SOUTHERN PAIN SPECIALISTS

PATIENT REGISTRATION SHEET

DATE: ____________________

REFERRING M.D.: ____ PHONE: (____)________________________

PRIMARY CARE M.D.: ____ PHONE: (____)________________________

PATIENT NAME: ____ SEX: ______ M ______ F

DATE OF BIRTH: _____________________ AGE: _______ SOCIAL SECURITY NO: __ __ __ - __ __ - __ __ __ __

STREET ADDRESS: ________________________________ CITY: ______________ ST: ______ ZIP: __________ COUNTY _______________

HOME PHONE: (_____)__________________ CELL: (_____)_______________ WORK (_____)_____________EXT_______

EMAIL ADDRESS: _____________________________________ FAX: ______________________________________

EMPLOYER'S NAME: ______________________________________

EMPLOYER'S ADDRESS: _____________________________ CITY: _______________ ST: ______ ZIP: ________

SPOUSE'S INFORMATION

NAME: ________________________________SS# _____________________ DOB: ____________________________

EMPLOYER: _______________________________________ WORK PHONE: (____)_____________________EXT: _________

CELL PHONE:____________________________________ **HIPAA ☐ YES ☐ NO**

PERSON TO NOTIFY IN CASE OF AN EMERGENCY (OUTSIDE THE HOME)

NAME: ____ RELATIONSHIP: _______________ **HIPAA ☐ YES ☐ NO**

HOME PHONE: (______)__________________________ WORK PHONE: (_____)______________________ EXT: ________

INSURANCE INFORMATION

PRIMARY INSURANCE:

INSURANCE CARRIER: ______________________________

CONTRACT NO: ___________________________________

GROUP NO: ______________EFFECTIVE DATE: _________

INSURED NAME: __________________________________

SECONDARY INSURANCE:

INSURANCE CARRIER: ______________________________

CONTRACT NO: ___________________________________

GROUP NO: _______________ EFFECTIVE DATE: _________

INSURED NAME: __________________________________

Is there an attorney involved in your pain condition? ☐ YES ☐ NO

If Yes, give name and phone number of attorney: ____

POLICY REGARDING INSURANCE PAYMENT

Patients of Southern Pain Specialists are responsible for payment of their insurance policy co-pay at the time of the visit. We reserve the right to deny a visit to any patient if they are unable to pay their co-pay at the time of service. Any fee not covered by your insurance company will be due at the time of service. Your insurance benefits will be verified, however, verification of benefits is not a guarantee of payment. You are responsible for any charges not covered by your insurance company.

_______________________________________ _______________________________

Patient Signature **Date**

PLEASE REMEMBER IT IS YOUR RESPONSIBILITY TO NOTIFY US OF INSURANCE CHANGES

What NOT to do before a procedure!

1) Do NOT eat anything after midnight the night before

2) Do NOT drink anything 4 hours before
   a) You may have clear liquids up to 4 hours before
      i) Water, black coffee, sprite, 7up, apple juice, tea
   b) NO MILK or MILK PRODUCTS…including cream
   c) NO orange juice

3) No Anti-Inflammatory medications 3 days prior
   a) Motrin, Ibuprofen, Advil, Naproxen, Aleve, Mobic, Volteran, Arthrotec
   b) Celebrex is OK to continue

4) Must STOP any bloodthinners 5 days prior unless Dr. Varley OK's
   a) Coumadin/Warfin, Plavix, Lovenox injections
      i) All new patients on coumadin/warfin must have a PT and INR the day before their procedure and results faxed to us!
   b) Asprin:
      i) 81mg once a day is OK
      ii) 325 mg once a day is OK
         (1) more than one 325 mg a day needs to be STOPPED 10 days prior

INFORMATION RELEASE AND INSURANCE ASSIGNMENT—ALL PATIENTS

I hereby authorize Southern Pain Specialists, P.C., to release medical information to any insurance company or any public agency that may be assisting in payment of benefits to which I am entitled. In addition, I authorize the payment of any insurance benefits directly to Southern Pain Specialists, P.C. This signature shall suffice for all insurance forms on a continuing basis.

SIGNED:____ DATE:_________________________
(Signed by patient or person legally authorized to sign for patient.)

MEDICARE ASSIGNMENT—MEDICARE PATIENTS ONLY

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER
(Extended Payment Request for Physician Services Applicable to Current and Future Treatment)

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made either to me or on my behalf to P.C. and/or Physicians, for any services furnished me by or in the name of such providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services. I recognize that this one-time authorization will permit P.C. and/or Physicians to submit any Medicare claim, on either an assigned or an unassigned basis, without obtaining any additional signature from me, and will remain in the files of P.C. for inspection by the Medicare carrier, and will continue in full force and effect unless cancelled by my request.

