Advanced
PAIN CONSULTANTS

Welcome to Advanced Pain Consultants!

PATIENT INFORMATION

First Name: _____ **Last Name:** _____ **MI:** _____
Date of Birth: _____ **Age:** _____ **Social Security #:** _____

Race: ☐Black/African American
☐White/Caucasian
☐American Indian/Alaska Native
☐Asian
☐Hawaiian Native/Pacific Islander
☐Other: _____

Sex: ☐Male ☐Female
Marital Status: ☐Married ☐Single ☐Divorced ☐Separated
Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino
Pharmacy: _____
(location, phone, fax): _____

Address: _____
City: _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Cell Phone:** _____
Email: _____

PHYSICIAN INFORMATION

Who is your Primary Care Physician? _____ **Phone:** _____
Who is your Referring Physician? _____ **Phone:** _____

INSURANCE INFORMATION

Primary Insurance: _____ **Secondary Insurance:** _____

CONSENT

I hereby voluntarily consent to the necessary treatment for the care of the above named person for whom I am legally responsible.

Signature: _____ **Date:** _____

DO NOT WRITE BELOW THIS LINE: FOR OFFICE USE ONLY

BP: _____/_____ **Height:** _____ **Pulse:**_____ **Res:**_____ **Temp:**_____ **Weight:** _____**Pain level:** _____

Visit Notes:

FOLLOW-UP:

☐**Narcotic Agreement** ☐**SCS DVD**
☐**Refer to:** _____
☐**Send records to:** _____
☐**Receive records from:** _____
☐**Schedule appointment(s):**

☐ **With UDS**

INITIAL EACH WHEN COMPLETED:

____**Scanned Rx** ____**Rx sent** ____**Appt scheduled**
____**Vitals entered** ____**MU Dashboard** ____**FU scanned**
____**Note made** ____**Notes done** ____**$ collected:** _____
____**Notes faxed to:** _____ **Date faxed:** _____

☐**Zanaflex 2/4/8mg**
_____#_____**Refill:** _____
☐**Skelxin 800mg**
_____#_____**Refill:** _____
☐**Flexeril 10mg**
_____#_____**Refill:** _____
☐**Celebrex 200mg**
_____#_____**Refill:** _____
☐**Meloxicam 7.5/15mg**
_____#_____**Refill:** _____
☐**Topamax 25/50/100mg**
_____#_____**Refill:** _____
☐**Cymbalta 30/60mg**
_____#_____**Refill:** _____
☐**Gabapentin 300/600mg**
_____#_____**Refill:** _____
☐**Nortriptyliene 10/25mg**
_____#_____**Refill:** _____
☐**Trazadone 50/100mg**
_____#_____**Refill:** _____
☐**Lidoderm Patches 5%**
_____#_____**Refill:** _____
☐**DermaTram Cream**
_____#_____**Refill:** _____
☐**Other:**

CHRONOLOGICAL PAIN HISTORY

(Please answer the following questions to the best of your ability)

What is the reason for your visit? _____

_____

Where is your pain located? _____

How long have you had this pain? _____

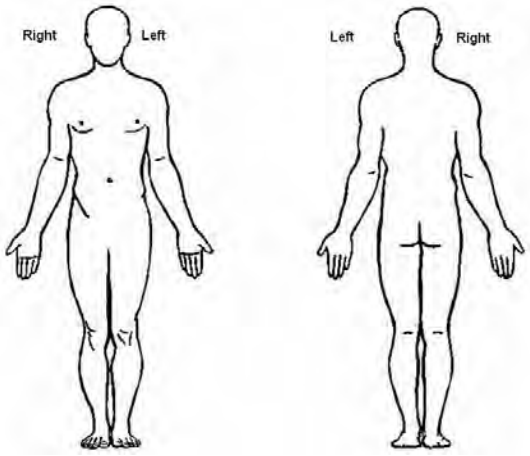
_____

What started your pain? *(If there was a specific event, please describe the circumstances of the injury/accident)*

_____

_____

DRAW BELOW IN THE LOCATION OF YOUR PAIN



VISUAL ANALOG PAIN SCALE

(Please place a mark along the line below to indicate your current pain level in relation to the two extremes.)

No Pain _____ **Worst Pain**

PAIN DESCRIPTORS

(Please circle any of the following words that describe your pain)

Burning
Painful Cold
Electric Shock
Tingling
Pins and Needles

Throbbing
Dreadful
Pulling
Dull

Agonizing
Sore
Sharp
Pressing

Numbness
Stabbing
Aching
Tender
Pulsing

Shooting
Nagging
Hurting
Nauseating

Is your pain: *(circle one)* **Continuous** ***OR*** **Intermittent** *(describe)* _____

_____

(Please circle any of the following words that make your pain worse)

Morning
Afternoon
Nighttime

Lying Flat
Sitting
Standing

Bending Forward
Leaning Back
Exercise

Physical Therapy
Resting
Bath/Shower

Heat
Ice

(Please circle any of the following words that make your pain better)

Morning
Afternoon
Nighttime

Lying Flat
Sitting
Standing

Bending Forward
Leaning Back
Exercise

Physical Therapy
Resting
Bath/Shower

Heat
Ice

ASSOCIATED SYMPTOMS

Do you have associated areas of numbness or tingling? *(Circle one)* **Yes *OR* No** *(If yes, where?)* _____

_____

Do you have associated areas of muscle weakness? *(Circle one)* **Yes *OR* No** *(If yes, where?)* _____

_____

Do you have associated skin changes? *(Circle one)* **Yes *OR* No** *(If yes, where?)* _____

_____

Have you had any recent bowel or bladder incontinence? *Circle one)* **Yes *OR* No** *If yes, where?)* _____

_____

PAST PAIN TREATMENTS

(Please indicate which treatments have you tried in the past)

Treatments	*Check if Tried*	*When? (Year)*	*Helpful? (Yes/No)*
Chiropractor			
Traction			
Braces			
Nerve Block			
Physical Therapy			
Hypnosis			
Acupuncture			
Biofeedback			
Ice/Heat			
Narcotics			
Massage			
Religious Counseling			
Psychological Counseling			
TENS			
Surgery			
Relaxation Training			
Other:			

Which treatment from the above list helped the most? _____

PAST MEDICATIONS

(Please circle all medicines below that you have tried in the past for your pain)

Elavil/amitiptyline
Pamelor/nortiptylene
Trazodone/desyrel
Effexor/venlafaxine
Cymbalta/duloxetine
Lexapro/escitalopram
Celaxa/citalopram
Motrin/ibuprofen
Aleve/naproxen
Lodine/etodolac
Celebrex/celecoxib
Relafen/nabumetone
Voltaren/diclofenac
Arthrotac
Neurontin/gabapentin
Lyrica/pregabalin
Topamax/topiramate
Trileptal/oxcarbazepine
Lamictal/lamotrigine
Gabatril/tigabine
Keppra/levetiracetam
Zonegran/zonisamide
Baclofen
Soma/carisoprodol
Robaxin/methocarbamol
Skelaxin/metaxalone
Felxeril/cyclobenzaprine
Zanaflex/Tizanidine
Lortab/Lorcet/Hydrocodone
Vicodin/Zydone
Darvocet/propoxyphene
Percocet/Tylox/oxycodone
Tylenol with codeine
Dilaudid/hydromorphone
MS Contin/Morphine ER
Avinza/Kadian
Oxycontin
Methadone
Duragesic/fentanyl patch
Ultram/Ultracet/tramadol
Lidoderm Patch

REVIEW OF SYMPTOMS

(Please Circle Any of the Following Conditions You Have Recently Experienced)

Weight Loss
Weight Gain
Recurrent Fevers
Visual Problems
Blurred Vision
Double Vision
Hearing Difficulty
Difficulty Swallowing
Congestion
Chest Pain
Irregular Heart Beat
Legs Swelling

Pain with Urination
Muscle Weakness
Muscle Aches
Joint Pain
Headaches
Memory Problems
Numbness
Loss of Consciousness
Impaired Balance
Dizziness
Heat Intolerance

Shortness of Breath
Chronic Cough
Coughing Up Blood
Nausea
Abdominal Pain
Constipation
Vomiting
Diarrhea
Blood in Stool
Urine Incontinence
Blood in Urine

Depressed Mood
Difficulty with Stress
Anxiety Attacks
Enlarged Lymph Nodes
Increased Bleeding
Easy Bruising
Skin Rash
Color Changes
Skin Irritations
Night Sweats
Cold Intolerance

BRIEF PAIN INVENTORY

Rate your pain by circling the number that describes how much pain you have RIGHT NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Possible

Rate your pain by circling the number that describes your pain at its LEAST in the last 24 hours:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Possible

Rate your pain by circling the number that describes your pain at its WORST in the last 24 hours:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Possible

Rate your pain by circling the number that describes your pain on AVERAGE:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Possible

Rate how your pain has interfered with your General Activity in the past 24 hours:

No Interference	0	1	2	3	4	5	6	7	8	9	10	Complete Interference

Rate how your pain has interfered with your Mood in the past 24 hours:

No Interference	0	1	2	3	4	5	6	7	8	9	10	Complete Interference

Rate how your pain has interfered with your Walking ability in the past 24 hours:

No Interference	0	1	2	3	4	5	6	7	8	9	10	Complete Interference

Rate how your pain has interfered with your Normal Work in the past 24 hours:

No Interference	0	1	2	3	4	5	6	7	8	9	10	Complete Interference

Rate how your pain has interfered with your Relations with other people in the past 24 hours:

No Interference	0	1	2	3	4	5	6	7	8	9	10	Complete Interference

Rate how your pain has interfered with your Sleep in the past 24 hours:

No Interference	0	1	2	3	4	5	6	7	8	9	10	Complete Interference

Rate how your pain has interfered with your Enjoyment of life in the past 24 hours:

No Interference	0	1	2	3	4	5	6	7	8	9	10	Complete Interference

PAST MEDICAL HISTORY

(Please indicate if you have been treated for any of the following conditions)

☐ Heart Failure	☐ Osteoarthritis	☐ Pneumonia	☐ Depression	☐ Prostate Disease
☐ Heart Attack	☐ Migraine	☐ Hepatitis	☐ Diabetes	☐ Rheumatoid Arthritis
☐ Emphysema	☐ Seizures/Epilepsy	☐ Kidney Disease	☐ Blood Clots	☐ Multiple Sclerosis
☐ Bronchitis	☐ Bipolar	☐ Fibromyalgia	☐ Heart Murmur	☐ Peripheral Neuropathy
☐ Kidney Stones	☐ High Blood Pressure	☐ Stroke	☐ Asthma	☐ Anxiety Disorder
☐ Thyroid Disease	☐ Irregular Heart Rhythm	☐ Memory Disorder	☐ Liver Disease	☐ Obesity

☐ Cancer: Type? _____ Date Last Treated: _____ ☐ Anticoagulation

☐ Other Conditions Not Listed Above: _____

PAST SURGICAL HISTORY

(Please list all surgical procedures you have had in the past below)

Procedure (Ex: Appendectomy)	***Date (Ex: September 2007)***

CURRENT MEDICATIONS

(Please list all medications you are currently taking below)

Medication	***Strength***	***Times/Day***	***Reason for Taking Medication***

ALLERGIES TO MEDICATIONS

(Please list all allergies you have to any medications below)

Drug (Ex: Aspirin)	***Reaction (Ex: Hives)***

CURRENT LIFESTYLE

(Check and List those that apply)

Do you smoke? ☐ Yes ☐ No ☐ Quit

If Yes: **How many packs/day: _____ Number of years: _____**

If Quit: **When? _____**

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit

If Yes: **How often: _____**

If Quit: **When? _____**

Have you ever abused Illegal Substances? ☐ Yes ☐ No (***If Yes, what type?)*** **_____**

Have you ever been treated for substance abuse? ☐ Yes ☐ No ***(If Yes, When?)*****_____**

Alcohol Use Disorders Identification Test (AUDIT)

Drinking alcohol can affect your health and may interact with medications you take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	Zero to two	Three or four	Five or six	Seven to nine	Ten or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Drug Abuse Screening Test (DAST-10)

Using drugs can affect your health and may interact with medications you take. Please help us provide you with the best medical care by answering the questions below.

Which recreational drugs have you used in the past year?

__Methamphetamines (speed, crystal) __Cocaine

__Cannabis (marijuana, pot) __Narcotics (heroin, oxycodone, methadone)

__Inhalants (paint thinner, aerosol, glue) __Hallucinogens (LSD, mushrooms)

__Tranquilizers (valium) __Other _____

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

BDI-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism
0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure
0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure
0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike
0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness
0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying
0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

Subtotal Page 1
Continued on Back

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San Diego • Philadelphia • Austin • Fort Worth • Toronto • London • Sydney

11. Agitation

0 I am no more restless or wound up than usual.

1 I feel more restless or wound up than usual.

2 I am so restless or agitated that it's hard to stay still.

3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.

