PAIN HISTORY

General Information

Name: _____ Date of Birth: _____ Height: ____ Weight: ____ Age: ____ Male ___ Female ___

Physician Notes: _____ Chief Complaint: _____

_____

List your pain and their intensities: Pain Start Date: _____

1. _____ mild ___ moderate ___ severe ___ On its own_____

2. _____ mild ___ moderate ___ severe ___ Due to Job Injury _____

About your Pain

		Increased by:	**Decreased by:**	**In the past week:**
___ constant	___ sharp/stabbing	___ activity	___ activity	
___ comes and goes	___ burning	___ walking	___ walking	Avg. Pain _____ (0-10)
___ worse in am	___ throbbing	___ standing	___ standing	Worst Pain ____ (0-10)
___ worse in pm	___ ache	___ sitting	___ medications	Least Pain _____ (0-10)
___ worse since began	___ radiates to ____	___cold	___other _____	0 = no pain
___ began 5-10 yrs ago	_____	___ other _____	_____	10 = unbearable pain
___ began > 10 yrs ago	___ numbness			

_____

Past Treatments Tried (Please check all that apply and treatment dates)

Chiropractor ___ (Date:_____) Physical Therapy ___ (Date: _____) Home Exercise ___ (Date: _____)

Trigger Points ___ (Date:_____) Epidural Steroids ___ (Date: _____) Facets/Sacroiliac Blocks ___ (Date: _____)

Radiofrequency Rhizotomy ___ (Date: _____) NSAIDS Muscle Relaxers _____ (Date: _____)

_____

Diagnostic Studies	Dates	Locations	Results (Physician Notes)
___ MRI	_____	_____	
___ CT	_____	_____	
___X-ray	_____	_____	
___Bone Scan	_____	_____	
___ Myelogram	_____	_____	
___ EMG/NCV	_____	_____	
___ Other	_____	_____	

Current Pain Medications (name of prescribing physician)
(Muscle relaxers, anti-inflammatory)

_____
_____
_____

Medications (current medication-**not** pain meds)

_____
_____
_____
_____
_____
_____

Name: _____

PAST MEDICAL HISTORY: (Indicate past and present problems)

Cardiovascular Disease
___ Pacemaker
___ Coronary Artery Disease
___ Valves
___ Hypertension

Bleeding Disorders
___ Yes
___ No

Liver Disease
___ Cirrhosis
___ Hepatitis C
___ Hepatitis B
___ Hepatitis A

Diabetes
___ Insulin
___ Medications
___ Diet

Thyroid Disease
___ Yes
___ No

Cancer
Type: _____

Lung Disease
___ Asthma
___ Emphysema
___ Shortness of breath

Arthritis
___ Yes
___ No

Kidney Disease
___ Stones
___ Dialysis

Other: _____

ALLERGIES (TO MEDICATIONS, LATEX, ETC...)

_____ _____
_____ _____
_____ _____

PAST MEDICAL HISTORY

___ AIDS
___ Alcoholism
___ Anemia
___ Asthma
___ Anorexia
___ Appendicitis
___ Arthritis
___ Bleeding Disorders
___ Breast Lump
___ Bronchitis
___ Bulimia
___ Cancer – Cervical
___ Cancer – Lung
___ Cancer – Ovarian
___ Cirrhosis
___ Chemical Dependency
___ Coronary Artery Disease
___ Dialysis
___ Diabetes I
___ Diabetes II
___ Emphysema
___ Epilepsy
___ Glaucoma
___ Goiter
___ Gonorrhea
___ Gout
___ Heart Disease
___ Hepatitis A
___ Hepatitis B
___ Hepatitic C
___ Hernia
___ Herpes
___ High Cholesterol
___ HIV Positive
___ Hypertension
___ Kidney Stones
___ Liver Disease
___ Measles
___ Migraine Headaches
___ Mononucleosis
___ Multiple Sclerosis
___ Mumps
___ Pacemaker
___ Pneumonia
___ Polio
___ Prostate Problems
___ Psychiatric Care
___ Rheumatic Fever
___ Scarlet Fever
___ Shortness of Breath
___ Stroke
___ Suicide Attempt
___ Thyroid Disease
___ Tonsillitis
___ Tuberculosis
___ Typhoid Fever
___ Ulcers
___ Valve Replacement
___ Venereal Disease

