Usman Ahmad, D.O.
Physical Medicine & Rehabilitation
Interventional Pain Management

Carolina Pain & Rehabilitation Specialists
8035 Providence Road, Suite 340
Charlotte, NC 28277

Phone: (704) 542-3988
Fax: (855) 529-0584

PATIENT INTAKE FORM

PATIENT INFORMATION

Name: _____ Today's Date:_____
Last Name First Name Middle Initial

Address: _____
City:_____ State: _____ Zip: _____
Date of Birth: _____ Soc. Sec. # _____ Gender: ☐ M ☐ F
Home Phone: _____ Mobile Phone: _____ Email: _____
Preferred Method of Contact: _____
In case of emergency, who should be notified? _____ Phone: _____

PRIMARY INSURANCE

Person Responsible for Account:_____
Last Name First Name Middle Initial

Relationship to Patient:_____ D.O.B. _____ Soc. Sec. # _____
Address (if different from patient's) _____ Phone: _____
City: _____ State: _____ Zip:_____
Person Responsible Employed by: _____ Occupation: _____
Business Address: _____ Business Phone: _____
Insurance Company: _____ Ins. ID No. _____

ADDITIONAL INSURANCE

Subscriber Name: _____
Relationship to Patient: _____ D.O.B. _____ Phone: _____
Address: _____
City: _____ State: _____ Zip:_____
Person Responsible Employed by: _____ Occupation: _____
Business Address: _____ Business Phone: _____
Insurance Company: _____ Ins. ID No. _____

ASSIGNMENT AND RELEASE

- I, the undersigned, certify that I (or my dependent) have insurance coverage with the insurance noted above.
- I hereby assign my insurance benefits to be paid directly to the physician
- I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize & give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize my provider's office to contact me by telephone to remind me of my appointments.
- A fee for no shows may apply.

Signed: _____ **Date:** _____

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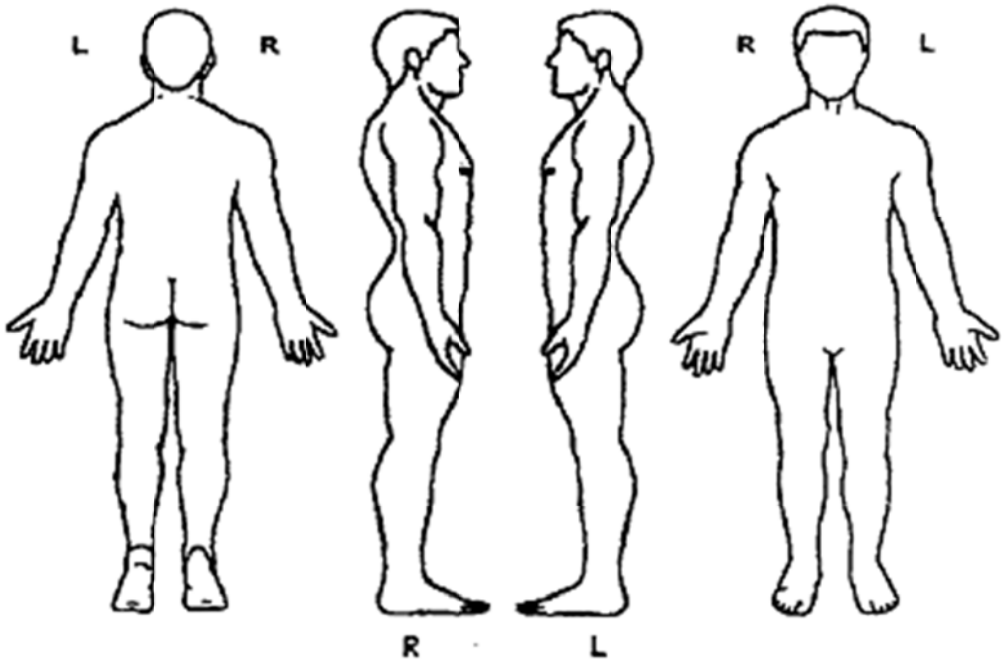
PAIN DIAGRAM

Mark the areas on your body where you feel the described sensations. Include all affected areas. Mark as follows:

A- Ache **B**- Burning **N**- Numbness **P**- Pins & Needles **S**- Stabbing **O**- Other



Primary Complaint: _____

Check **ALL** that apply to your symptoms:

Pain Quality:
- ☐ sharp
- ☐ aching
- ☐ burning
- ☐ shooting
- ☐ constant
- ☐ intermittent

Increase Pain:
- ☐ sitting
- ☐ lying down
- ☐ walking
- ☐ bending
- ☐ weather
- ☐ Coughing/sneezing

Decrease Pain:
- ☐ sitting
- ☐ lying down
- ☐ walking
- ☐ bending
- ☐ weather

Associated Symptoms:
- ☐ weakness
- ☐ numbness
- ☐ tingling
- ☐ fever
- ☐ weight loss
- ☐ bowel/bladder problems
- ☐ insomnia
- ☐ pain wakes at night
- ☐ sexual dysfunction
- ☐ other: _____

On a scale from one to ten, how do you rate your pain now? (circle)

1 2 3 4 5 6 7 8 9 10

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Secondary Complaint: _____

Check **ALL** that apply to your symptoms:

Pain Quality:
- ☐ sharp
- ☐ aching
- ☐ burning
- ☐ shooting
- ☐ constant
- ☐ intermittent

Increase Pain:
- ☐ sitting
- ☐ lying down
- ☐ walking
- ☐ bending
- ☐ weather
- ☐ Coughing/sneezing

Decrease Pain:
- ☐ sitting
- ☐ lying down
- ☐ walking
- ☐ bending
- ☐ weather

Associated Symptoms:
- ☐ weakness
- ☐ numbness
- ☐ tingling
- ☐ fever
- ☐ weight loss
- ☐ bowel/bladder problems
- ☐ insomnia
- ☐ pain wakes at night
- ☐ sexual dysfunction
- ☐ other: _____

On a scale from one to ten, how do you rate your pain now? (circle)

1 2 3 4 5 6 7 8 9 10

DIAGNOSTIC INFORMATION

Radiologic Studies		Part of Body	Date	Where	Results
X-Rays	☐ Y ☐ N	_____	____	_____	_____
MRI	☐ Y ☐ N	_____	____	_____	_____
CT Scan	☐ Y ☐ N	_____	____	_____	_____
EMG (Nerve Study)	☐ Y ☐ N	_____	____	_____	_____
Bone Scan	☐ Y ☐ N	_____	____	_____	_____
Myelogram	☐ Y ☐ N	_____	____	_____	_____
Other	☐ Y ☐ N	_____	____	_____	_____

PREVIOUS TREATMENT FOR PAIN

	Treatment	Helpful?	Currently Ongoing?	How Long?	Comments
TENS Unit	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	_____	_____
Physical/ Occupational therapy	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	_____	_____
Psychological evaluation	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	_____	_____
Chiropractic treatment	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	_____	_____
Nerve Blocks	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	_____	_____
Surgeries	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	_____	_____

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MEDICATIONS

☐ None ☐ I presently take the following: (Please print clearly)

Name of Medication	Amount Per day	Reason	Last dose taken	How long

ALLERGIES

☐ NO KNOWN DRUG ALLERGIES

Medication Name:	Reaction:
Other:	

Intravenous Dye: ☐ Y ☐ N Shellfish: ☐ Y ☐ N Anesthesia: ☐ Y ☐ N

FAMILY HISTORY

Has any of your family had the following?

☐ Y ☐ N Cancer, if yes, who _____
☐ Y ☐ N Diabetes, if yes, who _____
☐ Y ☐ N Heart Disease, if yes, who _____
☐ Y ☐ N Psychiatric Disorders, if yes, who _____what type _____
☐ Y ☐ N Alcoholism, if yes, who _____
☐ Y ☐ N Drug Abuse, if yes, who _____
☐ Y ☐ N Suicide, if yes, who _____

SURGICAL HISTORY

Surgeries: List type & date

_____
_____
_____
_____
_____
_____

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PAST MEDICAL HISTORY

List all medical conditions you have had

Anemia	☐ Y ☐ N	Hypertension	☐ Y ☐ N
Anxiety Disorder	☐ Y ☐ N	Kidney Disease	☐ Y ☐ N
Arthritis	☐ Y ☐ N	Leg or Foot Ulcers	☐ Y ☐ N
Asthma	☐ Y ☐ N	Liver Disease	☐ Y ☐ N
Bleeding Disorder	☐ Y ☐ N	Lung Disease	☐ Y ☐ N
Blood Clots	☐ Y ☐ N	Migraines	☐ Y ☐ N
Cancer-Type_____	☐ Y ☐ N	Osteoporosis	☐ Y ☐ N
Coronary Artery Disease	☐ Y ☐ N	Pacemaker	☐ Y ☐ N
Depression	☐ Y ☐ N	Peripheral Vascular Disease	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Pulmonary Embolism	☐ Y ☐ N
Gerd/Reflux	☐ Y ☐ N	Rheumatoid Arthritis	☐ Y ☐ N
Gout	☐ Y ☐ N	Seizures/Epilepsy	☐ Y ☐ N
HIV/AIDS	☐ Y ☐ N	Stroke	☐ Y ☐ N
Heart Attack	☐ Y ☐ N	Thyroid Problems	☐ Y ☐ N
Heart Disease	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N
Heart Problems	☐ Y ☐ N	Ulcers	☐ Y ☐ N
Hepatitis-Type_____	☐ Y ☐ N	Urinary Tract Infection	☐ Y ☐ N
Hernia	☐ Y ☐ N	Other _____	

