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PATIENT INFORMATION

Name____
Last Name First Name Middle

Date of Birth______________________**Social Security#**______________________________

Address ______________________________ **City**____________**State**____________

Zip Code_________________

Home#_____________________ **Cell#**_____________________

Ph. Provider: AT&T [ ] T-Mobile [ ] Sprint [ ] Verizon [ ] Cricket [ ] Metro [ ]

Email:____

Gender: Male [ ] Female [ ]

Marital Status: Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced [ ]

Primary care doctor: ______________________**Referring Doctor:** _____________________

Patient Employed By_____________________________**Occupation**______________
Work Address____
City________________**State**_____**Zip Code**___________ **Work #** ________________

In case of emergency who should be notified?_________________________________

Phone#_______________________**Relation to Patient**__________________________

**Race: Asian [ ] African American [ ] White [ ] Other [ ] Hispanic [ ]
Unknown [ ]**

Preferred Language: English Spanish

Do you have secondary insurance? Yes No

Is your condition work related? Yes No If yes, date of injury ___________

Is your condition auto accident related? Yes No

Preferred Pharmacy: ____

I understand that I am financially responsible for charges of services rendered to me, including the balance remaining after payment on insurance benefits.

Signature ____ **Date** _______________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ________________________and assign directly to Advanced Spine Pain Solutions all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Insurance Disclaimer:
Any payment given is based on a quote of benefits. A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.

Insurance Liability for Payment:
Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company be covered. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.

Beneficiary Agreement:
I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

APPOINTMENT NOTICE

We gladly reserve a time for you. If you have to cancel your appointment, we kindly request that you call at least 24 hours prior to appointment date.

There will be a $30.00 charge for no shows and/or cancellations without 24 hours of notice.

If you are more than 15 minutes late for your appointment we will have to reschedule you.

PRESCRIPTION NOTICE

The office will only refill prescriptions Monday thru Thursday from 9:00 am-3:00 pm. Medications will not be called in any other day. Please check your medication and advise us 2-3 days in advance. Patients on controlled medications need to see nurse every month, if not medication will not be refilled. Calls will not be answered on Friday nor the weekend.

____ ____________________

Signature Date

I am responsible for my pain medications:

- I agree to take this medication as prescribed. I will not change my dose unless discussed and approved by my doctor.
- This medication is for my use only. I agree not to share or sell my medication.
- Except for emergencies, I will not ask any other doctor for pain medicines. If I do, I will inform my doctor's office.
- I will not abuse my pain medication or other drugs.
- I agree to have random urine or blood sampling performed on me as requested by my doctor. These samples will be tested for prescribed or non-prescribed medication and illicit drug use. If test is positive you may be discharged from our clinic.
- I agree to come in every three months for follow up visit.
- *Female patients:* You are responsible for informing your physician immediately if you are pregnant, thinking of becoming pregnant, or might be pregnant. Medication should be stopped immediately.

My prescriptions for pain medications:

- Will be written or called in during regular office hours, Monday-Thursday. Will be called in at the end of the day. If you require a pharmacy to pick it up, you will make arrangements with that pharmacy.
- Will not be re-written if "I run out early" or "lose a prescription. I am responsible for taking the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will call the police and obtain a police report. Replacement prescriptions will be written at the discretion of my doctor.

*****Failure to adhere to above policies will be grounds for discharge from clinic.**

PATIENT INITIALS ________________

Soy responsible de mi medicamento para dolor:

- Tomare mi medicamento como lo es recetado. No cambiare la dosis- solo podré cambiar la dosis si mi medico lo autoriza.
- Este medicamento es para mi uso solamente. Estoy de acuerdo a no compartir o vender mi medicina.
- No pediré recetas de este medicamento a otros medicos, solo en una emergencia. Si lo hago, avisare de inmediatament a la oficina/enfermera.
- No abusare de mi medicamento o pediré otras drogas.
- Estoy de acuerdo en hacerme pruebas de orina o sangre en cualquier momento cuando lo pida mi doctor. Estas musetras serán utilizadas para comprobar si hay sustancias ilegales y si el medicamento se esta consumiendo. Si la prueba resulta positive ya no podrá ser nuestro paciente.
- Estoy de acuredo que necesito tener citas cada tres meses.
- *Pacientes de sexo femenino:* Es su responsabilidad de informar inmediatamente al medico si está embarazada, piensa quedar embarazada, o podria estar embarazada. El mecicamento debe ser suspendido inmediatamente.

Mis recetas de medicamento para dolor:

- Serán escritas o llamadas a la farmacia solamente durante horas de oficina, de lunes a jueves. Serán llamadas a la farmacia al final del dia. Si usted necesita que una farmacia la recoja, usted tendrá que hacer los arreglos.
- No serán escritas de nuevo si "se lo acaban antes de tiempo" o "se le pierde la receta" o "se le cayó la medicina". Soy responsible de tomar la medicina como es recetada y de mantener el conteo de mis pastilles. Si mi medicamento es robado, le llamare a la policia y obtendré un reporte policiaco. El reemplazo de recetas serán escritas de nuevo a la discreción de mi medico.

***** Si no sigo estas pólizas, ya no podré ser paciente de esta clínica.**

INICIALES DE PACIENTE________________

Pain Management Clinic Policy

1. Copy of our pain medication policies will be given to you. Please read in its entirety as you may be discharged from our clinic if any of our policies are disregarded or not complied with.
2. At Advanced Spine Pain Solutions we strive to provide the upmost care of our patients. If you do not have any recent MRI's or other diagnostic exams you will be required to have these done so that an appropriate plan of care can be established.
3. It is probable your pain medications may not be continued as prescribed by your previous physician. You will be placed on new medication regimen which may or may not include your current medications. Previous pain medications may be titrated down until a dose recommended by your new physician is reached.
4. COMM or SOAP Questionnaire mandatory for patients on opioid pain medications.
5. If you need to discuss change in medication, increase in medication, or want to add medication, you will need to come in for follow up. We will not be able to discuss change in medication management over a telephone call.
*If you agree with the following conditions please sign below and circle " I ACCEPT" and we accept you as our new patient.
**If you disagree please sign below and circle " I DO NOT ACCEPT" . Please understand if you do not agree we cannot accept you as a new patient.

[ ] I ACCEPT [ ] I DO NOT ACCEPT

X ____

Reglas para la Clínica de Especialistas de Dolor

1. Copia de nuestras reglas para el uso de medicamento de dolor se le dará a usted para que revise. Por favor lea en su totalidad ya que no lo podremos seguir atendiendo en nuestra clínica si cualquiera de nuestras reglas son ignoradas o no cumplidas.
2. En nuestra practica medica nos esforzamos para proporcionar el máximo cuidado a nuestros pacientes. Si no tiene ninguna resonancia magnética o otros exámenes diagnósticos recientes, se le recomendará obtener estos exámenes para que pueda establecerse un plan adecuado de tratamiento.
3. Medicamentos para el dolor probablemente no serán prescritas igual que por su médico anterior. Un nuevo régimen de medicamento se actualizara, que pueda o no incluir los medicamentos actuales. Medicamentos para su dolor serán disminuidos hasta que se alcance una dosis recomendada por su médico nuevo.
4. Cuestionario de COMM o SOAP es obligatorio para los pacientes que toman medicamentos opioides.
5. Si usted necesita algún cambio en su medicamento, incremento en su medicamento, o quisiera agregar algún medicamento, tendrá que poner cita con el médico para discutir en persona. No podremos discutir estos cambios por teléfono.

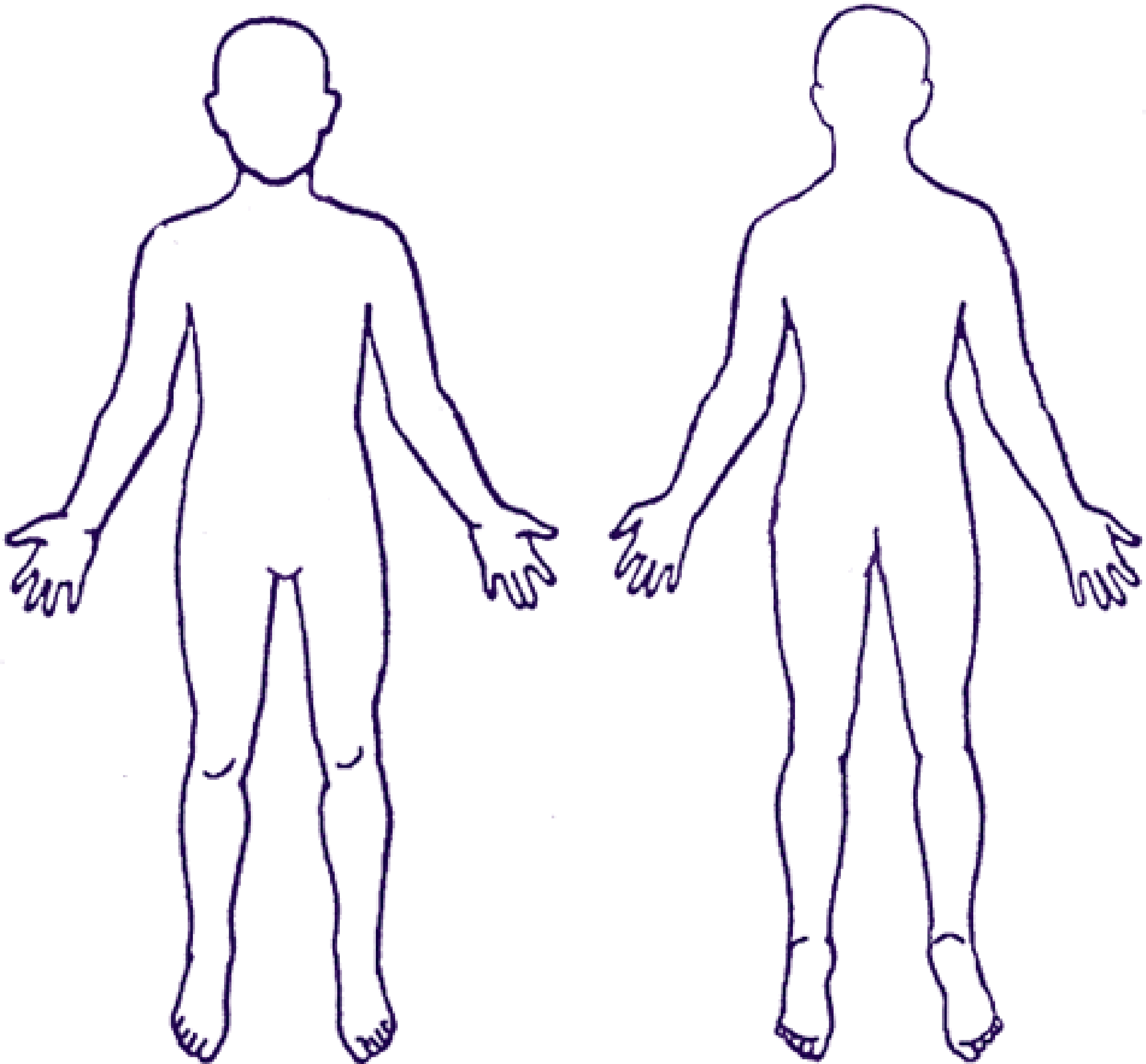
*Si está de acuerdo con las siguientes condiciones por favor firme a continuación, circule "SI ACEPTO" y lo aceptamos como nuestro paciente nuevo.
**Si no estás de acuerdo por favor firme a continuación y circule "NO ACEPTO". Por favor entienda que si no acepta estas condiciones, no lo podremos aceptar como un paciente nuevo.

[ ] SI ACEPTO [ ] NO ACEPTO

X ____

MARK WITH AN *X* WHERE YOU ARE HAVING PAIN

INDIQUE CON UNA *X* DONDE SIENTE DOLOR



INITIAL PAIN ASSESSMENT TOOL

Patient: ____ Date: _______________

Where is your pain: ____________________________________ DOB: _______________

Referring Physician: ____________________ Primary Care Physician: ______________________

1. Location: Please mark the location of your pain

RIGHT LEFT LEFT RIGHT

2. Pain History

When did the pain begin? Month __________ Year __________

How did it start ☐ Suddenly ☐ Gradually

☐ accident/fall at home ☐ accident at work ☐ at work but not an accident

☐ secondary to surgery ☐ no apparent cause

INITIAL PAIN ASSESSMENT TOOL

3. Intensity: On a scale of 0-10 rate your pain, where 0 means no pain and 10 means the worst possible/imaginable. Check the appropriate box:

1	2	3	4	5	6	7	8	9	10

4. Type/Describe: Please circle terms that describe the quality of your pain.
Sharp shooting numbing throbbing burning aching dull stabbing spasms

Do you have numbness to legs or arms? Yes ( ) No ( )

Duration: Constant Frequent Intermittent

5. What makes your pain worse? : **Please circle all that apply**
Walking turning crouching kneeling bending twisting moving lifting
lying down standing sitting varies various activities

6. What makes your pain better? **Please circle all that apply**
Walking injections medication massage physical therapy tens unit
Moving standing sitting lying down ice heating pad topical creams

7. Effects of Pain: **Please circle all that apply**
Decreased function
decreased quality of life
Decreased sleep
increased sleep
Decreased appetite
increased appetite
Decreased physical activity
increased physical activity

8. Accompanying symptoms: **Please circle all that apply**
Nausea vomiting irritability anger crying depression stiffness
Anxiety panic attack decreased sexual activity decreased concentration leg cramps

9. Have you contemplated suicide? ____

10. Prior treatment: **Please circle all that apply**
Physical Therapy
Chiropractor
Acupuncture
Psychology
TENS Unit
Herbal Therapy
Chronic Pain Program
Epidural steroid injections
NSAIDS
Pain Medication
Bed Rest
No previous treatment

11. **Pain Management History:** Please check any of the medications, treatments or procedures below which you may have taken or undergone on the past for management of your pain.

Procedures:	Helpful? Yes	No	Side Effects
☐ Lumbar epidural steroid injection	☐	☐	______________________
☐ Cervical epidural steroid injection	☐	☐	______________________
☐ Facet injection (medial branch block)	☐	☐	______________________
☐ Trigger point injection	☐	☐	______________________
☐ Rhizotomy (Radiofrequency ablation)	☐	☐	______________________
☐ TENS Unit	☐	☐	______________________
☐ Spinal cord stimulator (trial/permanent)	☐	☐	______________________
☐ Infusion Pump	☐	☐	______________________
Medications:			
☐ Amitriptyline (Elavil)	☐	☐	______________________
☐ Baclofen	☐	☐	______________________
☐ Butrans Patch (Buprenorphine)	☐	☐	______________________
☐ Celebrex (celecoxib)	☐	☐	______________________
☐ Conzip (Tramadol/Ultram/Ultracet)	☐	☐	______________________
☐ cyclobenzaprine (flexeril/amrix)	☐	☐	______________________
☐ cymbalta (duloxetine)	☐	☐	______________________
☐ Exalgo (hydromorphoneER)	☐	☐	______________________
☐ Fentanyl (duragesic patch)	☐	☐	______________________
☐ Flector (diclofenac patch)	☐	☐	______________________
☐ Gabapentin (neurontin/gralise)	☐	☐	______________________
☐ Hydrocodone (Vicodin, Lortab, Norco)	☐	☐	______________________
☐ Hydromorphone (dilaudid)	☐	☐	______________________
☐ Lidoderm patch	☐	☐	______________________
☐ Lyrica (pregabalin)	☐	☐	______________________
☐ Meloxicam	☐	☐	______________________
☐ Methadone	☐	☐	______________________
☐ Morphine (MScontin/MSIR/Kadian)	☐	☐	______________________
☐ Nucynta (ER/IR)	☐	☐	______________________
☐ Opana (ER/IR)	☐	☐	______________________
☐ Oxycontn (OxyIR)	☐	☐	______________________
☐ Percocet (Primlev)	☐	☐	______________________
☐ Robaxin (methocarbamol)	☐	☐	______________________

☐ Soma (carisoprodol)	☐	☐	______________________
☐ Tizanidine (zanaflex)	☐	☐	______________________
☐ Topical creams/drops (voltaren/pennsaid)	☐	☐	______________________
☐ Tylenol #3 (codeine)	☐	☐	______________________

12. Medical History **Please circle all that apply**

Asthma	Diabetes	High Blood Pressure		Heart Attack	Anxiety
Angina	COPD	Arthritis	Cancer	Panic Attack	Depression
Thyroid (hyper/hypo)		Pacemaker	Stent(s)	Seizures/Epilepsy	DVT

Have you or do you see a psychiatrist? ____

Please list all other medical problems ____
____
____
____

13. Surgical History (Please list all surgeries below)

Type Year

____
____
____
____
____
____
____
____

14. Family History (Please list any diseases that run in your family)

____
____
____
____

15. Social History **Please circle No or Yes**

Do (or did) you smoke? **No/Yes** When did you quit? _______________________

Do (or did) you drink alcohol? **No/Yes** How much and how often?
____________________________When did you quit? _______________________

Have you ever used drugs? **No/Yes**
Please specify ____
When did you quit? ____

Occupation: ___________________________ Previous occupation (if retired):_________________
Are you disabled? No Yes

Are you able to do any of the following activities: **Please circle all that apply**
Housework Yardwork Walk Drive

16. Do you have any **drug/food allergies?** Yes No
If yes, please list them here ____
____

17. Please list ALL medications you are currently taking

Name of Medication	Dose	Frequency (how often/what time of day)	Reason

18. Review of Symptoms: If you have recently been bothered with these problems (i.e. in the past month) **please circle all that apply**

Constitutional
Fatigue
Fever

Eyes
Eyesight worsening

HEENT
Nasal congestion
Dental problems
Sore throat
Headaches

Cardiovascular
Chest pain
Irregular heartbeat
Dizzy spells
Loss of balance

Neurologic
Radicular pain
Numbness
Loss of balance

Musculoskeletal
Back pain
Neck pain

Gastrointestinal
Nausea
Vomiting
Diarrhea
abdominal pain
Constipation
Heartburn

Genitourinary
involuntary escape of urine (incontinence)
Difficulty urinating
Burning on urination

Respiratory
Cough

Integument
Rash
New skin lesions

Endocrine
Weight gain
Weight loss

Muscle pain
Muscle cramps
Lower leg pain

Decreased libido

Heme
Easy bruising

Psychiatric
Depression
Difficulty sleeping
Anxiety

Allergic
Sinus allergy symptoms

Comments or special problems: ____
____
____
____
____

19. Have you seen a prior pain management doctor before? If so please list the name and the reason you are no longer seeing them.

____
____
____
____

20. Have you had any new MRI's, CT's, X-rays related to your condition?
____
____