DIMURO PAIN MANAGEMENT

Personal Injury INITIAL INTAKE Questionnaire

Welcome to DiMuro Pain Management! This practice was created by Dr. John DiMuro shortly after he completed his government service as Chief Medical Officer for the State of Nevada under Governor Brian Sandoval. We are happy that you have chosen our practice for the treatment of your pain complaints. Our office is fully equipped to both diagnose and treat any type of pain complaint. However, in order to provide the best overall care, we need some information about you.

While we all hate to complete paperwork, **it is extremely important that this information be obtained by our office.** As many patients who suffer an injury have engaged legal representation, the information you provide here is part of the medical-legal record and will serve as the document of record for our practice regarding your injury and comprehensive medical history. While completing this *Initial Intake* form may be time-consuming, please understand that many of the recommendations made by our DPM providers including prescription medications, imaging studies and injection therapy, will be impacted by not only the details of your injury, but your medical history as well. For example, if you have cancer, medication allergies, have metal in your body or even use blood thinners, treatment options may vary as this information will directly impact your medical care.

If the information requested in this simple questionnaire seems redundant, please understand that each medical specialist may need to obtain different information than other specialists. **Pain Management is a unique medical subspecialty** that requires some additional information that if not provided in this document, will ultimately have to be obtained at some point during your visit today. You will likely be thinking, "Why do I have to answer the same questions again?" and "I already filled this out for another doctor." Please understand that medical offices do not routinely make it a simple process to share your medical records and we rely upon the information you provide in this document as the foundation for our medical decision-making.

Thank you for taking the time to complete this informational packet**.** We welcome you to our practice and look forward to working with you throughout your recovery.

DPM

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DATE OF APPOINTMENT: ____/_____/_____EMAIL ADDRESS: _____PHONE (___)_____

LANGUAGE PREFERENCE: □ ENGLISH □ SPANISH □ OTHER, PLEASE IDENTIFY: _____

PATIENT INFORMATION

LEGAL **FIRST** NAME: _____

LEGAL **LAST** NAME: _____

CURRENT ADDRESS: _____

DATE OF BIRTH: _____ AGE: _____ ARE YOU: □ RIGHT-HANDED □ LEFT-HANDED OR □ AMIDEXTROUS?

GENDER: □ MALE □ FEMALE HEIGHT: _____FT_____IN WEIGHT: _____LBS

DETAILS OF INJURY

1. IS YOUR INJURY DUE TO A MOTOR VEHICLE ACCIDENT? □ YES □ NO
2. IF YOUR INJURY IS DUE TO SOMETHING OTHER THAN A MOTOR VEHICLE ACCIDENT, PLEASE SKIP TO #14 ON FOLLOWING PAGE.
3. WERE YOU "ON THE CLOCK" OR WORKING AT THE TIME OF THE ACCIDENT? □ YES □ NO IF YES, WHAT IS THE NAME OF THE COMPANY FOR WHICH YOU WERE WORKING AT THE TIME OF THE ACCIDENT?

   _____
4. WHAT IS THE EXACT DATE, INCLUDING YEAR, OF THE ACCIDENT? _____/_____/_____
5. WHAT TIME OF DAY DID THE ACCIDENT? _____ □ AM □PM
6. HOW MANY VEHICLES WERE INVOLVED IN THE ACCIDENT? _____
7. WHAT MAKE AND MODEL OF MOTOR VEHICLE WERE YOU IN? MAKE: _____MODEL: _____
8. WHAT WAS YOUR POSITION IN THE CAR? □ DRIVER □ PASSENGER □ REAR BEHIND DRIVER □ REAR BEHIND PASSENGER □ REAR CENTER □ OTHER (PLEASE DESCRIBE):

   _____
9. WERE YOU WEARING A SEAT BELT? □ YES □ NO
10. WAS ANYONE ELSE IN THE VEHICLE WITH YOU AT THE TIME OF THE ACCIDENT? □ YES □ NO IF YES, WHAT ARE THEIR NAMES?

    _____
11. WHAT MAKE AND MODEL CAR(S) WERE INVOLVED IN THE ACCIDENT (IF KNOWN)? MAKE: _____ MODEL: _____ MAKE: _____ MODEL: _____ MAKE: _____ MODEL: _____
12. □ DID YOUR VEHICLE IMPACT THE OTHER VEHICLE **OR** □ DID THE OTHER VEHICLE IMPACT YOUR VEHICLE?

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13. WHAT PART OF YOUR VEHICLE WAS IMPACTED? ☐ FRONT ☐ REAR ☐ PASSENGER ☐ DRIVER ☐ SIDE

14. PLEASE DESCRIBE HOW THE INJURY/ACCIDENT OCCURRED? (INCLUDE LOCATION -STREET NAMES) _____

_____

_____

_____

15. DID YOU ANTICIPATE THE CRASH? ☐ YES ☐ NO DID AIRBAGS DEPLOY ☐ YES ☐ NO
DID YOU LOSE CONSCIOUSNESS? ☐ YES ☐ NO IF YES, FOR HOW LONG? _____

16. DID THE POLICE COME TO THE SCENE OF THE ACCIDENT/INJURY? ☐ YES ☐ NO

17. DID AN AMBULANCE COME TO THE SCENE OF THE ACCIDENT/INJURY? ☐ YES ☐ NO

18. HOW EXACTLY DID YOU LEAVE THE SCENE OF THE ACCIDENT/INJURY? SELECT ONE: ☐ DID YOU DRIVE THE CAR FROM THE ACCIDENT? ☐ DID SOMEONE COME PICK YOU UP AND GIVE YOU A RIDE? ☐ WERE YOU TRANSPORTED VIA AMBULANCE FROM THE SCENE? ☐ OTHER (PLEASE DESCRIBE):

_____

_____

19. WHERE DID YOU GO IMMEDIATELY AFTER THE CRASH? SELECT ONE: ☐ DID YOU GO TO YOUR HOME?
☐ A RELATIVE'S HOME? ☐ AN URGENT CARE? ☐ A HOSPITAL? ☐ OTHER (PLEASE DESCRIBE):

_____

_____

MEDICAL CARE SINCE INJURY

20. WHAT IS THE EXACT DATE YOU FIRST SOUGHT MEDICAL CARE FOR INJURIES SUSTAINED IN THE ACCIDENT?
____/____/_____

20. WHAT TYPE OF MEDICAL PROVIDER WERE YOU EVALUATED BY? ☐ HOSPITAL EMERGENCY ROOM?
☐ URGENT CARE? ☐ PRIMARY CARE DOCTOR? ☐ CHIROPRACTOR? ☐ PHYSICAL THERAPIST?
☐ PAIN DOCTOR? ☐ OTHER? (PLEASE DESCRIBE):

_____

_____

_____

21. HAVE YOU HAD ANY IMAGING STUDIES PEFORMED? ☐ YES ☐ NO IF YES, HAVE YOU HAD X-RAYS? ☐ YES ☐ NO
HAVE YOU HAD AN MRI ☐ YES ☐ NO IF YES, PLEASE IDENTIFY EXACTLY WHERE YOU HAD THEM PERFORMED AND THE NAME OF THE PROVIDER)? ☐ A DOCTORS OFFICE, ☐ HOSPITAL, ☐ FREE-STANDING IMAGING CENTER,
☐ OTHER (PLEASE DESCRIBE):

_____

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22. IF KNOWN, WHAT BODY PARTS WERE IMAGED? ☐ NECK? ☐ BACK? ☐ SHOULDER? ☐ LEG? ☐ OTHER? EXPLAIN:

_____

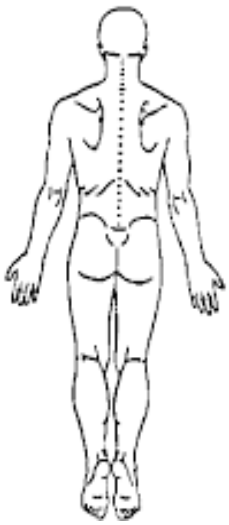
_____

MEDICAL COMPLAINTS SINCE THE INJURY:

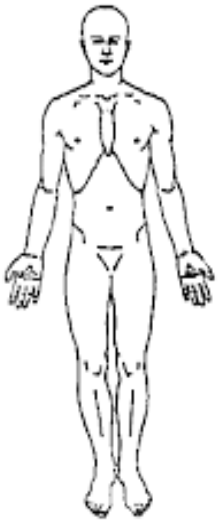
23. WHAT BODY PARTS ARE CURRENTLY PAINFUL? _____

_____

24. SINCE THE INJURY, PLEASE MARK ON THIS DRAWING WHERE YOU ARE CURRENTLY EXPERIENCING PAIN



Left Right



Right Left

25. ARE THERE SPECIFIC TIMES WHEN YOUR PAIN IS WORSE SUCH AS DRIVING, SITTING, STANDING, WORKING?
☐ YES ☐ NO IF YES, PLEASE BE SPECIFIC AS TO WHAT MOVEMENTS MAKE YOUR PAIN WORSE:

_____

_____

26. DO YOU EXPERIENCE PAIN EVEN AT REST SUCH AS LAYING IN BED OR WHEN YOU ARE RELAXING? ☐ YES ☐ NO
27. CAN YOU RECALL IF YOU HAVE EVER SOUGHT TREATMENT FOR PAIN IN THOSE BODY PARTS PRIOR TO THIS INJURY?
☐YES ☐NO
28. DO YOU REMEMBER EVERY HAVING HAD IMAGING STUDIES SUCH AS AN X-RAY OR MRI OF THESE BODY PARTS BEFORE THIS INJURY? ☐ YES ☐ NO IF YES, PLEASE INDICATE:

_____

29. PLEASE LIST THE YEARS AND CITY/STATE IN WHICH YOU HAVE EVER HAD A MOTOR VEHICLE ACCIDENT OR TRAUMATIC INJURY IN THE LAST 20 YEARS:

YEAR: _____ CITY: _____ STATE: _____ YEAR: _____ CITY: _____ STATE: _____

YEAR: _____ CITY: _____ STATE: _____ YEAR: _____ CITY: _____ STATE: _____

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30. PLEASE LIST THE NAMES OF ALL OF THE MEDICAL PROVIDERS THAT YOU HAVE SEEN FOR YOUR INJURIES RELATED TO THE ACCIDENT. PLEASE INCLUDE PRIMARY CARE DOCTORS, MASSAGE THERAPISTS, PHYSICAL THERAPISTS, CHIROPRACTORS, PAIN DOCTORS, NEUROLOGISTS, NEUROSURGEONS, ORTHOPEDIC SURGEONS. IF YOU ARE UNSURE OF THE PROVIDER'S NAME, PLEASE JUST LIST THE SPECIALTY OF THE PROVIDER (NEXT PAGE):

SPECIALITY: NAME: SPECIALITY: NAME:

31. HAVE YOU HAD ANY "CORTISONE" INJECTIONS SINCE THE ACCIDENT? ☐ YES ☐ NO
32. HAVE YOU HAD TO HAVE ANY TYPE OF SURGERY SINCE THE ACCIDENT? ☐ YES ☐ NO IF YES, ON WHAT PART OF YOUR BODY DID YOU HAVE SURGERY?

MEDICAL HISTORY

ALLERGIES:

33. DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS FOR WHICH YOU ARE AWARE? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:

MEDICATIONS:

34. ARE YOU TAKING ANY BLOOD THINNERS (SUCH AS IBUPROFEN, NAPROXIN OR ASPIRIN)? ☐ YES ☐ NO ☐ NOT SURE
35. ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATION? ☐ YES ☐ NO IF YES, PLEASE LIST THE NAMES OF THE MEDICATIONS BELOW. IF YOU ARE UNSURE OF THE NAME OF THE MEDICATION, PLEASE TELL US THE REASON FOR WHICH YOU TAKE THE MEDICATION AND THE NAME OF THE PRESCRIBING DOCTOR.