PAST SURGICAL HISTORY

___ Unremarkable
___ Abd Surg-Type
___ Amputation
___ AV Fistula Creation
___ AV Graft
___ Aortic Valve Replacement
___ Appendectomy
___ Back Surgery
___ Bronchoscopy
___ CABG
___ Carotid Endarterectomy
___ Carpal Tunnel
___ Cataract Extraction
___ Cholecystectomy
___ Colon Resection
___ Craniotomy
___ Gastric Bypass
___ Hemorrhoidectomy
___ Hip Replacement
___ Interventional pain procedures
___ Knee Arthroscopy
___ Knee Replacement
___ Kyphoplasty
___ L A-F Bypass
___ Mitral Valve Replacement
___ Nephrectomy-Native
___ Nephrectomy-Transplant
___ Pacemaker
___ Parathyroidectomy
___ Pneumonectomy
___ Prostatectomy
___ PTCA
___ R A-F Bypass
___ Rotator Cuff Repair
___ TURP +
___ Tonsillectomy
___ Tunneled Dialysis Catheter
___ UPPP
___ Urinary Incontinence Surgery
___ Anesthesia Pro-Yes
___ Anesthesia Pro-No
___ Surgical Complications-No
___ Surgical Complications-Yes
___ Post-op Delirium

FAMILY HISTORY

___ FH Alcoholism
___ FH Anemia
___ FH Arthritis
___ FH Anesthetic Complications
___ FH Anxiety
___ FH Asthma
___ FH Back Problems
___ FH Birth Defects
___ FH Blood Clots
___ FH Blood Transfusions
___ FH Breast Cancer
___ FH Cervical Cancer
___ FH Colon Cancer
___ FH Depression
___ FH Diabetes
___ FH Growth/Development Disorder
___ FH Hearth Disease
___ FH Angina
___ FH Hypertension
___ FH High Cholesterol

FAMILY HISTORY

___ FH Psychiatric Care
___ FH Osteoporosis
___ FH Seizures
___ FH Severe Allergies
___ FH Stroke
___ FH Suicide Attempt
___ FH Bowel Disease
___ FH Heart Disease
___ FH Kidney Disease
___ FH Respirator Disease
___ FH Liver Disease
___ FH STD
___ FH Ulcers
___ FH Surgery-Cervical
___ FH Surgery-Lumbar
___ FH Surgery-Thoracic
___ FH Other Diseases
___ FH CHD male <55
___ FH CHD female <65
___ FH Colon Cancer-Father
___ FH Colon Cancer-Mother
___ FH Lung Cancer
___ FH Melanoma
___ FH Ovarian Cancer
___ FH Uterine Cancer
___ FH Other Cancer
___ FH Thyroid Disease
___ FH Weight Disorder
___ FH Headaches
___ FH Other Medical Problems
___ FH PMS
___ FH Endometriosis

SOCIAL HISTORY

___ Current Smoker
___ Former Smoker
___ Never Smoked
___ Counseled to Quit?
___ Passive Smoke-Yes
___ Passive Smoke-No
___ Alcohol Use-Yes
___ Alcohol Use-No
___ Drug Use-Yes
___ Drug Use-No
___ HIV High Risk-Yes
___ HIV High Risk-No
___ Regular Exercise-No
___ History Domestic Abuse
___ Religious Belief Affecting Care

PSYCOSOCIAL HISTORY

Marital Status
___ Single
___ Widowed
___ Divorced
___ Live Alone
___ Married

Are You Pregnant?
___ Yes ___ No

Work History
___ Currently Working
___ Unemployed
___ Retired
___ Disabled - SSI
___ Short Term Disability
Last Day Worked _____

