Welcome to our practice!

Thank you for choosing us for your health care needs & we are looking forward to your first visit with us on: _____. Please check in at _____ for your _____ appointment.

Your appointment is scheduled with:

Your appointment will be at:

Our goal is to provide the highest quality care for all our patients in a timely and respectful manner. We have saved this time especially for you to welcome you, answer any questions you may have, allow you to meet our staff, and provide a careful, thorough examination.

Please feel free to visit our website at www.dallaspainconsultants.com as it answers many questions about our practice as well as listing our telephone number, patient forms, and locations.

Please complete the attached forms and bring them with you to your appointment along with your insurance card and a photo ID. These forms can be completed, printed & brought with you**.** If you complete your health history on the patient portal, you do NOT need to complete the 3 page health history enclosed in this packet.

Patient Portal
Your user ID for the patient portal will be emailed directly to the email we have on file. Your temporary password will be Password1. Through our portal you can communicate directly with your provider's team for medication refills & general questions. The portal should not be used in the case of emergencies.

All forms must be fully completed & brought to your appointment. If your forms are not completed your appointment may be rescheduled. If you are unable to print or access the forms, please check in 30 minutes early to allow time for completion of the forms.

All co-pays and any past due balances are expected at time of service.

Please let our staff know if any information changes between appointments (address, insurance, etc.). You are rquired to fill out new registration forms annually.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are past your scheduled appointment time. We strive to stay on time during clinic. However, from time to time, we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

If you have any questions, please give us a call (214) 948-7700. We look forward to seeing you!
Dallas Pain Consultants, Providers & Staff

REGISTRATION FORM

Today's Date: _____ (Please print)

First Name: _____ Middle: _____ Last: _____

DOB: _____ Gender: _____ Social Security: _____

Preferred Language: English Spanish Other: _____

Street Address: _____

City: _____ State: _____ Zipcode: _____

Cell Phone No: (_____)_____ Email: _____

Referring Physician: _____ Phone #: (_____)_____

Primary Care Physicia _____ Phone #: (_____)_____

Is this a Workers' Compensation Injury? ( ) Yes ( ) No If Yes - Please see the front desk

Please list an emergency contact (with a different number than your own)

Name of Emergency Contact: _____

Relationship to Patient: _____ Contact Phone No.: (_____)_____

Patient Portal: Dallas Pain Consultants requires patients to communicate through our patient portal for non-emergent issues, such as medication refills & general questions. Some questions cannot be answered through the portal & may require an office visit for further discussion.

Courtesy Reminders & Cost Estimations: I understand that I will receive courtesy reminders and cost estimates via HIPAA compliant texts & emails to the contact information I have provided. I understand that it is my responsibility to update this information if the contact number or email is changed & cannot hold Dallas Pain Consultants responsible for any information disclosed inadvertently due to wrong contact information.

Email & text should never be used for emergency problems. Contact the office directly at 214-948-7700 or call 911.

By signing below, you confirm that the information you have provided is correct and true to the best of your knowledge. It is your responsibility to inform Dallas Pain Consultants of any changes to your contact or insurance information.

x_____

Patient's or Authorized Representatives Signature

Expires 1 year from today's date

Name: _____ DOB: _____

General Patient Consent for Care Form

I, the undersigned, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Dallas Pain Consultants on an outpatient / office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider, including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

I agree and acknowledge that Dallas Pain Consultants is not liable for the actions or omissions of, or the instructions given y the physician/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations at Dallas Pain Consultants facilities.

Telemedicine
I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultive, diagnostic, and treatment service(s) may be employed to facilitate my medical care. All electronic transmission pf data will be restricted to authorized recipients in compliance with Federal Health Insurance Portability and Accountability Act (HIPAA) and applicable state privacy laws.

