PREFERRED PAIN ASSOCIATES OF AL. P.C.

1110 N Challkville Road, Ste. 120
Trussville, Al 35173
205-508-5300
Alpainclinic.com

PATIENT INFORMATION

Date: ________________ **Name:** __________________________________

Height: ____________ **Weight:** ________ **Social Security#:** ________________

Date of birth: _____________ **Age:** _______ **Email address:** ______________

Address: Street______________________ **City** _______ **State** _______ **Zip** ___

Home Phone: __________________ **Work Phone:** ___________ **Cell:**________

Race: _____ **Ethnicity:** ______________ **Language** _______________________

Employer's Name ____

Address ___________________ **City** ________________ **State** ______________

Spouse's Name __________________ **Spouse Date of Birth** ________________

Spouse's Employer _______________________ **Phone** ____________________

Emergency Contact Person not living with you: __________________________
Emergency Contacts Relation to you: __________________________________
Insurance Information Primary Insurance:
____

Subscriber's Name _________________________________
Subscriber's Date of birth ____________________ **ID**______________________
Group # ________________ **Relationship to Patient** ______________________

PREFERRED PAIN ASSOICATES OF ALABAMA

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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth: ________________

Authorization for use/disclosure of my medical information: I voluntarily authorize and direct the healthcare provider's name below to disclose my health information during the term I am being treated in this clinic to the recipients I have identified below.

PROVIDERS NAME AND ADDRESS FOR RELEASE OF MY RECORDS:

Provider's Name: ____

Provider's Address: ____

____

Provider's Fax Number: ____________________ Provider's Phone number: ______________

NAME AND ADDRESS OF RECIPIENT FOR THE DELIVERY OF MY MEDICAL RECORDS:

Preferred Pain Associates of Alabama
1110 N Chalkville Road, Ste. 120
Trussville, Alabama 35173
Phone: 205-508-5300
Fax: 205-508-5230

Purpose: I understand that the purpose of this authorization is to help my doctors at the above pain clinic manage my care.

Information to be disclosed: Any of my health information that the Provider has including my medical history, mental or physical condition, any treatment received by me, xray reports, HIV/Aids status, psychotherapy or mental health information, drug alcohol, or other controlled substance information, and record some other healthcare providers that the above named healthcare provider may hold.

All of my healthcare information described above may be forwarded to Preferred Pain Associates of Alabama except for the following: ____

Patient Signature: ____

PREFERRED PAIN ASSOCIATES OF ALABAMA

PATIENT NAME_____________________________ DATE OF BIRTH________________

PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received a copy of Preferred Pain Associates of Alabama P.C. Notice of privacy Practices:

SIGNATURE: _____________________________ DATE______________________________________

I also authorize Preferred Pain Associates of Alabama P.C. to disclose and/or release my protected health information to the following:

__________________________________ Relationship to Patient

DO NOT RLEASE INFORMATION TO ANYONE:

SIGNATURE______________________________ Relationship________________________________

It is okay to leave information on an answering machine and/or voicemail Yes____ No _____

Sign____ Date __________________________________

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FINANCIAL POLICY

We appreciate the confidence that you expressed in selecting PREFERRED PAIN ASSOCIATES OF AL., P.C. for your healthcare needs and we look forward to working with you. If you have any questions about our services, fees or other aspects of your care please feel free to discuss your concerns with us.

A payment for your office visit is required at the time of service for:

Patients without insurance.

Patients with private insurance. We must have a copy of your insurance card on file.

ALL MONIES OWED BY THE PATIENTS, CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICES ARE PAYABLE AT TIME OF SERVICE.

Any service that is rendered by this office that is not a covered benefit of your insurance policy is your responsibility to pay. Our staff will assist you in dealing with your insurance company, but it is your responsibility to know and understand your own insurance policy. It is our sincere hope that this policy will be helpful and reduce any confusion or misunderstanding at a later date.

A 48 HOUR ADVANCE NOTICE IS REQUIRED FOR ALL CANCELLATION, Please call 205-508-5300 to cancel or reschedule your appointment. A FEE OF $ 50.00 MAY BE CHARGED FOR FAILURE TO TIMELY CANCEL AN APPOINTMENT. I WILL PAY TODAY AND FUTURE CHARGES BY CASH or CREDIT CARD. **WE DO NOT ACCEPT CHECKS**.

I UNDERSTAND THE ABOVE POLICY AND ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED AND AUTHORIZE PREFERRED PAIN ASSOICATES OF AL., P.C. TO TAKE ASSIGNMENT OF MY INSURANCE BENEFITS.

Name of Patient Signature______________________________ Patient Date______________________

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OPIATE AGREEMENT

I UNDERSTAND THAT I AM ENTERING INTO AN AGREEMENT WITH Preferred Pain Associates, P.C. to undergo comprehensive pain management. I understand that if I am found to be in violation of any of these statements I will be dismissed from care.

(1) I am responsible for my pain medication. I agree to take the medication only as prescribed and I understand it is my responsibility to make sure I do not run out. I understand I **MUST** keep medication in a safe place as refills will not be given for lost or stolen medications

(2) I will not accept/fill any narcotic prescriptions from any other Dr. (Emergency/Urgent Care, Surgeon, or Dentist) *This includes cough syrup

(3) My medication should never be given, shared or sold to others because it may endanger that person's health and it is against the law.

(4) I agree to refrain from using any/all illicit substances while taking the medication prescribed to me.

(5) Prescriptions **will not** be written in advance due to vacations, meetings, or other commitments/circumstances.

(6) I understand that my physician reserves the right to perform random or unannounced urine drug testing and pill counts. If requested, I agree to cooperate. I understand that failure to do so may result in the discontinuation of my care.

(7) I agree to allow my physician to contact any health care professional, pharmacy, legal authority, or regulatory agency in order to obtain or provide information about my care or actions if the physician feels it is necessary.

(8) It is my responsibility to provide my health care provider with my current address and phone number.

I have read the above information or it has been read to me. I hereby give my consent to participate in pain management and acknowledge the receipt of this document.

Signature______________________________ Date ________________________

Witness ______________________________ Date ________________________

Comprehensive Medical Questionnaire

Comprehensive Medical Questionnaire Referring Physician ______________________________

Primary Care Physician ______________________________________

Please list the names of any healthcare professionals who have been involved in the evaluation and /or treatment(s) of your pain condition

(Please Print Names Clearly)

Orthopedic Surgeon: _____________________________

Physiatrist / Rehabilitation Specialist: ___________________________

Spine Surgeon: ________________________________ Chiropractor: ________________________________

Neurologist: ___________________________________ Acupuncturist: ______________________________

Neurosurgeon: ___________________________ Pain Management Specialist: _______________________

Rheumatologist: ______________________________ Other: _______________________________________

Pain History

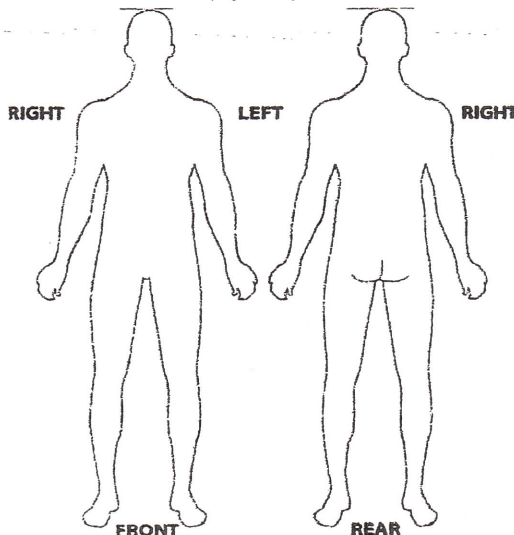
1. **Please Describe Your Pain Problem; where is your pain?**

   Where does your Pain Spread or Radiate? (Example: "Low back pain radiates down the back on my left leg to the heel")

   ____

   ____

   Please use the diagram to the left to demonstrate where your pain is located by shading the areas that are painful.



2. When did your pain begin? (Please be as specific as possible – for example "4 months ago")

____

____

3. How did your pain begin?

(Please check one and describe below)

[ ] Pain just started______________________________

[ ] Injury or Accident atwork______________________________

[ ] Injury or Accident at home ______________________________

[ ] Motor Vehicle Accident ______________________________

[ ] Following Surgery ______________________________

[ ] Following illness ______________________________

[ ] Other (specify) ______________________________

4. What does your pain feel like? ______________________________

____

(Please circle any of the words below which describes the character of your pain)

Sharp, Dull, Annoying, Penetrating, Burning, Aching, Miserable, Piercing, Electricity, Sore, Intense, Tight, Shooting, Hurting, Unbearable, Numb, Stabbing, Heavy, Troublesome, Squeezing, Lancinating, Tender, Cool, Tingling, Tiring, Cold, Throbbing, Sickening, Nauseating, Pounding, Terrifying, Agonizing, Cramping Punishing, Dreadful, Crushing, Blinding, Torturing, Pulling.

5. How does your Pain Change with Time?

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

Continuous, Rhythmic, Brief, Steady, Periodic, Momentary, Constant, Intermittent, Transient

6. Which activities or body positions (e.g. walking, bending, etc.) bring on or worsen your Pain?

____

____

____

7. Which symptoms are associated with your pain?

(Check all that apply)

[ ] Weakness of arm(s) – Left / Right /Both

[ ] Weakness of leg(s) - Left / Right /Both [ ] Numbness of arm(s)- Left / Right /Both

[ ] Numbness of leg(s) - Left / Right /Both [ ] Loss of bladder or Bowl control

[ ] Headaches [ ] Tenderness of Affected area [ ] Pain with only light touch [ ] Cool pal Skin

[ ] Weight Gain (how many lbs. past 6 months _____) [ ] Discolored or mottled Skin [ ] Weight Loss (how many lbs. past 6 months _____) [ ] Difficulty Sleeping [ ] Decreased sex drive
[ ] Pain awakens you at night [ ] Depression [ ] Fever [ ] Other

8. Please help us rate your pain on a numerical Scale:

(0 – No Pain at all 10 – The worst pain imaginable) Today 0 1 2 3 4 5 6 7 8 9 10

On good Days 0 1 2 3 4 5 6 7 8 9 10 On Bad Days 0 1 2 3 4 5 6 7 8 9 10

Average past week 0 1 2 3 4 5 6 7 8 9 10 Average past month 0 1 2 3 4 5 6 7 8 9 10

9. How does pain affect your lifestyle? (What can you no longer do because of your pain condition?)

____

____

10. Which Treatments have been used for your pain? (Check all that apply) Helpful?

When did you receive this treatment?

[ ] Pain Killers [ ] Yes [ ] No ______________________

[ ] Anti-Inflammatory Med's [ ] Yes [ ] No ______________________

[ ] Muscle Relaxants [ ] Yes [ ] No ______________________

[ ] Bedrest [ ] Yes [ ] No ______________________

[ ] Physical Therapy [ ] Yes [ ] No ______________________
[ ] Exercise [ ] Yes [ ] No ______________________
[ ] TENS (electrical stim) [ ] Yes [ ] No ______________________

11. Have you ever been diagnosed with or treated for any of the following health problems?

(Please check those that apply)

[ ] Angina / Chest Pain [ ] Hepatitis (circle type: A / B / C) [ ] Angioplasty or Stent for Blocked Artery [ ] High Blood Pressure [ ] Anxiety, Depression, or Panic Disorder [ ] HIV or AIDS [ ] Arrhythmia /Atrial Fibrillation / Cardiac Arrest [ ] Implantable Defibrillator [ ] Arthritis (Type: Osteo / Rheumatoid) [ ] Kidney Failure / Dialysis [ ] Asthma / Wheezing [ ] Liver Disease / Cirrhosis [ ] Bipolar Disorder [ ] Neuropathy (Type ________________) [ ] Bleeding Disorder (Hemophilia, ITP, Etc.)] Obesity [ ] Cancer (Type ____________________)

[ ] Pacemaker [ ] Chronic Cough

[ ] Paralysis (Describe ______________________________) [ ] Congestive Heart Failure (year ________) [ ] Previous Suicide attempt [ ] Deep Venous Thrombosis (Blood Clot Leg)

[ ] Pulmonary Embolism (blood clot in lung) [ ] Diabetes (Type I _____ Type II _____)

[ ] Seizure or Epilepsy [ ] Drug or Alcohol Abuse / Addition [ ] Sickle Cell Disease

[ ] Emphysema, Chronic Bronchitis or COPD [ ] Stomach or Duodenal ulcer (year ______)

[ ] Fibromyalgia [ ] Stroke or TIA [ ] Headache (Migraine, Cluster, or Tension)

[ ] Thyroid Disease (over or underactive) [ ] Heart attack (Year __________)

12. Please list any Surgeries / operations you have had in the past. Year Type of Surgery

____

____

____

13. Please list your Allergies to Medications or Other Drugs: Name of Medication Type of Reaction Experience;

NAME OF MEDICATIONS:	TYPE OF REACTION EXPERIENCE
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

14. Are you allergic to Iodine Contrast Dye (e.g.IVP Dye)

[ ] Yes [ ] No If you answered yes, What Type of reaction did you have?

____

15. Are you allergic to Aspirin or Anti-Inflammatory Medications (e.g. Ibuprofen?)

[ ] yes [ ] No If you answered yes, What Type of reaction did you have?

____

Current Medications:

16. Please list the medications which you currently take strictly for Pain:

Name of Medication Dosage	Number of Pills per Day
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

17. Please list the medications which you currently take for other medical conditions:

Name of Medication:

______________________, ______________________

______________________, ______________________, ______________________

______________________, ______________________, ______________________

______________________, ______________________, ______________________

18. Do you take Aspirin?

[ ] Yes [ ] No If yes, when was you last dose? ______________________

19. Do you take Coumadin, Plavix, Pletal, Aggrenox or Ticlid? [ ] Yes [ ] No

If yes, when was you last dose? ______________________

If you answered yes will the prescribing physician allow you to discontinue this blood thinner medication for any length of time? [ ] Yes [ ] No

Please Note: You must have permission from the physician who prescribed or manages the blood thinner in order to stop this medication.

Please check the box if you currently have any of the following:

[] fever, weight loss, sweats [] cough, sputum production, wheeze [] shortness of breath [] weakness or paralysis of arms or legs [] easy bruising or bleeding [] headache (s), how often? _________ [] dizziness, vision changes, lightheadedness [] swelling or rash [] abdominal pain [] change in bowel habits, nausea [] chest pain, palpitations [] change in bladder habits (frequency, pain)

[] PREGNANT OR POSSIBLY PREGNANT?

20. Do you take any herbal medication? [ ] Yes [ ] No

(If Yes, List which ones ________________________________)

Do you take Vitamin E [ ] Yes [ ] No

21. What is your current marital status?

(Please check one) [ ] Single – Never Married [ ] Married Years _______________

[ ] Divorced Years _______________ [ ] Widowed Years _______________

[ ] Separated Years _______________

22. With whom do you live? (Check all that Apply)

[ ] Live alone [ ] With Parents [ ] With In-Laws [ ] With Spouse [ ] with other relatives [ ] With Other Significant other, Roommate, etc.) [ ] With Children (Ages________________________)

[ ] With Brothers or Sisters

23. How far did you get in school?

(Please check one) [ ] Less than 8th Grade [ ] Completed 8th Grade [ ] Completed High School [ ] Some College (years ___) [ ] Completed College [ ] Technical or Business School [ ] Advance Degree (Type ______)

24. Do you currently Smoke Cigarettes?

[ ] Yes [ ] No If yes how many packs do you smoke during a average day? __________ Packs If Yes, for how long in years have you smoked __________ Years If No and you are a former smoker, when did you quite for good _____________

25. Do you Drink Alcoholic beverages?

[ ] Yes [ ] No If yes how often? What is your drink of choice (i.e. beer, wine, gin, vodka etc.) ______________________________ [ ] Never [ ] Less than once a week [ ] about once a week [ ] Daily or

more often [ ] Several times a week [ ] I am a Heavy Drinker How many drinks do you have each time you consume alcohol? ______________________

26. Have you ever been diagnosed with or treated for Drug or Alcohol abuse?

[ ] Yes [ ] No if yes when? ____________________ Please Describe____________________________

Work History

27. What is your employment status? (Please Check One)

[ ] Retired [ ] Homemaker [ ] Student [ ] Working Part Time [ ] Able to work but currently un-employed [ ] Not Working, on workers comp (On Leave since _________________________) [ ] Not Working, on Disability since (date _____________) [ ] Working full time (Light Duty)

28. What is (was) your occupation or Job Title? (Please describe) ______________________________

29. Which of the following are regular requirements of your job?

____

(Check those that apply)

[ ] Heavy lifting (over 30 pounds)] Light lifting (15 – 30 pounds) [ ] Frequent Stooping, Bending, Twisting [ ] Standing for long periods of time (over one hour at a time) [ ] Sitting for long periods of time (over one hour at a time)] Computer Work [ ] Other Physical requirements

30. How much work have you missed as a result of your pain problems?

(Check one) [ ] None [ ] I have missed ______ days of work due to my pain problems

[ ] I have missed ______ weeks of work due to my pain problems

[ ] I have missed ______ months of work due to my pain problems

[ ] Not Applicable to my situation

[ ] other____

31. Please use the following space to address any other issues related to your pain condition not already covered in this questionnaire. Your comments and concerns are welcome.

____

____

____

WHICH DIAGNOSTIC STUDIES HAVE BEEN DONE TO EVALUATE YOUR PAIN PROBLEMS (Please check all that apply)

[ ] Blood order by: ______________________ [ ] X-Rays order by: ______________________ [ ] MRI order by: ______________________ [ ] CT scan order by: ______________________ [ ] Bone Scan order by: ______________________ [ ] other ______________________

[ ] EMG / Nerve Conduction Studies order by: ______________________

I Certify That I Have Answered All Of The Above Questions Truthfully And To The Best Of My Ability.

______________________________ ______________________________

Patient Signature Date