WELCOME TO OUR PRACTICE

Thank you for choosing River Cities Interventional Pain Specialists (RCIPS) as your trusted interventional pain care provider. To better prepare you for your upcoming new patient appointment, we have put together this introductory letter so you are ready for your appointment.

- Please make sure you complete all required new patient paperwork prior to your visit and bring them to your appointment. This information will be used by the provider during your evaluation. Failure to have the forms completed prior to your arrival may result in your appointment being delayed or rescheduled. If possible, you may fax or mail back to our facility. This will help us provide more efficient quality of care for you at the time of service. Our fax number is (318) 797-5844. Our mailing address is: River Cities Interventional Pain Specialists, Attn: New Patient Coordinator, 8731 Park Plaza Drive, Shreveport, LA 71105.
- If you would like to complete all forms in the Patient Portal online, call the office to discuss setting up your online account.
- Please arrive at least 30 minutes prior to your visit and anticipate being at our office for your initial appointment approximately 2-3 hours. You will need to bring any medical records available, including but not limited to: imaging, a photo identification card, a valid health insurance card (or cards), and form of payment for any copay, deductible, or coinsurance as required per your health insurance.
- We require at least 24 hours notice for cancellations and rescheduling of appointments. Failure to do so may result in a no show/cancellation fee.

We appreciate the confidence you have by trusting your care to our team. We look forward to working with you to help manage your chronic pain. Please feel free to reach out to us with any questions that you may have at (318) 797-5848.

Sincerely,

The Office of
River Cities Interventional Pain Specialists

GENERAL OFFICE POLICIES

SCHEDULING & NURSE CALLS

Reaching our Practice: You can reach our office at (318) 797-5848, during normal office hours of 8am-5pm Monday-Friday. You will be directed to the appropriate personnel for your specific question or concern: Scheduling, Billing, Procedure Scheduling, or Referrals. You may also reach the office by utilizing the myHealthspot Patient Portal, however this is not monitored 24/7 and best used if you do not have a pressing matter. Our answering service will take calls after-hours at (318) 797-5848. **If you believe your concern is a medical emergency, call 911 or seek immediate medical assistance at the nearest full-service emergency room.**

Nurse Calls. Your phone call is automatically sent to a nurse when you leave a message with the receptionist. The nurses generally return calls within **48-72 hours**, depending on the nature of the call. If your call has not been returned after 72 hours, please call our office at (318) 797-5848 and ask to speak to the practice manager. Please **do not make multiple phone calls** to the office within the day. You will be asked to make an appointment for issues of general consultation other than medication side effects. Nurse and/or provider calls with the patient, should they meet certain criteria, may be considered billable services.

Surgery by Other Physicians. You will need to schedule an appointment with our clinic **BEFORE** undergoing any surgical procedure for any condition that you receive treatment for by this clinic and notify the provider of post-operative medication(s) prescribed.

Opioid Treatment. If you are receiving narcotics from our office, please remember that you have signed a written agreement to follow certain safeguards. The purpose of the narcotic treatment agreement is to help us maintain a safe, controlled treatment plan for you. You must remember:

- You are not to receive pain medications from any other physician besides those at River Cities Interventional Pain Specialists. We monitor your pharmacy records periodically and if discovered that you have obtained narcotics from another provider, it will result in a referral for addiction treatment and loss of prescription privileges.
- You must take your medication exactly as instructed. Do not change dosage amounts without talking to our office first. If you want to change medications, you must bring un-used medicine with you to your appointment.
- You must keep all regular follow-up appointments and attend nurse visits.
- If prescribed a controlled medication you may be called for a mandatory compliance visit which you must present to the office within 48 hours of being notified. This is standard procedure for practices prescribing controlled medication as required by schedule II-V license holders of the state of Louisiana.

It is important to make sure that you have enough medication to make it through the weekend or after hours. Medication refills **will not** be called in or refilled by the provider on-call after hours or on weekends.

APPOINTMENTS

When to Arrive for Your Appointment. Please be advised that patients are asked to arrive early for appointments.

FOR ESTABLISHED PATIENTS, patients are to arrive 15 minutes before their scheduled appointment and have visit paperwork completed prior to coming. Forms can be completed in the Portal or printed from the website.

FOR NEW PATIENTS, we ask that you arrive at least 30 minutes prior to your scheduled appointment time and visits generally last 2-3 hours. Please allow time and prepare for a visit of this length on the day of your initial appointment. Please make sure you complete all required new patient paperwork prior to your visit and bring them to your appointment. This information will be used by the provider during your evaluation. Failure to have the forms completed prior to your arrival may result in your appointment being delayed or rescheduled to a later date.

Late/Cancellations/No-show Appointments. Our practice strives to provide not only the finest medical care, but also to provide a high level of efficiency and patient service. In order to have adequate office hour coverage, and to keep on schedule during our office hours, we follow a strict Late/No-show Policy. A fee may be charged if the following guidelines are not followed.

- If you arrive 15-20 minutes past your scheduled appointment time the Director of Nursing will be consulted for permission to be seen.
- Any tardiness over 20 minutes will not be seen that day and must be rescheduled. If you need a prescription refill, the receptionist will have a nurse contact you to discuss your prescription refill.
- Cancellation of an appointment for established patients require 24 hour notice.
- All New Patients must give 48 hours' notice if needing to cancel or reschedule the appointment or will forfeit the New Patient Deposit.
- Established patients that reschedule within 24 hours of appointment or No-show may be billed a fee. Following three (3) "No-show" appointment cancellations you may not be allowed to reschedule another appointment.

Note: Pain medications cannot be called in, so it is imperative to keep scheduled appointments.

ZERO TOLERANCE POLICY

Our Practice staff aim to be polite, helpful, and sensitive to all patients' individual needs and circumstances. We value our teammates and patients and treat them with respect and dignity, acting in a professional manner at all times. We believe in treating people the way we all want to be treated. We will nurture an environment in which everyone feels included, valued, and appreciated.

Aggressive behavior, be it verbal or violent, toward any patient, staff member or member of the community will not be tolerated and may result in discharge from the practice. Individuals behaving in an aggressive verbal or physical manner while on the property will be requested to leave immediately. Failure to do so will result in the police being notified. Any threats or verbal abuse towards patients or staff is grounds for discharge from the practice.

FORMS AND LETTERS

Work Excuses. If you require a work excuse, please ask for it at the time of your appointment. Work excuses are only allowed for the same day of a scheduled appointment or procedure.

Disability Forms. Our office will not initiate long-term disability. Our requirements for the completion of disability forms or letters are listed below:

- The office will consider continuance of disability forms, first initiated by another provider, subject to review and decided upon by a case-by-case basis.
- There will be a charge that must be paid prior to the completion of the form/letter. The charge for most forms is $25.00.
- Ten (10) to fourteen (14) working days will be required for the completion of the form/letter.
- The completion of some forms/letters may require an office visit if additional assessment is required.
- We reserve the right to refuse to complete a form if it requests information that we do not have as part of your treatment plan.

FINANCIAL POLICY

Most insurance plans cover the cost of the visits, less any applicable co-pays, co-insurance, and deductibles. It is your responsibility to: check with your plan in advance to ensure that we participate with your insurance plan, review your benefit coverage; and ensure all pre-approval requirements are met to avoid denials or out-of-network benefits.

In summary, your financial responsibility pertains to:

1. For your convenience, we accept cash, checks, and most major credit cards. Please note that there is a $25.00 service charge for all returned checks and, if a check is returned for insufficient funds, the practice will no longer accept checks for payment from the individual.
2. We will collect your deductible, co-pay, uncovered services or the percent you are responsible for at the time of your visit. Please be prepared to pay at the time of check-in before you are seen by the provider. If you do not have your payment, you may be asked to reschedule. It is the patient's responsibility to know the terms of their insurance plan.
3. You must bring your insurance card and photo I.D. with you to every visit as well as any authorization information your insurance may require. Policies change frequently and we must have these to identify correct claims processing and avoid possible payment delays from your insurance payer. Without these, you may be asked to reschedule.
4. Medicaid consists of five different bayou health plans. If you have Medicaid, you will need to present the new card associated with your specific plan. Please be advised, our office can only accept Medicaid if it is secondary to another insurance payer.
5. If your insurance leaves a balance for patient responsibility or denies payment on your account, you will be asked to pay by check, cash, or charge. You may also pay your bill online through your patient portal. If you do not pay in a timely fashion, your account may be placed into Bad Debt status and no appointments will be scheduled until paid in full. If you fail to meet the financial obligations agreed upon in this financial policy or have not made other payment arrangements with our billing department, your outstanding balance will be sent to a collection agency. You will be required to pay your entire balance and any collection agency fees, up to 25% of your account balance, before being scheduled for any further appointments.
6. In accordance with AMA CPT guidelines, we reserve the right to charge for telephone calls with our medical professionals that include evaluation and management of your medical condition. We will bill your insurance for such calls, but if it is not covered by your plan, you may be responsible for the charges.

Patient Name: _____ **Date of Birth:** _____

7. **TRICARE, HMO or PPO PATIENTS REQUIRING A REFERRAL**: You are responsible for making sure your visits with our office are authorized by your primary care physician or manager (PCP/PCM) or insurance payer. This authorization must be obtained *before* your scheduled visit. It is the patient's responsibility to make sure we have received authorization. If you do not have the proper authorization, your appointment will be rescheduled.
8. **SELF-PAY PATIENTS:** This category includes patients with no insurance and the patients who have an insurance plan with which we do not participate. Payment for medical services is required prior to services being rendered. We accept Visa, MasterCard, Discover and American Express, checks, cash, and money orders. A Good Faith Estimate and receipt will be provided.
9. Should you need to cancel or change your office visit appointment we require 24 hours' notice or you may be subject to a **$25.00 charge**.
10. We understand that there may be times and circumstances that come up where you are unable to pay your entire bill. In these situations, it is very important that you contact our billing office at (318) 797-5848 option 4 so a financial representative can assist you in setting up a reasonable payment plan and to keep your account in good standing. The provider and/or practice manager must approve payment plans and discounts. Payment arrangements are understood and agreed upon by the patient and provider prior to services being rendered.

AS A FINAL NOTE:

Your policy is a contract between you and your insurance company. We are not a part of that contract and cannot guarantee payment by your insurance carrier. If your insurance plan does not pay for all services or denies coverage, you will be responsible for all fees due. If your insurance company denies payment of your claim, contact your insurance company directly. If they have not paid you will be held responsible for any balance due, and you will be billed accordingly. Dissatisfaction with your insurance company does not constitute reason to withhold payment of your account with RCIPS. We do accept assignment of your benefits; however, please be aware that some or all of the services provided may be a non-covered service under your plan. You will be responsible for these non-covered charges. In the event that your insurance coverage relates to a plan where we are not a participating provider, you will be 100% responsible for all charges incurred.

If you have any questions regarding this financial policy, please call BEFORE you are seen. Our business office is prepared to answer any questions you may have at (318) 797-5848 option 4.

CONSENT TO TREAT

Thank you for choosing River Cities Interventional Pain Specialists as your health care provider. The following is a statement of our Release of Information, Financial, and Medical Policies which we require you to read and sign prior to any treatment.

ASSIGNMENT OF BENEFITS: I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to River Cities Interventional Pain Specialists rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION-For Billing Purposes: I hereby authorize River Cities Interventional Pain Specialists to release medical information to Medicare, my employer's benefits department, or my other insurance company for the sole purpose of obtaining payment for my medical care. I understand that only information pertaining to obtaining payment for my care will be released. I agree that a copy of this release may be used in place of the original.

AUTHORIZATION TO RELEASE INFORMATION-For Coordination of Care: I hereby authorize River Cities Interventional Pain Specialists to release medical information to my referring physician, primary care doctor, case manager, and any other individual involved in my medical care for the sole purpose of facilitating treatment. I understand that my medical information is confidential and that I have a chance to request that my physician not share my medical records with any of the above individuals. Should I choose to exercise this right, I will provide in writing to my physician and any of the individuals involved in my care whom I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original. I am aware that I may request that this Release of Medical Information may be revoked at any time by providing the physician's office with a dated and signed letter.

PAYMENT FOR MEDICAL SERVICES: All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with the billing office. Necessary forms will be completed to file for insurance carrier payments. I hereby assume financial responsibility for all charges incurred for services rendered. I understand that I will be required to pay co-payments, amounts applied to deductibles and balance of bills not paid in accordance with the benefits of my current insurance policy. If I am unable to make payments in full for my medical treatment, I agree to call the billing office and make payment arrangements. I hereby authorize payment for all medical insurance benefits which are payable under the term of my insurance policy to be paid directly to River Cities Interventional Pain Specialists or designates for services rendered. I certify that the information I have reported regarding my insurance coverage is correct. I authorize the doctor's office to verify insurance coverage and benefits allowed in accordance with my insurance company's policy. I understand that it is my full responsibility that any third party which I

direct River Cities Interventional Pain Specialists to bill, in the event of non-payment for whatever reasons in accordance with the benefits of my current insurance policy, I will pay immediately. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. In the event that your account is turned over to an outside collection agency, you will be required to pay your entire balance and any collection agency fees, up to 25% of the balance owed and/or all attorney fees and costs incurred to collect the unpaid debt, before being scheduled for any further appointments.

PATIENT PORTAL GUIDELINES

Our Patient Portal lets established patients communicate more easily with us. The portal is not intended for 'Web Visits' or new problems. Instead, it will make regular communication more flexible. The portal is a voluntary option and is free of charge to all patients. The portal provides you with a much more seamless way to access your health information and contact our office.

Through the portal, you can:

- Update your contact and insurance information
- Check your lab results, medication list, medical history and your visits
- Request your own appointments and prescription refills
- View current and past statements, pay your bill and email billing questions
- Email us securely back and forth

The following will **NOT** be accepted through the Patient Portal:

- Receiving advice on the best course of treatment for your medical problem; *All diagnoses will be made by your provider when you are seen in the clinic for an office visit*
- Request for narcotics/controlled medications
- Request for refill for medication not currently being prescribed by an RCIPS provider

Reminders for the Patient Portal:

- If you forget your password you may request another one through the patient portal by clicking on the "Forgot Password" link.
- Avoid using a public computer to access the portal.
- The patient portal is provided as a courtesy service for our patients. There is no service fee. However if the patient abuses or misuses the portal we reserve the right to suspend or terminate the patient portal at any time and for any reason.
- You can access the portal day or night, but **we do not have a 24 hour presence** on our end**.** Our hours of operation are 8:00 am - 5:00 pm Monday-Friday. We encourage you to use the portal at any time; however messages are held for us until we return the next business day. Messages are typically handled within 2 business days. If your doctor is out of the office, your request may be held until your doctor returns to the office.

How the Secure Patient Portal Works. A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks. This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1. The secure message must reach the correct email address, and
2. Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address.**

You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Online communications should never be used for life threatening, emergency communications or urgent requests. As a safeguard, the portal should not be used for pressing issues. If you are experiencing an emergency or have an urgent medical need, call 911 or seek immediate medical assistance at the nearest Urgent Care or Emergency Room.

Patient Name: _____ **Date of Birth:** _____

MEDICATION REFILLS & ELECTRONIC PRESCRIBING POLICY

State law requires compliance and close monitoring for narcotic medications. If these are prescribed to you, you will be asked to sign an “Opioid Treatment Policy”. **Failure to comply, may result in termination from our practice.**

Prescriptions will only be refilled during normal business hours. No prescriptions will be filled during weekends, holidays, or after hours. It is your responsibility to make sure you have a sufficient amount of medications. You must remember:

- The patient is responsible for his/her pain medication.
- There are no early prescription refills.
- Call the office 3 BUSINESS DAYS before your medication runs out. You may not have someone else call for you.
- This facility does not fill narcotic prescriptions on the weekend, holidays, or after hours. If you require a refill outside of your appointment time, we require 3 days’ notice to fill a prescription once it has been evaluated by the practitioner. Be aware of holidays and office closings that might interfere with the 3 day notice.
- Due to the availability of your physician, your refill request may take up to three business days to be processed. Please check your prescription levels and make your request prior to running out of medication or the start of a weekend to ensure you have adequate medication supplies to last until your refill is processed. When weekends and/or holidays are involved, this could be a wait of four to five days.
- If your pharmacy runs out of the medication before you can fill it, and need your prescription sent to another pharmacy, we are not able to “call around” to other pharmacies to see who has it in stock. You must do this and then call our office and request to have the prescription cancelled from the pharmacy that cannot fill it and send to the new pharmacy.
- Due to the nature of our practice, our clinic nurses and advanced practice practitioners can generate prescriptions however ALL prescriptions must be reviewed and then signed by Randall Brewer, M.D. before sending electronically to your pharmacy. This is completed daily following the end of afternoon clinic.
- **MEDICATIONS ARE NOT REFILLED ON WEEKENDS, HOLIDAYS, or AFTER HOURS.**

Please be prepared to provide the following information when calling regarding your medication:

- Your Name & Telephone Number
- Pharmacy Name & Telephone Number
- Medication Name & Strength

CONSENT FOR ELECTRONIC PRESCRIBING

River Cities Interventional Pain Specialists is enrolled in an electronic prescribing program. This program is meant to help our providers with understanding what medications our patients are currently using and to give them the best possible treatment.

By acknowledging this form, you are consenting to allow RCIPS to retrieve electronic prescribing information from other providers through the PDMP database. Additionally, you acknowledge understanding of the *Medication Refills & Electronic Prescribing* stated above.

Patient Name: _____ **Date of Birth:** _____

ACKNOWLEDGEMENT OF POLICIES

I, the patient named above, attest that I am capable of reading and comprehending this form and accompanying policies, without assistance, and I have signed the form of my own free will. I agree that I have been made aware of the availability of assistance and/or an interpreter to help me in completing this form. I have also been made aware that a copy of the policies are available to me upon request.
My **initials** below verify that I have read and understand the RCIPS:

_____ *General Office Policies* _____ *Patient Portal Guidelines*

_____ *Financial Policy* _____ *Medication Refill & Electronic Prescribing*

_____ *Consent to Treat*

NOTICE OF PRIVACY PRACTICES

River Cities Interventional Pain Specialists, as well as the employees and agents of the Organization, will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care.

We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution.

My signature below acknowledges:

- I have received a copy of the Notice of Privacy Practices.
- I have been informed of my rights and obligations as a patient.
- My understanding of the information contained herein.

I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf.

_____ _____
Print Patient Name Date of Birth

_____ _____
Patient/Guardian Signature Today's Date

For Office Use Only

RCIPS Representative

_____
Print Name Signature Date

Complete this section if you are unable to obtain signature
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices however acknowledgment could not be obtained due to:

☐ Individual refused to sign ☐Communication barriers prevented obtaining acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other: _____

CLINIC PATIENT INFORMATION RECORD

RIVER CITIES INTERVENTIONAL PAIN SPECIALISTS

PATIENT DEMOGRAPHICS

First:_____ **MI:**____ **Last:**_____ **DOB:** _____ **SSN:**_____

Who referred you: _____ **Primary Care Provider:**_____

Employment Status: ☐Full Time ☐Part Time ☐Unemployed ☐Disability ☐Retired ☐Student

Employer:_____

Gender: ☐ Male ☐ Female **Marital Status:** ☐S ☐M ☐W ☐D ☐Sep

Ethnicity: ☐Hispanic or Latino
☐Not Hispanic or Latino

Race:_____

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

Communication Needs:_____

Residence Address:_____
_____

Mailing Address:_____
☐*Check if the same*

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

Okay to receive appointment/medication reminders via text?
☐ Yes ☐ No

Email:_____ **Required to access Patient Portal*

EMERGENCY CONTACT (other than someone living with you)

First:_____ **MI:**____ **Last:**_____ **Relationship:**_____

Home Phone:_____ **Alternate Phone:**_____

Address:_____

RESPONSIBLE PARTY (Do you carry the insurance or someone else? If someone else, fill out information below)

Name:_____ **Relationship:**_____

Date of Birth:_____ **SSN:**_____

Address:_____

Home Phone:_____ **Alternative Phone:**_____

Employer:_____ **Work Phone:**_____

INSURANCE COVERAGE Is your illness/injury due to an Auto/Work Accident? ☐ Yes ☐ No

Primary Insurance Company:_____

Policy Number:_____ **Group Number:**_____

Employer:_____ **Guarantor:**_____

Secondary Insurance Company:_____

Policy Number:_____ **Group Number:**_____

Employer:_____ **Guarantor:**_____

Tertiary Insurance Company:_____

Policy Number:_____ **Group Number:**_____

Policy Number:_____ **Guarantor:**_____

ALTERNATIVE CONTACTS

We at River Cities Interventional Pain Specialists take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff members to speak only with an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below: (***Please Initial)***

_____ I **do not authorize** anyone to receive information regarding my medical care.

_____ I **authorize** my physician and the employees of River Cities Interventional Pain Specialists to speak with:

Name:_____ Relationship:_____ Phone Number:_____
☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

Name:_____ Relationship:_____ Phone Number:_____
Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

Name:_____ Relationship:_____ Phone Number:_____
☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

Alternate means of contacting me are:

Voicemail/Machine	_____ ☐*preferred*
Cell Phone	_____ ☐*preferred*
Email	_____ ☐*preferred*
Other	_____ ☐*preferred*

By signing below I understand:
-This authorization will remain in effect unless changed by me while I am a patient at this practice.

-It is my responsibility to notify this office of changes and to complete a new form.

-Any problems and/or questions concerning this form are to be referred to the Privacy Officer.

-That should I desire to revoke this authorization, I will give written notice.

_____ _____
Patient Name Date of Birth

_____
Signature Today's Date

MEDICAL HISTORY &
BRIEF PAIN INVENTORY

RIVER CITIES INTERVENTIONAL PAIN SPECIALISTS

IDENTIFICATION DATA

Name: _____ **Date of Birth:** _____

Referred by: _____ **Today's Date:** _____

Gender: ☐Male ☐Female

MEDICATION HISTORY

Preferred Pharmacy & Street Address:

_____

List <u>ALL</u> medications you are currently taking *(prescription, over the counter, herbals, supplements, etc.),* **using the back of this packet if additional space is needed.** ☐ *None*

Medication	Dose	Daily Frequency	Prescribing MD	Reason

ALLERGIES

List any medication you are allergic to and your reaction. ☐ *No known allergies*

Medication	Reaction
_____	_____
_____	_____
_____	_____

MEDICAL HISTORY

Please list all surgeries, hospitalizations, and/or serious injuries, including date. ☐ *None*

_____

_____

_____

FAMILY HISTORY

List immediate family members who have died *(Father, Mother, etc).*

_____

_____

Check illnesses immediate family members have had:

☐ Allergies	☐ Asthma	☐ Cancer	☐ High Blood Pressure
☐ Depression	☐ Diabetes	☐ Glaucoma	☐ Hay Fever
☐ Heart Disease	☐ Obesity	☐ Sickle Cell Anemia	☐ Tuberculosis

SOCIAL & WORK HISTORY

Marital Status: ☐S ☐M ☐W ☐D ☐Sep **Children:** ☐No ☐Yes-**#Sons:** ____ **#Daughters:** ____

Lives Alone: ☐Yes ☐No **Do you feel safe in your environment?** ☐Yes ☐No _____

Tobacco Usage: ☐Current ☐Never ☐Former **Type:**_____ **#Years:** ____

Drinks Alcohol: ☐Yes ☐No Formerly **Type:** _____ **Frequency:** ____ *(x per wk)*

Drug Use/Abuse: ☐Yes ☐No ☐Formerly **Type:** _____ **Frequency:** ____ *(x per wk)*

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student

Highest Level of Education:

☐ Some High School ☐ High School Diploma/GED ☐ Some College ☐ Associates Degree
☐ Bachelor's Degree ☐ Graduate/Professional Degree ☐ Technical College

Did you stop working because of your pain? ☐ Yes ☐ No

Have you received financial compensation because of your pain? ☐ Yes ☐ No

Are you now bringing a lawsuit because of your pain? ☐ Yes ☐ No

Have you already filed suit for compensation? ☐ Yes ☐ No

SOCIAL & WORK HISTORY, continued

Is this visit related to Worker's Compensation? ☐ Yes ☐ No

If so, what was the initial date of injury? _____

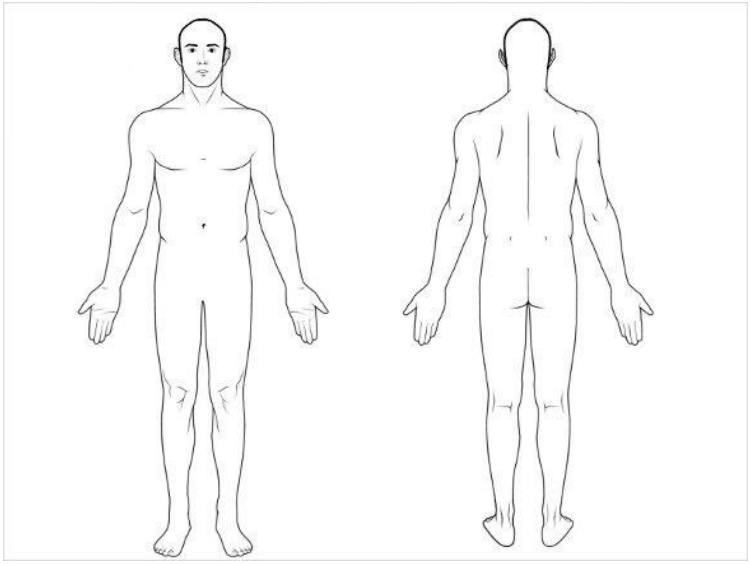
What is the location of your injury? _____

What is the name and contact information of you case adjuster?

Name: _____ Phone Number: _____

BRIEF PAIN INVENTORY

On the diagram, shade the areas where you feel pain. Put an "X" on the area that hurts the most.



Additional information you would like to note: _____

How long has it been since you first learned of your diagnosis? _____

Current Level of Pain 1 – 10 *(10 is worst)*: _____

Describe the frequency of your pain: ☐ Intermittent ☐ Constant ☐ Occasional ☐ Rare

Select the words that describe your pain:

☐ Ache ☐ Burning ☐ Deep ☐ Discomforting ☐ Dull ☐ Numbness

☐ Piercing ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing

What makes your pain worse?

☐ Movement ☐ Sitting ☐ Standing ☐ Stress ☐ Walking ☐ Other: _____

What relieves your pain?

☐ Exercise ☐ Heat ☐ Ice ☐ Injections ☐ Medication ☐ Physical Therapy ☐ Rest ☐ Sitting

Other methods you use to relieve your pain?

☐ Warm Compress ☐ Cold Compress ☐ Relaxation/Distraction Techniques ☐ Biofeedback

☐ Hypnosis ☐ Other: _____

BRIEF PAIN INVENTORY, continued

Rate your pain by choosing ONE number that best describes your pain at its *worst* last week.

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

No Pain *Worst Pain Imaginable*

Rate your pain by choosing ONE number that best describes your pain at its *least* last week.

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

No Pain *Worst Pain Imaginable*

Rate your pain by choosing ONE number that best describes your pain on *average*.

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

No Pain *Worst Pain Imaginable*

In the past week how much relief have pain treatments or medications provided?

☐0% ☐10% ☐20% ☐30% ☐40% ☐50% ☐60% ☐70% ☐80% ☐90% ☐100%

No Relief *Complete Relief*

Choose the number that best describes how pain has interfered this *past week* with your-

General Activity:

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

Does Not Interfere *Completely Interferes*

Mood:

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

Does Not Interfere *Completely Interferes*

Walking Ability:

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

Does Not Interfere *Completely Interferes*

Normal Work:

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

Does Not Interfere *Completely Interferes*

Relations with Other People:

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

Does Not Interfere *Completely Interferes*

Sleep:

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

Does Not Interfere *Completely Interferes*

Enjoyment of Life:

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

Does Not Interfere *Completely Interferes*

Have you ever had pain due to your present disease? ☐ Yes ☐ No

When you first received your diagnosis, was pain a symptom? ☐ Yes ☐ No

BRIEF PAIN INVENTORY, continued

Have you had surgery in the past month? ☐ Yes ☐ No

If YES, what kind? _____

I believe my pain is due to:

The effects of treatment *(ex. Medication, surgery, radiation, prosthetic device)* ☐ Yes ☐ No

My primary disease *(the disease currently being treated and evaluated)* ☐ Yes ☐ No

A medical condition unrelated to my primary disease *(ex. arthritis)* ☐ Yes ☐ No

What treatments or medications are you receiving for your pain?

_____

_____

_____

PAIN MEDICATION

I prefer to take my pain medicine:

☐ On a regular basis ☐ Only when necessary ☐ Do not take medicine

If you take pain medicine, how many hours does it take before the pain returns?

☐ 1 hour ☐ 2 hours ☐ 3 hours ☐ Pain medication does not help

☐ 4 hours ☐ 5 to 12 hours ☐ 12+ hours ☐ I do not take pain medicine

I take my pain medicine *(in a 24 hour period)***:**

☐ Not every day ☐ 1 to 2 times per day ☐ 3 to 4 times per day

☐ 5 to 6 times per day ☐ More than 6 times per day

Do you feel you:

Need a stronger type of pain medication? ☐Yes ☐No ☐Uncertain

Need to take more than what the doctor has prescribed? ☐Yes ☐No ☐Uncertain

Need to receive more information about your pain medication? ☐Yes ☐No ☐Uncertain

Are you concerned that you use too much pain medicine? ☐Yes ☐No ☐Uncertain

If yes, why? _____

Do you have side effects from your pain medicine? ☐Yes ☐No ☐Uncertain

If yes, which side effects? _____

PAIN MEDICATION, continued

Medications NOT prescribed by my doctor that I take for pain are:

_____

_____

REVIEW OF SYSTEMS

Please list the date of your last:

Dental Exam _____ Tetanus Shot _____

Chest X-Ray _____ EKG _____

Please check the box if your medical history includes any of the symptoms below.

EYE, EAR, NOSE, THROAT

Ear Infection	☐	_____
Eye Problems	☐	_____
Hay Fever	☐	_____
Hearing Loss	☐	_____

CARDIO-RESPIRATORY

Activity Limitation	☐	_____
Asthma	☐	_____
Congestive Heart Failure	☐	_____
Cough *(if chronic)*	☐	_____
Pacemaker/Defibrillator	☐	_____
Pneumonia	☐	_____
Rheumatic Fever	☐	_____
Trouble Breathing	☐	_____

GENITO-URINARY

Difficulty Starting Stream	☐	_____
Kidney Disease	☐	_____
Night Time Urination	☐	_____
Urinary Infection	☐	_____

SKELETAL

Arthritis	☐	_____
Back Problems	☐	_____
Joint Pain/Swelling	☐	_____
Neck Pain/Stiffness	☐	_____

GASTROINTESTINAL

Change in Bowel Habits	☐	_____
Jaundice *(hepatitis)*	☐	_____
Rectal Bleeding	☐	_____
Stomach Pain	☐	_____
Ulcers	☐	_____

ENDOCRINE

Diabetes	☐	_____
Hyperlipidemia	☐	_____
Recent Wt. Gain/Loss *(#10)*	☐	_____
Thyroid Problems	☐	_____

HEMATOLOGIC

Anemia	☐	_____
Bleeding Tendencies	☐	_____
Sickle Cell Disease	☐	_____
Thrombophlebitis/Blood Clot	☐	_____

VASCULAR

Arteriosclerosis	☐	_____
Coronary Artery Disease	☐	_____
Hypertension	☐	_____
Peripheral Artery Disease	☐	_____
Peripheral Vascular Disease	☐	_____

REVIEW OF SYSTEMS, continued

NEURO-MUSCULAR

Disorientation	☐	_____
Migraine/Headaches	☐	_____
Multiple Sclerosis	☐	_____
Muscle Pain	☐	_____
Numbness	☐	_____
Paralysis	☐	_____
Seizures/Epilepsy	☐	_____
Speech	☐	_____
Stroke	☐	_____
Tingling	☐	_____
Tremors	☐	_____
Weakness	☐	_____

RHEUMATOLOGY

Ankylosing Spondylitis	☐	_____
Fibromyalgia	☐	_____
Osteoarthritis	☐	_____
Osteoporosis	☐	_____
Polymyalgia Rheumatica	☐	_____
Psoriatic Arthritis	☐	_____
Rheumatoid Arthritis	☐	_____
Systemic Lupus Erythematosus	☐	_____

OTHER

Cancer	☐	_____
Depression	☐	_____
Mental Disorders	☐	_____
V.D. History	☐	_____

WOMEN ONLY

☐ Irregular Periods ☐ Abnormal Flow ☐ PID/Pelvic Pain ☐ Breast Disease

Last Menstrual Period *(date)*: _____ **Last Pelvic/Pap Smear** *(date)*: _____

Birth Control: ☐ No ☐ Yes, *what type?* _____ **#Pregnancies:** _____ **#Births:** _____