1 I am less interested in other people or things than before.

2 I have lost most of my interest in other people or things.

3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.

1 I find it more difficult to make decisions than usual.

2 I have much greater difficulty in making decisions than I used to.

3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.

1 I don't consider myself as worthwhile and useful as I used to.

2 I feel more worthless as compared to other people.

3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.

1 I have less energy than I used to have.

2 I don't have enough energy to do very much.

3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.

1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.

2b I sleep a lot less than usual.

3a I sleep most of the day.

3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.

1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.

2b My appetite is much greater than usual.

3a I have no appetite at all.

3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatigued to do a lot of the things I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

3 4 5 6 7 8 9 10 11 12 A B C D E

_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score

Advanced
PAIN CONSULTANTS

Patient Financial Policy

Thank you for choosing Advanced Pain Consultants! We are committed to providing outstanding patient care to you and your family members. Before we provide medical services, we require that you review our financial policies and agree in writing to accept them.

1. **Current information**
   We ask that you notify our staff of all changes in your patient information, such as insurance, benefits, employer, patient name, home address, and/or contact numbers. You will be asked to present your current insurance cards at each appointment. Please help us and give accurate information.
2. **Payment at Time of Service**
   If you are a self- pay patient or your insurance information cannot be verified prior to your appointment, you will be required to pay in full at the time of service. If your insurance plan requires payment of an annual deductible and/or co-insurance (i.e 8/20 plans), payment will be calculated and due at check-out.
3. **Claims Filing**
   As a courtesy to our patients, we file claims with your insurance company and also coordinate benefits with secondary payers. You will be responsible for timely payment of any patient balances as directed by your insurance. You will also be responsible in the event that the claim is disputed.
4. **Patient Billing and Collections**
   Patients that receive a statement from our office are expected to remit full payment upon receipt. If your account must be referred to an outside collection agency for non-payment, you may be responsible to pay a fee to cover the cost charged by the outside collection agency. Patients in collections must make payment arrangements prior to scheduling additional appointments.
5. **Failure to Keep Appointment "No Shows"**
   Please notify our office if you cannot keep your appointment. "No Shows" will be charged a fee of $25.00, which is not payable from your insurance carrier.
6. **Returned Checks and Fees**
   A returned check from any patient will be charged a $35.00 fee, to the extent permitted by law. From there on payment will need to be made in cash or by credit card or money order
7. **Assignment of Benefits**
   I authorize direct remittance of payment of all insurance benefits to Advanced Pain Consultants for all covered medical services and supplies provided to me during all courses of treatment and care provided by Advanced Pain Consultants and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Advanced Pain Consultants, and will constitute a continuing authorization, maintained on file with the Advanced Pain Consultants authorize and allow for direct payment to Advanced Pain Consultants of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies, and/or care provided to me by Advanced Pain Consultants.
8. **Authorization to Release Information**
   I authorize the release of any medical or any other information to my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Advanced Pain Consultants. A copy of this authorization will be sent to my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by Advanced Pain Consultants.

_____ _____

Patient Signature **Date**

_____

Print Name

Advanced
PAIN CONSULTANTS

HIPPA PRIVACY AUTHORIZATION
FOR USE AND DISCLOSURE OF PRIVATE HEALTH INFORMATION

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Numbers: (Please List Below) **<u>Can messages be left?</u>**

Home: _____ **Yes _____ No _____**

Work: _____ **Yes _____ No _____**

Cell: _____ **Yes _____ No _____**

Name of Designated Relative: _____

Relationship: _____ Phone Number: _____

Name of Designated Relative: _____

Relationship: _____ Phone Number: _____

This notice was initially published and became effective on April 14, 2003. We are required by law to maintain the privacy of our patients and provide individuals with this notice of our legal duties and privacy practices with respect to the protected health information. If you have any question regarding these forms, please feel free to ask to speak with our HIPPA Compliance Officer. Your signature below acknowledges that you give permission to release information to insurance companies, pharmacies, and other doctors. Your signature also authorizes that anything you request be released, may be picked up by the above listed person.

_____
Patient's Signature

_____
Patient's Printed Name

_____
Date