# Alabama Spine and Pain
Pavan Telang, MD

541 West College Street, Suite 2000
Florence, AL 35630
Phone 256-712-2422
Fax 256-712-2377


Thank you for choosing Dr. Telang at Alabama Spine and Pain. We have included our New Patient Registration Packet to complete and bring to your first appointment. Please make sure that you complete the form in detail and entirely. Please provide and Email and telephone numbers in your registration form so that you can access your medical record as well as receive appointment reminders in the future.

Please arrive 30 minutes prior to your appointment time.

In order for us to do a proper registration as well as a thorough evaluation, please bring the following documents with you.

1. Photo ID/ Driver's License.
2. Current Insurance card – Primary Insurance and Secondary Insurance (if any).
3. Co-payments required by your insurance plan for a specialist visit.
4. Up-to-date list of medications/allergies.
5. MRI test reports if available.
6. If you have been to a pain management facility, we request copies of these records, prior to your initial visit. You may request these records to be faxed to Fax # 256-712-2377.

We are located in the Collin's Medical Office Building, 2nd Floor,
Next to ECM Hospital, At the corner of Dr. Hicks Blvd and College Street

Our Address is: 541 W. College Street, Suite 2000 Florence, Al. 35630

Telephone: 256 712 2422 : Fax: 256 712 2377 : Email: telangmd@gmail.com

You may also visit www.alabamaspineandpain.com for further information on our practice.

Thank you,

Medical Office Staff
Alabama Spine and Pain

Alabama Spine and Pain
Pavan Telang, MD

541 West College Street, Suite 2000
Florence, AL 35630
Phone 256-712-2422
Fax 256-712-2377

## Our philosophy: Multidisciplinary approach to Pain Management

We believe that successful pain management therapy requires that we first identify the cause and then utilize appropriate therapies to target the cause of the pain. Research shows there is no "one size fits all" for pain management, instead, we have to target the cause of the pain from multiple directions. We have identified the following core methods that have proven to be effective in treating pain.

1. **Patient Education**
2. **Home Exercise Program**
3. **Physical Therapy**
4. **Interventional Therapies that target the cause of pain**
5. **Medication that target nerve pain, muscle relaxants, anti-inflammatories**
6. **Treatment of depression, if present.**
7. **Advanced Therapies like Radiofrequency and Spinal Cord Stimulation**
8. **Opioid Medications to be used along with other treatment modalities if absolutely necessary.**

**Our Goal** is to use proven, evidence based techniques to target and treat various pain disorders so that you can lead a pain free, productive lifestyle **without reliance** on addicting narcotic pain medications alone.

# Alabama Spine and Pain
Pavan Telang, MD

541 West College Street, Suite 2000
Florence, AL 35630
Phone 256-712-2422
Fax 256-712-2377


## NEW PATIENT REGISTRATION FORM

**DATE OF VISIT** ___/___/____

Please fill this form **COMPLETELY** before your appointment. ☐CP ☐ MRI LS / CS

| | | | |
|---|---|---|---|
| FIRST | MI | LAST NAME | GENDER ☐MALE ☐FEMALE / DATE OF BIRTH |
| STREET ADDRESS | | | |
| CITY , STATE & ZIP CODE | | | |
| HOME PHONE | | CELL PHONE | WORK PHONE |
| SOCIAL SECURITY NUMBER : | | | MARITIAL STATUS ☐Single ☐ Married ☐ Divorced ☐ Widow (Er) |
| EMAIL: | | | DISABILITY: ☐FULL ☐ PARTIAL |
| EMPLOYER: | | | OCCUPATION |
| WORK ADDRESS: | | | |
| RACE:<br>☐WHITE ☐AFRICAN AMERICAN ☐HISPANIC<br>☐ASIAN/PACIFIC ISLANDER ☐AMERICAN INDIAN | | | ETHNIC GROUP:<br>☐AFRICAN AMERICAN ☐ ASIAN ☐ LATINO/HISPANIC<br>☐NON HISPANIC |

### INSURANCE INFORMATION

| | | |
|---|---|---|
| PRIMARY INSURANCE | POLICY HOLDER | POLICY HOLDER SSN # |
| PRIMARY INSURANCE HOLDER'S DATE OF BIRTH: | | |
| SECONDARY INSURANCE | POLICY HOLDER | POLICY HOLDER SSN # |
| SECONDARY INSURANCE HOLDER'S DATE OF BIRTH: | | |
| WORKER'S COMPENSATION BENEFITS ☐ NO ☐YES | IF YES – PLEASE SEE RECEPTIONIST ASAP | |
| EMERGENCY CONTACT: | RELATIONSHIP: | PHONE NUMBER: |

