NEW PATIENT HEALTH HISTORY AND PAIN QUESTIONNAIRE

Patient Name: _____**Age** _____

☐ Male ☐ Female ☐ Right handed ☐ Left handed ☐ Ambidextrous

History of Problem for which you are being seen:

Reason for visit: _____

By whom were you referred to our practice?_____

Expectations from treatment:_____

Type of injury: ☐ Job Accident ☐ Sports Injury ☐ Other: _____

Car accident: ☐ Driver ☐ Passenger Seat-belted: ☐ Yes ☐ No Airbag: ☐ Yes ☐ No

Date injury/symptoms started: _____

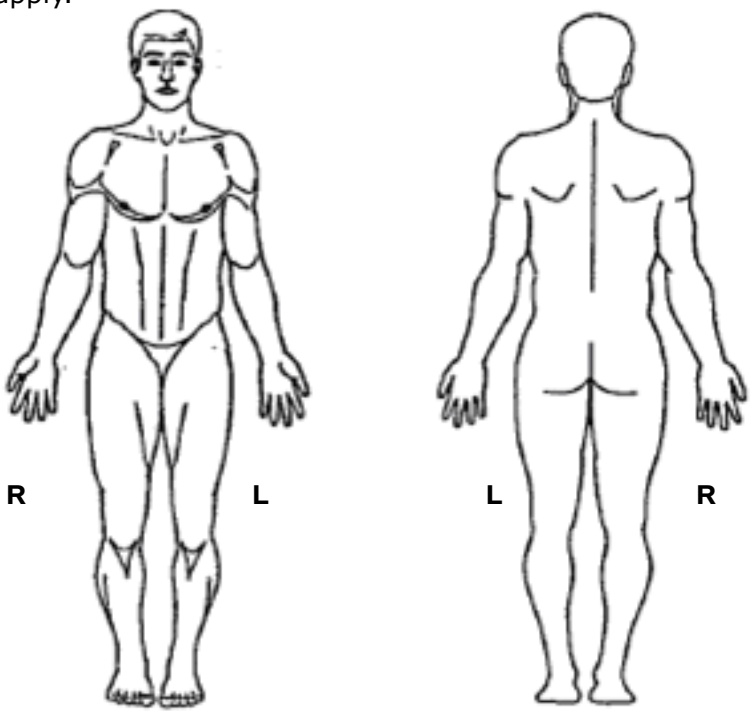
Do you have cancer? ☐ Yes ☐ No Cancer Type: _____

Stage of cancer: _____

How would you describe your mood in a word or two?_____

On the diagram below, shade the areas where you feel pain. Put an **"x"** where it hurts the most; check all terms that apply.

☐ Aching
☐ Burning
☐ Stabbing
☐ Shooting
☐ Constant
☐ Transient
☐ Sharp
☐ Dull
☐ Mild
☐ Moderate
☐ Severe
☐ Unbearable
☐ Numbness
☐ Tingling



Rate your pain by circling the one number that best describes your pain at its **worst:**

0 1 2 3 4 5 6 7 8 9 10

No Pain Pain worst imaginable

Rate your pain by circling the one number that best describes your pain at its **least:**

0 1 2 3 4 5 6 7 8 9 10

No Pain Pain worst imaginable

Rate your pain by circling the one number that best describes your pain on the **average**:

0 1 2 3 4 5 6 7 8 9 10

No Pain Pain worst imaginable

What makes pain **worse**: _____

What makes pain **better**: _____

Time of the day when pain is worse:_____

Do you have the following:

Weakness in your: ☐ arms ☐ right ☐ left ☐ legs ☐ right ☐ left

Numbness in your: ☐ arms ☐ right ☐ left ☐ legs ☐ right ☐ left

New or recurrent problems with bowel or bladder control? ☐ Yes ☐ no

Change in pain with cough/sneeze/bowel movements? ☐ Yes ☐ no

Medication History Indicate what you have used **for your *current* pain condition**:

Narcotics

Tried	Helped: Yes	No
☐ Hydromorphone(Dilaudid)	☐	☐
☐ Hydrocodone (Vicodin)	☐	☐
☐ Codeine	☐	☐
☐ Oxycodone (Percocet)	☐	☐
☐ Oxycontin	☐	☐
☐ Morphine, MS Contin	☐	☐
☐ Duragesic Patch	☐	☐
☐ Ultram	☐	☐

Other:_____

Anti-Inflammatory

Tried:	Helped: Yes	No
☐ Lodine	☐	☐
☐ Naprosyn (Aleve)	☐	☐
☐ Aspirin	☐	☐
☐ Voltaren	☐	☐
☐ Tylenol	☐	☐
☐ Daypro	☐	☐
☐ Ibuprofen(Advil, Motrin)	☐	☐

Other:_____

Nerve Medications

Tried:	Helped: Yes	No
☐ Neurontin	☐	☐
☐ Lyrica	☐	☐
☐ Amitriptyline	☐	☐
☐ Nortriptyline	☐	☐
☐ Cymbalta	☐	☐
☐ Topamax	☐	☐
☐ Savella	☐	☐

Other:_____

Muscle Relaxants

Tried:	Helped: Yes	No
☐ Carisoprodol (Soma)	☐	☐
☐ Cyclobenzaprine(Flexeril)	☐	☐
☐ Skelaxin (Metaxalone)	☐	☐
☐ Zanaflex (Tizanadine)	☐	☐

Other_____

Yes No

Have you ever taken Anticoagulants? ☐ ☐

if yes, what type?

☐ Warfarin/Coumadin

☐ Plavix

Other:_____

Reason:_____

Treatment History Indicate the treatment you have received **for your *current* pain condition**:

Tried:	Helped: Yes	No
☐ Physical Therapy	☐	☐
☐ Trigger Point Injections	☐	☐
☐ Facet Blocks	☐	☐
☐ Acupuncture	☐	☐
☐ Psychiatric/ psychological care	☐	☐
☐ Other:_____		

Tried:	Helped: Yes	No
☐ Epidural Steroid Injections	☐	☐
☐ Chiropractic Care	☐	☐
☐ Radio Frequency Ablation	☐	☐
☐ TENS Unit	☐	☐

Name of Previous Pain Physician(s): _____

Diagnostic Studies:

X-Ray	☐ Yes	☐ No	MRI Scan	☐ Yes	☐ No
CT Scans	☐ Yes	☐ No	Bone Scan	☐ Yes	☐ No
EMG	☐ Yes	☐ No	Other _____		

Past Medical History:

Cardiac

☐ High Blood Pressure	☐ Congestive Heart Failure	☐ Heart Attack	☐ Rheumatic Fever
☐ Angina	☐ Irregular Heartbeat	☐ Heart Murmur	☐ Vascular Disease
☐ Pacemaker	☐ Blood Thinners	☐ Valvular Disease	

Pulmonary

☐ Pneumonia	☐ Emphysema	☐ Asthma	☐ COPD
☐ Sleep Apnea	☐ Bronchial Disease	☐ Tobacco	

Renal

☐ Dialysis	☐ Renal Insufficiency	☐ Kidney Stone	☐ Prostate Problems

Neurological

☐ Stroke ☐ Transient Ischemic Attack ☐ Seizures ☐ Nerve Damage

Infectious

☐ Valley Fever ☐ Tuberculosis ☐ HIV/AIDS ☐ Polio

☐ MRSA ☐ Other _____

Hepatic

☐ Jaundice ☐ Cirrhosis ☐ Hepatitis ☐ Gall Bladder

Gastrointestinal

☐ Hiatal Hernia ☐ GERD ☐ Gastric Ulcers ☐ Colitis

Endocrine

☐ Thyroid Disease ☐ Parathyroid Disease ☐ Diabetes Mellitus

Psychological

☐ Depression ☐ Bipolar ☐ Addiction ☐ Schizophrenia

General

☐ Anemia/Bleeding ☐ Arthritis ☐ Obesity ☐ Alcoholism

Past Surgical History (be as specific as possible, including surgery type and year of surgery):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Serious Injury:

List serious injuries you have sustained: _____

Allergies to Medications: ☐ Yes ☐ No (if yes, indicate below drug and reaction)

Drug	Reaction
_____	_____
_____	_____
_____	_____

Current Medications (Include vitamins, antacids, birth control, etc., attach list if necessary):

	Name:	Dose:	How often:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Family History: _____

Social History:

Occupation: _____

Are you currently working? ☐ Yes ☐ No ☐ Part-time ☐ Full-time

Education: ☐ Elementary ☐ High school ☐ College ☐ Graduate school

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Single ☐ Significant Other

Children: Y/N If yes, how many? _____

Do you have any lawsuits pending? ☐ Yes ☐ No

Are you on disability? ☐ Yes ☐ No Worker's Comp? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No ☐ #of packs per day _____ How many years? _____

Do you use alcohol? ☐ Yes ☐ No ☐ #of drinks per day _____ How many years?_____

Do you use illicit substances? ☐ Yes (describe) _____ ☐ No

Review of Systems (*List only current or very recent symptoms*):

General:	☐ Weight Change ☐ Fever ☐ No Problems	☐ Fatigue ☐ Loss of Appetite	☐ Weakness ☐ Chills
Cardiac:	☐ Chest pain/Angina ☐ Peripheral Edema	☐ Shortness of Breath ☐ No problems	☐ Palpitations
Endocrine:	☐ Heat intolerance ☐ Cold intolerance	☐ Excessive sweating ☐ Excessive thirst	☐ Excessive urination ☐ No problems
Gastrointestinal:	☐ Diarrhea ☐ Change in appetite ☐ Loss of bowel control ☐ No Problems	☐ Reflux ☐ Abdominal pain ☐ Blood or Black Stool	☐ Constipation ☐ Nausea ☐ Vomiting
Genitourinary:	☐ Difficulty Urinating ☐ Loss of Bladder Control	☐ Painful Urination ☐ No Problems	☐ Blood in urine
HEENT:	☐ Sinus Problems ☐ Jaw Problems ☐ Mouth Problems	☐ Difficulty Swallowing ☐ Dry Mouth ☐ No Problems	☐ Headache ☐ Migraines
Hematology / Oncology:	☐ Chemotherapy History ☐ Radiation History	☐ Bleeding Disorder ☐ Anticoagulation Therapy	☐ No Problems
Musculoskeletal:	☐ Muscle Cramps ☐ Joint Redness ☐ Joint Heat	☐ Joint Stiffness ☐ Joint Swelling	☐ Muscle atrophy ☐ No Problems
Neurological:	☐ Blackouts ☐ Fainting ☐ Hallucinations ☐ Tremors	☐ Weakness ☐ Paralysis ☐ Dizziness ☐ Confusion	☐ Numbness ☐ Gait Difficulties ☐ No Problems
Opthalmology:	☐ Blurred Vision ☐ Double Vision	☐ Eye Pain ☐ Photophobia (light is painful)	☐ No Problems
Psychiatric:	☐ Depression ☐ Drug Abuse	☐ Suicidal Ideation ☐ Homicidal Ideation	☐ Anxiety ☐ No Problems
Respiratory:	☐ Cough ☐ Hemoptysis	☐ Shortness of Breath ☐ No Problems	☐ Wheezing
Skin:	☐ Dry Skin ☐ Changes in Skin Color ☐ Itching	☐ Changes in Hair or Nail ☐ Recurrent Rashes	☐ Eczema ☐ No Problems
Toxins:	☐ Asbestos ☐ Pesticides	☐ Industrial Chemicals ☐ Drug Use	☐ Lead ☐ No Problems

_____ _____/_____/_____

Patient Signature *Date*

Reviewed by: _____ _____/_____/_____

Provider Signature *Date*

PATIENT REGISTRATION FORM

Date_____

Patient's Name_____

Address_____

City _____State _____Zip Code_____ email _____

Home Phone (___) _____Mobile (___) _____Preferred Phone (___) _____Text Appointment Reminders: Y N

Social Security #_____ Date of Birth_____ Sex _____Marital Status_____

Referring Physician_____Phone_____

Primary Care Physician_____Phone_____

Patient's Employer _____

Employer Address_____

Responsible Party Information Self _____ Spouse _____ Parent _____ Other _____

Guarantor's Name_____

Address_____

City _____State _____Zip Code_____

Home Phone (___) _____ Mobile (___) _____ Preferred Phone (___) _____

Relationship to Patient _____Date of Birth _____Social Security #_____

Guarantor's Employer _____Work Phone (_____) _____

Employer Address_____

Emergency Contact Information

Name_____Relationship_____

Address_____

Home Phone (___) _____ Mobile (___) _____ Work Phone (___) _____

Insurance Information

Primary Carrier:

Name _____Group #_____

Address_____

Policy Holder's Name _____Relationship to Patient_____

Policy Holder's Date of Birth_____ Social Security #_____

Policy #_____

Secondary Carrier:

Name _____Group #_____

Address_____

Policy Holder's Name _____Relationship to Patient_____

Policy #_____ Policy Holder's Date of Birth_____

Workmen's Comp:

Carrier_____

Address_____

Date of Injury _____Claim #_____

Claim Representative _____Phone (_____) _____

Employer_____

OPIOID AGREEMENT FOR PAIN MANAGEMENT

(Please read carefully)

This opioid agreement between Physicians' Pain and Spine Specialists, PLLC and you the patient, _____, is drawn to clarify the way opioid is used to treat your severe chronic pain conditions. The consensus statement of the American Academy of Pain Medicine (AAPM) and American Pain Society (APS) in 1996 has supported the usage of opioids to treat patients suffering from severe chronic pain. There are potential limitations to this mode of therapy: sedation, constipation, nausea, vomiting, itching, swelling, of extremities and respiratory depression are some of the common side effects. Additional concerns include addiction, tolerance, and physical dependence.

ADDICTION: It is an abnormal behavior manifested by impaired control over drug use, compulsive use, continued use despite harm and craving. It is a condition where there is a psychological need without a physiological need or true pain generator. It is uncommon in the use of chronic opioid therapy.

TOLERANCE: It is a state of adaptation in which exposure to a drug induces changes that result in diminution of the drug's effects over time. Tolerance to an opioid after prolonged use is expected which means an increased dose is needed to achieve the same amount of relief. As the dose of the opioid cannot be increased indefinitely, multi-modality treatment such as physical therapy, psychological therapy, interventional techniques and a combination of pharmacotherapies (adding NSAIDs, TCA, Antiepileptic, etc.) will be use in this clinic to decrease the likelihood of developing opioid tolerance.

PHYSICAL DEPENDENCE: It occurs in many classes of medications including steroids and antihypertensive agents. Physical dependence is different from addiction. Physical dependence is a state of adaptation manifested by a drug class-specific abstinence syndrome following abrupt cessation, rapid dose reduction of administration of antagonist. Therefore, you must not abruptly stop taking opioid medication, as withdrawal symptoms will occur. Opioid withdrawal symptoms include anxiety, irritability, chills alternating with flashes, salivation, lacrimation rhinorrhea, diaphoresis, piloerection, nausea, vomiting, abdominal cramps, and diarrhea.

MALES ONLY: I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, and sexual desire, physical and sexual performances. I understand that my doctor(s) may check my blood testosterone level when necessary.

FEMALES ONLY: If I plan to become pregnant or believe that I am pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that should I carry a baby to delivery while taking these medications; the baby will be physical dependent upon opioids. I am aware that the use of opioids is not generally associated with the risk of birth defects. However, birth defects occur whether or not the mother is on medicine. There is always the possibility that my child will have a birth defect while I am taking an opioid.

You must follow the pain medicine directives as set forth in this agreement. If you decide not to follow these directives then we may discharge you from this office.

1) Must receive opioid medication from ONE pharmacy. The pharmacy name, phone number and address must be given to us so that we can keep them on file.

2) Must not receive opioid medication from other doctors without prior approval from our office.

3) Must maintain dosing schedule as was prescribed. If escalation of medicine is required you must call our clinic and discuss this with the doctor(s) before any changes are made to the dosing schedule.

4) Psychological therapy most likely will be recommended. Additional therapy, such as physical therapy, massage therapy may be recommended.

5) Do not operate heavy machinery during the titration phase of opioids or during increase of opioids for 5-7 days. MOST OPIOID MEDICATIONS CANNOT BE CALLED IN. You will need to call our clinic 3-5 days before your medication runs out.

6) Urine test, as well as blood test may be required on an unscheduled basis to verify your compliance with the opioid program, and to exclude any use of an acknowledged illicit medication.
Testing of the opioid medication on your mental capacity may be required when deemed necessary by our doctor(s.

7) You MUST BE SEEN IN CLINIC AT LEAST ONCE PER MONTH, IF YOU PLAN TO CONTINUE RECEIVING MEDICATION FROM OUR OFFICE. Our doctor(s) will decide how frequently you are to be seen in our clinic. This initially may be at two-week intervals expanding to 1 month intervals, when we stabilize the dose. This dose may vary somewhat from patient to patient.

8) You must be accountable for the proper use and be aware of the number of pain pills that you have at any time. You may be required to bring your medicine in for an evaluation and pill count. You must present to our clinic with your opioid pills within 24 hours from the time you are contacted for a random pill count. Failure to do so may result in you being discharged from our clinic.

9) If you are running low on medication or anticipate an extended absence you must contact the doctor during working hours or the designated time for refills.

10) Frequent phone calls after business hours or weekends to request “emergency refills” suggest inappropriate opioid use, and shows addictive behavior. Such behavior may be grounds for dismissal or discontinuation of opioid therapy.

11) If a new acute pain problem develops, such as injury or surgery, the doctor who is taking care of you for that acute event may give you opioids for a short time to cover the expected or increased pain. If this is done without the consent of the doctor(s) from this clinic then we may not be held accountable for any untold potential side effects (example: Respiratory depression or death).

12) DEA law states the patient is the only one authorized to pick up his/her prescriptions. The only exception is if the patient is bedridden, and the doctor has documented this in his/her chart. Under rare circumstances an immediate relative may be allowed to pick up the patients prescription if authorized by the doctor.

This opioid agreement is in good faith. We will not tolerate diversion of medications, manipulation by the patient, or any behavior that would attempt to extort opioid medication from the doctor. These actions would require the staff of Physicians’ Pain and Spine Specialists, PLLC to notify the proper authorities. This would include local police and state officials.

Patient Signature Date

Witness Signature Date

Shawn X. Wu, M.D. PhD Date

AUTHORIZATION AND RELEASE

I authorize the release of any Protected Health Information information including the diagnosis and the records of any treatment rendered to my child or me during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to Physicians' Pain and Spine Specialists, PLLC insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of services rendered on my behalf or my dependents.

_____ _____

Signature of Patient or Parent, if a minor **Date**

_____

Printed Name of Patient / Minor

CONSENT TO RELEASE INFORMATION TO FAMILY

I hereby give my consent to release Protected Health Information information from my medical and/ or financial records from Physicians Pain and Spine Specialists, PLLC to whomever requests it and identifies themselves as an immediate family member, including spouse, sibling, children, grandchildren, and anyone specifically listed below.

_____ _____

I specifically DENY **permission to release information to anyone without my written consent.**

_____ _____

Signature of Patient or Parent, if a minor **Date**

_____

Printed name of Patient/ Minor

CONSENT TO RELEASE INFORMATION TO PHYSICIAN

I hereby give consent to release Protected Health Information information regarding my treatment and/or copies of my medical record to my referring physician and/or primary care physician as listed on the Patient Registration Sheet.

_____ _____

Signature of Patient or Parent, if a minor **Date**

_____

Printed Name of Patient/ Minor

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. PPSS's Notice of Privacy Practices explains the process for revocation, which includes a request in writing. Unless I revoke this authorization earlier, this *Consent for Release of Protected Health Information* will remain in effect until terminated by me in writing.

Physicians' Pain and Spine Specialists, PLLC

Dear Patient _____,

Due to all of the various HMO and PPO insurance plans now available in the marketplace, it has become a very complicated process to become familiar with each plan. All of the various companies and plans have their individual requirements for various procedures.

It has therefore become necessary to request that all patients provide all information needed from their insurance company, and that they assume responsibility for providiing this information to our office, and to any other health facility involved in their particular treatment or illness, including hospitals. Patients must also notify their insurance company of any changes in their care or treatment so that proper handling and payment will be made by their insurance company.

You may receive a pre-certification or authorization number from your insurance company. Please remember that this does not guarantee that your insurance company will pay for the procedure. It is your responsibility to call your insurance benefits department to see if you have any pre-existing or routine testing clauses in your contract which would prevent your insurance company from paying the bill.

We have always filed and will continue to file claims for patients, but you must share equal responsibility for obtaining and giving the doctor or insurance company the necessary information needed to get your claim processed and paid within a reasonable time period.

We realize that patients are not always given all the information required by their insurance company or agent, but it is still your responsibility to call and obtain this information before receiving treatment and before filing claims for treatment. We cannot emphasize enough how important this is, in order for you to receive the proper benefit you are entitled to under your insurance plan or contract.

We are requesting your cooperation so that we may better serve you and give you the health care you deserve, without having to spend an exorbitant amount of time dealing with your insurance company. You should have and know all the information required by your individual plan(s) of insurance to avoid any confusion on your behalf of what services are covered by your insurance policie(s).

Thank you for your cooperation.

_____ _____

Patient Signature or Parent of Minor Date

CONSENT FOR THE USE OR RELEASE OFPROTECTED HEALTH INFORMATION FOR TREATMENT PAYMENT OF HEALTHCARE OPERATIONS

As set forth more fully in our Notice of Privacy Practices, we are permitted to obtain your consent for any use or disclosure of your health information to carry out treatment, payment, or health care operations. In our Notice of Privacy Practices, we provide you information about how this office can use or disclose your health information. You have a right to review our Notice of Privacy Practices before signing this Consent. The Notice is available on our website or a brochure can be obtained at the front desk.

We reserve the right to change the terms of our Notice of Privacy Practices at any time. If you have any questions related to the notice, you may contact PPSS's Privacy Officer, (telephone: 228.220.4637).

By signing this form below, you consent to our use and disclosure of your health information for treatment, payment or health care operations. You have the right to request that we restrict how your health information is used or disclosed to carry out treatment, payment or health care operations. We are not required to agree with your requested restrictions; however, if we do agree to your restrictions, we are bound to follow them.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Valley's Notice of Privacy Practices explains the process for revocation, which includes a request in writing. Unless I revoke this authorization earlier, this ***Consent for Release of Protected Health Information*** will remain in effect until terminated by me in writing.

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, treatment of alcohol and/or drug abuse. My signature authorizes release of information as it pertains to authorization or billing needs.

_____ _____

Signature of Patient or Legal Representative Date

If signed by Legal Representative, please describe the authority of Legal Representative to sign for patient: _____

o I have received a copy of the Notice of Privacy Practices Yes ☐ No ☐ Initials ___

o I have declined a copy of the Notice of Privacy Practices Yes ☐ No ☐ Initials ___

EXPECTATIONS OF PATIENT/CAREGIVER

The following statements are expectations that we as a practice would like you to be informed. Once signed, you as a patient/caregiver acknowledge understanding of these policies and are aware that any violation of these policies may result in discharge from our practice.

I_____ understand that the medications I may receive from this practice are provided for their therapeutic value; however, they may have serious side effects. These side effects may be accentuated by the concurrent use of other medications and/or alcohol. It is unsafe to combine any medications and/or alcohol without first consulting with my physician. I also understand that I will need to take steps to prevent any pregnancy while on these medications due to the potential impact on the fetus.

I understand that any medication that I receive from this practice may affect my ability to operate a motor vehicle, boat, or heavy machinery. I am accountable for determining whether my ability to do these things is impaired. I will be solely accountable for my decision regarding this as outlined under Arizona State Law, Title 28, Chapter 4, Article 3: "It is unlawful for a person to drive or be in actual physical control of a vehicle in this state under the influence of intoxicating liquor, and drug, a vapor releasing substance containing a toxin or any combination of liquor, drugs, or vapor releasing substances if the person is impaired to the slightest." In Arizona, this may be grounds for prosecution of a Driving While Intoxicated (DWI)offense._____ initials)

I am expected to be respectful of the physicians and staff, and I understand that inappropriate behavior will not be tolerated and may result in my dismissal from the Valley Pain Consultants practice.

Patient Signature_____ Date _____

Physicians' Pain and Spine Specialists, PLLC

Permission to Pick-up Prescriptions

I _____ give permission for the following person(s) to pick up my prescriptions on my behalf:

_____
(Name(s) of authorized person(s)

I understand that no one other than the above listed person(s) will be able to pick up my prescriptions. I understand that if something should happen to the prescriptions while in the possession of the listed person(s), I am still fully responsible. This consent is good for one year from date signed unless you notify the office in writing of a change.

Patient Signature _____ Date _____

Staff Initials _____ Date _____