NEW MEXICO PAIN CENTER
It's Time To Feel Better

3600 Coors Blvd. NW Ste A200
Albuquerque, NM 87120
T. 505-264-9961
F. 505-289-3887

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedures or drug therapy to be used, so that you may make an informed decision whether or not to take the drugs that have been recommended after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by the providers of New Mexico Pain Center-Albuquerque . For the purpose of this agreement the use of the word "physician" is defined to include not only my treating physicians but also my physician's authorized associates, technical assistants, nurses, nurse practitioners, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physicians at New Mexico Pain Center-Albuquerque to treat my medical condition. I hereby authorize and give my voluntary consent for my physicians to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my medical condition if needed.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIANS PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY PHYSICIANS WILL EXPLAIN THE TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from care.

I UNDERSTAND that New Mexico Pain Center-Albuquerque is a team of Board Certified Doctors and Nurse Practitioners. As such I understand that following my initial visit at New Mexico Pain Center-Albuquerque I may be seen by other Physicians and/or Nurse Practitioners for the Follow Up visits and/or Procedures.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery and have been advised to not do so while on these medications. In addition, while using these medications and I may be impaired during all activities, including work.

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The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my medical condition.

The goal of this treatment is to help me gain control of my pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physicians of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

I UNDERSTAND AND AGREE TO THE FOLLOWING:
That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) prescribed by my physicians. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My physicians may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued**.
- I will **disclose** to my physicians **all medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physicians**.
- I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will **not allow or assist in the misuse/diversion of my medications**; **nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physicians to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money**. If either are lost or stolen, they may NOT BE REPLACED.**
- Refill(s) **will not be ordered before the scheduled refill date**. I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive pain medication(s) **ONLY from the New Mexico Pain Center-Albuquerque physicians** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. If treated in the Emergency Room, I understand that I may be treated for any emergency, but I am not to fill prescriptions for pain medications provided to me at the time of discharge unless otherwise authorized by my physicians at New Mexico Pain Center-Albuquerque . Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.

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- Over the course of my treatment, **my physicians may try alternative medication(s) or therapies and may try to taper me off all medication(s**). I will not hold my physicians liable for problems caused by the discontinuance of medication(s).
- I **agree to submit to urine, saliva, blood and/or other laboratory screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., my treatment may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- I recognize that my condition may represent a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physicians to achieve increased function and improved quality of life.
- I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physicians **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physicians. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physicians or my treatment may be discontinued. If I cannot make a scheduled appointment, I must contact New Mexico Pain Center-Albuquerque 24 hours prior to my scheduled appointment. I understand that repeated failure to do so may result in discontinuation of my care or a financial penalty.
- **I must bring my prescribed pain medications to every visit for my physicians to review. I understand that failure to do so will result in frequent urine/blood/saliva or other testing and may result in discontinuation of my care.**
- **I agree that my treatment at New Mexico Pain Center-Albuquerque may be DISCONTINUED if I am in any way hostile, combative, aggressive or inappropriate with any of my physicians, staff or other patients at New Mexico Pain Center-Albuquerque .**

FOR FEMALE PATIENTS ONLY:

To the best of my knowledge **I am NOT pregnant. Initials** ____________
If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is **MY responsibility** to inform my physicians immediately if I become pregnant. **If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIANS IMMEDIATELY**. All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physicians harmless for injuries to the embryo/ fetus / baby.

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I certify and agree to the following:

1. I am **not currently using illegal drugs or abusing prescription medication**(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.
2. I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)
3. **No guarantee or assurance has been made** as to the results that may be obtained from my treatment. With full knowledge of the potential benefits and possible risks involved, I consent to treatment, since I realize that it provides me an opportunity to lead a more productive and active life.
4. I have reviewed the side effects of the medication(s) that may be used in the treatment of my condition. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) for my treatment.**

______________________	Rumbaugh,Craig E	________
Provider Signature	Provider Printed Name	Date

______________________________ ________
Patient Signature Date

FINANCIAL RESPONSIBILITY

We charge what is usual and customary for our area of practice.

