NATIONAL® Spine & Pain CENTERS

A Patient's Rights

Your Rights as Our Patient

Quality Treatment You Can Expect

As a patient being treated in our office, you have a right to:

- Respectful care given by competent personnel.
- Consideration of your privacy concerning your own medical care.
- The names of all physicians and/or staff directly assisting in your care.
- Have medical records pertaining to your medical care treated as confidential (except as required by law or third-party contractual agreement).
- Know what rules and regulations in our practice apply to your conduct as a patient.
- Expect emergency procedures to be implemented without delay; if there is a need to transfer you to another facility, a responsible person and the facility will be notified of your condition prior to your arrival.
- Good quality care and high professional standards continually maintained and reviewed.
- Full information in layman's terms concerning diagnosis, treatment, prognosis, and possible complications.
- Give an informed consent to the physician prior to the start of each procedure.
- Be advised of participation in a medical care research program or donor program. (You will be asked to give your informed consent prior to participation in such a program, and you may refuse to continue in a program that you have previously given informed consent to participate in.)
- Refuse drugs or procedures and have a physician explain the medical consequences of your refusal.
- Medical and nursing services without discrimination based upon age, race, color, religion, national origin, handicap, disability or source of payment.
- Have access to an interpreter whenever possible.
- Access to all information contained in your medical record, within a reasonable time, unless access is specifically restricted by your attending physician for medical reasons or is prohibited by law.
- Expect good management techniques to be implemented that consider effective use of your time and to avoid unnecessary discomfort.
- Examine and receive a detailed evaluation of your bill.
- Be informed at your request of your provider's credentials.
- Be free from abuse, neglect, harassment and exploitation.
- Receive ambulatory center (ASC) services without discrimination based upon race, color, religion, gender, national origin, or payer. The ASC is not required to provide uncompensated or free care and treatment unless otherwise required by law.
- Appropriate and professional care relating to physician orders.
- Formulate advance directives and to have the surgery center comply with the directives unless the care team notifies the patient of the inability to do so. The ASC will decline to implement elements of a Do Not Resuscitate / DNR advanced directive. The ASC medical team will always attempt to resuscitate a patient and transfer the patient to a Medicare-certified hospital in the event of deterioration.
- Receive information necessary to make informed decisions prior to the start of any procedure or treatment.
- Refuse treatment within the confines of the law and to be informed of the consequences of his/her actions.
- Personal and data privacy and confidentiality.
- Voice grievances and suggest changes in services.
- Exercise your rights without discrimination or reprisal.
- Receive care in a safe setting.

Notice of Financial Interest:

Federal regulations require that we inform you that our physicians have a financial interest in ASC Development Company, LLC. They are: Drs. Richard Brouillette, Carey-Walter Closson, Mark Coleman, Michael Daly, Ali El-Mohandes, Tameta Clark, Dontese Nicholson, Kristoffer DeLara, Varada Nargund, Michael Wong, Anish Patel, Jeffrey Schneider, Aneesh Singla, Steven Sloan, Abdul Soudan, and Lester Zuckerman. An interest in this facility enables them to have a voice in the Administrative and Medical Policy of this healthcare institution. This involvement helps us ensure the finest quality surgical care for their patients.

ASC Development Company, LLC Grievance Process: ASC Development Company, LLC provides a process for patients' concerns to be heard and addressed by administrative personnel. You may contact the Board Members, Executive Directors, or state agency. Medicare patients may contact the Ombudsman at: www.medicare.gov/ombudsman/resources.asp.

The Medicare Beneficiary Ombudsman is to ensure that Medicare beneficiaries receive the information and help needed to understand their Medicare options and to apply their Medicare rights and protections.

National Spine & Pain Centers, 11921 Rockville Pike Suite 505,
Rockville, MD 20852. 301-881-7246

Maryland Department of Health and Mental Hygiene, Office of Health Care Quality, Program Manager,
Spring Grove Center / Bland Bryant Building, 55 Wade Avenue, Catonsville, MD 21228.
410-402-8040, 800-492-6005

We recognize that you have a choice for healthcare services, and we are grateful that you have chosen us as your provider.

For more information or to report a problem: If you have questions or would like additional information, please contact the Privacy Officer at 844-234-2642 or compliance@treatingpain.com. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

It is important for you to know what you can expect from our relationship.

We want you to be satisfied with the treatment you receive.
Please notify your physician or another member of our staff if
there is any way we can serve you better.

For an appointment call: 855.836.PAIN (7246)
Visit our website: treatingpain.com

NATIONAL Spine & Pain CENTERS

Bel Air
510 Upper Chesapeake Dr., ste 415
Bel Air, MD 21014

Bowie
16900 Science Dr., ste 100
Bowie, MD 20715

Chevy Chase
5505 Friendship Blvd, ste 100
Chevy Chase, MD 20815

Columbia
7120 Minstrel Way, ste 106
Columbia, MD 21045

Clinton
7501 Surratts Road, ste 202
Clinton, MD 20735

Cumberland
940 Seton Drive, ste A
Cumberland, MD 21502

Frederick
75 Thomas Johnson Dr., ste C
Frederick, MD 21702

Germantown
19735 Germantown Rd., ste 360
Germantown, MD 20874

Glen Burnie
1600 Crain Hwy SW, ste 301
Glen Burnie, MD 21061

Greenbelt/Berwyn Heights
8824 Cunningham Dr., ste B
Berwyn Heights, MD 20740

Hagerstown
1150 Professional Ct., ste P
Hagerstown, MD 21740

Pikesville
1838 Greene Tree Rd., ste 150
Pikesville, MD 21208

Rockville
11921 Rockville Pike, ste 505
Rockville, MD 20852

Silver Spring
8455 Colesville Rd., ste 200
Silver Spring, MD 20910

Waldorf
3460 Old Washington Rd., ste 300
Waldorf, MD 20602

White Marsh
6820 Hospital Dr., ste 302
White Marsh, MD 21237

In addition to the enclosed paperwork, please bring the following with you to your appointment:

- ✓ A picture ID
- ✓ Insurance cards
- ✓ Your co-pay (if required by your insurance)
- ✓ Your referral (if required by your insurance)
- ✓ Any report, film, or disc of radiology relating to
- ✓ Any medical records relating to your pain and treatment
- ✓ A list of medications you are currently taking or their medication bottles

TODAY'S DATE:	ACCOUNT #:

PATIENT INFORMATION

INSURANCE INFORMATION

LAST NAME:	PRIMARY INSURANCE COMPANY:
FIRST NAME:	BILLING ADDRESS:
ADDRESS:	CITY: STATE: ZIP:
CITY: STATE: ZIP:	PHONE #:
HOME PHONE #: MAY WE LEAVE A MESSAGE? Y N	ID #: GROUP #:
CELL PHONE #: MAY WE LEAVE A MESSAGE? Y N	
EMAIL*:	SECONDARY INSURANCE COMPAY:
PREFERRED METHOD TO CONTACT YOU:	BILLING ADDRESS:
DATE OF BIRTH:	CITY: STATE: ZIP:
SOCIAL SECURITY #:	PHONE #:
SEX (PLEASE CIRCLE): MALE FEMALE	ID #:
HOW DID YOU HEAR ABOUT US:	
PREFERRED LANGUAGE:	
RACE:	

PERSON TO NOTIFY IN CASE OF EMERGENCY:

NAME:	PHONE #: RELATION TO YOU:

IF INSURANCE IS NOT IN YOUR NAME, PLEASE COMPLETE:

NAME OF POLICY HOLDER:	PATIENT'S EMPLOYER:
DATE OF BIRTH:	EMPLOYER ADDRESS:
SOCIAL SECURITY #:	WORK #:
POLICY HOLDER EMPLOYER:	CITY: STATE: ZIP:
EMPLOYER ADDRESS:	MAY WE CONTACT YOU AT WORK? Y N
CITY: STATE: ZIP:	MAY WE LEAVE A MESSAGE? Y N

REFERRING PHYSICIAN AND PRIMARY CARE PHYSICIAN INFORMATION:

REFERRING PHYSICIAN:	PRIMARY CARE PHYSICIAN:
ADDRESS:	ADDRESS:
CITY: STATE: ZIP:	CITY: STATE: ZIP:
PHONE #:	PHONE #:
FAX #:	FAX #:

IF WORKERS COMPENSATION OR LEGAL CLAIM, PLEASE COMPLETE:.

COMPANY NAME:	ADJUSTER NAME:
MAILING ADDRESS:	PHONE #: FAX #:
CITY: STATE: ZIP:	NURSE CASE MANAGER:
CLAIM #:	PHONE #: FAX #:
DATE OF INJURY:	INJURY YOU ARE BEING TREATED FOR:
EMPLOYER AT TIME OF INJURY:	

www.treatingpain.com

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Educational pamphlet titled notice of privacy practices provides information about national spine and pain centers many years in the schools protected health information about you and is compliant with the requirements of the health insurance probability and accountability act of 1996 (HIPAA).

- Our notice of privacy practices states that we reserve the right to change the terms described. Should this happen to you, you will receive a revised copy either by mail or in person.
- You have the right to request restrictions and how you're protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

RELEASE OF MEDICAL INFORMATION FOR COORDINATION OF CARE

I hereby authorize national spine and pain centers to release medical information to my referring physician, primary care doctor, case manager, and any other individual involved in my medical care for the sole purpose of facilitating my treatment. National spine and pain centers may also obtain my medication history for the purpose of continued treatment. I understand that my medical information is confidential and that I have a choice to request that my physician not share my medical records with any of the above individuals involved in my care whom I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original. I am aware that I may request that this agreement to release medical information may be revoked at any time by providing the physician's office with a dated and signed letter. I have read and agreed to those terms.

AUTHORIZATIOIN TO DISCUSS INFORMATION WITH DESIGNATED PERSON

It is often difficult to reach a patient to discuss appointments, medications, and other information that is pertinent to our patients care. In this event, we will discuss such information to the person that you for which you sign authorization and designate hello. Please complete the following section:

I hereby authorize national spine and pain centers to discuss any information required in the course of my examination or treatment when I cannot be reached by phone to the following designated person(s):

Name of Designee: _____ Phone Number: _____

Relationship to Patient: _____

Name of Designee: _____ Phone Number: _____

Relationship to Patient: _____

☐ None I agree to all of the above information.

_____ _____

Patient Signature or Legal Guardian Signature Date

RELEASE OF MEDICAL INFORMATION

I hereby authorize National Spine & Pain Centers to release medical information to Medicare, my employer's Benefits Department, or my other insurance company for the sole purpose of obtaining payment for my medical care. Although medical information is confidential, many carriers require medical documentation prior to my payment for services. I understand that only information pertaining to obtaining payment for my care will be released. I agree that a copy of this release may be used in place of the original. I am aware that I may request this release of medical information to be revoked at any time by providing the physician's office with a dated and signed letter. I have read and agree to these terms.

AUDIO/VIDEO RECORDING PROHIBITED

Please be advised that, in order to better enable us to assure compliance with HIPAA Privacy and Security laws and regulations, and in recognition of the legitimate privacy concerns of our patients and staff, the use of any audio or video recording devices in this office by patients or other visitors, including but not limited to cell phones, is strictly prohibited. We reserve the right to terminate any patient as permitted under State law if the patient or anyone accompanying the patient is found to be in violation of this office policy. We appreciate your understanding and cooperation.

PAYMENT FOR MEDICAL SERVICES

I hereby assume financial responsibility for all charges incurred for services rendered. I understand that I will be required to pay co-payments, amounts applied to deductibles, and balances of bills not paid in accordance with the benefits of my current insurance policy. If I am unable to make payments in full for my medical treatment within 30 days, I agree to call the business office to make payment arrangements.

I hereby authorize payment for all medical insurance benefits which are payable under the terms of my insurance policy to be directly paid to National Spine & Pain Centers, or designate payment for services rendered. I certify that the information I have reported regarding my insurance coverage is correct. I authorize the doctor's office to verify insurance coverage and benefits allowed in accordance with my insurance company's policy.

I understand that it is my full responsibility that any third party which I direct National Spine & Pain Centers to bill, in the event of non-payment for whatever reason in accordance with the benefits of my current insurance policy, I will pay immediately. It is further agreed that in the event that I fail to pay upon demand, my account will be referred to an outside collection agency or an attorney. I accept full responsibility to pay all collection costs not to exceed 30% and interest of 1.25% per month not to exceed 18% annum and reasonable court costs.

Please sign below that you understand this information..

_____ _____

Patient Date

LATE ARRIVAL POLICY

The appointment time you are given is when you are expected to be in the exam room or operating room. We require that new patients and established patients come in 30 minutes early to complete paperwork. If you do not arrive 30 minutes early, you may not have enough time to complete the necessary paperwork. Arriving late means not arriving 30 minute prior to the appointment time. We are a surgery center and not a private physician's office. This is standard protocol for any inpatient or outpatient surgery center.

It is the policy of National Spine & Pain Centers that patients are to arrive on time. Patients who arrive late for visits or procedures cannot expect or demand to be seen. Other patients who have arrived on time expect to be seen at their allotted appointment time. Many appointments are scheduled for only 15 minutes. Arriving late by even five minutes will affect the schedule. We have a limited number of exam rooms and only one operating room. Because of this, seeing one late patient will make the schedule run late for the rest of the day. This is not considerate to the other patients who have arrived on time.

There are many things that can occur to make patients late; i.e. car trouble, traffic, parking, etc.. We understand that this can happen, but we cannot change the schedule for the rest of the day to accommodate any of these reasons.

If you arrive late for any reason, please check in at the front desk. The practice manager or office manager will check the schedule for the day, and, if possible, offer you another available time the same day. For example, if another patient has cancelled or rescheduled and there is an open slot available, you will be offered the open time slot. If one is not available, an appointment on a different day will be offered to you. Please remind the staff if your medication will run out prior to this new appointment date.

We specifically ask that all new patients and existing patients with follow-ups arrive 30 minutes early. This request is made both verbally at the time of scheduling your appointment and is heard on our recording when you are on hold with our office. We also request that patients who will be having a procedure arrive 30 minutes early when having a procedure with and without sedation. This information is also repeated on the recall slip.

There may be times when we run late, this is due to unforeseen patient clinical needs that we must accommodate. We respect out patients' time and will to all that we can to be on schedule.

I have read the late arrival policy and understand that if I arrive late I am not guaranteed that I will be seen the same day.

_____ _____

Patient Signature Date

NATIONAL Spine & Pain CENTERS

www.TreatingPain.com

MEDICAL APPOINTMENT AND PROCEDURE CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to National Spine and Pain Centers and its affiliated practices. When you schedule an appointment with our offices, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule a visit or procedure, please contact our office as soon as possible, and **no later than 24 hours** prior to your scheduled appointment or procedure. This gives us time to schedule other patients who are waiting for our services. Please read our Cancellation/No Show Policy below:

- ✓ Effective Sept. 1, 2020, any established patient who fails to show or cancels/reschedules an **appointment** and has not contacted our office with **at least 24 hours' notice** will be considered a No Show and charged a **$75.00 fee**.

- ✓ Effective Sept. 1, 2020, any established patient who fails to show or cancels/reschedules a **procedure** and has not contacted our office with **at least 24 hours' notice** will be considered a No Show and charged a **$200 fee**.

- ✓ These fees are charged to the patient, not your insurance company, and are **due that the time of your next office visit**, or before.

- ✓ As a courtesy, when time permits, we may make reminder calls, or send reminder texts, for appointments. If you do not receive a reminder call or text, the above Policy still remains in effect.

Questions about the cancellation and no show fees and their implementation may be addressed to the Center Manager at this location.

I have read and understand the Medical Appointment/Procedure Cancellation/No Show Policy and agree to its terms.

_____ _____

Patient Signature Date

NATIONAL® Spine & Pain CENTERS

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth NSPC's privacy practices and my rights regarding privacy of my protected health information.

PATIENT SIGNATURE (or Representative) **DATE**

FOR OFFICE USE ONLY

We have made every possible effort to obtain written acknowledgement of receipt of our notice of privacy practices from this patient but it could not be obtained because:

- ☐ The patient refused to sign
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgement
- ☐ We were unable to communicate with the patient
- ☐ Other (please provide specific details)

_____
_____
_____
_____

_____ _____

Employee Signature Date

By signing below, I authorize National Spine and Pain Centers (NSPC) & all affiliate companies to send email communications regarding the patient portal to the email address identified below and give my expressed consent for my medical information to be made available to me using the **Patient Portal**. I understand that I have the right to receive a completed copy of this consent.

Patient Name: _____
Last Name Middle First Name Date of Birth

Address: _____
Street City State Zip

Please clearly print or type the email address authorized to receive the email invitation:

_____

Please clearly re-print or re-type the email address authorized to receive the email invitation:

_____

Complete the following if the email address does not belong to the patient:

Recipient:

_____
Last Name Middle Initial First Name

_____
Relationship to the Patient

I understand that my health information is protected by federal and state law. This consent applies to records that may contain information related to the testing, diagnosis or treatment for conditions, including, but not limited to, drug and alcohol abuse; psychotherapy, mental or other behavioral health; HIV/AIDS or other communicable diseases; genetic testing; or any other condition expressly protected by state Law. This consent will remain in effect unless I deactivate my account or written notice is provided to the National Spine and Pain Centers (NSPC) & all affiliate companies.

I understand that my username and password will be unique to my health information and sharing my username and password may grant others access to my health information. I further understand that any health information disclosed as a result of sharing my username and password may no longer be protected under federal or state law and could be further released by the individual who receives the information.

I understand that I may refuse to sign this consent and such refusal will not prohibit me from receiving treatment or payment for my treatment. I further understand that my refusal to sign this consent will not prevent me from receiving a copy of my medical records.

☐ **YES** I do wish to access my medical information and give my expressed consent the National Spine & Pain Centers (NSPC) & ASC Development Company, LLC to make my medical information available to me using the **Patient Portal.**

Patient or Representative

_____
Signature

_____
Print Name Date

_____
Relationship to Patient*

NSPC or Affiliate Company Witness:

_____
Signature

_____
Print Name Date

**Legal authority must be verified when an individual is signing on behalf of the patient*

NATIONAL® Spine & Pain CENTERS

*Office use * Provider _____

Appt time _____ Entered _____

Vitals _____

_____

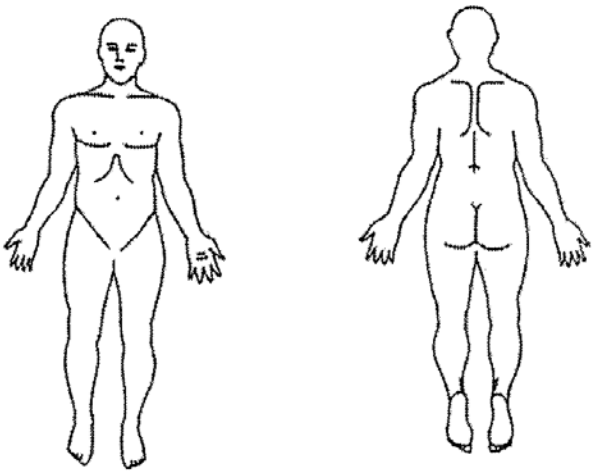
PAIN COMPREHENSIVE QUESTIONNAIRE

Patient Name _____ DOB _____ Date _____

Referring Physician _____ Primary Care Physicians _____

Chief Complaint (main problem seeking treatment) _____ Side ☐ right ☐ left

On the Diagram, shade in or circle the area where you feel pain:



R L **L R**

Preferred Pharmacy Name/Address:

_____

Preferred Pharmacy Phone:

_____

Are you pregnant or possibly pregnant?

☐Yes ☐No ☐N/A

---- (0 = no pain 10 = unbearable pain) ----

Pain level today

0 1 2 3 4 5 6 7 8 9 10

Over the last 4 weeks, please identify your pain levels below:

Severe pain level (on a bad day)

0 1 2 3 4 5 6 7 8 9 10

Average pain level (on an average day)

0 1 2 3 4 5 6 7 8 9 10

Allergies _____

Email _____

The onset of your pain was:

☐Motor vehicle accident

Date of Accident _____

Were you wearing a seatbelt: ☐Yes ☐No

Position during the accident:

☐Driver ☐Passenger in front seat ☐Passenger in back seat

☐Falling from a height

☐Injury at work

Date of injury _____

What injury occurred? _____

☐Insidious onset ☐Lifting an object ☐Playing a sport ☐Slipping and falling ☐Trauma ☐Tripping/uneven surface

Your pain occurs: ☐Constantly ☐Intermittent ☐Worse after activity ☐Worse at the end of the day ☐Worse during activity ☐Worse during cold seasons ☐Worse during the day ☐Worse during the night ☐Worse in the morning

Describe your pain: ☐aching ☐burning ☐cramp-like ☐dull ☐in a glove distribution ☐in a stocking distribution ☐pins & needles-like ☐sharp ☐shooting ☐stabbing

Your pain has been occurring for: _____ ☐days ☐weeks ☐months ☐years

Symptoms	Associated with your pain	**Symptoms**	Associated with your pain
Arm numbness		Insomnia	
Awakens you from sleep		Leg numbness	
Changes in bladder function		Perineal numbness	
Changes in bowel function		Sexual Dysfunction	
Changes in temperature in the affected area		Shoulder numbness	
Depression		Suicidal ideation	
Finger numbness		Sweating in affected area	
Flushing in affected area		Toe numbness	
Hand numbness		Hand numbness	

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PAIN COMPREHESIVE QUESTIONNAIRE

What activities aggravate/relieve your symptoms?

ACTIVITIES	AGGRAVATES YOUR PAIN	RELIEVES YOUR PAIN
All Movements		
Bending Forward		
Exercise		
Lifting Objects		
Lying Flat		
Rest		
Rotating the neck		
Sitting		
Standing for long periods		
Walking long distances		

What treatments have you used to treat the symptoms?

TREATMENTS	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
ACTIVITY MODIFICATION			
ACUPUNCTURE			
BRACE			
What type of Brace?	☐Back Brace ☐Neck Brace ☐Cervical traction ☐TENS unit ☐Ankle Brace (R or L) ☐Wrist Brace (R or L) ☐Knee Brace (R or L)		
How long have you had the product?			
Are you obtaining relief?			
Are your products in good condition?			
CHIROPRACTIC MANIPULATION			
HEAT TREATMENT			
ICE TREATMENT			
PHYSICAL THERAPY			
PILATES			
WEIGHT REDUCTION			
YOGA			
MEDICATIONS	**Check mark all medication that apply below**		

Opioids		NSAIDs/Tylenol		Muscle Relaxants
☐ Tramadol	☐ Methadone	☐ Tylenol	☐ Lodine	☐ Soma
☐ Demerol	☐ Morphine	☐ Aspirin	☐ Orudis	☐ Lorzone
☐ Codeine	☐ Nucynta	☐ Ibuprofen	☐ Relafen	☐ Flexeril
☐ Fentanyl (Duragesic)	☐ Butrans	☐ Naproxen	☐ Celebrex	☐ Baclofen
☐ Hydromorphone (Dilaudid,)	☐ Suboxone	☐ Daypro	☐ Toradol	☐ Zanaflex
☐ Hydrocodone (Vicodin)		☐ Indocin		☐ Robaxin
☐ Oxycodone (Percocet, Oxycontin)		☐ Feldene		☐ Skelaxin
☐ Oxymorphone (Opana)		☐ Voltaren		☐ Valium (Diazepam)

Antidepressants		Other	
☐ Elavil (Amitriptyline)	☐ Paxil	☐ Neurontin (Gabapentin)	☐ Lyrica
☐ Pamelor (Nortriptyline)	☐ Prozac	☐ Tegretol	☐ Ativan
☐ Desipramine	☐ Serzone	☐ Dilantin	☐ Xanax
☐ Impramine (Tofranil)	☐ Cymbalta	☐ Topamax	☐ Imitrex
☐ Zoloft	☐ Savella	☐ Depakote	☐ Ergotamine
		☐ Klonopin	☐ Mexillitine

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PAIN COMPREHESIVE QUESTIONNAIRE

Do you have any adverse effects since starting any treatment?

☐Constipation ☐Drowsiness ☐Mental slowness ☐Other

What procedures have you had to treat the pain?

PROCEDURE	Mark if applicable
No Procedure	
Epidural Steroid Injection	
Facet Joint Injection	
Medial Branch Block Trial	
Peripheral Nerve Injection	
Rhizotomy	
Fusion, anterior	
Fusion, posterior	
Fusion, combined anterior and posterior	
Laminectomy	
Microdiscectomy	
Other	

What imaging studies have you had for the pain?

☐Bone scan

☐CT Scan

☐EMG

☐ MRI

☐ Radiographs

How has the pain limited you? (check mark all that apply)

Activities	Limit Pain	Activities	Limit Pain
No limitations		Inability to attend school	
Attending school on a limited basis		Inability to perform daily activities (ADL's)	
Difficulty getting up from chair		Inability to work	
Difficulty sitting		Requiring constant assistance	
Difficulty standing		Requiring occasional assistance	
Difficulty walking		Working on a limited basis	
Difficulty with daily activities (ADL's)		Working light duty	
Difficulty with recreational sports		Other	
Functional limitations			

Who have you seen for this problem? ☐Chiropractor ☐Emergency Room ☐General Surgeon ☐ Internist

☐Orthopedic Doctor ☐Pediatrician ☐Primary care ☐ Therapist ☐Trainer ☐Urgent Care Center ☐Walk in clinic

NATIONAL Spine & Pain CENTERS

INTAKE AND HISTORIES

***** PLEASE COMPLETE THE REMAINDER OF THIS PAPERWORK ON THE PATIENT PORTAL *****

https://treatingpain.ema.md **Contact our office at 855-836-7246 for a username and password**

Past Medical History (please check all that apply):

- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bipolar Disorder
- ☐ Breast Cancer
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non-Insulin Dependent
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity, Morbid
- ☐ Obesity
- ☐ PBPH
- ☐ Prostate Cancer
- ☐ Radiation Therapy
- ☐ Fibromyalgia
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke
- ☐ **None**
- ☐ Other_____

Past Surgical History (please check all that apply):

- ☐ Appendix (Appendectomy)
- ☐ Bladder Removed
- ☐ Breast: Mastectomy ☐Right ☐Left ☐Both
- ☐ Breast: Lumpectomy ☐Right ☐Left ☐Both
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Gallbladder Removal
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Removed: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Tonsillectomy
- ☐ Hysterectomy: Caesarean
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ **None**
- ☐ Other_____

NATIONAL Spine & Pain CENTERS

INTAKE AND HISTORIES

Interventional Pain History (please check all that apply):

- ☐ Epidural Injection(s)- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Facet Injection(s)- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Medial Branch Block- Injection(s)- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Rhizotomy- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Intrathecal Pump
- ☐ Spinal Cord Stimulator
- ☐ **None**
- ☐ Other_____

Musculoskeletal History (please check all that apply):

- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Adhesive Capsulitis
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ DISH
- ☐ Epidural Injections, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Polio
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shoulder Impingement
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ **None**
- ☐ Other_____

Musculoskeletal Surgery (please check all that apply):

- ☐ Achilles Tendon Repair
- ☐ ACL Reconstruction
- ☐ Ankle Fracture ORIF ☐Right ☐Left ☐Both
- ☐ Bunion Correction
- ☐ Carpal Tunnel Decompression ☐Right ☐Left ☐Both
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ CMC Arthroplasty
- ☐ Distal Radius ORIF ☐Right ☐Left ☐Both
- ☐ Ganglion Cyst Excision
- ☐ Intramedullary Nailing Femur ☐Right ☐Left ☐Both
- ☐ Intramedullary Nailing Tibia ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Hip ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Knee ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Shoulder ☐Right ☐Left ☐Both
- ☐ Knee Arthroscopy ☐Right ☐Left ☐Both
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Lumbar Fusion
- ☐ Lumbar Laminectomy
- ☐ Lumbar Spine Surgery: Decompression
- ☐ Lumbar Spine Surgery: Decompression & Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement
- ☐ Meniscus Repair
- ☐ Reverse Total Shoulder Replacement
- ☐ Revision of Total Hip Arthroplasty
- ☐ Revision of Total Knee Arthroplasty
- ☐ Revision of Total Shoulder Arthroplasty
- ☐ Rotator Cuff Repair ☐Right ☐Left ☐Both
- ☐ Shoulder Arthroscopy
- ☐ **None**
- ☐ Other_____

NATIONAL Spine & Pain CENTERS

INTAKE AND HISTORIES

Medications (please list all current medications or check option, which applies):

- Complete the information below regarding all medications you are currently taking, have discontinued, or modified.
- Be certain to list both prescription and non-prescription medication, including any herbals or supplements you take.

☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)

☐ Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

Allergies (please list all known allergies or check option, which applies):

☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)

☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

NATIONAL Spine & Pain CENTERS

INTAKE AND HISTORIES

Social History (please check all that apply):

Cigarette Smoking
- ☐ Never Smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily
  - o # packs per day_____

Alcohol Use
- ☐ Do not drink alcohol
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Exercise Frequency
- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never
- ☐ Other_____

Drug Use
- ☐ Drug Use
- ☐ IV Drug Use
  - o _____

Family History:

Please check appropriate box "Alive" or "Decease" and list ages for the following Blood Family Members. If Parents or Grandparents are deceased, please write in Age and Cause of Death, if known.

	Alive	Age (if known)	Deceased	Age at Death	If deceased, cause of death	Unknown Status
Father						
Mother						
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						

	Number Alive	Age (if known)	Number Deceased	Age at Death	If deceased, cause of death	Unknown Status
Brothers						
Sisters						
Sons						
Daughters						

Family History (continued):

Please mark YES or NO if a Blood Family Member has ever had any of these conditions. If you mark YES, please mark the box under the relationship of the person to you

				Relationship of Person to you				
	YES	NO	DO NOT KNOW	Father	Mother	Grandparent	Brother /Sister	Son/ Daughter
Cancer								
Heart Disease								
Diabetes								
High Blood Pressure								
Stroke/TIA								
Alcohol Abuse								
Drug Abuse								
Psychiatric Illness								
Seizures								
Depression/Suicide								
Osteoarthritis								
Osteoporosis								
Scoliosis								
Other Conditions								

NATIONAL Spine & Pain CENTERS

INTAKE AND HISTORIES

Review of Systems* (check yes or no if you are currently experiencing any of the following):

Symptom	Yes	No	Symptom	Yes	No
Joint pains			Wheezing		
Joint swelling			Pain w/ breathing		
Difficulty Walking			Palpitations		
Muscle Pain			Ankle Swelling		
Pain Radiating down to leg(s)			Labored breathing w/exertion		
Weakness			Nausea/ Vomiting		
Numbness			Diarrhea		
Tingling			Constipation		
Fever			Heartburn		
Weight Gain			Ulcers		
Rash			Blood in Stool		
Chest Pain			Urinary Incontinence		
Incontinence			Urinary hesitancy		
Shortness of Breath			Urinary retention		
Suicidal thoughts			Blood in urine		
Weight loss			Genital pain		
Chills			Excessive bruising		
Fatigue			Excessive bleeding		
Discoloration			Cancer		
Scarring			Excessive thirst		
Environmental Allergies			Heat/Cold intolerance		
Immunosuppression			Diabetes		
HIV/AIDS			Thyroid Disease		
Blurred Vision			Joint Stiffness		
Double Vision			Dizziness		
Glaucoma			Fainting		
Eye pain			Headaches		
Ringing in the Ears			Tremor		
Loss of hearing			Seizure		
Nose bleeds			Memory Loss		
Hoarseness			Depression		
Difficulty Swallowing			Anxiety		
Cough			Hallucinations		

Other Medical Conditions* (check yes or no for the following):

*Please inform the physician, medical assistant or front desk staff of any other medical conditions or concerns.

Symptom	Yes	No	Symptom	Yes	No
Blood Thinners			Rheumatoid Arthritis		
Pacemaker			Hepatitis B or C		
Defibrillator			Pregnancy or planning a pregnancy		
Premedicate Prior to Procedure			HIV/ADS		
Hepatitis B or C			Diabetes		