SIGNED:____ DATE:________________________
(Signed by patient or person legally authorized to sign for patient.)

FINANCIAL ASSIGNMENT—ALL PATIENT

I understand that I am directly responsible to Southern Pain Specialists, P.C., for all charges for medical services rendered to me regardless of insurance coverage. In the event of default, I agree to pay all costs of collection, including reasonable attorney’s fees.

SIGNED:____ DATE:________________________
(Signed by patient or person legally authorized to sign for patient.)

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION TO SPECIFIED INDIVIDUALS

Southern Pain Specialists is committed to the protection of our patient's personal health information. However, we recognize that individuals other than themselves attend to many of our patient's healthcare needs. In accordance with new HIPAA regulations, we ask that you take a moment to give us the names of individuals with whom we are able to discuss your medical appointments, condition, treatment options, insurance/private payment information, or other information necessary to our responsibility in your treatment. Please list the names (and phone numbers, if readily available) of any individuals with whom we may have communication, which may include all, or part of your personal health information. If you fail to list any names, we will not discuss your medical information

Examples include: spouse, parent, child, brother/sister, friend, etc.

Patient's Signature: ________________________________ Date: _____________________

Contact/Relationship to patient: Telephone number:

1. ____________________________________ _________________
2. ____________________________________ _________________
3. ____________________________________ _________________

CONSENT FOR THE USE OF NON-IDENTIFYING PATIENT INFORMATION

It is the practice of Southern Pain Specialists to gather non-specific patient data for such purposes as teaching, marketing, and research. This data does not include any identifying information that would compromise the privacy of your identity, health condition, insurance or payment information. Examples include (but are not limited to): age, sex, race, treatment options, response to treatment and/or a non-identifying photograph or x-ray. Southern Pain Specialists is bound by the conditions of the Health Insurance Portability and Accountability Act and will not disclose further Personal Health Information beyond such non-identifying information without the express written consent of the patient. However, we request your permission to use your non-identifying patient information for such purposes as listed above.

I, (print name)____________________________________ , grant permission to Southern Pain Specialists to use non-identifying patient information about me (exclusive of Personal Health Information) for such purposes that may include, but are not restricted to, teaching, marketing and/or research.

____ ____________________________

Signature Date

POLICY REGARDING MISSED PROCEDURE/OFFICE APPOINTMENTS

PROCEDURE APPOINTMENTS

If you are scheduled for a procedure we want you to be aware of our cancellation and no-show policy.

If you need to cancel your scheduled procedure appointment, please call us at least **48 business hours** in advance, and we will be happy to reschedule your procedure to a more convenient time. This time period allows us to schedule another waiting patient in the time slot.

Should you fail to show up the day of your scheduled procedure, and you have not notified us at least **48 business hours** in advance of the scheduled time, you will be charged **$150.00**. This charge is not billable to your insurance and must be paid by you.

OFFICE APPOINTMENTS

Please call our office if you need to cancel an office visit at least **24 hours** in advance. If you do not show up for an office appointment or if you cancel with less than 24 hours notice, you will be charged **$25.00**. This charge is not billable to your insurance and must be paid by you.

Please call our office if you have any questions (205) 995-9967.

Thank you!

____

Patient Signature

____

Date

Authorization for Release of Medical Information

Date: ____________________________

To: ____________________________

____

____

Patient Name	Date of Birth	Social Security #

This is to authorize and request that you furnish all medical or hospital information, including any radiology reports, concerning your examination, treatments, and care of the patient listed above.

Southern Pain Specialists, P. C.
7191 Cahaba Valley Road, Suite 204
Birmingham, Alabama 35242

Attention: Medical Records

(205) 995-9967
FAX: (205) 995-0635
(888) 436-4560

WWW.SOUTHERNPAIN.COM

Patient (or Guardian) Signature: ____

7191 Cahaba Valley Rd, Suite 204,
Birmingham, Alabama 35242-6402
Phone: (205) 995-9967 FAX: (205) 995-0635
1-888-436-4560
http://www.southernpain.com

For Office Use Only
Wt:_____ **T:** _____
P: ______ **R:** _____
BP: _____ / _______
Ht: _____

PAIN PATIENT QUESTIONNAIRE

It is very important that this form be filled out *completely before* coming for your visit!

Today's Date: _________________ Ref. MD: ____

I. IDENTIFICATION:

___________________________________ ______________________________ ____
(Last Name) (First Name) (MI)

Date of Birth: ________________ Age:___ ____ Weight ______ lbs Height @ age 25 :______

II.CHIEF COMPLAINT

1. Please list your pain site in order of importance (rank the worst problem, as "**a**" the next as "**b**", etc.)

a. ___________________________ b. ________________________ c.________________________________

III.HISTORY OF PRESENT ILLNESS

2. Date when your pain **began**? ________________Did this pain begin: → ☐ Gradually or → ☐ Suddenly

3. **How** did this pain begin? (check)

Accident? ☐ At Work ☐ At Home ☐ Auto Other_______________________________

☐ **Following an Illness?** ☐ **Following Surgery**

Explain: ____

____

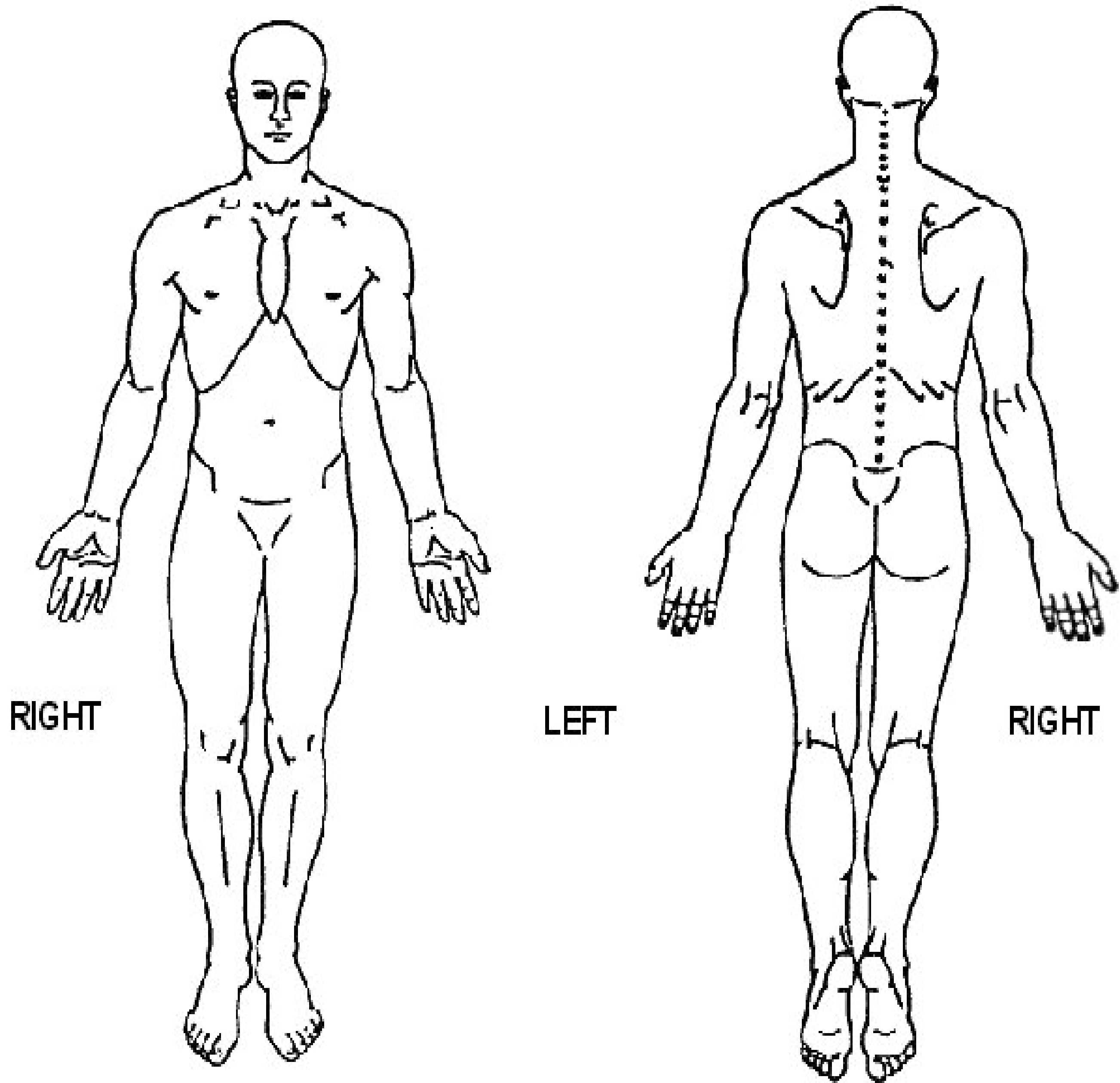
4. Is the pain the same now as it was when it began? ☐ SAME ☐ BETTER ☐ WORSE

5. Is there a time of day that your pain is worse ☐ Morning ☐ Noon ☐ Afternoon ☐ Evening ☐ Wakes you at night

6. **PLEASE INDICATE WHICH *DIAGNOSTIC* PROCEDURES (TESTS) YOU HAVE HAD FOR THIS PAIN PROBLEM**

☐ X-Ray Date:___________ Where: ______________________________
☐ CT Scan Date:___________ Where: ______________________________
☐ Myelogram Date:___________ Where: ______________________________
☐ EMG Date:___________ Where: ______________________________
☐ Discogram Date:___________ Where: ______________________________
☐ Bone Scan Date:___________ Where: ______________________________
☐ MRI Date:___________ Where: ______________________________
☐ Bone Mineral Density (BMD) Date:___________ Where: ______________________________
(Test for Osteoporosis)
☐ Vertebral Fracture Assessment (VFA) Date:____________Where: ______________________________

IV. Please Draw the LOCATION and the TYPE of your pain on the figure below:



Use this legend to draw your pain

O O O O O	**Pins and Needles**	/ / / / / / / / / /	**Spasm: Tension Type**
# # # # # #	**Dull Aching Pain**	▽▽▽▽▽	**Excruciating**
●●●●●	**Burning, sharp, shooting**	= = = = = =	**Numbness**
X X X X X X	**Unbearable**		**Other: ________________**

7. Please check those words that describe your pain, as mild, moderate, or severe:

☐ Throbbing	☐ Cramping	☐ Heavy
☐ Shooting	☐ Gnawing	☐ Tender
☐ Stabbing	☐ Hot-Burning	
☐ Sharp	☐ Aching	

8. You will be using the **MANKOSKI Pain Scale** to ***estimate the level of your pain***. Please note that the subjective experience of pain varies from person to person. In order to make your pain rating more valid, **please read the following descriptions** of the various pain levels and physical responses. Please be realistic in your pain rating, so we can help you better.

0 – Pain free
1 – Minor annoyance
2 – Annoyance
3 – Distracting; mild painkillers needed (aspirin, Tylenol).
4 – Cannot be ignored; Mild painkillers remove pain for 3-4 hours.
5 – Cannot be ignored for more than 30 minutes. Mild painkillers decrease pain for 3-4 hours.
6 – Cannot be ignored for any length of time. Stronger painkillers (codeine, narcotics) reduce pain for 3-4 hours.
7 – Cannot concentrate; interferes with sleep. Stronger painkillers are only partially effective.
8 – Physical activity is severely limited. Nausea and dizziness set in as factors in pain.
9 – Unable to speak. Crying out or moaning uncontrollably; near delirium.
10 – Unconscious. Pain makes you pass out.

Using the above definitions, enter the number that describes your **pain level right now here:** ⟶ ☐
and also ***circle it*** on the scale below:

On the same scale (**0 =** no pain; **10** = the worst), rate your pain at its **WORST:** ____ At its **LEAST (best):** ______

9. PAIN MODIFIERS. How is your pain ***changed***? For each of the following please check (**X**) the appropriate box:

The following make your pain….

	Worse	Better	Same
Bending	☐	☐	☐
Climbing Stairs	☐	☐	☐
Cold Weather	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Exercise	☐	☐	☐
Bowel Movements	☐	☐	☐
Heat/Heating Pads	☐	☐	☐
Hot Weather or Room	☐	☐	☐
Ice Packs	☐	☐	☐
Liquor	☐	☐	☐

	Worse	Better	Same
Lying Down	☐	☐	☐
Pressure	☐	☐	☐
Sex	☐	☐	☐
Shifting Position	☐	☐	☐
Sitting – prolonged time	☐	☐	☐
Sleep, Rest	☐	☐	☐
Standing - prolonged time	☐	☐	☐
Twisting/Turning	☐	☐	☐
Urination	☐	☐	☐
Physical Labor	☐	☐	☐

10. Please list ***ALL the treatments*** you have had and are currently having **for your pain.** Include operations, hospitalizations, anesthetic procedures, nerve blocks, physiotherapy, and psychological treatments.