REVIEW OF SYSTEMS

General
___ weight loss
___ weakness
___ fatigue
___ fever

Eyes
___ vision loss
___ double vision
___ glasses

ENT
___ pain/tearing
___ hearing loss
___ dizzy
___ tooth/gum pain

Cardiovascular
___ high blood pressure
___ chest pain
___ palpitations
___ murmur
___ shortness of breath

Respiratory
___ cough
___ bronchitis
___ coughing up blood

GI
___ trouble swallowing
___ nausea/vomiting
___ heartburn
___ constipation
___ diarrhea
___ bloody stool
___ abdominal pain

GU
___ bloody urine
___ urgency/incontinence
___ pain with urination

Musculoskeletal
___ joint pain
___ stiffness
___ limp
___ spasms
___ muscle pain
___ limited movement

Derm/Skin
___ rash
___ lumps
___ redness
___ itching
___ swelling

Neurological
___ seizures
___ paralysis
___ fainting
___ numbness
___ tingling

Psychological
___ depression
___ anxiety
___ moodiness

Endocrine
___ sweating
___ thirsty
___ always cold
___ always hot

Hematology
___ bleeding
___ blood clots

Allergy
___ urticaria
___ allergic rash
___ hay fever
___ recurrent infections

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signed: _____ Dated: _____

Received: _____ Dated: _____

I understand that as part of my healthcare, Hot Springs Interventional Pain Management originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:
A basis for planning my care and treatment,
A means of communication among the many health professionals who contribute to my care,
A source of information for applying my diagnosis and surgical information to my bill,
A means by which a third-party payer can verify that services billed were actually provided, and
A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:
The right to review the notice prior to signing the this consent,
The right to object to the use of my health information for directory purposes, and
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that Hot Springs Interventional Pain Management is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Hot Springs Interventional Pain Management reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Hot Springs Interventional Pain Management change their notice, they will send a copy of any revised notice to the address I've provided (weather U.S. Mail or, If I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I grant the clinic's staff and physician's permission to discuss my protected health information and other personal information with the following persons:

NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER

I { } do { } do not
Authorize Hot Springs Interventional Pain Management to forward/fax Return to Work excuses to employer or school.

I { } do { } do not
Authorize Hot Springs Interventional Pain Management to leave appointment information on my answering machine.

I understand that as part of this organization's treatment, payment or health care operation, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures, via fax.

I fully understand and accept the terms of this consent.

Patient's Signature: _____ Date: _____

BASIC POLICY:
Payment for services is due in full at the time the service is provided in our offices unless we are a member of your insurance group. Please contact your insurance company regarding covered members, or prior arrangements must be made with this office.

FOR PATIENTS WITH INSURANCE:
If we are members of your insurance group, we will bill the insurance carrier for payment to come directly to us. You will be responsible for co-payment and deductibles only. All co-payments and deductibles are due and payable at the time the service is provided.

If we are not members of your insurance group, we will bill most insurance carriers for you if the proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Payment for these claims will come directly to us. If our office can be of any assistance with your insurance carrier, please let us know.

MEDICARE PATIENTS:
Our office accepts Medicare assignments. We will also bill secondary insurances for you. All co-payments and deductibles are due and payable at the time service is provided.

NON-COVERED SERVICES:
Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of an insurance claim denial.

ASSIGNMENT AND RELEASE:
I, the undersigned patient, have insurance coverage and assign directly to Hot Springs Interventional Pain Management all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the office of Hot Springs Interventional Pain Management to release all information necessary to secure the payment of benefits or to pre-certify their services as required by my insurance company. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

MEDICARE AUTHORIZATION:
I request that payment of authorized Medicare benefits be made to Hot Springs Interventional Pain Management for any services furnished me by any member of this clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or if electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown in Medicare, assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the determination of the Medicare carrier.

_____ _____

Signature of Insured/Guardian/Beneficiary Date

I have read, understand and agreed to the above financial policy for payment of professional fees. I understand that I, the patient, am ultimately responsible for all professional fees.

_____ _____

Signature Date

If your prescription is to be called to your pharmacy or picked up at the office, please notify us 72 business hours in advance.

If your prescription is to be mailed to your pharmacy, please notify us seven (7) business days in advance.

Prescriptions will not be mailed to your home.

You will not be notified of when your prescription is ready. If you called the office three (3) business days before your refill date, you may come by the office on the third day after 2:00 p.m. to pick up your prescription. If your prescription was mailed to your pharmacy, please check with them on the due date to see if your medication is ready. We ask that you refrain from making numerous calls to see if your prescription is ready.

When leaving a message for a refill, please speak slowly and clearly. Please spell your last name and list a phone number where you can be reached. Please list the names of your medications you will need refilled.

If the pharmacy fills your medication early, it will not change your due date the next month.

Refills will not be given early if you take more medication than prescribed.

You are responsible for your prescriptions and medication. If lost, stolen, or misplaced, we will not give a replacement prescription.

For prescription refills, you may call 501-321-4772 and leave a message on the prescription refill line.

Pharmacy_____ Phone Number _____. You will use only the pharmacy listed above for filling all medications.

If you do not keep your appointments or follow your plan of treatment, you are at risk of your medication being stopped or being terminated as a patient from the clinic.

Random urine or blood drug screens will be performed to document the proper use of your medication, as well as to confirm your compliance.

The physician has the right to refer you to your Primary Care Physician for Med Management.

Due to circumstances beyond the control of the Physician, appointment times are estimates, not exact times that you will be seen. If you have not been seen within one hour of your appointment time, please see the receptionist.

Patient's Signature: _____ Date: _____

Nurse's Signature: _____ Date: _____

HOT SPRINGS INTERVENTIONAL PAIN MANAGEMENT
ONE MERCY LANE, SUITE 304 • HOT SPRINGS, AR 71913
(501) 321-4772 • Fax (501) 321-2945

Authorization for Release of Protected Health Information (PHI)

Name: _____ DOB: _____ Phone #: _____

PLEASE OBTAIN INFORMATION FROM:	PLEASE SEND INFORMATION TO:
_____ Name of Provider/Clinic/Organization	Hot Springs Interventional Pain Management
_____ Street Address	One Mercy Lane, Suite 304
_____ City, State, Zip Code	Hot Springs, AR 71913
Phone: _____ Fax: _____	Phone: 501-321-4772 Fax: 501-321-2945

I AUTHORIZE the following information to be disclosed: (Please check all that apply)

____ Entire Medical Record	____ Consultation	__X__ Radiology/Imaging Reports/Films
__X__ Progress Notes	____ Immunizations Record	____ Billing Records
__X__ Most Recent History & Physical	____ Laboratory Reports	____ Other _____

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

REASON for disclosure of health information: (Please check one)

____ Continuing Care	____ Legal Purposes	____ SS/Disability (provide SSA letter)
____ Consultation	____ Insurance	____ Job/School
____ Second Opinion	____ Personal Use	____ Other _____

EXPIRATION of this Authorization: (Please check one)

____ 180 days after signature date ____ On this date _____ ____ After this event _____

This authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying the Health Information Management Department at Hot Springs Interventional Pain Management. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date tat is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

ADDITIONAL PATIENT INFORMATION:

- I understand that I have the right to withdraw this authorization as indicted in the above paragraph.
- I understand that I do not have to sign this authorization to get treatment.
- I understand that once my health care information is disclosed as I have authorized, it could be redisclosed by the recipient and is no longer protected by Hot Springs Interventional Pain Management.
- I understand that signing this authorization does not cancel any rights I have under other state or federal laws.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed Name of Patient or Patient's Representative

_____ or _____
Relationship to Patient Legal Authority (attach supporting documentation

HOT SPRINGS INTERVENTIONAL PAIN MANAGEMENT
ONE MERCY LANE, SUITE 304
HOT SPRINGS, AR 71913
Phone (501) 321-4772 Fax (501) 321-2945

