Pain Management Specialists Of Atlanta

OFFICE LOCATIONS:

STOCKBRIDGE:

165 North Park Trail
Stockbridge, GA 30281

GRIFFIN:

161-A South 8th Street
Griffin, GA 30224

PEACHTREE CITY:

440 Prime Point
Peachtree City, GA 30296

LITHIA SPRINGS:

939 Bob Arnold Blvd., Ste. G
Lithia Springs, GA 30122

JOHNS CREEK:

10680 Medlock Bridge Rd., Ste. 102
Johns Creek, GA 30097

APPOINTMENT REQUIREMENTS:

1) Please complete your new patient packet prior to your appointment. If all of the paperwork is not completed your appointment may be rescheduled. (If this packet of information is not completed in full, you must arrive **one** (1) **hour** prior to your appointment time.)

2) ***Please arrive 30 minutes prior to your scheduled arrival time listed below.*** **This ensures that all patients are seen in a timely manner.**

3) Bring copy of all requested medical records, medication list and insurance cards.

4) **CO-PAYMENTS ARE DUE AT THE TIME OF YOUR OFFICE VISIT.** We except: CASH, DEBIT AND CREDIT CARDS ONLY.

Please remember your first visit may be for evaluation only! Please notify us at least 48 hours in advance if you are unable to keep this appointment. Charges may be made for broken appointments.

DIRECTIONS

TO OUR STOCKBRIDGE OFFICE, FROM I-75 (Interstate 75):

TAKE I-75 TO EXIT # 224, EAGLES' LANDING PARKWAY. GO EAST AND TURN LEFT ONTO ROCK QUARRY RD. TURN LEFT AT THE FIRST LIGHT ONTO NORTH PARK TRAIL. PAIN MANAGEMENT SPECIALISTS OF ATLANTA WILL BE ON YOUR RIGHT LOCATED AT 165 NORTH PARK TRAIL.

TO OUR GRIFFIN OFFICE, FROM I-75 (Interstate 75):

TAKE I-75 TO EXIT # 216, HWY. 155/McDONOUGH. TURN, OFF THE EXIT, ONTO HWY. 155 SOUTH. GO 8.7 MILES, TO THE 4-WAY STOP SIGN (GAS STATION ON RIGHT), AND TURN RIGHT (STAYING ON HWY.155 SOUTH/JACKSON ROAD) GO 5.7 MILES, (STAY LEFT AT THE FORK), TO ANOTHER STOP SIGN AND TURN LEFT, (STAYING ON HWY.155/ N. HILL STREET. (YOU WILL THEN GO OVER THE RAILROAD TRACKS.) GO 0.2 MILES TO THE 3RD LIGHT AND TURN RIGHT ONTO TAYLOR STREET. (IMMEDIATELY GET IN THE LEFT TURNING LANE), AND AT THE 1ST LIGHT (BY BURGER KING) TURN LEFT ONTO S. 8TH STREET. THEN GO 0.5 MILE. OUR BUILDING (# 614-620) IS ON THE LEFT. (ACROSS FROM SPALDING REGIONAL HOSPITAL). ENTER THE 2ND DRIVEWAY. OUR OFFICE IS THE LAST DOOR ON LEFT, (# 616-B SOUTH 8th STREET.)

TO OUR PEACHTREE CITY OFFICE: FROM NEAR HARTSFIELD-JACKSON INTERNATIONAL AIRPORT:

TAKE I-85 SOUTH TOWARD COLUMBUS/MONTGOMERY. TAKE EXIT #61, GA-74 SOUTH. TURN LEFT ONTO SENOIA RD./GA-74 SOUTH. CONTINUE FOLLOWING GA-74 SOUTH FOR APPROX. 7.5 MILES. TURN LEFT ONTO NORTH PEACHTREE PARKWAY. TURN LEFT ONTO STEPHENS ENTRY. TURN LEFT ONTO PRIME POINT. PAIN MANAGEMENT SPECIALISTS OFATLANTA WILL BE ON YOUR RIGHT.

TO OUR LITHIA SPRINGS OFFICE FROM I-75 (Interstate 75):

FROM THE DOWNTOWN CONNECTOR I-75/85 HEAD WEST ON I-20 FOR 12.8 MILES. TAKE EXIT 44 FOR GA-6/THORNTON RD AUSTELL, GA. TURN LEFT (SOUTH) ONTO THORNTON RD, GO 0.5 MILE. THEN TURN RIGHT (WEST) ONTO BLAIRS BRIDGE RD, GO 0.2 MILE. TURN LEFT (SOUTH) ONTO BOB ARNOLD BLVD. AFTER 0.1 MILE OUR OFFICE WILL BE ON THE RIGHT, SUITE G, LAST DOOR FAR END OF BUILDING.