			Did it Help?	
	YES	NO	YES	NO
Physical Therapy	☐	☐	☐	☐
Chiropractic	☐	☐	☐	☐
Water Therapy	☐	☐	☐	☐
Massage Therapy	☐	☐	☐	☐
Steroid Injections (I.e. epidural, facet, other)	☐	☐	☐	☐

1. Did you have any ***surgeries*** for this pain condition? ☐ YES ☐ NO

If YES, what kind? ______________________________

____

Dates of the surgeries, if any:______________________________

Did they/it help? ☐YES ☐ NO If YES for how long? ______________

2. List **ANY** other treatment you have had for this pain condition: ______________________________

____

3. How many times have you been to the **emergency room**, this year, because of present pain? _________

4. How many times have you been **admitted to the hospital** because of the present pain problem? _________

5. How many times have you seen a **medical doctor** in the past **six (6) months**: _________

6. How many of these visits were for a **pain-related** problem? _________

____

V. CURRENT MEDICATIONS. Please list **ALL** medications or drugs you **are taking NOW** for any reason, whether PRESCRIBED by a doctor or not (include home remedies; painkillers; over-the-counter medications; birth control pills).

Name of the Medication	Dosage/ Strength	How many a day/how often	Who prescribed it

VI. PREVIOUS MEDICATIONS. Please list **ALL** medications or drugs you have tried in the past for any reason, whether PRESCRIBED by a doctor or not (include home remedies; painkillers; over-the-counter medications; birth control pills).

Name of the Medication	Dosage/ Strength	How many a day/how often	Who prescribed it

Your PHARMACY: ______________________________ ______________________
(Name of pharmacy) (Phone)

☐ **Check this box if you used the back for extra room for your medications.**

VII. MEDICAL HISTORY

1. ALLERGIES ☐ YES ☐ NO ☐ ASPIRIN ☐ LATEX

Drug allergies: ______________________________

Other Allergies: ______________________________

2. Have you recently taken	**YES**	**NO**	**Date last taken**
Coumadin,	☐	☐	______________
Plavix	☐	☐	______________
Aspirin, Goody's powder	☐	☐	______________
Cortisone or steroids	☐	☐	______________

3. Have you ever had a history of malignancy **(cancer)**? ☐ Yes ☐ No

If Yes, please provide the following: Type: ______________________________

Approximate date discovered: ______________ Treating physician: ______________

Currently receiving treatments (such as chemotherapy or radiation)? ☐ **Yes** ☐ **No**

4. Have you had or do you presently have any of the following problems:

☐ Heart Attack; Angina
☐ Hypertension
☐ Diabetes
☐ Bleeding Disorders
☐ Kidney Failure; stones
☐ Seizures, Convulsions
☐ Asthma in the past year
☐ Strokes (CVAs)
☐ Emphysema of the lungs
☐ Stomach ulcer or duodenal ulcer
☐ TMJ Dysfunction
☐ Thyroid Dysfunction
☐ Interstitial Cystitis
☐ Irritable Bowel / Crohn's Disease
☐ Hepatitis Type ☐ A ☐B ☐ C

5. List any ***surgeries*** you have had and when: ______________________________

____

6. List any **injuries** or **accidents** you have had/date of injury: ______________________________

____

VIII. HABITS

1. Do you smoke ***cigarettes?*** ☐ **YES** ☐ **NO** If YES, how many a day? ______________

2. Do you use ***other tobacco*** products? ☐ **YES** ☐ **NO** If, YES, what? ______________

3. Please indicate the number of ***caffeinated beverages*** (including coffee, tea, and sodas) you drink each day; specify type: ______________________________

4. Do you drink ***alcohol***? ☐ **YES** ☐ **NO**

Type: ______________ Glasses / cans Per day ______________ Per week: ______________

5. Recreatinal drug use? ☐ **YES** ☐ **NO**

IX. WORK AND LIFE STYLE:

1. Education:
Finished ___th grade ☐ GED ☐ HS Graduate ☐ College _____ (yrs) Post-Graduate____

2. Are you presently working? ☐ **YES** ☐ **NO** **Date last worked**: ________________________

3. What type of work do you do or did you do last? (include housewife): ___________________________________

4. If you are not working presently:

a. Is your pain preventing you from working? ☐ **YES** ☐ **NO**

b. Have you applied for **Social Security Disability** or **Disability** Retirement: ☐ **YES** ☐ **NO**

6. Do you exercise regularly? ☐ **YES** ☐ **NO**

7. Do you own any type of exercise equipment? ☐ **YES** ☐ **NO** If YES, what kind: _________________

8. HOME ENVIRONMENT

a. Are there any others who are regular members of the household? ☐ **YES** ☐ **NO**

b. Is there anybody in the household who has special care needs? ☐ **YES** ☐ **NO**

If, YES, describe: ____

c. Is anybody in your household on ***disability*** ? ☐ **YES** ☐ **NO**

d. Is anybody in your household ***applying for disability***? ☐ **YES** ☐ **NO**

e. Are you in charge of the person needing ***special care***? ☐ **YES** ☐ **NO**

If, YES, what is expected of you: ____

f. Are you ***getting any help***? ☐ **YES** ☐ **NO**

X. FAMILY HISTORY

1. ORIGINAL FAMILY

a. Have any immediate family members died? ☐ **YES** ☐ **NO**

If YES, who? ____

Cause of death? ____

b. Has anybody in your family had back or neck surgery? ☐ **YES** ☐ **NO**

If YES, who? ____

2. MARRIAGE ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

What is your partner's occupation? ____

3. CHILDREN living (ages, sex, living at home, or not):____

a. Any children deceased? Date: ____________________Age: ____ Reason: ___________________________

XI. REVIEW of SYSTEMS: Symptoms **or** Problems List (check the box for EACH symptom you have):

General/Constitutional
- ☐ Fever/ Chills
- ☐ Fatigue
- ☐ Morning Fatigue
- ☐ Morning Stiffness
- ☐ Weight loss
- ☐ Weight gain
- ☐ Loss of appetite
- ☐ Mood Changes
- ☐ Trouble Falling Asleep
- ☐ Trouble Staying Asleep
- ☐ Night Sweats

Skin
- ☐ Itching/dryness
- ☐ Rashes
- ☐ Bruises
- ☐ Change in skin color

Ears, Eyes, Nose and Throat
- ☐ Headaches
- ☐ Problems with vision
- ☐ Sore Throats
- ☐ Problems with Hearing
- ☐ Ringing of the Ears
- ☐ Hoarseness
- ☐ Nose Bleeds
- ☐ Change in the color of the white of your eyes

Lungs
- ☐ Shortness of breath when resting
- ☐ Wheezing
- ☐ Cough
- ☐ Coughing up blood
- ☐ Short of breath exercising

Heart and circulation
- ☐ Chest pain
- ☐ Skipped heartbeats
- ☐ Ankle swelling
- ☐ Short of breath when resting
- ☐ Heart flutter/Palpitations
- ☐ Pain in legs walking
- ☐ Poor circulation
- ☐ Cold Hands or Feet

Gastrointestinal
- ☐ Difficulty swallowing
- ☐ Nausea/vomiting
- ☐ Throwing up blood
- ☐ Stomach pain
- ☐ Diarrhea
- ☐ Constipation

Endocrine
- ☐ Frequent Urination
- ☐ Frequent Drinking
- ☐ Heat intolerance
- ☐ Cold intolerance

Hematologic
- ☐ Anemia
- ☐ Easy Bleeding
- ☐ Swollen Glands

Genito-Urinary
- ☐ Difficulty starting stream
- ☐ Loss of bladder control
- ☐ Nighttime urination
- ☐ Change in color of urine
- ☐ Discharge
- ☐ Painful Urination

Reproductive
- ☐ Change in Sexual Libido
- ☐ Post-Menopausal
- ☐ Nipple discharge
- ☐ Erectile Dysfunction

Neurological
- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Fainting spells
- ☐ Memory Problems

Muscles and Bones
- ☐ Joint pain
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Cramping
- ☐ Weakness
- ☐ Tenderness
- ☐ Muscle Twitches
- ☐ Restless Legs

Emotional
- ☐ Depression
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Irritability
- ☐ Stress

Wahler Physical Symptoms Inventory

1983 Edition

by H.J. Wahler, Ph.D.

Published by

WESTERN PSYCHOLOGICAL SERVICES
Publishers and Distributors
12031 Wilshire Boulevard
Los Angeles, California 90025

Name:____________________ Age:________ Sex: M F Date:________

WHAT YOU ARE TO DO:

Below is a list of physical troubles. Please indicate how often each of these bothers you. Do this by circling the number to the right of each trouble which shows how often you are bothered by that trouble. Keep in mind that the LARGER the number the MORE OFTEN the trouble bothers you. Please DO NOT SKIP any troubles. You may take as much time as is necessary.