MEDICATION: PRESCRIBED BY: MEDICATION: PRESCRIBED BY:

PAST MEDICAL HISTORY:

36. **DO YOU HAVE ANY MEDICAL PROBLEMS ("Past medical history")?** FOR EXAMPLE, DIABETES, HIGH BLOOD PRESSURE, THYROID DISEASE, ETC.:

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SURGICAL HISTORY:

37. **HAVE YOU EVER HAD SURGERY?** WE UNDERSTAND THAT IS CAN BE TIME-CONSUMING TO LIST EVERY SURGERY AND THE YEAR IN WHICH THE SURGERY WAS PERFORMED, BUT THIS IS VERY IMPORTANT INFORMATION FOR US TO HAVE IN THE MEDICAL RECORD SO PLEASE DO YOUR BEST TO COMPLETE THIS SECTION ACCURATELY.

SURGERY: _____ YEAR: _____ SURGERY: _____ YEAR: _____

_____ _____

_____ _____

SOCIAL HISTORY (needed for a comprehensive profile in your medical record)

38. IN WHAT CITY, STATE AND COUNTRY WERE YOU BORN? CITY: _____ STATE: _____ COUNTRY: _____
39. IN WHAT CITY AND STATE DO YOU CURRENTLY LEGALLY RESIDE? CITY: _____ STATE: _____ COUNTRY: _____ SINCE WHEN? _____
40. WHAT IS YOUR HIGHEST LEVEL OF EDUCATION COMPLETED? ☐ GRADE SCHOOL, ☐ HIGH SCHOOL, ☐ COLLEGE, ☐ GRADUATE DEGREE?
41. ARE YOU MARRIED? ☐ YES ☐ NO HOW MANY CHILDREN DO YOU HAVE? _____
42. DO YOU SMOKE/VAPE OR USE TOBACCO-CONTAINING PRODUCTS? ☐ YES ☐ NO
43. DO YOU CONSUME ALCOHOL? ☐ YES ☐ NO DO YOU CONSUME ALCOHOL ☐ DAILY, ☐ WEEKLY, ☐ SOCIALLY, ☐ RARELY OR ☐ NEVER?
44. HAVE YOU EVER UNDERGONE TREATMENT FOR ANY TYPE OF SUBSTANCE ABUSE? ☐ YES ☐ NO

EMPLOYMENT

45. ARE YOU CURRENTLY EMPLOYED? ☐ YES ☐ NO IF YES, APPROXIMATELY HOW MANY HOURS PER WEEK DO YOU LEGALLY WORK? _____
46. WHAT IS THE NAME OF THE COMPANY FOR WHICH YOU ARE EMPLOYED?
    _____
47. HOW MANY YEARS HAVE YOU BEEN EMPLOYED BY THIS COMPANY?
    _____
48. HAS YOUR ABILITY TO FUNCTION IN YOUR JOB RESPONSIBILITIES CHANGED SINCE THE ACCIDENT? ☐ YES ☐ NO
    IF YES, PLEASE BRIEFLY EXPLAIN HERE:
    _____

    _____

    _____

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REQUEST FOR MEDICAL RECORDS

PEDIDO DE INFORMACION MEDICA

TODAY'S DATE: _____

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____

PATIENT SOCIAL SECURITY NUMBER: _____

DATE OF INJURY/DATE(S) OF SERVICE: _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO DIMURO PAIN MANAGEMENT ANY AND ALL MEDICAL RECORDS INCLUDING BUT NOT LIMITED TO MEDICAL EXAMINATION, TREAMENT AND SERVICES RENDERED, RADIOGRAPHIC REPORTS AND/OR FILMS PERTAINING TO THE ABOVE-LISTED DATE OF INJURY AND/OR DATE(S) OF SERVICE

YO AUTORIZO Y DOY CONSENTIMIENTO QUE PROVEA UD. A DIMURO PAIN MANAGEMENT TODOS LOS EXPEDIENTES MEDICOS QUE TENGA INCLUYENDO, PERO NO LIMITADO A LA EXAMINACION, EL TRATAMIENTO Y LOS SERVICIOS QUE SE ME HAN PREVEIDO, REPORTES RADIOLOGICOS Y/O RADIOGRAFIAS QUE PERTENEZCAN A LA FECHA LASTIMADURA O DE SEVICIOS NOTADA ARRIBA.

_____

SIGNATURE OF PATIENT OR LEGAL GAURDIAN
FIRMA DEL PACIENTE O PERSONA RESPONSABLE

_____

PRINTED NAME OF PATIENT OR LEGAL GAURDIAN
NOMBRE DEL PACIENTE O PERSONA RESPONSABLE

DIMURO PAIN MANAGEMENT

OPIOID AGREEMENT FORM

Patient Name: _____

Medical Record Number: _____

AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

The use of _____ (print names of medication(s)) may cause addiction and is only one part of the treatment for: _____ (print name of condition-e.g., pain, inflammation, etc.).

The goals of this medicine are:

- ☐ to improve my ability to work and function at home.
- ☐ to help my_____ (print names of condition-e.g., pain, inflammation, etc.) as much as possible without causing dangerous side effects.

I have been told:

1. if I drink alcohol, marijuana or use street drugs, I may not be able to think clearly, and could become sleepy and risk personal injury.
2. I may get addicted to this medication.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

I agree to the following (please initial):

_____ I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine.

_____ I will not increase my medicine until I speak with my doctor or nurse.

_____ My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.

_____ I will keep all my appointments set up by my doctor (e.g., primary care, physical therapy, mental health, substance abuse treatment, pain management)

_____ I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.

_____ I agree to give a blood or urine sample, if asked, to test for drug use.

Refills

Refills will be made only during regular office hours- Monday through Friday, 9:00AM-5:00 PM.
No refills on nights, holiday, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. **No exceptions will be made.** I must keep track of my medications. No early or emergency refills may be made.

Pharmacy

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I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines.

The name of my pharmacy is: _____ Location: _____

Prescription from Other Doctors

If is see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to DPM in the original bottle, even if there are no pills left.

Privacy

While I am taking this medication, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medication. I will be asked to sign a release at that time.

Termination of Agreement

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way. I have talked about this agreement with my doctor and I understand the rules stated in this agreement.

Provider Responsibilities

As your doctor, I agree to perform regular checks to see how well the medicine is working. I agree to provide care for you as needed that may not involve getting controlled medicines from me.

☐ Please check here if you would like a copy of this agreement.

_____ _____

Patient's Signature Date

_____

Patient's printed name

_____

Physician's Signature

Dr. John DiMuro

PATIENT AUTHORIZATION/EMERGENCY CONTACT FORM:

DIMURO PAIN MANAGEMENT

Authorization to release Information to Family Members

- Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures, and financial information. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic/test results and/or financial information release to any family members you must sign this form.
- You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I AUTHORIZE DIMURO PAIN MANAGEMENT (DPM) TO RELEASE MY RECORDS AND ANY INFORMAITON REQUESTED TO THE FOLLOWING INDIVIDUALS:

1. _____ _____
   Name Relation to patient
2. _____ _____
   Name Relation to patient
3. _____ _____
   Name Relation to patient

Authorization Regarding Messages
(please check all that apply)

___I authorize DPM to leave a detailed message on my home or cell number regarding appointments.

___I authorize DPM to leave a detailed message on my home or cell number regarding medical treatment, care, test/diagnostic results, or financial information.

___I authorize DPM to leave a message with anyone who answers the phone.

___Messages may only be left with _____

IN CASE OF EMERGENCY CONTACT:

1. _____ _____ (____)_____
   Name Relation to patient Phone

   _____
   Street Address City State Zip

2. _____ _____ (____)_____
   Name Relation to patient Phone

   _____
   Street Address City State Zip

_____ _____
Patient Name (PLEASE PRINT) **Date**

_____
Patient Signature