TO OUR JOHN'S CREEK OFFICE FROM I-85 (Interstate 85):

FROM I-285 TAKE EXIT 31B TO MERGE ONTO GA-141N. USE THE LEFT 2 LANES TO TAKE THE GA-141N EXIT TOWARD CUMMING/DAHLONEGA/GA400. USE THE RIGHT 2 LANES TO MERGE ONTO GA-141N. CONTINUE TO PARSONS ROAD. TURN LEFT ONTO PARSONS ROAD. TAKE FIRST RIGHT INTO PARSONS MEADOW. AT THE STOP SIGN TURN LEFT. CONTINUE TO SECOND BUILDING ON THE LEFT. 10680 MEDLOCK BRIDGE ROAD #102.

PATIENT REGISTRATION

PATIENT NAME _____ D.O.B. _____ SS # _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ CELL PHONE _____
E-MAIL ADDRESS _____
LANGUAGE_____ RACE _____ ETHNICITY _____MALE ____ FEMALE _____
MARITAL STATUS: MARRIED ___ SINGLE ___ DIVORCED ___ SEPARATED___WIDOWED ___
EMPLOYER _____ PHONE _____
SPOUSE NAME _____ S.S # _____ D.O.B. _____
PERSON TO NOTIFY IN CASE OF EMERGENCY_____
PHONE _____ RELATIONSHIP _____
REFERRING PHYSICAN _____ PHONE # _____
PRIMARY CARE PHYSICAN _____ PHONE # _____
PHARMACY NAME _____ PHARMACY NUMBER _____
VISIT TYPE: ____*WORK COMP ___ AUTO____ DR REFERRAL ____ ATTY ____SELF REFERRAL

PRIMARY INSURANCE:

INSURANCE NAME _____
ADDRESS _____
CITY_____ STATE _____ ZIP _____PHONE _____
POLICY_____GROUP _____
POLICY HOLDER NAME _____ DOB _____

SECONDARY INSURANCE:

INSURANCE NAME _____
ADDRESS _____
CITY_____ STATE _____ ZIP _____PHONE _____
POLICY_____GROUP _____
POLICY HOLDER NAME _____ DOB _____

***IF WORK RELATED INJURY, PLEASE FILL OUT THE FOLLOWING INFORMATION:**

DATE OF INJURY _____ CLAIM # _____
ADJUSTER _____ PHONE _____
WORK COMP CARRIER NAME _____
ADDRESS_____ CITY _____ STATE _____ ZIP _____

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide this information we will be unable to file your insurance and payment in full will be required. Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity will also be your responsibility. Your office visit copay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply. For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request. I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature: _____Date:_____

***********INSURANCE CARD AND DRIVERS LICENSE MUST BE PRESENT AT TIME OF SERVICE ***************

Financial Responsibility

Copayment: All office visits generally require a copayment from your insurance company and this payment is expected on the date services are rendered. Exceptions may include postoperative visits for a determined period of time for some surgical procedures. Some insurance plans require copayments for post-operative visits.

Deductible: A deductible is a portion of the bill that is the responsibility of the patient to pay before an insurance company will cover the service. It is the patient responsibility to know where they are with their benefits. Generally, a copayment is required for the visit, in addition, some services and all procedures performed in the office require the patient to meet their deductible before the insurance pays benefits. If you have not met your deductible, you will be responsible for full or partial payment, depending on your insurance contract. Please verify this information. Procedures performed in the office are considered the same as surgery to the insurance company and are billed as surgery. Please verify this information with your insurance company prior to scheduling any procedures so you will know your possible estimated cost, if any.

Diagnostic Procedure Consent: Your visits may include diagnostic procedures, which will be coded to your insurance carrier as **SURGICAL PROCEDURES**. Depending on the specifics of your insurance policy, your insurance carrier will pay all, part, or none of the cost of a procedure. It is the responsibility of you, the patient, to be aware of the limits of coverage prior to procedures being performed. Any charges not covered by the insurance carrier will be your responsibility.

