Axis Spine & Pain
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Axis Pain Center New Patient Packet

PATIENT INFORMATION

Last Name: First Name: M.I.

DOB: Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Emergency Contact: Emergency Contact Phone:

ADVANCE DIRECTIVE

Do you have an advance directive/living will? ☐ Yes ☐ No

If YES, please bring us with a copy for our records. If NO, please let us know if you require information.

INSURANCE

Primary Insurance: Insurance Cardholder Name:

Primary Subscriber #: Group #:

Secondary Insurance: Insurance Cardholder Name:

Secondary Subscriber #: Group #:

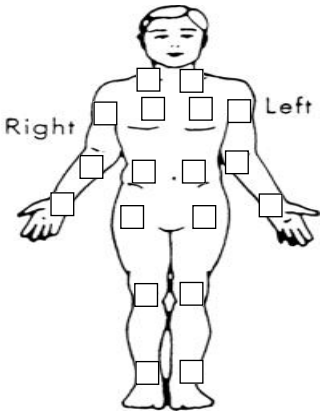
I understand The Nexus Pain Center of Houston County, LLC is doing business as Axis Pain Center and my insurance will be billed as Axis Pain Center. I verify that all the above information is correct. I hereby authorize payment of medical benefits billed to my insurance by The NEXus Pain Center of Houston County, LLC d/b/a Axis Pain Center. I accept responsibility for any/all payments not made by my insurance company for services rendered by The NEXus Pain Center of Houston County, LLC d/b/a Axis Pain Center. I understand that payment is due at time of service for all co-pays, deductibles, co-insurance, or out of network fees. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information in this packet and have completed the answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

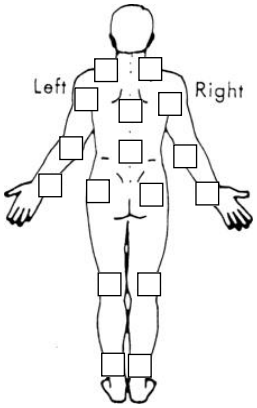
Patient/Guardian

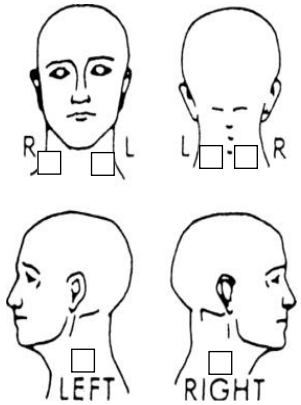
Signature: Date:

HISTORY OF PRESENT ILLNESS

1. **Use figures below to check areas where you have pain.**







2. **Approximate Date Current Pain Began:**

3. **How did pain symptoms first start:** ☐ Car Accident ☐ Unknown ☐ Workplace Injury ☐ Other:

   If Workplace Injury, are you being treated under Workers' Compensation? ☐ Yes ☐ No

   If YES, do you have an Attorney? ☐ Yes ☐ No

4. **How OFTEN do you have this pain?** ☐ Constantly ☐ Daily ☐ Weekly ☐ Monthly ☐ Intermittently

5. **Using pain scale below, rate your pain:**

   PAIN SCALE: 0 1 2 3 4 5 6 7 8 9 10 (0=no pain , 10 = worst pain)

   LOWEST: out of 10 MAX: out of 10

6. **Describe your pain:** ☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Tight

   ☐ Pressure ☐ Tingling ☐ Pins/Needles ☐ Numbness ☐ Stiffness ☐ Pulling ☐ Shooting

AGGRAVATING/ALLEVIATING FACTORS

1. **What activities improve or worsen your pain? Check Selection.**

   Exercise: ☐ Worsens ☐ Improves ☐ No Change

   Lying down: ☐ Worsens ☐ Improves ☐ No Change

   Walking: ☐ Worsens ☐ Improves ☐ No Change

   Standing: ☐ Worsens ☐ Improves ☐ No Change

   Sitting: ☐ Worsens ☐ Improves ☐ No Change

   Driving: ☐ Worsens ☐ Improves ☐ No Change

   Lifting: ☐ Worsens ☐ Improves ☐ No Change

   Eating: ☐ Worsens ☐ Improves ☐ No Change

   Climbing Stairs: ☐ Worsens ☐ Improves ☐ No Change

   Cough or Sneeze: ☐ Worsens ☐ Improves ☐ No Change

   Bright Lights: ☐ Worsens ☐ Improves ☐ No Change

   Cold: ☐ Worsens ☐ Improves ☐ No Change

   Heat: ☐ Worsens ☐ Improves ☐ No Change

   Weather Change: ☐ Worsens ☐ Improves ☐ No Change

   Looking Up/Down: ☐ Worsens ☐ Improves ☐ No Chg.

   Other: ☐ Worsens ☐ Improves ☐ No Change

2. **Are you experiencing any of the following:** ☐ Muscle Weakness ☐ Numbness/Tingling ☐ Bladder/Bowel Dysfunction ☐ NO – Not Experiencing Symptoms ☐ Other

3. **Are you currently working?** ☐ Yes ☐ No

   If YES, how many hours per week do you work: ☐ Less than 10 ☐ 11-20 ☐ 21-30 ☐ 31-40 ☐ 40+

   If NO, are you receiving: ☐ Short Term Disability ☐ Long Term Disability ☐ Social Security Disability

   ☐ Social Security ☐ None ☐ Other:

4. **Has your pain affected your activities of daily living:** ☐ Sleep ☐ Appetite ☐ Relationships ☐ Work ☐ Physical Activity ☐ Other

5. **Have you had Physical Therapy?** ☐ Yes ☐ No

6. **Have you had Chiropractic Care?** ☐ Yes ☐ No

7. **Have you had Guided Home Exercise?** ☐ Yes ☐ No

TREATMENTS AND DIAGNOSTIC TESTING

1. **What treatments have you received for pain in the past? Check Selection. If Checked, mark if it was Helpful or Not Helpful.**

   ☐ Surgery: If YES, ☐ Helpful or ☐ Not Helpful

   ☐ Injections (Epidural Steroid, Nerve Block, Trigger Point): If YES, ☐ Helpful or ☐ Not Helpful

   ☐ Acupuncture: If YES, ☐ Helpful or ☐ Not Helpful

☐ Traction: If YES, ☐ Helpful or ☐ Not Helpful

☐ Physical Therapy / Occupational Therapy / Chiropractic Treatment: If YES, ☐ Helpful or ☐ Not Helpful

2. **Have you had any of the following tests for this pain in the last 24 months? Check Selection. If Checked, please mark where it was performed and the approximate date.**

☐ X-Ray: If YES, Where: Date:

☐ CT Scan: If YES, Where: Date:

☐ MRI: If YES, Where: Date:

☐ EMG/Nerve Conduction: If YES, Where: Date:

☐ Myelogram: If YES, Where: Date:

3. **Have you been to another Pain Clinic?** ☐ Yes ☐ No

If YES, Where? When?

CURRENT MEDICATIONS

1. **Please list all medications (pain meds, anticoagulants, vitamins, supplements).**

☐ **None**

Medication	Strength	Times Per Day	Effectiveness

PAST MEDICAL HISTORY

1. **Please check all that apply. If checked, please specify further details.**

☐ **None**

☐ **Diabetes:**

☐ **Depression:**

☐ **High Blood Pressure:**

☐ **HIV / AIDS:**

☐ **Hepatitis / Cirrhosis:**

☐ **Ulcer:**

☐ **Migraines:**

☐ **Arthritis:**

☐ **Cancer:**

☐ **Seizures:**

☐ **Head Injury:**

☐ **Bleeding Problems:**

☐ **Neurologic Disease:**

☐ **Kidney Problems:**

☐ **Heart Problems:**

☐ **Respiratory Problems:**

ALLERGIES

1. **Do you have any allergies to the following:** ☐ Latex ☐ Iodine / Shellfish ☐ Contrast Dye ☐ Tape / Adhesive
2. **Please list any known medication allergies below.**

   ☐ None

   Medication: Reaction:

   Medication: Reaction:

   Medication: Reaction:

   Medication: Reaction:

   Medication: Reaction:

SURGICAL HISTORY

1. **Please list any past surgeries below.**

   ☐ None

   Surgery: Date:

   Surgery: Date:

   Surgery: Date:

   Surgery: Date:

   Surgery: Date:

SOCIAL HISTORY

1. **Do you smoke or use tobacco / nicotine?** ☐ Yes - Smoke ☐ Yes - Vape ☐ Yes - Chewing Tobacco ☐ No

   Current Smoker: If YES, how many packs per day? # of years?
2. **Are you a former smoker or user of tobacco/ nicotine?** ☐ Yes - Smoke ☐ Yes - Vape ☐ Yes - Chewing Tobacco ☐ No

   Former Smoker: If YES, when did you quit?
3. **Do you drink alcoholic beverages?** ☐ Yes ☐ No

   If YES, How many drinks per day? What type? ☐ Beer ☐ Wine ☐ Liquor
4. **Do you use "recreational" or "street" drugs?** ☐ Yes ☐ No

   If YES, please list:
5. **Do you use CBD or THC products?** ☐ Yes ☐ No
6. **Occupation?** If Yes, please enter: ☐ No ☐ Retired ☐ Disabled