ORT ASSESSMENT

Patient Name: _____ DOB: _____

Please answer these questions truthfully; it will help us better treat your pain

		Female	Male	Score
Is there a history of substance abuse in your family?	Alcohol	Yes / No	Yes / No	_____
	Illegal Drugs	Yes / No	Yes / No	_____
	Prescription Drugs	Yes / No	Yes / No	_____
Have you had a history of substance abuse?	Alcohol	Yes / No	Yes / No	_____
	Illegal Drugs	Yes / No	Yes / No	_____
	Prescription Drugs	Yes / No	Yes / No	_____
Is your age between 16 and 45?		Yes / No	Yes / No	_____
Is there a history of preadolescent (childhood) sexual abuse?		Yes / No	Yes / No	_____
Do you have a history of any of the following conditions?	ADD/OCD, Biopolar, Schizophrenia	Yes / No	Yes / No	_____
	Depression	Yes / No	Yes / No	_____
			Total	_____

Score column for Office Use only

Impressions: _____

_____ _____

Jacob Abraham, M.D. / Sharon England, APN / Chris Jarvis, APN Date

BRIEF PAIN INVENTORY (Short Form)

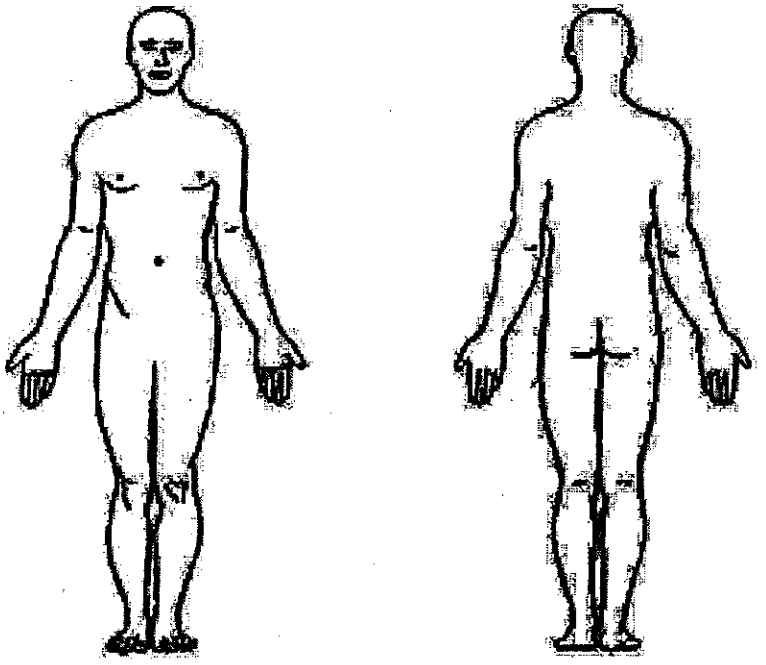
Date: _____ Time: _____

Name: _____ _____ _____
Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

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



Right Left Left Right

3) Please rate your pain by circling the one number that best describes your pain at its **WORST** in the past 24 hours

0 1 2 3 4 5 6 7 8 9 10
No pain Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the past 24 hours

0 1 2 3 4 5 6 7 8 9 10
No pain Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have **RIGHT NOW**

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

8) In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much **RELIEF** you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No relief										Complete Relief

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity:

0	1	2	3	4	5	6	7	8	9	10
Does Not Interfere										Completely Interferes

B. Mood:

0	1	2	3	4	5	6	7	8	9	10
Does Not Interfere										Completely Interferes

C. Walking ability:

0	1	2	3	4	5	6	7	8	9	10
Does Not Interfere										Completely Interferes

D. Normal work (includes both work outside the home and housework):

0	1	2	3	4	5	6	7	8	9	10
Does Not Interfere										Completely Interferes

E. Relations with other people:

0	1	2	3	4	5	6	7	8	9	10
Does Not Interfere										Completely Interferes

F. Sleep:

0	1	2	3	4	5	6	7	8	9	10
Does Not Interfere										Completely Interferes

G. Enjoyment of life:

0	1	2	3	4	5	6	7	8	9	10
Does Not Interfere										Completely Interferes

F. Sleep: