

# PAIN SOUTH

## PERSONAL MEDICAL INFORMATION FORM

NAME \_\_\_\_\_ APPOINTMENT DATE \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_

FAMILY DOCTOR \_\_\_\_\_

REFERRING DOCTOR \_\_\_\_\_

Name and relation of person filling out form if not self \_\_\_\_\_

### PLEASE RANK ONLY 3 MAIN PAIN COMPLAINTS

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

### Briefly describe WHEN, WHERE, and HOW you began having your pain complaint:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Accident or Injury date if applicable \_\_\_\_\_

Injury occurred: \_\_\_\_\_ At work or work related  
\_\_\_\_\_ At home  
\_\_\_\_\_ In a car accident  
\_\_\_\_\_ Unknown cause (happened spontaneously)  
\_\_\_\_\_ Other \_\_\_\_\_

Were you taken off work by a doctor? Yes / No Doctor's Name \_\_\_\_\_

Have you ever been treated for Substance Abuse? Yes / No

When and where? \_\_\_\_\_

Are you currently or have you ever been enrolled in a Methadone Clinic? Yes / No

Methadone Clinic Date of Last Visit and Dosage \_\_\_\_\_

Have you been charged with any crime concerning illegal drugs or prescription medications? Yes / No

Are you or have you ever been enrolled in law enforcement or court ordered program because of alcohol or illegal drugs or prescription medications? Yes / No

# PAIN SOUTH

TESTS PERFORMED example: MRI X-Rays Labs Myelograms Etc...	PERFORMED WHEN AND WHERE?	ORDERED BY WHAT PHYSICIAN?	TEST RESULTS REVEALED WHAT FINDINGS?	RECOMMENDED TREATMENT?

When is your worst time of day? Not Applicable / Morning / Afternoon / Evening / Night

What activities or positions cause your pain to *worsen* or start? \_\_\_\_\_

What positions, activities, treatments *improve* your symptoms? \_\_\_\_\_

How long have you had this pain? \_\_\_\_\_

How often does the pain occur and how long does it last? \_\_\_\_\_

√	Pain Description	WHERE is this type of pain located?
	constant	
	comes and goes	
	dull ache	
	sharp stab	
	throbbing	
	knots	
	cramps	
	burning	
	electrical	
	tingling / pin pricks	
	stiffness	
	soreness	
	tightness	
	stationary	
	radiates (moves)	
	numbness	



# PAIN SOUTH

## Present Function

How long are you able to walk? \_\_\_\_\_ minutes / hours  
 What prevents you from walking longer? \_\_\_\_\_  
 How long can you comfortably sit? \_\_\_\_\_  
 I am able to perform household duties/chores... Almost Always / Most of the time / Occasionally / Rarely  
 I Sleep about \_\_\_\_\_ hours at night. My sleep is....Good....Fair....Poor  
 If you have trouble sleeping, what interferes with your sleep? \_\_\_\_\_  
 List your usual activities/hobbies/chores that you enjoy and indicate if you have been able to do them since your condition has occurred:

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## Past or Present Treatment: Check ALL that you are CURRENTLY using or used in the PAST

	Modality	Last Time Used or Performed	Results
<input type="checkbox"/>	Rest at Home		
<input type="checkbox"/>	Home Exercise program		
<input type="checkbox"/>	TENS Unit		
<input type="checkbox"/>	Chiropractic Care		
<input type="checkbox"/>	Accupuncture		
<input type="checkbox"/>	Physical Therapy		
<input type="checkbox"/>	Occupational Therapy		
<input type="checkbox"/>	Work Hardening		
<input type="checkbox"/>	Epidural Nerve Blocks/Duramorphs		
<input type="checkbox"/>	Spinal column Stimulator		
<input type="checkbox"/>	Implanted Medication Pump		
<input type="checkbox"/>	Other		

## Current Medicines (name, strength, how many per day)

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## List your pharmacies and telephone numbers

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## Past Medications that Have Helped

## Past Medications that were NOT Helpful

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

## What Medications Cause What Type of ALLERGIC Reaction

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# PAIN SOUTH

## Family History

**Mother:** Living / Deceased    Medical Problems \_\_\_\_\_

**Father:** Living / Deceased    Medical Problems \_\_\_\_\_

**How many Brothers** \_\_\_\_\_ **Sisters** \_\_\_\_\_

Medical Problems \_\_\_\_\_

## Work/Employment History (more than one may be marked as needed)

<input type="checkbox"/>	Employed by _____	
<input type="checkbox"/>	Currently working	
<input type="checkbox"/>	Currently off work for now because of this medical condition	
<input type="checkbox"/>	When was the last time you worked? _____	
<input type="checkbox"/>	Retired	
<input type="checkbox"/>	Early Retirement because of disability	
<input type="checkbox"/>	Temporary Disability from Worker's Compensation	MMI given? Y N Date _____
<input type="checkbox"/>	Permanent Disability from Worker's Compensation	PPI _____% By: _____
<input type="checkbox"/>	Personal or Group Temporary Disability	FCE done? Y N Date _____
<input type="checkbox"/>	Personal or Group Permanent Disability	Restrictions: _____
<input type="checkbox"/>	Applying for group Disability or Early Retirement	_____
<input type="checkbox"/>	On Social Security Disability Income	_____
<input type="checkbox"/>	Applying for Social Security Disability	Restrictions given by: _____
<input type="checkbox"/>	Other _____	

## Do You Now Have or Ever Have Had Problems With Any of the Following Areas?

ENT     
  Eyes     
  Heart or Vessels     
  Abdomen     
  Genitourinary  
 Skin     
  Hormones     
  Muscles     
  Psychologic or Psychiatric Treatment  
 Large Weight Swings     
  Hepatitis     
  HIV (Aids Virus)  
 Other: \_\_\_\_\_

Name:

Date:

Family Physician:

All my current medications:

Medicine	Dose	Frequency	Doctor	Pharmacy
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				

**Patients Please do not write below this line**

Office Use Only:

Pain Scores: \_\_\_\_\_

Activities: \_\_\_\_\_

Self Care \_\_\_\_\_

Housebound \_\_\_\_\_

Today: \_\_\_\_\_

Exercise \_\_\_\_\_

Average This Month: \_\_\_\_\_

Work \_\_\_\_\_

Aberrant Behaviors: \_\_\_\_\_

Adverse Reactions: \_\_\_\_\_

Analgesic (Effectiveness): \_\_\_\_\_

**PainSouth, Inc.**

**Patient Authorization for Use and/or Disclosure of Protected Health Information**

Patient Name:	Date of Birth:
Address:	Social Security or Account Number:

I hereby authorize PainSouth, Inc. ("PainSouth") to use, disclose and/or obtain the above-named patient's health information as follows (*check all that apply*):

**use the following health information maintained by PainSouth until:**

Expiration Date/ will expire one year from signed date unless otherwise specified above.

**disclose the following health information to:**

Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**obtain the following health information from:**

Address: \_\_\_\_\_  
\_\_\_\_\_

Specific description of the health information to be used/disclosed/obtained (*include dates of service, i.e., appointment date, type of service, etc*): \_\_\_\_\_

This health information is used/disclosed/obtained for the following purpose (*if Authorization requested by the patient put: "At the request of the individual"*): \_\_\_\_\_

By providing this Authorization, I understand as follows:

- I understand that this Authorization may result in the sending of clinical information and x-rays with reference to the above-named patient's diagnosis and/or any alcohol, drug or child abuse problems, behavioral or mental health services, and/or information concerning sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency syndrome (HIV). I understand that these records are strictly confidential and are solely for the information of the person to whom addressed.**
- I understand that this Authorization is voluntary. I may refuse to sign this Authorization and the above-named patient's treatment and/or payment obligations will not be affected unless either of the following applies:
  - The treatment is related to research and the use and/or disclosure is related to such research; or
  - The treatment is solely for the purpose of creating protected health information for disclosure to a third-party.
- I understand that PainSouth will not receive financial or in-kind compensation or remuneration in exchange for the use and/or disclosure of the above-named patient's protected health information unless an applicable legal exception applies.
- I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by federal or state law.
- I understand that this Authorization is continuous in nature and is to be given full force and effect, including disclosing and/or utilizing any and all of the foregoing information learned or determined after the date hereof but prior to the expiration date noticed below.
- I understand that I may revoke this Authorization at any time by notifying PainSouth in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. Unless otherwise revoked, this Authorization will expire on \_\_\_\_\_ (date, event, or condition). If I fail to specify a date, event, or condition, this Authorization will expire in one (1) year.
- I understand that, upon request, I may receive a copy of this Authorization form after I sign it.



8. I understand that a photocopy or facsimile of this Authorization shall be valid and effective, just as the original.

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient's Representative (*if applicable*)

\_\_\_\_\_  
Representative's Relationship to Patient (*if applicable*)

# PAIN SOUTH

## Prescription Drug Policy and Contract

- 1. WE WILL NOT FILL OR REFILL MEDICATIONS THAT ARE LOST, STOLEN, OR DAMAGED IN ANY WAY.** All medications are controlled substances and it is your responsibility to take care of your medication. *We only refill medications during office hours.* **The answering service will not forward messages about refills until the office is open.**
- 2. ALTERING PRESCRIPTIONS IS A FELONY.** If you alter or forge any prescription you may be prosecuted. Use of **illegal drugs** may result in *immediate dismissal* from this clinic. We will not treat any patient engaged or implicated in such criminal activities.
3. Some forms of Chronic Pain can be treated with opioid pain medicines when appropriately indicated. It is your responsibility to **EXERCISE SELF-CONTROL** when taking these types of medications. You should take them only as directed. If you feel that your medication is not helping or feel that you need something stronger or different, you must call and make an appointment to talk with the nurse or doctor concerning your medication. *Please do not ask for early refills for any reason.*
- 4. We will make efforts to assure you have an appropriate supply of pain medications to treat your pain. WE MUST BE THE ONLY PHYSICIANS PRESCRIBING PAIN MEDICATIONS FOR YOU.** We will not treat or prescribe medications for patients who seek or receive pain medications from other doctors. If another **physician or practitioner** plans to provide you with a medication to treat your pain, have them **CONTACT US** to discuss and authorize the treatment. **This includes your family doctor, emergency rooms, surgeons and dentists.**
- 5. Do not take any other medications other than those prescribed for you by your doctors.** Do not give your medication to others or “borrow” medications from others. Let **ALL** your treating **doctors** know **ALL** of the **medications** you are taking and why.
- 6. If you fail to keep your follow-up appointment and run out of your medication, we will only call in enough medication to get you through to your make-up appointment.** If you fail to keep a make-up appointment after your medications have been called in for you, we will not call in any additional pain medications. You must see the doctor for an evaluation.
- 7. Periodic blood tests may be required to determine if Liver or Kidney function is being harmed, if toxic levels of medication are present, or if there are potentially dangerous drug combinations in your system.** These blood tests are NOT intended for legal purposes; rather, they help aid in treatment and compliance. The results of these tests are generally held as confidential as are the rest of your medical records. **HOWEVER,** we will cooperate fully and disclose this information to city, county, state, and federal law enforcement agencies in the event of an investigation.

***I HAVE READ, UNDERSTAND, AGREE, and WILL COMPLY WITH THIS POLICY. I UNDERSTAND FAILURE TO COMPLY WITH ANY PORTION OF THIS POLICY MAY RESULT IN IMMEDIATE DISCHARGE FROM TREATMENT AT PAIN SOUTH.***

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PATIENT SIGNATURE

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DATE



# ***PAIN*SOUTH**

## **Our Policy Regarding Missed Procedure Appointments**

**Effective 2/11/99**

We at PainSouth will continue to provide you the best service you will ever receive. As a medical practice, we are only able to schedule a certain number of patients each morning for procedures.

In the event we schedule you for a procedure, we would like to make you aware of our No-Show policy.

If you should need to cancel your scheduled procedure appointment, simply call us at 297-9801, and we will be happy to reschedule it to a day that is more convenient for you. You may also leave your cancellation request with our answering service in the event we are out of the office and we will return your call to reschedule your appointment as soon as we return. If you cancel your procedure through the surgery center you still need to call our office and leave a message to cancel with us as well. We understand that you may get sick, feel bad, have transportation problems, etc. This allows us to schedule another patient in that slot and help them.

**HOWEVER, should you fail to show up the day of your scheduled procedure and you have not notified us in advance, we will charge you \$50.00 and collect this in full. This charge is not billable to your insurance and will be payable by you.**

**Thank You**

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Patient Name

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Date

**2700 10<sup>th</sup> Avenue South, Suite 444, Birmingham, Alabama 35205  
(205) 297-9801 Fax (205) 297-9804**

7/25/2013

# **PAIN SOUTH**

## **Our Policy Regarding Missed Appointments**

**Effective 04/01/2011**

If you should need to cancel your scheduled appointment, simply call us at 297-9801, and we will be happy to reschedule it to a day that is more convenient for you. You may also leave your cancellation request with our answering service in the event we are out of the office and we will return your call to reschedule your appointment as soon as we return. **If you cancel your procedure through the surgery center you still have to call our office and leave a message to cancel with us as well or you will be charged our no show fee.** We understand that you may get sick, feel bad, have transportation problems, etc. This allows us to schedule another patient in that slot and help them.

- **Should you fail to show up the day of your scheduled procedure and you have not given us 24 hours notice, we will charge you \$50.00 and collect this in full. This charge is not billable to your insurance and will be payable by you.**
- **Should you fail to show up the day of your scheduled new patient appointment and you have not given us 24 hours notice, we will charge you \$50.00 and collect this in full. This charge is not billable to your insurance and will be payable by you.**
- **Should you fail to show up for your follow up appointment and have not given us 24 hours notice, we will charge you \$25 and collect this in full. This charge is also not billable to your insurance and will be payable by you.**

Thank you for your cooperation!

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Patient Name

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Date

2700 10<sup>th</sup> Avenue South, Suite 444, Birmingham, Alabama 35205  
(205) 297-9801 Fax (205) 297-9804

7/25/2013