



JEROME O. CARTER, M.D.

Interventional Pain Management & Rehabilitation

OKEZIE N. OKEZIE, M.D., FAAPMR

Interventional Pain Management & Rehabilitation

KEVIN SMITH, PhD

Clinical Psychology

Dear Patient,

Thank you for choosing Advanced Pain Management Specialist for your pain management needs. We have attached our New Patient Packet for completion. **Please** have this completed prior to your initial visit. We work hard to have our patients' seen in a timely manner once they arrive, and not having this completed can delay and sometimes even cause us to reschedule your visit.

The following is information regarding your first visit and is important in making the experience more pleasant and stress free.

1. For prompt and proper care, fill the packet out **completely** to the best of your ability and do not leave anything blank. If it does not pertain to you, please write **N/A**.
2. Bring picture ID and Insurance card to the appointment. We **MUST** have this for your records.
3. Your initial visit is a consultation with our physicians, so please understand that pain medication is **NOT** guaranteed.
4. On your initial visit we will **REQUIRE** a urine sample.

Again, thank you for choosing us for your care and we look forward to seeing you. If you have any questions or concerns, please contact us by phone at **281-420-9355** or fax at **281-420-9332**.

Patient Information

(Please Print)

Date _____

Main Phone # _____

Name: _____
Last First Middle

Soc Sec# _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

Sex: M F Age: _____ DOB: _____ Single Married Widowed Separated Divorced
(circle) (circle)

Patient Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

In case of emergency who should be notified? _____ Phone: _____

Primary Insurance

Person Responsible for account: _____

Relation to Patient: _____ DOB: _____ Soc Sec # _____

Address if different from patient patient: _____

Person responsible Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company: _____ Group # _____ Subscriber _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
_____ and assign directly to Jerome O. Carter MD and Okezie N. Okezie MD
(Name of Insurance Company)

benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

Please let us know how you heard about us? _____

APMS of Baytown Visitor Checklist

As an extra preventative measure, and as per recommendations from Health Authorities, all patients are required to complete the following checklist. This measure is to safeguard the health and safety of the people we support, staff, and the broader community.

All VISITORS to this facility are required to complete the following checklist before entering.

QUESTIONS	CIRCLE ONE	
<p>1. Do you have any of the following symptoms?</p> <p>*Note: if you have a chronic condition (i.e. Asthma or allergies), only indicate symptoms that are either NEW or WORSE than usual. For example: if you always have a cough related to a chronic condition and your cough is not NEW or WORSE today, then answer "NO" below in the cough line.</p> <ul style="list-style-type: none"> ● Fever ● Cough ● Shortness of breath/breathing difficulties ● Loose bowels ● Rash ● Other symptoms such as sore throat, fatigue, or feeling unwell 	YES	NO
2. Have you traveled outside of the US in the last 14 days?	YES	NO
3. Have you had close contact (face-to-face contact within 6ft) with someone who is ill with cough and/or fever?	YES	NO
4. Have you been in contact in the last 14 days with someone that is being investigated for or is confirmed to have COVID-19?	YES	NO
5. Are you on self isolation for COVID-19?	YES	NO
6. Have you been tested for COVID-19?	YES	NO
7. Have you tested positive for COVID-19? If yes, please provide dates of your test: _____	YES	NO

If you answered **YES** to any of the questions above, please provide a negative Covid-19 test before entering our facility. If you answered **NO** to all the questions above, you may enter after signing below.

Our goal is to minimize the risk of infection to people we support and staff. We thank-you for your understanding and cooperation.

Name: _____ Signature: _____ Date: _____





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FINANCIAL POLICY SHEET

Our Practice Financial Policy:

We are dedicated to providing you with the best possible care and service, and regard your understanding of your financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made in advance by either your or your health coverage carrier, full payment is due at the time of service. For your convenience we accept Visa and Mastercard.

Your Insurance:

We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any required co-payment at the time of service. The co-payment will be collected when you arrive for your appointment. In the event your health plan determines a service to be "not covered"; you will be responsible for the complete charge. In the event we will bill you, and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you, on an unassigned basis. In this case, your insurer will send the payment directly to you. Therefore charges for your care and treatment are due at the time of service.

We will also bill your health plan for all services that we provide in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Advanced Pain Management Specialists
720 Rollingbrook, Baytown, TX 77521
Tel:281-420-9355 Fax:281-420-9332



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Minor Patient:

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

Missed Appointments:

In order to provide the best possible service and availability to all our patients, it is our policy to charge a visit fee, of \$25 .00, for any missed appointments if not canceled at least 24 hours prior.

Please call us as early as possible if you know you will need to reschedule your appointment.

I have read and understand the financial policy service of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice

Signature of Patient or responsible party if a minor

Date

Signature of Co-Responsible Party

Please print the name of the Patient

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Payment Policy

Thank you for choosing us as your pain management provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance** - we participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact our insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles** - all co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services** - please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable and necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance** - all patients must complete our patient form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
5. **Claims submission** - we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes** - if your insurance changes, please notify us before your next visit so we can make appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will be automatically billed to you.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party

Date

Print patient name

Date of birth



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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Jerome O. Carter MD and/or Okezie N. Okezie MD originates and maintains paper and/or electronic records describing my health history, systems, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complex description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Jerome O. Carter MD and/or Okezie N. Okezie MD is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereof. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the code of Federal Regulations.

I further understand that Jerome O. Carter MD and/or Okezie N. Okezie MD reserves the right to change their notice and practices and prior to implementation, in accordance with section 164.520 of the code of Federal Regulations. Should Jerome Carter MD and/or Okezie N. Okezie MD change their notice, they will send a copy any revised notice to the address I've provided (whether U.S. Mail or, if I agree, email). I wish to have the following restrictions to use or disclosure of my health information.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including via fax.

I fully understand and accept/decline the terms in this consent.

(Circle one)

Patient's Signature: _____

Date: _____



INFORMED CONSENT AND MEDICATION AGREEMENT

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

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physicians to treat my conditions, which has been explained to me as chronic pain. I hereby authorize and give voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled medications as an element in the treatment of my chronic pain.

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

I HAVE BEEN INFORMED AND understand that I will undergo medical test and examinations before and during my treatment. These test include, but are not limited to, random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary. I hereby give my permission to perform the test or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

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

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), low blood pressure, irregular heartbeat, insomnia, depression, impairment of reasoning and judgment, respiratory depression, impotence, tolerance to medication(s) physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and may be impaired during all activities, including work.

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

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

Patient Initials: _____



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PAIN MANAGEMENT AGREEMENT

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s).

Therefore, medication(s) will only be provided so long as I follow the rules specified in this agreement.

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment.

Discharge may be immediate for any criminal behavior:

* My progress will be periodically reviewed and, if medication(s) are not improving my quality of life, the **medication(s) may be discontinued.**

* I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.

* I will use the medication(s) **exactly as directed by my physician.**

* I agree **not** to share, sell or otherwise permit others, including my family and friends, to have access to these medications.

- I will **not allow or assist in the misuse/diversion of my medication; nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible.**
- Should the need arise to change pharmacies, my physician must be informed. I authorize my physician to release my medical records to my pharmacist as needed.

* I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. **If either are lost or stolen, they may NOT BE REPLACED.**

* I will receive medication(s) **only from ONE physician** unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to discontinuation of medication(s) and treatment.

* If it appears to my physician that there are not demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s).** I will not hold my physician liable for problems caused by the discontinuation of medication(s).

* I **agree to submit to urine/and or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, Or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

* I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life. If alcohol is consumed, it should be discussed with my physician. A failed UA (labs resulting in a positive) from alcohol and/or unprescribed drugs will be a breach of this agreement and can result in termination of doctor/patient relations.

* I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.

* I hereby give my physician **permission** to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

* I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.

* I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

Patient Signature

Date

Witness

Date



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Compliance & Disclosure under Texas Occupations Code – Section 102.006

In compliance with Section 102.006 of the Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation of patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or facility have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and/or facility: (A) his affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he will receive, directly or indirectly, remuneration for referring upon my request and exercising my right of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and Section 102.006 of Texas Occupations Code.