To the Patient:
You have the right to discuss the treatment plan with your physician/provider about the purpose, potential risks and benefits of any tests/procedures ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Nurse Practitioner & Physician Assistant Consent

Here at, Dallas Pain Consultants, we strive to offer you high quality medical care and give strong consideration to your wait time. We employ Advanced Practice Registered Nurses, also known as Nurse Practitioners and/or Physician Assistants to assist us in carrying out your plan of care. Nurse Practitioners and Physician Assistants have received advanced education and training in the provision of health care. They are graduates of a certified training program and licensed by the Texas State Medical Board. They can diagnose, treat and monitor routine and complex pain disorders as well as provide health maintenance care. If you are seen by one of these providers, your doctor will review your care with them as part of your treatment plan. “Supervision” does not require the constant physical presence of the supervising physician, but rather, observing the activities of accepting responsibility for the medical services provided.

I have read the above and understand that in this practice a team approach is used with my unique needs presented and reviewed by one or more physicians in the development of my plan of care. I also understand that from time to time I may be seen by any or all of the providers in this practice, including the physicians, Nurse Practitioners and Physician Assistant.

I hereby consent to the services of a Nurse Practitioner or Physician Assistant for my healthcare needs. I understand that I can refuse to see the Nurse Practitioner or Physician Assistant and request to see a physician. I understand that this may require my appointment to be rescheduled.

Disclosure of Physician Interest & Ownership

To better serve you, our physicians, have ownership or financial interests in various other health care providers and/or facilities. Today’s medical business climate is very complicated, and physicians have little negotiation power with insurance companies. Our physicians are committed to providing high quality health care services to our patients and may refer you to one of these providers and/or facilities to receive health care items or services that he has determined you need. Their ownership interest in these often provides them a voice in administrative, clinical and operational policies. This involvement helps ensure the highest level of patient care and customer service. During a physician/patient relationship you may be referred to a provider/facility or service. I am providing this information to help you make an informed decision about your health care. However, you have the right to choose your health care provider and you have the option to use a health care provider/facility/service other than the provider/facility/service to which you might be referred you. You will not be treated any differently if you choose to obtain health care from a provider/facility/service other than the provider/facility/service in which DPC Providers have an ownership or financial interest. If you require assistance, we will be happy to provide information about alternative providers/facilities/services. A list of these facilities/providers is available upon request.

If you have questions, please do not hesitate to ask. We welcome you as a patient & we value our relationship with you. By signing below, you acknowledge that you have read and understood this Disclosure, and that you

X_____

Patient’s or Authorized Representative’s Signature Expires 1 year from today’s date

Name:_____ DOB:_____

Financial Policy & Assignment of Benefits

Our financial policy outlines our practice guidelines which should allow you to receive all the benefits offered to you by your health plan. We ask that you read the following carefully and agree to our terms and conditions which are necessary to facilitate your care.

- All insurance cards & photo ID must be brought to every visit.
- We file claims as a courtesy to our patients and are only responsible for filing claims to contracted insurance companies.
- Any dispute for unpaid charges from the insurance company will be billed to you the patient.
- **All copays, coinsurance, & deductibles must be paid at the time of service, this is an insurance requirement and part of your contract with the insurance company.**
- **Contract –** Your insurance policy is a contract between you, your employer (if applicable) and the insurance company. We are not a party to that contract. It is important that you understand the provisions of your policy, as we cannot guarantee payment of claims. In the instance your insurance company denies payment for services provided you are responsible for payment.
- **Procedures & Injections Costs –** In all cases we collect an **estimate** of your financial responsibility amount at the time of service. Procedures & injections may be rescheduled if the estimated amount is not paid on or prior to the time of service. This will be an estimate ONLY and may be subject to change depending on the services provided. We will either bill you for the remaining balance or credit any overpayment in a timely manner.
- **HMO/Managed Care plans –** It is your responsibility to ensure you have a current referral on file to cover your visits. In the event you are seen without a referral you will be subject to our self-pay rates. New Patient rate $200.00, Follow-up office visits rate $98.00; Urine Drug Testing rate $150.00. All other procedures will be priced according to the self-pay fee schedule rate.
- **Payment Methods –** We accept cash, checks (Under $100), money orders and all major credit cards (VISA, Mastercard, Discover, American Express & CareCredit).

Charges and Fees:

- **Charges for Forms -** Our charge for completing FMLA, Disability or Life Insurance paperwork is $35.00 per form and is due in full before the paperwork can be picked up, faxed or mailed. Allow 7-10 days processing.
  No Show Fees – Appointments without a 24-hour notice will be subject to a no-show/late cancellation fee. Patients who habitually fail to keep appointments will be discharged from our clinic. Office visits will incur a $25.00 fee and procedures will incur a $100.00 fee. These charges are not payable by your insurance company. You will be required to pay this charge before your next scheduled appointment.
- **Returned Checks -** A $25.00 fee will be charged for any returned checks, and we will no longer accept your checks.

Delinquent Accounts – If your account becomes "delinquent" (past due) we reserve the right to refuse any further appointments or prescribe medications until your account is brought current.

Account Billing Questions & Refunds – Questions or concerns regarding your account or insurance claim can be directed to our billing department (214) 948-7700. If your account has a credit balance, we will issue a refund once all outstanding claims on your account have processed. Payment plans are available upon request, please contact us PRIOR to your appointment. Unless you make prior arrangements, our financial policy will stand.

Assignment of Benefits – Insurance is considered a method of reimbursing you the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage for the charge. It is your responsibility to pay any copay, deductible amount, coinsurance, or other balance not paid for by your insurance at the time of service.

I understand that I am responsible for providing **Dallas Pain Consultants** all insurance information at the time of registration to allow for verification of benefits, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

I hereby assign all medical and /or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to **Dallas Pain Consultants.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether paid by said insurance. I hereby authorized said assignees to release all information necessary to secure payment

By signing below, you agree to all terms and conditions stated above, you fully understand DPC financial policy and as the patient you are ultimately responsible for all liable amounts.

X_____

Patient's or Authorized Representative's Signature Today's Date

This authorization will expire 1 year from the date of signature

Name: _____ DOB: _____

Consent for Use & Disclosure of Protected Health Information & Authorization to Release Information

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and my plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand I have the right to:

- Object to the use of my health information for directory purposes.
- Request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that the organization is not required to agree to the restrictions requested.
- Revoke this consent in writing, except to the extent that the organization has already taken the action in reliance therein.

To protect your privacy under HIPAA, we have created this consent form for releasing medical information about you, for treatment, payment, and health care operations, or to family members and other people of your choosing. This will also be used for consent to leave you detailed telephone messages at the mentioned phone numbers. Many times, we have patient's family member's call requesting medical information and legally we are not allowed to release that information without the patient's written consent. The purpose of this document is to protect your privacy.

I authorize Dallas Pain Consultants (DPC) to furnish requested information from the patient's medical and other records to: (1) any insurance company or third party for purpose of obtaining payment on account of DPC, (2) the disability insurance company to expedite my claim, (3) any other person(s) or entities financially responsible for the patient's care or treatment, and (4) representatives of local, state, or federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable disease such as Acquired Immune Deficiency Syndrome ("AIDS"). I also authorize the release of information and /or review of patient's records for purpose of conducting medical audits, utilization reviews, or quality assurance reviews.

I hereby give my permission for the release of specific information to the following person(s):

Name:_____Relation:_____Phone:_____
Circle one: Financial and Medical Information Financial Information ONLY Medical Information ONLY

Name:_____Relation:_____Phone:_____
Circle one: Financial and Medical Information Financial Information ONLY Medical Information ONLY

Name:_____Relation:_____Phone:_____
Circle one: Financial and Medical Information Financial Information ONLY Medical Information ONLY

Do you have an Advance Directive/Living Will (circle one)? Yes No

I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for the communication of my health information. **I have received a copy of Dallas Pain Consultants' Noticy of Privacy Practices.**

x_____
Patient's or Authorized Representative's Signature Expires 1 year from today's date

Authorization Form for Release and Disclosure of Protected Health Information

Patient Name:_____ Date of Birth:_____

Address:_____ Social Security:_____

City:_____ State:_____ Zip:_____ Phone:_____

I hereby authorize the following doctor or person to release and disclose my protected health information to Dallas Pain Consultants located at 1411 North Beckley Avenue Suite 152 Dallas, TX 75203:

Name:_____ Phone:_____

Address:_____ Fax:_____

City:_____ State:_____ Zip:_____

Please circle all that apply to this release and disclosure:

Office Visit Notes Radiology Records Procedure Notes Lab Results

Financial Records Other: _____

This information is being disclosed for the following purpose(s):

_____

I understand that the information in my health record may include information relating to communicable diseases, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

Unless otherwise revoked, this authorization will expire on the following date, event or condition. If I fail to specify an expiration date this authorization will expire by law 180 days from the date of this authorization.

Expiration date, event or condition: _____

I understand that I have the right to revoke this authorization at anytime. I understand that in order to revoke this authorization, I must do so in writing and the written revocation can be delivered or mailed to Dallas Pain Consultants, 1411 N Beckley Ave, Pav. 3, Ste. 152, Dallas, TX 75203 or faxed to 214-948-7701. The revocation does not affect any actions taken before the receipt of the written revocation and does not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once this information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

I understand I will be given a copy of this authorization form, after signing.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Printed Name of Patient or Patient's Representative Relationship to Patient

_____ _____

Signature of Witness Date

Name: _____ DOB: _____

Pain Management Agreement

The purpose of this agreement is to outline our practice policies & expectations for patients in our pain management practice.

Prescriptions:

- Pain medication prescriptions are obtained from our office only. Exception: If you have a surgery, dental procedure/surgery or urgent care/ER visit, that provider may prescribe pain medication as they deem necessary. **You must notify the office immediately.**
- Only use **one** pharmacy, if there is a change in pharmacies you must notify us.
- Prescribed medication(s) must be taken strictly as ordered.
- Do not take medication(s) not prescribed to you.
- Do not take old medication(s). Old medication(s) should not be mixed with your current medication(s). Please discuss with provider.
- Medication(s) must be kept in a safe and secure place. Lost or stolen medication must be reported to the police and your physician immediately. **Prescriptions will not be refilled early.**
- Refills of medication(s) will only be given as authorized by your provider.
- Refills will not be made at night, on weekends, or during holidays.
- It is against the law to give or sell your medication(s) to any other person.
- We cannot force a pharmacy to fill or your insurance to pay for your prescription.

Appointments:

- You must keep your scheduled appointments. Patients who habitually fail to keep appointments will be discharged from our clinic.
- Appointments are scheduled per the providers requirements & may require you being seen every month.
- You must arrive on time. Arriving late will result in your appointment being rescheduled without your medication being prescribed.
- Arriving too early to your appointment may result in a longer wait time. You may be "worked in" if the schedule allows.
- Appointment reminders are a courtesy. It is your responsibility to know when your appointment is.

Treatment Plans:

- Accurately list all medical conditions and medications, including herbal remedies & over the counter medications.
- We may contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions if the physician deems it necessary.
- You will be asked to participate in other conservative treatment plans prescribed by your provider.
- Treatment plans & medications may be altered at any time for any reason as provider sees fit.

Compliance:

- No use of any illicit substances or alcohol is permitted.
- You will be subject to a urine drug test on your 1st visit & periodic unannounced urine drug testing thereafter. (See Financial below)
- You will be subject to periodic unannounced pill counts. Pain medication(s) must be brought to every visit.
- Patient is responsible to comply with all laws and regulations while taking these medications.
- Unauthorized visits to any of the offices without an appointment are not permitted.
- Physical & verbal abuse towards office staff or pharmacists will **NOT** be tolerated. This includes disruptions affecting daily operations within the office as well as abuse on the phone with office staff. **This will result in immediate discharge from the practice.**

Warnings:

- Side effects and addiction to these medications is possible. If you have a history of alcohol or drug misuse/addiction, you must notify the physician.
- Suddenly stopping these medications could be dangerous. Discuss stopping medication(s) with your provider, prior to doing so.
- Do not drive or use dangerous equipment when taking medication(s) that may cause impairment as advised by your provider.
- Narcan is strongly recommended to be available if taking opioid narcotics.
- We strongly discourage taking benzodiazepines, such as, Diazepam, Lorazepam, Clonazepam, etc. while taking narcotics. We will work with your prescriber to find alternative treatments to minimize the risk to your safety.

Financial:

- All copays, coinsurance, & deductibles must be paid at the time of service.
- You will be financially responsible for cost of urine drug test ($150.00) if insurance does not pay for it.
- Your account must remain current & compliant with DPC Financial Policies.

Violation of any of the above, will result in my prescription being terminated and/or discharge from the clinic. Final decisions will be made by the providers of Dallas Pain Consultants and will be final.

I understand the above list is not complete, I will be careful to exercise caution and common sense, asking questions where a full understanding is not met or if I feel that I may be having trouble with treatment provided.

X_____

Patient's or Authorized Representative's Signature

Expires 1 year from today's date

New Patient Health History and Pain Management Questionnaire

Name: _____ **Date:** _____
First Middle Last

Date of Birth: _____ **Age:** _____ **Gender:** _____ **Marital Status:** ( ) S ( ) M ( ) D ( ) W

Ethnicity: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ Caucasian □ Decline to specify □ Other: _____

Referring Physician: _____ **Phone #:** _____
Primary Care Physician: _____ **Phone #:** _____
Cardiologist: _____ **Phone #:** _____
Pharmacy: _____ **Phone #:** _____

Previous Pain Physician: _____ **Phone #:** _____

Under what circumstances did the pain begin?
□ Work Accident □ Home Accident □ Auto Accident □ Surgery □ Fall □ Other_____

Location of Pain (circle all that apply): Head Neck Shoulder (left or right) Arm (left or right)
Upper Back Lower Back Buttock Hip (left or right) Leg (left or right) Knee (left or right)

How long have you had pain in this location? _____ hours _____ days _____ months _____ years
Please circle severity of your pain: (No pain)0 1 2 3 4 5 6 7 8 9 10(Unbearable pain)

Mark what best describes your pain: **Is your pain:** □ Constant □ Off and on
Aching □ Burning □ Penetrating □ Sharp □ Shooting □ Stabbing □ Throbbing

Do you have any of the following? **Are these:** □ Constant □ Off and on
Numbness □ Tingling (Pins & Needles) □ Weakness □ Coldness □ Muscle Spasm □ Tightness

Does your pain interfere with your sleep? □ Occasionally □ Frequently □ Does not Affect

What makes the pain better or worse? Please check the appropriate box for each.

	Better	Worse
Sitting		
Standing		
Walking		
Coughing		
Bending Over		
Exercise		
Lifting		
Deep Breathing		
Lying on your Back		
Other:		

Do you take pain medicaton? □ Yes □ No **If yes, do you have relief?** □ Yes □ No
How long does the pain relief last? _____
How many times a day do you take pain medication? _____
In the past 2 weeks, have you taken more, the same, or less pain medication? _____

Name: _____ DOB: _____

What diagnostic test(s) or treatment(s) have you had? Please indicate when and where they were done.

	Date	Location
X-ray		
MRI/CT Scan		
EMG		
Physical Therapy		
Chiropractor/Acupuncture		
Braces/TENS unit		
Other:		

ALLERGIES: Medication allergies will be listed on page 11

	Reaction (mark all that apply)				
Anesthestic	Rash	Nausea/Vomiting	Diarrhea	Wheezing	Other:
Iodine/Shellfish	Rash	Nausea/Vomiting	Diarrhea	Wheezing	Other:
Latex	Rash	Nausea/Vomiting	Diarrhea	Wheezing	Other:
Tape	Rash	Nausea/Vomiting	Diarrhea	Wheezing	Other:
Other:	Rash	Nausea/Vomiting	Diarrhea	Wheezing	Other:

Are you currently taking anti-coagulants or blood thinners? □ Yes □ No _____

Who is prescribing this for you? Doctor: _____ Tel #: _____

Do you have any **metal** in your body? Including stents, pacemaker/defibrillator, bullets, stimulators, joint replacements, or other metal implants, including dental implants (Please list all)

_____

_____

Systems Review: Circle any of the following which you have had in the **last 3 months or currently have**:

Fatigue	Yes	No	Joint Pains	Yes	No
Unexpected Weight Loss	Yes	No	Joint Stiffness	Yes	No
Easy Bleeding/Bruising	Yes	No	Joint Swelling	Yes	No
Chest Pain	Yes	No	Unsteady Gait	Yes	No
Irregular Pulse	Yes	No	Muscle Spasms	Yes	No
Fainting	Yes	No	Numbness	Yes	No
Leg Cramps	Yes	No	Tingling	Yes	No
Heart Murmur	Yes	No	Dizziness	Yes	No
Leg Pain When Walking	Yes	No	Headaches	Yes	No
Swollen Ankles	Yes	No	Tremors	Yes	No
Varicose Veins	Yes	No	Muscle Weakness	Yes	No
Shortness of Breath	Yes	No	Loss of Control of Arms or Legs	Yes	No
Wheezing	Yes	No	Loss of Control of Bladder or Bowel	Yes	No
Heart Burn	Yes	No	Excessive Thirst/Urination	Yes	No
Nausea/Vomting	Yes	No	Cold/Heat Intolerance	Yes	No
Constipation	Yes	No	Anxiety	Yes	No
Bloody/Tarry Stools	Yes	No	Depression	Yes	No
Abdominal Pain - Chronic	Yes	No	Sleeping Difficulty	Yes	No
Jaundice	Yes	No	Memory Loss	Yes	No

Name: _____ DOB: _____

DID YOU COMPLETE YOUR HEALTH HISTORY THROUGH THE ONLINE PORTAL? □ YES □ NO

IF YES - YOU DO NOT NEED TO CONTINUE UNLESS YOU NEED TO ADD MORE EXPLANATION

Interventional Pain History:

	Date	Physician
Steroid Injections		
Facet Injections/Medial Branch Block		
RF (Rhizotomy) Procedure		
Intrathecal Pump (Pain Pump)		
Spinal Column Stimulator		
Other:		

Past Medical History (check all that apply): NONE

□ ADD/ADHD	□ Anxiety Disorder	□ Asthma	□ Atrial Fibrillation
□ Blood Clot	□ Cancer	□ Chronic Anemia	□ Chronic Pain
□ COPD	□ Coronary Heart Disease	□ Depressive Disorder	□ Diabetes
□ Diabetic on Insulin	□ Epilepsy	□ Fibromyalgia	□ GERD
□ Hepatitis	□ High Cholesterol	□ HIV/AIDS	□ Hypertension
□ Hyperthyroidism	□ Hypothyroidism	□ Kidney Disease	□ Leukaemia
□ Liver Disease	□ Malignant Lymphoma	□ Malignant Tumor of Colon	□ Migraine
□ Obesity	□ PTSD	□ Pulmonary Embolism	□ Sleep Apnea
□ Stroke	□ Stomach Ulcers		
Other:			

Spinal Surgeries (check all that apply and provide dates): NONE

□ Arthroscopy of Knee	□ Kyphoplasty
□ CTR - Carpal Tunnel Release	□ Meniscus Repair
□ Cervical Spine Fusion	□ Rotator Cuff Repair
□ Thoracic Spine Fusion	□ Total Knee Replacement
□ Lumbar Spine Fusion	□ Total Hip Replacement
□ Lumbar Laminectomy	□ Total Shoulder Replacement
Other:	

Past Family History –List all medical conditions a family member has, had or died from:

Is your mother still living? □ Yes □ No Is your father still living? □ Yes □ No

_____

_____

_____

Social History:

Occupation: _____ Work status (Full, Part-Time, Retired, Disabled) _____

Alcohol: □ Yes □ No How many drinks per week? _____ Month? _____

Tobacco: □ Yes □ No

Smoking: _____ cigs/day # Years: _____ Year quit: _____

Chewing: _____ cans/week # Years: _____ Year quit: _____

E-Cig or Vaping: _____ /day # Years: _____ Year quit: _____

Do you use recreational drugs? □ Yes □ No If yes, what type and when was your last use?_____

Have you ever been treated for alcohol dependence or addiction? □ Yes □ No

Have you ever been treated for drug dependence or addiction? □ Yes □ No

Immunizations:

Have you had the flu vaccine? □ Yes □ No When? _____

Have you had the pneumonia vaccine? □ Yes □ No When? _____

Name: _____ DOB: _____

MEDICATION ALLERGIES ☐ **NO KNOWN DRUG ALLERIGES**

Medication Name	Reaction
	Rash Nausea/Vomiting Diarrhea Wheezing Other:
	Rash Nausea/Vomiting Diarrhea Wheezing Other:
	Rash Nausea/Vomiting Diarrhea Wheezing Other:
	Rash Nausea/Vomiting Diarrhea Wheezing Other:
	Rash Nausea/Vomiting Diarrhea Wheezing Other:
	Rash Nausea/Vomiting Diarrhea Wheezing Other:

MEDICATION LOG

CURRENT AS OF: _____

Medication Name	Dose / Strength	How often do you take it? (3 x day, 2 x day, at bedtime, etc.)

Name: _____ DOB: _____

SOAPRR

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1 How often do you have mood swings?	O	O	O	O	O
2 How often have you felt a need for higher doses of medication to treat your pain?	O	O	O	O	O
3 How often have you felt impatient with your doctor?	O	O	O	O	O
4 How often have you felt that things are just too overwhelming that you can't handle them?	O	O	O	O	O
5 How often is there tension in the home?	O	O	O	O	O
6 How often have you counted pain pills to see how many are remaining?	O	O	O	O	O
7 How often have you been concerned that people will judge you for taking pain medications?	O	O	O	O	O
8 How often do you feel bored?	O	O	O	O	O
9 How often have you taken more pain medication than you were supposed to?	O	O	O	O	O
10 How often have you worried about being left alone?	O	O	O	O	O
11 How often have you felt a craving for medication?	O	O	O	O	O
12 How often have others expressed concern over your use of medication?	O	O	O	O	O
Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13 How often have any of your close friends had a problem with alcohol or drugs?	O	O	O	O	O
14 How often have others told you that you had a bad temper?	O	O	O	O	O
15 How often have you felt consumed by the need to get pain medication?	O	O	O	O	O
16 How often have you run out of pain medication early?	O	O	O	O	O
17 How often have others kept you from getting what you deserve?	O	O	O	O	O
18 How often, in your lifetime, have you had legal problems or been arrested?	O	O	O	O	O
19 How often have you attended an AA or NA meeting?	O	O	O	O	O
20 How often have you been in an argument that was so out of control that someone got hurt?	O	O	O	O	O
21 How often have you been sexually abused?	O	O	O	O	O
22 How often have others suggested that you have a drug or alcohol problem?	O	O	O	O	O
23 How often have you had to borrow pain medications from your family or friends?	O	O	O	O	O
24 How often have you been treated for alcohol or drug problems?	O	O	O	O	O

Name: _____ DOB: _____

Modified Oswestry Disability Index

Total: _____

Please answer each section by marking in each section **one number** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just mark the number that most closely describes your problem.**

Section 1 - Pain Intensity

0 The pain comes and goes and is very mild.
1 The pain is mild and does not vary much.
2 The pain comes and goes and is moderate.
3 The pain is moderate and does not vary much.
4 The pain comes and goes and is severe.
5 The pain is severe and does not vary much.

Section 2 - Personal Care

0 I do not have to change my way of washing or dressing to avoid pain.
1 I do not normally change my way of washing or dressing even though it causes me pain.
2 Washing and dressing increase the pain, but I manage not to change my way of doing it.
3 Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4 Because of the pain I am unable to do some washing and dressing without help.
5 Because of the pain I am unable to do any washing and dressing without help.

Section 3 - Lifting (skip if you have not attempted lifting since the onset of your low back pain)

0 I can lift heavy weights without extra low back pain.
1 I can lift heavy weights but it causes extra pain.
2 Pain prevents me lifting heavy weights off the floor.
3 Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
4 Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5 I can only lift light weights at the most.

Section 4 - Walking

0 I have no pain walking.
1 I have some pain on walking, but I can still walk my required to normal distances.
2 Pain prevents me from walking long distances.
3 Pain prevents me from walking intermediate distances.
4 Pain prevents me from walking even short distances.
5 Pain prevents me from walking at all.

Section 5 - Sitting

0 Sitting does not cause me any pain.
1 I can sit as long as I need provided I have my choice of sitting surfaces.
2 Pain prevents me from sitting more than 1 hour.
3 Pain prevents me from sitting more than 1/2 hour.
4 Pain prevents me from sitting more than 10 minutes.
5 Pain prevents me from sitting at all.

Section 6 - Standing

0 I can stand as long as I want without pain.
1 I have some pain while standing, but it does not increase with time.
2 I cannot stand for longer than 1 hour without increasing pain.
3 I cannot stand for longer than 1/2 hour without increasing pain.
4 I cannot stand for longer than 10 minutes without increasing pain.
5 I avoid standing because it increases the pain immediately.

Section 7 - Sleeping

0 I have no pain while in bed.
1 I have pain in bed, but it does not prevent me from sleeping well.
2 Because of pain I sleep only 3/4 of normal time.
3 Because of pain I sleep only 1/2 of normal time.
4 Because of pain I sleep only 1/4 of normal time.
5 Pain prevents me from sleeping at all.

Section 8 - Social Life

0 My social life is normal and gives me no pain.
1 My social life in normal, but increases the degree of pain.
2 Pain prevents me from participating in more energetic activities e.g. sports, dancing.
3 Pain prevents me from going out very often.
4 Pain has restricted my social life to my home.
5 I hardly have any social life because of pain.

Section 9 - Traveling

0 I get no pain while traveling.
1 I get some pain while traveling, but none of my usual forms of travel make it any worse.
2 I get some pain while traveling, but it does not compel me to seek alternative forms of travel.
3 I get extra pain while traveling that requires me to seek alternative forms of travel.
4 Pain restricts all forms of travel.
5 Pain prevents all forms of travel except that done lying down.

Section 10 - Employment/Homemaking

0 My normal job/homemaking duties do not cause pain.
1 My normal job/homemaking duties cause me extra pain, but I can still perform all that is required of me.
2 I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activitiese.g. lifting, vacuuming, etc.
3 Pain prevents me from doing anything but light duties.
4 Pain prevents me from doing even light duties.
5 Pain prevents me from performing any job or homemaking chore.

Name: _____ DOB: _____

PHQ-9 & GAD-7

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1) Little interest or pleasure in doing things	0	1	2	3
2) Feeling down, depressed or hopeless	0	1	2	3
3) Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4) Feeling tired or having little energy	0	1	2	3
5) Poor appetite or over-eating	0	1	2	3
6) Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7) Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8) Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9) Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

PHQ9 – Total Score _____

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1) Feeling nervous, anxious on edge	0	1	2	3
2) Not being able to stop or control worry	0	1	2	3
3) Worrying too much about different things	0	1	2	3
4) Trouble relaxing	0	1	2	3
5) Being so restless it is hard to sit still	0	1	2	3
6) Becoming easily annoyed or irritable	0	1	2	3
7) Feeling afraid as if something awful might happen	0	1	2	3

GAD 7 – Total Score _____