NEW PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Address: _____ City/State: _____Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SSN: _____ Date of Birth: _____ Male _____ Female _____

Employer: _____ Occupation: _____E-Mail: _____

Emergency Contact: _____Relationship: _____Phone: _____

Referring Physician: _____Primary Care Physician: _____

Marital Status: Married ____ Divorced _____ Widowed _____ Single _____ Separated _____

Spouse's Name: _____Date of Birth: _____

Spouse Employer: _____Employer Phone: _____

Primary Insurance Carrier ID#/Policy Holder/DOB: _____

Secondary Insurance Carrier ID#/Policy Holder/DOB: _____

NOTE: We will bill your secondary insurance as a courtesy. If claims are not paid within 60 days, the balance will be transferred to patient responsibility.

Is your condition the result of a work-related injury? _____

Date of Injury: _____

My signature below indicates that I have been given the chance to read and review the following and understand and agree to their terms:

*Patient Acknowledgement Form (see page 2)
*Financial Policy, Consent for Treatment, and Release of Medical Information Form (see page 3)
*Notice of Privacy Practices at my discretion (located at front desk).

I agree that the above information is true, and I authorize Precision NeuroDiagnostics, PLLC, **to use this information to obtain financial reimbursement. Additionally, I authorize** Precision NeuroDiagnostics **to administer treatment and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to Precision NeuroDiagnostics. In the event my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. This authorization is to remain in full force unless I revoke the same in writing.**

Patient's Signature: _____ Date: _____

Reviewed by: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT FORM

I understand that the patient's health information is private and confidential. I understand that Precision NeuroDiagnostics works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information. Precision NeuroDiagnostics displays a copy of their "NOTICE OF PRIVACY PRACTICES" in every office location.

I understand that Precision NeuroDiagnostics may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that there may be situations where Precision NeuroDiagnostics is required by federal, state, or local law to release this information without my permission. One example would be in response to a warrant, summons, court order, subpoena or similar legal process.

Precision NeuroDiagnostics has a detailed document called the "NOTICE OF PRIVACY PRACTICES". It contains more information about the policies and practices protecting the patient's privacy including other potential disclosures and uses of patient's health information. I understand that I can receive a copy of this document at any time of my choosing. One example would be disclosure of health information for research purposes. I understand that I have the right to read the "NOTICE OF PRIVACY PRACTICES" before signing this Acknowledgment.

Precision NeuroDiagnostics may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Precision NeuroDiagnostics will provide me with the most current "Notice of Privacy Practices". Within this Notice of Privacy Practices is contained a complete description of my privacy/ confidentiality rights. These rights include, but are not limited to, access to my medical records, restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative locations.

Precision NeuroDiagnostics has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non- routine information needs; etc. I will assist Precision NeuroDiagnostics by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

Patient's Name:
_____

Patient's Signature: _____ **Date:** _____

Witness: _____**Date:** _____

Financial Policy, Consent for Treatment, Release of Medical Information

Thank you for choosing Precision NeuroDiagnostics**!**

PLEASE READ CAREFULLY

You and your insurance carrier are responsible for your bill.
Knowing your insurance benefits plan is your responsibility.
Thank you for your understanding

1. If you have medical insurance, we are committed to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance and your understanding of our financial policy.

2. Insurance information must be presented/updated at the time of making your appointment not at the time of service. Most insurance companies have requirements for authorization of services and/or referrals from the Primary Care Provider prior to the services. If you present for your appointment and you have not provided your correct insurance to ensure verification, authorization of services and all required referrals we will not be able to see you and your appointment will need to be rescheduled.

3. Payment in Full for non-insurance services is expected at the time of service. Please be advised that we are contractually obligated by your insurance carrier to collect your co-payment at the time of service. If you arrive without the ability to pay for your services or your co-pay, we will not be able to see you and your visit will be rescheduled.

4. If you have insurance, as a courtesy to you, we will file your primary and secondary insurance claim for services at no cost to you. However, we are unable to wait more than 45 days for the insurance to pay. After 45 days it is your responsibility to contact your insurance company and follow up on why your claim has not been paid. You must take the necessary action required to get your claim paid and communicate your actions to our office. Failure to assist our office in timely payment of your insurance claim will result in the total charges being transferred to patient liability. Any patient liability assigned to you by your insurance carrier will be billed to you. Once insurance has paid, payment in full of the patient assigned liability will be expected with the receipt of your statement. You will receive two billing statements regarding your balance. If we do not hear from you after these two statements, your account will be subject to our collection process unless prior arrangements are made with our financial office.

5. Precision NeuroDiagnostics is committed to providing the highest quality care for our patients and we charge what is usual and customary for our area. You are ultimately responsible for all clinic and testing fees relating to your care. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates. Your insurance policy is a contract between you and your insurance company. Any disagreement you have concerning the amount your insurance pays, should be directed to your insurance company.

6. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. Your policy may also contain plan specific limitations that apply to referrals, referral dates and number of visits. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier. The contract of coverage is between you and your insurance carrier, and it is your responsibility to understand your coverage, coverage requirements and limitations due to the variations between policies. You will be expected to pay for the patient liability assigned to you by your insurance carrier.

7. For services that are not covered by insurance, the practice requires payment of 100% of the total estimated charges unless prior payment arrangements have been set up with our office.

Financial Policy, Consent for Treatment, Release of Medical Information (Continued)

8. Insured individuals electing to be self-pay: The patient has the right to elect not to file their health insurance and elect to be a self-pay patient for services provided. The patient will be financially responsible for charges incurred and payment will be due at the time of service. After services have been rendered, the patient will not be able to file their health insurance for the services due to insurance claim submission requirements. The patient's election to not file the services to their insurance company does not affect or reduce any out-of-pocket financial responsibility for future services as determined by their insurance plan.

9. If you do not have insurance coverage for the service, are self-pay, or have insurance that Precision NeuroDiagnostics does not participate in or accept, payment is expected at the time of service. We offer a discounted self-pay rate for our services. Prior financial arrangements must be made and approved before your visit if you cannot pay 100% at the time of service. No discount of assigned insurance patient liability (co-pay, deductibles, co-insurance) will be made to comply with federal insurance regulations and law. We are required to collect these fees. If financial arrangements have not been made and you arrive without the ability to pay for the services your visit will need to be rescheduled.

10. Out of Network Insurance – Some insurance plans require you to pay different out-of- pocket amounts based on the provider and/or location where the service is performed. Deductibles, co-insurance and co-payments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. It is your responsibility to inquire about any plan specific coverage limitations with your insurance company. You can choose to have the services performed as "Out of Network" or as self-pay. You may also apply for financial hardship review if the "Out of Network" patient liability exceeds your ability to pay.

11. Insurance information provided after the services have been provided will be billed or not billed at the discretion of Precision NeuroDiagnostics. Due to the Insurance contractual requirements for referrals, authorization of services and timely filing limitations, insurance must be presented prior to services being provided. If Precision NeuroDiagnostics agrees to bill your insurance, you will be held liable for the charges if the insurance denies your claim as untimely because of late presentation of coverage or for lack of timely authorizations or referrals.

12. Patients who request payment arrangements and/or financial hardship adjustments are required to supply financial documentation to support their request. Financial documentation will include income and expenses as outlined on our financial assistance application. Failure to supply the required documentation will result in normal collection activity being adhered to.

13. In the event your account/s must be turned over for outside collections, you will be billed and are responsible for all fees involved in the collection process. Returned checks are subject to a handling fee of $30.00.

14. Please note that our office does have last minute cancellation/no-show fee; $50 for regular office visits, $75 for EMG/NCS test and $100 for EEG test. Please contact our office hours in advance to reschedule your appointment to avoid this fee. We understand things come up.

15. In the event you have an account with a credit balance, we reserve the right to transfer credits to any other outstanding account balances prior to issuing a refund.

16. Patients with a history of presenting for their appointment without the ability to pay their co-pay, short notice (less than hours) canceling of appointment or not showing up for their appointments will unfortunately be subject to reviewed for dismissal from our practice.

17. Normally there is a charge of $30.00 per page to complete FMLA paperwork, forms for disability claims, accident or injury claims, attorney verification of medical condition, disability placard paperwork or any other non-medical services reimbursement paperwork. Payment must be made at the time the forms are completed. Some third-party forms requests must be paid prior to the completion of the forms.

Financial Policy, Consent for Treatment, Release of Medical Information (Continued)

18. We realize that temporary financial problems do occur. If such problems do arise, we encourage you to contact us promptly for assistance. **We are always here to help our patients.** If you have any questions about the above information, or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us.

Authorization: I hereby authorize Precision NeuroDiagnostics, LLC, Jamshid Lotfi M.D. to administer treatment, diagnostic testing and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to Precision NeuroDiagnostics. In the event my insurance makes payment directly to me for services I will immediately endorse and assign the payment to Precision NeuroDiagnostics. If my insurance does not cover services rendered, I agree to be personally, and fully responsible for payment. I give Precision NeuroDiagnostics permission to appeal any denials by my insurance for services rendered on my behalf. I will assist Precision NeuroDiagnostics with follow up of timely payment, requests for information and appeals to my insurance as necessary to ensure full and timely payment for services received.
I have read the Precision NeuroDiagnostics Financial Policy, Consent for Treatment, Release of Medical Information, policy and understand and agree to its terms. This authorization is to remain in full force unless I revoke the same in writing.

(Patient/Responsible Party) Signature _____Date: _____

(Patient/Responsible Party) Printed Name: _____Date: _____

Patient Contract for Pain Management and Medication Agreement

This agreement between_____ (the patient) and Dr. Jamshid Lotfi of Precision NeuroDiagnostics, LLC, (the physician) is for the purpose of establishing an agreement between the doctor and patient on clear conditions that the patient agrees to in order to receive pain management and/or pain medications. This may include the care from multiple disciplines, including diagnostic and/or therapeutic interventions, behavioral medicine (psychology, psychiatry, coping strategies, biofeedback), alternative therapies, physical therapy, weight management and the prescription use of medications. The doctor and the patient understand that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship. Pain medication may not completely eliminate your pain but is expected to reduce it enough that you may become more functional and improve your quality of life.

I agree to and accept the following conditions for my pain management:

** Your initials are required next to each statement in the space provided **
1. I understand that strong medications, which may include opioids and other controlled substances, may be prescribed for pain relief, if my physician determines it would be of benefit. I understand that there are potential risks and side effects involved with taking any medications, including the risk of addiction. Overdose of opioid medication may cause injury or death. Other possible complications include, but are not limited to, constipation which could be severe enough to require medical treatment, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function. Not taking the medicine as prescribed may result in death. Men may have decreased testosterone from chronic opioids.

2. I realize that it is my responsibility to keep others and myself from harm. This includes the safety of my driving and the operation of machinery. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve. This applies to all medication prescribed to me. Prescriptions and bottles of medications must be safeguarded from loss and out of reach of children.

3. I realize that all medications have potential side effects and interactions. I will inform the office of any adverse effects I am experiencing when they are of a nature to cause me concern. I understand and accept that there may be unknown risks associated with the long-term use of the substances prescribed.

4. I understand that if I am pregnant or become pregnant while taking medications, my child could be physically dependent on the opioids and withdrawal can be life threatening for a baby. If a female of childbearing age, I certify that I am not pregnant, and I will use appropriate contraceptive measures during the course of treatment, with medications. Many medications could harm the fetus or cause birth defects. I will tell my physician right away if I am pregnant.

5. I understand I must contact my physician before taking newly prescribed tranquilizers or prescription sleeping medications.

6. I understand that the combined use of various drugs, opioids, benzodiazepines (i.e. Xanax) as well as alcohol, produce confusion, profound sedation, respiratory depression, blood pressure decrease, and/or death.

7. I understand that opioid analgesics could cause physical dependence within a few weeks of starting opioid therapy. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (including nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose.

8. Withdrawal from other medications can also have serious consequences, including the risks of injury or death. 8. I will not discontinue any medication I take regularly without consulting my physician.

9. I agree that continued treatment and/or refill of medications may be contingent upon compliance with other pain treatment modalities recommended by my doctor.

10. I am responsible for keeping my scheduled appointment. Prescription renewals are contingent upon keeping each scheduled appointment. Requests for refills of medications due to rescheduled or missed appointments are prohibited, except in emergency circumstances, as determined by and at the Physician's discretion and will only be bridged until the next available appointment. Also, rude behavior to ANY staff member will result in being discharged, as it weakens trust and confidence, and weakens the doctor patient relationship.

10.1. Refill requests for medication requiring a written prescription must be called to the office 48 business hours prior to pick up. Written prescriptions must be picked up at the office. Written prescriptions will not be mailed or delivered by any other manner.
10.2. Refills will not be made after hours, at night or on weekends. This policy will be strictly adhered to.
10.3. Refill will not be made if I "run out early" or "lose a prescription" or "spill or misplace my medication" or if someone else has taken some of my prescription. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
10.4. Refills will not be made as an "emergency". I will call my pharmacy at least 4-5 business days prior to needing my prescription(s) (for medications that do not require a written prescription).

11. I agree that I will use my medication at a rate no greater that the prescribed rate unless it is discussed directly with my physician. I understand, I can be asked to bring any or all my prescribed medications to my office appointment or at a random time for a prescription compliance check (Pill Count).

12. I will not use any illegal substances (cocaine, heroin, marijuana, etc.) while being treated with controlled substances.

13. I agree to not use alcohol as this can also result in death. Violation of this will result in the cessation of the prescribing
Of any controlled substances and termination of my care.

14. I will not share, sell, or trade my medication or exchange medication for money, goods, or services.

15. I will not alter my medication in any way (for example: crushing or chewing tablets) or use any other route of delivery (for example: injection or insufflation) other than as prescribed.

16. I understand that changing dates, quantity, or strengths of medication or altering a prescription in any way is against the law. Forging prescriptions or physician's signature is also against the law. Our office cooperates fully with law enforcement agencies in regard to infraction involving prescription medications.

17. I will discontinue all previously used pain medication, unless told to continue them by my physician. I will keep this office informed of all medications I may receive from other physicians.

18. I agree that I will submit to random urine, blood, saliva toxicology test if requested to determine my compliance with this agreement and my regimen of pain control medication. Tests may include screens for illegal substances. These tests may need to be witnessed by one of our staff members or affiliates.

18.1. I understand that I will be financially responsible for the charges for any urine, blood, or saliva test. If you have insurance coverage it will be billed but you will be responsible for all patient liability.

18.2. I understand that I will be financially responsible for the charges for any urine, blood, or saliva test that must be sent out to an outside lab for testing or confirmation.

18.3. Presence of unauthorized substances or the lack of prescribed medications may necessitate a referral to an addiction specialist, as well as dismissal from this practice.

19. I will not attempt to get pain medication from any other health care provider without telling them that I am already taking pain medication prescribed by this office. I will not fill any prescriptions for pain medicine from anyone else.

Patient Contract for Pain Management and Medication Agreement (Continued)

20. I understand that my medication regimen may be continued for a definitive period as determined by my physician. My case will be reviewed periodically. If there is not significant evidence that I am improving or that progress is being made to improve my functioning or quality of life, the regimen might be tapered or possibly discontinued and my care referred to my primary care physician. I will keep all scheduled follow up appointments as outlined in my treatment plan.

21. I understand that the main treatment goal using pain medications is to improve my ability to function and/or to work and/or to reduce pain. In consideration of that goal, and the fact that I may be given potent medication to help me reach that goal, I agree to help myself by following better health habits. This may include exercise, weight control, and avoiding the use of nicotine. I must also comply with the treatment plan as prescribed by my doctor.

Patient Contract for Pain Management and Medication Agreement (Continued)

22. I understand with respect to the prescribing of my pain medications, the doctors, my pharmacy, and insurers will cooperate fully with any city, state, or federal agency in the investigation of any possible misuse, sale, or other diversion of my pain medication as required by law, state and federal regulations.

23. I authorize my physician to provide a copy of this agreement to my pharmacy, other healthcare providers, and any emergency department upon request. I give my permission to allow sharing of medical history regarding medication use with other health care agencies.

24. I agree that this agreement is important to my doctor's ability to treat my pain effectively, and that my failure to comply with the agreement may result in the discontinuation of prescribed medication by my doctor and termination of the doctor/patient relationship.

I have thoroughly read, understand and accept all the above provisions. Any questions I had regarding this agreement have been answered to my satisfaction. I understand all the policies regarding the prescribing and use of opioids and other medications. I agree to comply with the pain management program. I also agree to testing physiological, toxicology and/or psychological and detoxification if indicated.

Your physician understands that emergencies can occur and under some circumstances exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.

Lack of strict adherence to any provision of this agreement by your physician in no way invalidates any other provisions of this agreement. If at any time you are concerned about your medication or side effects of your medication, you may call the office at (713) 550-6242.

I agree to use Pharmacy, located at _____telephone number _____ for all my pain medications. If I change my pharmacy for any reason, I agree to notify this office at the time I receive a prescription. I will also advise my new pharmacy of my prior pharmacy's address and telephone number.
This agreement is entered into on (DATE): ____/____/____

_____
Patient Signature

_____
Jamshid Lotfi, M.D.
Neurologist

Physician Authorization to Discuss or Disclose Health Information

I authorize Precision NeuroDiagnostics/Dr. Lotfi to discuss and/or disclose my health information with the following person/persons listed below:

1. _____
2. _____
3. _____

I understand that this information may include all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases, including human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care and evaluations; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should not be released: _____

Patient's Name: _____

SSN#: _____

DOB: _____

Patient's Signature: _____

Date: _____

In witness of (name and signature): _____

Date: _____

Please let us know in writing at the below address if the above list should change

Phone: (713) 550-6242 Fax: (713) 554-1701

5555 West Loop South Bellaire, Texas, 7740 USA

Your Name: _____

Today's Date _____

Referral

Were you referred to our clinic by another physician? If so, whom? _____

↳ If not, how did you hear about us? ❑ Radio ❑ Insurance Company ❑ Family ❑ Friend ❑ PCP

❑www.PrecisionNeuroDiagnostics.com ❑ Facebook ❑ Twitter ❑ YouTube ❑ Other ❑ Google

Pain Description & Location

Where is your **worst** area of pain located?

Does this pain radiate? ❑ Yes ❑ No, If yes to what area _____

Please list any additional areas of pain:

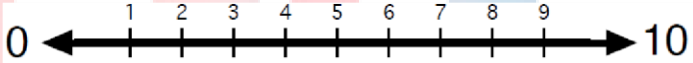
Approximately when did this pain begin?

What caused your current pain episode?

How did your current pain episode begin? ❑ Gradually ❑ Suddenly

Since your pain began, how has it changed? ❑ Decreased ❑ Increased ❑ Stayed the same

Use the pain scale described below to rate your pain for the questions below:



1. Very minor annoyance, occasional minor twinges
2. Minor annoyance, occasional strong twinges
3. Annoying enough to be distracting
4. Can be ignored if you are really involved in your work/task, but still distracting
5. Cannot be ignored for more than 30 minutes
6. Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7. Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8. Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9. Unable to speak, crying out or moaning uncontrollably, near delirium.
10. Unconscious, pain makes you pass out

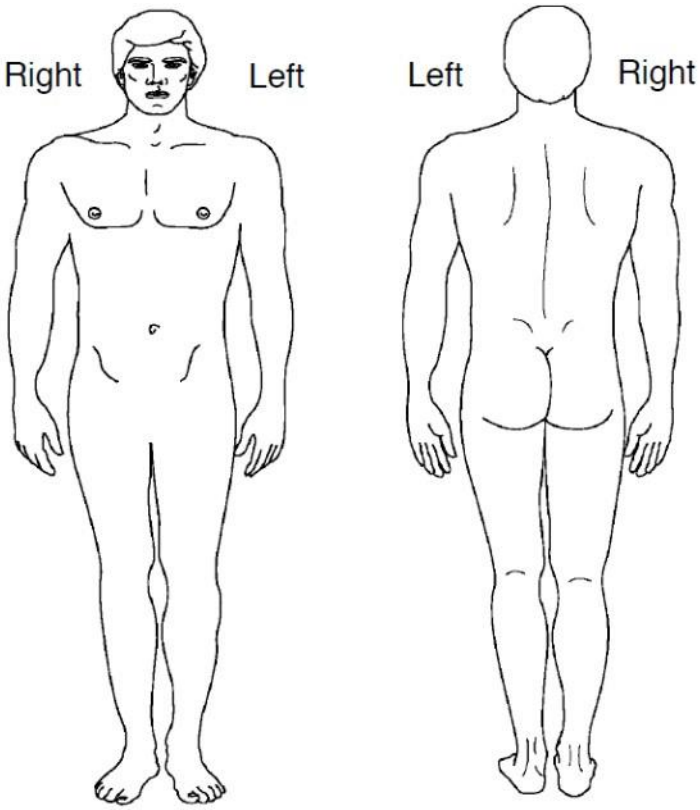
What number on the pain scale (0-10) best describes your pain **right now**? _____

What number on the pain scale (0-10) best describes your **worst pain**? _____

What number on the pain scale (0-10) best describes your **least pain**? _____

What number on the pain scale (0-10) best describes your **average pain over the last month**? _____

Use this diagram to draw the location of your pain and check all of the following that describe your pain.



- ❑ Cramping
- ❑ Dull
- ❑ Hot/Burning
- ❑ Numbness
- ❑ Shock-like
- ❑ Shooting
- ❑ Spasming
- ❑ Squeezing
- ❑ Stabbing/Sharp
- ❑ Throbbing
- ❑ Tingling/Pins & Needles
- ❑ Tiring/Exhausting

Pain Frequency

When is your pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings ❑ Middle of the night

Mark all of the following activities that are adversely/negatively affected by your pain

- ❑ Enjoyment of Life
- ❑ General Activity
- ❑ Mood
- ❑ Relationships with People
- ❑ My goal is to resume normal activities
- ❑ Normal Work
- ❑ Recreational Activities
- ❑ Sleep
- ❑ Walking
- ❑ Other: _____

In the past three months have you developed any new:

❑ Balance Problems ❑ Bladder incontinence ❑ Bowel incontinence ❑ Chills
❑ Difficulty Walking ❑ Fevers ❑ Nausea ❑ Vomiting
❑ Numbness/Tingling – Where?_____ ❑ Weakness – Where? _____

❑ **I HAVE <u>NOT</u> RECENTLY DEVELOPED ANY OF THE ABOVE CONDITIONS**

What makes the pain worse? _____
_____
_____
What makes the pain better?_____

Diagnostic Tests and Imaging

What recent tests have you had that are related to your current pain complaints (please specify body part):

❑ X-ray _____ Date: _____

❑ Ultrasound _____ Date: _____

❑ MRI _____ Date: _____

❑ CT scan _____ Date: _____

❑ EMG/NCV study _____ Date: _____

❑ **I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS**

Pain Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:

❑ Physical Therapy ❑ Psychological Therapy ❑ Podiatrist Treatment

❑ Chiropractic

❑ Epidural Steroid Injection – (circle proper levels) Cervical / Thoracic / Lumbar

❑ Joint Injection – Joint(s)_____

❑ Medial Branch Blocks or Facet Injections – (circle proper levels) Cervical / Thoracic / Lumbar

❑ Pain Pump _____

❑ Radiofrequency Ablation – (circle proper levels) Cervical / Thoracic / Lumbar

❑ Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant

❑ Spine Surgery _____

❑ Trigger Point Injection

❑ Vertebroplasty / Kyphoplasty – Level(s) _____

❑ Other:

❑ **I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS**

Medications

Please list **ALL** of the medications you are taking, **Pain meds listed first.** Attach an additional sheet if necessary.

Medication	Dose	Frequency

Please list ALL pain medications you have taken in the past and are now **not** taking.

_____

_____

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical

- ❑ Cancer – Type _____
- ❑ Diabetes – Type _____
- ❑ HIV / AIDS

Head/Eyes/Ears/Nose/Throat

- ❑ Glaucoma
- ❑ Headaches
- ❑ Head Injury
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Migraines

Cardiovascular / Hematologic

- ❑ Anemia
- ❑ Bleeding Disorders
- ❑ Coronary Artery Disease
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Mitral Valve Prolapse
- ❑ Murmur
- ❑ Pacemaker/Defibrillator
- ❑ Phlebitis
- ❑ Poor Circulation
  - ❑ Stroke

Respiratory

- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema / COPD
- ❑ Pneumonia

Gastrointestinal

- ❑ Bowel Incontinence/IBS
- ❑ Acid Reflux (GERD)
- ❑ Gastrointestinal Bleeding
- ❑ Constipation

Musculoskeletal

- ❑ Amputation
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Chronic Low Back Pain
- ❑ Chronic Neck Pain
  - ❑ Chronic Joint Pain
- ❑ Fibromyalgia
- ❑ Joint Injury
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Phantom Limb Pain
- ❑ Rheumatoid arthritis
- ❑ Tennis Elbow
- ❑ Vertebral Compression fracture

Genitourinary/Nephrology

- ❑ Bladder Infection(s)
- ❑ Dialysis
- ❑ Kidney Infection(s)
- ❑ Kidney Stones
- ❑ Urinary Incontinence

Hepatic

- ❑ Hepatitis A (active / inactive / unsure)
- ❑ Hepatitis B (active / inactive / unsure)
- ❑ Hepatitis C (active / inactive / unsure)

Neuropsychological

- ❑ Alcohol Abuse
- ❑ Alzheimer Disease
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Epilepsy
- ❑ Prescription Drug Abuse
- ❑ Multiple Sclerosis
- ❑ Paralysis
- ❑ Peripheral Neuropathy
- ❑ Schizophrenia
- ❑ Seizures
- ❑ Complex Regional Pain Syndrome

Other Diagnosed Conditions

_____

_____

_____

_____

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the **date, type,** and any pertinent **details.**

_____

_____

_____

_____

❑ **I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE**

Family History

Mark all appropriate diagnoses as they pertain to your biological *MOTHER AND FATHER* only.

	Alcohol Abuse	Drug Abuse	Diabetes	Cancer	Headaches	Heart Disease	High Blood Pressure	Stroke	Epilepsy
Mother									
Father									

Other medical problems: _____

❑ **I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY** ❑ **I AM ADOPTED (No Medical History Available)**

Social History

Are you capable of becoming pregnant? ❑ Yes ❑No *If so*, are you currently pregnant? ❑ ❑Yes No

Highest level of education obtained: ❑ High school ❑ College ❑ Post-graduate

Are you currently working? ❑ Yes ❑ No What is/was your occupation? _____

Alcohol Use: ❑ Denies alcohol use ❑ Consumes alcohol How much? _____
❑ History of alcohol abuse

Tobacco Use ❑ Denies tobacco use ❑ Current tobacco user How much? _____
❑ Former tobacco user

Illicit Drug Use: ❑ Denies any Illicit drug use ❑ Currently using Illicit drugs Which? _____
❑ History of illicit drug use

Have you ever abused narcotic or prescription medications? ❑ Yes ❑ No *If So* name:_____

Are you currently in remission for alcohol or any other addictions ❑ Yes ❑ No ❑ not applicable

Allergies

Do you have any known drug allergies? ❑Yes ❑No

If so, please list all medications you are allergic to:

Medication Name	**Allergic Reaction Type (What Happens?)**

Please check if you are allergic to ❑ Iodine or ❑ Tape

Are you allergic to latex? ❑Yes ❑No

Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? ❑ Yes ❑No

If so, have you ever had any adverse reaction to anesthesia? ❑ Yes ❑No

Which type of anesthesia did you react adversely to? Please check all that apply.

❑ Local anesthesia ❑ Epidural ❑ General anesthesia ❑ IV Sedation

What was the reaction? _____

Do you have a family history of adverse reactions to anesthesia? *If so*, to which of the following?

❑ Local anesthesia ❑ Epidural ❑ General anesthesia ❑ IV Sedation

Goals of Treatment

Please explain your goals of treatment_____

_____

_____

_____

If on opioids, **please explain how they help you**, what they allow you to do if you were not taking them otherwise_____

_____

_____

Review of Systems

Mark the following symptoms that you **currently** suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.*

Constitutional: ❑ Weakness ❑ Fatigue ❑ Weight gain ❑ Weight loss ❑ Fever ❑ Chills ❑ Night sweats

Eyes: ❑ Recent visual changes ❑ Glaucoma ❑ Double vision

Ears/Nose/Throat: ❑ Dental Problems ❑ Ear aches ❑ Hearing problems ❑ Nosebleeds
❑ Recurrent sore throats ❑ Ringing in the ears ❑ Sinus problems

Cardiovascular: ❑ Chest pain ❑ Irregular heartbeat ❑ Murmur ❑ Rapid heartbeat ❑ Blood clots
❑ Swollen extremities ❑ Palpitations ❑ Fainting

Respiratory: ❑ Cough ❑ Shortness of Breath on Exertion/Effort ❑ Wheezing ❑ Shortness of breath at rest

Gastrointestinal: ❑ Acid reflux ❑ Abdominal cramps ❑ Constipation ❑ Diarrhea ❑ Vomiting
❑ Coffee ground appearance in vomit ❑ Dark and tarry Stools

Genitourinary/nephrology: ❑ Blood in Urine ❑ Decreased urine flow/Frequency/Volume ❑ Flank pain
❑ Erectile dysfunction ❑ Painful urination ❑ Incontinence

Integumentary/Skin ❑Change in skin color ❑ Rashes ❑ Pruritus ❑ Dry skin

Musculoskeletal ❑ Joint swelling ❑ Back pain ❑ Muscle spasms ❑ Joint pain ❑Neck pain
❑ Pelvic pain ❑ Joint stiffness

Psychiatric: ❑ Depressed mood ❑ Anxiety ❑ Stress ❑ Suicidal Thoughts

Endocrine ❑ Heat Intolerance ❑ Cold Intolerance ❑ Hair changes ❑ Excessive thirst

Neurological: ❑ Dizziness ❑ Seizures ❑ Headaches ❑ Numbness/tingling ❑ Memory loss
❑ Difficulty with speech ❑ Loss of coordination ❑ Difficulty walking

Hematologic/Lymphatic: ❑ Easy bruising ❑ Easy bleeding ❑ Impaired wound healing ❑ Lymphadenopathy
❑ Recurrent infection ❑ Hives ❑ Swelling ❑ Itching eyes or nose

PLEASE ANSWER THE FOLLOWING QUESTIONS

Patient Name: _____ DOB: _____ Today's Date: _____

Questions	Never	Seldom	Sometime	Often	Very often
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○

19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○