P: 702-879-2005 F: 702-805-0019
851 South Rampart Blvd. Suite 100 Las Vegas, NV 89145
100 N. Green Valley Pkwy. Ste 225 Henderson, NV 89074
3603 N. Las Vegas Blvd. Ste 111 Las Vegas, NV 89115

New Patient Packet

Welcome to Las Vegas Injury Pain Center!

We are an interventional pain management practice and are equipped to diagnose and treat any type of pain complaint.

Our goal is to deliver optimal care to our patients. In order to do that we will need some information regarding your health history. As many patients who have suffered an injury have engaged in legal representation, it is of utmost importance that the information provided in this packet be accurate as it will be part of the legal medical record for your case. Prior medical history may also have a big impact on the course of your treatment. Some of the conditions that may be impactful include Diabetes, Hypertension, if there is any metal in your body, or if you are taking anti-biotics.

We understand that the legal process associated with an injury may be overwhelming. We have done our best to make the questions in this packet as straightforward as possible.

We want to do our best to respect your time and that of other patients. Therefore, we ask that you please complete this packet prior to your appointment and bring a photo ID. If you need assistance or are unable to complete this packet beforehand please arrive at least 20 minutes prior to your appointment so that we may assist you.

Thank You for trusting us with your care and we look forward to seeing you!

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Patient Information				
First Name / Last Name / Middle			Birth Date	Gender ☐ Male ☐ Female
Address / Apt/Unit		City	State	Zip Code
Preferred Phone	Email		Social Security Number	
Employer	Occupation		Employer Phone	
Preferred Method of Contact ☐ Email ☐ Call ☐ Text - LVIPC has your consent to text your preferred phone number in regards to your appointment information				
Emergency Contact Name	Relationship to patient		Emergency Contact Phone Number	

Attorney Information	
Attorney Name/Attorney Phone number	Date of Injury:

Please check the details that apply to you in the categories below

MVA

- ☐ Driver
- ☐ Passenger
- ☐ Wearing seatbelt
- ☐ Not wearing seatbelt
- ☐ Airbags deployed
- ☐ Airbags did not deploy
- ☐ Rear ended
- ☐ T-boned
- ☐ Sideswiped
- ☐ Front/Head on collision
- ☐ Lost consciousness
- ☐ Ambulance arrived on scene
- ☐ Police arrived on scene
- ☐ Evaluated at the hospital/Urgent care

Slip and Fall

- ☐ Tripped
- ☐ Slipped
- ☐ Lost consciousness
- ☐ Ambulance arrived on scene
- ☐ Evaluated at the hospital/Urgent care

Other

- ☐ Motor vehicle vs pedestrian
- ☐ Assault
- ☐ Ambulance arrived on scene
- ☐ Evaluated at the hospital/Urgent care

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Present Complaint

Where is your pain located?

What makes your symptoms feel better?	What makes your symptoms feel worse?

Circle words that describe your pain:

Aching	Continuous	Gnawing	Occasional	Sharp	Tender
Burning	Cramping	Deep	Dull	Miserable	Numb/Tingling
Penetrating	Sore	Shooting	Stabbing	Throbbing	Unbearable

Which other providers have you seen for this problem?

- ☐ Chiropractor Other_____
- ☐ Urgent care Other_____
- ☐ Physical therapist Other_____
- ☐ Hospital Which one?_____

Have you had any imaging studies performed?

- ☐ X-rays Facility:_____ Body Part (s):_____
- ☐ MRI's Facility:_____ Body Part (s):_____
- ☐ CT Scan Facility:_____ Body Part (s):_____
- ☐ Other _____Body Part (s):_____

Before the injury for which we are treating you for today, did you ever experience and seek treatment for pain for the same body part(s)? Yes or No
If so, which one (s)_____
Which providers did you see and what treatment did you receive?_____

Who is your Primary Care Physician?	Phone Number:

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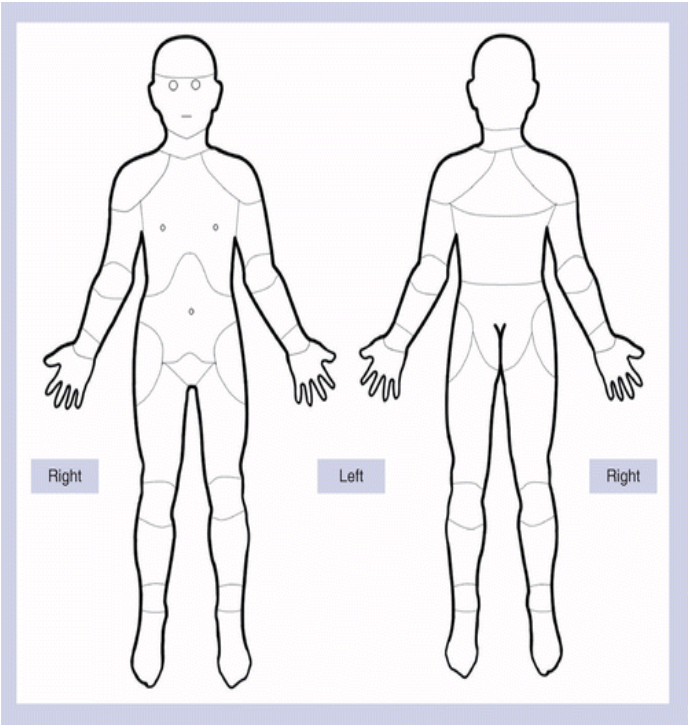
Please mark/circle where you usually feel pain/symptoms.



Please place an X next to the description(s) that best describe(s) your symptoms/function due to pain on MOST days.	
	0 - No Pain
	1 - Minimal Discomfort – barely noticeable. Rarely uncomfortable. Does NOT limit function.
	2 - Mild Discomfort – Only notice pain if I focus on it. I only avoid the most rigorous activities.
	3 - Mild Pain – Pain is annoying, but I can mostly ignore it. Stops some productive activities.
	4 - Mild to Moderate – Short intervals of pain, but I can do most normal daily activities and work tasks. Sometimes interferes with daily activities, such as running errands, exercise, job performance, and house chores.
	5 - Moderate – Pain is troubling and breaks my concentration. Pain is ALWAYS on my mind, but I push through the day. I cannot perform normal tasks without increase in pain.
	6 - Moderate to Severe – Pain significantly limits my normal daily life functions. I cannot concentrate due to pain. Hard to do anything but think about pain. Almost unable to work because of pain.
	7 - Severe – Pain is impossible to tolerate for long periods. Frequent crying. I cannot perform basic tasks due to pain.
	8 - Debilitating – I no longer do ANY normal activities due to pain. I cannot focus on anything else but pain. I no longer work due to pain, or I rarely leave my bed because of pain.
	9 - Disabling – Uncontrollable screaming and crying due to pain. I can barely function or talk. I feel like I should go to the emergency room.
	10 - Worst imaginable – Call an ambulance I need immediate emergency medical attention. Paralyzing. In and out of consciousness due to pain.

Medications & Drug Allergies	
Please list any prescription or over-the-counter medicine you are taking: ☐ I am not taking any medication	**Please list any drug allergies** ☐ No known drug allergies

Medication/Dose	**Frequency Taken**

**If you take medication(s) that thin your blood, list them here:_____

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Past Medical History
Do you have any medical issues? Please mark them below.

☐ I do not have any known medical problems/I am otherwise healthy

Cardiovascular (heart):
- Atrial fibrillation/arrhythmia
- Congestive heart failure
- Coronary artery disease
- Deep vein thrombosis(DVT/blood clot)
- Heart Attack, when:_____
- Hypertension (high blood pressure)
- Peripheral vascular disease

Endocrine/Metabolic:
- Diabetes: Type I / Type II
- Diabetic Neuropathy
- High Cholesterol
- Hyperthyroid (high thyroid)
- Hypothyroid (low thyroid)
- Obesity

Musculoskeletal:
- Arthritis/osteoarthritis
- Fibromyalgia
- Gout
- Muscular Dystrophy
- Osteoporosis
- Rheumatoid Arthritis

Gastrointestinal:
- Gastric ulcer
- GERD/heartburn/acid reflex
- Inflammatory Bowel Disease

Infectious/Integument/Immunity:
- Herpes simplex (HSV 1 / 2)
- Herpes zoster (shingles)
- Hepatitis: A / B / C
- HIV/AIDS
- Impaired Immunity

Eyes:
- Glaucoma

Kidney/Urinary:
- Chronic Kidney Disease
- Kidney Stones

Respiratory:
- Asthma
- COPD/Chronic bronchitis
- Pulmonary hypertension
- Sleep apnea

