COMPREHENSIVE PAIN SPECIALISTS

www.CPSPAIN.com

PATIENT INFORMATION SHEET

Today's Date ________ PT DOB: ______________

Patient Last Name: ____ First Name: ___________________________

Social Security # _________________________Previous Last Name and/or NickName: _______________________

Sex: ___ Male ___Female **Marital Status:** ___ Married ___Single ___ Divorced ___Widowed ___Other

Mailing Address ____

City: ______________________________State:_________________________Zip Code:____________________

Patient's Street Address (If different from mailing address) ____

If Patient resides in Skilled Nursing Facility what is the name of the facility? ________________________________

If Patient is a Hospice patient, what is the name of the Hospice Service? __________________________________

Patient's Primary Care Provider:_____________________________Referring Provider:_______________________

PCP Phone Number: ____________________________ Referring Provider Phone Number: ____________________

I wish to be Contacted in the Following Manner

☐ Home Telephone #: ______________________ ___ **(Extended)** O.K. to leave message with detailed information
___ **(Brief)** Leave message with call-back number only

☐ Cell Phone #: ________________________ ___ **(Extended)** O.K. to leave message with detailed information
___ **(Brief)** Leave message with call-back number only

☐ Work Telephone: ________________________ ___ **(Extended)** O.K. to leave message with detailed information
___ **(Brief)** Leave message with call-back number only

☐ Email Address:________________________________@_______________________________________

Primary Language: ____ English ____ Spanish ____ French ____ Japanese ____ Chinese ____ Other _________________

Patients Race: (For Medical Purposes Only, This is now a requirement for us to have on file.)

___ American Indian or Alaska native ___ Asian ___ Native Hawaiin or other pacific island
___ Black or African American ___ White ___ Hispanic or Latin
___ Other Race ________________ ___ Refused to report

Emergency Contact Information

Contact Name: ______________________________ Home Number: (___)_________________________

Work Number: (______)________________________ Relationship to Patient: ___________________

Pharmacy Information

Pharmacy Name: ________________________________Pharmacy Number: (___)________________

Pharmacy Address:____

Authorization and Consent To View RX History from External Source:
I authorize Comprehensive Pain Specialists to view any and all available RX History from an External Source. I am aware that Comprehensive Pain Specialists uses a secure connection to SureScripts to send and receive prescriptions.

____________________________________ ________________________ ____________________________________
(Signature of Patient, or Personal Representative) Date Relationship to Patient if not signed by Patient

(Authorization will remain in effect from date signed until revoked in writing by patient or guardian) *Page 1 of 2*

COMPREHENSIVE PAIN SPECIALISTS

Patient Name: ____ **DOB:** ___________________

Employment Information

Employer Name: _________________________________ Employer's Phone #:___________________

Employment status: ___FT ___PT ___Retired

Is this a worker's comp or auto insurance claim? Yes or No If yes, please answer the following questions:

Company Name: ____________________________________ Claim Number:_________________________

Contact Person: ____________________________________ Contact Person's Phone Number: ____________________

Date of Injury: ______________

Insurance Information

Primary Insurance: ____ Co-pay: ______________

Policy Holder's Name: ___________________________________Policy Holder's Date of Birth: ___________

Policy Holder's Social Security Number: _______________________ Insurance ID# : ________________

Policy Holder's Gender: ☐ Male ☐ Female

Policy Holder's Mailing Address: ____

Policy Holder's City/State/Zip: ____

Policy Holder's Employer Name: ____________________________ Policy Holder's Employer Phone Number: ( ) ______________________

Policy Holder's Relationship to Patient: ____________________________ Home Phone: ( ) ___________

Secondary Insurance: ____ Co-pay: _______________

Policy Holder's Name: _________________________________ Policy Holder's Date of Birth: ___________

Policy Holder's Social Security Number: _____________________ Insurance ID# : ______________________

Policy Holder's Gender: ☐ Male ☐ Female

Policy Holder's Mailing Address: ____

Policy Holder's City/State/Zip: ____

Policy Holder's Employer Name: ____________________________ Policy Holder's Employer Phone Number: ( ) ______________________

Policy Holder's Relationship to Patient: ____________________________ Home Phone: ( ) ___________

Consent for Insurance Assignment/Payment:
I hereby authorize the assignment of benefits (payments) directly to Comprehensive Pain Specialists for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party:_______________________________________ **Date:** ______________

(Authorization will remain in effect from date signed until revoked in writing by patient or patient representative)

COMPREHENSIVE PAIN SPECIALISTS

***Patient Name:** ____ **DOB:** ____________________

Medical Records Request

Patient's Address: ____

Patient's Telephone Number: ____

Last 4 digits of SS# ___________________

Please "Print" and complete all sections to insure your request is processed in a timely manner

FAX RECORDS TO: ____

____

PURPOSE OF DISCLOSURE: Continuity of Care

I authorize ________________________________to release or disclose to the above-named entity all of my medical records, including any specially protected records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle-cell anemia, or HIV infection for the purpose of medical treatment. If you Do Not Want certain portions of your medical records released, please read this section carefully and identify the information you do not want released below:

____

Please check all that apply: ☐Past Dates of Service ☐ Present Dates of Service ☐ Future Dates of Service

* I understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by Comprehensive Pain Specialists or its physicians, employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to Comprehensive Pain Specialists.
* I understand that I am not required to sign this Authorization. Comprehensive Pain Specialists will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.
* I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit Comprehensive Pain Specialists' or its physicians', employees' or agents' ability to use or disclose my information for treatment, payment, or health care operations, or as otherwise permitted by law.
* I authorize CPS to request records pertinent to my treatment from providers and other healthcare entities, as needed, within the time this authorization is valid. This Authorization will expire a year from date of signature.

Patient or Authorized Representative's Signature: ______________________________ Date: __________________

Relationship to the patient if not signed by patient: _____________________________POA Provided?_________

Driver's license verified: _____________ Scanned by (initials):_________

Specific Records Needed (to be completed by the provider/nurse): ____

☐ MRI of ______________ ☐ Operative Report ____________________ ☐ CT of ___________________

☐ Other __________________ ☐ X-ray of _________ ☐ Discharge Letter ☐ Recent Progress Notes

Revised 10/24/2016

COMPREHENSIVE PAIN SPECIALISTS

Patient Name: ____ **DOB:** _________________

Acknowledgement of Receipt of HIPAA Notice

Comprehensive Pain Specialists is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for: Comprehensive Pain Specialists

____ __________

Signature of Patient or Legal guardian Date

Authorization To Discuss Your Medical Information

In accordance with the HIPAA guidelines this practice is authorized to discuss my medical information with the following individuals.

Please list up to 3 people we may leave messages with in the event we are unable to contact you.

HIPAA Authorized Person's Name	Relationship to patient	Telephone Number
____________________________________	________________	_______________
____________________________________	________________	_______________
____________________________________	________________	_______________

Do you utilize a transportation service? Yes_____ No_____

If yes, do you authorize CPS to give information in regards to dates and times of appointments to this service? Yes_____ No______

Do you have a medical Power of Attorney? Yes ____ No ____ If so, please provide a copy for our records

____ ___________________

Signature of Patient or Legal guardian Date

____

Relationship to Patient if Not Patient

Pharmacy Ownership Disclosure

I acknowledge that Comprehensive Wellness Pharmacy is wholly owned by Anesthesia Services Associates and may be used to fill prescriptions via mail order to my home. I further acknowledge that it is my choice regarding which pharmacy I use and this will not affect my treatment at Comprehensive Pain Specialists.

____ ___________________

Signature of Patient or Legal guardian Date

COMPREHENSIVE PAIN SPECIALISTS

Patient Name: ____ DOB: ___________________

Financial Policy

Our office can no longer accept cash from self-pay patients per State guidelines

We are pleased that you have chosen our practice for your pain management needs. We are committed to providing you with the highest quality care and achieving desired outcomes through collaborative effort. We would like to take this opportunity to thank you for allowing us to take care of you.

In keeping with our philosophy of open communication and education, it is important that you understand the financial policies of the practice. It is equally important that you understand the terms of YOUR medical coverage. Although our staff is very knowledgeable of most insurance plans, it is important that you understand the details and terms of your personal plan. Typically you will find the insurance company's phone number on the back of your insurance card and we encourage you to contact them with questions specific to YOUR coverage.

If you have Medical Insurance Benefits:

- If you have an insurance plan that requires a referral, you must contact your Primary Care Physician PRIOR to receiving care from a specialty provider. Regretfully, many insurers will not cover specialty services that are rendered without a referral and you may be held responsible for the costs. If we do not have a referral on file, we will not be able to render services.
- We participate in most major health plans and our business office will submit claims for services rendered. It is the patient's responsibility to provide all necessary information to file the claims prior to leaving our office. We will file your primary and secondary insurance claims and work diligently with the carrier to resolve any conflicts that may arise. However, your insurance company may need you to supply certain information directly. It is your responsibility to comply with this request.
- Please bring your insurance cards to **EACH** and **EVERY** visit to our office.
- Your insurance company **REQUIRES** us to collect co-payments at the time services are rendered. Failure to collect or waiver of your co-payment may constitute fraud under state and federal law. Please be prepared to pay your co-payment on the date services are rendered as this is a requirement per your insurance carrier. If you do not have your co-payment, we are not required to see you.
- Additionally, you may have coinsurance and/or deductible amounts required by your insurance carrier. Any outstanding balance on your account following insurance processing will be billed to you.
- It is the policy of the practice to treat **ALL** patients in an equitable fashion related to account balances. The practice will **NOT** waive or fail to collect any co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law as well as participating agreements with payers. Full or partial financial responsibility may only be waived in accordance with the practice's Financial Hardship Policy.
- Your insurance carrier may also pay you directly, if your clinic is out of network, as a patient, you are responsible for bringing in the payment and the Explanation of Benefit (EOB) from your insurance company.

Patient Balances:

- Any patient balances that remain delinquent after 90 days, with no response to requests, payment, may be referred to a collection agency. You will be responsible for any and all costs associated with the collection agency up to and including all legal costs.
- Patients with account balances in excess of 120 days with no payment arrangements or hardship request may be discharged from the practice. If this occurs you will have 30 days to seek alternative medical care. During the 30 day period our physicians will only be able to treat you on an emergency basis.
- For your convenience, our office accepts the following payment methods:
  Money order --- Check --- Cashier'sCheck –-- Cash --- Credit Card
  (Except self–pay patients: Cashier's Check, Check or credit card only can be accepted for payment per state regulations)
- Returned checks will be charged a $40.00 fee.

PLEASE READ THE FINANCIAL POLICY CAREFULLY BEFORE SIGNING

I, the undersigned, understand the financial policies of Comprehensive Pain Specialists, and agree to abide by the plan I have signed. In addition, I understand and agree to the following.

- To pay the amount charged by Comprehensive Pain Specialists for all professional treatment and services to the undersigned.
- I understand that I am financially responsible for any and all charges whether or not they are covered by insurance. In the event that I do not pay all costs of collection and reasonable legal fees in addition to the amount originally owed.

If genuine financial difficulties exist, please call our office. We are happy to work with you in resolving your balance and may be able to set up payment arrangements.

______________________	____	______________________	______________	_______
(Signature of Patient, or Personal Representative)	Date	Relationship to Patient if not signed by Patient	ID Verified by	Date

COMPREHENSIVE PAIN SPECIALISTS

Patient Name: ____ **DOB:** ____________________

Treatment Agreement

This agreement must be reviewed and signed in order to proceed with narcotic and/or non-narcotic treatment with Comprehensive Pain Specialists. The agreement is required to comply with the law regarding controlled pharmaceuticals and to prevent any misunderstandings about <u>any</u> treatments you receive.

Please <u>initial</u> at the bottom of this page and sign page 2 to indicate that you have read and/or have had the information explained to you.

- ✓ I agree to submit to a blood, urine or saliva test, if requested by my Provider, to determine compliance with my program of pain medication.
- ✓ I understand that my first office visit may be a consultation only and no pain medication given at that time if further investigation and/or testing are deemed necessary.
- ✓ I understand that I may be called at any time to bring all prescribed medication for a mandatory pill count within a specified time period (usually 24 hours).
- ✓ I understand that I am to bring my medications prescribed by CPS in their original bottles to **EVERY** appointment. I am to bring the bottle even if it is empty.
- ✓ I agree that I will use my medications **ONLY** as prescribed by my doctor. I understand that any change to my prescriptions will require an office visit. I understand that self-medicating is not tolerated. No refills will be made during evenings or weekends.
- ✓ I will not use any illegal substances, including marijuana, cocaine, etc.
- ✓ I understand that lost or stolen medication or unfilled prescriptions **WILL NOT** be replaced, and I will safeguard my medication from theft.
- ✓ **I understand that I will follow the guidelines on properly disposing of controlled substances that will be explained to me by clinical staff.**
- ✓ I will not share, sell or trade my medications with anyone.
- ✓ I will not alter the form of the medication nor will I take the medication in a route other than as prescribed by my provider.
- ✓ I will not attempt to obtain controlled medication from any other provider, nor will I borrow or buy medication from any other person.
- ✓ In the event of an emergency, if I do obtain controlled substances from another provider, I understand I am required to disclose this information to CPS within 48 hours of discharge or emergency service. I understand it is my responsibility to make sure CPS is notified of any such treatments and that I am to check with CPS before combining any pain medication with the prescriptions CPS provides me.
- ✓ I will notify CPS of any change in name, address or phone number. I understand that I must at all times have an updated phone number with my provider. I cannot be on dangerous medications, such as opioids, if my provider cannot reach me in a reasonable period of time (usually considered within 24 hours of the initial attempt). I agree to return any phone call from CPS within 24 business hours.
- ✓ I authorize my provider to investigate fully any possible misuse of my pain medication using any city, state or federal law enforcement agency, including this state's Board of Pharmacy.
- ✓ I understand that any follow-up appointment may be scheduled with a Licensed Nurse Practitioner or Physician Assistant. Additionally I understand that refusing to see one of CPS providers will likely result in my no longer being able to be treated by the practice.
- ✓ Once a prescription has been filled, all questions regarding that prescription should be directed to that pharmacy.
- ✓ I understand that CPS does not mail narcotic prescriptions under any circumstances.

Initials_______

Patient Name: ____ DOB: ____________________

Treatment Agreement (continued)

- ✓ I understand that with any controlled substance that is prescribed to me there are inherent risks, namely
  - loss of efficacy over time, symptoms of withdrawal if abruptly stopped, and addiction;
  - medication taken in excess (this is different for everyone – ranging from the prescribed dose to taking more than prescribed or combining with other controlled substances or even alcohol) may result in respiratory suppression or failure or death;
  - sedation, loss of function, impairment may also occur – I agree not to drive while under the influence of any prescribed controlled substance;
  - constipation, allergic reaction, itching, nausea and dry mouth are also common side effects;
  - my immune system may be suppressed and my hormone levels may decrease over time while being on chronic opioids.
- ✓ I understand that the combination of controlled substances and alcohol are contra-indicated; the combination may result in serious harm or even death.
- ✓ I understand that non-professional or inappropriate behavior toward any CPS staff, affiliate or provider will not be tolerated. I agree to be respectful to other patients I may encounter in the waiting room, lobby, hallways, etc. I understand that I may not loiter in the parking lot of any CPS location.
- ✓ I understand that there may be a medication prescribed or administered to me that is a "compounded" medication – these are compounded by specialty pharmacies and are regulated differently than typical medications found stocked on shelves at commercial pharmacies. If I have questions regarding any of these, CPS is able to provide pharmacy information upon request.
- ✓ I understand that CPS providers utilize tests to determine the best option for my care. My unwillingness to complete the tests requested may result in being released from further care with CPS.
- ✓ I understand that non-compliance with my pain management treatment plan may result in providers' inability to properly treat my symptoms and could cause symptoms to worsen or become life threatening.
- ✓ I understand that I may be released from CPS for missing appointments or cancelling/rescheduling appointments with less than 24 hour notice.

