PATIENT FACE SHEET

Patient Name: _____

DOB: _____ Gender: Female Male

Race: African American Hispanic or Latino White Other

SSN: _____

Address: _____

_____

Marital Status Single Married Divorced Widowed

Employment Status Employed Unemployed Retired Disabled

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Emergency Contact:

Name: _____

Phone: _____

Relationship: _____

Primary Care Provider: _____

Pharmacy Name: _____

Location: _____

Phone: _____

Primary

Insurance: _____

Effective Date: _____

Policy Holder: _____

Policy Holder Date of Birth: _____

Relationship: _____

Secondary

Insurance: _____

Effective Date: _____

Policy Holder: _____

Policy Holder Date of Birth: _____

Relationship: _____

Group No: _____

Insured ID: _____

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

Southern Pain Specialists

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.

7500 Hugh Daniel Drive, Suite 360

Birmingham, Alabama 35242

Attention: Medical Records

(205) 995-9967

FAX: (205) 995-0635

(888) 436-4560

WWW.SOUTHERNPAIN.COM

Patient (or Guardian) Signature: _____

Southern Pain Specialists
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: _____

_____

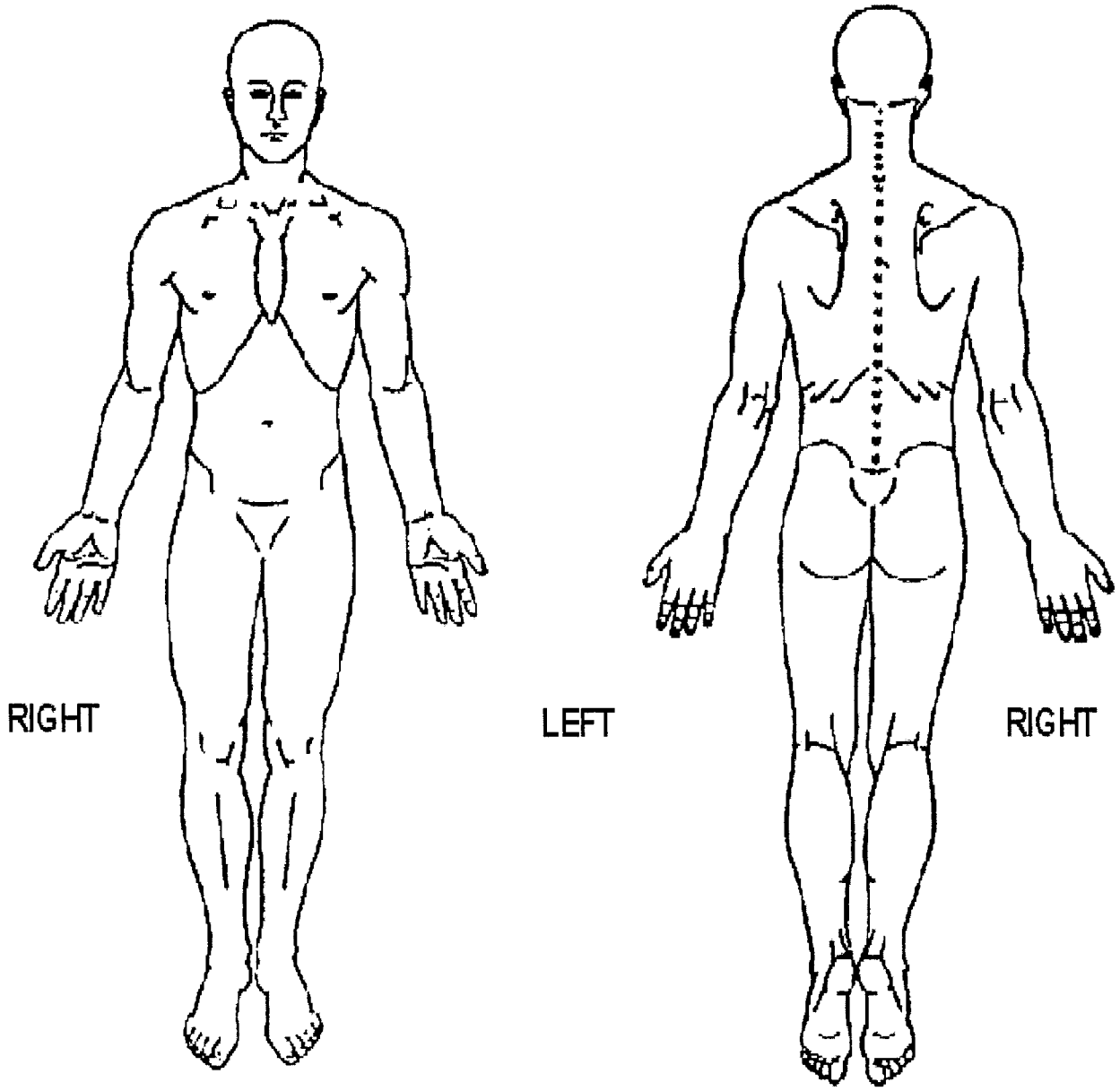
4. Is the pain the same now as it was when it began? ☐ SAME ☐ BETTER ☐ WORSE

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

OOOOO	Pins and Needles	//////////	Spasm: Tension Type
######	Dull Aching Pain	▽▽▽▽▽	Excruciating
●●●●●	Burning, sharp, shooting	======	Numbness
XXXXXX	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:

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

No Pain	*Mild Pain Annoyance*	*Pain Interferes With Normal Activities of Daily Living*	*Severe Nausea Dizziness*	*Unconscious Pain Makes You Pass Out*

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		Worse	Better	Same
Bending	☐	☐	☐	Lying Down	☐	☐	☐
Climbing Stairs	☐	☐	☐	Pressure	☐	☐	☐
Cold Weather	☐	☐	☐	Sex	☐	☐	☐
Coughing/Sneezing	☐	☐	☐	Shifting Position	☐	☐	☐
Exercise	☐	☐	☐	Sitting – prolonged time	☐	☐	☐
Bowel Movements	☐	☐	☐	Sleep, Rest	☐	☐	☐
Heat/Heating Pads	☐	☐	☐	Standing - prolonged time	☐	☐	☐
Hot Weather or Room	☐	☐	☐	Twisting/Turning	☐	☐	☐
Ice Packs	☐	☐	☐	Urination	☐	☐	☐
Liquor	☐	☐	☐	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	☐ Seizures, Convulsions	☐ TMJ Dysfunction
☐ Hypertension	☐ Asthma in the past year	☐ Thyroid Dysfunction
☐ Diabetes	☐ Strokes (CVAs)	☐ Interstitial Cystitis
☐ Bleeding Disorders	☐ Emphysema of the lungs	☐ Irritable Bowel / Crohn's Disease
☐ Kidney Failure; stones	☐ Stomach ulcer or duodenal ulcer	☐ 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 <u>not</u> 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