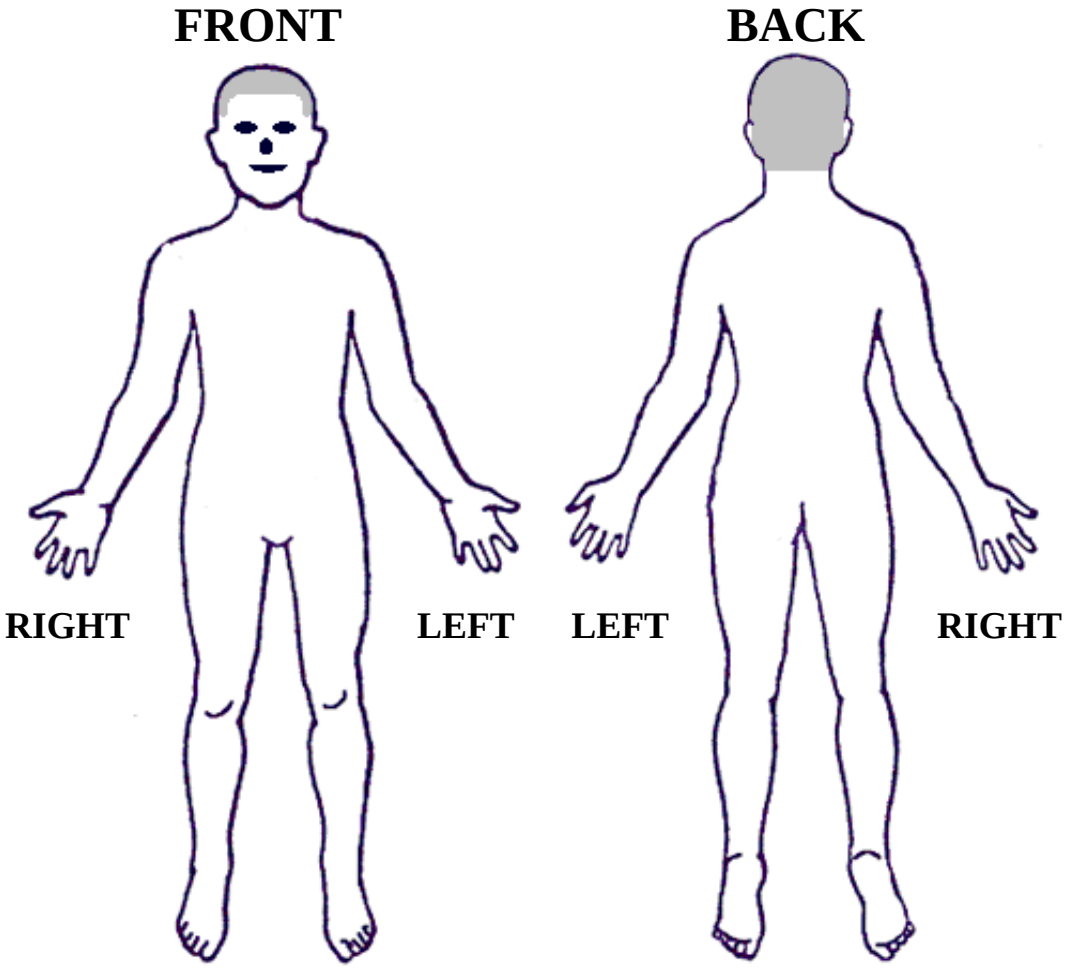
In what part of your body do you feel it? _____

How long ago did it begin? _____

Do you experience any weakness: □ YES □ NO

If yes, where? _____

Please mark the location(s) of your pain on the diagrams with an "x".
If whole areas are painful, please shade the entire area.



PREVIOUS TREATMENTS (please describe what, where and when):

	Helpful	Not Helpful
☐ Back Surgery: if yes, year _____ type _____	☐	☐
☐ Previous spinal injections: _____	☐	☐
☐ Physical Therapy: when? _____	☐	☐
☐ Other: _____	☐	☐

PAIN MEDICATIONS: please check/circle all that you have tried in the past or are currently taking:

	Helpful	Not Helpful
☐ TYLENOL/ACETAMINOPHEN _____	☐	☐
☐ NSAIDS: Motrin, Advil, Aleve, ibuprofen, naproxen, Celebrex _____	☐	☐
☐ MUSCLE RELAXANTS: Flexeril, tizanidine, cyclobenzaprine, Zanaflex, Soma _____	☐	☐
☐ NARCOTICS: Tramadol, Percocet, Vicodin, oxycodone, hydrocodone, morphine, dilaudid, methadone, Duragesic patch, MS Contin, Oxycontin, Other: _____	☐	☐
☐ OTHER PAIN MEDICATIONS: Lyrica, gabapentin/neurontin, amitriptyline _____	☐	☐
☐ OTHER: _____	☐	☐

PAST MEDICAL HISTORY:

Are you diabetic? □ YES □ NO

If yes, what is your average blood sugar?
□ less than 150
□ 150-200
□ over 200

Are you currently taking blood thinners? □ YES □ NO

If yes, which one?
□ Warfarin/Coumadin
□ Plavix
□ Aggrenox
□ Other: _____

Do you have any medical devices implanted in your body? □ YES □ NO
(e.g., pacemaker, defibrillator, portacath, pump, rods, artificial knee/hip)

If yes, please describe: _____

Do you have sleep apnea? □ YES □ NO

Do you have a history of cancer? □ YES □ NO

If yes, please describe what type, when/where/how it was treated: _____
_____

Do you have any allergies to: iodine, betadine, CT Scan dye,
IVP dye, contrast dye, or shellfish? □YES □NO

If yes, please specify reaction: _____

Do you have any other allergies? □YES □ NO

Please list, and describe reaction: _____

Current Medications:	Dose	Frequency	Date started	Efficacy (pain meds)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list all surgeries that you have had:

Surgery:	Date:	Surgery:	Date:
_____		_____	
_____		_____	
_____		_____	

Do you have any history of:

Asthma	□ YES	□ NO	Arthritis	□ YES	□ NO
COPD/Emphysema	□ YES	□ NO	Marked weight change	□ YES	□ NO
Bronchitis	□ YES	□ NO	Osteoporosis	□ YES	□ NO
Thyroid disease	□ YES	□ NO	Depression	□ YES	□ NO
Heart attack	□ YES	□ NO	Anxiety	□ YES	□ NO
Arrhythmia	□ YES	□ NO	Incontinence	□ YES	□ NO
Chest pain	□ YES	□ NO	Kidney disease	□ YES	□ NO
Ankle swelling	□ YES	□ NO	Liver disease	□ YES	□ NO
High blood pressure	□ YES	□ NO	Hepatitis	□ YES	□ NO
Coronary artery dis.	□ YES	□ NO	Alzheimer's	□ YES	□ NO
Fatigue	□ YES	□ NO	Brain tumor	□ YES	□ NO
Persistent fever	□ YES	□ NO	High cholesterol	□ YES	□ NO
Reflux	□ YES	□ NO	Abdominal pain	□ YES	□ NO
Ulcers	□ YES	□ NO	Seizure	□ YES	□ NO
Constipation	□ YES	□ NO	Stroke/TIA	□ YES	□ NO
Blood in stools	□ YES	□ NO	Tuberculosis	□ YES	□ NO
Hearing loss	□ YES	□ NO	Neck stiffness	□ YES	□ NO
Goiter	□ YES	□ NO	HIV	□ YES	□ NO

Other: _____

During the past month, how much did pain interfere with the following activities?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Ability to eat independently	1	2	3	4	5
Ability to bathe independently	1	2	3	4	5
Ability to toilet independently	1	2	3	4	5
Ability to dress independently	1	2	3	4	5
Ability to get up from bed/chair	1	2	3	4	5
Going to work	1	2	3	4	5
Performing household chores	1	2	3	4	5
Yard work or shopping	1	2	3	4	5
Socializing with friends	1	2	3	4	5
Recreation and hobbies	1	2	3	4	5
Having sexual relations	1	2	3	4	5
Physical exercise	1	2	3	4	5
Sleep	1	2	3	4	5
Appetite	1	2	3	4	5

During the past month have you been tense or anxious?

Never Seldom Sometimes Frequently Always

During the past month have you been depressed or discouraged?

Never Seldom Sometimes Frequently Always

During the past month have you been irritable and upset?

Never Seldom Sometimes Frequently Always

When you are in pain, how often is your husband/wife/other family supportive and encouraging?

Never Seldom Sometimes Frequently Always

Do you smoke? □ Yes □ No Per day: ____ No. of years: _____

How much Beer / Wine / Liquor do you use per week? _____

Did you ever in your life abuse alcohol, prescription drugs or any illegal drugs? □ Yes □ No

If yes, please describe: _____

PERSONAL:

Significant other: _____

Relationship: _____ Phone: _____

Do you take care of other family members? □ Yes □ No

(i.e. parents, children, etc): _____

Previous/Current Occupation: _____

Are you currently working? □ Yes □ No If no, why? _____

RESIDENCE:

□ House □ Apartment

□ Others: _____

□ Live alone

□ Live with anyone

□ Steps to climb (#) _____

Are you receiving compensation or disability payments now? □ Yes □ No
Are you in litigation because of your pain or injury? □ Yes □ No
Expectations from the Pain Center: _____

Tests Done:	Date:	Facility:
□ MRI	_____	_____
□ CAT SCAN	_____	_____
□ X-RAYS	_____	_____
□ EMG	_____	_____
□ Other	_____	_____

Do you have difficulty with:

Speaking □ Yes □ No
Vision □ Yes □ No
Hearing □ Yes □ No

Do you learn best by:

Verbal Instruction □
Visual Demonstration □
Written Instruction □
Hands on (if possible) □
Any of the above □

ASSISTIVE DEVICES:		Date Started Using	Frequency of Use
□ Glasses	□ Wheelchair	_____	_____
□ Contact Lenses	□ Cane	_____	_____
□ Hearing Aid	□ Walker	_____	_____
□ Dentures	□ Crutches	_____	_____
□ Prosthesis	□ Other	_____	_____

Reviewed by: Sasa Periskic, MD _____

REVIEW OF SYSTEMS

Please Circle Any Symptoms You Experience

General: fever, chills.