I agree that the goals of pain management have been explained to me as to what is considered appropriate and reasonable and that alternative treatment plans, outside of use of controlled pain medications, have been made available to me. I have agreed to proceed with pain management after a full explanation of the risks and benefits. I understand if I break this agreement, it will result in a change in my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the provider/patient relationship.

I understand that I am only to use the pharmacy listed below for all my medication needs with CPS or any other provider and that information will be shared between CPS and my pharmacy to process the prescription:

Pharmacy Name: ____ Phone Number:____________________

Pharmacy Address: ____

I have read and/or this information has been explained to me and I understand the terms of this agreement:

Signature of Patient or Legal Representative: ______________________________ Date: ____________________

Relationship to patient if not signed by patient: ______________________________

COMPREHENSIVE PAIN SPECIALISTS - Patient Evaluation

Date __________ PATIENT NAME: ____________________________________ PT DOB: ____________

Please tell us the first and last name of your Referring Provider:____

Please tell us the first and last name of your Primary Care Provider:____

If you are a Female, please tell us your pregnancy status: O Hysterectomy O Post-Menopausal O Not able to get pregnant
O Child-Bearing Age-No Contraception O Child-Bearing Age-Birth Control Medication O Child-Bearing Age-Other Contraception

Where is the location of your pain: ____

When did your pain first begin, please tell us month and year if known? mm/yyyy ___________________________________

What is the main cause of your pain? O Unknown O Normal aging O Fall O Sporting accident
O Motor vehicle accident O Work injury

What is the frequency of your pain? O Constant O Fluctuating but always present O Fluctuating but usually present
O Fluctuating and rarely present

What best describes your pain? O Aching O Burning O Cramping O Dull O Numb
O Sharp O Stabbing O Stinging O Throbbing O Tingling

What is your pain level most of the time?
O 0- No Pain O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10-Unbearable Pain

What makes your pain worse? O Bending or stooping O Changing from sitting to standing O Sitting
O Lifting or carrying heavy loads O Lifting or carrying small loads O Lying on back
O Lying on side O Nothing

What makes your pain better? O Lying on side O Lying on my back O Sitting O Standing
O Walking O Stretching O Exercise O Nothing

What does your pain interfere with? O Daily chores O Employment O Exercise O Grooming O House Chores
O Mood O Sleep O Relationships O Walking O Nothing

Have you had any of the following Imaging/Tests to assist in the evaluation of your pain?

MRI: O No O Yes X Ray: O No O Yes
CT Scan: O No O Yes EMG/Nerve Conduction: O No O Yes

Have you ever had Genetic Testing done? O No O Yes

Have you had any of the following to assist in the evaluation of your pain?
O Blood work completed in the past year O Bone Scan O Vascular Studies
O Drug Screening O Bone Density O Functional Capacity Evaluation
O Depression Screening

Have you had any of the following injections to assist with the treatment of your pain? O Spinal O Joint O Muscle O None

Have you had any of the following related to your pain? O Back Brace O Neck Brace O Tens Unit O None

Have you had any of the following Surgeries? O Low Back O Mid Back O Neck O Hip O Knee O Shoulder O None

Have you tried any of the following therapies to assist with treatment of your pain?

O Physical Therapy O Chiropractic Therapy O Aquatic Therapy O None

Have you had or done any of the following to assist with the treatment of your pain?

O Spinal Cord Stimulator O Spinal Traction O Cane O Walker O Exercise Program O Weight loss Program O Intrathecal Pain Pump

COMPREHENSIVE PAIN SPECIALISTS - Patient Evaluation

Date __________ PATIENT NAME: ______________________________ PT DOB: ____________

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (Add additional page if needed):

MEDICATION	DOSAGE	INSTRUCTIONS

If you have tried any of the Anti Inflammatory Medications below, were they helpful or not helpful? or please mark O None tried

Aspirin:	O Helpful	O Not Helpful
Celebrex:	O Helpful	O Not Helpful
Diclofenac:	O Helpful	O Not Helpful
Daypro:	O Helpful	O Not Helpful
Etodalac(Lodine):	O Helpful	O Not Helpful
Ibuprofen(Motrin,Advil):	O Helpful	O Not Helpful
Indomethacin(Indocin):	O Helpful	O Not Helpful
Ketroprofen:	O Helpful	O Not Helpful
Mobic (Meloxicam):	O Helpful	O Not Helpful
Naproxen (Naprosyn,Aleve,Anaprox):	O Helpful	O Not Helpful
Relafen:	O Helpful	O Not Helpful
Toradol:	O Helpful	O Not Helpful
Duexis:	O Helpful	O Not Helpful

If you have tried any of the Muscle Relaxer Medications below, have they been helpful or not helpful? or please mark O None tried

Baclofen:	O Helpful	O Not Helpful
Cycloobenzaprine(Flexeril):	O Helpful	O Not Helpful
Carisoprodol(Soma):	O Helpful	O Not Helpful
Diazepam(Valium):	O Helpful	O Not Helpful
Methocarbamol(Robaxin):	O Helpful	O Not Helpful
Norflex:	O Helpful	O Not Helpful
Parafon Forte:	O Helpful	O Not Helpful
Skelaxin:	O Helpful	O Not Helpful
Tizanidine(Zanaflex):	O Helpful	O Not Helpful

If you have tried any of the Narcotic Medications below, have they been helpful or not helpful? or please mark O None tried

Avinza:	O Helpful	O Not Helpful
Codeine:	O Helpful	O Not Helpful
Duragesic:	O Helpful	O Not Helpful
Dilaudid(Hydomorphone):	O Helpful	O Not Helpful
Hydrocodone (Lortab,Lorcet,Norco):	O Helpful	O Not Helpful
Kadian:	O Helpful	O Not Helpful
Opana:	O Helpful	O Not Helpful
Oxycontin:	O Helpful	O Not Helpful
Oxycodone (Percocet,Roxicodone,OxyIR):	O Helpful	O Not Helpful
MSIR:	O Helpful	O Not Helpful
Methadone:	O Helpful	O Not Helpful
Morphine ER (MS Contin, Avinza, Kadian):	O Helpful	O Not Helpful
Tramadol(Ultracet):	O Helpful	O Not Helpful

If you have tried any of the "Other" Medications below, have they been helpful or not helpful? or please mark O None tried

Cymbalta:	O Helpful	O Not Helpful
Clonidine:	O Helpful	O Not Helpful
Elavil(Amitriptyline):	O Helpful	O Not Helpful
Keppra:	O Helpful	O Not Helpful
Klonopin:	O Helpful	O Not Helpful
Lidoderm Patch:	O Helpful	O Not Helpful
Lyrica:	O Helpful	O Not Helpful
Neurontin:	O Helpful	O Not Helpful
Savella:	O Helpful	O Not Helpful
Topamax:	O Helpful	O Not Helpful
Trileptal:	O Helpful	O Not Helpful
Zonegran:	O Helpful	O Not Helpful

Allergies/Intolerance: O Penicillin O Sulfa O IV Dye/Contrast List other:______________________

Have you tried any Over the Counter Medications such as BioFreeze, IcyHot, Bengay, Aspercreme? O No O Yes

Have you ever tried Prescription Creams such as EMLA Cream, Voltaren Gel, etc for your pain? O No O Yes

Date __________ PATIENT NAME: ______________________________ PT DOB: ____________

Have you ever tried a Compounded Pain or Scar cream from a specialty pharmacy? O No O Yes

Past Medical History (please check all disease or disorders you have had):

O Migraine headaches O High blood pressure O Emphysema O Cirrhosis O Kidney disorder O Cancer
O Head injury O High cholesterol O Asthma O Hepatitis O Fibromyalgia O Depression
O Stroke O Coronary artery disease O Sleep apnea O Gallbladder disease O Osteoporosis O Anxiety
O Seizures O Heart attack (MI) O Hiatal hernia O Pancreatitis O Spine disorder O Alcoholism
O Multiple Sclerosis O Heart arrhythmia O Reflux O Diabetes O Arthritis OA/RA O Addiction
O Peripheral nerve disease O HIV O Ulcers O Bowel disease O Muscle disorder

Past Surgical History (please list all surgeries you have had):

________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

Family Medical History (please check all disease or disorders your family has had):

O Migraine headaches O High blood pressure O Emphysema O Cirrhosis O Kidney disorder O Cancer
O Head injury O High cholesterol O Asthma O Hepatitis O Prostate disorder O Depression
O Stroke O Coronary artery disease O Sleep apnea O Gallbladder dz O Osteoporosis O Anxiety
O Seizures O Heart attack (MI) O Hiatal hernia O Pancreatitis O Spine disorder O Alcoholism
O Multiple Sclerosis O Heart arrhythmia O Reflux O Diabetes O Arthritis OA/RA O Addiction
O Peripheral nerve disease O Ulcers O Bowel disease O Muscle disorder

What is your marital status? O Single O Married O Separated O Divorced O Widowed

Who resides in your same home and or assists in your care if needed? O Alone O Friend O Spouse O Children O Parents O Skilled Nursing Facility O Hospice Care

What is your employment status? O Employed Full time O Employed Part time O Unemployed O Retired O Short Term disability O Long Term Disability

Smoking Status: O Current smoker O Former smoker O Nonsmoker O Current every day smoker O Current some day smoker

Alcohol use: O None O Rarely O Occasionally O Regularly

Do you have any street drug use? O Yes O No

Review of Systems: Please mark each of the following symptoms/problems that you currently have (Mark all that apply)

General
O Weight loss
O Weight gain
O Fever
O Night sweats
O Fatigue
O Many infections

HEENT
O Headache
O Facial pain
O Sinusitis
O Loss of vision
O Hearing loss
O Teeth/gum problems

Respiratory
O Chronic cough
O Wheezing
O Shortness of breath
O Sleep apnea
O Home oxygen use
O C-PAP

Cardiology
O Chest pain (angina)
O Murmur
O Congestive failure
O Abnormal EKG

Neurology
O Drowsiness
O Dizziness
O Blackouts
O Tremors
O Numbness

Gastroenterology
O Appetite loss
O Chronic nausea
O Heartburn
O Constipation
O Diarrhea
O Bowel control loss

Genitourinary
O Painful Urination
O Blood in urine
O Bladder control loss
O Enlarged prostate
O Testicular pain
O Irregular bleeding
O Pregnancy

Endocrine/Hematological
O Abnormal blood sugars
O Easy bruising/bleeding

Vascular
O Poor circulation
O Current blood clot
O Swelling in legs

Musculoskeletal
O Joint pain
O Muscle spasm
O Neck pain
O Back Pain

Psychiatric
O Panic attacks
O Insomnia

Skin
O Rash

Preventative Medicine: Falls Risk Screening: If you are 65 or older, please check all that apply to you

O No Falls in the past year
O One Fall with injury in the past year
O One Fall without injury in the past year
O Two or more falls with injury in the past year
O Two or More Falls without injury without injury in the past year

COMPREHENSIVE PAIN SPECIALISTS

Today's Date: ________________

PATIENT NAME: ________________________________ DOB:_______________

Please tell us the location of your pain and any numbness you are currently experiencing.

Draw small X's where your pain is located.

Draw small O's where any numbness is located.