SOUTHWEST PAIN MANAGEMENT
Relief begins here.

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PATIENT INFORMATION FORM

PRINT PLEASE

REGISTERED BY: _____

PATIENT NAME: LAST	FIRST	MIDDLE	DATE OF BIRTH	GENDER M / F	SOCIAL SECURITY NUMBER

RESIDENCE ADDRESS: NUMBER	STREET	CITY	STATE	ZIP CODE

MAILING ADDRESS: NUMBER	STREET	CITY	STATE	ZIP CODE

HOME PHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS

EMERGENCY CONTACT NOT LIVING WITH YOU	RELATIONSHIP	PHONE NUMBER	HOW DID YOU HEAR ABOUT US? Circle selection below: GOOGLE YELP DR._____ INSURANCE OTHER: _____

WOMEN ONLY

ARE YOU CURRENTLY PREGNANT ? Y / N

ARE YOU TRYING TO GET PREGNANT? Y / N

HAVE YOU HAD A HYSTERECTOMY? Y / N

DATE OF YOUR LAST MENSTRUAL CYCLE? _____/_____/_____

YOUR PERSONAL PHYSICIAN INFORMATION

REFERRING DOCTOR NAME	STREET ADDRESS	CITY	ZIP CODE	REFERRING DOCTOR PHONE NUMBER

FAMILY DOCTOR NAME	STREET ADDRESS	CITY	ZIP CODE	FAMILY DOCTOR PHONE NUMBER

HEALTH PLAN INFORMATION

PRIMARY INSURANCE COMPANY	MEMBER ID	GROUP NUMBER

ARE YOU THE SUBSCRIBER? Y / N IF NO, SUBSCRIBERS NAME:	RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER DATE OF BIRTH:

SECONDARY INSURANCE COMPANY	MEMBER ID	GROUP NUMBER

IS YOUR MEDICAL CONDITION ATRIBUTED TO A WORK RELATED INJURY? ☐ YES ☐ NO

IS YOUR MEDICAL CONDITION ATRIBUTED TO AN AUTO ACCIDENT? ☐ YES ☐ NO

DO YOU HAVE AN ATTORNEY REPRESENTING YOU? ☐ YES ☐ NO

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Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Reason for Today's Visit (Mark ALL that apply)

☐Neck Pain ☐Leg Pain
☐Low Back Pain ☐Shoulder Pain
☐Mid Back Pain ☐Arm Pain
☐Facial Pain ☐Other: _____

My CHIEF PAIN COMPLAINT is: (Mark only ONE)

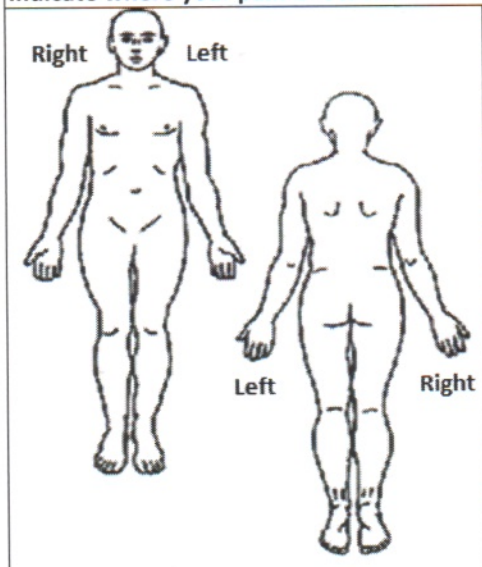
☐headache	☐neck pain	☐left arm pain
☐facial pain	☐mid-back pain	☐right arm pain
☐chest wall pain	☐low-back pain	☐left leg pain
☐abdominal pain	☐buttock pain	☐right leg pain
☐groin pain	☐tailbone pain	☐other: _____

My ADDITIONAL pain complaint(s) is (are): (Mark ALL that apply)

☐headache	☐neck pain	☐left arm pain
☐facial pain	☐mid-back pain	☐right arm pain
☐chest wall pain	☐low-back pain	☐left leg pain
☐abdominal pain	☐buttock pain	☐right leg pain
☐groin pain	☐tailbone pain	☐other: _____

Your pain right now: ____/10	☐constant
Your average pain: ____/10	☐fluctuating, rarely present

Indicate where your pain is located:



1. Use the following letters to describe your pain.
Ache = A
Burning = B
Cramping = C
Dull = D
Numbness = N
Pins/Needles = P
Stabbing = S
Throbbing = T
Muscle spasm = M

2. Draw arrows where the pain radiates.

What makes your pain worse?

My MEDICAL HISTORY:

Mark all that apply.	☐HTN	☐Asthma	☐Arthritis
	☐Hyperlipidemia	☐Anxiety	☐Heart Disease
	☐Diabetes	☐Depression	☐Other/Please List:

Current PAIN Medications

Medication Name	Dose	Frequency	Prescriber/Provider

Are your pain medications helping? ☐Yes ☐No
-Improved Pain Relief: _____% (0-100%)
-Functional Improvement: _____% (0-100%)
-Improved Quality of Life: _____% (0-100%)
-Are there any side effects? ☐Yes ☐No
-If 'Yes', which?

Have you had pain injections? ☐Yes☐No
If 'Yes', which?

If you have had an injection, how much relief did it provide?
_____% (0-100%) ☐ N/A (I did not have a recent injection)

Have you tried other treatments for your pain? ☐Yes ☐No
-Physical therapy: ☐Helpful ☐Not Helpful ☐N/A
-Chiropractic: ☐Helpful ☐Not Helpful ☐N/A
-Massage/Acupuncture: ☐Helpful ☐Not Helpful ☐N/A
-TENS Therapy: ☐Helpful ☐Not Helpful ☐N/A
-Bracing/Orthotics: ☐Helpful ☐Not Helpful ☐N/A
-Other: _____ ☐Helpful ☐Not Helpful ☐N/A

Have you had any testing/images? ☐Yes ☐No
If 'Yes', which?

Do you have any DRUG ALLERGIES? ☐Yes ☐No
If 'Yes', Please list:

Do you currently use any form of TOBACCO? ☐Yes☐No
If 'Yes', How many packs per day?

Do you currently drink ALCOHOL? ☐Yes☐No
If 'Yes', How much? How often?

Do you currently or do you have a history of illicit drug use?
☐Yes ☐No If 'Yes', Please explain?

Have you had any SURGERIES? ☐Yes ☐No
If 'Yes', please list:

FAMILY HISTORY

Mother: age___ ☐Alive ☐Deceased, Health Issues ☐Yes ☐No
Father: age___ ☐Alive ☐Deceased, Health Issues ☐Yes ☐No
Sibling: age___ ☐Alive ☐Deceased, Health Issues ☐Yes ☐No
Sibling: age___ ☐Alive ☐Deceased, Health Issues ☐Yes ☐No

Patient Signature:_____ Date:_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

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
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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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 you taken medication other than the way that it was prescribed?	0 1 2 3 4
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
5. 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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I _____ authorize my Southwest Pain Management (SPM) physician and any other physician or medical providers who provide care or services to me, as well as my attorney and pharmacy to exchange information relating to my medical condition(s)/services provided. In the event that I am hospitalized during the course of my care with SPM. I authorize the hospital to release information to SPM regarding any treatment provided to me.

If my treatment is covered by an acceptable insurance, I hereby authorize my benefits to be paid directly to SPM. I understand that I am financially responsible for all deductibles, co-payments, co-insurance, and all products and services not covered by my insurance company. *I understand that if I do not show up for my scheduled appointment or I do not call to cancel or reschedule my appointment with at least 48-hours advance notice I will be charged $50.00 for missed clinic appointments and $150.00 for missed procedure appointments.* _____ (Initial)

I authorize SPM to release, to my insurance company, contracted reviewing agency and/or state or governmental agency, any information necessary on the processing of my medical claim, including information relating to medical condition(s).

All information disclosed within these sessions meets applicable standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and will not be released without my written permission except as identified above and disclosure is required by law. I have been provided with a copy of this "Notice of Privacy Practice" and have been informed a copy of the complete notice is available for review in the Lobby at SPM. I may also request a copy of the notice.

Disclosure or PHI may be required by law in the following circumstances: when there is reasonable suspicion of child or elder abuse, when there is reasonable suspicion that the patient presents a danger of violence to others or themselves. Disclosure may also be required pursuant to a legal proceeding.

This authorization shall extend for the duration of my treatment at SPM unless otherwise specified in writing by me or my responsible representative(s).

_____ (Initial) I have received a copy of SPM rights and responsibilities.

Please place an X in the box that applies and sign authorization form.

☐ **Patient** ☐ **Parent** ☐ **Guardian of Minor** ☐ **Guardian or conservator of an incompetent patient**

☐ **Beneficiary or personal representative of deceased patient**

Date: _____ **Signature:** _____

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Financial Policies

At Southwest Pain Management, we have implemented to following financial policies to ensure you understand the financial expectations we have of our patients.

PAYMENT:
We are in network with most health plans. When requested by SPM staff, present your insurance card(s) and picture identification. Your benefits and eligibility will be verified before your appointments. Once your out of pocket estimate for your visit is determined, payment is expected at the time of your appointment for services rendered. If you do not present your insurance information prior to your visit, you will be expected to pay for your visit in full.

At each appointment, your estimated out-of-pocket portion including deductible, co-insurance, and co-payments will be collected. All outstanding balances due must also be paid in full before each visit. Our office accepts cash, checks or credit cards (MasterCard, Visa, Discover and American Express. Health savings accounts (HSA), Health reimbursement accounts (HRA) and flexible spending accounts (FSA) may also be used to pay for your appointments.

CANCELLATION OF APPOINTMENTS:
We have set aside time for you and as a specialized practice. A 48-hour notice of cancellation is required for all office visits and procedures. All cancellations must be made by telephone by calling our office at 214-560-2000.

A fee of $50 will be charged for late cancellations or no show of office visits, and a fee of $150 will be charged for late cancellations or no show of procedures.

I acknowledge the polices as stated above and authorize Southwest Pain Management to file insurance claims on my behalf for services rendered.

_____ _____
Patient Name Date of Birth

_____ _____
Signature Date