No Show: Patients are given a scheduled time for appointments in this office. We do not accept walk-in appointments. As such, patients who fail to show for their scheduled appointment, procedure, or surgery or did not notify the office within 24 hours prior to the appointment shall be subject to a No Show penalty of $25.00 for a follow-up, $75.00 for a nerve conduction study (NCV/EMG), $150.00 for an office/surgery procedure. Please be advised that this No Show payment is **NOT** covered by your insurance carrier or other payer and payment of missed visit must be paid prior to next scheduled appointment. A total of 3 successive ***no shows*** with ***any*** provider will prompt a re-evaluation of your commitment to this program and could possibly result in dismissal from the practice.

Guarantee of Payment for Services & Assignment of Benefits: It is the policy of this office that I must pay for services when rendered. If this applies to me, this practice will file my claim and I will be expected to pay only the portion that is not covered by my insurance company. In the event that my insurance carrier fails to make prompt payment, I hereby give my personal guarantee of payment for all charges incurred. This includes all charges for office visits, procedures performed, copayments, and deductibles. I further hereby authorize insurance benefits to be paid directly to my physician and I am financially responsible for non-covered services. I also authorize the physician to release my medical information in the processing of my claim(s).
*****If this account is placed in collections, I agree to pay full balance, which will include an additional 30% collections fee attached to that balance, plus any and all court costs and attorney's fees****************

Insurance Coverage: I understand that it is my responsibility to keep current insurance information on file with this office. I further understand that every attempt to verify accurate insurance information will be performed by this office. Should it be determined that I was not eligible for coverage at the time of my visit to this office, whether for an office visit or a procedure, and/or the medical services performed are deemed to be not covered, I understand that I will be responsible for payment of all services provided.

Referral Waiver: I understand that if my insurance carrier requires a referral to be seen by this office that it is my responsibility to obtain this referral. I further understand that every attempt will be made by this office to acquire a referral before my scheduled appointment and should it not be obtained after exhausting all means to obtain this referral, I agree to pay in full for all services rendered on that date of service at the selfpay rate.

_____ _____

Patient Signature Date

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE AND A BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Pain Management Specialists of Atlanta, PC**, as well as all employees, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, and/or medications that ***have been*** OR ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals or any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA or PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20_____.

_____
Patient Signature

_____
Guardian Signature (If Applicable)

_____
Patient Printed Name

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a Privacy Rule to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive always to take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum information necessary only to those we feel are in need of your healthcare information and information about treatment, payment, or healthcare operation, in order to provide your healthcare needs.

There are times when you may wish other family members and friends to inquire about your appointments or have access to your medical information. We will not release any information to anyone that is not listed below. If you wish us to leave messages on answering machines/voicemail other than to say “please call us back,” please indicate this also.
Answering Machine/Voicemail:

_____ Do not leave message other than to return our call
_____ You may leave messages with information

List any family member or others you wish to have access to your records, for example, who may call us regarding your condition or who may call for you. ***We will not release information to spouses or children unless you list them below***. We will require signed releases from you for anyone wanting access to your records other than the insurance companies you have listed with us, your healthcare provider as necessary for your care, or persons listed below.

Name	How related to you
_____	_____
_____	_____
_____	_____

I acknowledge that I have received a copy of Pain Management Specialists of Atlanta's Notice of Privacy Practices. This notice describes how Pain Management Specialists of Atlanta may use and disclose my protected healthcare information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected healthcare information. I also understand that I may revoke this authorization at any time or receive a copy of this authorization.

PRINTED NAME _____

SIGNATURE _____ DATE _____

Patient's Consent to Photograph

I, the undersigned, do hereby authorize Pain Management Specialists of Atlanta, PC to utilize my photograph while under the care of the above institution. I understand that this is solely for identification purposes and will not be used for any other reason.

_____ _____

Patient Signature Date

MEDICATION AGREEMENT PLEASE READ!

As part of your treatment, our medical staff may prescribe medications for you. As you know, medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows the prescribed guidelines. No prescriptions will be written unless you accept the following agreement.

