WELCOME LETTER

WELCOME TO miSPINE & Joint Care!

We are honored you have chosen to seek care with Dr. Anish Mirchandani.

- At miSPINE & Joint Care we strive to provide the best possible care to treat all pain conditions.
- We use the most advanced minimally invasive treatments available.
- Our providers are compassionate and caring.

FIRST VISIT GUIDE:

- Please complete this new patient intake packet to your best abilities.
- We understand this intake process can take a significant amount of time thus we encourage you to arrive early or fill this out prior to your appointment date.
- Please ensure you have your health insurance cards (primary/secondary).
- A valid government issued picture ID
- Imaging Reports, X-rays, MRIs, CT scans, etc.
- Any relevant documentation (Ie. Doctor's notes, reports, ER notes)
- Current list of your medications.
- We encourage you to come to your initial consultation with a written list of questions to ensure all your concerns are thoroughly addressed when you visit the doctor.
- All copays are due prior to being seen.
- We will do our utmost best in keeping with your scheduled appointment time. Please understand that circumstances in healthcare can lead to delays.
- Please call our office or visit our website at *mispineandjointcare.com* for further information.

PATIENT PORTAL:

- We encourage all our patients to engage with the online patient portal.
- At the time of patient registration one of our staff members will ensure an activation email is sent to you.

WE LOOK FORWARD TO SEEING YOU!

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miSPINE & Joint Care, PLLC
1970 W University Dr, Ste 210 Prosper, TX 75078
Tel: 469-757-7623
Fax: 469-757-7613
mispineandjointcare.com
scheduling@mispineandjointcare.com

REGISTRATION FORM

Today's Date ___/____/_____

Demographic Information:

Legal First Name:_____ Last Name:_____

Date of Birth _____/____/_____ Social SN# _____

Sex: ☐ Male ☐Female Race: ☐Asian/Pacific Islander ☐ Black
☐ Caucasian ☐ Hispanic ☐ American Indian ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

Patient Address:_____

Can we call, text, or leave messages:

Cell Phone #_____ ☐YES ☐ NO ☐Other _____
Alternate # _____ ☐YES ☐ NO ☐Other _____
Email: _____
Emergency Contact: _____ Relationship to patient:_____
Contact # _____

Work Status:☐Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Disabled ☐ Student
Occupation:_____ Employer Employer #_____

Is this a worker's compensation Injury: ☐Yes ☐No Date of Injury: _____
Is this an auto injury case ☐Yes ☐No Date of Injury:_____

Insurance Information:

Primary Insurance Name:_____
Policy # _____ Group #_____
Subcriber Name: _____
Subcriber's Social_____ Subscriber's DOB_____
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Primary Insurance Name:_____
Policy # _____ Group #_____
Subcriber Name: _____
Subcriber's Social_____ Subscriber's DOB_____
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Medical Care Team:

Referring Physician:_____
Primary Care Provider_____
Other specialist names:_____
Pharmacy/Location_____ Phone #_____

_____/_____/_____
Patient's or Authorized Legal Representative Signature/NAME/TODAY's DATE

Notice of Privacy Practices | HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. IT ALSO EXPLAINS 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 (PHI) to carry out treatment, payment or health care operations (TPO) 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 and/or mental health/condition and related health care services.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing care services to you, in order to pay your health care bills, to support the operation of the physician's practice, and for any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care needs and any related services including the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Another example, your protected health information may be provided to a physician whom you have been referred to, thus ensuring that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services including certain activities your health insurance plan may undertake before it approves or pays health care services recommended for you such as: determination of your insurance eligibility and benefits , medical necessity and utilization review of services provided to you. For example, obtaining approval for a hospital stay requires that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as required By law: Public Health issues, Communicable Diseases, Health Oversight Abuse or Neglects Food and Drug Administration requirement Legal Proceedings Law Enforcement, Coroners, Funeral Directors, and Organ Donation research, Criminal Activity, Military Activity, National Security, Workers Compensation, and Inmate situations. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine compliance with the requirement of Sections 164.500.

We may use and disclose your medical information in instances where it is deemed necessary to prevent or lessen a serious and/or imminent threat to your health and safety or the health and safety of the public or another individual. This disclosure would be to a person or agency able to help stop or reduce the threat.

We may use your protected health information in cases involving Worker's Compensation or similar programs as authorized or required by law.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. 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 between us and the business associate 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. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you. Other permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization Or Opportunity To Object Unless Required By Law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected 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 any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any 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 to.

You have the right to request an addendum or amendment to your if you feel the information we have on file about you is incorrect or incomplete. Your request must be submitted to miSPINE & Joint Care in writing. You must also provide a reason for the modification/correction request.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted You then have the right to use another Healthcare Professional

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also place conditions on this accommodation by asking you for information as to how payment will be handled, specification of an alternative address or other methods of contact. We will not request an explanation for you as to the basis for the request. Please make this request in writing to our Privacy Contact.

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 as described in this Notice of Privacy Practices.

We are required to abide by the terms of this 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 this time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Complaints:

You may complain to us or to the Office of Civil Rights if you believe your privacy rights have been violated by us. You may obtain the address of the OCR Regional Manager, Denver, CO, from our privacy officer. You may file a complaint with us by notifying our privacy contact of your complaint at info@mispineandjointcare.com. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 469-757-7623.

Signature below is only an acknowledgement that you have received this Notice of our Privacy Practices:
Print Name: _____

Signature: _____

Date: _____

Consent for Treatment

This consent indicates your authorization to receive medical care by miSPINE & Joint Care, PLLC as directed by your provider. Your consent includes all medical care guided by your provider.

I, _____] , authorize miSPINE & Joint Care, PLLC to provide evaluation and treatment services for myself. I understand that although miSPINE & Joint Care, PLLC strives in providing the best treatment possible for their patients, the treatment provided may not always yield the desired results and that there are no guarantees. Every treatment will be conducted in a **confidential** manner, as stated under the **HIPAA Regulations.** My consent is for the duration I will remain an active patient with miSPINE & Joint Care, PLLC. With my written notice I may discontinue this consent at any time.

PATIENT SIGNATURE/AUTHORIZED REPRESENTATIVE

DATE: _____

FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

INDVIDIUAL'S FINANCIAL RESPONSIBILITY. Please retain a copy for your records.

- Please immediately inform us regarding any changes to your address, insurance coverage, telephone, or legal name.
- Please contact our office within 24 hours to cancel or reschedule an appointment.
- A no show fee will be assessed if changes are made with less than 24 hours' notice. A fee of $25 for office visits and $50 for procedure appointments.
- For patients who frequently accrue a no show charge on their account, may be discharged from miSPINE & Joint Care.
- We accept Cash, Credit cards (VISA/Mastercard/Discover), and checks.
- At the time of Check-In your insurance card will be requested at each appointment
- A returned check will result in a $40 fee and we will discontinue accepting personal checks on your account

INSURANCE:

- You are expected to know the services and level of benefits your insurance plan covers. Our providers are specialists and will often require prior authorizations for office visits and procedures. Our billing team does verify benefits and request prior authorizations on your behalf. For questions and to ensure you have the needed authorization please contact your insurance provider. This is particularly important for patients with HMO Plans. It is your responsibility to ensure that a valid referral is on file prior to being seen.
- We will file claims only with your insurance carrier that we have a contract with.
- **All unpaid or disputed charges from your insurance company will be billed to you as the patient.**
- As part of your contract with the insurance company all Copays, deductibles, and coinsurance amounts are due at the time services are rendered.
- If you are unable to pay this amount your appointment will be rescheduled.
- We are unable to waive or discount the cost of your copay.
- Procedures/Injections/Surgeries: We will attempt to verify your benefits to estimate a cost to the patient. Be aware that this is only an estimate and not a guaranteed amount. The estimated amount will be collected at the time of the procedure appointment. Your procedure may be delayed or rescheduled if you are unable to provide payment. Once the services have been provided any outstanding balance will be billed to you. In the case of an overpayment, it will be credited to your account.
- Any balance on your account past 90 days will result in a statement to be sent to the account holder and payment will be due upon receipt of the statement.
- For patient's with a past due balance we have the right to discontinue scheduling future appointments.

ASSIGNMENT OF BENEFITS:

I hereby request that payment of authorized insurance benefits, including Medicare, other government sponsored programs, private insurance plans and other health plans be made to miSPINE& Joint Care, PLLC for services rendered to me by the providers. I acknowledge that this assignment shall remain in

effect until revoked by me in writing**. I understand that I am responsible for any unpaid balance that my insurance does not pay.**

I hereby assign all medical insurance benefits directly to miSPINE & Joint Care, PLLC for the payment of services rendered to me by the providers. I also authorize release of my medical records necessary to thoroughly process my health claims. I fully understand that in the event my insurance company does not pay for the services rendered to me my miSPINE & Joint Care, PLLC, that I will be financially responsible for payment.

_____

PATIENT SIGNATURE/AUTHORIZED REPRESENTATIVE/RESPONSIBLE PARTY

DATE:_____

OFFICE WITNESS SIGNATURE:_____DATE:_____

CONTROLLED SUBSTANCES

This document outlines and provides disclosures and consent as It pertains to controlled substances. Controlled substances may include opioid/narcotic medications.

IT IS MY UNDERSTANDING THE FOLLOWING IS PROVIDED TO ME FOR EDUCATIONAL AND INFORMATIONAL PURPOSES. THE LIST INCLUDES THE RISKS OF OPIOID MEDICATION USE BUT IS NOT LIMITED TO THIS LIST

GENERAL INFORMATION

While opioids can be helpful for long term management of chronic pain in carefully selected patients their use does not come without risks. Below is some important information on how opioids work and some of the potential side effects with their use. Should you have any questions or concerns please call the miSPINE & Joint Care at 469-757-7623 to discuss these with a provider. Please continue to take your medication as prescribed unless or until advised otherwise by your doctor. As you start your medication it can be difficult to know how you will react. **For that reason that we advise you avoid driving or operating heavy machinery until you know how the medication will affect you. We also recommend you start your medicine when you will have others around to monitor you should you have any problems. It is also important to adhere to these recommendations when there are any changes made to your medication (e.g. increase in your dose).**

How Opioids Work:

Opioids works by binding to opioid receptors in the brain, spinal cord, and other areas of the body. It reduces the sending of pain messages to the brain and reduce feelings of pain. Opioids are used to treat moderate to severe pain that may not respond well to other pain medications.

Side Effects

Opioids have multiple side effects that you need to be aware of. These can be separated into short and long term effects although there is not a specific amount of time that determines which effects you may be susceptible to. In other words, any of these side effects may occur at any period of time after being on opioids.

Short-Term Effects

Taking opioids can cause addiction or death if you take too much. Mixing opioids with other drugs can heighten the chances of death.

1. • Respiratory depression
2. • Hallucinations
3. • Sedation
4. • Mood changes
5. • Dizziness
6. • Nausea

- Severe allergic reaction
- Confusion
- Itching
- Unconsciousness
- Suppression of pain
- Coma
- Euphoria
- Constipation
- Physical dependence
- Addiction
- Death
- Impaired judgement/driving
- Cardiac toxicity

Long-Term Effects

Taking methadone for a prolonged period of time, even at doses prescribed by your doctor, can lead to reversible and irreversible side effects. Some of these effects include but are not limited to:

- Liver disease
- Kidney disease
- Cell death in vital organs
- Brain damage
- Other severe withdrawal symptoms when the long-term user stops using
- Constipation
- Physical dependence
- Addiction
- Worsened pain (hyperalgesia)
- Immune suppression
- Hormone dysfunction
- Muscle stiffness
- Sexual dysfunction
- Decreased libido
- Insomnia
- Cardiac toxicity

Should you have any additional questions or concerns please contact miSPINE & Joint Care at 469-757-7623.

TREATMENT GOAL:

Opioids are used to treat moderate to severe painful conditions. The primary goal is to improve functional capacity for your activities of daily living and to also reduced your pain. Sometimes due to the chronic nature of the condition treated the opioid medication may be used in a long-term setting. There is no guarantee or warranty of the treatment outcome.

CONSENT

I hereby give my written consent to miSPINE & Joint Care, PLLC and my treating provider to administer or write controlled prescriptions as a part of my treatment for chronic pain. I have had the chance to ask questions and it has been thoroughly explained to me that these medications are dangerous and can be harmful if not taken as guided by my provider. I understand that these medications may lead to dependence and/or addiction. I understand that these medications may also cause other side effects and complications such as respiratory (breathing) depression, and/or death. The alternative options to using controlled prescriptions have been discussed with me in the context of my medical conditions, the risks of these medications have also been explained. I agree that the list below is not inclusive of all possible complications. I agree that occasionally the medication that I am prescribed may be used in certain "OFF-LABEL" situations which is determined by the drug company and FDA. I agree to discuss all medication changes and the possibility of safely discontinuing my medications with my treating provider.

Print Name: _____

Signature/Authorized Representative Signature: _____

Date: _____

PAIN MANAGEMENT AGREEMENT

THE PURPOSE OF THIS DOCUMENT IS TO OUTLINE THE PROPER USE AND CLINC EXPECTATIONS IN ORDER TO BEST ENSURE THE SAFE HANDLING OF OPIOIDS. THIS DOCUMENT SHOULD BE RETAINED AND ENSURES THAT YOU AND THE CLINIC COMPLIES WITH ALL FEDERAL AND STATE REGULATIONS REGARDING THE PRESCRIPTION OF CONTROLLED SUBSTANCES.

I HEREBY AGREE TO COMPLY WITH THE FOLLOWING PAIN MANAGEMENT POLICIES:

1. Pain medications for chronic conditions will be prescribed by miSPINE & Joint Care. Changes to the treatment can occur from time to time based on the provider's discretion.
2. I will follow the instructions provided on my prescriptions. I will not take additional medication unless guided by miSPINE & Joint Care to do so. I am, however able to take less medication than prescribed.
3. I will not crush, snort, chew, or alter the medication in any way.
4. The medication is prescribed to me and will not be shared, sold, or utilized by anyone other than myself. It is illegal to sell or share your medications.
5. I will store my medications in a safe place, locked away from access to other individuals.
6. I will not operate heavy machinery while impaired.
7. I will not consume old medication that is no longer actively being prescribed to me.
8. I will use one pharmacy consistently; I will notify the office regarding changes needed.
9. I will not consume alcohol, marijuana, THC products or any other illicit substances while being prescribed opioid medications
10. I agree to random urine drug testing as advised by the clinic.
11. I am aware and I will comply with any requests for presenting to the office for urine drug testing or pill counts within 7 days of request.
12. Medications or prescriptions that are lost or stolen should be reported to local law enforcement and to the clinic. miSPINE & Joint Care does not guarantee any lost or stolen medication will be replaced.
13. I am aware that suddenly stopping the medication may cause side effects and could be dangerous and I will consult with my provider prior to making any medication changes.
14. I will contact the office should I have any questions or side effects with taking the prescribed medications.
15. I give my provider permission to discuss all treatment details with my other providers and pharmacist(s) regarding my use of medications prescribed by my other physician(s). I give my pain physician permission to obtain all medical records necessary to diagnose and treat my painful conditions.
16. Pregnancy: You are encouraged not to consume opioids while pregnant and are expected to notify your provider. The risks of using opioids while pregnant have been discussed with you.
17. I will conduct myself in a respectful manner while at the miSPINE & Joint Care facilities. I will treat all staff with respect. I am further aware any harassment, aggression, or conflict provoking behavior may lead to dismissal from miSPINE & Joint Care.
18. I will dispose of any unwanted, unused, extra, left over, controlled substances in a safe disposal bin at my local pharmacy or law enforcement center.
19. I agree that I will come to my scheduled office visits in a timely manner to review my medication treatment plan.

PAIN MANAGEMENT AGREEMENT

20. I agree to inform my treating provider regarding all medications, supplements, and home based remedies that I am currently taking. Failure to do so may result in unwanted side effects or adverse effects.
21. I agree that medication refills are not medical emergencies and will not be done on evenings, weekends or holidays. I will contact the office with at least 3 business days' notice regarding refill requests.
22. I agree that failure to comply with the above mention items may result in termination from miSPINE & Joint Care and discontinuation of controlled prescriptions.
23. I agree that while this pain agreement is in effect with miSPINE & Joint Care, PLLC that I will not receive prescriptions for controlled substances from other providers, unless I have provided advanced notice to the provider and received medical guidance for the circumstances such as a planned surgery. For medical emergencies I will notify the provider as soon as reasonably possible of my condition and I will provide the office all relevant treatment notes pertaining to my emergency.

I agree that I have read this document in its entirety. I am aware this document is not inclusive of all safety measures that may be considered, and I will use my best judgement for my own safety and the community. I will ask questions at all instances where I have doubts to ensure best practices are being followed.

PRINT NAME_____

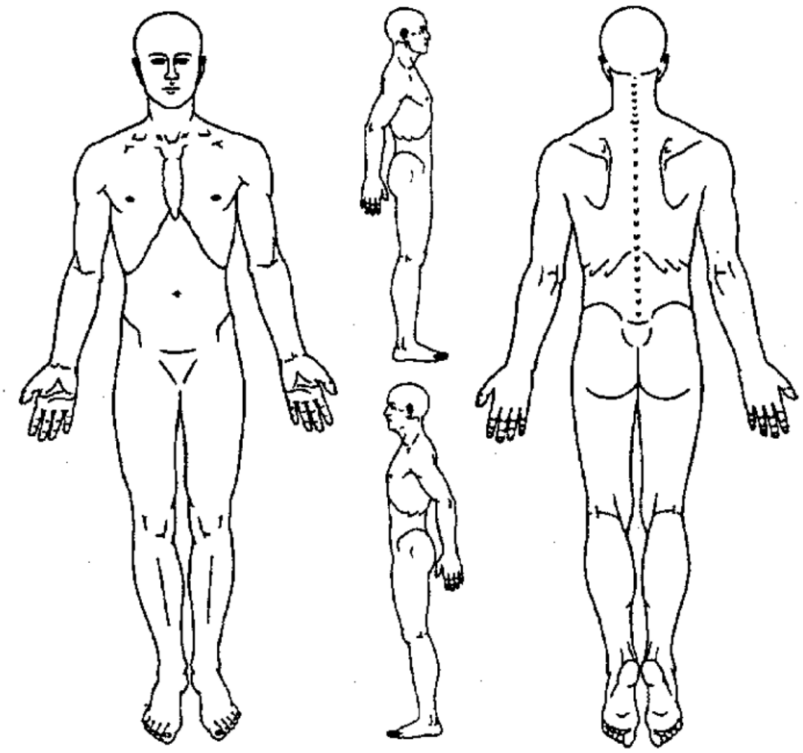
PATIENT SIGNATURE or AUTHORIZED REPRESENTATIVE: _____

DATE: _____

1970 W University Dr. Ste#210
Prosper, TX 75078
Phone: (469) 757-7623
Fax: (469) 757-7613

Patient Name: _____ Date of Birth: _____
Referring Provider: _____ Today's Date: _____

Reason for visit: _____
On the diagram below, please mark where you are feeling your symptoms:
Mark "**P**" for Pain, "**N**" for Numbness, "**T**" for Tingling, "**B**" for Burning



When did the pain begin? _____

How did it start? _____

If you have a history of accident or injury, please answer the following:
Was the accident at work? (Yes/No)
Are you using Workman's Compensation? (Yes/No)
Are you currently involved in litigation? (Yes/No)

Duration of pain: (Please circle)

1-4 weeks	3-6 months	More than 1 year
1-3 months	Less than 1 year	Many years

How often does the pain occur? (Please circle)

Continuously	Occasionally (26-50% of the day)	Less than daily
Constantly (76-100% of the day)	Intermittently (0-25% of the day)	Monthly
Frequently (51-75% of the day)		

Select one or more items below to describe the nature of your pain: (Please circle all that apply)

Sore	Shooting	Hot/Burning	Numbing	Other
Throbbing	Cramping	Stabbing	Dull/Achy	

How do you rate your pain? (Please circle on a scale of 0 to 10, 0 being none, and 10 being unbearable)

Current Pain Level:

0	1	2	3	4	5	6	7	8	9	10

Average Pain Level:

0	1	2	3	4	5	6	7	8	9	10

Pain Level at Best:

0	1	2	3	4	5	6	7	8	9	10

Pain Level at Worst:

0	1	2	3	4	5	6	7	8	9	10

Please describe the progression of your pain, overall: (Please circle)

Better	Worse	Unchanged/Stable

What factors make your pain ***BETTER***? (Please circle all that apply, if "other" please describe)

Standing	Changes in Weather	Heat	Twisting	Rest
Walking	Lifting	Cold	Movement	Nothing
Sneezing	Lying down	Bending Forward	Changes in Position	Other
Coughing	Sitting	Bending Backwards	Sex	

What factors make your pain ***WORSE***? (Please circle all that apply, if "other" please describe)

Standing	Changes in Weather	Heat	Twisting	Rest
Walking	Lifting	Cold	Movement	Nothing
Sneezing	Lying down	Bending Forward	Changes in Position	Other
Coughing	Sitting	Bending Backwards	Sex	

When is the pain worst? (Please circle)

Morning	Afternoon	Evening	Night	Other

What previous treatments have you had for this pain? (Please circle and indicate the date of treatment)

Acupuncture	Biofeedback
Chiropractor	Massage
Epidural Injection	Facet Block
Physical Therapy	Exercise
Bracing	Radiofrequency Ablation
Nerve Block	TENS unit
Trigger Point Injection	Other
Surgery	

Have you had any previous Imaging Studies/Tests? (Please circle and indicate the date of treatment)

Please bring copy of recent studies and the results, or sign a release to have the records sent to our office

MRI	X-rays
CT Scan	EMG/NCS
Ultrasound	Other

Past Medical History: (Please Circle all that apply)

Constitutional		**Cardiovascular**		**Respiratory**	
Obesity	Weight Gain	Angina	Heart Stent	Asthma	Obstructive Sleep Apnea
Weight Loss	Cancer	Pacemaker	Pacemaker	Lung Cancer	Chronic Bronchitis
Musculoskeletal		Heart Attack	High Blood Pressure	Emphysema	COPD
Arthritis	Muscle spasms	**Endocrine Hematologic/Immunologic**		**Gastrointestinal**	
Fibromyalgia		Diabetes	High Cholesterol	Reflux	Diverticulitis
Neurological		HIV	Lymphoma	Ulcer	Irritable Bowel Syndrome
Headache	Migraines	Leukemia	Hypothyroidism	Cirrhosis	Heart Burn
Seizures	Stroke	Hypothyroidism	Multiple Myeloma	Hepatitis	Colon Cancer
Psychiatric		**Rheumatologic**		**Genitourinary**	
Depression	Substance Abuse	Lupus	Polymyalgia Rheumatica	Impotence	Incontinence
Bipolar Disorder	Anxiety	Scleroderma	Rheumatoid Arthritis	Kidney Stones	
Schizophrenia		Sjogren"s		**Other:**	

Surgical History (Please circle all that apply):

Appendectomy	Hysterectomy	Shoulder Surgery	Hernia Repair	Knee Replacement
Mastectomy	Knee Surgery	Coronary Bypass	Vasectomy	Liver Surgery
Hip Replacement	Gallbladder Surgery	Prostate	Colon	Other
Tonsillectomy/Adenoids	Breast Biopsy	Cataracts	Tubal Ligation	
Lumbar Spinal Surgery/Back Surgery (Include dates)				
Cervical Spinal Surgery/Neck Surgery (Include dates)				

Females:

Are you Pregnant?

Yes	No	Not Sure

Patient's initials _____

Social history: (Please circle all that apply)

Are you a:

Never Smoker	Current Smoker	Former Smoker	Quit Date:
	Type:	Packs/day:	Years Smoking:

Do you use chewing and/or smokeless tobacco?

Have you quit? If so, when? _____

Do you drink alcohol? (Yes/No)

Type(s):	Amount:	How Often:

Do you use Marijuana or other Marijuana products? (*ie. CBD)* (Yes/No)

If yes, please describe: _____

Do you use illicit drugs (Heroin, Cocaine, Methamphetamines)? (Yes/No)

Type(s):	Last used:

Marital Status: (Please circle one)

Single	Cohabitating	Divorced	Married	Separated	Widowed

Who do you live with? (Please circle all that apply)

Alone	Children	Roommate	Spouse	Parents	Other

What is your **occupation**?_____

How do you sleep? (Please circle one)

Good	Fair	Poor

On average, how many hours of sleep do you get per night? _____

How is your diet? (Please circle one)

Good	Fair	Poor

What are your stressors? (Please circle all that apply)

Work	Commute	Family	Other

Family History: (Please circle all that apply)

Mother		**Father**		**Brother(s)**		**Sister(s)**	
Heart Disease	Kidney Disease	Heart Disease	Kidney Disease	Heart Disease	Kidney Disease	Heart Disease	Kidney Disease
Diabetes	Depression	Diabetes	Depression	Diabetes	Depression	Diabetes	Depression
Anxiety	Back pain	Anxiety	Back pain	Anxiety	Back pain	Anxiety	Back pain
Cancer	Osteoarthritis	Cancer	Osteoarthritis	Cancer	Osteoarthritis	Cancer	Osteoarthritis
Liver Disease	Other	Liver Disease	Other	Liver Disease	Other	Liver Disease	Other

Allergies: (Please circle all that apply)

Latex	IV Contrast	Betadine/Iodine	Shellfish/seafood

Drug Allergies: _____

List All Medications You Are Currently Taking:

Medication	**Dose**	**Prescribing Physician**	**Medication**	**Dose**	**Prescribing Physician**
1)			8)		
2)			9)		
3)			10)		
4)			11)		
5)			12)		
6)			13)		
7)			14)		

Are you taking any medications that are **Blood Thinners**? (Yes/No)
Are you taking any medications that are **prescription pain relievers**? (Yes/No)

Past **pain** medications tried:

Medication	**Dose**	**Prescribing Physician**	**Medication**	**Dose**	**Prescribing Physician**
1)			4)		
2)			5)		
3)			6)		

What do you want to accomplish from today's visit? (Please circle all that apply)

Diagnosis	X-ray	Medication management	Injection
Treatment Options	MRI	Review Test	Other

Please share any other information you would like us to know:_____

I ACKNOWLEGE THAT I HAVE COMPLETED THIS QUESTIONNAIRE ACCURATELY AND TO THE BEST OF MY KNOWLEDGE

_____ _____ _____

Patient or Legal Guardian Signature Print Name Date

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

Initials_____

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

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

Initials_____

Please answer each section by marking in each section **one number** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just mark the number that most closely describes your problem.**

Section 1 - Pain Intensity

0 The pain comes and goes and is very mild.
1 The pain is mild and does not vary much.
2 The pain comes and goes and is moderate.
3 The pain is moderate and does not vary much.
4 The pain comes and goes and is severe.
5 The pain is severe and does not vary much.

Section 2 - Personal Care

0 I do not have to change my way of washing or dressing to avoid pain.
1 I do not normally change my way of washing or dressing even though it causes me pain.
2 Washing and dressing increase the pain, but I manage not to change my way of doing it.
3 Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4 Because of the pain I am unable to do some washing and dressing without help.
5 Because of the pain I am unable to do any washing and dressing without help.

Section 3 - Lifting (skip if you have not attempted lifting since the onset of your low back pain)

0 I can lift heavy weights without extra low back pain.
1 I can lift heavy weights but it causes extra pain.
2 Pain prevents me lifting heavy weights off the floor.
3 Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
4 Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5 I can only lift light weights at the most.

Section 4 - Walking

0 I have no pain walking.
1 I have some pain on walking, but I can still walk my required to normal distances.
2 Pain prevents me from walking long distances.
3 Pain prevents me from walking intermediate distances.
4 Pain prevents me from walking even short distances.
5 Pain prevents me from walking at all.

Section 5 - Sitting

0 Sitting does not cause me any pain.
1 I can sit as long as I need provided I have my choice of sitting surfaces.
2 Pain prevents me from sitting more than 1 hour.
3 Pain prevents me from sitting more than 1/2 hour.
4 Pain prevents me from sitting more than 10 minutes.
5 Pain prevents me from sitting at all.

Section 6 - Standing

0 I can stand as long as I want without pain.
1 I have some pain while standing, but it does not increase with time.
2 I cannot stand for longer than 1 hour without increasing pain.
3 I cannot stand for longer than 1/2 hour without increasing pain.
4 I cannot stand for longer than 10 minutes without increasing pain.
5 I avoid standing because it increases the pain immediately.

Section 7 - Sleeping

0 I have no pain while in bed.
1 I have pain in bed, but it does not prevent me from sleeping well.
2 Because of pain I sleep only 3/4 of normal time.
3 Because of pain I sleep only 1/2 of normal time.
4 Because of pain I sleep only 1/4 of normal time.
5 Pain prevents me from sleeping at all.

Section 8 - Social Life

0 My social life is normal and gives me no pain.
1 My social life in normal, but increases the degree of pain.
2 Pain prevents me from participating in more energetic activities e.g. sports, dancing.
3 Pain prevents me from going out very often.
4 Pain has restricted my social life to my home.
5 I hardly have any social life because of pain.

Section 9 - Traveling

0 I get no pain while traveling.
1 I get some pain while traveling, but none of my usual forms of travel make it any worse.
2 I get some pain while traveling, but it does not compel me to seek alternative forms of travel.
3 I get extra pain while traveling that requires me to seek alternative forms of travel.
4 Pain restricts all forms of travel.
5 Pain prevents all forms of travel except that done lying down.

Section 10 - Employment/Homemaking

0 My normal job/homemaking duties do not cause pain.
1 My normal job/homemaking duties cause me extra pain, but I can still perform all that is required of me.
2 I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities e.g. lifting, vacuuming, etc.
3 Pain prevents me from doing anything but light duties.
4 Pain prevents me from doing even light duties.
5 Pain prevents me from performing any job or homemaking chore.

Total: _____

Initials_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Total: _____

Initials_____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total: _____

Initials_____