Neurologic:
- Migraine
- Multiple sclerosis
- Peripheral neuropathy
- Parkinson Disease
- Seizure: last seizure_____
- Stroke/TIA, when _____

Psychiatric:
- Anxiety disorder
- Bipolar disorder
- Major Depressive Disorder
- Obsessive Compulsive Disorder
- Schizophrenia

Hematologic:
- Anemia
- Bleeding disorder
- Blood clotting disorder
- Cancer: Type & Treatment _____
  _____
  _____
- Other: _____
  _____
  _____
  _____
  _____

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Review of Systems
Have you experienced these symptoms since the injury date? Please mark them below.

☐ I have not experienced any of the issues below.

Cardiovascular (heart):
- Chest pain
- Palpitations (racing heart)

Endocrine/Metabolic:
- Unintentional weight loss/gain

Respiratory:
- Difficulty breathing

Constitutional:
- Fevers
- Chills
- Night sweats

Kidney/Urinary:
- Blood in urine
- Unable to urinate
- Uncontrolled urination

Gastrointestinal:
- Abdominal Pain
- Bloody Stools
- Constipation
- Diarrhea
- Nausea
- Vomiting

Integumentary:
- Skin Rash

Eyes/Ear/Nose/Throat:
- Difficulty swallowing
- Hearing loss
- Nosebleed
- Ringing in ears
- Vision changes

Neurologic:
- Dizziness/Vertigo
- Lightheadedness
- Passing out/Syncope
- Headache

Psychiatric:
- Feeling sad/Depressed/Irritable
- Flashback/Nightmares
- I am having suicidal thoughts

Other: _____
_____
_____
_____
_____

Past Surgical History
Have you had any surgery in the past? (please include dates)

☐ I have never had a Surgery

Appendix Removal _____
C-Section _____
D & C _____
Gallbladder Removal _____
Hysterectomy _____
Joint Replacement _____

Tonsillectomy_____
Tubal Ligation _____
Vasectomy_____
Other:_____
Other: _____
Other: _____

Do you have any metal in your body? _____ If yes, is it MRI-compatible (titanium)?_____

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Family and Social History	
Do any diseases run in your family? ☐ Yes ☐ No Unknown If so, which one(s):	
Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed	Alcohol Use? ☐ Yes ☐ No If so, how much? _____
Tobacco use: ☐ Never ☐ Former, Quit: _____ Current Smoker: Packs/day: ____ # of years: ____ Chewing tobacco	Recreational drug use? If so, which ones? _____
Are you pregnant or nursing? ☐ Yes ☐ No	Employment Status? ☐ Full-time ☐ Part-time ☐ Disabled ☐ Unemployed ☐ Retired
Number of Children:	

Opioid Risk Tool	
This is a screening tool to be administered by each patient on an initial visit. State law requires opioid risk screening prior to prescribing opioids. It is our policy to screen all patients regardless of whether medications are prescribed.	
Mark each box that applies:	
1. Someone in my immediate family abuses:	
Alcohol	**1**
Illegal Drugs	**1**
Prescription Drugs	**1**
2. I have a history of substance abuse:	
Alcohol	**1**
Illegal Drugs	**1**
Prescription Drugs	**1**
3. I am between 16-45 years old	**1**
4. I have a history of psychological disorder:	
ADD, OCD, Bipolar, Schizophrenia, Depression	**1**
Total the points above:	

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Authorization Pertaining to Medical Records

Patient Information			
Name	Birth Date	Phone	
Address	City	State	Zip Code

Authorization to Request Medical Records

My signature below authorizes Las Vegas Injury Pain Center to request ALL of my medical records on my behalf INCLUDING the following:

- ☐ Mental Health
- ☐ Xray/MRI/Imaging Report
- ☐ Operative Reports
- ☐ Lab Work
- ☐ Office Notes
- ☐ Other:_____

I understand that I am entitled to a copy of this Authorization.

_____ _____

Patient/Guardian Signature Date

Notes: _____

_____

_____

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Authorization to Release Medical Records

Information to be disclosed: I authorize the release of the following health information:

All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

Only the following records or types of health information_____

_____

I Authorize my medical records to be released to:

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

_____ _____
Patient/Guardian Signature Date