1. I agree to follow the dosing schedule prescribed by my doctor.
2. I will never share, sell or exchange my medications with anyone for any reason.
3. I understand that I am solely responsible for the safekeeping of my medications. I will treat my medications as I would any valuable possession. I know that Pain Management Specialists of Atlanta does not replace LOST OR STOLEN prescriptions or controlled medications.
4. I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive functions.
5. I agree to notify Pain Management Specialists of Atlanta if I experience any adverse effects or dosage problems with my prescribed medications. I may be asked to bring any unused medication to Pain Management Specialists of Atlanta for Disposal.
6. I agree that if I receive a controlled substance prescription Pain Management Specialists of Atlanta, I am not allowed to accept controlled substance prescriptions (any pain medication(s)) from any other physician without my doctor's consent.
7. I agree to use only one pharmacy for my pain-related medications. In the event, that circumstances require the use of another pharmacy, I will notify Pain Management Specialists of Atlanta of this immediately and provide them with all pertinent contact information.
8. I understand that prescriptions involving narcotics require a scheduled appointment in the office. Narcotic refills will not be called into a pharmacy. Narcotic dosages will not be increased by phone.
9. I agree to keep all scheduled appointments. I understand that no medications will be given for canceled or no-show appointments. I understand that if I am more than 15 minutes late to my scheduled appointment time, I will have to reschedule for another time. There is a $25.00 "No Show" fee.
10. I know that I cannot be seen at the office without a scheduled appointment for ANY reason.
11. Pain Management Specialists of Atlanta phone triage hours are 8:30 am to 4:00 pm, Monday through Friday for Non-Emergency medication questions. I know that I cannot call this line more than two times in any day.
12. I know that I can be asked to bring any or all of my prescribed medications to my office appointment or at a random time for a prescription compliance check (Pill Count).
13. I understand that Pain Management Specialists of Atlanta will write and dispense medication prescriptions on a 30 day basis. In order to receive another narcotic medication prescription I must schedule another office visit within 30 days of the date on my current prescription so my doctor can properly evaluate my progress.
14. I understand that abusive behavior or harassment toward any Pain Management Specialists of Atlanta Staff cannot be tolerated. The doctor will determine what actions can be considered harassment on a case-by-case basis and, if warranted, I can be dismissed from the practice.
15. I understand that dealing with a forged, falsified or altered prescription will result in my immediate dismissal from Pain Management Specialists of Atlanta and may be reported to the local police.
16. I understand that Pain Management Specialists of Atlanta reserves the right to PERFORM A URINE DRUG SCREEN AT ANY TIME WHILE I AM BEING TREATED WITH PRESCRIBED CONTROLLED SUBSTANCES. If the results of the urine drug screen do not reflect medicine prescribed by my doctor or test positive for illegal drugs, I understand that I can be dismissed immediately from the practice. I also agree to pay any cost not covered by my insurance.
17. I understand that if I have a problem or need to change my medication(s), I will need to make an appointment and bring in **ALL THE MEDICATION(S)** PRESCRIBED BY Pain Management Specialists of Atlanta. If I fail to bring them, Pain Management Specialists of Atlanta will not issue a new prescription.

By signing this agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood and accepted these terms. Non - compliance with this agreement will be terms for dismissal from the practice.

PHARMACY NAME _____ PHARMACY NUMBER _____

PATIENT NAME (PRINT) _____

PATIENT SIGNATURE_____ DATE _____

URINE DRUG SCREEN POLICY

Prescription pain medications are potentially addictive. The number of deaths in the US from prescription drug overdoses has doubled in the past 10 years to more than 30,000 per year. Prescription medications are the number one abused drugs in our country.

At Pain Management Specialists of Atlanta we're committed to helping our patients have the best quality of life possible and that includes responsible prescribing of pain medications. Part of this responsibility includes random drug screens at a minimum of two times per year.

Please be prepared to offer a urine sample at every visit. If you are unable to provide a urine sample when asked we will not be able to prescribe pain medication(s).

Please understand that our patient's health and safety is our number one priority and we are committed to providing excellent patient healthcare at Pain Management Specialists of Atlanta.

Sincerely,

Pain Management Specialists of Atlanta Physicians

By signing below I understand that urine drug screens are a part of the medication agreement I have signed and I agree to do my part as a patient to ensure compliance with all my pain medications.

Patient Name (PRINT) _____

Patient Signature _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date of Birth: _____ Social Security Number: _____

I, _____, hereby authorize _____ to

Release To Obtain From Name: _____
Address: _____
_____,
any medical information from my health record for the purpose of continuity of care. Information to be disclosed includes: Office notes, test results, medication history, surgery reports and lab results, for the purpose of treatment.

