Integrated Pain Specialists of Southern California, Inc.
Kevin S. Smith, M.D.
7525 Linda Vista Road, Suite C, San Diego, CA 92111
Phone: (619) 398-2988 Fax: (619) 398-2987

Appointment Location: 7525 Linda Vista Road, Suite C, San Diego, CA 92111

Appointment Date: _____ **Appointment Time**: _____

Check-in Time: _____ **with your new patient packet completely filled out.**

If you are unable to complete your new patient packet, please check-in 1 hour prior.

New patients need to have paperwork completed prior to your appointment to avoid being rescheduled.
Please be on time for your appointment or it may be rescheduled.

Directions:

CA-163 SOUTH

Take CA-163 South and exit Genesee Ave. Turn right onto Genesee Ave. In 0.30 miles, take the 1st right onto Linda Vista Rd *(Linda Vista Rd is 0.1 miles past Richland St. If you reach Whitney St you've gone about 0.2 miles too far).*In 0.64 miles our office will be on the right *(If you reach Family Cir you've gone a little too far).*

CA-163 NORTH

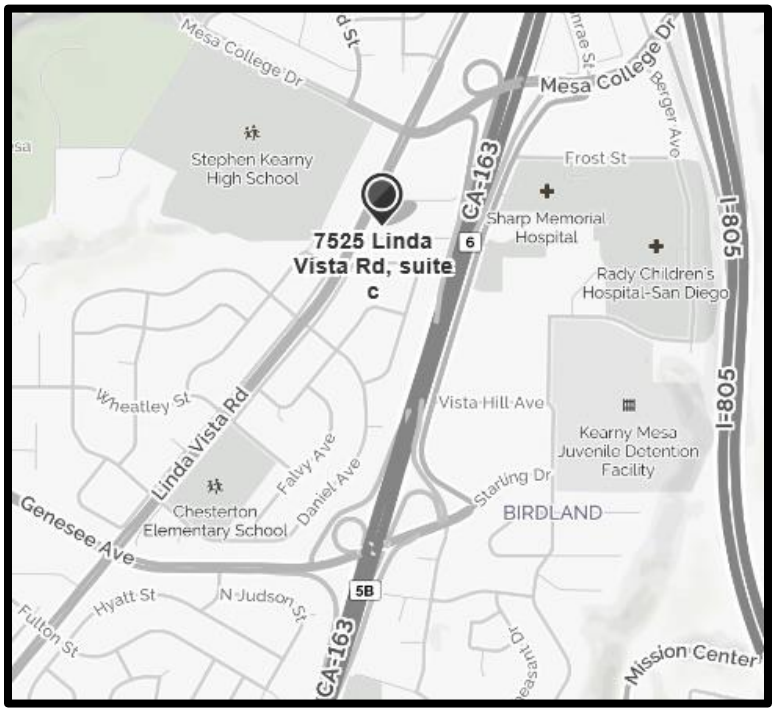
Take CA-163 North to Genesee Ave W. Turn right onto Genesee Ave. In 0.51 miles, turn right onto Linda Vista Rd. Go 0.64 miles, and our office is on the right *(If you reach Family Cir you've gone a little too far).*

I-805 NORTH

Take I-805 north. Then take the Mesa College Dr/Kearny Villa Rd exit. Keep left to turn left onto Kearny Villa Rd, then turn left onto Kearny Villa Rd. Kearny Villa Rd becomes Mesa College Dr. In about a half mile, turn left onto Linda Vista Rd. *(Linda Vista Rd is 0.2 miles past Annrae St. If you reach Ashford St you've gone a little too far).* Then 0.18 miles, make a u-turn onto Linda Vista Rd *(If you reach Korink Ave you've gone about 0.1 miles too far).*In 0.04 miles, our office is on the right *(If you reach Family Cir you've gone a little too far)*

◆ Please Note ◆

Bus Stop / San Diego Metropolitan Transit System (MTS)
Route 44 is located directly in front of our building.



Patient Copy

Kevin S. Smith, M.D.

Board Certified in Pain Management and Anesthesiology

Dear Sir/Madam:

Enclosed you will find several forms; which we ask that you complete and bring with you to our office prior to your consultation. Please arrive thirty (30) minutes prior to your appointment; this will help expedite the process of setting up your account. If you have not completed this paperwork prior to your appointment time, please check-in one (1) hour prior to your appointment time so that you can complete the paperwork in our waiting room before you are seen. If your paperwork is not complete prior to your appointment, you will need to be rescheduled.

Our office will obtain records from your referring physician prior to scheduling your appointment. If you have any additional records or radiology studies you would like to have reviewed, bring them to your appointment, please arrive a few minutes early so that we can get them into your chart for the doctor's review.

Upon check-in with the receptionist, please provide your identification and insurance card(s) to copy for your chart and pay any co-pays that apply.

If your co-pay is not paid at the time of service there will be a twenty ($20) charge to bill for a co-payment.

Our Practice focuses on one on one personalized service, quality care and attention to detail. To do so, we must ensure that we allow enough time for each patient's appointment. With this in mind, for all appointments longer than one hour, we require indication of commitment by payment at the time of scheduling.

In the event that you must cancel your appointment, the following is our cancellation policy.

Appointments:	48 business hours notice or $45 charge
Procedures scheduled 1 hour or less:	7 business days notice or $200 charge
Procedures scheduled longer than 1 hour and less than 2 hours:	7 business days notice or $200 charge.
Procedures scheduled 2 hours or more:	10 business days notice or $500 charge

We look forward to meeting you at your consultation with Dr. Smith.

Sincerely,

Medical Office Staff
Integrated Pain Specialists

Office Address: 7525 Linda Vista Road, Suite C, San Diego, CA 92111-5344

Office Phone: (619) 398-2988 ◆ **Office Fax:** (619) 398-2987 ◆ **After Hours:** (619) 270-4951

Integrated Pain Specialists of Southern California
PATIENT REGISTRATION

Updated By + Date: _____ *DOS:* _____

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Patient Name		Date of Birth	Sex	Age
SSN #	Student? ❑ FT ❑ PT ❑ N/A	Marital Status S M W D	Primary Language:	Race: _____ Ethnicity : _____
Street Address:		City	State	Zip
Mailing Address (if different from above):				
Patient Portal: ❑ Web-Enable me so I may update my information, view reports & appointment info, receive conf. calls, send/receive messages		E-mail Address		
Phone Number(s): Please check the box ☑ of your preferred / primary phone number that we may reach you at.	❑ Home:_____ ❑ Work:_____ ❑ Mobile:_____	Ok to Leave a Message? Home: ☐ No ☐ Yes → ☐ Brief ☐ Detailed message Work: ☐ No ☐ Yes → ☐ Brief ☐ Detailed message Mobile: ☐ No ☐ Yes → ☐ Brief ☐ Detailed Message		
Occupation:	Work Status: ❑ FT ❑ PT ❑ Self-employed ❑ Disabled ❑ Retired ❑ Not Employed ❑ Student ❑ Other (please specify):			
Employer Name:		Employer Address:		
Spouse Name:		Employer:		
Primary Physician's Name				
Whom May We Thank for Referring You to Our Practice?				

NOTIFY IN CASE OF EMERGENCY

Name	Relationship		
Address	City	State	Zip
Home Number	Work Number	Mobile Number	

FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES

Name	Telephone		
Address	City	State	Zip
Primary Insurance	ID Number:		
Primary Insured's Name	Subscriber's DOB	Subscriber's SSN #.	
Claims Address	City	State	Zip
Secondary Insurance	ID Number		
Primary Insured's Name	Subscriber's DOB	Subscriber's SSN #.	

Were You Injured on the Job? ❑ YES ❑ NO	If yes, Have You Informed Your Employer? ❑ YES ❑ NO		
Original Date of Injury:	Adjuster Name:	Adjuster Phone:	
Attorney Name	Attorney Phone:	Attorney Fax:	
Do you have an Advanced Directive / Power of Attorney?	❑ YES ❑ NO	If yes, please bring proof/documentation of this, to your initial visit. If you are unable to provide proof/documentation, please explain: _____	

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Kevin S. Smith M.D. I understand that I am financially responsible for any balance. I authorize Integrated Pain Specialists or my insurance company to release any information required to process my claims.

Signature: _____ Date: _____

Integrated Pain Specialists of Southern California, Inc.
Kevin S. Smith, M.D.
7525 Linda Vista Road, Suite C, San Diego, CA 92111
Phone: (619) 398-2988 Fax: (619) 398-2987

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION:
I hereby authorize the release of information between the following two parties, regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above-named health care provider may hold, by means of mail, fax, or other electronic methods.

From: _____ (name of person, healthcare provider, or facility)

Phone: _____ Fax: _____

To: **INTEGRATED PAIN SPECIALISTS OF SOUTHERN CALIFORNIA, INC. DBA. KEVIN S. SMITH, M.D.**
Address: **7525 LINDA VISTA ROAD, SUITE C** City, State, Zip: **SAN DIEGO, CA 92111-5344**
Phone: **(619) 398-2988** Fax: **(619) 398-2987** Please send records by: ❑ Fax ❑ Mail

The medical information/records will be used for the following purpose:
PAIN MANAGEMENT CONTINUATION OF CARE

This authorization is:
- ❑ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV, Diagnosis/Treatment)
- ❑ Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____(initial)
Psychiatric/Mental Health _____(initial)
Tests for Antibodies to HIV _____(initial)
HIV Diagnosis/Treatment _____(initial)
Genetic Information _____(initial)

DURATION:
This authorization shall be effective immediately and remain in effect until: _____(date)
***** If no duration date is specified, the form will remain valid for one (1) year from the signature date below. *****

RESTRICTIONS:
Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

Signature of Patient (*or legal/personal representative)*
Relationship (*if other than patient)*
Patient's Name (*please print)*
Today's Date
Patient's Social Security Number
Patient's Date of Birth
Witness Name
Witness Signature

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AUTHORIZATION:
I hereby authorize the release of information between the following two parties, regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above-named health care provider may hold, by means of mail, fax, or other electronic methods.

From: **INTEGRATED PAIN SPECIALISTS OF SOUTHERN CALIFORNIA, INC. DBA. KEVIN S. SMITH, M.D.**
Address: **7525 LINDA VISTA ROAD, SUITE C** City, State, Zip: **SAN DIEGO, CA 92111-5344**
Phone: **(619) 398-2988** Fax: **(619) 398-2987** Please send records by: ❑ Fax ❑ Mail

To: _____ (name of person, healthcare provider, or facility)
Phone: _____ Fax: _____

The medical information/records will be used for the following purpose:
CONTINUITY OF MEDICAL CARE

This authorization is:
- ❑ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV, Diagnosis/Treatment)
- ❑ Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____(initial)
Psychiatric/Mental Health _____(initial)
Tests for Antibodies to HIV _____(initial)
HIV Diagnosis/Treatment _____(initial)
Genetic Information _____(initial)

DURATION:
This authorization shall be effective immediately and remain in effect until: _____(date)
***** If no duration date is specified, the form will remain valid for one (1) year from the signature date below. *****

RESTRICTIONS:
Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

_____ Signature of Patient (*or legal/personal representative)*
_____ Relationship (*if other than patient)*
_____ Patient's Name (*please print)*
_____ Today's Date
_____ Patient's Social Security Number
_____ Patient's Date of Birth
_____ Witness Name
_____ Witness Signature

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Notice of Privacy Practices

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

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and laboratory results, diagnoses, treatments, and any plans for future care or treatment.

I understand that this information serves as:

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

I understand that I have the right to view and or request a Notice of Privacy Practices that provides a more complete description of information uses and disclosures prior to signing this consent. I understand that the organization reserves the right to change their notice and practices, and; prior to implementation will post and make available, the revised notice at physical practice site(s). I also understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my healthcare operations; and that the organization 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 thereon.

I request the following person(s) **to be restricted** to the use or disclosure of my health information.

_____

_____

I request the following person(s) **to be allowed** to discuss my medical care with the Clinic.

_____

_____

I have read and understand the Notice of Privacy Practices.

_____ _____

Signature of Patient (or Legal Representative) Witness

_____ _____

Today's Date Notice of Effective Date

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Financial Agreement for Services Provided

Please initial on each line below, to show that you have read and understand each statement, and agree to the policy as listed:

_____ I agree to notify Integrated Pain Specialists of any changes to my insurance, including but not limited to, insurance coverage and switching to a new HMO medical group.

_____ I have chosen **Integrated Pain Specialists** to provide medical services. **I agree to be financially responsible for all of the fees charged for medical services provided that are not covered by my health insurance.**

_____ I understand that I am responsible for the co-payment or deductible requirements of my insurance and for payment for any services that are not covered or are ineligible for payment by my insurance. If it is determined that I am not eligible for insurance coverage, I agree to pay the fee charged by IPS.

_____ I acknowledge that if I present for medical services without the proper authorization or referral which is required by my insurance company, I will be responsible for paying the fee charged by IPS.

_____ I also understand that if a service is provided that is not included as a benefit under my insurance coverage, that I will be responsible for paying the fee charged by IPS.

_____ I understand I may be personally responsible for payment of services that I am electing to proceed with. I agree to pay for all services at the time of service or within 30 days of receipt of a bill as well as pay for any outstanding fees owed to IPS.

_____ I also agree that if my account is transferred to any outside entity for collection, I will pay for the collection agency and any attorney's fee and costs in connection with obtaining payment.

_____ If my appointment has been scheduled at a facility, I understand that I will receive bills for services rendered by the facility separate and apart from the physicians' charges.

_____ I understand if I have an HMO with POS option and wish to use my PPO benefits without using HMO benefits, I cannot switch once treatment has been initiated.

_____ I have asked and had answered to my satisfaction, all questions I have regarding my responsibility for payment of services. I understand and agree to proceed with medical services.

_____ I acknowledge that I have been informed that Integrated Pain Specialists does not accept, and **is NOT contracted with Medi-Cal, or any of its affiliates** as a Primary or Secondary insurance coverage, effective March 8, 2011. I have agreed to continue my care with Integrated Pain Specialists. I am aware that I will be financially responsible for all charges accrued that are not covered by my insurance.

_____ _____

Signature of Patient (or Responsible Party) **Date**

_____

Print Patient Name

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No Show / Cancellation Policy

We strive to provide excellent medical care. With this in mind, we require that you give us notice if you are unable to keep your scheduled appointment. This allows other patients to be scheduled into that appointment. A cancellation fee will be applied for missed appointments without any notice given as follows:

- **Office Appointments** – 48 business-hour notice or $45 cancellation fee will be applied
- **Procedures Scheduled 1 hour or less** – Requires 7 business days notice or $200 cancellation fee will be applied
- **Procedures Scheduled longer than 1 hour and less than 2 hours** – Requires 7 business days notice or $200 cancellation fee will be applied
- **Procedures Scheduled 2 hours or more** – Require 10 business days notice or $500.00 cancellation fee will be applied.

We apologize for the need of this but when a patient No Shows or Cancels last minute it is too late to fill that appointment time with another patient who may have been in need of an urgent appointment.

Please be informed that multiple cancellations or "no-shows" may result in the termination of our physician/patient relationship and discharge from the practice.

I have read and understand the above policy.

Patient Signature	**Patient Name** (please print)	**Date**

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Patient Code of Conduct

In an effort to provide a safe and healthy environment for Integrated Pain Specialists, we ask that you refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of our patients, staff and guests.

The following behaviors are prohibited and may result in your immediate discharge from the practice or removal from the facility:

- Possession of firearms or any weapon
- Physical assault, arson or inflicting bodily harm
- Menacing gestures and verbal threats to harm another individual or destroy property
- Intentionally damaging equipment or property
- Attempting to intimidate or harass other individuals
- Harassing, offensive or intimidating statements or threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal or electronic communication
- Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or sexuality
- Possession and/or use of street drugs and alcoholic beverages are not allowed
- Throwing objects
- Inappropriate language or profanities
- Requests that would constitute illegal or unethical behavior on the part of IPS
- Adults are expected to supervise the children in their care at all times
- Climbing on furniture is not allowed
- Do not visit if you are sick or have an illness that could be transmitted to a patient
- Photographs require consent from the person before taking their picture

Additionally, if you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member.

Patient Signature	Patient Name (please print)	Date

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NEW PATIENT QUESTIONNAIRE

Name: _____ Date :_____

Date of Birth: _____ Age:_____ Sex: ☐ Male ☐ Female

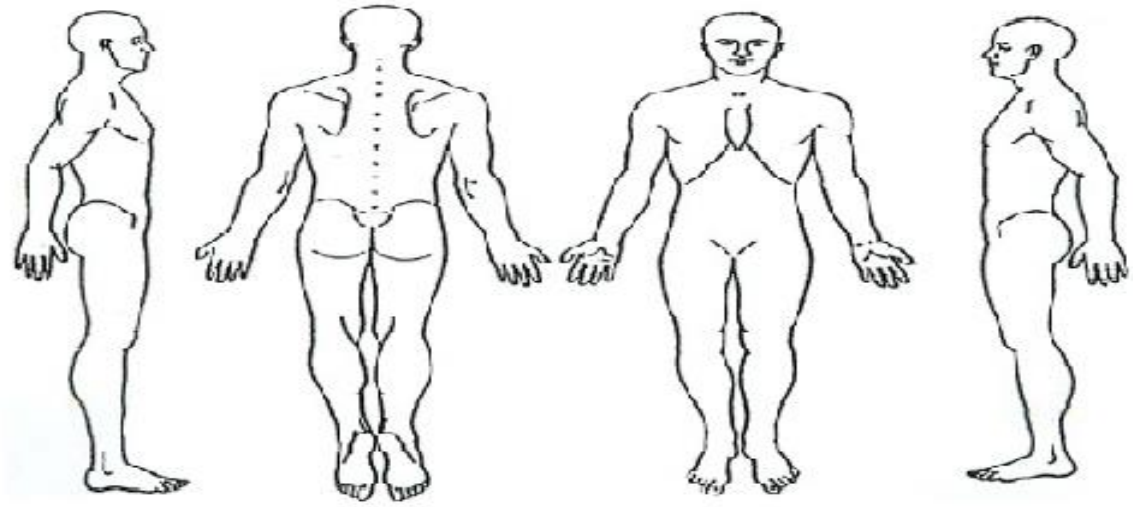
Referring Physician: _____ Primary Treating Physician: _____

Reason for Referral: _____

Interpreter Name & Phone Number (if needed):_____

☐ Right-hand dominant ☐ Left-hand dominant

On the diagram, shade the area where you feel pain. Put an "X" on the area that hurts the most.



What is your pain right now? Circle the number that best reflects your pain level.

0	1	2	3	4	5	6	7	8	9	10
No Pain		*Mild*		*Moderate*		*Severe*		*Very Severe*		*Worst Possible*

What does the pain feel like? Check all that apply:

❑ Pressure	❑ Nagging	❑ Tender	❑ Burning	❑ Itching	❑ Pinching
❑ Tingling	❑ Numbing	❑ Cramping	❑ Stinging	❑ Splitting	❑ Heavy
❑ Pulsing	❑ Throbbing	❑ Crushing	❑ Squeezing	❑ Shooting	❑ Dull
❑ Aching	❑ Radiating	❑ Cutting	❑ Sharp	❑ Stabbing	

Do you have? Check all that apply:

❑ Numbness	❑ Pins and needles	❑ Increased sweating	❑ Skin sensitivity
❑ Weakness	❑ Coldness	❑ Muscle spasms	
❑ Tingling	❑ Tightness	❑ Skin discoloration	

Does the pain make it hard for you to Check all that apply:

❑ Walk	❑ Sit	❑ Exercise	❑ Be with family	❑ Have sex
❑ Sleep	❑ Work	❑ Eat	❑ Enjoy life	

for office use only:

B/P: _____ P: _____ T:_____ O2:_____ HT: _____ WT: _____ ROOM: _____ MA: _____

Patient **Denies** Allergy to : ❑ **Latex** ❑ **Adhesive** ❑ **Tape** ❑ **Contrast Dye**

Patient Identification:

PATIENT NAME: _____

When is the pain worse? Check all that apply:

- ❑ Morning (6-9 am)
- ❑ Mid-Morning (9-Noon)
- ❑ Afternoon (12-3 pm)
- ❑ Late Afternoon (3-6 pm)
- ❑ Evening (6-9 pm)
- ❑ Late Evening (9-Midnight)
- ❑ Night (12-6 am)
- ❑ With Activity
- ❑ Can't Predict
- ❑ Before Next Dose of Meds Due

How do you control flare-up pain? Check all that apply:

- ❑ Cold
- ❑ Heat
- ❑ Exercise
- ❑ Massage
- ❑ Acupuncture
- ❑ Sleep
- ❑ Alcohol
- ❑ Smoking
- ❑ Food
- ❑ Hypnosis
- ❑ Relaxation
- ❑ Positioning
- ❑ Self-medication

Rate your pain score for each question: 0 = does not interfere 10 = Completely interferes

Rate your pain at its worst in the last 7 days	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Rate your pain at its least in the last 7 days	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Rate your pain on an average daily basis	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Rate the highest pain level that you can function/live at (what number do you want your pain number to be)	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Rate how pain has interfered with activities: 0 = does not interfere 10 = Completely interferes

General activity	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Mood	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Walking ability	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Sleep	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Work outside home	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Relationships	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Work inside the home	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Constipation	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Enjoyment of life	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Sexual relations	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Is your pain: ❑ Constant ❑ Unpredictable ❑ With increased activity

If you have back pain, how long can you:

Sit _____ Stand _____ Lay flat on your back _____ Walk _____

PAIN HISTORY

Onset? When did your pain begin (if the exact date is not known, then put down approximately when)?

Was there a particular incident? (injury, accident, illness): ❑ No ❑ Yes, explain

If work related, have you notified your employer? ❑ No ❑ Yes

Are you involved in litigation? ❑ No ❑ Yes

Are you still working? ❑ No ❑ Yes If yes: ❑ Regular work / No Restrictions
❑ Modified Work / with Restrictions
❑ Taken off work / temporarily totally disabled

Are you receiving any Disability Benefits because of this injury? ❑ No ❑ Yes

Name of Physician who performed you initial evaluation for your injury: _____

Have you seen any other medical providers for this injury? ❑ No ❑ Yes, explain:

DIAGNOSTIC HISTORY

What tests (and dates) have you had to evaluate your pain?

Patient Identification:

PATIENT NAME: _____

EXAM PERFORMED	WHEN?	ORDERING PHYSICIAN or NAME OF IMAGING FACILITY?
❑ MRI	_____	_____
❑ Myelogram	_____	_____
❑ X-Rays	_____	_____
❑ Discogram	_____	_____
❑ CT Scan	_____	_____
❑ EMG/NCV	_____	_____
❑ Bone Scan	_____	_____
❑ Other:	_____	_____

THERAPEUTIC HISTORY

Have you seen other pain providers? ❑ No ❑ Yes. Please explain: _____

_____

What procedures have been done to treat your pain?

If you have had any of the following procedures, and they were helpful, then please also indicate on a percentage scale how much pain relief you received (0% = No Relief - 100% =Complete Relief), and how long did the pain relief last (hours, days, months, years)?

❑ Trigger Point Injections	When? _____ Done by: Dr. _____	❑ Not Helpful ❑ Helpful	_____% Pain Relief, that lasted for: _____
❑ Joint Injections	When? _____ Done by: Dr. _____	❑ Not Helpful ❑ Helpful	_____% Pain Relief, that lasted for: _____
❑ Nerve Blocks	When? _____ Done by: Dr. _____	❑ Not Helpful ❑ Helpful	_____% Pain Relief, that lasted for: _____
❑ Epidural Steroids	When? _____ Done by: Dr. _____	❑ Not Helpful ❑ Helpful	_____% Pain Relief, that lasted for: _____
❑ Radiofrequency Ablation	When? _____ Done by: Dr. _____	❑ Not Helpful ❑ Helpful	_____% Pain Relief, that lasted for: _____
❑ Spinal Cord Stimulation	When? _____ Done by: Dr. _____	❑ Not Helpful ❑ Helpful	_____% Pain Relief, that lasted for: _____
❑ Pain Pump (Intrathecal)	When? _____ Done by: Dr. _____	❑ Not Helpful ❑ Helpful	_____% Pain Relief, that lasted for: _____
❑ Other: _____	When? _____ Done by: Dr. _____	❑ Not Helpful ❑ Helpful	_____% Pain Relief, that lasted for: _____

OTHER CONSERVATIVE TREATMENTS/THERAPIES TRIED :

Type of Treatment	Start Date	Duration # of days, weeks, or months	Helpful ? Yes/No	If helpful, what ____% pain relief achieved?	If Helpful, how long did the Pain Relief last? (# days, wks, months)	N/A
Physical Therapy			❑ Yes ❑ No			❑
TENS Unit			❑ Yes ❑ No			❑
Traction			❑ Yes ❑ No			❑
Heat Therapy			❑ Yes ❑ No			❑
Chiropractic			❑ Yes ❑ No			❑
Osteopathic			❑ Yes ❑ No			❑
Herbal/Homeopathic			❑ Yes ❑ No			❑
Bio-feedback			❑ Yes ❑ No			❑
Acupuncture			❑ Yes ❑ No			❑
Psychological			❑ Yes ❑ No			❑
Other: _____			❑ Yes ❑ No			❑

Patient Identification:

PATIENT NAME: _____

SOCIAL HISTORY

Occupation: _____

❑ Currently working ❑ Retired ❑ Stopped due to pain ❑ Disabled

Highest Degree Earned: _____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Domestic Partner

Children: Number: _____ Ages: _____

Tobacco Use: ❑ Cigarettes ❑ Cigar ❑ Pipe ❑ Never smoked
❑ Current smoker ❑ Former smoker When quit? _____ ❑ Passive smoker

Smokeless tobacco ❑ Never ❑ Current ❑ Former When quit? _____

Alcohol use: ❑ Beer ❑ Wine ❑ Liquor Drinks per week: _____

Caffeine use: ❑ Soda Drinks per week: _____ ❑ Coffee Drinks per week: _____

Recreational drug use: ❑ Never ❑ Former ❑ Current

Drug(s) used: _____

DUI: ❑ Yes ❑ No

Alcohol or Drug Treatment Program: ❑ Yes ❑ No

Have you attended: ❑ AA ❑ NA ❑ Alanon

Do you currently attend: ❑ AA ❑ NA ❑ Alanon How many meetings per week: _____

Do you have an attorney because of a medical problem? ❑ Yes ❑ No

Were you ever verbally or physically abused: ❑ Yes ❑ No

Do you exercise? ❑ No ❑ Rarely ❑ 1-2 times/week ❑ 3-4 times/week ❑ 5 or more times/week

What do you for exercise? _____

1. Family history of substance abuse?
   - Alcohol ❑ Yes ❑ No
   - Illegal Drugs ❑ Yes ❑ No
   - Prescription Drugs ❑ Yes ❑ No
2. Personal history of substance abuse?
   - Alcohol ❑ Yes ❑ No
   - Illegal Drugs ❑ Yes ❑ No
   - Prescription Drugs ❑ Yes ❑ No
3. Age between 16 and 45 years old? ❑ Yes ❑ No
4. History of preadolescent sexual abuse? ❑ Yes ❑ No
5. Psychological disease? ❑ Yes ❑ No
   - ADD, ADHD, Obsessive-Compulsive disorder, Bi-polar, or Schizophrenia ❑ Yes ❑ No
   - Depression ❑ Yes ❑ No

Patient Identification:

PATIENT NAME: _____

SLEEP HISTORY

Do you snore? ❑ Yes ❑ No
Are you excessively tired during the day? ❑ Yes ❑ No
Have you been told that you stop breathing or gasp for breaths during sleep? ❑ Yes ❑ No
Do you have a history of hypertension? ❑ Yes ❑ No
Is your neck size > 17 in. (male) or > 16 in. (female)? ❑ Yes ❑ No

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 – No chance of falling asleep
1 – Slight chance of falling asleep
2 – Moderate chance of falling asleep
4 – High chance of falling asleep

Situation	Chance of Falling Asleep
Sitting and reading	0 1 2 3 4
Watching TV	0 1 2 3 4
Sitting inactive in a public place (e.g. a theatre or a meeting)	0 1 2 3 4
As a passenger in a car for an hour without a break	0 1 2 3 4
Lying down to rest in the afternoon as circumstances permit	0 1 2 3 4
Sitting and talking to someone	0 1 2 3 4
Sitting quietly after lunch without alcohol	0 1 2 3 4

MEDICAL HISTORY

Do you now, or have you ever had any of the following? If so, please provide details.

❑ No ❑ Yes Seizures or stroke
❑ No ❑ Yes Heart Problems
❑ No ❑ Yes Lung or breathing problems _____
❑ No ❑ Yes Kidney problems _____
❑ No ❑ Yes High blood pressure _____
❑ No ❑ Yes Diabetes or high blood sugar _____
❑ No ❑ Yes GI problems (Ulcer, gastritis, hiatal hernia) _____
❑ No ❑ Yes Liver problems or hepatitis _____

Do you now, or have you ever had any of the following? If so, please provide details.

❑ No ❑ Yes Sleep Apnea _____
❑ No ❑ Yes Depression or Anxiety _____
❑ No ❑ Yes Cancer _____
❑ No ❑ Yes Bleeding disorder or use of blood thinners _____
❑ No ❑ Yes Allergy to contrast dye _____

Are there any other medical conditions not listed above that you are currently seeing a doctor or medications for?

_____

_____

SURGICAL HISTORY Please list the SURGERIES you have had, who performed them, and when they were done

_____

_____

Patient Identification:

PATIENT NAME: _____

FAMILY HISTORY

Problem		Grandfather	Grandmother	Father	Mother	Son	Daughter	Sibling
❑	Anxiety	❑	❑	❑	❑	❑	❑	❑
❑	Arthritis	❑	❑	❑	❑	❑	❑	❑
❑	Back/Neck Surgery	❑	❑	❑	❑	❑	❑	❑
❑	Chronic Fatigue	❑	❑	❑	❑	❑	❑	❑
❑	Chronic Pain	❑	❑	❑	❑	❑	❑	❑
❑	Depression	❑	❑	❑	❑	❑	❑	❑
❑	Diabetes	❑	❑	❑	❑	❑	❑	❑
❑	Fibromyalgia	❑	❑	❑	❑	❑	❑	❑
❑	Irritable Bowel	❑	❑	❑	❑	❑	❑	❑
❑	Mental Illness	❑	❑	❑	❑	❑	❑	❑
❑	Migraine	❑	❑	❑	❑	❑	❑	❑
❑	Neurological Dx	❑	❑	❑	❑	❑	❑	❑
❑	Skeletal Disorder	❑	❑	❑	❑	❑	❑	❑
❑	Abdominal Pain	❑	❑	❑	❑	❑	❑	❑

RELATIVE	CURRENT AGE (OR AGE AT DEATH)	CONDITION (OR CAUSE OF DEATH
Father:		
Mother:		
Sister(s):		
Brother(s):		
Spouse:		
Son(s):		
Daughter(s)::		

Patient Identification:

PATIENT NAME: _____

REVIEW OF SYSTEMS Have you experienced any of the following in the past month?

General:
- ❑ Fatigue
- ❑ Fainting spells
- ❑ Loss of appetite
- ❑ Weight loss
- ❑ Poor sleep
- ❑ Fever/chills
- ❑ Night Sweats

Cardiovascular:
- ❑ Chest pain
- ❑ Palpitations
- ❑ Swelling in legs

Urinary:
- ❑ Urinary incontinence
- ❑ Pain or burning on urination

Musculoskeletal:
- ❑ Joint pain
- ❑ Joint swelling
- ❑ Muscle pain

Allergic/Immunologic:
- ❑ Seasonal allergies

Eyes, Ears, Nose, Throat:
- ❑ Blurred vision
- ❑ Difficulty hearing
- ❑ Hoarseness
- ❑ Difficulty swallowing

Respiratory:
- ❑ Cough
- ❑ Wheezing
- ❑ Shortness of breath

Genito-Reproductive:
- ❑ Decreased sexual desire
- ❑ Decreased ability to achieve erection

Neurologic:
- ❑ Seizures/Epilepsy
- ❑ Stroke
- ❑ Paralysis of arms
- ❑ Paralysis of legs
- ❑ Loss of balance/coordination
- ❑ Frequent Headaches

Gastrointestinal:
- ❑ Nausea
- ❑ Vomiting
- ❑ Bowel incontinence
- ❑ Constipation

Skin:
- ❑ Dryness
- ❑ Itching
- ❑ Rash
- ❑ Ulcers

Endocrine:
- ❑ Cold intolerance
- ❑ Heat intolerance

Hematologic/Lymphatic:
- ❑ Easy bruising/bleeding
- ❑ Use of blood thinners

Psychiatric:
- ❑ Depression
- ❑ Difficulty with thinking/memory
- ❑ Other mental illness

Allergies? ❑ No ❑ Yes, Explain:

_____

_____

List all PAIN MEDICATIONS you are currently taking

Medicine	**Dose (amount)**	**Time per day**

Are you taking medications to prevent your blood from clotting? ❑ Yes ❑ No

❑ warfarin (COUMADIN) ❑ enoxaparin (LEVONOX) ❑ dalteparin (FRAGMIN) ❑ heparin
❑ clopidogrel (PLAVIX) ❑ ticlopidine(TICLID) ❑ fondaparinux (ARIXTRA) ❑ cilostazol (PLETAL)

Have you ever stopped these medications for medical procedures? ❑ Yes ❑ No

Name of physician who prescribes these medications to you? _____

Are you prescribed any other medications from any other providers? ❑ No ❑ Yes, explain:

_____

_____

MEDICATION HISTORY

Check the Pain medications that you have used to treat your pain currently or in the past, and check whether the medication was helpful or not helpful.

Medication generic name (BRAND NAME)		Currently taking	Helpful	Not helpful	Please list any side-effects
Short Acting Opioids					
❑	tramadol (ULTRAM, ULTRAM ER)				
❑	tapentadol (NUCYNTA)				
❑	hydrocodone (VICODIN, NORCO)				
❑	oxycodone (PERCOCET, ROXICET)				
❑	hydromorphone (DILAUDID)				
❑	morphine IR (MSIR)				
❑	fentanyl (ACTIQ, FENTORA)				
❑	codeine (TYLENOL #3, #4)				
Long Acting Opioids					
❑	CR oxycodone (OXYCONTIN)				
❑	Morphine, long acting (MS CONTIN, KADIAN, AVINZA, ORAMORPH)				
❑	methadone (DOLOPHINE)				
❑	fentanyl patch (DURAGESIC)				
❑	levorphanol (LEVODROMORAN)				
❑	buprenorphine (BUTRANS)				
❑	buprenorphine/naloxone (SUBOXONE)				
Anticonvulsants					
❑	gabapentin (NEURONTIN)				
❑	pregabalin (LYRICA)				
❑	topiramate (TOPAMAX)				
Benzodiazepines					
❑	diazepam (VALIUM)				
❑	alprazolam (XANAX)				
❑	lorazepam (ATIVAN)				
❑	clonazepam (KLONOPIN)				
Antidepressants					
❑	amitriptyline (ELAVIL)				
❑	nortriptyline (PAMELOR)				
❑	doxepin				
❑	trazadone				
SNRI					
❑	duloxetine (CYMBALTA)				
❑	venlafaxine (EFFEXOR)				
❑	milnacipran (SAVELLA)				
Topicals					
❑	Lidoderm/Lidocaine Patch				
❑	Flector/Pennsaid Patch				
❑	Voltaren Gel				
❑	Topical Creams				

Patient Identification:

PATIENT NAME: _____

MEDICATION HISTORY (CONTINUED)

Medication generic name (BRAND NAME)	Currently taking	Helpful	Not helpful	Please list any side-effects
Muscle-Relaxant				
❑ cyclobenzaprine (FLEXERIL)				
❑ carisoprodol (SOMA)				
❑ metaxalone (SKELAXIN)				
❑ methocarbamol (ROBAXIN)				
❑ tizanidine (ZANAFLEX)				
❑ baclofen				
Migraine				
❑ ergotamine (CAFERGOT, DHE45)				
❑ MIDRIN				
❑ naratriptan (AMERGE)				
❑ frovatriptan (FROVA)				
❑ sumatriptan (IMITREX)				
❑ rizatriptan (MAXALT)				
❑ FIORICET				
Sleep Aids				
❑ diphenhydramine (NYTOL, SOMINEX)				
❑ temazepam (RESTORIL)				
❑ triazolam (HALCION)				
❑ zolpidem (AMBIEN)				
❑ eszopiclone (LUNESTA)				
❑ OTC sleep aid: _____				
Stimulants				
❑ modafinil (PROVIGIL)				
❑ amphetamine (ADDERALL)				
❑ methylphenidate (RITALIN, CONCERTA)				
❑ atomoxetine (STRATTERA)				
Atypical				
❑ olanzapine (ZYPREXA)				
❑ haloperidol (HALDOL)				
❑ ziprasidone (GEODON)				
Anti-inflammatories / NSAID's				
❑ aspirin (BAYER, EXCEDRIN)				
❑ celexicob (CELEBREX)				
❑ Ibuprofen (ADVIL, MOTRIN)				
❑ naproxen (ALEVE)				
❑ **OTHER:**				
❑ **OTHER:**				

Thank you for taking the time to fill out this document. The information above is accurate to the best of my knowledge.

Patient Signature _____ **Date** _____

Disclaimer

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Smith will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.