Full private payment or insurance co-pays/co-insurance and/or deductible for office visits, labs, toxicology screens, and/or any other service provided within The Pain Center are due at the time of service. Furthermore, account balances are due at the time of service unless prior arrangements have been made.

Initials _______

If I know I will be unable to make my appointment, I will notify the The Pain Center as soon as possible. I understand that cancellations must be made at least 24 hours before the scheduled appointment or I will be charged $25. This fee is not charged to your insurance company.

Initials _______

This agreement is necessary in order to accept your insurance without having to bill you upfront. An account past due 90 days or more and payment plans that are not kept current, may be subject to collection and associated fees. By signing the agreement below, you assign insurance benefits to be paid directly to The Pain Center's parent company, EPMed, PA, and authorize the release of any information which may be needed for processing of all claims; certification/ case management/quality improvement; and/or other purposes related to the benefits of your health plan. Furthermore, understand that it is your responsibility to ensure that proper referrals or authorizations are obtained for each visit. Finally, we require notification of insurance changes at least one week prior to your scheduled appointment to avoid appointment delays and/or private pay expenses.

Initials _______

Please note we only bill insurance companies that we are contracted with. Furthermore, it is your responsibility to follow up with the insurance company to ensure the claim is paid within 60 days of the date of service. We must emphasize that as healthcare providers, our relationship is with you, our patient, and NOT with your insurance company. You are responsible for knowing what your insurance benefits are, including what your insurance will and will not pay for; and how to access your benefits, including obtaining referrals, etc. If you are unsure please contact your insurance carrier. This office assumes no responsibility for your lack of knowledge regarding your insurance benefits. **You are responsible for any remaining unpaid charge(s) as determined by your insurance company regardless of cause.**

Initials _______

By signing below, you are stating that you understand and agree to all of the above.

Patient Signature: ____ Date: _________________

AGREEMENT AS TO GOVERNING LAW AND FORUM

The patient or the patient's representative and health care provider, including employees and agents of the health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by New Mexico Law and in no event shall the law of any other state apply to any health care rendered to patient; and (2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a New Mexico Court in the county/district where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

Patient Signature: ___________________________________ Date: ______________________

CONSENT TO LABORATORY TESTING & USE OF RESULTS

In consideration of services rendered, I transfer and assign any benefits of insurance to The Pain Center and its affiliates (known collectively hereafter as EPMed, PA) and authorize EPMed, PA to submit claims on my behalf directly to my health insurance provider/plan. I acknowledge that EPMed, PA may submit laboratory specimens to a licensed reference laboratory to perform testing. I authorize EPMed, PA to release to my insurance carrier, or any health plan of which I am a member, any medical information needed for claim processing. I understand that EPMed, PA may be an out of network provider and my practitioner may hold an ownership interest in this laboratory, and as such, may receive a return of investment from this interest. I understand that I have the option of obtaining lab services from another facility and that upon my request will be provided a list of alternative laboratory facilities. I understand that if the insurance company pays me directly for services rendered by EPMed, PA, I am responsible to forward the payment to EPMed, PA. I agree that this Consent to Testing & Use of Results will cover all medical services rendered by EPMed, PA to me until such authorization is revoked in writing by me.

Patient Signature: ___________________________________ Date: _________________________

AUTHORIZATION /AUTORIZACIÓN

RELEASE OF MEDICAL RECORDS / PARA SOLICTAR REGISTROS MÉDICOS

I/Yo, ______________________________________, date of birth/fecha de Nacimiento _______________________
authorize the custodian of records to release the following/autorizo al custodio de registros médicos a liberar lo siguiente:

☐ My medical records, including but not limited to: office visit notes, all imaging and all laboratory reports / Mis registros médicos, incluyendo pero no limitado a: notas de visita al consultorio, todos los informes de radiología y todo los informes de laboratorio.

Please list any additional records or provide any restrictions on records to be forwarded/anote registros adicionales o restricciones en los registros que se mandaran:

____

____

____

Please fax or mail indicated records to / Por favor envie por fax o correo los registros indicados:

Fax:
(915) 633-6598

EPMed, PA
Medical Records Department
P.O. Box 221530
El Paso, TX 79913

This information may be used/disclosed for the purpose of my healthcare / Esta información puede ser usada/revelada con el proposito de mi atencion de la salud.

Patient Signature / Firma del Paciente: Date / Fecha:

____ _________________

PATIENT EDUCATION: SUICIDE RISK PREVENTION

AN IMPORTANT MESSAGE TO THE PATIENT AND/OR PATIENT'S LOVED ONES

If you or a loved one notice these warning signs listed below, seek help **immediately** and/or call one of the available suicide telephone hotlines listed below. Please know that if you have access to firearms or know your loved one has access to firearms, it is important to secure those safely away from reach NOW.

TWO (2) telephone numbers are provided for you today. One number is a national toll-free Suicide Prevention Hotline that is available 24 hours per day, 7 days per week.

- **Suicide Prevention Lifeline: 1-800-273-TALK (8255).** This national crisis hotline number serves English & Spanish speaking callers.
- **Suicide & Crisis Center of Bernalillo : (855) 662-7474**

Please Initial the Following Statements

________________ I understand that driving can be dangerous if I am not fully alert and oriented, and I will not drive if I feel impaired.

________________ I understand that managing my medications may be difficult if I am distracted, angry, or confused and I will ask for help with managing my medications if needed.

________________ I understand that it is important that I am not alone, and I will call one of the numbers above if I am feeling lonely, unsafe, or need someone to talk to.

________________ I understand that I should not use drugs, alcohol, or medication not currently prescribed to me in any other way than how my doctor has prescribed them to me.

Suicide risks and warning signs- Please call for help IMMEDIATELY if you experience any of the following warning signs:

* Seeking access to guns, pills, or other potentially harmful items or substances
* Talking or writing about death/dying or suicide when out of the ordinary
* Feeling of hopelessness
* Acting recklessly
* Feeling trapped as if there is no way out
* Increasing alcohol or drug use
* Withdrawal from family and friends
* Feeling anxious, agitated, unable to sleep or sleeping all of the time
* Dramatic Mood changes
* Seeing no reason for living or having no sense of purpose in life
* Giving away possessions to others that are of importance to the individual
* Cutting oneself or exhibiting other self-destructive or self-harming actions.

I have received my suicide risk prevention education above and I understand its contents and my duties in regard to the information provided. I have had my questions answered to my satisfaction.

Patient Signature:____ Date:___________________________

PHI is any health information that can be tied to an individual, which under HIPAA means protected health information. Under HIPAA, protected health information (PHI) is considered to be individually identifiable information relating to the past, present, or future health status of an individual that is created, collected, or transmitted, or maintained by a HIPAA-covered entity in relation to the provision of healthcare, payment for healthcare services, or use in healthcare operations PHI such as diagnoses, treatment information, medical test results (ie. lab,radiology), HIV/AIDS status, and prescription information are considered protected health information under HIPAA, as are national identification numbers and demographic information such as birth dates, gender, ethnicity, and contact and emergency contact information.

HIPAA ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, I acknowledge that I have read and understand The Pain Center's Notice of Privacy Practices. Upon my request I can be provided a copy for my records.

I consent to the use and disclosure of my medical information as set forth herein, except as expressly stated below. I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

Patient Signature: ____ Date: _________________________

HIPAA PRIVACY AUTHORIZATION FORM

☐ I do not authorize the use and/or disclosure of my Protected Health Information (PHI).

☐ I authorize The Pain Center to use and/or disclose the Protected Health Information (PHI) selected below:

Name	DOB	Prescriptions Pick Up Only	All PHI*
______________________________	__________	☐	☐
______________________________	__________	☐	☐
______________________________	__________	☐	☐

This authorization is valid for the following:

☐ All past, present, and future appointments.

☐ Only from _______________ to _________________
Date Date

I understand that I have the right to revoke this authorization, in writing at any time.

Patient Signature: ______________________ Date: ___________________

Patient Information		
	Last Name:	First Name: Middle Initial:
	Physical Address: Apt. #	City/State/Zip:
	Mailing Address (if different)	City/State/Zip:
	Home Phone: Cell Phone: Work Phone:	
	Referring Physician:	Who is your primary care physician?
	Date of Birth:	Gender:
	Social Security #:	Emergency Contact Name:
	Emergency Contact Phone:	Relationship to Patient:
	Would you prefer appointment reminders via text or voice call? ☐ Text ☐ Phone	
	What is your preferred phone number to receive reminders? ☐ Cell Phone ☐ Home Phone	
	How Did You Hear About Us? ☐ Billboard ☐ Flyer ☐ Friend ☐ Google/Internet ☐ Magazine ☐ Radio	
	☐ Other Doctor: ____________________ ☐ Other: ____________________	
	Have you been treated by a pain specialist in the past? ☐ No ☐ Yes, Name of pain specialist:	
	Do you have an implanted pain pump? ☐ No ☐ Yes	
	Do you reside in a nursing home? ☐ No ☐ Yes, Where:	

Insurance	**Primary Medical Insurance**	**Secondary Medical Insurance ☐ N/A**
	Insurance Company Name:	Insurance Company Name:
	Policy Number:	Policy Number:
	Policy Holder's Name & Date of Birth: ☐ Self ☐ Other	Policy Holder's Name & Date of Birth: ☐ Self ☐ Other
	Policy Holder's Social Security #: ☐ Self ☐ Other	Policy Holder's Social Security #: ☐ Self ☐ Other
	Patient Relationship to Policy Holder: ☐ Self ☐ Other	Patient Relationship to Policy Holder: ☐ Self ☐ Other

Additional Information	
	Email Address: ______________________________ ☐ Does Not Have Email ☐ Will Not Disclose
	Race
	☐ African American ☐ Asian ☐ Caucasian ☐ Declined to Specify ☐ Other: ___________
	Ethnicity
	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify ☐ Other: ___________
	Preferred Language
	☐ English ☐ Spanish ☐ Other: ______________________________
	Preferred Pharmacy & Location/Phone Number:

Signature	
	In an effort to make communication seamless and allow open access to your medical records EPMed, PA and its affiliates will use, but not share, your email for correspondence to include but not limit its use to the following: appointment reminders, prescriptions, medical records access and newsletter updates. By signing our treatment agreement you authorize the use of your email for such purposes. **Signature**: ______________________________ **Date**:________________

Do you suffer from migraine headaches? ☐ No ☐ Yes, on occasion ☐ Yes, frequently

Please answer each question by placing a ✓ in the appropriate box	Not at All	Several Days	More than Half the Days	Nearly Everyday
1. Little interest or pleasure in doing things?				
2. Feeling down, depressed, or hopeless?				
3. Trouble falling or staying asleep, or sleeping too much?				
4. Feeling tired or having little energy?				
5. Poor appetite or overeating?				
6. Feeling bad about yourself -or that you are a failure or have let yourself or family down?				
7. Trouble concentrating on things such as reading the newspaper or watching TV?				
8. Moving or speaking so slowly that other people have noticed? Or the opposite? Being so fidgety or restless that you have been moving around more than usual?				
9. Thoughts that you would be better off dead, or hurting yourself in someway?				

