THE NEXus PAIN CENTER OF COLUMBUS

WE LOOK FORWARD TO MEETING WITH YOU ON YOUR APPOINTMENT

ON_____@_____ EST (ARRIVAL TIME) WITH:

DR CHANG DR. OGLESBY DR. PRINSELL

PLEASE RETURN YOUR NEW PATIENT PACKET TO OUR OFFICE 5 DAYS BEFORE YOUR SCHEDULED APPOINTMENT. **WITHOUT THIS PACKET WE WILL HAVE TO RESCHEDULE YOUR APPOINTMENT.**

THIS CAN BE MAILED TO:

7351 OLD MOON ROAD

COLUMBUS, GA 31909

FAXED TO: 706-653-7800

EMAILED TO: _____@nexuspaincenter.com

OR DROPPED OFF AT THE ABOVE ADDRESS

ALL MEDICATIONS MUST BE BROUGHT TO THE OFFICE IN THE ORGINAL BOTTLES TO INCLUDE ANY SUPPLEMENTS AND OVER THE COUNTER MEDICATIONS.

COPAYMENT IS EXPECTED AT THE TIME OF APPOINTMENT OR YOU APPOINTMENT WILL BE RESCHEDULED.

APPOINTEMENTS THAT ARE NOT CANCELED WITHIN 24 HOURS OF NOTICE WILL BE ASSESSED A $50.00 NO SHOW FEE.

The NEXus Pain Center of Columbus, LLC &

North Columbus Surgery Center

SMOKING POLICY

THIS IS A

SMOKE FREE FACILITY

THANK YOU
FOR NOT SMOKING

Please adhere to the above guidelines. As we are a smoke free facility, please extinguish before coming on the premises.

GA CODE 31-12A-A

The NEXus Pain Center of Columbus, LLC

Patient Information and Expectations

Welcome to **The NEXus Pain Center of Columbus, LLC**. Enclosed is a packet of information that will need to be completed in its entirety prior to your appointment. If you have any questions, a member of our staff will be available to help you at the time of your appointment.

What you need on your first visit with **The NEXus Pain Center of Columbus, LLC**:

- The New Patient Packet completely filled out.
- A copy of your medical records from any other physicians that you have seen regarding your current complaint(s).
- All of the medication(s) you are currently taking. Please bring the actual bottles with you.
- All insurance cards. All Co-Payments and deductibles will be due at time of service. Failure to pay your bill can result in discharge from the practice.
- All **SELF PAY** patients are expected to pay all payments at the time of service.

What to expect from your visit with **The NEXus Pain Center of Columbus, LLC**:

- Prompt, professional and courteous service from all **The NEXus Pain Center of Columbus, LLC** employees.
- A thorough history of your pain will be obtained as well as treatments you may have received in the past. You will then be examined by the physician.
- As a courtesy to our patients, your insurance will be filed for you by **The NEXus Pain Center of Columbus, LLC**. You will then be responsible for any and all charges not paid by your insurance company. Workers Compensation will be filed for the full amount of your bill.
- There will be a **$50.00 NO SHOW fee** charged to your account if you fail to cancel or reschedule an appointment 24 hours prior to the designated appointment time.

The NEXus Pain Center of Columbus, LLC is NOT a primary care facility. You must obtain a referral to make an appointment with The NEXus Pain Center of Columbus, LLC. Once you have reached maximum medical improvement, you will follow up with your primary care physician for continued care.

Acknowledgement of Patient Information and Expectations

By signing below, I_____, have read and understand the information given to me from **The NEXus Pain Center of Columbus, LLC** of the Patient Information and Expectations.

_____ _____/_____/_____

SIGNATURE/GUARDIAN **Date**

WELCOME TO THE NEXus PAIN CENTER OF COLUMBUS

Patient Demographics

Patient's Legal Name:_____ SS #:_____

DOB:_____ Marital Status: **Married / Divorced/ Separated/ Widowed**

Gender: **M / F** Race/Ethnicity:_____

Email Address:_____

Address:_____ City:_____

State:_____ Zip Code:_____ Home Phone:_____

Cell Phone:_____ Work Phone:_____ ext:____

Employers Name:_____

Spouse Name:_____ SS#:_____

Emergency Contact information – Name #1:_____

Relationship to you:_____ Best Phone Number:_____

Emergency Contact information – Name #2:_____

Relationship to you:_____ Best Phone Number:_____

Circle of Care : Primary Care Phyisican:_____

Referring Physician or List your other Doctors:_____

Primary Insurance Information

Most of the information requested below can be found on your insurance card. If you have more than one insurance policy and do not know which one is your primary, please let us know and we will investigate for you. It is considered insurance fraud if you choose to use the secondary insurance plan as your primary.

Primary Insurance Company's Name:_____

Policy #_____ Group #_____

Person Insured:_____ DOB:_____

Relationship to Insured:_____

SS# of the Insured if not SELF:_____

Secondary Insurance Information

- o I do not have a secondary insurance policy (if checked leave the section below blank)

Secondary Insurance Company's Name:_____

Policy #_____ Group #_____

Person Insured:_____ DOB:_____

Relationship to Insured:_____ SS# if not SELF:_____

I verify that all the above information is correct. I hereby authorize payment of medical benefits billed to my insurance by The NEXus Pain Center of Columbus, LLC. I accept responsibility for any/all payments not made by insurance company for services rendered by The NEXus Pain Center of Columbus, LLC. I understand that payment is due at time of service for all co-pays, deductibles, and coinsurance or out of network fees. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information in this packet and have completed the answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____/_____/_____

Patient or Guardian Signature **Date**

The NEXus Pain Center of Columbus, LLC

PAYMENT AUTORIZATION PRIVACY REGULATIONS

I request that payment of authorized benefits be made to **The NEXus Pain Center of Columbus, LLC.** I authorize any holder of my medical information to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine the benefits or the benefits payable for related services.

SIGNATURE/GUARDIAN_____ DATE_____/_____/_____

I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any health care related to utilization review or quality assurance activities or to any healthcare professional requiring this information in order to treat me.

I hereby assign and authorize payment **to The NEXus Pain Center of Columbus, LLC** for all medical and/or surgical benefits, including major medical policies, to which I am entitled under any insurance policy or policies, any self-insurance programs, or any other type of benefit plans.

I understand and acknowledge that this assignment of the benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf. I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to **The NEXus Pain Center of Columbus, LLC** by any insurance policy, self-insurance program, or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

PERSON PROVIDING THE AUTHORIZATION_____

RELATIONSHIP TO PATIENT, IN NOT PATIENT_____

DATE:_____/_____/_____

NOTICE OF PRIVACY PRACTICES

I have been offered a copy of the **"NOTICE OF PRIVACY PRACTICES"** for my records.

SIGNATURE/GUARDIAN:_____**DATE:**_____/_____/_____

The Nexus Pain Center of Columbus, LLC
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective February 23, 2015

Our Confidentiality Commitment. The Nexus Pain Center of Columbus, LLC takes the privacy of health information seriously and is committed to protecting your privacy. This notice describes our practices related to the privacy of your health information and how we may use the information we collect and maintain related to your care. We must provide you a copy of our privacy practices upon your request. We may change what this notice says, but we will provide you with information about any changes made the next time you receive services from us or if you request our updated privacy practices from us.

Meaning of "you," "we," "us," and "our." In this notice, when we say "we," "us," or "our," we mean our office and all of its employees, staff, volunteers, and providers. When we say "you," "your," or "yours," we mean you as an individual and/or your designated personal representative.

Understanding Your Personal Health Information. Personal health information is any information created and used by us, or received from a health care provider, about your health care. Information may include your name, address, birth date, phone number, social security number, health insurance policies, health information, your diagnoses, and the medical treatments you received.

How We Use Your Personal Health Information. Except as explained in this notice, we will only use or share your personal health information with your written authorization. Most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes, and disclosures for the sale of information require your authorization. If you authorize us to share your personal health information with anyone, you may revoke your authorization at any time and we will no longer share information with that person or entity. Please note that if you choose to revoke an authorization, we may have already relied on your consent to share information and your revocation of consent will only apply once it is received by us.

We may use your personal health information for treatment, payment, and health care operations without your written authorization. We may perform other treatment, payment, or healthcare operations not specifically listed below in which we may use your health information. The following is intended to serve as examples of the types of activities in which your health information may be used. "Treatment" refers to the care we provide to you, including coordinating and managing your care with other providers. Uses for "payment" include our activities to collect amounts owed for the services provided to you. These activities may include, for example, sending a bill to your insurance company for services covered under your insurance plan, managing your account internally or with associated businesses we may contract with for

the collection of payment, and/or sending statements to collect remaining amounts owed. "Health care operations" means activities related to assessing the quality of care we provide, developing care guidelines, coordinating care, contacting other providers or you to discuss care options, training our workforce, business management and administrative activities, customer service, and investigation and resolution of complaints.

We may also use or disclose your personal health information to:

- Keep you informed about appointments, program information, and benefits and services that may be of interest to you;
- Notify another person responsible for your care if necessary;
- Communicate with any person you identify about your care or payment for your care;
- Business associates that perform functions on our behalf;
- Other agencies as required for oversight activities such as licensure, inspections, investigations, audits, or Facility Accreditation;
- Law enforcement personnel for specific purposes, including reporting any suspected child abuse or neglect;
- Staff or research projects that ensure the continued privacy and protection of protected health information;
- Public health agencies to prevent or control disease and for statistical reporting, to the Food and Drug Administration for reporting reactions to medications, Worker's Compensation for benefit coordination, to government agencies in cases of national security or for military purposes, or to correctional institutions;
- Comply with any law, regulation, or code requiring us to report certain information;
- Respond to a court order, or subpoena if efforts have been made to tell you about the request or to obtain an order protecting the information requested; and
- Share with our business partners who perform case management, coordination of care, other assessment activities, or payment activities, and who must abide by the same confidentiality requirements.

Your Health Information Rights. You have the following rights regarding your personal health information maintained by our office:

- You may request restriction on certain uses and disclosure of your information. If you request we restrict disclosures of your information for payment or operations purposes to your health plan and pay in full for the services you ask be restricted, we must agree to your request unless sharing the information is required by law. You may request other restrictions on the use and disclosure of your information, but we are not required to agree to those requests. If your request is approved, we will abide by it except in an emergency treatment situation or as required by law;

- If you feel that some information our office has created about you is wrong, you may ask that we change that information. You must send us your request to change or correct your information in writing to the Privacy and Security Officer listed at the bottom of this notice and include an explanation of why you would like the information to be changed. In certain situations, we may deny your request. We will notify you if we deny your request and tell you how to request a review of the denial;
- You may inspect and obtain a copy of your personal health information in our possession. We may limit or deny you access only in very limited circumstances. You have the right to request a review of most denials. We will notify you if we deny your request and tell you how to request a review of the denial. We may charge a fee for copies you request for personal use;
- You may obtain a paper or electronic copy of this notice upon request;
- You may revoke a signed authorization for the use or disclosure of your protected health information except to the extent we have already acted based on your authorization;
- If you request, we will account for disclosures we have made of your protected health information made by us, except for disclosures made to you, under an authorization, for treatment, payment, or health operations purposes, and a limited other situations. We will not charge for the first accounting given to you in a twelve-month period. We may charge a fee for an additional accounting requested in that twelve-month period for the cost of producing the accounting of disclosures for you;
- You may request that we contact you about personal health care matters only in a certain way (phone, e-mail, in writing) and at a certain location (home, office, at an address you have given); and
- If there has been a breach of your health information, you will be notified unless we determine, after thorough risk analysis, that there is a low probability your information has been compromised.

For More Information or to Report a Problem. If you have questions, complaints, or concerns related to our privacy practices, please contact the Privacy and Security Officer whose contact information is provided below. It is our policy to take questions, complaints, and concerns seriously and you will not be retaliated or discriminated against, or penalized in any way if you choose to communicate your concerns about our privacy practices with us.

Privacy and Security Officer
7351 Old Moon Road
Columbus, GA 31909
Phone: (706) 653 – 700

You may also file a complaint with the Secretary of the Department of Health and Human Services by visiting the Department of Health and Human Service's Health Information Privacy website or contact the Office for Civil Rights.

THE NEXus
PAIN CENTER
of Columbus, LLC

MEDICAL INFORMATION RELEASE FORM

(HIPAA Release Form)

Name:_____ **Date of Birth:**_____/_____/_____

Primary Car Physician:_____

First Name **Last Name**

Release of Information

( ) I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

( ) Spouse _____

( ) Child(ren)_____

( ) Other_____

( ) **Information is not to be release to anyone.**

The Release of Information will remain in effect until terminated by me in writing.

MESSAGES

Please call ( ) my home ( ) my work (my cell Number):_____

If unable to reach me:

( ) you may leave a detailed message on my ( ) Home ( ) Cell ( ) anyone stated above

( ) please leave a message asking me to return your call

( ) _____

Signed:_____ Date:_____/_____/_____

Witness:_____ Date:_____/_____/_____

The NEXus Pain Center of Columbus, LLC

APPOINTMENT NO SHOW POLICY

Our schedules stay very full. Our **NO SHOW** policy is designed to encourage our patients to give us an opportunity to offer appointment times to others if you are unable to make your appointment. Patients who do not cancel or reschedule by 12 Noon the day prior to their appointment or who fail to show up for their scheduled appointment **will be charged $50.00** for their missed appointment. This charge is **NOT** covered by insurance and cannot be **waived**. This charge **must** be paid before your next visit with physician.

If you fail to show up for 3 appointments, you are subject to discharge from the practice.

Please be considerate of our other patients and call our office if you are not able to keep or make your appointment. For your convenience, we have initiated an automated reminder system; however this is a courtesy. It is ultimately your responsibility to keep track of your appointments. The reminder system will call you 48 hours in advance of your appointment. It is also posted to your patient portal.

Your cooperation in this matter is greatly appreciated.

By Signing below, I (patient name)_____, have read and understand the no show policy and agree to abide by the guidelines listed above.

SIGNATURE/GUARDIAN:_____ **DATE:**_____/_____/_____

THE NEXus PAIN CENTER OF COLUMBUS, LLC
Release of Medical Information

Permission to get records

I, _____,with a date of birth,_____, give my permission for
(patient name) (patient's DOB)

_____to give my medical records (as described on p. 2) to
(doctor's or hospital name who has records)

_____so that he/she can better understand my condition and help me.
(my doctor's name)

Permission to get sensitive information

By putting my initials by each item below, I understand that I give permission for records to be sent that may contain information about:

_____ my mental health,
_____transmittable disease I may have like HIV/AIDS,
_____genetic records, and/or
_____drug and alcohol records.

I understand that:

- **I do not have to give my permission to share these records.**
- **If I want to take away the permission for my doctor to get these records, I need to talk to my doctor or a staff person and sign a paper.**
- **This form is only good for 1 YEAR from the date I sign it.**
- **If I would like a copy of my medical records for myself, I will pay the fee of $25.00 or more depending on the depth of my records**

Patient's Signature_____ Date _____

Authorized Representative's Signature_____ Date_____

Relationship of Authorized Representative_____

Consent for release of medical records for _____
(patient name)

Date: _____

Requesting records from:

Name of Practice:_____

Name of Physician:_____

Fax number:_____

Address:_____

Types of records we are requesting

☐ Any and all types of records you have for this patient

☐ Doctor visit notes
☐ Emergency Room notes
☐ Urgent care notes
☐ History and physical
☐ Hospital Progress Notes
☐ Operation or procedure notes
☐ Clinic notes
☐ Pathology reports
☐ Doctors orders
☐ Nurses notes
☐ Discharge Summary
☐ Lab reports
☐ Radiology Reports
☐ Consultations
☐ Other _____

Records within the following dates:

☐ **All records for this patient**

☐ **Records dated between _____and _____**

Please send records to:

Attention: MEDICAL RECORDS

At fax number: 7065-653-7800

Or mail to: THE NEXUS PAIN CENTER OF COLUMBUS, LLC

7351 OLD MOON ROAD

COLUMBUS, GA 31909

For any questions please call (phone number): 706-653-7000 EXT. 222

Name (please print) _____ Date of Birth _____

The NEXus Pain Center of Columbus, LLC

Informed Consent and Controlled Substances Agreement

I, _____, understand and agree to follow the policies of The NEXus Pain Center (NPC) as set forth below. I understand that NPC is under no obligation to prescribe these medications for me. I also understand that there may be other, more reasonable treatment options available for my condition that my doctor may recommend instead of or in addition to the use of these medications.

DEFINITIONS OF OPOIDS, BENZODIAZAPINES, AND OTHER CONTROLLED SUBSTANCES

I understand the definitions of these medications to be:

1. Opioid – An opioid medication is a derivative or morphine or similar compound and thus has strong pain relieving properties.
2. Benzodiazepine – A Benzodiazepine is a drug that is related to Valium. Their primary role is for the treatment of anxiety.
3. Other related drugs – For the purpose of this agreement "other related drugs" includes medications such as muscle relaxants (e.g., Flexerill), membrane stabilizers (e.g., Neurontin), and non-narcotic analgesics (e.g., Ultram). These medications may cause sedation, altered mental status, occasionally dangerous withdrawal effects when stopped abruptly, and may have medication interactions similar to or different from opioids or benzodiazepines.
4. Controlled Substance – For the purposes of this agreement, a controlled substance will apply to opioids, benzodiazepines, or other related medications as described above.3

RISKS OF OPIOIDS, BENZODIAZAPINES, AND OTHER RELATED MEDICATIONS ("CONTROLLED SUBSTANCES")

I understand that these medications have potential risks with the most significant being:

1. Physical Dependence – the abrupt discontinuation of controlled substances could lead to withdrawal symptoms such as abdominal cramping, diarrhea, anxiety, hypertensive crisis, cardiac arrest or other cardiac dysfunction, seizures, and death.
2. Psychological Dependence or Addiction – the use of these medicines may lead to behavior focused on obtaining and misuse of the controlled substances.
3. Overdose – may lead to respiratory arrest and death.
4. Altered Mental Status – These classes of medications may cause4 confusion, sedation, drowsiness, problems with coordination and changes in thinking ability. This may make it unsafe for you to drive a motor vehicle, operate hazardous equipment and machinery, or perform dangerous activities. Other side effects may include but are not limited to, the following: nausea, constipation, unsteadiness, decreased appetite, difficulty urinating, depression, and loss of sexual drive with testicular atrophy (in males).