Eyes: double vision, eye pain.

Ears/Nose/Throat: earache, difficulty swallowing.

Cardiovascular: chest pain or pressure, palpitations.

Respiratory: productive cough, coughing up blood.

Gastrointestinal: vomiting, jaundice.

Urologic: blood in urine, flank pain.

Musculoskeletal: spine pain, joint pain.

Skin: rash, suspicious lesions.

Neurologic: nausea/vomiting, visual disturbances.

Psychiatric: thoughts of suicide, excessive anger.

Endocrine: excessive hair growth, palpitations.

Heme/Lymphatic: fevers, unusual bleeding.

Boston Pain Specialist

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

TELEPHONE: _____

ADDRESS: _____

I hereby authorize _____, MD to release my confidential medical records to:

Boston Pain Specialist
50 Tremont Street, Suite 103
Melrose, MA 02176
tel: 781-662-7246
fax: 781-662-7241

This medical information is being released and will be used for the purpose of patient care.

I have read this form carefully, understand the purpose of this form, and voluntarily consent to the disclosure of my medical records to Boston Pain Specialist. This includes alcohol/drug abuse records and test results including HIV/AIDS results.

I understand that I may revoke this consent at any time in the future, and that it will automatically expire 90 days after it is signed or after the specified release of medical records has been accomplished. I also understand that additional disclosure of this information is not permitted without my expressed written consent.

I further release _____, MD from any liability arising from the disclosure of my medical information to Boston Pain Specialist.

Today's Date: _____

Patient Signature: _____

Print Name: _____

Witnessed By: _____

Boston Pain Specialist

PATIENT INFORMATION

NAME: _____

DATE OF BIRTH: _____/_____/_____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: (_____) _____

MOBILE PHONE: (_____) _____

EMAIL ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____

IF NOT YOUR PCP, WHO REFERRED YOU? _____

Boston Pain Specialist

INSURANCE AUTHORIZATION

PATIENT NAME: _____

DATE OF BIRTH: _____

I hereby authorize my health care provider Boston Pain Specialist to affix my name to all insurance submissions, documents and/or information requested by my insurance company(s) relating to any and all health benefits due to my dependents and me.

I also authorize payment of healthcare benefits otherwise payable to me, directly to my doctor/healthcare provider as listed above. I understand that I will be held responsible for all charges and services not paid by my insurance company.

This signature on file (SOF) is valid from this date. A photocopy of this authorization may act as the original.

Today's Date: _____

Patient Signature: _____

Print Name: _____

Witnessed By: _____

Boston Pain Specialist

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW YOUR MEDICAL/PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This notice is being given to you because federal law gives you the right to be told about:

1) How we will handle your medical information.
2) How your medical information may be used and/or disclosed by us.
3) Your rights regarding your medical information.

As a patient you have the following rights:

1) The right to review and receive copies of your information.
2) The right to request corrections if you think there is a mistake in your information or that information is missing.
3) The right to request that your information be restricted, however you may not ask us to not share information in cases where we are obligated to do so by law.
4) The right to ask that your health information be communicated to you in a confidential way.
5) The right to a report about when your private information has been shared; this does not mean sharing information among your doctors, as this is necessary to provide you with treatment.
6) The right to receive a paper copy of this notice.

We want to assure you that your medical/protected health information is secure with us. Except when prohibited by law, we may legally use and share your private information for treatment, payment and health care operations, which includes services such as transcription, storage and auditing. We do not need to ask for your specific permission to do these things.

We may disclose your information without your specific permission in the following situations:

1) In discussing your care and treatment with your other physicians, other health care providers and your pharmacies.
2) As required by state and federal laws and regulations.
3) For public health activities including required reports to public health or elder/disabled persons protection authorities.
4) For legal proceedings on receipt of a subpoena.
5) To avert a serious threat to health or safety.
6) As authorized by and as necessary to comply with workers compensation laws.

☐ Check this box only if we should <u>not</u> leave messages on your telephone answering machine.

Acknowledgement:
I hereby acknowledge that I have received a copy of this practice's Privacy Notice and my questions have been answered.

_____
Patient Name (please print)

_____ _____
Patient Signature Date