The RSD / CRPS Treatment Center and Research Institute

Last Update: May 6, 2011

PATIENT INFORMATION FORM

To better serve your care, please complete the following and bring this form with you to your first appointment. Important: It is strongly recommended that you provide the following documents at the time of your evaluation:

- 1.) Your doctors' dictations for the last two years about your pain problem.
- 2.) A copy of reports for the tests listed under "K" in this questionnaire.

A. General Information:	
Today's Date:	
Name:	S.S.#
Age: Sex: M F	Date of Birth:
Address:	
City:	
Home Phone:	
Work/Cell Phone:	
Email:	
B. Referral Source:	
Physician:	
Attorney:	
Insurance Carrier:	
Other:	
Name of Primary Care Physician:	
Address of Referral Source:	

C. (Chief Complair	nt:					
(1) What	(1) What is your main problem?						
D.	History of Pre	sent Pain:					
∻ Lo	cation: Please	describe exac	tly where y	our pain is	s located on you	ur body.	
(3) What	event led to yo	ur present pro	blem? (Ple	ase circle)		
Cance	r Disease	Operation	Injury	Other			
(4) What	was the date of	f your injury?					
` '	u have pain fre now long do the						
	McGill Pain Qu d severity.	estionnaire: F	Please ched	k one box	per file line tha	at describes your pain in	
Throbbir	ng	None	Mil	d	Moderate	Severe	
Shooting)	None	Mil	d	Moderate	Severe	
Stabbing)	None	Mil	d	Moderate	Severe	
Sharp		None	Mil	d	Moderate	Severe	

Cramping	None	Mild	Moderate	Severe
Gnawing	None	Mild	Moderate	Severe
Hot-Burning	None	Mild	Moderate	Severe
Aching	None	Mild	Moderate	Severe
Heavy	None	Mild	Moderate	Severe
Tender	None	Mild	Moderate	Severe
Splitting	None	Mild	Moderate	Severe
Tiring-Exhausting	None	Mild	Moderate	Severe
Sickening	None	Mild	Moderate	Severe
Fearful	None	Mild	Moderate	Severe
Punishing-Cruel	None	Mild	Moderate	Severe
(7) What factors aggrav Massage	/ate your pain? (d Anxiety	circle)	Lying Down	
Sitting	Walking		Coughing	
Sex	Running		Cold	
Heat	Straining)	Standing	
(8) What helps your pai	in?			

(9) What is a comfortable position for you?
(10) Please describe your activities before your pain problem started.
E. Previous physicians. Please complete the following information regarding doctors who have evaluated your pain problem. Start with the first doctor who evaluated your pain.
Doctor #1
Doctors Name:
Doctors Specialty:
Year of Doctors Care:
Doctors Diagnosis:
List Treatments Performed by Doctor
Doctor #2
Doctors Name:
Doctors Specialty:
Year of Doctors Care:
Doctors Diagnosis:
List Treatments Performed by Doctor

Doctor #3								
Doctors Name:								
Doctors Specialty:								
Year of Doctors Care:								
Doctors Diagnosis:								
List Treatments Performed by Do	octor							
Doctor #4								
Doctors Name:								
Doctors Specialty:								
Doctors Diagnosis:								
List Treatments Performed by Do	octor							
* If evaluated by more than four of on the back of this page.	loctors for the pain prob	lem, list their names and same information						
F. Social History								
(1) Marital Status: Single D	Divorced Widowed M	larried						
(2) Highest Level of Education:	:							
(3) Children: Yes No How	v Many? Age	es						
(4) Present source of financial	support: (circle)							
Personal earnings V	Vorkman's Comp	Spouses earnings						
Disability payment F	Disability payment Pension Insurance							
None C	None Other							
None C)ther							

	(5) Do you work? (ci	rcle)	Full time	•	Part time			
	(6) Do you smoke?	Yes	No	Do	ou drink alcol	hol?	Yes	No
	(7) Is there legal acti	ion pen	ding?					
G	. Past medical histo	ry: (cird	cle conditi	on)				
	Asthma/breathing pr	oblems	•					
	Bleeding Problems							
	Diabetes							
	Liver Problems							
	Kidney problems							
	High Blood Pressure	9						
	Headaches							
	Other							

H. Previous Treatments for pain:

Modalities	Yes	No	Effectiveness
Block			
TENS			
Physiotherapy			
Biofeedback			
Counseling			
Pain Management			
Surgery			
Other			

I. Surgical Hist	ory							
		ou an	nd the dates that	they w	ere perform	ed:		
J. Medications	:							
(1) Allergies:								
(2) Previous r	medication f	or pa	in:					
Drug Effectiveness Side Effects								
							l	
(3) Current Me	edications:							
Drugs	Dosag	е	Purpose	Effe	ctiveness	Doctor		
							<u> </u>	
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K. This portion of the questionnaire is extremely important. Please provide the dates and the results of the tests listed below. Also, provide a copy of these reports (not films) at the time of your evaluation. Previous Studied Laboratory Tests Performed to Evaluate Pain:
1. X-rays
2. CAT Scan
3. MRI
4. EMG
5. Nerve Conduction Studies
6. Myelogram
7. Thermogram
8. Bone Scan
L. Physical Status: Height Weight

IMPORTANT INFORMATION

1. Fees:

The fee schedule at the Institute can be found at the following site:

http://rsdhealthcare.org/Fee Schedule.htm

2. Consultant's Role:

Our role in your care is that of a consulting physician. Your primary care physician will be responsible for prescribing your medications. The Institute will be available to consult with your doctor about your medications.

3. Patient instructions for Procedures:

- -No food or drink 8 hours before procedure
- -Take home medications with a sip of water, DO NOT take diabetic medication-bring it with you
- -Bring any lung inhalers
- -Do not bring any valuables
- -Do not use any moisturizer / lotions on any extremities during the ketamine infusions.
- -Arrive 30 minutes before procedure
- -You cannot drive yourself home and need to make arrangements with a responsible person for transportation

4. Will Medicare reimburse you for your linstitute?	our medical services at the
The Center is OUT OF NETWORK for Medicare. A Center WILL NOT be reimbursed to you by Medicary you are a Medicare Beneficiary.	
Read and Understood:	
Signature:	Date: