ANDREW HUFF, M.D.

201 RIDGE STREET SUITE 102
COUNCIL BLUFFS, IA 51503

Shelly Schutte, P.A.-C

OFFICE: (712) 396-4359
FAX: (712) 396-4358

____
(Patient's Name)

Enclosed please find a copy of our patient registration form, which needs to be completed and brought with you to your appointment on___________________________________.

Please be sure to bring:

- Insurance Card
- Photo ID
- **Co-Pay (Due at time of service)**
  If you do not have insurance, $150 is due at time of visit
- X-rays, CT, and MRI reports
- Medication List
- This packet of completed information

Failure to provide the above information could result in rescheduling your visit.

No Show Policy:
$50.00 will be charged to you if you fail to notify our office
Within 24 hours to reschedule or cancel your appointment.

Bluffs Pain Management
201 Ridge St., Suite 102
Council Bluffs, IA 51503
Phone 712-396-4359
Fax 712-396-4358

PATIENT INFORMATION (Please Print) REGISTRATION FORM

Patient's Name____Age_____________

DOB_____________Sex___M____F Social Security #_______________________________

Address_________________________________City & State_____________________________

Zip Code____________________ Phone # (____)___________________________________

Email Address___________________________Family Physician___________________________

Patient's Employer____________________________Phone # (____)_________________________

Address_________________________________City & State_____________________________

Zip Code____________________ Spouse____

Alternate Contact in Case of Emergency ____

Address_________________________________City & State_____________________________

Zip Code____________________ Phone # (____)___________________________________

Relationship____

How did you hear about Bluffs Pain Management ?__________________________________

What pharmacy do you use?____

We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient and he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections from insurance companies and will credit such collections to the patient's account.

PAYMENT AUTHORIZATION____

I,_______________________________, hereby authorize Bluffs Pain Management to furnish information concerning my present illness. I direct the insurer to pay with equivocation, directly to the physician, all benefits due him as a result of this claim. Although covered by insurance, I an aware that I am personally responsible for all charges. A photostatic copy of this authorization will be as valid as the original.

*Signature of Patient*____________________________________*Date*____________________

PATIENT MEDICAL HISTORY

DATE THAT YOUR SYMPTOMS BEGAN OR DATE OF YOUR INJURY: ______________________________

HAVE YOU HAD ANY PREVIOUS PROBLEMS? ☐ YES ☐ NO | IF YES, WHEN? ______________________

IS THE CURRENT PROBLEM A RESULT OF: ☐ WORK RELATED ACCIDENT ☐ MOTOR VEHICLE ACCIDENT

IF THIS IS A WORK-RELATED INJURY, IS YOUR VISIT TODAY RELATED TO A WORKERS COMPENSATION CLAIM? ☐ YES ☐ NO

HOW DID THE INJURY OCCUR OR SYMPTOMS BEGIN? (PLEASE GIVE A BRIEF EXPLANATION):

____

____

____

IF CURRENTLY WORKING, IS THE PAIN AFFECTING YOUR WORK? IF YES, HOW? ______________________

PLEASE LIST ANY OTHER ACTIVITIES LIMITED BY YOUR PAIN: ______________________

HOW WOULD YOU DESCRIBE YOUR PAIN?

☐ CONTINUOUS
☐ INTERMITTENT
☐ DULL
☐ ACHING
☐ HEAVY
☐ THROBBING
☐ SHARP
☐ SHOOTING
☐ STABBING
☐ TENDER
☐ GNAWING
☐ PRESSURE
☐ BURNING/HOT
☐ CRAMPING
☐ TINGLING | EXHAUSTING
☐ SICKENING
☐ FEARFUL
☐ PUNISHING | CRUEL

PLEASE LIST ANY OTHER AREAS OF PAIN: ______________________

____

____

RATE YOUR PAIN: 0 = NO PAIN | 10 = WORST PAIN IMAGINABLE

CURRENTLY: ______________________

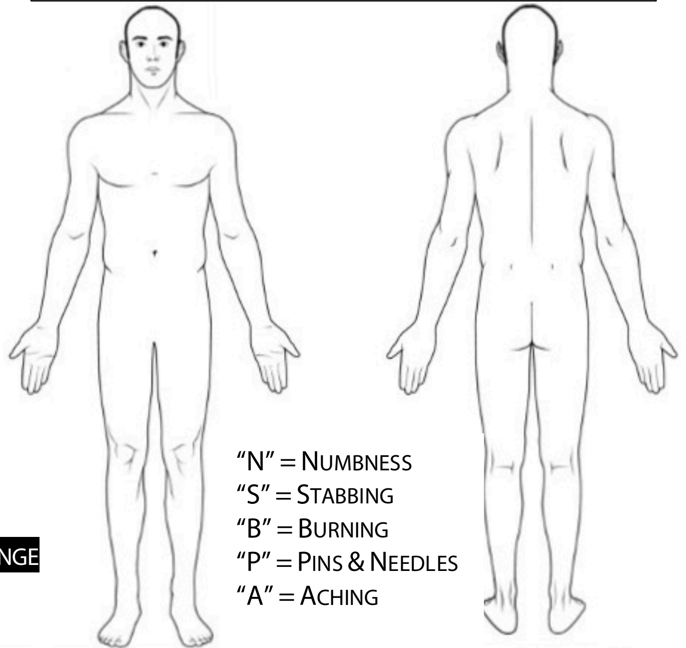
AT YOUR BEST: ______________________

AT YOUR WORST: ______________________

HOW DO THE FOLLOWING ACTIVITIES AFFECT YOUR PAIN?

	INCREASES PAIN	DECREASES PAIN	NO CHANGE
RESTING	☐	☐	☐
LYING DOWN	☐	☐	☐
SITTING	☐	☐	☐
STANDING	☐	☐	☐
BENDING	☐	☐	☐
WALKING	☐	☐	☐
CHANGING POSITIONS	☐	☐	☐
WORKING	☐	☐	☐
COUGHING/SNEEZING/STRAINING	☐	☐	☐
LIFTING	☐	☐	☐
PROLONGED POSITION	☐	☐	☐

PLEASE DRAW THE LOCATION OF YOUR PAIN USING THE KEY BELOW:



"N" = NUMBNESS
"S" = STABBING
"B" = BURNING
"P" = PINS & NEEDLES
"A" = ACHING

ARE YOU EXPERIENCING:

☐ NUMBNESS | TINGLING WHERE? ______________
☐ WEAKNESS
☐ LOSS OF BOWEL/BLADDER CONTROL?
EXPLAIN: ______________________
☐ SLEEP DISTURBANCE
☐ ANXIETY
☐ DEPRESSION

Pain Treatment History

Treatment

☐ I Have Had No Treatment For My Symptoms To Date

Please Select All Of The Following Treatments That You Have Used For Pain Relief:

	Helped Pain	Worsened Pain	No Change	Dates Of Visit
Acupuncture				
Biofeedback				
Brace Support				
Chiropractic				
Electrical Stimulation				
Hot/Cold Packs				
Injection Therapy				
Massage Therapy				
Medications				
Physical Therapy				
Tens Units				
Traction				

Pain Clinic

☐ I Have Not Been Treated By Another Pain Physician Or Clinic

Please List The Names Of Other Pain Physicians You Have Seen, Along With A Brief Description Of Therapy Received:

Facility | Physician	Description Of Therapy	Dates

Psychological | Behavioral Therapy

☐ I Have Not Been Treated For Psychological health

Please List The Names Of Physicians You Have Seen, Along With A Brief Description Of Therapy Received:

Facility | Physician	Description Of Therapy	Dates

Steroid Injections

☐ I Have Not Had Any Injections

If You Have Had Any Injections, Please Provide The Information Below:

Date	Location (Low Back, Neck?)	Performed By MD Or CRNA?	X-Ray Guided? Y Or N	Relief? No Or Mild	Relief? Temporary Or Long Lasting ?	Made Symptoms Worse? Y Or N

Results Of Injection

Spine Surgery

☐ I Have Not Had Spine Surgery

If You Have Had Spine Surgery In The Past, Please Provide The Information Below:

Date	Location (Low Back, Neck?)	Name Of Surgeon	Relief? No Or Mild	Relief? Temporary Or Long Lasting ?	Made Symptoms Worse? Y Or N

Results Of Injection

Diagnostics Tests And Imaging

☐ I Have Not Had Any Diagnostic Tests Performed For My Current Pain Complaints

Please Provide Information For All Of The Following Tests You Have Had That Are Related To Your Current Pain Complaints:

Test	Of The (Neck, Back)	Date	Facility
MRI			
X-RAY			
CT			
EMG			
MYELOGRAM			
OTHER:			

Current Medications | Vitamins & Supplements:

Please List All Medications That You Are Currently Taking, Including Vitamins and Supplements:

Medication Name	Dose	Frequency

Surgical History

☐ I Have Never Had Any Surgical Procedures Performed

Please List Any Surgical Procedures You Have Done In The Past, Including The Date:

Surgical Procedure	Dates

Did You Experience An Adverse Reaction To The Anesthesia? ☐ Yes ☐ No

If Yes, Please Explain:

____

____

_

Allergies

Do You Have Any Drug/Medication Allergies? ☐ Yes ☐ No

If So, Please List All Medications You Are Allergic To:

Medication Name	Allergic Reaction

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ Iv Contrast

☐ Other Medical Problems:____

____

Social History

Occupation: ______________________________ Employer: ______________________________

Are You Currently Working? ☐ Yes ☐ No ☐ Retired ☐ Disabled ☐ Unemployed

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Education: ☐ Elementary School ☐ High School Diploma ☐ GED ☐ Some College ☐ College Degree ☐ Trade School

Do You Exercise? ☐ Yes ☐ No If Yes, What Type Of Exercise? ______________________________

Hobbies | Interests: ____

Alcohol Use: ☐ Yes ☐ No Amount: ____________________

Tobacco Use: ☐ Yes ☐ No Amount: ____________________ E-Cigarette Use: ____________________

Illicit/Recreational Drug Use:

☐ Denies Any Illicit/Recreational Drug Use ☐ Currently Uses Illicit/Recreational Drugs

☐ Formerly Used Illicit/Recreational Drugs (Not Currently Using)

Have You Ever Abused Narcotic Or Prescription Medications? ☐ Yes ☐ No

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AUTHORIZATION FOR RELEASE OF INFORMATION

I AUTHORIZE Bluffs Pain Management to disclose information from the medical records to the extent necessary to obtain Payment of the clinic and/or physicians accounts. Information may be released to Any person, corporation, governmental or private review agency including but not Limited to workers compensation, insurance carriers, employers and medical services companies which may be liable for all or part of the clinic's charges or May require information for review of medical treatment. Information may also be Disclosed to the referring physician or to other health care providers, facilities or Agencies. I understand that the clinic will protect the patient's rights to Confidentiality of medical information but I release the clinic from liability when responding in good faith to an apparent valid request for such information.

I herby authorize any insurance company, organization, employer, hospital, physician, surgeon or pharmacy to release any information requested by Bluffs Pain Management. A photostatic copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF PATIENT___________________________________DATE______________