



**INTERVENTIONAL PAIN**  
CONSULTANTS

**PATIENT INFORMATION SHEET**

<b>Today' s Date:</b> _____		<i>Patient Date of Birth:</i>	
<i>Patient First Name:</i>		<i>Patient Last Name:</i>	
<i>Social Security #:</i>		<i>Previous Last Name/Nick Name:</i>	
<i>Gender:</i>		<i>Marital Status:</i>	
<i>Mailing Address:</i>			
<i>Street Address (If different from mailing address):</i>			
If Patient resides in Skilled Nursing Facility, what is the name of the facility?			
If Patient is a Hospice patient, what is the name of the Hospice Service?			
<i>Patient's Primary Care:</i>		<i>Referring Provider:</i>	
<i>PCP Phone Number:</i>		<i>Referring Provider Phone #:</i>	

**Emergency Contact Information**

<i>Contact Name:</i>
<i>Phone Number:</i>
<i>Relationship to Patient:</i>

*I wish to be contacted in the Following Manner*

<i>Home Telephone:</i>	<input type="checkbox"/> (Extended) OK to leave message with Detailed information <input type="checkbox"/> (Brief) Leave message with Call back number only
<i>Cell Phone:</i>	<input type="checkbox"/> (Extended) OK to leave message with Detailed information <input type="checkbox"/> (Brief) Leave message with Call back number only
<i>Work Telephone:</i>	<input type="checkbox"/> (Extended) OK to leave message with Detailed information <input type="checkbox"/> (Brief) Leave message with Call back number only

<i>Email Address:</i>
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<i>Primary Language:</i> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Japanese <input type="checkbox"/> Chinese <input type="checkbox"/> Other
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<i>Race: (This is now a requirement for us to have on file and only used for medical purposes)</i>	
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> White/Caucasian
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native American or other Pacific Island
<input type="checkbox"/> Asian	<input type="checkbox"/> Refuse to report
<input type="checkbox"/> Hispanic or Latin	

<i>Patient Name:</i> _____	<i>Date of Birth:</i> _____
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### Employment Information

<i>Employer Name:</i> _____	<i>Employer's Phone #:</i> _____
<i>Employment status:</i> ___ Full Time ___ Part time ___ Retired	

*Is this a worker's comp or auto insurance claim?* \_\_\_ Yes \_\_\_ No *If yes, please answer the following questions:*

*Company Name:* \_\_\_\_\_ *Claim Number:* \_\_\_\_\_

*Contact Person:* \_\_\_\_\_ *Contact Person's Phone Number:* \_\_\_\_\_

*Date of Injury:* \_\_\_\_\_

### Insurance Information

<i>PRIMARY Insurance:</i>		
<i>Insurance ID:</i> _____	<i>Copay:</i> _____	
<b><i>If Policy Holder is other than SELF please complete below information regarding the Policy Holder</i></b>		
<i>Policy Holders Name:</i> _____	<i>DOB:</i> _____	<i>Gender:</i> _____
<i>Social Security Number:</i> _____		
<i>Policy Holders Address:</i> _____	<i>City:</i> _____	<i>State:</i> _____
<i>Policy Holders Home Number:</i> _____		
<i>Policy Holders Employer Name:</i> _____	<i>Work phone number:</i> _____	
<i>Policy Holders Relationship to Patient:</i> _____		

<i>SECONDARY Insurance:</i>		
<i>Insurance ID:</i> _____	<i>Copay:</i> _____	
<b><i>If Policy Holder is other than SELF please complete below information regarding the Policy Holder</i></b>		
<i>Policy Holders Name:</i> _____	<i>DOB:</i> _____	<i>Gender:</i> _____
<i>Social Security Number:</i> _____		
<i>Policy Holders Address:</i> _____	<i>City:</i> _____	<i>State:</i> _____
<i>Policy Holders Home Number:</i> _____		
<i>Policy Holders Employer Name:</i> _____	<i>Work phone number:</i> _____	
<i>Policy Holders Relationship to Patient:</i> _____		

#### **Consent for Insurance Assignment/Payment:**

I hereby authorize the assignment of benefits (payments) directly to Interventional Pain Consultants for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

**Signature of Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*(Authorization will remain in effect from date signed until revoked in writing by patient or patient representative)*

## Interventional Pain Consultants

*Patient Name:* \_\_\_\_\_

*Date of Birth:* \_\_\_\_\_

### Acknowledgement of Receipt of HIPAA Notice

Interventional Pain Consultants is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary. I acknowledge that I have received the Notice of Privacy Practices for: Interventional Pain Consultants

\_\_\_\_\_  
Signature of Patient or Legal guardian

\_\_\_\_\_  
Date

### Authorization To Discuss Your Medical Information

In accordance with the HIPAA guidelines this practice is authorized to discuss my medical information with the following individuals. Please list up to 3 people we may leave messages with in the event we are unable to contact you.

HIPAA Authorized Person's Name

Relationship to patient

Telephone Number


Do you utilize a transportation service? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, do you authorize IPC to give information regarding dates/times of appointments to this service? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have a medical Power of Attorney? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, please provide a copy for our records

\_\_\_\_\_  
Signature of Patient or Legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient if Not Patient



## AUTHORIZATION FOR COMMUNICATION

Patient Name:		Date of Birth:
Email Address:	Cell Phone # :	Home Phone # :

Our goal at IPC is to develop an environment of open communication and shared decision making with our patients. Having the ability to reach you regarding your treatment, your appointments and account, and how we can better serve you is very important to your overall care. In today's busy world, being able to reach patients via text and email allows us to be more agile and reach out more quickly and efficiently. It allows us to personalize our messaging to you and give you information that can help you live well. To make certain that we are using your personal information with your authorization, IPC keeps on file a copy of your written permission. Please take a minute to complete this form.

- I acknowledge and give my expressed consent to IPC to contact me by email to the email(s) I have provided with information that may include, but is not limited to, general health and well-being, changes to, and clarifications regarding company policies, procedures and services, and information, changes and documentation regarding my account. I understand that I have the right to opt-out of future emails at any time. I understand that opting out of emails may affect the timing and scope of content of information I receive from IPC.
- I acknowledge and agree that IPC and any of their affiliates or vendor thereof involved my care or the management of my account, including patient survey partners and billing or collection companies, may contact me by telephone or text message to any telephonic number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as an automated telephone dialing system (ATDS) or prerecorded message. I also agree that I will notify IPC if I have given up ownership or control of any such telephone number.

If the above permissions are given, I understand that:

- This authorization is voluntary. My treatment will not be impacted if I sign this authorization or not.
- Your privacy is very important to us. IPC will abide by all regulations protecting patient health information and will not communicate patient-specific treatment information via unsecured email or text.
- The option to opt-out of any future email is included with any email.
- If I do not sign this authorization, IPC will not disclose my health information as requested.
- This authorization will end only when the use and disclosure of my information is no longer needed for the purposes agreed to above. I may revoke this authorization by mailing or faxing a written request along with a copy of the original authorization to the clinic.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

- I do not consent – ***If you do not consent to additional information, then we will only communicate with you about your personal medical information via phone, fax, or email***

Medical Records Request

<i>Patient Name:</i> _____	<i>Date of Birth:</i> _____
<i>Patient's Address:</i> _____	<i>Telephone Number:</i> _____
<i>Last 4 digits of SS#:</i> _____	

Please "Print" and complete all sections to insure your request is processed in a timely manner

FAX RECORDS TO: \_\_\_\_\_  
\_\_\_\_\_

PURPOSE OF DISCLOSURE: Continuity of Care

I authorize \_\_\_\_\_ to release or disclose to the above-named entity all of my medical records, including any specially protected records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle-cell anemia, or HIV infection for the purpose of medical treatment. If you Do Not Want certain portions of your medical records released, please read this section carefully and identify the information you do not want released below:

Please check all that apply:     Past Dates of Service     Present Dates of Service     Future Dates of Service

- \* I understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by Intervetional Pain Consultants or its physicians, employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to Interventional Pain Consultants.
- \* I understand that I am not required to sign this Authorization. Interventional Pain Consultants will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.
- \* I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit Interventional Pain Consultants or its physicians', employees' or agents' ability to use or disclose my information for treatment, payment, or health care operations, or as otherwise permitted by law.
- \* I authorize IPC to request records pertinent to my treatment from providers and other healthcare entities, as needed, within the time this authorization is valid. This Authorization will expire a year from date of signature.

Patient or Authorized Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to the patient (If not signed by patient): \_\_\_\_\_

Power of Attorney Provided? \_\_\_\_\_ Photo ID verified: \_\_\_\_\_ Scanned by (initials): \_\_\_\_\_

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Specific Records Needed (to be completed by the provider/nurse):

- MRI of \_\_\_\_\_
- Operative Report \_\_\_\_\_
- CT of \_\_\_\_\_
- Xray of \_\_\_\_\_
- Other \_\_\_\_\_
- Discharge Letter
- Recent Progress Notes

## Interventional Pain Consultants

Patient Name:

Date of Birth:

### Financial Policy

#### **Our office can no longer accept cash from self-pay patients per State guidelines**

We are pleased that you have chosen our practice for your pain management needs. We are committed to providing you with the highest quality care and achieving desired outcomes through collaborative effort. We would like to take this opportunity to thank you for allowing us to take care of you. In keeping with our philosophy of open communication and education, it is important that you understand the financial policies of the practice. It is equally important that you understand the terms of YOUR medical coverage. Although our staff is very knowledgeable of most insurance plans, it is important that you understand the details and terms of your personal plan. Typically you will find the insurance company's phone number on the back of your insurance card and we encourage you to contact them with questions specific to YOUR coverage.

#### **If you have Medical Insurance Benefits:**

- If you have an insurance plan that requires a referral, you must contact your Primary Care Physician **PRIOR** to receiving care from a specialty provider. Regrettably, many insurers will not cover specialty services that are rendered without a referral and you may be held responsible for the costs. If we do not have a referral on file, we will not be able to render services.
- We participate in most major health plans and our business office will submit claims for services rendered. It is the patient's responsibility to provide all necessary information to file the claims prior to leaving our office. We will file your primary and secondary insurance claims and work diligently with the carrier to resolve any conflicts that may arise. However, your insurance company may need you to supply certain information directly. It is your responsibility to comply with this request.
- Please bring your insurance cards to **EACH** and **EVERY** visit to our office.
- Your insurance company **REQUIRES** us to collect co-payments at the time services are rendered. Failure to collect or waiver of your co-payment may constitute fraud under state and federal law. Please be prepared to pay your co-payment on the date services are rendered as this is a requirement per your insurance carrier. If you do not have your co-payment, we are not required to see you.
- Additionally, you may have coinsurance and/or deductible amounts required by your insurance carrier. Any outstanding balance on your account following insurance processing will be billed to you.
- It is the policy of the practice to treat **ALL** patients in an equitable fashion related to account balances. The practice will **NOT** waive or fail to collect any co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law as well as participating agreements with payers. Full or partial financial responsibility may only be waived in accordance with the practice's Financial Hardship Policy.
- Your insurance carrier may also pay you directly, if your clinic is out of network, as a patient, you are responsible for bringing in the payment and the Explanation of Benefit (EOB) from your insurance company.

#### **Patient Balances:**

- Any patient balances that remain delinquent after 90 days, with no response to requests, payment, may be referred to a collection agency. You will be responsible for any and all costs associated with the collection agency up to and including all legal costs.
- Patients with account balances in excess of 120 days with no payment arrangements or hardship request may be discharged from the practice. If this occurs you will have 30 days to seek alternative medical care. During the 30 day period our physicians will only be able to treat you on an emergency basis.
- For your convenience, our office accepts the following payment methods:  
Money order --- Check --- Cashier's Check --- Cash --- Credit Card  
(Except self-pay patients: Cashier's Check, Check or credit card only can be accepted for payment per state regulations)
- Returned checks will be charged a \$40.00 fee.

#### **PLEASE READ THE FINANCIAL POLICY CAREFULLY BEFORE SIGNING**

I, the undersigned, understand the financial policies of Interventional Pain Consultants, and agree to abide by the plan I have signed. In addition, I understand and agree to the following.

- To pay the amount charged by Interventional Pain Consultants for all professional treatment and services to the undersigned.
- I understand that I am financially responsible for any and all charges whether or not they are covered by insurance. In the event that I do not pay all costs of collection and reasonable legal fees in addition to the amount originally owed.

If genuine financial difficulties exist, please call our office. We are happy to work with you in resolving your balance and may be able to set up payment arrangements.

\_\_\_\_\_  
(Signature of Patient, or Personal Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient if not signed by Patient

\_\_\_\_\_  
ID Verified by

\_\_\_\_\_  
Date

## Interventional Pain Consultants

Patient Name:

Date of Birth:

### Treatment Agreement

This agreement must be reviewed and signed in order to proceed with narcotic and/or non-narcotic treatment with Interventional Pain Consultants. The agreement is required to comply with the law regarding controlled pharmaceuticals and to prevent any misunderstandings about any treatments you receive.

Please **initial** at the bottom of this page and sign page 2 to indicate that you have read and/or have had the information explained to you.

- I agree to submit to a blood, urine or saliva test, if requested by my Provider, to determine compliance with my program of pain medication.
- I understand that my first office visit may be a consultation only and no pain medication given at that time if further investigation and/or testing are deemed necessary.
- I understand that I may be called at any time to bring all prescribed medication for a mandatory pill count within a specified time period (usually 24 hours).
- I understand that I am to bring my medications prescribed by IPC in their original bottles to **EVERY** appointment. I am to bring the bottle even if it is empty.
- I agree that I will use my medications **ONLY** as prescribed by my doctor. I understand that any change to my prescriptions will require an office visit. I understand that self-medicating is not tolerated. No refills will be made during evenings or weekends.
- I will not use any illegal substances, including marijuana, cocaine, etc.
- I understand that lost or stolen medication or unfilled prescriptions **WILL NOT** be replaced, and I will safeguard my medication from theft.
- **I understand that I will follow the guidelines on properly disposing of controlled substances that will be explained to me by clinical staff.**
- I will not share, sell or trade my medications with anyone.
- I will not alter the form of the medication nor will I take the medication in a route other than as prescribed by my provider.
- I will not attempt to obtain controlled medication from any other provider, nor will I borrow or buy medication from any other person.
- In the event of an emergency, if I do obtain controlled substances from another provider, I understand I am required to disclose this information to IPC within 48 hours of discharge or emergency service. I understand it is my responsibility to make sure IPC is notified of any such treatments and that I am to check with IPC before combining any pain medication with the prescriptions IPC provides me.
- I will notify IPC of any change in name, address or phone number. I understand that I must at all times have an updated phone number with my provider. I cannot be on dangerous medications, such as opioids, if my provider cannot reach me in a reasonable period of time (usually considered within 24 hours of the initial attempt). I agree to return any phone call from IPC within 24 business hours.
- I authorize my provider to investigate fully any possible misuse of my pain medication using any city, state or federal law enforcement agency, including this state's Board of Pharmacy.
- I understand that any follow-up appointment may be scheduled with a Licensed Nurse Practitioner or Physician Assistant. Additionally I understand that refusing to see one of IPC providers will likely result in my no longer being able to be treated by the practice.
- Once a prescription has been filled, all questions regarding that prescription should be directed to that pharmacy.
- I understand that IPC does not mail narcotic prescriptions under any circumstances.

Initials\_\_\_\_\_

<i>Patient Name:</i>	<i>Date of Birth:</i>
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**Treatment Agreement (continued)**

- ✓ I understand that with any controlled substance that is prescribed to me there are inherent risks, namely
  - loss of efficacy over time, symptoms of withdrawal if abruptly stopped, and addiction;
  - medication taken in excess (this is different for everyone – ranging from the prescribed dose to taking more than prescribed or combining with other controlled substances or even alcohol) may result in respiratory suppression or failure or death;
  - sedation, loss of function, impairment may also occur – I agree not to drive while under the influence of any prescribed controlled substance;
  - constipation, allergic reaction, itching, nausea and dry mouth are also common side effects;
  - my immune system may be suppressed and my hormone levels may decrease over time while being on chronic opioids.
- ✓ I understand that the combination of controlled substances and alcohol are contra-indicated; the combination may result in serious harm or even death.
- ✓ I understand that non-professional or inappropriate behavior toward any IPC staff, affiliate or provider will not be tolerated. I agree to be respectful to other patients I may encounter in the waiting room, lobby, hallways, etc. I understand that I may not loiter in the parking lot of any IPC location.
- ✓ I understand that there may be a medication prescribed or administered to me that is a “compounded” medication – these are compounded by specialty pharmacies and are regulated differently than typical medications found stocked on shelves at commercial pharmacies. If I have questions regarding any of these, IPC is able to provide pharmacy information upon request.
- ✓ I understand that IPC providers utilize tests to determine the best option for my care. My unwillingness to complete the tests requested may result in being released from further care with IPC.
- ✓ I understand that non-compliance with my pain management treatment plan may result in providers’ inability to properly treat my symptoms and could cause symptoms to worsen or become life threatening.
- ✓ I understand that I may be released from IPC for missing appointments or cancelling/rescheduling appointments with less than 24 hour notice.

I agree that the goals of pain management have been explained to me as to what is considered appropriate and reasonable and that alternative treatment plans, outside of use of controlled pain medications, have been made available to me. I have agreed to proceed with pain management after a full explanation of the risks and benefits. I understand if I break this agreement, it will result in a change in my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the provider/patient relationship.

**I understand that I am only to use the pharmacy listed below for all my medication needs with IPC or any other provider and that information will be shared between IPC and my pharmacy to process the prescription:**

<i>Pharmacy Name:</i>	<i>Phone Number:</i>
<i>Pharmacy Location:</i>	

**I have read and/or this information has been explained to me and I understand the terms of this agreement:**

Signature of Patient or Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient if not signed by patient: \_\_\_\_\_ Date: \_\_\_\_\_



<i>Patient Name:</i>	<i>Date of Birth:</i>
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Please tell us the first and last name of your Referring Provider: \_\_\_\_\_

Please tell us the first and last name of your Primary Care Provider: \_\_\_\_\_

**If you are a Female, please tell us your pregnancy status:**     Hysterectomy     Post-Menopausal     Not able to get pregnant  
 Child-Bearing Age-No Contraception     Child-Bearing Age-Birth Control Medication     Child-Bearing Age-Other Contraception

**Where is the location of your pain:** \_\_\_\_\_

**When did your pain first begin, please tell us month and year if known?** mm/yyyy \_\_\_\_\_

**What is the main cause of your pain?**     Unknown     Normal aging     Fall     Sporting accident  
 Motor vehicle accident     Work injury

**What is the frequency of your pain?**     Constant     Fluctuating but always present     Fluctuating but usually present  
 Fluctuating and rarely present

**What best describes your pain?**     Aching     Burning     Cramping     Dull     Numb  
 Sharp     Stabbing     Stinging     Throbbing     Tingling

**What is your pain level most of the time?**  
 0- No Pain     1     2     3     4     5     6     7     8     9     10-Unbearable Pain

**What makes your pain worse?**     Bending or stooping     Changing from sitting to standing     Sitting  
 Lifting or carrying heavy loads     Lifting or carrying small loads     Lying on back  
 Lying on side     Nothing

**What makes your pain better?**     Lying on side     Lying on my back     Sitting     Standing  
 Walking     Stretching     Exercise     Nothing

**What does your pain interfere with?**     Daily chores     Employment     Exercise     Grooming     House Chores  
 Mood     Sleep     Relationships     Walking     Nothing

**Have you had any of the following Imaging/Tests to assist in the evaluation of your pain?**

MRI:     No     Yes    Xray:     No     Yes  
Ct Scan:     No     Yes    EMG/Nerve Conduction:     No     Yes

**Have you ever had Genetic Testing done for medication response?**     No     Yes

**Have you had any of the following to assist in the evaluation of your pain?**

Blood work completed in the past year     Bone Density     Functional Capacity Evaluation  
 Drug Screening     Ultrasound     Depression Screening  
 Bone Scan     Vascular Studies

**Have you had any of the following injections to assist with the treatment of your pain?**     Spinal     Joint     Muscle     Botox     None

**Have you had any of the following related to your pain?**     Back Brace     Neck Brace     Tens Unit     Knee Brace     None

**Have you had any of the following Surgeries?**     Low Back     Mid Back     Neck     Hip     Knee     Shoulder     None

**Have you tried any of the following therapies to assist with treatment of your pain?**

Physical Therapy     Chiropractic Therapy     Aquatic Therapy     Occupational Therapy     None

**Have you had or done any of the following to assist with the treatment of your pain?**

Spinal Cord Stimulator     Spinal Traction     Cane     Walker     Exercise Program     Weight loss Program     Intrathecal Pain Pump

<i>Patient Name:</i>	<i>Date of Birth:</i>
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**LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (Add additional page if needed):**

MEDICATION	DOSAGE	INSTRUCTIONS

**If you have tried any of the Anti Inflammatory Medications below, were they helpful or not helpful?** or please mark  None tried

Aspirin:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Vimovo	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Celebrex (Celecoxib):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Ketoprofen:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Diclofenac:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Mobic (Meloxicam):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Daypro:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Naproxen (Aleve/Naprosyn):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Etodalac(Lodine):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Relafen:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Ibuprofen(Motrin,Advil):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Toradol:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Indomethacin(Indocin):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Duexis:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful

**If you have tried any of the Muscle Relaxer Medications below, have they been helpful or not helpful?** or please mark  None tried

Baclofen:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Norflex:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Cyclobenzaprine(Flexeril):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Parafon Forte (Lorzone):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Carisoprodol(Soma):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Skelaxin (Metaxalone):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Diazepam(Valium):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Tizanidine(Zanaflex):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Methocarbamol(Robaxin):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful			

**If you have tried any of the Narcotic Medications below, have they been helpful or not helpful?** or please mark  None tried

Avinza:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Oxycontin:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Codeine:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Oxycodone (Percocet,Roxicodone,OxyIR):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Duragesic:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	MSIR:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Dilaudid(Hydromorphone):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Methadone:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Hydrocodone (Lortab,Lorcet,Norco):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Morphine ER (MS Contin, Avinza, Kadian):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Kadian:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Tramadol(Ultracet):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Opana:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful			

**If you have tried any of the "Other" Medications below, have they been helpful or not helpful?** or please mark  None tried

Cymbalta:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Lyrica:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Clonidine:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Neurontin:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Elavil(Amitriptyline):	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Savella:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Keppra:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Topamax:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Klonopin:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Trileptal:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful
Lidoderm Patch:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful	Zonegran:	<input type="radio"/> Helpful	<input type="radio"/> Not Helpful

