ADVANCED PAIN CARE CLINIC

PATIENT INFORMATION SHEET

PLEASE FILL FORM OUT COMPLETELY

TODAY'S DATE:	ACCOUNT #:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is This Your Legal Name? ☐ Yes ☐ No	If Not, What Is Your Legal Name?	(Former Name):	Birth Date: / /	Age:	Sex: ☐ M ☐ F

Street Address:	Social Security #	Home #: ( ) Cell #: ( )

P.O. Box:	City:	State:	Zip Code:

Employer:	Address: City: State: Zip:	Work#: ( )

Length Of Time Employed:	Supervisor's Name:	Employer Id:

Referring Source:	Referring Source #:

Is This A Job Related Injury? ☐ Yes ☐ No	(If Yes)Date Of Injury:	Is This Workman's Comp? ☐ Yes ☐ No

Is This An Injury Related To An Auto Accident? ☐ Yes ☐ No	(If Yes) Date Of Injury:

Name Of Friend/Relative (Not Living At Same Address):	**Phone #: ( )**

INSURANCE INFORMATION

Responsible Party: (If Different From Patient)	Birth Date: / /	Address (If Different): City: State: Zip:	Home #: ( ) Cell#: ( )

Is This Person A Patient Here?	☐ Yes	☐ No	Patient's Relationship To Subscriber:

Employer:	Address: City: State: Zip:	Work#: ( )

Name Of Primary Insurance:

Subscriber's Name:	Subscriber's SS #	Birth Date:	Group#:	Policy #:	Co-Payment:

Patient's Relationship To Subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name Of Secondary Insurance:

Subscriber's Name:	Subscriber's S.S. #	Birth Date:	Group#:	Policy #:	Co-Payment:

Patient's Relationship To Subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

I, THE UNDERSIGNED HEREBY AUTHORIZE THE STAFF TO PERFORM SUCH SERVICES AS DEEMED NECESSARY BY THE PHYSICIAN TO DIAGNOSE AND TREAT MY CONDITION(S). FURTHER I AUTHORIZE ASSIGNMENT OF MY INSURANCE RIGHTS AND BENEFITS DIRECTLY TO THIS PROVIDER AND ALSO AUTHORIZE THE RELEASE OF SUCH INFORMATION AS IS NEEDED TO PROCESS INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHICH MAY INCLUDE LEGAL FEE, COLLECTION FEE OR OTHER EXPENSES INCURRED BY THE PROVIDER IN COLLECTING MY ACCOUNT. I HEREBY ORDER ALL PARTIES TO ACCEPT A COPY OF THIS RELEASE AND ASSIGNMENT IN LIEU OF THE ORIGINAL. THIS SHALL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

PATIENT/GUARDIAN SIGNATURE:	DATE:

ADVANCED PAIN CARE CLINIC

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

PLEASE CHECK APPROPRIATE RESPONSE:

☐I have received a copy of Advanced Pain Care Clinic's Notice of Privacy Practices and am aware that I am at liberty to discuss any concerns I have with the appointed privacy officer

☐ I have declined to receive a copy of Advanced Pain Care Clinic's Notice of Privacy Practices. However, I do understand my privacy rights and that I am encouraged to contact the appointed privacy officer with any concerns I may have.

PATIENT NAME_____

SIGNATURE_____**DATE**___/___/____

NAME_____

RELATIONSHIP TO PATIENT: ***PLEASE CIRCLE APPROPRIATE RESPONSE***

SELF **PARENT/GUARDIAN** **POWER OF ATTORNEY**

Mailing Address: *PO Box 5249 Evansville, IN 47716*
Evansville Office: *1101 Professional Blvd. Evansville, IN 47714* ***Phone:*** *812.477.7246* ***Fax:*** *812.477.7240*

ADVANCED PAIN CARE CLINIC (APCC)
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact our Privacy Officer at APCC.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of PHI

Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your PHI that physician's offices are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we may disclose your PHI, as necessary, to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance to your physician with your health care diagnosis or treatment.

Payment: Your PHI will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a procedure may require that your relevant PHI be disclosed to the health plan to obtain approval for the surgery or service.

Health Care Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your PHI with third party "business associates" that perform various activities (for example, collections or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

We may use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

When Required By Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

For Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

For Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

For Health Oversight Requirements: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

For Abuse or Neglect Reports: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

For FDA Requirements: We may disclose your PHI to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

For Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

For Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

For Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

For Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Criminal Activity Reporting: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

For Workers' Compensation: We may disclose your PHI as authorized to comply with workers' compensation laws and other similar legally-established programs.

As Required for Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.

Other Permissions Required: We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Uses and Disclosures of PHI Based upon Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of PHI about you for so long as we maintain the PHI. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. Contact our Privacy Officer if you would like to request a copy of this information. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by submitting your request in writing to our Privacy Officer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to request that your physician amend your PHI. This means you may request an amendment of PHI about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at (812) 477- 7246 for further information concerning your PHI and how it is used for treatment, payment, and other health care operations as explained in this Notice.

This notice was reviewed and approved for publication on 12/27/2012.

ADVANCED PAIN CARE CLINIC

PATIENT AGREEMENT TO UP DATE INFORMATION

It is vitally important that your chart is kept up-to-date. Therefore, it is your responsibility to inform this office of any changes in your address, telephone number or insurance information. Failure to do so may make you fully responsible for any services rejected by your insurance carrier due to non-current demographic information.

I have read and understand the above information.

Patient Signature_____ **Date**___/___/____

Parent's Signature if patient is a minor_____

Mailing Address: PO Box 5249 Evansville, IN 47716
Henderson Office: 110 N Water Street Henderson, KY 42420 Phone: 270.869.9900 Fax: 270.869.9992
Evansville Office: 1101 Professional Blvd. Evansville, IN 47714 Phone: 812.477.7246 Fax: 812.477.7240

ADVANCED PAIN CARE CLINIC

INFORMATION RELEASE FORM

I AUTHORIZE YOU TO GIVE THE FOLLOWING PERSON(S) MEDICAL INFORMATION ON MY BEHALF:

NAME	RELATIONSHIP

YOU MAY DISCUSS THE FOLLOWING MEDICAL INFORMATION WITH THE ABOVE NAMED: (CIRCLE YES OR NO)

MEDICAL TEST & X-RAYS RESULTS **YES NO**

INFORMATION ON APPOINTMENTS **YES NO**

ANY MEDICAL INFORMATION **YES NO**

I GIVE YOU PERMISSION TO LEAVE MESSAGES ON MY HOME ANSWERING MACHINE:

YES NO

MAY WE CALL YOU AT WORK? **YES NO**

PHONE #_____

I AUTHORIZE THE FOLLOWING PERSON(S) PERMISSION TO PICK UP MY PRESCRIPTIONS:

NAME	RELATIONSHIP

I UNDERSTAND THAT ALL CHANGES TO AUTHORIZED PERSON(S) TO RELEASE INFORMATION TO / PERMISSION TO PICK UP PRESCRIPTIONS MUST BE SUBMITTED IN WRITING AND A NEW FORM FILLED.

SIGN_____**DATE**_____

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ADVANCED PAIN CARE CLINIC

PRESCRIPTION MEDICATION SIDE EFFECT AGREEMENT

There have been studies to show that people who have their pain adequately treated (provided they do not experience adverse side effects from their pain-medications) drive well and more safely than those persons who do not have their pain adequately treated. This is because severe, untreated pain can be distracting and cause lapses in attention. Lapses of attention are the main cause of accidents in the country.

However, certain pain medications, muscle relaxants, anti-anxiety agents, and antidepressant medications may cause a decrease in alertness, concentration, coordination, and response time. If you are experiencing any of these side effects with the medication used to treat your chronic pain condition, you should refrain from driving or operating any heavy equipment and you should inform your pain physician immediately. That way, your pain medication regimen may be modified to minimize such side effects and allow you to drive or operate heavy equipment safely.

If you ever require an increase or change in your medications, this may temporarily decrease alertness, attention span, coordination, and response time for approximately one to two weeks until the medications stabilize in your system. For this reason, any time you receive an increase or change in your medications, you should refrain from driving until you feel confident that your alertness, coordination, and response time have returned to an adequate level, and it is safe to drive or operate heavy equipment once again. **If you do drive while your alertness, concentration, coordination, or response time is hindered in any way, you could be charged with DUI. Do not drive while under the influence of medications.**

(Please check appropriate space below)

_____ I do currently have an active driver's license and agree to follow the above recommendations. I understand that if I do have an active driver's license, I may be tested at each visit for my alertness and response time. If inadequacies are noted, this information may be turned in to the Bureau of Motor Vehicles.

_____ I do not currently have an active driver's license. If, at a later date, I do choose to obtain a driver's license while being treated for my chronic pain, I agree to inform my pain physician immediately and to follow the above recommendation.

Patient Signature_____**Date**_____

Witness_____**Date**_____

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ADVANCED PAIN CARE CLINIC

PRESCRIPTION MEDICATION AGREEMENT

Advanced Pain Care Clinic, PSC (APCC) staff and I have a common treatment goal: to improve my ability to function and/or work. In consideration of that goal, I recognize that I may be treated with potent medication, some of which are narcotics or tranquilizers. The medications are controlled substances and therefore, monitored by local, state and federal agencies. These medications are highly effective when taken as directed under medical supervision, but they also have potential for misuse and abuse.

I, THEREFORE AGREE TO THE FOLLOWING: (*READ, INITIAL, AND SIGN*)

_____I agree that all medications for the control of the pain related to my pain condition will be prescribed only by my APCC physician. I will not use any medications for pain, or my pain condition, obtained from any other source.

_____If my referring physician or primary care physician prefers to write prescriptions for all of my medications, including those prescribed for pain, I will inform APCC SO that the APCC physician can consult with and make recommendations to my primary care or referring physician.

_____I agree to use only one pharmacy for filling all of my pain prescriptions. If I change pharmacies for any reason, I agree to immediately notify APCC. Please specific the pharmacy that you would like to use:

_____

_____I understand that my medications are prescribed for my use only. I will not share, give, or sell medications to anyone else. This is illegal as well as dangerous for the other person.

_____I agree to use my prescriptions exactly as written including the prescribed dose, time, interval, or frequency, and route.

_____I agree to provide APCC with information regarding any and all medications I am taking for any medical condition. If another physician prescribes any new or additional medications, I agree to notify APCC immediately.

_____I understand that I must be re-evaluated on a regular basis by my APCC physician. I agree to come in for all evaluations ordered by my APCC physician. I understand that failure to schedule visits and/or failure to show for the visits may result in an APCC decision to stop providing any further treatment to me.

_____I understand that some patients develop tolerance, which is the need to increase the dose of medication to achieve the same pain relief. I also understand that as a result of other treatment, therapy, or the natural course of my disease process, my pain may improve or increase. Therefore, my medication doses may have to be adjusted (increased or decreased) as deemed appropriate by my APCC physician. If I feel that my pain condition has worsened, I will contact my APCC physician because a worsening of my pain may necessitate further work-up. I will not adjust the medication by myself.

_____I understand that some of the medications prescribed for my pain condition are controlled substances and there is a risk of physical and psychological dependence. If this happens, I will follow my APCC physician's treatment plan and participates in any treatment program prescribed which may include medical treatment, psychological counseling, and detoxification.

_____I understand that to stop taking the medications abruptly may be dangerous and lead to withdrawal symptoms. If the medications need to be discontinued, I will do so gradually and ONLY under the medical supervision of my APCC physician or other healthcare professional that I may be referred to by my physician.

_____I am responsible for my pain center prescriptions and medications. Prescriptions or medications will not be replaced if they are lost, misplaced, or disappear for any reason.

_____I am responsible for ensuring that I obtain necessary refills of medication from APCC. I agree to follow the refill policy in place at the time.

_____I agree to periodic random drug screening and pill count(s) at the discretion of my APCC physician to assess the effectiveness of my medication as well as my compliance.

_____Generally, APCC will not provide early refills of narcotic medications. In the event of an emergency I agree to immediately contact APCC and abide by the policy on early refills in place at the time.

_____Occasionally a medication will not be effective to treat my pain. In such instances, I understand that my APCC physician may decide to try a different medication. I agree to provide my APCC physician with the unused portions of my current medications before obtaining a prescription for any new medications.

_____I authorize APCC to provide this Agreement and my medical records, and to discuss my condition, treatment, and prescribed medications, with my pharmacist and other physicians and healthcare providers. I also agree to sign a release authorizing my other health care providers to provide records to APCC and to discuss my treatment plan with APCC.

_____I understand that if I violate any of the above conditions, my treatment at APCC may be terminated. Moreover, if the violation involves pain and controlled substances or any prescription for my pain condition from another individual or any illegal activity such as altering a prescription, the incident may also be reported by APCC to other physicians caring for me, local facilities, pharmacies, and authorities such as local police department, drug enforcement agency, etc., as appropriate for the situation.

PATIENT SIGNATURE_____**DATE**__/__/____

WITNESS (OFFICE STAFF MUST WITNESS)_____**DATE**__/__/____

Name_____DOB_____Pharmacy_____Phone _____

ALLERGIES:_____

Date	HOME MEDICATIONS Including OTC's Herbals, and Home Remedies	Start Date	Stop date	Initials

DATE REVIEWED WITHOUT CHANGES:

Initials/date	Initials/date	Initials/date	Initials/date
Initials/date	Initials/date	Initials/date	Initials/date
Initials/date	Initials/date	Initials/date	Initials/date
Initials/date	Initials/date	Initials/date	Initials/date
Initials/date	Initials/date	Initials/date	Initials/date
Initials/date	Initials/date	Initials/date	Initials/date

WHAT PROBLEM BRINGS YOU TO SEE US TODAY? _____

_____

_____

WHEN DID THIS PROBLEM START? _____

WHAT CAUSED THE PROBLEM? _____

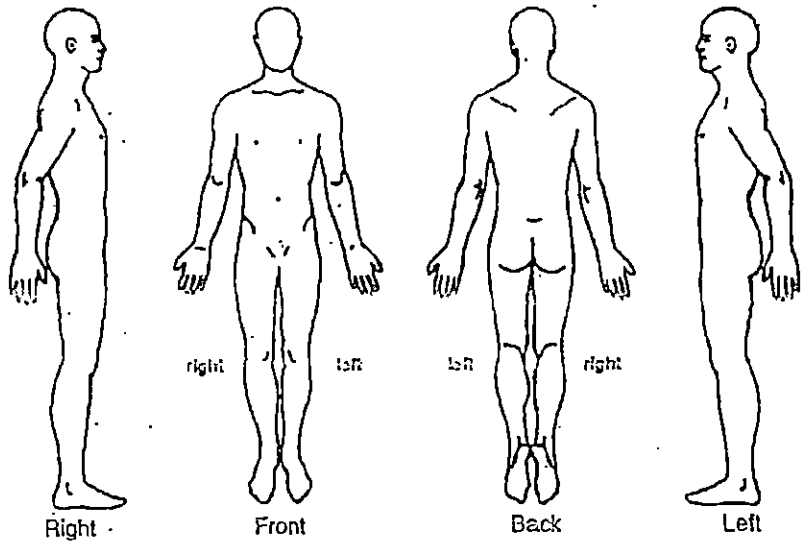
IF YOU WERE INJURED WAS IT:	Workman's Comp ☐ Yes ☐ No
☐ AT HOME	Case Manager's Name and phone number _____
☐ AT WORK	_____
☐ AUTO ACCIDENT	Involved in pending litigation?
☐ OTHER PERSONAL INJURY	☐ Yes ☐ No _____(Attorney's Name)

ON THE FIGURES AT THE RIGHT, PLEASE MARK YOUR AREAS) OF PAIN OR DISCOMFORT.
Type: (B) Burning (A) Ache (S) Stabbing
(P) Pins & needles (N) Numb
Circle the areas (if more than one) of pain and tell us on a scale of 1 to 10, with 1 being light pain to 10 being very severe, how severe is your pain in each area most of the time.

AREA 1 pain is (1-10) _____

AREA 2 pain is (1-10) _____

AREA 3 pain is (1-10) _____



DID YOUR PAIN COME ON:

☐ SUDDENLY ☐ GRADUAL

IS THE PAIN:

☐ Mild ☐ Moderate ☐ Intense

How would you describe your current mobility?

☐ Self Mobile ☐ Need Walker

ARE YOU ABLE TO:	YES	NO
SLEEP NORMALLY	☐	☐
DO DAILY ACTIVITIES	☐	☐
CARE FOR YOURSELF	☐	☐
FUNCTION NORMALLY	☐	☐

Which best describes your current employment?

☐ Working ☐ Full time ☐ Part time

☐ Unemployed ☐ Homemaker

☐ On sick leave ☐ Full time student

☐ On temporary disability

☐ On permanent disability ☐ Retired

If on temporary or permanent disability or sick leave:

Last full day of work was _____

What increases the pain?_____

What decreases the pain?_____

What time of the day is your pain worse?_____ What is your pain score(0-10)?_____

What time of the day is your pain least severe?_____ What is your pain score(0-10)?_____

PATIENT	ID#	DATE

ADVANCED PAIN CARE CLINIC

WHAT IS THE FREQUENCY OF YOUR PAIN?

☐ CONSTANT	☐ ON & OFF	☐ OCCASIONAL
☐ ONLY AT NIGHT	☐ ONLY ON EXERTION	

WHAT DOES YOUR PAIN FEEL LIKE?

Some of the words below describe your present pain. Look through the categories. **CIRCLE ONE SINGLE WORD IN EACH CATEGORY** that best describes your pain. Leave out any category that is not suitable.

1 FLICKERING QUIVERING PULSING THROBBING BEATING POUNDING	2 JUMPING FLASHING SHOOTING	3 PRICKING BORING DRILLING STABBING LANCINATING	4 SHARP CUTTING LACERATING
5 PINCHING PRESSING GNAWING CRAMPING CRUSHING	6 TUGGING PULLING WRENCHING	7 HOT BURNING SCALDING SEARING	8 TINGLING ITCHY SMARTING STINGING
9 DULL SORE HURTING ACHING HEAVY	10 TENDER TAUT RASPING SPLITTING	11 TIRING EXHAUSTING	12 SICKENING SUFFOCATING
13 FEARFUL FRIGHTFUL TERRIFYING	14 PUNISHING GRUELING CRUEL VICIOUS KILLING	15 WRETCHED BLINDING	16 ANNOYING TROUBLESOME MISERABLE INTENSE UNBEARABLE
17 SPREADING RADIATING PENETRATING PIERCING	18 TIGHT NUMB DRAWING SQUEEZING TEARING	19 COOL COLD FREEZING	20 NAGGING NAUSEATING AGONIZING DREADFUL TORTURING

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PREVIOUS EVALUATION OR TREATMENT BY ANOTHER PHYSICIAN.

If you previously had any of the following procedures, please list the date and place they were performed.

PROCEDURE	DATE	PLACE PERFORMED
X-Rays		
C.T. / MRI		
Myelogram		
Ultrasound		
E.M.G.		
Other		

Please indicate all therapies previously used to treat your condition, where given and the amount of relief obtained.

	Procedure / Therapy	Performed by or Description of therapy	Relief obtained
☐	Physical Therapy		
☐	Chiropractic Manipulation		
☐	Biofeedback		
☐	Massage therapy		
☐	Acupuncture		
☐	Occupational Therapy		
☐	Herbal or Homeopathic		
☐	TENS units		
☐	Home traction unit		

Have you undergone any psychological counseling for chronic pain or depression? ☐ YES ☐ NO

If yes, when and where _____

Have you undergone any surgical procedures, including nerve blocks to relieve your pain? ☐ YES ☐ NO

If yes, when, where and how much relief did they provide.

PREVIOUS MEDICATIONS PLEASE LIST ALL MEDICATIONS USED THAT DID NOT HELP Name of medication, Strength daily dose	What Medication or treatment, that you are not currently on, if any, seemed to help your pain before. Please list by name and give frequency that helped the most.	

PATIENT	ID#	DATE

PATIENT INTAKE FORM

SOCIAL AND FAMILY HISTORY

YOUR CURRENT AGE: _____ HEIGHT:_____ WEIGHT: _____

MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Filing for Divorce ☐ Divorced
(Please discuss with the Doctor any situation in your marriage that might contribute to your problem or inhibit your recovery.)

FAMILY STATUS	Name	Age	Health Status
SPOUSE:			
CHILDREN:			

Number of people living in your household? _____

Do you have stairs in your residence that you must climb? ☐ YES ☐ NO

Are you able to take medications by yourself? ☐ YES ☐ NO

Are you able to feed and bathe yourself? ☐ YES ☐ NO

Do you require any special care or have any other concerns that might affect your treatment or recovery?
☐ YES ☐ NO If yes please describe: _____

FAMILY HISTORY: Has anyone in your immediate family (mother, father, grandparents, brothers, sisters, children) had

	condition	who?		condition	who?
☐	Heart Disease		☐	Epilepsy	
☐	Hypertension		☐	Glaucoma	
☐	Stroke		☐	Bleeding disorders	
☐	Cancer		☐	Kidney disease	
☐	Diabetes		☐	Thyroid disease	

PATIENT	ID#	DATE

PATIENT INTAKE FORM

CURRENT MEDICATIONS PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. *(Prescription and over the counter)*	
Name of medication and Strength	# of doses / day

HOSPITALIZATION and SURGERY
PLEASE LIST ALL SURGERY AND ANY PERIODS OF HOSPITALIZATION. (give dates)

WHAT ARE YOU ALLERGIC TO ? _____

DO YOU HAVE IMPLANTS? ☐ Yes ☐ No PACEMAKER? ☐ Yes ☐ No DEFIBRILLATOR? ☐ Yes ☐ No

DO YOU NOW OR HAVE YOU EVER: (*This is confidential information we need to treat you properly.*)

Smoke ? ☐ YES ☐ NO ☐ STOPPED Packs per day? _____

Use Alcohol? ☐ YES ☐ NO Type and amount? _____

Drink Coffee / Caffeine? ☐ YES ☐ NO Type and amount? _____

Use recreational drugs? ☐ YES ☐ NO Type and frequency? _____

Been addicted to any drug? ☐ YES ☐ NO Type and how long? _____

Any history of drug or alcohol rehabilitation? _____

PLEASE MARK ANY CONDITION THAT YOU NOW HAVE OR HAVE RECOVERED FROM IN THE PAST.

☐ Severe headaches	☐ Chest pain / Angina	☐ Kidney Stones	☐ Digestive problems
☐ Hypertension	☐ Heart palpitations	☐ Renal disease	☐ Gout
☐ Stroke	☐ Heart murmur	☐ Diabetes	☐ Arthritis
☐ Epilepsy	☐ Arrhythmia	☐ Endocrine disease	☐ HIV / AIDS
☐ Fatigue	☐ Congenital heart disease	☐ Urinary or genital	☐ Claudication
☐ Dizziness / Fainting	☐ Rheumatic or Scarlet	☐ Prostate problems	☐ Ulcer
☐ Anemia	☐ Gall Stones	☐ Sexual dysfunction	☐ Venereal disease
☐ Shortness of breath	☐ Pancreatitis	☐ Menstrual dysfunction	☐ Mental Illness
☐ Asthma	☐ Liver disease	☐ Ovarian cysts	☐ Alcohol or Drug problems

WOMEN ONLY

Are you now or could you be pregnant ? ☐ YES ☐ NO

Date of last period: _____ Normal? ☐ YES ☐ NO

PATIENT	ID#	DATE

PATIENT INTAKE FORM