Lafayette Location

Center for Pain Management
Innovations Pain Management
3738 LANDMARK DRIVE
SUITE A
LAFAYETTE, IN 47905
PHONE (765) 807-2780
FAX (317) 706-3417
www.IndyPain.com

Dear New Patient:

Thank you for choosing the Center for Pain Management for your care.

Enclosed you will find a New Patient Packet**. It is essential that you complete this packet and bring it to your scheduled appointment**, along with your insurance card(s), photo ID, all of your bottles of medication, including anything over-the-counter or herbal supplements. DO NOT bring anything refrigerated. If you have an MRI, CT scan, or X-ray that you can bring with you, please do so.

Also enclosed is a Health History form. You may receive a phone call from our office a few business days prior to your appointment to go over your Health History form. Please expect the call to take about 20 minutes. The questions that will be asked are also available on our website (www.IndyPain.com), if you want to review them in advance. This will shorten the time needed for the phone call.

At the minimum please have available a list of your allergies, a list of all hospitalizations, surgeries, pain injections, and imaging tests with the facility name and the year. Please include all medication bottles. If you are not currently working, we will need the exact date you last worked.

We require that past medical records are to be received in our office 3 business days prior to your appointment. These should be sent from your primary care physician, previous pain management or any specialists you have seen in regards to your diagnosis, for which you are seeking treatment. Please have the records faxed directly from these providers to (317) 706-3417. If records are not received 3 business days prior to your appointment, we reserve the right to cancel your appointment.

If we cannot reach you to take this history or you do not call in prior to your appointment, please expect an extended wait to see the physician when you arrive.

Again, thank you for choosing the Center for Pain Management.

Attention Patients with Limited English Proficiency

Español (Spanish): [CFPM, CSS, CSSS] cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

繁體中文(Chinese): [CFPM, CSS, CSSS] 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Deutsch (German): [CFPM, CSS, CSSS] erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Deitsch (Pennsylvania Dutch): [CFPM, CSS, CSSS] iss willich, die Gsetze (federal civil rights) vun die Owwerichkeet zu folliche un duht alle Leit behandle in der seem Weg. Es macht nix aus, vun wellem Schtamm ebber beikummt, aus wellem Land die Voreldre kumme sinn, was fer en Elt ebber hot, eb ebber en Mann iss odder en Fraa, verkrippelt iss odder net.

العربية (Arabic): يلتزم [CFPM, CSS, CSSS] بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.

한국어 (Korean): [CFPM, CSS, CSSS] 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Tiếng Việt (Vietnamese): [CFPM, CSS, CSSS] tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Français (French): [CFPM, CSS, CSSS] respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

日本語(Japanese): [CFPM, CSS, CSSS] は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害または性別に基づく差別をいたしません。

Nederlands (Dutch): [CFPM, CSS, CSSS] voldoet aan de geldende wettelijke bepalingen over burgerrechten en discrimineert niet op basis van ras, huidskleur, afkomst, leeftijd, handicap of geslacht.

Tagalog (Tagalog – Filipino): Sumusunod ang [CFPM, CSS, CSSS] sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

Русский (Russian): [CFPM, CSS, CSSS] соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

ਪੰਜਾਬੀ (Punjabi): [CFPM, CSS, CSSS] ਲਾਗੂ ਸੰਘੀ ਨਾਗਰਿਕ ਹੱਕ ਦੇ ਕਾਨੂੰਨ ਦੀ ਪਾਲਣਾ ਕਰਦੀ ਹੈ ਅਤੇ ਨਸਲ, ਰੰਗ, ਰਾਸ਼ਟਰੀ ਮੂਲ, ਉਮਰ, ਅਸਮਰਥਤਾ, ਜ ਲਿੰਗ 'ਤੇ ਅਧਾਰ 'ਤੇ ਵਿਤਕਰਾ ਨਹ ਕਰਦੀ ਹੈ।

हंद (Hindi): [CFPM, CSS, CSSS] लागू होने योग्य संघीय नाग रक अधिकार क़ानून का पालन करता है और जाति, रंग, रा ीय मूल, आयु, विकलांगता, या लग के आधार पर भेदभाव नह करता है।

CPM-CENTER FOR PAIN MANAGEMENT
CSS-CENTER FOR SPECIAL SURGERY
CSSS-CENTER FOR SOUTHSIDE SURGERY

PHONE: 765-807-2780
FAX: 317-706-3417
www.IndyPain.com

New Patient Packet

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NEW PATIENT PACKET – KEEP FOR YOUR RECORDS

765-807-2780
(fax) 317-706-3417
www.IndyPain.com

Welcome to the Center for Pain Management

At the Center for Pain Management, we appreciate the impact that pain has on the quality of your life. We utilize a team approach to accomplish pain reduction, pain management, and return to activity.

Our team of healthcare providers includes:

- Edward Kowlowitz, M.D., Medical Director
- John J. Fitzgerald, M.D.
- Jocelyn L. Bush, M.D.
- Scott Kim, M.D.
- Saima Kamal, M.D.
- David Miller, M.D.
- David Gordon, M.D.
- Amanda Wakefield, Ph.D., HSPP
- Sandra Dolny, PA-C
- Ted Westlund, PA-C
- Dena Seifert, FHNP-BC
- Caroline Asava, NP-C
- Susan Sipes, AGPCNP-C
- Jennifer Emmert, ACNP-BC
- Physical therapists and support staff

Pain is rarely treated effectively by any single mode of treatment alone. For that reason, your treatment at the Center will most likely include medication management along with one or more of the following: physical therapy, psychological services, nerve block procedures, and education. This is best accomplished by professionals who can work together to meet your needs. For this reason, you must let your Center for Pain physician know before you seek any pain management services from another provider while under our care.

Psychology

The role of psychology in our program is to help you cope with the impact that living with chronic pain has on your life; it is not to question the reality of your pain. We believe that being in pain, especially over a long period of time, does affect your stress level, relationships, sleep, and the ability to do things which are meaningful to you. Also, untreated depression or anxiety can make managing your pain more difficult. Successful treatment involves addressing all of these issues so that we can best improve your quality of life.

Physical Therapy

The goal of physical therapy is to address specific structural and functional problems and to increase your overall activity level. You may have had physical therapy before with little benefit or even an increase in pain. Our physical therapy staff works only with pain management patients. As pain management experts, we have unique approaches to helping patients break the cycle of pain and inactivity. If physical therapy is ordered for you, you will be expected to attend at least 80% of your appointments. Failure to do so can result in discharge from both therapy and medical services.

Medication Management

Opioid and non-opioid medications can be an important part of your treatment plan and can be instrumental in decreasing your pain and improving your quality of life. It is unrealistic, however, to expect your medications to relieve 100% of your pain. In addition, pain medications are not a substitute for treatments that address the cause of your pain. If you fail to comply with the non-medication components of your treatment plan, your medications may be withdrawn. In addition, due to recent changes in Indiana law, your medications may be withdrawn if you do not experience an increase in your activity level and ability to function.

Disability Forms and Letters

Our goal is to restore you to your highest level of function and, when necessary, to assist you with the completion of forms or letters in a timely manner. Our requirements for the completion of disability forms or letters are listed below:

- There will be a charge that must be paid prior to the completion of the form/letter. This charge ranges from $15.00 to $400.00 depending on the complexity of the request. The charge for most forms is $25.00.
- Ten working days will be required for the completion of the form/letter. Letters that require dictation by a physician may take additional time.
- The completion of some forms/letters may require an office visit if additional assessment is required.
- We reserve the right to refuse to complete a form if it requests information that we do not have as a part of your treatment with us.
- Disability/more complex forms may not be filled out for at least 6 months, until we have an established relationship with you.

Next Steps in the New Patient Registration Process

Following this letter, you will find a packet of information and forms which we need you to review and/or sign before we can see you for your first appointment.

****Please use the New Patient Checklist to make your registration process seamless****

Once you are under the care of the Center, it is essential that you understand the multidisciplinary treatment program planned for you. If you have any questions, please let a member of our staff know so a nurse or our administrator can address your concerns.

Thank you for choosing the Center for Pain Management

765-807-2780
(fax) 317-706-3417
www.IndyPain.com
3738 Landmark Drive, Ste A.
Lafayette, IN 47905

New Patient Checklist

Center for Pain Management

Did you:

- Read the **Welcome Letter**?
- Read the **Notice of Privacy Practices**?
- Complete the **Patient Registration Form**?
- Complete the **Pain History**?
- Complete the **Pain Questionnaire**?
- Complete the **P-3 Assessment**?
- Complete the **SOAPP** (Screener & Opioid Assessment for Patients with Pain)?
- Speak with our representative regarding your health history?

Your First Appointment

- When you attend your first appointment you must bring:
  - Any Radiology Films from other physician's offices; this includes MRI and CT scans or X-rays
  - All of your completed paperwork (see checklist above)
  - Your insurance card
  - Photo identification (Driver's License, etc.
  - All of your medications, including any over-the-counter medication you are currently taking as well as herbal supplements.
  - Your co-pay, if your insurance plan requires one

765-807-2780
(fax) 317-706-3417
www.IndyPain.com
3738 Landmark Dr., Ste. A
Lafayette, IN 47905

Ownership Disclosure Notice for Center for Pain Management, Center for Special Surgery and Center for Southside Surgery

This Ownership Disclosure Notice is required under Indiana law to inform you that Edward J. Kowlowitz, M.D. is the direct owner of Shadeland Anesthesia & Pain Management Associates, Inc., P.C. d/b/a Center for Pain Management ("CFPM") and has an indirect ownership interest in Center for Special Surgery, LLC ("CSS") and Center for Southside Surgery, LLC ("CSSS"). CFPM provides professional physician services, physical therapy services, psychology services, MRI services, and laboratory services. CSS and CSSS both provide outpatient surgical services.

If you are interested in receiving the diagnostic, medical, surgical or rehabilitative care that has been recommended for you by Dr. Kowlowitz from CFPM, CSS or CSSS, please let us know. However, you are not required to obtain any such diagnostic, medical, surgical or rehabilitative care from CFPM, CSS or CSS and you have the right to be referred to a practice or facility in which Dr. Kowlowitz does not have a financial interest. Please be aware, however, that in the case of surgical services, Dr. Kowlowitz may not have privileges or scheduled surgery time at any another' facility you may choose.

Should you choose to obtain diagnostic, medical, surgical or rehabilitative care somewhere other than CFPM, CSS or CSSS, we will be glad to provide you with the names of alternative providers upon your request.

Please sign and date below to acknowledge your receipt of this Ownership Disclosure Notice.

Acknowledged:

Date:____________________________

By:_____________________________

Name: ___________________________

North Location
8805 N Meridian St.
Indianapolis, IN 46260

South Location
533 E County Line Rd
Greenwood, IN 46143

Lafayette Location
3738 Landmark Dr.
Lafayette, IN 47905

www.IndyPain.com
765-807-2780
(fax) 317-706-3417

Notice of Privacy Practices

Center for Pain Management (Indianapolis, Greenwood, and Lafayette), Center for Special Surgery and Center for Southside Surgery

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment, or healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. Protected Health Information is information about you including demographic information that may identify you and that relates to your past, present, or future, physical or mental health condition, and related healthcare services. This notice is divided into three sections and describes the uses and disclosures of your Protected Health Information, your rights as they relate to your Protected Health Information, and our duties as a healthcare provider. We are required to abide by the terms of this notice of Privacy Practices. Your Protected Health Information is protected under federal law for 50 years after your death.

Section I – Uses and Disclosures of Your Protected Health Information

Federal law allows this practice to use and disclose your Protected Health Information to carry out treatment, payment, and healthcare operation activities. Your Protected Health Information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care for the purpose of providing healthcare services to you. Your Protected Health Information may also be used and disclosed to obtain payment for your health care services and to support the operation of our practice. The following examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

The use and disclosure of your Protected Health Information for treatment purposes includes uses and disclosures to provide, coordinate, or manage your healthcare. Examples of this would include disclosure of Protected Health Information to other physicians who may be treating you, including physicians who refer you to our practice. Also, Protected Health Information may be provided to a physician or another service provider to whom you have been referred by our practice to insure that individual has the necessary information to diagnose you and provide care. Information will also be disclosed to and received from pharmacies to coordinate and oversee prescription medication management.

Your Protected Health Information will also be used as needed to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for healthcare services that we recommend for you. Examples include determining eligibility or coverage for insurance benefit, reviewing services provided to you for medical necessity, and undertaking utilization review activities. This would include pre-certification or pre-determination of benefits for outpatient surgical procedures.

We may also use and disclose your Protected Health Information in order to support the business activities of this practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. A specific example of this would be the review of medical records by outside agencies who audit medical records for the purpose of insuring quality care. We may also use a sign-in sheet at the registration desk where you will be asked to sign your name and service you are receiving. We may also call you by name in

the waiting room when your physician or service provider is ready to see you. We may use or disclose your Protected Health Information as necessary to contact you to remind you of your appointments.
We will share your Protected Health Information with Third Party "business associates" that perform various activities for our practice. These activities include, but are not limited to, the provision of certain types of patient's specific medical equipment, the maintenance of computer software, and collection activities. Whenever an arrangement between our office and a business associate involves the use or disclosure of your Protected Health information, we will have a written contract that contains terms that will protect the privacy of your Protected Health Information.

We may use or disclose your Protected Health Information as necessary to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

In addition to the uses and disclosures described above that are permitted, as they relate to your treatment, payment for healthcare services, or the operations of this facility, certain other uses or disclosures are permitted or required by law. Specifically, unless you object, we may disclose to a member of your family, a relative, a friend, or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose Protected Health Information to identify your location or general condition to a family member, a personal representative, or any other person that is responsible for your care. Finally, we may use or disclose your Protected Health Information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care. If you were to die while a patient of our practice, we could share medical information and information required to facilitate payment for services received with an individual immediately involved in your care, unless the disclosure would be inconsistent with your prior expressed consent.

The following are specific uses and disclosures of your Protected Health Information that may be made without your agreement or authorization as required by law. We may use or disclose your Protected Health Information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relative requirements of the law.

We may disclose your Protected Health Information for <u>public health activities and purposes</u> to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. We may also disclose your Protected Health Information if directed by the public health authority to a foreign government agency that is collaborating with the public health authority.

We may disclose your Protected Health Information, if authorized by law, to a person who may have been exposed to a communicable disease or may be otherwise at risk of contracting or spreading the disease or condition. We may disclose Protected Health Information to a <u>health oversight agency</u> for activities authorized by law such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, other government regulatory programs, and civil rights laws.

We may disclose your Protected Health Information to a public health authority that is authorized by law to receive reports of <u>child abuse or neglect</u>. In addition, we may disclose your Protected Health Information if we believe that you have been a victim of <u>abuse, neglect, or domestic violence</u> to the governmental entity or agency authorized to receive such information. In this case, a disclosure will be made consistent with the requirements of applicable federal and state laws.

We may disclose your Protected Health Information to a person or company required by the <u>Food and Drug Administration</u> to report adverse events, product defects or problems, biologic product deviations; to track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance as required.

We may disclose Protected Health Information in the course of any <u>judicial or administrative proceeding</u> in response to a court order or administrative tribunal or in certain conditions in response to a subpoena, discovery request, or other lawful process. We may also disclose Protected Health Information so long as applicable legal requirements are met for <u>police law enforcement</u> purposes. These law enforcement purposes include legal processes, limited information requests for identification and location, those pertaining to victims of a crime, in the event that a crime occurs on the premises of the practice, and in the event of a medical emergency. Consistent with applicable federal and state laws, we may also disclose your Protected Health Information if we believe that the use or disclosure is necessary to prevent or lessen a serious and

imminent threat to the health or safety of a person or the public. We may also disclose Protected Health Information if it is necessary for law enforcement authorities to identify or apprehend an individual.

When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are armed forces personnel. Please inquire if you have specific questions regarding the disclosure of Protected Health Information as it relates to military service. We may disclose your Protected Health Information to authorize federal officials for conducting national security and intelligence activities, including for the provision of protective services.

Your Protected Health Information may be disclosed by us in compliance with Worker's Compensation and laws and other similar legally established programs.

We may also use or disclose your Protected Health Information if you are an inmate of a correctional facility and your physician created or received your Protected Health Information in the course of providing care to you.

In summary, we may use or disclose your Protected Health Information without your authorization for the purposes of providing healthcare services to you (treatment), securing payment for healthcare services, and supporting the operation of this practice. In addition, your Protected Health Information may also be disclosed without your authorization for certain purposes as described above and as required by law. Unless you object, your Protected Health Information can also be disclosed to family members or others involved in your care as described above.

All other uses and disclosures of your Protected Health Information will be made only with your written authorization. You may revoke this authorization at any time in writing except to the extent that your physician or physician's staff has taken an action in response to that authorization. Our practice does not maintain psychology records outside of your medical chart (electronic or paper), market for other companies, or sell your protected health information. We are however required to inform you that disclosure of separately maintained psychology notes, selling your Protected Health Information, or disclosures for marketing would require your written authorization,

Section II – Your Rights

You have the right to inspect and receive a copy (electronic or hard copy) of your Protected Health Information. This means that you may inspect, in the presence of a staff member, your Protected Health Information as well as request a copy of this information. You may request to inspect or to receive a copy of your Protected Health Information for as long as we maintain that information. This information may include medical and billing records and any other records that your physician and this practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes that are maintained outside of the medical record, information compiled in reasonable anticipation of or in use in a civil, criminal, or administrative action or proceeding, and Protected Health information that is subject to law that prohibits access to that information. Access may be denied if a healthcare provider has determined that access to the record is likely to endanger the life or safety of you or another individual, or cause substantial harm to another individual who is not a healthcare provider mentioned in the record. If access to your medical record is denied, you will be informed in writing of the denial. Certain reasons for denying access to your medical record are reviewable and you may have a right to request that a denial be reviewed. Please contact our Privacy Official if you have questions about access to your medical record, or if you wish to have a denial reviewed. The state approved fee for the copying of medical records will be applied to any request for copies of health information.

You have the right to request a restriction of your Protected Health Information. This means you may ask us not to use or disclose a part of your Protected Health Information for the purposes of treatment, payment, or health care operations. You may also request that a part of your Protected Health Information not be disclosed to family members or friends who may be involved in your care, or for notification purposes as described in this notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your Protected Health Information, as otherwise permitted by law, your Protected Health Information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. Our practice however, must honor any request to restrict disclosure to your medical insurance carrier of information related to a specific service if you pay for that service in full. You may request a restriction by informing any member of our staff of your desire to restrict the use and disclosure of your Protected Health Information.

The staff member will complete, with your assistance, a Restricted Disclosure Form, and forward it to the Privacy Official who will obtain the approval of the physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. This means you can ask us to contact you or leave messages at alternative phone numbers or send correspondence to an alternative address. We will accommodate all reasonable requests. We may, however, require you to provide us information as to how payment will be handled, or to specify an alternative address or method of contact. We will not request an explanation of your request from you. Please make this request in writing and ask any member of our staff to forward it to our Privacy Official.
You may have the right to have your physician amend your Protected Health Information. This means you may request that your physician correct information in your medical record that you believe to be inaccurate for as long as that health information is maintained in our practice. We may deny your request for an amendment if the information in question was not created by your physician or a member of the staff at this practice, or if your physician believes the information contained in your medical record is accurate and complete. If we deny your request for an amendment, you have the right to file a Statement of Disagreement with us, and we may prepare a rebuttal to your statement. Both your Statement of Disagreement and our prepared rebuttal, if any, will become part of your Protected Health Information and will be disclosed as part of any permitted or required disclosure. You will receive a copy of any written statement of rebuttal placed into your medical record. Please make any requests for amendment of your Protected Health Information to a member of our staff in writing and ask them to forward it to the Privacy Official.

You have the right to receive an accounting of certain disclosures we have made, if any, of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations, and does not apply to disclosures made in response to a valid authorization signed by you or a personal representative. It also excludes disclosures made to family members or others involved in your care. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. Your right to receive this information is subject to certain exceptions, restrictions, and limitations.

You have the right to be notified in the event of a breach of your unsecured Protected Health Information.

Section III – Our Duties
This practice is required by law to maintain the privacy of Protected Health Information and to provide you with notice of our legal duties and Privacy Practices with respect to Protected Health Information. We must provide to you this written notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all Protected Health Information that we maintain at that time. Upon your request, we will provide you with any revised notice of Privacy Practices. You may obtain a revised notice by calling the office and requesting that a revised copy be sent to you in the mail, or by asking for one at the time of your next appointment. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Official of your complaint. We will not retaliate against you for filing a complaint. Our Privacy Official is the facility administrator and may be contacted at (317) 706-7246. This notice was published and became effective on April 14, 2003 and updated September 23, 2013.

IT IS EACH PATIENT'S RESPONSIBILITY TO HAVE YOUR MEDICAL RECORDS FORWARDED TO OUR OFFICE AT THE FOLLOWING FAX#

317-706-3417

ATTN: NEW PATIENT

SHOULD YOUR PREVIOUS DOCTOR ASK FOR A RELEASE OF INFORMATION, IT HAS BEEN ATTACHED

www.IndyPain.com

INDIANAPOLIS
Phone: 317-706-7246
Fax: 317-706-3417
8805 North Meridian St.
Indianapolis, IN 46260

GREENWOOD
Phone: 317-706-7246
Fax: 317-706-3417
533 East County Line Rd.
Greenwood, IN 46143

LAFAYETTE
Innovations Pain Management
Phone: 765-807-2780
Fax: 317-706-3417
3738 Landmark Dr.
Lafayette, IN 47905

Edward J. Kowlowitz, M.D. John J. Fitzgerald, M.D. Jocelyn Bush, M.D.
Scott Kim, M.D. Saima Kamal, M.D. David Miller, M.D. David Gordon, M.D. Amanda Wakefield, Ph.D. HSPP

RELEASE OF INFORMATION

I, ____, with Date of Birth (month/day/year): ________________

authorize and release the disclosure of my health information by: ____________________________________

____

to the Center for Pain Management and/or Innovations Pain Management Group (a division of Center for Pain Management) for the purpose of: ____

The information to be released includes: ____

____

I understand that I may revoke this authorization at any time except to the extent that information has already been released in response to this authorization. I understand that I may revoke this authorization by making the request in writing and giving it to an office staff member of the Center for Pain Management and/or Innovations Pain Management Group. I understand that information disclosed in response to this authorization may be re-disclosed by the recipient and therefore is no longer protected. I understand that my treatment may not be conditioned upon the signing of this authorization.

AUTHORIZATION

Signature: ____

Relationship if other than patient:____

Date: ____

Expiration Date or Event: ___________________________

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New Patient Registration Form

Center for Pain Management (Indianapolis, Greenwood, Lafayette), Center for Special Surgery and Center for Southside Surgery

PATIENT INFORMATION

Name:____ Today's Date:__________________

SSN:_______-_______-_______ Sex: F / M D.O.B:_____/_____/_____ Marital Status:__________________

Address:____

City:____________________________________ State:_________________ Zip Code:_________________

Home Phone:(______)______-__________ Work:(______)______-__________ Cell:(______)______-__________

email Address:____

**Preferred Phone to Confirm Appointments between hours of 8 a.m. to 5 p.m.:*_____________________________

Spouse Name:____ Daytime Ph#:(______)______-__________

Emergency Contact:_______________________________________ Daytime Ph#:(______)______-__________

Referring Physician:_______________________________________ Phone#:(______)______-__________

Primary Care Physician:____________________________________ Phone#:(______)______-__________

When did you last see your Primary Care Physician?____

Employer Information Employment Status: *Employed* *Unemployed* *Disabled* *Retired*

Occupation:__________________________________ Employer:_________________________________

Employer Address:____ Ph#(______)______-__________

Are you retired? (please circle) Y / N If yes, date retired:___________________________________

Are you disabled or unemployed? Y / N If yes, exact date last worked:_____________________________

Are you currently in school? Y / N Full-time / Part-time School Name:_____________________________

GUARANTOR INFORMATION (the person responsible for the patient's account)

What is the patient's relationship to the guarantor? Self Spouse Child Other:_________________________

Guarantor Name:____________________________ D.O.B.:_____/_____/_____ SSN:_______-_______-_______

Address:____

City:____________________________________ State:_________________ Zip Code:_________________

Home Phone:(______)______-__________ Work:(______)______-__________ Cell:(______)______-__________

eMail Address:____

Occupation:__________________________________ Employer:_________________________________

Employer Address:____

INSURANCE INFORMATION

Do you have MEDICARE Part A? Y / N Part B? Y / N Medicare Policy Number:___________________________

If you have Medicare, do you also have a Medigap policy or other supplemental coverage? Y / N

Do you have MEDICAID? Y / N Medicaid Policy Number:____________________________

PRIMARY INSURANCE INFORMATION- Insurance card must be provided to front desk

Insurance Company Name:____

Claims Mailing Address:____

Contact Name:____ Ph#(________)________-____________

Policy Holder's Name:____ SSN:_________-_________-__________

Policy Holder's D.O.B.:________/________/__________ Relationship:____

Policy Number/ID#:_______________________________________ Group#:___________________________________

Group Name/Employer Name:____

SECONDARY INSURANCE INFORMATION- Insurance card must be provided to front desk

Insurance Company Name:____

Claims Mailing Address:____

Contact Name:____ Ph#(________)________-____________

Policy Holder's Name:____ SSN:_________-_________-__________

Policy Holder's D.O.B.:________/________/_________ Relationship:____

Policy Number/ID#:_______________________________________ Group#:___________________________________

Group Name/Employer Name:____

OTHER INSURANCE INFORMATION- Information must be provided to front desk, if applicable

Is this an Accident / Injury? Y / N If yes, date of Accident / Injury:____________________________________

Worker's Compensation, *Auto Accident,* *Other Accident / Injury* (circle if applicable)

Are you currently involved in or pursuing litigation over these injuries? Y / N

If yes, Attorney Name:___________________________________ Law Firm:___________________________________

Attorney Phone#:(________)________-____________ Claim/Case#:____

Insurance Company or Worker's Compensation Carrier Name:____

Claims Mailing Address:____

Contact Name:____ Ph#(________)________-____________

Policy Holder's Name:____ SSN:_________-_________-__________

Policy Holder's D.O.B.:________/________/__________ Relationship:____

Policy Number/ID#/Case#:_________________________________ Group#:___________________________________

Group Name/Employer Name:____

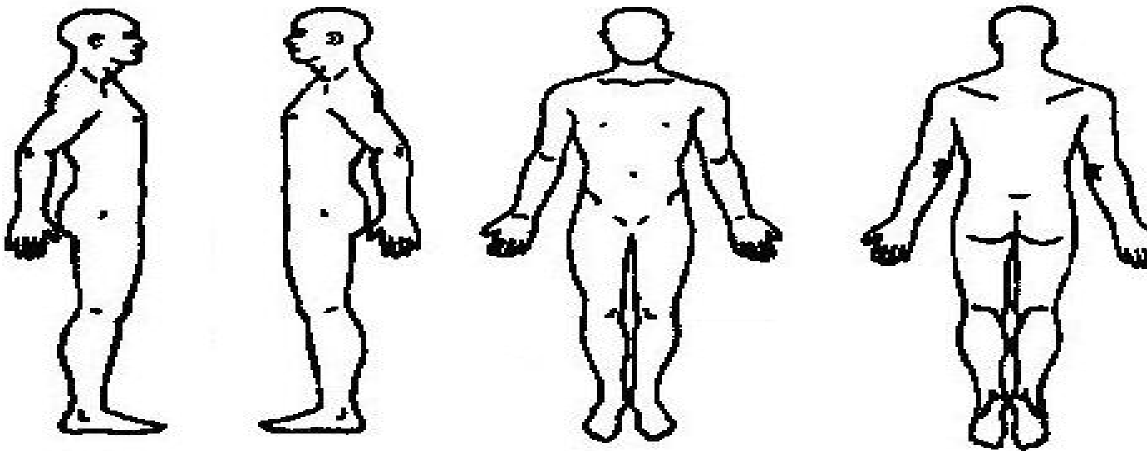
765-807-2780
(fax) 317-706-3417
www.IndyPain.com
3738 Landmark Dr, Ste. A
Lafayette, IN 47905

New Patient Pain History

Center for Pain Management (Indianapolis, Greenwood, Lafayette), Center for Special Surgery and Center for Southside Surgery

HISTORY of PRESENT ILLNESS

Patient Name (please print): ____ M/F Age ______
Last name, First Name, Middle Initial
Have you ever been to another Pain Center? Yes / No If Yes, where/when: _______________________
Have you had Physical Therapy before? Yes/No If Yes, where: _____________________
When was your last Physical Therapy Appointment? _______________
How many visits have you had this year? _________
What is the chief complaint that brings you to the doctor today? ___________________________________
____
How did these symptoms begin? ____
When did you first start experiencing these symptoms? MM/DD/YY _______________________________
When did the symptoms progress to the current level of severity? _________________________________
Please mark on the drawings below all areas where you are feeling pain:



Location: __________________________________ Severity: mild moderate severe

Quality: dull aching stabbing cramping shooting burning throbbing

Duration: Intermittent (stops & starts) or Persistent (all the time)

Pain worse in: morning afternoon evening Context: __________________________

Modifying Factors

What makes it better: ____

What makes it worse: ____

Associated Symptoms: ____

Please circle the number that reflects your current level of pain:
None 0 1 2 3 4 5 6 7 8 9 10 unbearable

On the average over the past 4 weeks my pain at the best was a:
None 0 1 2 3 4 5 6 7 8 9 10 unbearable

On the average over the past 4 weeks my pain at the worst was a:
None 0 1 2 3 4 5 6 7 8 9 10 unbearable

Please list 3 specific things you are unable to do because of your pain:

___________________________ ___________________________ ___________________________

Please identify which of the following medications have been tried in the past by checking the appropriate box. (Do not check any drug never taken)

	Helpful?			Helpful?			Helpful?	
NSAID	Y	N	**Muscle Relaxant**	Y	N	**Anticonvulsant**	Y	N
Motrin			Skelaxin			Neurontin		
Lodine			Norflex			Lamictal		
Naprosyn			Soma			Topamax		
Relafen			Robaxin			Depakote		
Indocin			Flexeril			Tegretol		
Celebrex			Zanaflex			Dilantin		
Mobic			Valium			Lyrica		
Opioid (narcotic)			**Others**			**Antidepressant**		
Darvocet			Stadol			Elavil		
Percocet			Talwin			Pamelor		
Lortab/Vicodin			Fioricet			Doxepin		
Norco/Zydone			Ultram			Tofranil		
Duragesic			Zostrix			Desyrel		
Dilaudid			Ketamine Gel			Wellbutrin		
Oxycontin			Lidoderm			Anafranil		
MS Contin			Imitrex			Luvox		
MS IR			Amerge			Zoloft		
Kadian			DHEA			Remeron		
Levorphanol			Guaifenesin			Paxil		
Methadone			Dextromethorphan			Prozac		
Actiq			Steroids			Serzone		
			Suboxone			Effexor		
						Respiradol		
						Zyprexa		
						Cymbalta		

CENTER FOR PAIN MANAGEMENT-PAIN QUESTIONNAIRE PATIENT NAME: ____

This questionnaire has been designed to give us information on how your injury or condition currently affects your ability to manage in everyday life. Please answer every question by selecting the answer that best describes your condition. Check the box next to that answer. If you cannot find an answer that exactly describes your condition, choose the answer that most closely fits and check that box

	SECTION 1 – PERSONAL CARE		**SECTION 8 – STANDING**
	I can look after myself without causing extra pain.		I can stand as long as I want without pain.
	I can look after myself normally, but it causes extra pain.		I have some pain on standing but it does not increase with time.
	It is painful to look after myself but I am slow and careful.		I can't stand for longer than 1 hour without increasing pain.
	I need some help but manage most of my personal care.		I can't stand for longer than ½ hour without increasing pain.
	I need help every day in most aspects of self care.		I can't stand for longer than 10 minutes without increasing pain.
	I do not get dressed, I wash with difficulty, and stay in bed.		I avoid standing because it increases my pain immediately.
	SECTION 2 – LIFTING		**SECTION 9 – SLEEPING**
	I can lift heavy weights without extra pain.		I have no trouble sleeping.
	I can lift heavy weights but it causes extra pain.		My sleep is slightly disturbed (less than 1 hour sleepless)
	Pain prevents me from lifting heavy weights off the floor but I manage if they are conveniently positioned (i.e. on a table)		My sleep is mildly disturbed (1-2 hours sleepless)
	Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.		My sleep is moderately disturbed (2-3 hours sleepless)
	I can only lift very light weights at the most.		My sleep is greatly disturbed (3-5 hours sleepless)
	I cannot lift or carry anything at all.		My sleep is completely disturbed (5-7 hours sleepless)
	SECTION 3 – DRIVING		**SECTION 10– RECREATION**
	I can drive my car without pain.		I am able to do all of my usual recreational activities with no pain.
	I can drive my car as long as I want with slight pain.		I am able to do all or most of my usual recreational activities with some pain.
	I can drive my car as long as I want with moderate pain.		I am able to do most but not all of my recreational activities.
	I can't drive my car as long as I want because of moderate pain.		I am able to do only a few of my recreational activities.
	I can hardly drive at all because of severe pain.		I can hardly do any recreational activities because of pain.
	I can't drive my car at all.		I cannot do any recreational activities at all because of pain.
	SECTION 4 – WALKING		**SECTION 11 – SEX LIFE (If inactive, estimate how it would be)**
	Pain does not prevent me from walking any distance.		My sex life is normal and causes no extra pain.
	Pain prevents me from walking more than 1 mile.		My sex life is normal but increases the degree of pain.
	Pain prevents me from walking more than ½ mile.		My sex life is nearly normal but is very painful.
	Pain prevents me from walking more than ¼ mile.		My sex life is severely restricted by pain.
	I can only walk using a cane, crutches, or a walker.		My sex life is nearly absent because of pain.
	Pain prevents me from walking at all.		Pain prevents any sex life at all.
	SECTION 5 – READING		**SECTION 12 – HOUSE AND YARD WORK**
	I can read as much as I want with no pain.		I can do house and yard work without extra pain.
	I can read as much as I want with slight pain.		I can do my house and yard work but it causes extra pain.
	I can read as much as I want with moderate pain.		I can do most of my house and yard work but it is very painful.
	I can't read as much as I want because of moderate pain.		I can do most house and yard work with extreme pain.
	I can't read as much as I want because of severe pain.		I can hardly do any house and yard work at all.
	I cannot read at all because of pain.		I cannot do any house and yard work.
	SECTION 6 – SITTING		**SECTION 13 – SOCIAL LIFE**
	I can sit in a chair as long as I like.		My social life is normal and gives me no extra pain.
	I can only sit in my favorite chair as long as I like.		My social life is normal but increases the degree of pain.
	Pain prevents me from sitting more than 1 hour.		Pain has no significant effect except for limiting energetic interests.
	Pain prevents me from sitting more than ½ hour.		Pain has restricted my social life to my home.
	Pain prevents me from sitting more than 10 minutes.		I have hardly any social life because of pain.
	I avoid sitting because it increases my pain.		
	SECTION 7 – WORK		**SECTION 14 – TRAVELING**
	I can do as much work as I want to.		I can travel anywhere without extra pain.
	I can only do my usual work but no more.		I can travel anywhere but it gives me extra pain.
	I can do most of my usual work but no more.		Pain is severe but I manage journeys over two hours.
	I cannot do my usual work.		Pain restricts me to journeys of less than 1 hour.
	I can hardly do any work at all.		Pain restricts me to short necessary journeys under 30 min.
	I can't do any work at all.		Pain prevents me from traveling except to the doctor or to the hospital.

CENTER FOR PAIN MANAGEMENT P-3 ASSESSMENT

PATIENT NAME: ________________________

INSTRUCTIONS: The purpose of the P-3 is to assess your emotional functioning. The information obtained from this assessment will help your healthcare provider design a treatment program for you. If you have any questions about the P-3, please ask your healthcare provider.

The P-3 consists of 44 groups of statements. Each group has three choices (1, 2, or 3). Read each group of statements carefully. Choose the ONE statement in each group that best describes how you have been feeling LATELY, including TODAY. Be sure to read all of the statements in each group before making your choice. Then circle the number next to the statement you choose (1, 2, or 3). Do not leave any groups blank. If none of the statements describes exactly how you feel, choose the statement that comes closest to describing how you feel. If you decide to change an answer, please draw an X through your original answer and then circle your new answer (1, 2, or 3).

(1)
1. I usually sleep well.
2. I have some trouble with sleep.
3. I have a lot of trouble with sleep.

(2)
1. I am a calm person.
2. I am probably more nervous than most people.
3. I often feel so nervous and on edge that I am miserable.

(3)
1. Sometimes I think bad or evil thoughts about people.
2. I always think only the very best about most people.
3. I always think only the very best about all people.

(4)
1. I can do my work and chores around the house.
2. With help I can do my work and chores around the house.
3. I can no longer do my work and chores around the house.

(5)
1. I have no more pain problems than most people.
2. I seem to have more pain problems than others.
3. My life is spent in pain.

(6)
1. I wake feeling pretty good most mornings.
2. I wake feeling tired many mornings.
3. I wake with pain and feeling tired most mornings.

(7)
1. I will sometimes tell people what I think they want to hear rather than the hard truth.
2. I will occasionally tell a lie.
3. I never tell a lie.

(8)
1. People can count on me because I get things done.
2. I sometimes have trouble completing tasks.
3. Much of the time I feel useless to myself and others.

(9)
1. My memory is fine.
2. My memory is not as good as it used to be.
3. I have serious trouble remembering things.

(10)
1. My general health is as good as most people's.
2. Most people seem to be in better general health than I am.
3. I have some serious health problems.

(11)
1. I am a happy person.
2. I don't seem to be as happy as most people.
3. I am not happy.

(12)
1. I get things done and on time.
2. I must sometimes struggle to keep my concentration.
3. I seem to have trouble completing tasks because I keep getting sidetracked.

(13)
1. Most of the time I feel pretty good.
2. I seem to tire easier than most people.
3. I feel weak and tired much of the time.

(14)
1. There are several people in my life who treat me unfairly.
2. Some people seem to treat me unfairly.
3. Many people seem to treat me unfairly.

(15)
1. I am interested in outside activities and other people.
2. I have little interest in outside activities and other people.
3. I have no interest in outside activities and other people.

(16)
1. I am usually at peace with myself and others.
2. I seem to get angry more than most people.
3. I feel angry with somebody or something much of the time.

(17)
1. I seldom have a headache.
2. I have more headaches than most people.
3. I seem to have a headache much of the time.

(18)
1. I trust some people but not others.
2. I trust only a very few people.
3. I believe that most people are only out for themselves and don't care about others.

(19)
1. I am comfortable enough in a group of people.
2. In a group of people I sometimes feel a little nervous.
3. In a group of people I often feel like I don't really belong.

(20)
1. It takes a lot to get me upset.
2. I get upset easier than I used to.
3. It seems like I stay upset much of the time.

(21)
1. It takes a lot before I get tired.
2. I tire easily.
3. I stay tired most of the time.

(22)
1. I have no trouble making decisions.
2. Sometimes I struggle making decisions.
3. I now have more trouble making decisions than I used to.

(23)
1. My mind is usually relaxed.
2. Even when I am still, my mind seems to be racing.
3. It is sometimes impossible to get my mind to relax.

(24)
1. My neck and shoulders feel normal.
2. My neck and shoulders feel tight.
3. My neck and shoulders hurt.

(25)
1. No matter what the problem, I believe there is always hope.
2. Hoping for things to get better is beginning to be a struggle for me.
3. Most of the time I feel hopeless that my condition will improve.

(26)
1. I seldom say something in anger that I later wish I hadn't.
2. Sometimes I say something in anger that I later wish I hadn't.
3. I frequently say things in anger that I later wish I hadn't.

(27)
1. My stomach gives me very little trouble.
2. I seem to have more stomach trouble than most people.
3. My stomach causes me lots of problems.

(28)
1. I enjoy being around other people.
2. I can mix with others but I would rather be alone.
3. I avoid having to be around others.

(29)
1. The muscles in my body usually feel loose and relaxed.
2. The muscles in my body often feel tight.
3. The muscles in my body feel painfully tight.

(30)
1. I seldom have neck or back pain.
2. I will sometimes have neck or back pain.
3. My neck or back seems to hurt most of the time.

(31)
1. I am physically able to do some things but not others.
2. I am not physically able to do most things.
3. I am not physically able to do anything.

(32)
1. I look forward to the future.
2. Things must improve before I will really look forward to the future.
3. My future seems hopeless.

(33)
1. I seldom feel nervous.
2. I frequently feel nervous.
3. I feel nervous most of the time.

(34)
1. I believe that most back problems go away and don't return.
2. I believe that most back problems may go away but are likely to return.
3. I believe that once you have a bad back you will probably always have trouble with it.

(35)
1. I seldom worry about anything.
2. I worry too much.
3. I worry over almost everything.

(36)
1. I feel pretty calm and relaxed.
2. I am probably more tense and uptight than I should be.
3. Sometimes I feel like I am about to lose my mind.

(37)
1. Most of the time my head feels clear.
2. Most of the time my head feels cloudy and dull.
3. I sometimes start sweating and trembling for no known reason.

(38)
1. I have had my fair share of problems.
2. I have had more than my share of problems.
3. Recently it seems like my life is filled with problems.

(39)
1. My blood pressure and heart are in good shape.
2. I have had some problems with my blood pressure.
3. My heart often seems to beat too hard and fast.

(40)
1. I am almost always happy.
2. I am sometimes happy and sometimes sad.
3. I am almost always sad.

(41)
1. My arms and legs feel fine.
2. I sometimes have pain in my hand or foot.
3. Sometimes my entire arm or leg feels numb.

(42)
1. I live a good life.
2. Except for too many problems, my life is pretty good.
3. My life is in a rut.

(43)
1. I am basically satisfied with my life at present.
2. I have some big regrets in my life.
3. I am not satisfied with my life at present.

(44)
1. I am a useful person.
2. I am not as useful to others as I used to be.
3. I sometimes think that everybody would be better off if I were dead.

Screener and Opioid Assessment for Patients with Pain (SOAPP)® Version 1.0 - 14Q

The Screener and Opioid Assessment for Patients with Pain (SOAPP)® Version 1.0 is a tool for clinicians to help determine how much monitoring a patient on long-term opioid therapy might require. Physicians remain reluctant to prescribe opioid medication because of concerns about addiction, misuse, and other aberrant medication-related behaviors, as well as liability and censure concerns. Despite recent findings suggesting that most patients are able to successfully remain on long-term opioid therapy without significant problems, physicians often express a lack of confidence in their ability to distinguish patients likely to have few problems on long-term opioid therapy from those requiring more monitoring.

SOAPP® version 1.0 is a quick and easy-to-use questionnaire designed to help providers evaluate the patients' relative risk for developing problems when placed on long-term opioid therapy. Version 1.0 -14Q is:

- A brief paper and pencil questionnaire
- Developed based on expert consensus regarding important concepts likely to predict which patients will require more or less monitoring on long-term opioid therapy (content and face valid)
- Preliminary reliability data (coefficient α) from 175 patients chronic pain patients
- Preliminary validity data from 100 patients (predictive validity)
- Simple scoring procedures
- 14 items
- 5 point scale
- <8 minutes to complete
- Ideal for documenting decisions about the level of monitoring planned for a particular patient or justifying referrals to specialty pain clinic.
- The SOAPP® is for clinician use only. The tool is not meant for commercial distribution.
- The SOAPP® is **NOT** a lie detector. Patients determined to misrepresent themselves will still do so. Other clinical information should be used with SOAPP® scores to decide on a particular patient's treatment.
- The SOAPP® is **NOT** intended for all patients. The SOAPP® should be completed by chronic pain patients being considered for opioid therapy.
- It is important to remember that all chronic pain patients deserve treatment of their pain. Providers who are not comfortable treating certain patients should refer those patients to a specialist.

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SOAPP® Version 1.0-14Q

Name: ____ Date: ______________

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. 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. Thank you.

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 that 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 you 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

Please include any additional information you wish about the above answers. Thank you.

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PainEDU.org
IMPROVING PAIN TREATMENT THROUGH EDUCATION

Center for Pain Management 3738 Landmark Dr. Lafayette, IN 47905 **PHONE:** 765-807-2780 **FAX:** 317-706-3417

BALANCE SELF-TEST

(Circle)

1. Have you fallen in the past year? YES NO

2. Do you feel dizzy or off-balance if you make a sudden change in movement, such as bending down or quickly? YES NO

3. Do you have any hearing loss? YES NO

4. Do you require assistance to walk, such as a person supporting you, use a walker or wheelchair? YES NO

5. Do you have balance problems when you are walking climbing stairs? YES NO

Name:________________________________
(Please print)

Signature:_____________________________

Date:_____________

HEALTH HISTORY INTAKE QUESTIONS

Center for Pain Management (Indianapolis, Greenwood, Lafayette),
Center for Special Surgery and Center for Southside Surgery

A representative of our practice will call 2 to 3 days prior to your first appointment to complete the following HEALTH HISTORY. Please review these questions in advance to shorten the length of time needed for the phone call.

Name: ____ **Date: _________________**

ALLERGIES:

Do you have a Latex allergy? Yes/No

Please list all allergies and reactions you have: ____
____

FAMILY HISTORY:

Please circle any of the following that are present in your family members

Adverse Reaction to Anesthesia
Cancer
Chronic Pain
Diabetes Mellitus
Fibromyalgia
Heart Disease
Hypertension
Lung Disease
Mental Illness
Migraines
Rheumatoid Arthritis
Seizure Disorder
Stroke

PAST MEDICAL:

Please circle any of the following for which you have ever received treatment

Alcohol Abuse
Anemia
Anesthesia Complications
Anxiety Disorder
Arthritis
Asthma
Bleeding Disorders
Cancer[type:______________]
Coagulopathy
Congestive Heart Failure
COPD
Coronary Artery Disease
CVA (stroke)
Depression
Diabetes
Drug Dependence
Gastric Ulcer
Head Injury
Heart Disease
Hepatitis B
Hepatitis C
Hiatal Hernia
HIV
Hypercholesterolemia
Hypercoagulopathy
Hypertension
Hyperthyroidism
Hypothyroidism
Kidney Disease
Liver Disease
Obstructive Sleep Apnea
Postmenopausal
Osteoporosis
Psoriasis
Psychological Trauma
Seizure Disorder
Sexually Transmitted Disease
Spinal Cord Injury
Spinal Fusion
Thrombophlebitis
Transient Cerebral Ischemia
Tuberculosis
Urinary Tract Infection

Currently on a blood thinner? Yes / No

If yes please circle which one:

Aggrenox
Coumadin
Effient
Heparin
Lovenox
Prasugrel
Any medications containing NSAIDS (aspirin or ibuprofen)

I have had (or a family member has had) a problem (e.g. prolonged paralysis, awareness, malignant hyperthermia) under anesthesia: Yes / No

Immunizations: (date received)

Tetanus:____
Hepatitis: ____
TB test:____

Females:

Last menstrual period ________________________________

Are you or could you be pregnant? Yes / No
Are your periods regular? Yes / No / N/A
Hysterectomy? Yes / No
Birth Control Pills? Yes / No

PAST MEDICAL: (continued) Hospitalizations: (please list all major illnesses with diagnosis and year)

1.________________________ 2.________________________

3. ________________________ 4.________________________

5.________________________ 6. ________________________

Surgeries: (please list all surgeries and type along with year performed) (include spinal injections)

1.________________________ 2.________________________

3. ________________________ 4.________________________

5.________________________ 6. ________________________

When and where have you had any of the following: (list results, if known)

MRI(s): ________________________

CT(s): ________________________

X-ray(s): ________________________

Colonoscopy: ________________________

Mammogram: ________________________

SOCIAL HISTORY:
(please circle)

Race:
White
African American
Asian
Hispanic
Indian
Other___________

Language:
English
Spanish
Other:__________

Marital Status:
Single
Married
Divorced
Widowed

I currently live in a:
House
Apartment
Mobile Home
Retirement Center

Education:
Some High School (Grade________)
High School Graduate
Some College
College Graduate
Masters
Doctorate

Annual Household Income:
less than $10,000
$10,0001 to $20,000
$20,001 to $40,000
$40,001 to $100,000
$100,001+

Job History:
do not work
less than 20 hrs/week
20-40 hrs/wk
40hrs or more/week
retired
disability
applying for disability
missed work due to pain
no missed work due to pain

JOB HISTORY:

Job Title:________________________ Years in current position:____________

Prior Job:________________________ Years in that position: ____________

If you are currently NOT WORKING what was the exact date you last worked:________________

If you are disabled, what year were you declared disabled? ______ By whom? ________________

How much do you lift on your job?________________ How often? ________________

Tobacco Use: Do you smoke? Yes / No How many packs per day?

Did you ever smoke? Yes / No Do any immediate relatives smoke? Yes / No

Alcohol Use: How many drinks do you have per week?

How many times in a year do you have more than four drinks in one day?

Have you ever been treated for alcohol dependency? Yes / No

Do any of your immediate relatives have or had an alcohol problem? Yes / No

Substance Abuse: Do you currently use: marijuana, cocaine, crack, ecstasy, methamphetamines, any other _______________________ drugs off the street? Yes / No

Have you in the past used any of the above? Yes / No

Do any of your first degree relatives have a substance abuse problem? Yes / No

Have you ever been treated for substance abuse? Yes / No

Caffeine Use: How many caffeinated beverages do you drink per day? _______________________

MEDICATION HISTORY: Please list all current pain medication with mg doses and frequency (times taken per day):

1. ________________________________ 2. ____________________________________

3. ________________________________ 4. ____________________________________

5. ________________________________ 6. ____________________________________

Please list all other medication taken including over the counter, weight loss and nutraceuticals:

1. ________________________________ 2. ____________________________________

3. ________________________________ 4. ____________________________________

5. ________________________________ 6. ____________________________________

REVIEW OF SYSTEMS: Please indicate if you have any of the following conditions or symptoms. Circle all that apply.

General Health:
Chills
Fatigue
Fever
Night Sweats
Weight Gain >10lbs
Weight Loss >10lbs

Skin:
Change in Wart/Mole
Dryness
Excessive Sweating
Hair Loss
Nail Changes
New Lesions
Rash
Skin Color Changes

HEENT:
Bleeding Gums
Blurred Vision
Double Vision
Head Injury
Hearing Loss
Hoarseness
Nose Bleed
Ringing in Ears
Sinus Pain
Vertigo
Visual Loss

Neck:
Neck Mass
Neck Stiffness
Swollen Glands

Breast:
Breast Mass
Breast Pain
Nipple Discharge
Skin Changes

Cardiovascular:
Calf Cramps
Chest Pain
Difficulty Breathing Lying Down
Fainting/Blacking Out
Irregular Heart Beat
Shortness of Breath
Swelling of Extremities

Gastrointestinal:
Abdominal Pain
Black Tarry Stool
Bloody Stool
Change in Bowel Habits
Constipation
Diarrhea
Difficulty Swallowing
Heartburn
Jaundice
Nausea
Rectal Bleeding
Vomiting
Vomiting Blood

Musculoskeletal:
Joint pain
Joint Stiffness
Joint swelling
Muscle atrophy
Muscle weakness

Neurological:
Decreased Memory
Difficulty Speaking
Dizziness
Headaches
Incontinence Stool
Incoordination
Loss of Consciousness
Seizures
Stroke
Unsteadiness

Psychiatric:
Anxiety
Change in Sleep Pattern
Depression
Hallucinations
History of abuse
Mood Changes
Panic Attacks
Suicidal Ideation

Endocrine:
Cold Intolerance
Excessive Thirst
Excessive Urination
Hair Changes
Heat Intolerance
Hot Flashes
Libido Change
Sexual Dysfunction
Thyroid Problems

Hematology:
Abnormal Bleeding
Anemia
Blood Clots
Easy Bruising
Prolonged Bleeding

Other Medical Problems: ____

Information Provided by: ______________________________ Date: ________________