Chief Complaint/Reason for Visit: ______________________________

When did the pain start / Cause of Pain? (Please be detailed) ______________________________

____

____

Pain Scale **0 = No Pain & 10 = Excruciating Pain**											
Pain Level	**0/10**	**1/10**	**2/10**	**3/10**	**4/10**	**5/10**	**6/10**	**7/10**	**8/10**	**9/10**	**10/10**
Current Pain											
Least Pain											
Average Pain											
Acceptable Pain											
Max Pain											

Relief that medication(s) provide:
☐ 0-10% ☐ 10-20% ☐ 20-30% ☐ 30-40% ☐ 40-50% ☐ 50-60% ☐ 60-70% ☐ 70-80% ☐ 80-90% ☐ 90-100% ☐100%

If you have a list or the bottles, please provide them to the assistant and go to the next section.

Current Medications	
Medication Name	**Dose & How Taken**

SOAPP® VERSION 1.0-14Q

The following set of questions are given to all patients. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment plan.

Please answer the questions below using the following scale:

0 = Never 1 = Seldom 2 = Sometimes 3 = Often 4 = Very Often

1. How often do you have mood swings?	0	1	2	3	4
2. How often do you smoke a cigarette within an hour after you wake up?	0	1	2	3	4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0	1	2	3	4
4. How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
5. How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
6. How often have you attended an AA or NA meeting?	0	1	2	3	4
7. How often have you taken medication other than the way it was prescribed?	0	1	2	3	4
8. How often have you been treated for an alcohol or drug problem?	0	1	2	3	4
9. How often have your medications been lost or stolen?	0	1	2	3	4
10. How often have others expressed concern over your use of medication?	0	1	2	3	4
11. How often have your felt a craving for medication?	0	1	2	3	4
12. How often have you been asked to give a urine screen for substance abuse?	0	1	2	3	4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0	1	2	3	4
14. How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4

Patient Signature: ______________________________ **Date:** ____________

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The Pain is Described as (Please ✓all that apply)									
	Aching		Gnawing		Penetration		Stabbing		Tiring
	Burning		Miserable		Pressure		Tender		Twisting
	Cramping		Nagging		Sharp		Throbbing		Unbearable
	Dull		Numb		Shocking		Tingling		Other:

The Pain Interferes With (Please ✓ all that apply)					
	Enjoyment of Life		Mood		Relationships
	General Activity		Normal Work		Sleep
	None		Other:		

The Pain is Aggravated By (Please ✓all that apply)							
	Cold		Cough		Heat		Lifting
	Lying Down		Physical Activity		Sitting		Sitting to Standing
	Standing		Vomiting		Walking		Other:

The Pain is Improved By (Please ✓all that apply)							
	Cold		Massage		Position Changes		Standing
	Heat		Nothing		Physical Therapy		Walking
	Interventional Procedures		OTC Medications		Rest	Other:	
	Lying Down		Pain Medications		Sitting		

Previous Imaging Studies (Please ✓ all that apply)		
✓	**Type**	**Body Area/Facility/When**
	Bone Scan	
	CT Scan	
	MRI	
	X-Ray	
	Ultrasound	
	None	
	Other	

Previous Medications (Please ✓ all that apply)		
	Type of Medication	**Side Effects of Medication**
	None	
	Muscle Relaxants	☐ None ☐ Other: ____________
	Neuropathic Agents	☐ None ☐ Other: ____________
	NSAIDs (nonsteroidal anti-inflammatory drugs)	☐ None ☐ Other: ____________
	Opioids	☐ None ☐ Other: ____________
	OTC Medications (over the counter)	☐ None ☐ Other: ____________
	Steroids	☐ None ☐ Other: ____________
	Other Medication(s)	☐ None ☐ Other: ____________

Physical Therapy
☐ **Have Never Attended** ☐ **Yes, Have Previously Attended (please answer the questions below):**
(The following questions are important when requesting authorization for procedures)
Body part treated: ☐ Neck ☐ Low Back ☐ Shoulder(s) ☐ Knee(s) ☐ Ankle(s) ☐ Other: ___________
Where did you attend Physical Therapy? ______________________________
When did you receive the Physical Therapy? (Month / Year) ______________________________
Times per week? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
How long? ☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ 4 Months ☐ 5 Months ☐ 6 Months ☐ Other: ______
Relief received from Physical Therapy?
☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐100%