Dr. Okezie and Dr. Carter has affiliation and may or may not have remuneration with: Pain Management Professionals Surgery Center, Discovery Lab Services, Ally Lab Services and Principle Healthcare Systems.

I certify that I was informed of the effective alternative resources reasonable available at the time of my decision-making, and my option to use one of the alternative resources, and that I was assured by my attending physician that I will not be treated differently by the physician and his staff if I choose an alternative provider or entity.

I certify that my attending physician(s) has made referrals to the other non-participating providers or entities based only on the needs of my individual healthcare, the medical community standard of care, and my informed choice for quality and safety of the care that I will be expecting and receiving, and for the provider's professional reputation and patient satisfaction in order to provide me with quality and affordable healthcare that I personally expected under my health plan for out-of-network coverage.

I have read and fully understand this Disclosure and Authorization Form. I hereby authorize this referral to non-participating and out-of-network provider(s) or entities as named above.

Patient Name (print)

Signature of Patient

Date



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I hereby acknowledge that I have received a copy of the Pain Management Professionals of Baytown, dba Advanced Pain Management of Baytown Notice of Privacy Practices.

Signature

Date

Printed Name

OFFICE USE ONLY

Unable to obtain patient's written acknowledgement because:

____ Patient refused to sign

____ Patient is incapacitated, and no responsible party is available

____ Other: _____

Date: _____ Staff Initials: _____



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**CONSENT TO RELEASE INFORMATION ORALLY
TO FAMILY OR FRIENDS
FOR PURPOSES OF TREATMENT, PAYMENT, AND
HEALTHCARE OPERATIONS**

Patient Name: _____ (Printed)

Jerome O. Carter, MD
Okezie N. Okezie, MD

The above named practitioners have my permission to release my confidential health information to the following individuals who are involved in my care:

<u>Individuals who may receive confidential health information</u>	<u>Relationship</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

I understand that I have the right to revoke this permission, in writing, at any time and that disclosures made in good faith may have already occurred and that the withdrawal of permission cannot be applied retroactively.

Signed: _____ Date: _____

COMPREHENSIVE INITIAL EVALUATION

Name: _____ DOB: _____ Eval Date: _____

How did you hear about us? _____

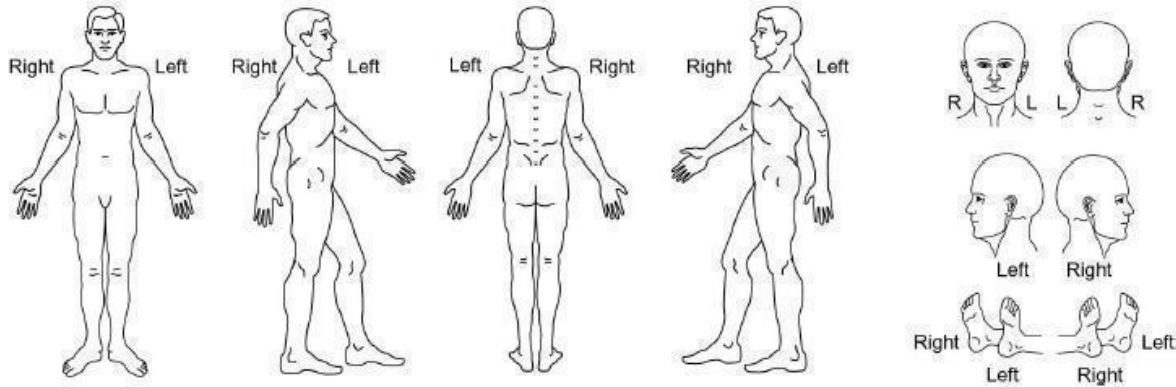
Describe your Chief Complaint: _____

HISTORY OF PRESENT ILLNESS:

Where is your pain located? Check all that apply. Circle side Left (L), Right (R), or Middle (M).

- | | | | | | |
|-------------------------------------|-------|-----------------------------------|-------|-----------------------------------|-------|
| <input type="checkbox"/> Low back | L M R | <input type="checkbox"/> Buttocks | L M R | <input type="checkbox"/> Head | L M R |
| <input type="checkbox"/> Mid Back | L M R | <input type="checkbox"/> Thigh | L M R | <input type="checkbox"/> Face | L M R |
| <input type="checkbox"/> Upper Back | L M R | <input type="checkbox"/> Calf | L M R | <input type="checkbox"/> Shoulder | L M R |
| <input type="checkbox"/> Neck | L M R | <input type="checkbox"/> Ankle | L M R | <input type="checkbox"/> Arm | L M R |
| <input type="checkbox"/> Chest | L M R | <input type="checkbox"/> Foot | L M R | <input type="checkbox"/> Hand | L M R |
| <input type="checkbox"/> Abdomen | L M R | <input type="checkbox"/> Other | _____ | | |

Please indicate on the diagram where your pain occurs by shading the painful areas.



Circle the number that best describes your pain at its worst during the last month.

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst possible pain

Circle the number that best describes your pain at its least during the last month.

0 1 2 3 4 5 6 7 8 9 10
No pain Worst possible pain

Circle the number that best describes your pain on average during the last month.

0 1 2 3 4 5 6 7 8 9 10
No pain Worst possible pain

Circle the number that best describes your pain as it is right now.

0 1 2 3 4 5 6 7 8 9 10
No pain Worst possible pain

Have you seen other physicians for your pain?

Date	Physician	Specialty	Diagnosis/Treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Approximately how many physician visits have you had for pain in the last year? _____

How many visits to other health care professionals (circle all that apply)?

Physical Therapist, Occupational Therapist Other: _____

What tests have you had done to diagnose your pain? (Circle all that apply)

X-Ray CT Scan MRI Scan Bone Scan Myelogram EMG Other Test _____

Please make sure we have the results of all tests done.

Have you had any injections for pain relief? () Yes () No

If yes, how long of relief? () None () Few hours () Few days () Few Weeks () A month or more

Have you had any of the following for relief or pain? If yes, did it relieve your pain?

- Hypnosis () Yes () No () Relief Comment: _____
- Biofeedback () Yes () No () Relief Comment: _____
- TENS () Yes () No () Relief Comment: _____
- Acupuncture () Yes () No () Relief Comment: _____
- Chiropractic () Yes () No () Relief Comment: _____
- Heat Therapy () Yes () No () Relief Comment: _____
- Bed Rest () Yes () No () Relief Comment: _____
- Osteopathic () Yes () No () Relief Comment: _____
- Psychotherapy () Yes () No () Relief Comment: _____
- Other: _____

Comment: _____

Do you exercise, and if please describe? _____

Since your pain began, overall has it () Increased () Decreased () Stayed the same

Circle the number that best describes how your pain interferes with your daily functioning.

General Activity

1 2 3 4 5 6 7 8 9 10
Does not interfere Completely Interferes

Mood

1 2 3 4 5 6 7 8 9 10
Does not interfere Completely Interferes

Date: _____ Patient Name: _____ M F DOB: _____

SS# _____ Injury Date: _____ Referring Doctor: _____

Patient History

Where is your pain? (Please circle)

Neck Shoulders/Arms Lower Back/Legs Midback Knees Ankle/Foot Other _____

How did you injure yourself? _____

How severe is your pain? (Please circle) Mild Moderate Severe

Circle the words that describe your pain: Aching Sharp Burning Electric-like Throbbing Dull

Circle the time when you experience the most pain: Morning Afternoon Evening Night

Does your neck pain radiate to your shoulder/arms/fingers? (Please circle) No Yes Right or Left

Does your back pain radiate to your hip/buttocks/legs/feet? (Please circle) No Yes Right or Left

Do you have numbness? (Please circle) No Yes Where? _____

Do you have tingling? (Please circle) No Yes Where? _____

Please circle what aggravates your pain: Standing Sitting Bending Walking Other _____

Please circle what relieves your pain: Laying down Sitting Physical Therapy Meds Ice Heat TENS

Steroid Injections Behavioral Therapy Other _____

Circle the number that best describes your pain **at its worst** during the last month:

No Pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

Circle the number that best describes your pain **on average** during the last month:

No Pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

Drug allergies to Medications? No or Yes

List Medications and reaction _____

Are you taking any blood thinners or Aspirin Therapy? No or Yes

List Medications _____

How bad does your pain affect you? Please circle one that best describes you.

General activity: None 1 2 3 4 5 6 7 8 9 10

Work activity: None 1 2 3 4 5 6 7 8 9 10

Enjoyment: None 1 2 3 4 5 6 7 8 9 10

Sleep: None 1 2 3 4 5 6 7 8 9 10

Mood: None 1 2 3 4 5 6 7 8 9 10

Please check if you have any of the following symptoms:

Loss of balance _____ Insomnia _____ Headache _____

Excessive Sweating _____ Anxiety _____ Weakness _____

Mood Swings _____ Fatigue _____ Skin rash _____

Urinary retention _____ Memory loss _____ Swelling in hands _____

Urinary urgency _____ Joint pain _____ Swelling in feet _____

Urinary frequency _____ Dizziness _____ Indigestion _____

Bowel changes _____ Itching _____ Abdominal pain _____

List all your current and past medical problems (Medical History):

Onset Date	Medical Problem/Disorder	Current Treating Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any surgery you have had for pain (Surgical History):

Date	Procedure	Surgeon	Result/Outcome/Relief
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all other surgery you have had (Surgical History Continued):

Date	Procedure	Surgeon	Result/Outcome/Relief
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you having any medication side effects?

Nausea/Vomiting	None	0	1	2	3	4	5	6	7	8	9	10	Extreme
Constipation	None	0	1	2	3	4	5	6	7	8	9	10	Extreme
Memory Loss	None	0	1	2	3	4	5	6	7	8	9	10	Extreme
Sedation	None	0	1	2	3	4	5	6	7	8	9	10	Extreme
Itching	None	0	1	2	3	4	5	6	7	8	9	10	Extreme
Insomnia	None	0	1	2	3	4	5	6	7	8	9	10	Extreme

Family History

Describe your families health status. Describe any chronic illness or pain problems in family members.

Father ()Alive ()Well ()Deceased Illness: _____
Mother ()Alive () Well ()Deceased Illness: _____
Brother(s) _____#Alive _____#Deceased Illness: _____
Sister(s) _____#Alive _____#Deceased Illness: _____
Son(s) _____#Alive _____#Deceased Illness: _____
Daughter(s) _____#Alive _____#Deceased Illness: _____

Any family member with chronic pain? _____

Any family member with psychiatric illness? _____

Social History

Are you: ()Married ()Never Married ()Widowed ()Divorced() # times
You live with () Alone ()With spouse ()w/Relatives ()w/Friends ()Roomates
How much do you smoke? ()None _____#packs per day _____#Years Cigar ChewingTobacco
How much do you drink?()None _____#beer/Day_____#wine/day _____#cocktails/day_____Occasionally
What is you current occupation? _____ Previous _____

What are your specific duties? _____

() Full Time () Part Time () Don't work Date last worked _____

Do/did you find your job satisfying? () Yes () No

Do/did you find your job financially satisfying? () Yes () No

Did you stop working because of pain? () Yes () No

Do you feel you can return to work? () Yes () No

If no, explain _____

What is the highest grade in school that you completed? _____

Have you received financial compensation related to your pain? () Yes () No

Are you receiving continued financial support related to your pain? () Yes () No From _____

Are you now bringing a lawsuit because of you pain? () Yes () No

Are you planning to file a lawsuit because of your pain? () Yes () No

Your attorney: _____

Mental Health History

Have you ever had psychological treatment? () Yes () No

() Outpatient () Inpatient Diagnoses: _____

Have you ever had psychiatric treatment? () Yes () No

() Outpatient () Inpatient Diagnoses: _____

Have you ever taken any medications for anxiety?

If so, please list: _____

Have you ever taken any medications for depression?

If so, please list: _____

Do you have previous substance abuse problems? () Yes () No

Explain: _____

Have you had problems with alcohol? () Yes () No

Explain: _____

Have you lived with someone with alcohol or substance abuse problems?

Explain relationship and substance: _____