PREMIER PAIN® CENTERS
An affiliate of National Spine & Pain Centers

Sean, Li, MD
John Mak, MD
Bimal Patel, DO

Kulbir Walia, MD
Jolly Ombao, MD
Patrick McGinn, PA-C

Phone: 732-380-0200 • Fax: 732-380-0124

WORKERS COMPENSATION FORM

Patient Name_____ Date: _____

1. Adjuster Name _____ Tel: _____ Fax:_____
2. Nurse Case Manager_____ Tel: _____ Fax:_____
3. WC Insurance Name: _____ Date of Accident:_____
4. Claim#: _____ Injuries Sustained to which part of your body: _____
5. Cause and Circumstances of Accident:_____

   _____
6. Employer: _____Occupation: _____
7. Employer Address: _____State: _____ Zip: _____
8. Employment Status: Part-time Full time As Needed
9. Date you reported your accident: _____To Whom: _____
10. Did you complete your duties on the day of the accident? YES NO
11. Did you miss any work immediately following the injury: _____If so how much: _____
12. Are you Currently Working: _____ If NO, your last date of work: _____
13. Did you seek immediate medical attention: ____ With Whom_____
14. Attended Physical Therapy: _____ If YES, with Whom: _____
15. Chiropractic Treatment: _____If YES with Whom: _____
16. Other Pain Management Treatment: _____ With Whom:_ _____
17. List other Treatments for this injury: _____
18. Any chronic/pre-existing injuries contributing to current injury:_____
19. Any other accidents: _____ If YES, is it Work MVA Slip & Fall Sports Injury
20. Injuries sustained as a result of other accidents: _____
21. Treatment for other accidents: _____
22. Did those Injuries resolve: _____ IF NO, what are you currently being treated for_____
23. Do you have another job: _____ If YES, Employer's name _____
24. Prior MRI/CT SCANS: _____ Facility: _____
25. Do you participate in any athletic, recreational or sporting activities? YES NO
26. Attorney Name: _____ Tel: _____
27. Patient Signature: _____ Date: _____

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Demographics

Name (first, mi, last): _____ **DOB:** _____/_____ / _____

Address (no PO Box please):_____

_____

SSN: _____-_____ - _____ **Gender:** ❑ M ❑ F **Marital Status:** ❑ S ❑ M ❑ D ❑ W

Ethnicity: ❑ Latino ❑ Not Latino ❑ Declined

Race: ❑ White ❑ Black/African American ❑ Asian ❑ Other ❑ Declined

Primary Language: ❑ English ❑ Spanish ❑ Indian ❑ Russian ❑ Other ❑ Declined

Home #: _____ **Cell #:**_____ **Work #:** _____

Email:_____ **Occupation**: _____

Employer: _____ **Employer Address:** _____

Referring MD: _____ **Primary MD:** _____

Emergency Contact:_____ **Phone #:** _____ **Relationship:** _____

Pharmacy Name: _____ **Pharmacy Address**: _____

Pharmacy Phone: _____ **Pharmacy Fax:** _____

How did you hear about our office? _____

Insurance

Is your visit related to: 1) Worker's Comp? 2) Motor Vehicle Accident? (If yes, circle one)

Primary Health Insurance: _____ **Effective Date:** _____ / ____ / _____

Health Ins. Address: _____

Member ID#_____ **Group #:** _____

Policyholder's Name: _____ **Referral required: Y N**

Policyholder's DOB: _____/_____/_____ **SSN#**_____-_____ - _____ **Deductible $** _____

Co-Pay $_____ **Relation to Insured:** _____

Policyholder's Employer:_____

Secondary Health Insurance:_____ **Effective Date:** _____ / ____ / _____

Health Ins. Address: _____

Member ID#_____ **Group #:** _____

Policyholder's Name: _____ **Referral required: Y N**

Policyholder's DOB: _____/_____/_____ **SSN#**_____-_____ - _____ **Deductible $** _____

Co-Pay $_____ **Relation to Insured:** _____

Policyholder's Employer:_____

*****Please bring driver's license and insurance card along with you to your appointment*****

SHREWSBURY • FREEHOLD • TOMS RIVER

NATIONAL Spine & Pain CENTERS

Patient Name: _____

www.TreatingPain.com

MEDICAL APPOINTMENT AND PROCEDURE CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to National Spine and Pain Centers and its affiliated practices. When you schedule an appointment with our offices, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule a visit or procedure, please contact our office as soon as possible, and **no later than 24 hours** prior to your scheduled appointment or procedure. This gives us time to schedule other patients who are waiting for our services. Please read our Cancellation/No Show Policy below:

- ✓ Effective Sept. 1, 2020, any established patient who fails to show or cancels/reschedules an **appointment** and has not contacted our office with **at least 24 hours' notice** will be considered a No Show and charged a **$75.00 fee**.

- ✓ Effective Sept. 1, 2020, any established patient who fails to show or cancels/reschedules a **procedure** and has not contacted our office with **at least 24 hours' notice** will be considered a No Show and charged a **$200 fee**.

- ✓ These fees are charged to the patient, not your insurance company, and are **due that the time of your next office visit**, or before.

- ✓ As a courtesy, when time permits, we may make reminder calls, or send reminder texts, for appointments. If you do not receive a reminder call or text, the above Policy still remains in effect.

Questions about the cancellation and no show fees and their implementation may be addressed to the Center Manager at this location.

I have read and understand the Medical Appointment/Procedure Cancellation/No Show Policy and agree to its terms.

_____ _____

Patient Signature Date

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DESIGNATION OF DISCLOSURE

Designation of Certain Relatives, Close Friends and Other Caregivers:

I agree that Premier Pain Centers may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with may health care or payment relating to my health care. In that case, Premier Pain Centers will disclose information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner (check all that apply):

You can disclose my health information as described below: (Please check all that apply)

1. ____ OK to leave message with detailed information at my home/cell number: (_____)_____
   ____ on my answering machine
   ____ with my spouse
   ____ with anyone answering the phone
   ____ Leave message with call back numbers only

2. ____ OK to leave message with detailed information at my work number: (_____)_____
   ____ leave message with call back numbers only

3. ____ OK to fax to my work fax: (____)_____
   ____ OK to fax to my home fax: (____)_____

4. ____ OK to email. Email Address: _____
   ____ OK to text to my cell phone number: (____)_____

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Premier Pain Centers making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this at any time in writing. I understand that Premier Pain Center will not disclose health information to any person not designated except in case of an emergency.

Name: _____ Last 4 digits of his/her SS# or DOB (required as identifier) _____

Name: _____ Last 4 digits of his/her SS# or DOB (required as identifier) _____

Name: _____ Last 4 digits of his/her SS# or DOB (required as identifier) _____

The following person(s) <u>are not authorized</u> to receive my Patient Health Information:

Name: _____ Name: _____

Name: _____ Name: _____

Signature: _____ Print: _____ Date: _____
Patient or Authorized representative

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Practice Policies

Thank you for choosing Premier Pain Centers. We are committed to the treatment of your condition. In order to provide your care, we require both treatment and financial compliance with our policies. Your clear understanding of our policies is important to our professional relationship.

We will bill your primary insurance company directly if a copy of both sides of your insurance card is provided at the time of service as well as required demographic information necessary to file your claim. If you fail to provide the necessary demographic information to file your claim, you will be responsible for payment in full at the time of service. You are required to notify us when any demographic information changes. You are required to provide a copy of your insurance card if your coverage changes. If payment is not received from your insurance company in 60 days, you will be expected to assist in the resolution of the open claim. If the claim continues to be unpaid after 120 days, we reserve the right to bill you directly. It is in your best interest to ensure that the correct insurance information is provided at the time of service.

If you have HMO coverage, it is your responsibility to obtain the necessary referral for your visit or procedure and forward a copy of this referral to our office prior to your visit or procedure.

All patients are expected to pay at the time of service. We accept check, money order, Master Card, Visa, American Express and Discover. Self-pay patients are required to pay in full at the time of service. If your insurance plan requires a copayment, it is payable at the time of service. **If you present without the copayment, we reserve the right to bill you a $15.00 administration fee.** If for any reason a payment is dishonored by your bank, there will be a $40.00 service fee added to your bill and you will be required to pay by cash, certified check, money order or credit card for all future services.

We are participating providers for many insurance plans. However, we encourage you to use your out-of-network benefits for all other carriers. You will be required to show your insurance card and driver's license at the time of service. If you do not have your insurance information or we are unable to verify your coverage, you will be required to pay for the services rendered to you that day. If your insurance coverage terminates or changes, you are responsible for notifying us of this change immediately so that we can assist you in receiving your maximum reimbursement. **In the event that your insurance carrier issues payment directly to you, it is your responsibility to forward that payment along with the explanation of benefits for appropriate posting of the payment to Premier Pain Centers.**

There may be times when your physician is out of the office and you are required to see a physician who is not in your network. In these instances, we will work with your insurance plan to obtain in-network benefits to minimize your out-of-pocket costs.

Filing a secondary claim is a courtesy to the patient. We will only submit to your secondary carrier if they have electronic submission capability. If no response is received, the balance will be your responsibility. If we receive payment from you and your secondary carrier, a refund of the overpayment will be made to you. We

will not file tertiary insurance claims, but will provide a claim to you upon request. You are responsible for all tertiary balances.

If you fail to meet your financial obligations in a timely manner, we reserve the right to discontinue care and refer your account to a collection agency. **You are responsible for any interest, agency and legal fees associated with collections.**

We do accept **Workers Compensation and Personal Injury Cases.** We will only file these claims with your regular insurance if a written denial from the workers compensation or personal injury carrier is received. **We accept liens on an individual basis only for services provided by our office.** All necessary legal contact information must be provided in advance of your service to allow us time to process the necessary lien paperwork.

Disability Forms, Reports, Etc.

Requests for completion of disability forms, reports or other paperwork will require a minimum fee of $15.00, paid in advance, related to the amount of the preparation involved. If you have not seen your physician recently, you may be required to see your physician before the form can be completed. Please allow five business days for completion.

Appointments

Please be sure to provide a telephone number where you may be reached. If you have voice mail on your contact telephone number, our staff will leave a message including the time, date and location of your appointment. You can also check our Patient Portal online for all your appointment information.

We require 24 hours' notice if you intend to cancel your appointment. Should you cancel, reschedule or no-show for an appointment, we reserve the right to charge a no-show fee of $50.00.

If you are scheduled for a procedure at any office and cancel without a 24 hour notice to our office, a cancellation fee of $50.00 may be billed to you directly. Missed appointments for procedures at surgery centers (including taking of medications and lack of transportation) may be billed in the amount of $100.00.

If you are late for your appointment, we reserve the right to reschedule your appointment or see you as the schedule permits. If you are a new patient and do not complete your forms in advance, you are required to be at the office at least 45 minutes in advance of your appointment to complete the necessary forms. **Failure to do so may result in the rescheduling of your new patient visit.**

HIPPA Privacy

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of the Offices of Premier Pain Centers. This policy explains your rights including your right to see and receive a copy of your records, to limit disclosure of your protected health information and to request an amendment to your record. You may revoke, in writing, any consent for release of your healthcare information except to the extent the Practice has already made disclosures with your prior consent. Because of the privacy regulations, we are not at liberty to discuss your treatment with anyone unless you specifically designate your permission to do so. If you wish to allow access to your protected health information to any individual, ask our receptionist for an Access to Medical Records form. By signing this release, you allow us to discuss your care with the specified individual(s). If a family member has concerns about your care, we may not discuss these concerns without your written permission. Our Notice of Privacy Practices provides information on your rights and is available

on our website. We encourage you to read it in full. If you have any questions regarding our notice and if we change our notice, you may obtain a copy of the revised notice by contacting us at 732-380-0200 or visiting our website at www.premierpain.com.

Authorization to Release Information and Assignment of Benefits

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, Blue Shield, HMO's and commercial insurance to Premier Pain Centers and to Specialty Anesthesia if anesthesia is administered for procedures at a surgery center. **I understand that I am fully responsible for all charges whether or not they are covered by said insurance.** I hereby authorize assignee to release any information necessary to secure payment on my behalf.

Medication Policy

It is important to your health that you follow the directions carefully on all medications that we prescribe. In addition, we must be informed of all other medications, prescription, over-the-counter and supplements that you are taking. **We will not refill controlled medications in advance of their refill date, nor will we mail prescriptions. They must be given in person to you at the time of your appointment. If there is an unavoidable reason that you cannot make an appointment, we require a 3-day notice for a medication refill.** Patients receiving chronic medication management will be required to sign a separate medication contract.

Psychological Evaluations

Because of the nature of our treatment, there may be occasions when the physician determines that a psychological evaluation is necessary. For example, many healthcare plans require evaluations prior to intrathecal pump or dorsal column stimulator placements. **We reserve the right to discontinue care if you fail to obtain an evaluation as requested.**

Staff

We require our staff to address our patients with professionalism and we ask our patients to do the same. If, at any time, our staff feels that your tone or language is offensive or abusive, we expect them to terminate the conversation immediately and notify their immediate supervisor or practice administrator. **We will document your record, and depending on the severity of the situation, you may be discharged from the practice.**

We are committed to providing the best possible treatment and ask your cooperation in following our policies.

I READ AND UNDERSTAND THE ABOVE POLICIES AND AGREE TO ABIDE BY THEM. I FURTHER UNDERSTAND THAT FAILURE TO DO SO MAY RESULT IN MY DISCHARGE FROM THE PRACTICE.

Signature:_____ **(Please sign form in office)**

Patient or Authorized representative

Print Name:_____ **Date:**_____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #:_____

I request and authorize PREMIER PAIN CENTERS to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State:_____ Zip Code: _____

Fax#: _____

This request and authorization applies to:

❑ Healthcare information relating to the following treatment, condition, or dates:

_____

❑ All healthcare information

❑ Other: _____

Reason for request_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia,, nonspecific urethritis, syphilis, VDRL, chancroid, lymphogranuoloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

❑ Yes ❑ No I authorize the release of my STD results, HIC/AIDS testing, whether negative or positive to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

❑ Yes ❑ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature:_____Date Signed:_____

REPLY TO: _____ PHONE: 732-380-0200 FAX: 732-370-0124

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*Office use * Provider _____

Appt time _____ Entered _____

Vitals _____

_____

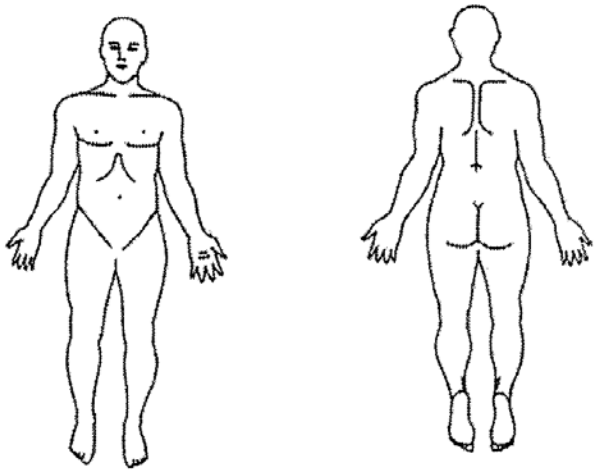
PAIN COMPREHENSIVE QUESTIONNAIRE

Patient Name _____ DOB _____ Date _____

Referring Physician _____ Primary Care Physicians _____

Chief Complaint (main problem seeking treatment) _____ Side ☐ right ☐ left

On the Diagram, shade in or circle the area where you feel pain:



R L **L R**

Preferred Pharmacy Name/Address:

_____

Preferred Pharmacy Phone:

_____

Are you pregnant or possibly pregnant?

☐Yes ☐No ☐N/A

---- (0 = no pain 10 = unbearable pain) ----

Pain level today

0 1 2 3 4 5 6 7 8 9 10

Over the last 4 weeks, please identify your pain levels below:

Severe pain level (on a bad day)

0 1 2 3 4 5 6 7 8 9 10

Average pain level (on an average day)

0 1 2 3 4 5 6 7 8 9 10

Allergies _____

Email _____

The onset of your pain was:

☐Motor vehicle accident

Date of Accident _____

Were you wearing a seatbelt: ☐Yes ☐No

Position during the accident:

☐Driver ☐Passenger in front seat ☐Passenger in back seat

☐Falling from a height

☐Injury at work

Date of injury _____

What injury occurred? _____

☐Insidious onset ☐Lifting an object ☐Playing a sport ☐Slipping and falling ☐Trauma ☐Tripping/uneven surface

Your pain occurs: ☐Constantly ☐Intermittent ☐Worse after activity ☐Worse at the end of the day ☐Worse during activity ☐Worse during cold seasons ☐Worse during the day ☐Worse during the night ☐Worse in the morning

Describe your pain: ☐aching ☐burning ☐cramp-like ☐dull ☐in a glove distribution ☐in a stocking distribution ☐pins & needles-like ☐sharp ☐shooting ☐stabbing

Your pain has been occurring for: _____ ☐days ☐weeks ☐months ☐years

Symptoms	Associated with your pain	**Symptoms**	Associated with your pain
Arm numbness		Insomnia	
Awakens you from sleep		Leg numbness	
Changes in bladder function		Perineal numbness	
Changes in bowel function		Sexual Dysfunction	
Changes in temperature in the affected area		Shoulder numbness	
Depression		Suicidal ideation	
Finger numbness		Sweating in affected area	
Flushing in affected area		Toe numbness	
Hand numbness		Hand numbness	

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PAIN COMPREHESIVE QUESTIONNAIRE

What activities aggravate/relieve your symptoms?

ACTIVITIES	AGGRAVATES YOUR PAIN	RELIEVES YOUR PAIN
All Movements		
Bending Forward		
Exercise		
Lifting Objects		
Lying Flat		
Rest		
Rotating the neck		
Sitting		
Standing for long periods		
Walking long distances		

What treatments have you used to treat the symptoms?

TREATMENTS	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
ACTIVITY MODIFICATION			
ACUPUNCTURE			
BRACE			
What type of Brace?	☐Back Brace ☐Neck Brace ☐Cervical traction ☐TENS unit ☐Ankle Brace (R or L) ☐Wrist Brace (R or L) ☐Knee Brace (R or L)		
How long have you had the product?			
Are you obtaining relief?			
Are your products in good condition?			
CHIROPRACTIC MANIPULATION			
HEAT TREATMENT			
ICE TREATMENT			
PHYSICAL THERAPY			
PILATES			
WEIGHT REDUCTION			
YOGA			
MEDICATIONS	**Check mark all medication that apply below**		

Opioids		NSAIDs/Tylenol		Muscle Relaxants
☐ Tramadol	☐ Methadone	☐ Tylenol	☐ Lodine	☐ Soma
☐ Demerol	☐ Morphine	☐ Aspirin	☐ Orudis	☐ Lorzone
☐ Codeine	☐ Nucynta	☐ Ibuprofen	☐ Relafen	☐ Flexeril
☐ Fentanyl (Duragesic)	☐ Butrans	☐ Naproxen	☐ Celebrex	☐ Baclofen
☐ Hydromorphone (Dilaudid,)	☐ Suboxone	☐ Daypro	☐ Toradol	☐ Zanaflex
☐ Hydrocodone (Vicodin)		☐ Indocin		☐ Robaxin
☐ Oxycodone (Percocet, Oxycontin)		☐ Feldene		☐ Skelaxin
☐ Oxymorphone (Opana)		☐ Voltaren		☐ Valium (Diazepam)

Antidepressants		Other	
☐ Elavil (Amitriptyline)	☐ Paxil	☐ Neurontin (Gabapentin)	☐ Lyrica
☐ Pamelor (Nortriptyline)	☐ Prozac	☐ Tegretol	☐ Ativan
☐ Desipramine	☐ Serzone	☐ Dilantin	☐ Xanax
☐ Impramine (Tofranil)	☐ Cymbalta	☐ Topamax	☐ Imitrex
☐ Zoloft	☐ Savella	☐ Depakote	☐ Ergotamine
		☐ Klonopin	☐ Mexillitine

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PAIN COMPREHESIVE QUESTIONNAIRE

Do you have any adverse effects since starting any treatment?

☐Constipation ☐Drowsiness ☐Mental slowness ☐Other

What procedures have you had to treat the pain?

PROCEDURE	Mark if applicable
No Procedure	
Epidural Steroid Injection	
Facet Joint Injection	
Medial Branch Block Trial	
Peripheral Nerve Injection	
Rhizotomy	
Fusion, anterior	
Fusion, posterior	
Fusion, combined anterior and posterior	
Laminectomy	
Microdiscectomy	
Other	

What imaging studies have you had for the pain?

☐Bone scan

☐CT Scan

☐EMG

☐ MRI

☐ Radiographs

How has the pain limited you? (check mark all that apply)

Activities	Limit Pain	Activities	Limit Pain
No limitations		Inability to attend school	
Attending school on a limited basis		Inability to perform daily activities (ADL's)	
Difficulty getting up from chair		Inability to work	
Difficulty sitting		Requiring constant assistance	
Difficulty standing		Requiring occasional assistance	
Difficulty walking		Working on a limited basis	
Difficulty with daily activities (ADL's)		Working light duty	
Difficulty with recreational sports		Other	
Functional limitations			

Who have you seen for this problem? ☐Chiropractor ☐Emergency Room ☐General Surgeon ☐ Internist

☐Orthopedic Doctor ☐Pediatrician ☐Primary care ☐ Therapist ☐Trainer ☐Urgent Care Center ☐Walk in clinic

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INTAKE AND HISTORIES

***** PLEASE COMPLETE THE REMAINDER OF THIS PAPERWORK ON THE PATIENT PORTAL *****

https://nspc.ema.md **Contact our office at 732-380-0200 for a username and password**

Past Medical History (please check all that apply):

- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bipolar Disorder
- ☐ Breast Cancer
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non-Insulin Dependent
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity, Morbid
- ☐ Obesity
- ☐ PBPH
- ☐ Prostate Cancer
- ☐ Radiation Therapy
- ☐ Fibromyalgia
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke
- ☐ **None**
- ☐ Other_____

Past Surgical History (please check all that apply):

- ☐ Appendix (Appendectomy)
- ☐ Bladder Removed
- ☐ Breast: Mastectomy ☐Right ☐Left ☐Both
- ☐ Breast: Lumpectomy ☐Right ☐Left ☐Both
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Gallbladder Removal
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Removed: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Tonsillectomy
- ☐ Hysterectomy: Caesarean
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ **None**
- ☐ Other_____

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INTAKE AND HISTORIES

Interventional Pain History (please check all that apply):

- ☐ Epidural Injection(s)- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Facet Injection(s)- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Medial Branch Block- Injection(s)- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Rhizotomy- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Intrathecal Pump
- ☐ Spinal Cord Stimulator
- ☐ **None**
- ☐ Other_____

Musculoskeletal History (please check all that apply):

- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Adhesive Capsulitis
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ DISH
- ☐ Epidural Injections, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Polio
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shoulder Impingement
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ **None**
- ☐ Other_____

Musculoskeletal Surgery (please check all that apply):

- ☐ Achilles Tendon Repair
- ☐ ACL Reconstruction
- ☐ Ankle Fracture ORIF ☐Right ☐Left ☐Both
- ☐ Bunion Correction
- ☐ Carpal Tunnel Decompression ☐Right ☐Left ☐Both
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ CMC Arthroplasty
- ☐ Distal Radius ORIF ☐Right ☐Left ☐Both
- ☐ Ganglion Cyst Excision
- ☐ Intramedullary Nailing Femur ☐Right ☐Left ☐Both
- ☐ Intramedullary Nailing Tibia ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Hip ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Knee ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Shoulder ☐Right ☐Left ☐Both
- ☐ Knee Arthroscopy ☐Right ☐Left ☐Both
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Lumbar Fusion
- ☐ Lumbar Laminectomy
- ☐ Lumbar Spine Surgery: Decompression
- ☐ Lumbar Spine Surgery: Decompression & Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement
- ☐ Meniscus Repair
- ☐ Reverse Total Shoulder Replacement
- ☐ Revision of Total Hip Arthroplasty
- ☐ Revision of Total Knee Arthroplasty
- ☐ Revision of Total Shoulder Arthroplasty
- ☐ Rotator Cuff Repair ☐Right ☐Left ☐Both
- ☐ Shoulder Arthroscopy
- ☐ **None**
- ☐ Other_____

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INTAKE AND HISTORIES

Medications (please list all current medications or check option, which applies):

- Complete the information below regarding all medications you are currently taking, have discontinued, or modified.
- Be certain to list both prescription and non-prescription medication, including any herbals or supplements you take.

☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)
☐ Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

Allergies (please list all known allergies or check option, which applies):

☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)
☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

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INTAKE AND HISTORIES

Social History (please check all that apply):

Cigarette Smoking
- ☐ Never Smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily
  - o # packs per day_____

Alcohol Use
- ☐ Do not drink alcohol
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Exercise Frequency
- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never
- ☐ Other_____

Drug Use
- ☐ Drug Use
- ☐ IV Drug Use
  - o _____

Family History:
Please check appropriate box "Alive" or "Decease" and list ages for the following Blood Family Members. If Parents or Grandparents are deceased, please write in Age and Cause of Death, if known.