	ALMOST NEVER	ABOUT ONCE A YEAR	ABOUT ONCE A MONTH	ABOUT ONCE A WEEK	ABOUT TWICE A WEEK	NEARLY EVERY DAY
1. Nausea (Feeling like throwing up).	0	1	2	3	4	5
2. Headaches.	0	1	2	3	4	5
3. Trouble with ears or hearing.	0	1	2	3	4	5
4. Neck aches or pains.	0	1	2	3	4	5
5. Feeling hot or cold regardless of the weather	0	1	2	3	4	5
6. Arm or leg aches or pains.	0	1	2	3	4	5
7. Shakiness.	0	1	2	3	4	5
8. Swelling of arms, hands, legs, or feet	0	1	2	3	4	5
9. Stuttering or stammering.	0	1	2	3	4	5
10. Difficulty sleeping	0	1	2	3	4	5
11. Losing weight.	0	1	2	3	4	5
12. Backaches.	0	1	2	3	4	5
13. Intestinal or stomach trouble.	0	1	2	3	4	5
14. Difficulty with urination (Passing water).	0	1	2	3	4	5
15. Heart trouble.	0	1	2	3	4	5
16. Trouble with teeth.	0	1	2	3	4	5
17. Numbness, or lack of feeling in any part of the body.	0	1	2	3	4	5
18. Aches or pains in hands or feet.	0	1	2	3	4	5
19. Fainting spells.	0	1	2	3	4	5
20. Excessive perspiration.	0	1	2	3	4	5
21. Abnormal blood pressure.	0	1	2	3	4	5
22. Paralysis (Unable to move parts of the body).	0	1	2	3	4	5
23. Trouble with eyes or vision.	0	1	2	3	4	5
24. Burning, tingling or crawling feelings in the skin.	0	1	2	3	4	5
25. Skin trouble (Rashes, boils or itching).	0	1	2	3	4	5
26. Feeling tired.	0	1	2	3	4	5
27. Muscular weakness.	0	1	2	3	4	5
28. Dizzy spells.	0	1	2	3	4	5
29. Muscular tensions.	0	1	2	3	4	5
30. Any trouble with the senses of taste or smell.	0	1	2	3	4	5
31. Difficulty breathing (Short of breath, asthma, etc.).	0	1	2	3	4	5
32. Twitching muscles.	0	1	2	3	4	5
33. Poor health in general.	0	1	2	3	4	5
34. Excessive gas.	0	1	2	3	4	5
35. Difficulty swallowing.	0	1	2	3	4	5
36. Seizures (Convulsions or fits).	0	1	2	3	4	5
37. Gaining weight.	0	1	2	3	4	5
38. Difficulty with appetite.	0	1	2	3	4	5
39. Bowel trouble (Constipation or loose bowels).	0	1	2	3	4	5
40. Vomiting.	0	1	2	3	4	5
41. Chest pains.	0	1	2	3	4	5
42. Hay fever or other allergies.	0	1	2	3	4	5

Please write down any important physical symptoms not listed above which trouble you: ____________________

Copyright © 1973 by WESTERN PSYCHOLOGICAL SERVICES
Not to be reproduced in whole or in part without written permission of Western Psychological Services.
All rights reserved.

W-118A 3 4 5 6 7 8 9 Printed in U.S.A.

____ ____________________

Name ***Date***

SPOUSE'S OR SIGNIFICANT OTHER'S QUESTIONNAIRE

When you spouse is in pain, how likely are you to *(circle the appropriate number):*

a. Express sympathy

0------1-------2------3------4-------5-------6-------7--------8-------9-------10

No (zero) likelihood — *Good likelihood* — *absolute certainty*

b. Bring medication

0------1-------2------3------4-------5-------6-------7--------8-------9-------10

No likelihood — *Fair* — *Good likelihood* — *Very Good* — *absolute certainty*

c. Give massage

0------1-------2------3------4-------5-------6-------7--------8-------9-------10

No likelihood — *Fair* — *Good likelihood* — *Very Good* — *absolute certainty*

d. Ignore

0------1-------2------3------4-------5-------6-------7--------8-------9-------10

No likelihood — *Fair* — *Good likelihood* — *Very Good* — *absolute certainty*

e. Tell not to exert

0------1-------2------3------4-------5-------6-------7--------8-------9-------10

No likelihood — *Fair* — *Good likelihood* — *Very Good* — *absolute certainty*

f. Express anger

0------1-------2------3------4-------5-------6-------7--------8-------9-------10

No likelihood	*Fair*	*Good likelihood*	*Very Good*	*absolute certainty*

g. Bring presents

0------1-------2------3------4-------5-------6-------7--------8-------9-------10

No likelihood	*Fair*	*Good likelihood*	*Very Good*	*absolute certainty*

h. Express frustration

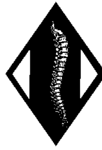
0------1-------2------3------4-------5-------6-------7--------8-------9-------10

No likelihood	*Fair*	*Good likelihood*	*Very Good*	*absolute certainty*

i. Take over duties and chores

0------1-------2------3------4-------5-------6-------7--------8-------9-------10

No likelihood	*Fair*	*Good likelihood*	*Very Good*	*absolute certainty*



Bone Densitometry Patient Questionnaire

Name (print):____ DOB :_________________ Date: ________________

Address :__________________________________ City :_____________________ State :___________ Zip :__________

Primary Care Physician :____

Is there a chance that you are pregnant? Yes No
Have you had a barium X-ray in the last 2 weeks? Yes No
Have you had a nuclear medicine scan or injection of an X-ray dye in the last week? Yes No
Have you had hyperparathyroidism or a high calcium level in your blood? Yes No

If you answered yes to any of the above, speak to our receptionist right away.

1. Your: Age: ____ Sex: Male Female

2. Your ethnicity (check one):
__Caucasian (White) __Black __Asian __Hispanic __Other

3. Have you ever had a bone density test? Yes No
If YES, when and where? ____

4. Have you had a recent weight change? Yes No
If YES, tell us about it: _________________________________ Current Weight_________

5. Your tallest height (late teens or young adult): ______________ Current Height_________

6. Have you ever broken a bone? Yes No

Bone broken	**Simple fall?**	**If not a simple fall, please describe the circumstances**	**Age when this occurred**

7. Has a parent or sibling had a broken hip from a simple fall or bump? Yes No

8. Has a parent or sibling had any other type of broken bone from a simple fall or bump? Yes No

9. How many times have you fallen in the last year? ________

10. Have you ever had surgery of the spine, hips, legs or arms? Yes No
If YES, describe what type of surgery you had and which side was affected
____
____

11. Are you currently receiving or have you previously received prednisone pills (cortisone)?
Yes, currently ____ Yes, previously _____ No ____
If YES, for how long? _______ What is your dose? _____mg or ______ pills each day

12. List any chronic medical conditions that you have:

_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________

13. Are you currently receiving or have you previously received any of the following medications?

	No	**Yes**	**For how long?**
Medication for seizures or epilepsy			
Chemotherapy for cancer			
Medication for prostate cancer			
Medication to prevent organ transplant rejection			

14. Have you been treated with any of the following medications?

Medication	**Ever?**	**Currently?**	**If current, how long?**
Hormone replacement therapy (Estrogen)			
Tamoxifen			
Raloxifene (Evista)			
Testosterone			
Etidronate (Didronel/Didrocal)			
Alendronate (Fosamax)			
Risedronate (Actonel)			
Intravenous pamidronate (Aredia)			
Clodronate (Bonefos, Ostac)			
Calcitonin (Miacalcin nasal spray)			
PTH (Forteo)			
Zoledronic acid (Zometa)			
Sodium fluoride (Fluotic)			

15. Do you take any calcium supplements (including TUMS)? Yes No

16. Do you take any vitamin D supplements (including multivitamins and halibut liver oil)? Yes No

17. Do you smoke? Yes No

For women only…

18. Are you still having menstrual periods? Yes No

19. Before menopause, have you ever missed your periods for 6 months or more, besides during pregnancy? Yes No

20. Have you had your menopause? Yes No
If yes, at what age? ___________

21. Have you had a hysterectomy? Yes No
If YES, at what age? _______
Have you had both of your ovaries removed? Yes No
If YES, at what age? ________

I, _________________________________, understand that I am having a Bone Density and/or Vertebral Fracture Assessment test done. I have been informed that my insurance may or may not cover all the cost of the test and that I will be responsible for the remaining balance. *

_________________________________ _________________________________
Patient Signature Technologist Signature

*Insurance companies allow a bone density test every 2 years, unless the patient is under treatment, develops new risk factors or has had a recent fracture. Please ask the technologist if you have any questions about your insurance coverage.

Directions

Coming from Summit/I-459 on 280 East, about 5 miles from I-459. Left on Hwy 119 – Cahaba Valley Rd. Right at first light – Greystone Way – then immediate left into the parking lot of St.Vincent's ***One Nineteen Health & Wellness Center*** building.

From Sylacauga and points south, travel on Hwy 280 West to Hwy 119 – Cahaba Valley Rd. Right on Hwy 119, the Right at first light – Greystone Way – then immediate left into the parking lot of St.Vincent's ***One Nineteen Health & Wellness Center*** building.

We are on the **2nd floor** of the Doctors' Wing of the Center: **Suite 204**