PLEASE BRING TO YOUR SCHEDULED APPOINTMENT at NJ Pain Care Specialists the office of Dr. Harris Bram

Photo ID- Drivers License, Passport

INSURANCE CARD AND REFERRAL IF NECESSARY

WORKER'S COMP OR AUTO-PIP CLAIM INFORMATION IF APPLICABLE INCLUDING INSURANCE COMPANY ADDRESS, CLAIM NUMBER AND DATE OF ACCIDENT, ADJUSTER/CASE MANAGERS NAME AND PHONE NUMBER AND YOUR ATTORNEY'S NAME, ADDRESS AND PHONE NUMBER

MRI, CT SCAN OR X-RAY FILMS AND REPORTS
(EVEN IF THE FILMS ARE 2 TO 3 YEARS OLD)

A **LIST OF ALL MEDICATIONS** THAT YOU ARE CURRENTLY TAKING

A List of all over the counter medications that you are currently taking for example: St John's Wort, Vitamins , supplements etc.

COMPLETED PATIENT FORMS (attached)

NAME AND ADDRESS OF YOUR **REFFERING AND PRIMARY CARE DOCTOR**

IF YOU HAVE ANY QUESTIONS REGARDING YOUR APPOINTMENT, PLEASE CALL 732-720-0247

NJ Pain Care Specialists

Intake form

Harris Bram, MD

Date:_____

Patient Information

Last Name:_____First Name:_____M:_____

Sex: Male / Female Date of Birth:_____ Social Security:_____

Marital Status: Single / Married / Divorced / Widowed E-Mail Address:_____

Address:_____Town:_____ State/Zip:_____

Primary Telephone Contact # _____Cell Telephone Contact #_____

Next of Kin:_____ Relationship:_____

Address:_____ Phone:_____

Referring Doctor:_____**Primary Care Doctor**:_____

Employer/School:_____Occupation:_____

Pharmacy Name,Address,Phone:_____

Primary Insurance Information

Type: Health Insurance Workers Comp Auto/PIP Accident None/Self-Pay

Subscriber's Name:_____**Date of Birth**:_____
Address:_____SS#_____
Insurance Company:_____**Date of Accident**:_____
Address:_____Phone#_____
Group/Claim #_____Policy/ID#_____
Case Manager:_____Phone #_____

Secondary Insurance Information

Type: Health Insurance Workers Comp Auto/PIP Accident None/Self-Pay

Subscriber's Name:_____**Date of Birth**:_____
Address:_____SS#_____
Insurance Company:_____**Date of Accident**:_____
Address:_____Phone#_____
Group/Claim #_____Policy/ID#_____
Case Manager:_____Phone #_____

INITIAL PATIENT INTAKE Page 1

PATIENT NAME:_____ **DOB** ___/_____/_____ **DATE:** _____

Chief Complaint:_____

Is Your Pain From an Auto or Worker's Compensation Accident? YES / NO Date______________

Initial Pain Level (0-10): 0 1 2 3 4 5 6 7 8 9 10 **How often is your pain present?** Occasional Frequent Constant

What makes symptoms worse?

Walking_____ Standing _____ Sitting_____ Lying Down_____ Other_____

What makes symptoms better?

Walking_____ Standing_____ Sitting_____ Lying Down_____Other_____

Medical History:

- **Patient Medical History:**

			Previous Hospitalizations/Surgeries	**When?**
Diabetes	No	Yes	_____	
Blood Pressure	No	Yes	_____	
Asthma/COPD	No	Yes	_____	
Stroke	No	Yes	_____	
Heart Problems	No	Yes		
Kidney Problems	No	Yes		
Seizure disorders	No	Yes		
Bleeding/Clotting	No	Yes		
Liver/Hepatitis	No	Yes		
Sleep Apnea	No	Yes		
Cancer	No	Yes		
Thyroid	No	Yes		

ALLERGIES

Latex Yes / No

Dye Yes / No

Other Medication Allergies

_____

_____

Current Medications: name, dose , frequency

`1)_____ 2)_____

3)_____ 4)_____

5)_____ 6)_____

7)_____ 8)_____

9)_____ 10)_____

herbals, vitamin$

_____

- **Patient Social History:** **Occupation:**_____ **Full time Part time** (circle one)

Marital status: Single_____Married _____Separated_____Divorced_____Widowed_____

Use of alcohol: Never_____Rarely_____Moderate_____Daily_____(alcoholics anonymous yes or no)

Use of tobacco: Never_____Previously, but quit_____ Current packs/day_____

Use of illegal drugs Never_____Type/Frequency_____marijuana, cocaine, heroin, cocaine, pills

Family History of Drug Abuse: No_____Yes_____ relationship_____

- **Family Medical History, if pertinent:**

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____

- **Please check off if any current problems in any of the following areas**:

____General Wellness	____Lungs/Breathing	____Neurological	____Chest pain	____Reproductive/Urinary
____Headaches	____Fatigue	____Skin	____Thyroid Endocrine	____Trouble Sleeping
____Nausea	____Ears, Nose, Throat	____Blood/Lymph	____Memory	____Ringing in Ears
____Stomach/Digestion	____Psychiatric	____Dizziness	____Muscles/Joints/Bones	Eyes

If any of above areas are checked, please explain: _____

Indicate the location of your pain

Previous back/neck pain history? _____

Do you experience weakness or numbness? ( ) Yes ( ) No

Do you experience pain at night? ( ) Yes ( ) No

Does cough, sneeze or strain increase pain? ( ) Yes ( ) No

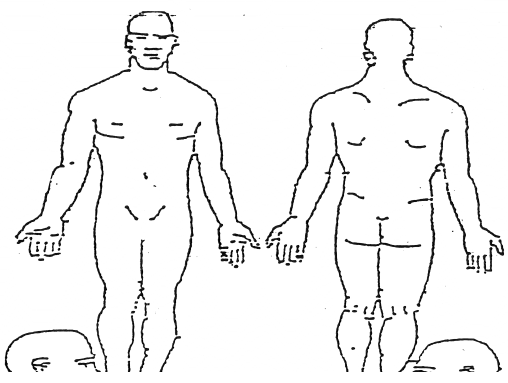
Do you experience loss of bowel or bladder control? ( ) Yes ( ) No

Recent weight loss, how much? _____

Previous treatment? Please CIRCLE any of the following you have had:

Physical Therapy Chiropractic Treatments Surgery

Anti-Inflammatories Medications Nerve Blocks/Injections



Previous tests:

MRI Back Yes_____ No_____ Date of Most Recent Exam______________
MRI Neck Yes_____No_____Date of Most Recent Exam______________
X-Rays Back Yes_____No_____ Date of Most Recent Exam______________
X-Rays Neck Yes_____No_____ Date of Most Recent Exam______________
CT SCAN
Myelogram
X-RAYS
EMG

Patient Signature: _____

INITIAL PATIENT INTAKE

Patient Name:_____ Age:_____ DOB:_____ DOS: _____

Is this work related or motor vehicle accident injury:_____ Date of accident:_____

Describe accident:_____

_____

Any prior history of pain before the accident :_____

HISTORY:

_____

_____

_____

C/O:

_____

_____

_____

Past Treatments:_____

_____

Scans or testing: _____

PHYSICAL EXAM:
Vitals: BP:_____ / _____ Temp:_____ Pulse: _____Resp:_____ Height:_____ Weight:_____