	Alive	Age (if known)	Deceased	Age at Death	If deceased, cause of death	Unknown Status
Father						
Mother						
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						

	Number Alive	Age (if known)	Number Deceased	Age at Death	If deceased, cause of death	Unknown Status
Brothers						
Sisters						
Sons						
Daughters						

Family History (continued):

Please mark YES or NO if a Blood Family Member has ever had any of these conditions. If you mark YES, please mark the box under the relationship of the person to you

				Relationship of Person to you				
	YES	NO	DO NOT KNOW	Father	Mother	Grandparent	Brother /Sister	Son/ Daughter
Cancer								
Heart Disease								
Diabetes								
High Blood Pressure								
Stroke/TIA								
Alcohol Abuse								
Drug Abuse								
Psychiatric Illness								
Seizures								
Depression/Suicide								
Osteoarthritis								
Osteoporosis								
Scoliosis								
Other Conditions								

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INTAKE AND HISTORIES

Review of Systems* (check yes or no if you are currently experiencing any of the following):

Symptom	Yes	No	Symptom	Yes	No
Joint pains			Wheezing		
Joint swelling			Pain w/ breathing		
Difficulty Walking			Palpitations		
Muscle Pain			Ankle Swelling		
Pain Radiating down to leg(s)			Labored breathing w/exertion		
Weakness			Nausea/ Vomiting		
Numbness			Diarrhea		
Tingling			Constipation		
Fever			Heartburn		
Weight Gain			Ulcers		
Rash			Blood in Stool		
Chest Pain			Urinary Incontinence		
Incontinence			Urinary hesitancy		
Shortness of Breath			Urinary retention		
Suicidal thoughts			Blood in urine		
Weight loss			Genital pain		
Chills			Excessive bruising		
Fatigue			Excessive bleeding		
Discoloration			Cancer		
Scarring			Excessive thirst		
Environmental Allergies			Heat/Cold intolerance		
Immunosuppression			Diabetes		
HIV/AIDS			Thyroid Disease		
Blurred Vision			Joint Stiffness		
Double Vision			Dizziness		
Glaucoma			Fainting		
Eye pain			Headaches		
Ringing in the Ears			Tremor		
Loss of hearing			Seizure		
Nose bleeds			Memory Loss		
Hoarseness			Depression		
Difficulty Swallowing			Anxiety		
Cough			Hallucinations		

Other Medical Conditions* (check yes or no for the following):

*Please inform the physician, medical assistant or front desk staff of any other medical conditions or concerns.

Symptom	Yes	No	Symptom	Yes	No
Blood Thinners			Rheumatoid Arthritis		
Pacemaker			Hepatitis B or C		
Defibrillator			Pregnancy or planning a pregnancy		
Premedicate Prior to Procedure			HIV/ADS		
Hepatitis B or C			Diabetes		

NATIONAL Spine & Pain CENTERS

Patient Name _____

DOB _____ **Date**_____

NSPC is dedicated to providing comprehensive care to patients and following the federal guidelines regarding important public health issues. Please answer the following questions.

SECTION 1: TOBACCO USE SCREENING

Please select the option that best describes your current tobacco use.

☐Current every day smoker ☐Current some day smoker (tobacco) ☐Current some day smoker (cigarette) ☐Former smoker ☐Never smoker

SECTION 2: ALCOHOL USE SCREENING

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? _____

SECTION 3: BMI

What is your height? _____feet _____inches

Office Use Only	Weight: _____lbs.

SECTION 4: BLOOD PRESSURE

Office Use Only	Systolic (mmHg): _____ Diastolic (mmHg): _____

The below sections are for patients aged 65 years or older.

SECTION 5: ADVANCED DIRECTIVE:

Do you have a health care proxy in the event you are unable to make your own medical decisions? *Provide name, phone number, and relationship. If none assigned, leave blank.*

_____

SECTION 6: PNEUMONIA VACCINATION

Have you received a pneumonia vaccination? ☐YES ☐NO

Patient Signature: _____ Date_____

E-Mail Address: _____