**Allergies/Intolerance:**  Penicillin  Sulfa  IV Dye/Contrast  NKDA List other: \_\_\_\_\_

**Have you tried any Over the Counter Medications such as BioFreeze, IcyHot, Bengay, Aspercreme?**  No  Yes

**Have you ever tried Prescription Creams such as EMLA Cream, Voltaren Gel, etc for your pain?**  No  Yes

<i>Patient Name:</i>	<i>Date of Birth:</i>
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**Have you ever tried a Compounded Pain or Scar cream from a specialty pharmacy?**  No  Yes

**Past Medical History (please check all disease or disorders you have had):**

- |  |   |                                     |                                      |   |                                  |
|--|---|-------------------------------------|--------------------------------------|---|----------------------------------|
| <input type="radio"/> Migraine headaches       | <input type="radio"/> High blood pressure     | <input type="radio"/> Emphysema     | <input type="radio"/> Cirrhosis      | <input type="radio"/> Kidney disorder   | <input type="radio"/> Cancer     |
| <input type="radio"/> Head injury              | <input type="radio"/> High cholesterol        | <input type="radio"/> Asthma        | <input type="radio"/> Hepatitis      | <input type="radio"/> Prostate disorder | <input type="radio"/> Depression |
| <input type="radio"/> Stroke                   | <input type="radio"/> Coronary artery disease | <input type="radio"/> Sleep apnea   | <input type="radio"/> Gallbladder dz | <input type="radio"/> Osteoporosis      | <input type="radio"/> Anxiety    |
| <input type="radio"/> Seizures                 | <input type="radio"/> Heart attack (MI)       | <input type="radio"/> Hiatal hernia | <input type="radio"/> Pancreatitis   | <input type="radio"/> Spine disorder    | <input type="radio"/> Alcoholism |
| <input type="radio"/> Multiple Sclerosis       | <input type="radio"/> Heart arrhythmia        | <input type="radio"/> Reflux        | <input type="radio"/> Diabetes       | <input type="radio"/> Arthritis OARA    | <input type="radio"/> Addiction  |
| <input type="radio"/> Peripheral nerve disease |   | <input type="radio"/> Ulcers        | <input type="radio"/> Bowel disease  | <input type="radio"/> Muscle disorder   |                                  |

**Past Surgical History (please list all surgeries you have had):**

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**Family Medical History (please check all disease or disorders your family has had):**

- |  |   |                                     |                                      |   |                                  |
|--|---|-------------------------------------|--------------------------------------|---|----------------------------------|
| <input type="radio"/> Migraine headaches       | <input type="radio"/> High blood pressure     | <input type="radio"/> Emphysema     | <input type="radio"/> Cirrhosis      | <input type="radio"/> Kidney disorder   | <input type="radio"/> Cancer     |
| <input type="radio"/> Head injury              | <input type="radio"/> High cholesterol        | <input type="radio"/> Asthma        | <input type="radio"/> Hepatitis      | <input type="radio"/> Prostate disorder | <input type="radio"/> Depression |
| <input type="radio"/> Stroke                   | <input type="radio"/> Coronary artery disease | <input type="radio"/> Sleep apnea   | <input type="radio"/> Gallbladder dz | <input type="radio"/> Osteoporosis      | <input type="radio"/> Anxiety    |
| <input type="radio"/> Seizures                 | <input type="radio"/> Heart attack (MI)       | <input type="radio"/> Hiatal hernia | <input type="radio"/> Pancreatitis   | <input type="radio"/> Spine disorder    | <input type="radio"/> Alcoholism |
| <input type="radio"/> Multiple Sclerosis       | <input type="radio"/> Heart arrhythmia        | <input type="radio"/> Reflux        | <input type="radio"/> Diabetes       | <input type="radio"/> Arthritis OARA    | <input type="radio"/> Addiction  |
| <input type="radio"/> Peripheral nerve disease |   | <input type="radio"/> Ulcers        | <input type="radio"/> Bowel disease  | <input type="radio"/> Muscle disorder   |                                  |

**What is your marital status?**  Single  Married  Separated  Divorced  Widowed

**Who resides in your same home and or assists in your care if needed?**  Alone  Friend  Spouse  Children

Parents  Skilled Nursing Facility  Hospice Care

**What is your employment status?**  Employed Full time  Employed Part time  Unemployed  Retired  
 Short Term disability  Long Term Disability

**Smoking Status:**  Current smoker  Former smoker  Nonsmoker  Current every day smoker  Current some day smoker

**Alcohol use:**  None  Rarely  Occasionally  Regularly

**Do you have any street drug use?**  Yes  No

**Review of Systems: Please mark each of the following symptoms/problems that you currently have (Mark all that apply)**

<b><u>General</u></b>	<b><u>HEENT</u></b>	<b><u>Respiratory</u></b>	<b><u>Cardiology</u></b>	<b><u>Gastroenterology</u></b>
<input type="radio"/> Weight loss	<input type="radio"/> Headache	<input type="radio"/> Chronic cough	<input type="radio"/> Chest pain (angina)	<input type="radio"/> Appetite loss
<input type="radio"/> Weight gain	<input type="radio"/> Facial pain	<input type="radio"/> Wheezing	<input type="radio"/> Murmur	<input type="radio"/> Chronic nausea
<input type="radio"/> Fever	<input type="radio"/> Sinusitis	<input type="radio"/> Shortness of breath	<input type="radio"/> Congestive failure	<input type="radio"/> Heartburn
<input type="radio"/> Night sweats	<input type="radio"/> Loss of vision	<input type="radio"/> Sleep apnea	<input type="radio"/> Abnormal EKG	<input type="radio"/> Constipation
<input type="radio"/> Fatigue	<input type="radio"/> Hearing loss	<input type="radio"/> Home oxygen use		<input type="radio"/> Diarrhea
<input type="radio"/> Many infections	<input type="radio"/> Teeth/gum problems	<input type="radio"/> C-PAP		<input type="radio"/> Bowel control loss
<b><u>Genitourinary</u></b>	<b><u>Endocrine/Hematological</u></b>	<b><u>Musculoskeletal</u></b>	<b><u>Neurology</u></b>	<b><u>Psychiatric</u></b>
<input type="radio"/> Painful Urination	<input type="radio"/> Abnormal blood sugars	<input type="radio"/> Joint pain	<input type="radio"/> Drowsiness	<input type="radio"/> Panic attacks
<input type="radio"/> Blood in urine	<input type="radio"/> Easy bruising/bleeding	<input type="radio"/> Muscle spasm	<input type="radio"/> Dizziness	<input type="radio"/> Insomnia
<input type="radio"/> Bladder control loss		<input type="radio"/> Neck pain	<input type="radio"/> Blackouts	
<input type="radio"/> Enlarged prostate	<b><u>Vascular</u></b>	<input type="radio"/> Back Pain	<input type="radio"/> Tremors	<b><u>Skin</u></b>
<input type="radio"/> Testicular pain	<input type="radio"/> Poor circulation		<input type="radio"/> Numbness	<input type="radio"/> Rash
<input type="radio"/> Irregular bleeding	<input type="radio"/> Current blood clot			
<input type="radio"/> Pregnancy	<input type="radio"/> Swelling in legs			

**Preventative Medicine: Falls Risk Screening: If you are 65 or older, please check all that apply to you**

- |  |  |
|--|--|
| <input type="radio"/> No Falls in the past year                      | <input type="radio"/> One Fall without injury in the past year                         |
| <input type="radio"/> One Fall with injury in the past year          | <input type="radio"/> Two or More Falls without injury without injury in the past year |
| <input type="radio"/> Two or more falls with injury in the past year |  |

## Interventional Pain Consultants

Today's Date: \_\_\_\_\_

*Patient Name:*

*Date of Birth:*

**Please tell us the location of your pain and any numbness you are currently experiencing.**

Draw small X's where your pain is located.

Draw small O's where any numbness is located.