Previous Pain Treatments Tried (Please ✓ all that apply)		
✓	**Type of Procedure**	**When / Where / Percentage of Relief**
	Epidural/Steroid Shots	
	Joint Injection(s)	
	Kyphoplasty/Vertebroplasty	
	Medial Branch Blocks	
	Nerve Block(s)	
	Pain Pump	
	Radiofrequency Ablation	
	Neurostimulation	
	None	
	Other(s):	

Past Medical History (Please ✓ all that apply)									
	Anxiety Disorder		CHF		Fibromyalgia		High Cholesterol		Osteoarthritis
	Arrythmia		Clotting Disorder		GERD		HIV Positive		Osteoporosis
	Asthma		Depression		Heart Attack		Kidney Disease		Pacemaker
	Bowel Disorders		Diabetes		Hepatitis C		Liver Disease		Seizures
	Cancer		Drug Abuse		High Blood Pressure		Lung Disease		Stroke
	NONE		Other:						Thyroid Disease

Allergies (Please ✓ all that apply)					
	None/NKDA		Penicillin		Latex
	Iodine		Sulfa Drugs		NSAIDs (Nonsteroidal anti-inflammatory drugs)
	Other:				

✓	Past Surgical History (Please ✓ all that apply)		
✓	**Procedure**	**Number of Procedures / Side / Other Details**	**Month/Year**
	Appendectomy		
	C-Section		
	Cervical Fusion		
	Cholecystectomy		
	Heart Bypass		
	Heart Stent		
	Knee Replacement		
	Kyphoplasty/Vertebroplasty		
	Lumbar Fusion		
	Pacemaker		
	Thyroidectomy		
	No Previous Surgeries		
	Other:		

Have you been hospitalized within the last 3 Months? ☐ No ☐ Yes

If yes, please provide location & reason: ____

____

Family History (Please ✓ all that apply)								
Family Member	**Status**	**Cancer**	**Diabetes**	**Heart Attack**	**Hypertension**	**Mental Illness**	**Stroke**	**Other**
Mother	☐ Alive ☐ Deceased ☐ Unknown							
Father	☐ Alive ☐ Deceased ☐ Unknown							
Siblings	☐ Alive ☐ Deceased ☐ Unknown ☐ N/A							
Other								

Social History

Highest Education/Degree Completed: ☐ Elementary/Middle School ☐ High School ☐ GED ☐ Technical School

☐ Associates Degree ☐ Bachelor's Degree ☐ Post Graduate Degree ☐ MD ☐ JD ☐ Other: ______________

Employment Status? ☐ Not Currently Employed ☐ Retired ☐ Disabled

☐ Employed (Location and Job Title): ______________________________________

Do you have Children? ☐ No ☐ Yes, ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐____________

Do you drink caffeine? ☐ No ☐ Yes, ☐ On occasion ☐ 1-2 cups per day ☐ 3 or more per day

Do you exercise? ☐ No ☐ Yes - what type: ☐ Walking ☐ Jogging ☐ Weights ☐ Yoga ☐ Other ___________________

How often? ☐ Never ☐ Occasionally ☐ 1-2/week ☐ 3-4/week ☐ 4-5/week ☐5-7/week

Do you currently use recreational drugs? ☐No ☐Yes: ☐Marijuana ☐ Heroin ☐Cocaine ☐MDMA ☐Other: ___________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you currently smoke? ☐ No ☐ Yes **(if yes, please answer questions below):**

Tobacco Use:

How soon after you wake do you smoke? ☐ within 5 minutes ☐ within 1st hour ☐ more than 1 hour
How many cigarettes a day? ☐ 5 or less ☐ 6 - 10 ☐ 11 - 20 ☐ 21+
Are you interested in quitting? ☐ Ready to Quit ☐ Thinking about Quitting ☐ No, Not Ready to Quit

In the last year have you consumed alcohol? ☐ No ☐ Yes **(if yes, please answer questions below):**

Alcohol Use:

How often? ☐ Monthly or Less ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4+times per week
How many in a typical day? ☐ 0-2/day ☐ 3-4/day ☐ 5-6/day ☐ 7-9/day ☐ 10+/day
How often did you have 6 or more drinks in one occasion? ☐ Never ☐ Less than monthly ☐ Monthly ☐Weekly ☐ Daily/Most Days

Review of Systems

Please ✓ all that apply

	CONSTITUTIONAL		GASTROENTEROLOGY		MUSCULOSKELETAL
	Unexpected Weight Gain		Abdominal Pain		Muscle Pain
	Unexpected Weight Loss		Nausea		Joint Pain
	Fatigue		Diarrhea		Joint Swelling
	Insomnia		Constipation		Joint Redness
	Fever		Blood in Stool		**None**
	None		**None**		**HEMATOLOGY**
	HEENT		**FEMALE REPRODUCTIVE**		History of Stroke
	Throat Pain		Pregnant		Blood Clots
	Ear Pain		Post Menopausal		Abnormal Bleeding
	Change in Vision		Breast Pain		**None**
	None		**None**		**NEUROLOGY**
	CARDIOLOGY		**MALE REPRODUCTIVE**		Difficulty Walking
	Chest Pain		Diminished Sexual Drive		Headaches
	Pacemaker		**None**		Tingling
	Irregular Heartbeat		**UROLOGY**		Numbness
	Leg Swelling		Painful Urination		Seizures
	None		Difficulty Urinating		**None**
	RESPIRATORY		Urinary Incontinence		**PSYCHOLOGY**
	Shortness of Breath		Blood in Urine		Depression
	Cough		**None**		Bipolar
	None		**ENDOCRINOLOGY**		Anxiety
			Excessive Thirst		Suicidal Ideation
			Excessive Urination		**None**
	Other Concerns:		**None**		History of Psychiatric Hospitalization: ☐**No** ☒**Yes** (When & Where):

New Patient Encounter Form   Room

Any imaging in the past? ☐ No ☐ Yes
____
☐ **Imaging Requested and Action Created**
☐ **Picture on File**

Provider on all appts today match? ☐ No ☐ Yes
Is the provider in network? ☐ No ☐ Yes
Botox Questionnaire Needed? ☐ No ☐ Yes
Payer ID in eCw Matches Ins Card ☐ No ☐ Yes ☐ NA

Scheduled Labs: ☐ UDS ☐ Blood ☐ DNA

Total Expected: $____________ **Collected:** $____________ **Payment Agreement** ☐ Verbal ☐ RCC ☐ NA

FD Clerk Full Name: ______________________________________

Tier 1 MA Full Name:
____

Tier 2 MA Full Name:
____

☐ **SNOMED Error Cleared**

PMP: ☐Consistent ☐Inconsistent PC: Y N 1 2 2+

Medication:	____________	____________
Frequency:	____________	____________
Dosage:	____________	____________
Fill Date:	____________	____________
Provider:	____________	____________

MD Briefing: Last PT: ____________________ Last Procedure: ____________________

Surgical Hx: ____

Medical Hx: ____

eRx: ______ **In Hand:** ______ **Faxed:** ______

Next fill Date: ________ **RTC:** ______ Weeks ☐ Follow Up ☐ Stim Ed ☐ Stim Programming ☐ PRN

☐ Procedure ____ ☐ Pre/Post OP Instructions Provided

Visit Level: ☐ 99202 ☐ 99203 ☐ 99204 ☐ 99205 **Additional Services (check all that apply):**

☐ Toradol ☐ Flu Vaccine ☐ BBHI ☐ Stim Programming ☐ StimEd ☐ Brace ☐ Other DME

O2: ______ BP: ______ HR: ______ WT: ______ Temp: ______ RR: ______ HT: ______ BMI: ______

Provider Notes & Treatment Plan: