PAINSOUTH

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

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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	

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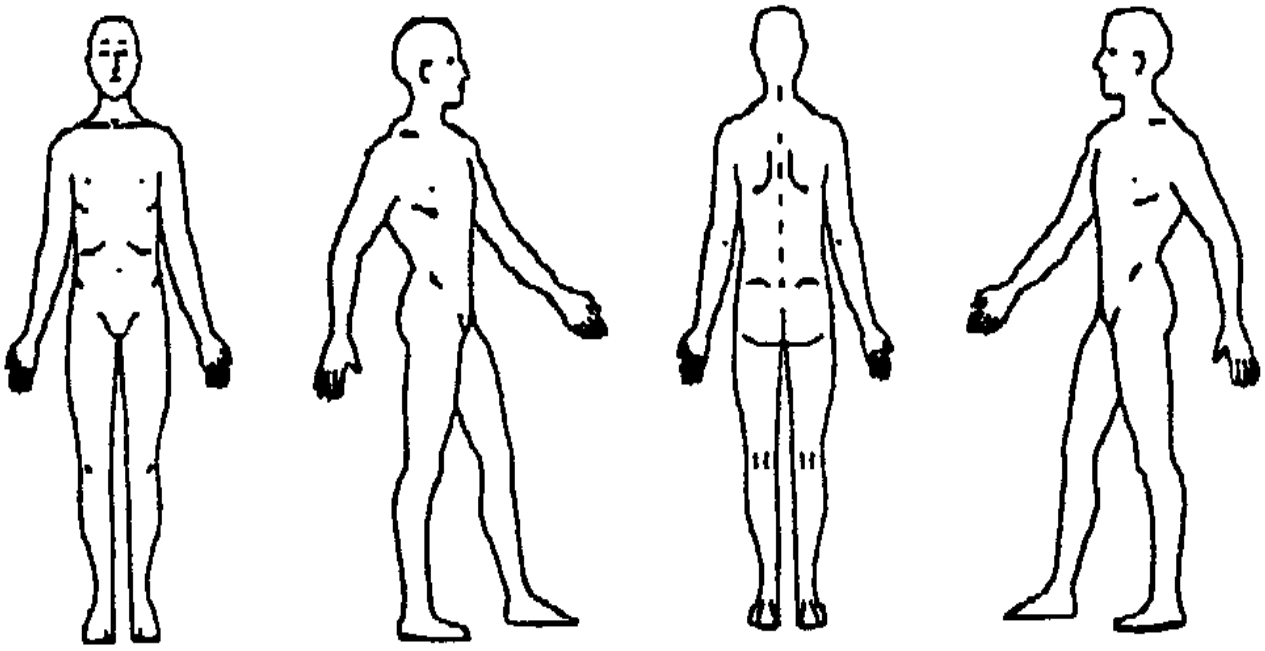
PRESENT SYMPTOMS:

Mark primary pain areas with xxxxx
Mark areas of numbness with ……..
Mark areas of weakness with ////////



ZERO = NO PAIN >>>>>>>>>>>>>>> TEN = WORST PAIN *EVER* EXPERIENCED

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

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

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

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

0 1 2 3 4 5 6 7 8 9 10

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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:

_____
_____
_____

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

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

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

_____
_____
_____
_____
_____

List your pharmacies and telephone numbers

_____
_____

Past Medications that Have Helped

_____
_____
_____

Past Medications that were NOT Helpful

_____
_____
_____

What Medications Cause What Type of ALLERGIC Reaction

_____
_____

PAINSOUTH

Your Past Medical History - Please check or List all OTHER medical conditions:

- [ ] Heart Disease
- [ ] Lung Disease
- [ ] Kidney Disease
- [ ] Diabetes
- [ ] High Blood Pressure
- [ ] Peptic Ulcer Disease or severe Heart Burn
- [ ] Arthritis
- [ ] Other _____
- [ ] Other _____
- [ ] Other _____

Your Past Surgical History - Please list all operations and procedures you have ever had

DATE	OPERATION	SURGEON

Social History

Marital Status ____Single ____Divorced ___Separated
____Married ____Remarried ___Widowed

Children:	number	ages	live at home	deceased
boys				
girls				

Do you smoke? YES / NO How much? _____ How long have you smoked?

Do you drink alcohol? YES / NO What type?_____ How much? _____

Do you currently use "Street" drugs like marijuana, cocaine, etc? yes no What?_____

PAINSOUTH

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)

- ☐ Employed by _____
- ☐ Currently working
- ☐ Currently off work for now because of this medical condition
- ☐ When was the last time you worked? _____
- ☐ Retired
- ☐ Early Retirement because of disability
- ☐ Temporary Disability from Worker's Compensation — MMI given? Y N Date_____
- ☐ Permanent Disability from Worker's Compensation — PPI _____% By:_____ _____
- ☐ Personal or Group Temporary Disability — FCE done? Y N Date_____
- ☐ Personal or Group Permanent Disability — Restrictions:_____
- ☐ Applying for group Disability or Early Retirement — _____
- ☐ On Social Security Disability Income — _____
- ☐ Applying for Social Security Disability — Restrictions given by:_____
- ☐ 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 ___Psycologic 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:

Today: _____

Average This Month: _____

Activities: Self Care _____

Housebound _____

Exercise _____

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:**	□ **disclose the following health information to**:	□ **obtain the following health information from:**
_____ **Expiration Date/ will expire one year from signed date unless otherwise specified above.**	_____ **Address**:_____ **City, State, Zip**:_____ **Phone**:_____	_____ **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:

1. **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.**

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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*)	

PAINSOUTH

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 PAINSOUTH.

_____ _____

PATIENT SIGNATURE **DATE**

1424 Carraway Blvd. Suite 200, Birmingham, Alabama 35234
(205) 297-9801 Fax (205) 297-9804

PAINSOUTH

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 <u>procedure</u> 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

_____
Patient Name

_____
Date

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

PAINSOUTH

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 <u>procedure</u> 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 <u>new patient appointment</u> 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 <u>follow up</u> 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!

_____

Patient Name

_____

Date

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