

**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:

Diabetes No Yes
Blood Pressure No Yes
Asthma/COPD No Yes
Stroke No Yes
Heart Problems No Yes
Kidney Problems No Yes

Previous Hospitalizations/Surgeries

When?

ALLERGIES

Latex Yes / No
Dye Yes / No
Other Medication Allergies _____

Current Medications: name, dose, frequency

Seizure disorders No Yes 1) _____ 2) _____
Bleeding/Clotting No Yes 3) _____ 4) _____
Liver/Hepatitis No Yes 5) _____ 6) _____
Sleep Apnea No Yes 7) _____ 8) _____
9) _____ 10) _____

Cancer No Yes
Thyroid No Yes

herbals, vitamins

• 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: _____

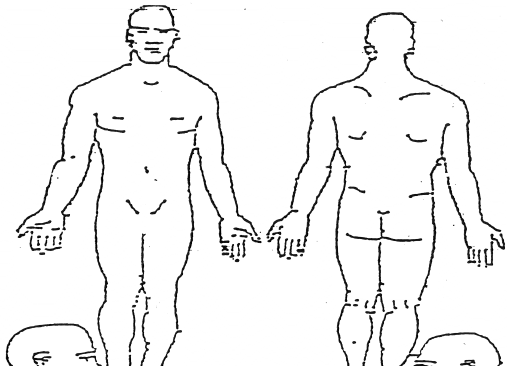
Indicate the location of your pain

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: _____