### OTHER INFORMATION

| | | |
|---|---|---|
| REFERRING PHYSICIAN'S NAME : | | PHONE: |
| PRIMARY PHYSICIAN'S NAME: | | PHONE: |
| PHARMACY NAME: | | PHONE: |
| HEIGHT: | WEIGHT: | SMOKER: ☐NO ☐ YES |

**ALLERGIES:** ☐None - No Known Drug Allergy

☐Iodine/shellfish ☐Latex ☐ Adhesive Tape ☐X ray Dye or Contrast Media ☐ Lidocaine or Novocain ☐ Steroids
☐Other, Please List :

ARE YOU TAKING **BLOOD THINNERS** : ☐NO ☐ YES If Yes, Name of the Medication:

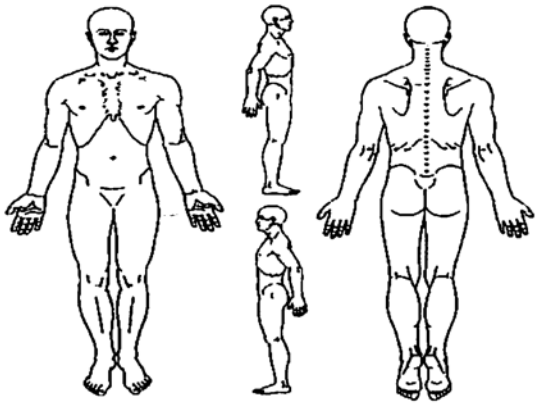
Have you been prescribed a Pain Medication in the past 6 months: ☐NO ☐ YES

Please list name of Medication:

Do you have any PRESENT OR PAST HISTORY OF SUBSTANCE ABUSE OR ADDICTION : ☐NO ☐ YES

# PAIN HISTORY

Mark "X" the areas that hurt the most.



Please describe your pain?

- ☐ Constant
- ☐ Intermittent

- ☐ Sharp / Shooting
- ☐ Dull Aching
- ☐ Pins and Needles
- ☐ Numbing
- ☐ Tingling
- ☐ Burning
- ☐ Throbbing
- ☐ Aching

**Please list ALL pain medications**

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Please CIRCLE one number below that best describes your pain:

| **0 =No pain** | **8 = Need to be in the hospital for treatment of SEVERE PAIN** | | | | | | | | | | **10 = Worst pain of your life** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Worst pain** in the past 10 days | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **8** | 9 | 10 |
| **Least Pain** in the past 10 days | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **8** | 9 | 10 |
| **Average Pain** in the past 10 days | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **8** | 9 | 10 |
| Pain you have **RIGHT NOW** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **8** | 9 | 10 |

Please CIRCLE one number below that best describes how pain interferes with the following activity (0=Pain Free)

| | Does not Interfere | | | | | | | | | | Completely Interferes |
|---|---|---|---|---|---|---|---|---|---|---|---|
| General Activity | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Mood | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Walking Ability | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Work at home and outside | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Relationships with other people | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Sleep | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Enjoyment of Life | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

DURATION: How long have you had the pain _____

**PAIN LOCATION**: Where do you hurt?

- ☐ Low Back
- ☐ Right Side of Back
- ☐ Left Side of Back
- ☐ Other Area: _____

Neck

- ☐ Right Side of Neck
- ☐ Left Side of Neck
- ☐ Other Area: _____

**PAIN RADIATION**: Where does pain radiate?

- ☐ Both Legs
- ☐ Right Leg
- ☐ Left Leg
- ☐ Below the Knee
- ☐ Side of the Thigh
- ☐ Top of the Foot
- ☐ Sole of the Foot

- ☐ Both Arms
- ☐ Right Arm
- ☐ Left Arm
- ☐ Shoulder
- ☐ Forearm
- ☐ Fingers

What eases the pain?? _____

What makes the pain worse?? _____

Do you have any: Weakness ☐NO ☐ YES Numbness? ☐NO ☐ YES Loss of bowel or bladder function: ☐NO ☐ YES

**I certify that I have tried the following treatments for Pain relief before this visit:**

- ☐ Rest and Home Exercises
- ☐ Heat or Ice
- ☐ NSAID medications: Tylenol / Ibuprofen / Aleve / Mobic/ Diclofenac etc.
- ☐ Neurontin / Gabapentin/ Lyrica/ Cymbalta
- ☐ Muscle relaxants: Flexeril / Zanaflex / Robaxin / Baclofen / Skelaxin etc.
- ☐ OPIOID MEDICATIONS
- ☐ TENS unit
- ☐ **Physical Therapy:** ☐NO ☐ YES if yes, Where _____ When _____
- ☐ **Chiropractic / Osteopathic manipulation** ☐NO ☐ YES if yes, Where _____ When _____
- ☐ Surgery _____

**DIAGNOSTIC TESTS:** Which of the following tests have you had to establish the cause of your pain?

MRI Scan ☐NO ☐ YES Where _____
CT Scan ☐NO ☐ YES Where _____
X-ray ☐NO ☐ YES Where _____
Nerve Conduction ☐NO ☐ YES Where _____

**PAST SURGICAL HISTORY** (Please check (✓) Surgeries you currently have or have had in the past)

- ☐ Back Surgery - Laminectomy
- ☐ Back Surgery – Rods
- ☐ Back Surgery - Discectomy
- ☐ Neck Surgery_____Fusion
- ☐ Other _____
- ☐ Other _____
- ☐ Knee Surgery
- ☐ Hip Surgery
- ☐ CABG
- ☐ Heart Stents
- ☐ Brain Surgery
- ☐ _____
- ☐ Appendix Surgery
- ☐ Gall Bladder
- ☐ Hysterectomy
- ☐ C - Section
- ☐ Breast Surgery
- ☐ _____

**PAST MEDICAL HISTORY** (Please check (✓) conditions you currently have or have had in the past)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Attacks
- ☐ Heart Stents / CABG surgery
- ☐ Other Stents in the body, Leg Stents
- ☐ Peripheral Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation
- ☐ Problems with heart valves
- ☐ Pacemaker/Automatic Defibrillator
- ☐ Asthma / COPD
- ☐ Sleep Apnea
- ☐ Blood Clots in Legs / DVT
- ☐ Blood Clots in Lung
- ☐ _____
- ☐ Blood transfusion
- ☐ Bleeding Disorder
- ☐ Easy bleeding or bruising
- ☐ Hepatitis A B C
- ☐ HIV Infection/AIDS
- ☐ Liver Disease or Jaundice
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Arthritis
- ☐ Chronic back problems
- ☐ Scoliosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Joint Pain
- ☐ _____
- ☐ Currently/possible pregnant
- ☐ Abuse (Physical/Sexual/Verbal)
- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal thoughts
- ☐ Blood in Urine or Stool
- ☐ Nausea or Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Anemia
- ☐ Stroke
- ☐ TIA (Transient Ischemic Attack)
- ☐ Epilepsy/seizures
- ☐ Weakness or paralysis
- ☐ History of Polio
- ☐ Cancer – where _____

**FAMILY HISTORY**

| RELATION | AGE | STATE OF HEALTH | AGE OF DEATH | CAUSE OF DEATH | Circle if you have family history of the following diseases Other: | |
|---|---|---|---|---|---|---|
| Father | | | | | Hypertension | Addiction / Chemical Dependency |
| Mother | | | | | Diabetes | Psychiatric conditions |
| Brother | | | | | Heart Disease | Kidney Disease |
| Sister | | | | | Rheumatoid Disorder | Stroke / Bleeding Disorder/ Cancer |

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Name Signature Date

# Opioid Risk Tool

| CIRCLE each box | Female patients use this column | Male patients use this column |
|---|---|---|
| **Family history of substance abuse** | | |
| Alcohol | 1 | 3 |
| Illegal drugs | 2 | 3 |
| Rx drugs | 4 | 4 |
| **Personal history of substance abuse** | | |
| Alcohol | 3 | 3 |
| Illegal drugs | 4 | 4 |
| Rx drugs | 5 | 5 |
| **Age between 16—45 years** | 1 | 1 |
| **History of preadolescent sexual activity / abuse** | 3 | 0 |
| **Psychological disease** | | |
| ADD, OCD, bipolar, schizophrenia | 2 | 2 |
| Depression | 1 | 1 |
| **Scoring totals (office use)** | | |

# PHQ 9 – Depression Screen

| **Over the Last 2 Weeks, how often 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 overeating | 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 |

(Office use )TOTAL SCORE = _____ _____ + _____ + _____ + ____