AUTHORIZATION INCLUDES AUTHORITY TO RELEASE MENTAL HEALTH / REHABILITATION / ALCOHOL OR DRUG RECORDS / HIV TEST RESULTS AND/OR AIDS DIAGNOSIS AND TREATMENT. (IF UNDER 18 YEARS OF AGE, PARENT OR GUARDIAN MUST SIGN.) INITIAL EACH BOX THAT APPLIES IF SUCH INFORMATION IS NOT TO BE RELEASED.

-My diagnosis and/or treatment for alcoholism and/or drug abuse or dependency may not be released to the recipient noted above.

-My diagnosis and/or treatment concerning mental health/rehabilitation may not be released to the recipient noted above

-HIV Antibody test results and/or AIDS diagnosis and treatment may not be released to the above noted recipient.

Purpose of disclosure: _____

I understand that this consent is revocable by me, in writing, at any time except to the extent that action has been taken in reliance on it. I also understand that this consent will expire either ninety (90) days after the date of the signature or automatically when the records requested on this form have been mailed/faxed to the requestor.

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Any further disclosure is strictly prohibited.

Date: _____ Signed: _____ ____(Patient)

Medical Record #: _____

If Patient is unable to give consent because of physical condition or age, complete the following: Patient is a minor, ____ years of age or is unable to give consent because (describe condition):

Date:_____ Signed: _____(Parent/Guardian)

NEW PATIENT PAIN HISTORY

1. Today's date: _____
2. Date pain began: _____
3. Where is your pain: _____
4. What caused your pain? ( ) Work Injury ( ) Auto Accident ( ) Home Injury ( ) Unknown
5. Description of Injury: _____

   _____

   _____

   _____
6. Do you have a lawsuit on going or pending or are you hiring an attorney regarding this matter? ( ) Yes ( ) No
7. Describe your pain (check all that apply):

( ) **Aching**	( ) **Burning**	( ) **Colicky**	( ) **Constricting**	( ) **Cramping**
( ) **Deep-pressure**	( ) **Dull**	( ) **Gnawing**	( ) **Gripping**	( ) **Numbness**
( ) **Pricking**	( ) **Sharp**	( ) **Shooting**	( ) **Spasmodic**	( ) **Squeezing**
( ) **Stabbing**	( ) **Throbbing**	( ) **Tightness**	( ) **Tingling**	( ) **Toothache-like**

   If above choices are inapplicable, please describe: _____

   _____

   _____
8. How frequent is your pain? ( ) Constant ( ) Intermittent ( ) Occasional ( ) Other: _____
9. Do you experience any of the following associated symptoms? (Check all that apply):

( ) **Blurry vision**	( ) **Memory loss**	( ) **Bruising**	( ) **Cramps**	( ) **Difficulty walking**
( ) **Dizziness**	( ) **Fever**	( ) **Joint stiffness**	( ) **Joint pain**	( ) **Joint swelling**
( ) **Morning stiffness**	( ) **Nausea**	( ) **Shortness of breath**	( ) **Vomiting**	( ) **Headache**
( ) **Loss of function of affected area** Which area: _____ _____	( ) **Loss of sensation of affected area** Which area: _____ _____	( ) **Bowel/bladder changes** If yes, describe: _____ _____	( ) **Muscle atrophy** Which area: _____ _____	( ) **Muscle spasms** Which area: _____ _____
( ) **Numbness** Which area: _____ _____	( ) **Tingling** Which area: _____ _____	( ) **Swelling** Which area: _____ _____	( ) **Weakness** Which area: _____ _____	( ) **Other** Please describe: _____ _____

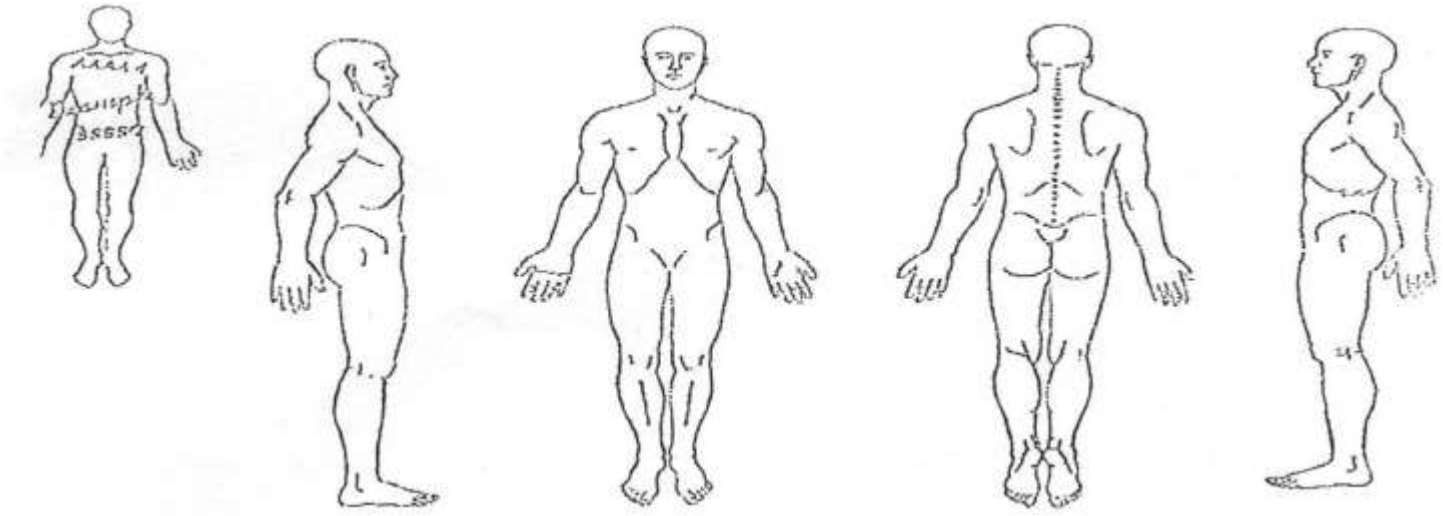
10. What makes your pain better? (Check all that apply):

( ) **Activity**	( ) **Application of cold**	( ) **Application of heat**	( ) **Application of topical pain killer**	( ) **Elevation of affected part(s)**
( ) **Exercise**	( ) **Leaning forward**	( ) **Local pressure**	( ) **Lying on back**	( ) **Massaging**
( ) **Medication**	( ) **Movement**	( ) **Rest**	( ) **Sitting**	( ) **Standing**
( ) **Stretching**	( ) **Warm baths**	( ) **Wearing of brace**	( ) **Nothing**	( ) **Other:** _____

11. What makes your pain worse? (Check all that apply):

( ) **Bearing weight**	( ) **Bending over**	( ) **Bending to the sides**	( ) **Brace**	( ) **Breathing**
( ) **Carrying**	( ) **Climbing stairs**	( ) **Cold**	( ) **Coughing**	( ) **Driving**
( ) **Exercise**	( ) **Grasping**	( ) **Gripping**	( ) **Head tilting**	( ) **Heat**
( ) **Lifting**	( ) **Lying down**	( ) **Pulling**	( ) **Medication**	( ) **Pushing**
( ) **Reaching**	( ) **Rest**	( ) **Rising**	( ) **Shaking**	( ) **Sitting**
( ) **Squatting**	( ) **Standing**	( ) **Straining**	( ) **Turning over**	( ) **Twisting**
( ) **Typing**	( ) **Walking**	( ) **Prolonged sitting**	( ) **Nothing**	( ) **Other:** _____
( ) **Lying of affected side**	( ) **Movement of injured part**	( ) **Repetitive pinching/ grasping**	( ) **Doing excessive work**	( ) **Any activity or movement**

12. Please mark the area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols.



Description:	Numbness	Pins/Needles	Burning	Aching	Stabbing
Symbol:	NNNN	PPPP	BBBB	AAAA	SSSS

ALLERGY QUESTIONNAIRE

If you are allergic to any substance listed below, please mark "X" in the corresponding box. Then, on each corresponding line, list the adverse reaction(s) you experience to each of the substances selected.

☐	Latex	_____
☐	Betadine/Iodine	_____
☐	Penicillin	_____
☐	Metal (any type)	_____
☐	IVP Dye	_____
☐	Fentanyl	_____
☐	Kenalog	_____
☐	Lidocaine	_____
☐	Marcaine	_____
☐	Sodium Chloride	_____
☐	Sulfur	_____
☐	Versed	_____
☐	Sarapin	_____
☐	Wydase	_____
☐	Steroids	_____
☐	Anti-inflammatory	_____
☐	Codeine	_____
☐	Alcohol	_____
☐	Omnipaque	_____
☐	Aspirin	_____
☐	Shell Fish	_____
☐	Peanuts/Peanut oil/Peanut butter	_____
☐	Strawberries	_____
☐	Anesthesia	_____
☐	Pain Medications	_____
☐	NO KNOWN DRUG ALLERGIES	

If you have allergies to any substance not listed above, please note below:

_____

Patient's Signature_____ Date _____

Name: _____ Today's Date: _____

SOCIAL HISTORY

Current employment status:

( ) **Full-time**
Job title: _____
Place of employment: _____

( ) **Part-time**
Job title: _____
Place of employment: _____

( ) **Retired**
Duration: _____
Prior place of employment: _____

( ) **Disabled**
Disability due to: _____
Prior place of employment: _____

( ) **Unemployed**
Duration: _____
Prior place of employment: _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Legally Separated ( ) Widowed

Do you live alone? ( ) Yes ( ) No

Tobacco products: ( ) **Current smoker.** Packs per day: _____ Start date: _____
( ) **Ex-smoker.** Quit date: _____
( ) **Never smoked.**

Alcohol use: ( ) **Current drinker.** # of drinks per week, month, or year: _____
Start date: _____
( ) **Former drinker.** Quit date: _____

Recreational drug use: ( ) **Current user.** Which drug(s): _____
Start date: _____

( ) **Former user:** Which drug(s): _____
Quit date: _____

FAMILY HISTORY

Please check any of the following symptoms/diseases your family has experienced and/or are currently experiencing:

( ) **Asthma**	( ) **Diabetes**	( ) **Heart Disease**	( ) **High cholesterol**	( ) **High blood pressure**
( ) **Stroke**	( ) **Thyroid disease**	( ) **Alcoholism**	( ) **Arthritis**	( ) **Bipolar disorder**
( ) **Drug abuse**	( ) **Schizophrenia**	( ) **Rheumatoid arthritis**	( ) **Seizures**	( ) **Eczema**
( )**Autoimmune disease**: _____	( ) **Cancer**: (list type) _____	( ) **Heart attack below the age of 55**	( ) **Bone disease**: (list type) _____	( ) **Other**: _____

PATIENT PAST MEDICAL HISTORY

( ) **Diabetes Mellitus**	( ) **Heart disease**	( ) **High blood pressure**	( ) **Gastritis**	( ) **Stroke**: (when) _____
( ) **Seizure**	( ) **Thyroid disease**	( ) **Abdominal hernia**	( ) **Hiatal hernia**	( ) **Asthma**
( ) **Glaucoma**	( ) **Arthritis**	( ) **Osteoporosis**	( ) **Anxiety**	( ) **Depression**
( ) **Ulcer**: (list type) _____	( ) **Cancer**: (list type) _____	( ) **Heart attack**: (when) _____	( ) **Bleeding disorder**: _____	( ) **Other**: _____

LAST TREATMENTS

( ) **Pain Management Procedures**: Helped pain? ( ) Yes ( ) No

Where on body: _____
What type of procedure(s): _____
How many procedures: _____
Performing doctor(s): _____
When: _____

( ) **Physical Therapy** Helped pain? ( ) Yes ( ) No

( ) **TENS Unit** Helped pain? ( ) Yes ( ) No

( ) **Current treating physicians:**

Name: _____ Type: _____ Phone: _____

Name: _____ Type: _____ Phone: _____

Name: _____ Type: _____ Phone: _____

SURGICAL HISTORY

Date: _____ Surgery: _____ Physician: _____

Date: _____ Surgery: _____ Physician: _____

Date: _____ Surgery: _____ Physician: _____

Date: _____ Surgery: _____ Physician: _____

Date: _____ Surgery: _____ Physician: _____

CURRENT MEDICATIONS

List all medications that you are currently taking. Please include all pain medications and as needed medications:

Medication: _____ Strength: _____ Frequency: _____ Prescribing physician: _____

Medication: _____ Strength: _____ Frequency: _____ Prescribing physician: _____

Medication: _____ Strength: _____ Frequency: _____ Prescribing physician: _____

Medication: _____ Strength: _____ Frequency: _____ Prescribing physician: _____

Medication: _____ Strength: _____ Frequency: _____ Prescribing physician: _____

Medication: _____ Strength: _____ Frequency: _____ Prescribing physician: _____

Medication: _____ Strength: _____ Frequency: _____ Prescribing physician: _____

( ) Additional information:

Patient's Signature_____ Date _____