REVIEW OF SYSTEMS

Check if you have any of the following:

CONSTITUTIONAL
__ Fever
__ Weight Loss
__ Weight Gain
__ Night Sweats
__ Exercise Intolerance

OPHTHAMOLOGY
__ Dry Eyes
__ Irritation
__ Vision Change

ENMT
__ Difficulty hearing
__ Ear pain
__ Frequent nosebleeds
__ Nose/Sinus Problems
__ Sore Throat
__ Bleeding Gums
__ Snoring
__ Dry Mouth
__ Mouth Ulcers
__ Oral Abnormalities
__ Teeth Problems

CARDIOLOGY
__ Angina/Chest Pain
__ Arm pain on exertion
__ Shortness of breath
While walking/lying down
__ Palpitation
__ Heart Murmur
__ Light Headedness

RESPIRATORY
__ Cough __Wet or __ Dry
__ Wheezing
__ Shortness of breath
__ Coughing Blood
__ Sleep Apnea

GASTROENTEROLOGY
__ Abdominal Pain
__Vomiting
__Change in appetite
__ Black/Bloody Stool
__ Frequent Diarrhea
__ Vomiting blood

GENITOURINARY
__ Incontinence
__ Difficulty Urinating
__ Hematuria
__ Increased Frequency
__ Urinary loss of Control
__ Incomplete Emptying

MUSCULOSKELETAL
__ Muscle Aches
__ Muscle Weakness
__ Arthralgias/Joint Pain
__ Back Pain
__ Swelling in the extremities

INTEGUMENTARY
__ Abnormal mole
__ Jaundice
__ Rashes
__ Itching
__ Dry skin
__ Growth/Lesions

NEUROLOGY
__ Loss of consciousness
__ Weakness
__ Numbness
__ Seizures
__ Vertigo or Dizziness
__ Frequent or severe headaches
__ Migraines
__ Restless legs

PSYCHOLOGY
__ Depression
__ Sleep Disturbances
__ Restless Sleep
__ Alcohol abuse
__ Feeling unsafe in relationship

ENDOCRINOLOGY
__ Fatigue
__ Increased Thirst
__ Hair loss
__ Increased hair growth
__ Cold Intolerance

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SOCIAL HISTORY

Smoking Status: ☐ **Never Smoker** ☐ **Someday Smoker** ☐ **Every day Smoker** ☐ **Former Smoker**
Smoking-How Much: ☐ **1 PPW** ☐ **2 PPW** ☐ **¼ PPD** ☐ **½ PPD** ☐ **1 PPD** ☐ **1 ½ PPD** ☐ **2 PPD** ☐ **3 + PPD**
Tobacco years of use _____
Are you able to care for yourself ☐ **Yes** ☐ **No**
Alcohol Intake: ☐ **None** ☐ **Occasional** ☐ **Moderate** ☐ **Heavy**
Are you currently employed ☐ **Yes** ☐ **No**
Auto related injury ☐ **Yes** ☐ **No**
Changes in family/social situation ☐ **Yes** ☐ **No**
Diabetes ☐ **Yes** ☐ **No**
Highest level of education completed: _____
Employer: _____
Exercise level: ☐ **None** ☐ **Occasional** ☐ **Moderate** ☐ **Heavy**
Family history of heart disease ☐ **Yes** ☐ **No**
General stress level ☐ **Low** ☐ **Medium** ☐ **High**
Hand dominance ☐ **Right** ☐ **Left**
Hard of hearing or deaf in one or both ears ☐ **Yes** ☐ **No**
High blood pressure? ☐ **Yes** ☐ **No** High cholesterol ☐ **Yes** ☐ **No**
If injured, is litigation on going ☐ **Yes** ☐ **No**
Illicit Drugs ☐ **Yes** ☐ **No**
Illicit drugs during pregnancy? ☐ **Yes** ☐ **No**
Illicit drugs- years of use _____
Live alone or with others? _____
Long commute/limited mobility? ☐ **Yes** ☐ **No**
Marital Status: ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Separated** ☐ **Widowed** ☐ **Domestic Partner**
Number of children _____

PHARMACY INFORMATION

Please write down your current pharmacy information

Name: _____
Address: _____
Phone Number: _____

HOW DID YOU FIND OUT ABOUT US?

☐ Referral – Doctor Name: _____
☐ Friend
☐ Website
☐ Google
☐ Other _____

All of the above information is true and accurate to the best of my knowledge.

Signature: _____ Date: _____