Name (please print) _____ Date of Birth _____

The NEXus Pain Center of Columbus, LLC

CONDITIONS OF AGREEMENT

1. Nexus Pain Center of Columbus will work closely with Law Enforcement to prevent any diversions.
2. I understand that I will be screened through resources like PDMP (Prescription Drug Monitoring Program) for medications that are prescribed to me.
3. I understand that Controlled Substances may be prescribed by my physician only if he determines that such treatment has a reasonable chance of improving my quality of life, ability to participate in work activities and social activities.
4. I do not currently have problems with substance abuse (drugs and/or alcohol).
5. I am not involved in the use, possession, diversion, or transport of illegally obtained controlled substances.
6. I agree to use these medications only as prescribed to me and will not take more of these medications than instructed.
7. I understand the risk of controlled substances to unborn children and will notify NPC if I am or become pregnant.
8. I will obtain controlled substances only from NPC and not from any other source unless a true medical emergency exists. I will notify NPC in advance of any anticipated acute needs (dental work or surgery).

9. I agree to accept generic brands of my controlled substances if available.
10. If it appears to my physician that the use of controlled substances is not providing a demonstrable therapeutic benefit such as improvement in daily function or improved ability to participate in the treatment program, if the controlled substance being prescribed are expected to be in the mainstay of pain treatment when other medical options exist and are practical, or that addiction, rapid loss of effect, or significant side effects are developing, I agree to gradually taper my medication as directed. If a substance abuse problem is suspected, I understand that I may be referred for evaluation and management of the problem.
11. I agree to keep my scheduled appointments prepared to provide a urine sample, failure to provide a sample may result in suspension of treatment with controlled substances and possibly discharge from NPC.
12. I agree to bring my medication to the office for random pill counts to assess compliance with treatments. Failure to provide medications for inspection may result in suspension of opioid treatment.

13. I agree to comply with my physicians' request for additional imaging studies, lab tests, diagnostic procedures (with separate informed consent), and referrals to additional specialists as recommended by my physician.
14. I understand that NPC is a specialty consulting practice. The NPC staff will communicate with my Primary Care Provider, Specialists, Pharmacists, therapists, and Family to assist in determining the best course for continued treatment for chronic pain. My care may be transferred back to my Primary Care Provider for continued prescriptions of controlled substances once my medical regimen has been optimized.

15. All of my controlled substance prescriptions will be filled at the same pharmacy. Should I choose to change pharmacies, I will notify NPC immediately.
16. **Early refills are not allowed.** Medications may be prescribed at office appointments only. The NEXus Pain Center will not prescribe any medication after hours or on weekends. The NEXus Pain Center will not prescribe replacement medications should they become misplaced, stolen, or destroyed.

Name (please print) _____ Date of Birth _____

The NEXus Pain Center of Columbus, LLC

17. If a controlled substance is not providing adequate therapeutic benefit and the controlled substance is changed, I understand that I must return or bring that controlled substance to my next appointment or to the office to be destroyed before any new prescriptions will be given to me. I understand that I am **NOT** to destroy the medication or dispose of it any way other (e.g. flushing).
18. I am seeking treatment for pain. The NEXus Pain Center is under no obligation to treat or prescribe medication for any other medical condition to include: high blood pressure, bronchitis, pneumonia, anxiety, depression, or any chronic medical condition. If I am referred to a Primary Care Provider or other specialist for a medical or mental condition, I will make and keep that appointment in a timely manner.
19. I authorize NEXus Pain Center to obtain a prescription history report on my behalf as part of my ongoing treatment.
20. I understand that I am to take my medication as prescribed. I am not to take any more than the daily doses that my prescription specifies. If for any reason I do not feel as though my medications are providing the adequate pain relief then I will call the office for instructions before I take any more medication other than my prescribed dose.

I understand that any violation of this agreement may pose a health risk to myself and others and may result in a discontinuation of treatment with controlled substances if deemed medically prudent. Violation of this agreement may result in dismissal from the care of The NEXus Pain Center as well as reporting any illegal activities to appropriate law enforcement agencies. All patients who demonstrate difficulties managing their controlled substance medications will be referred to an Addiction Psychiatrist and/or Clinical Psychologist for further evaluation.

I have read this document, understand it, have had all questions regarding risks and conditions of the agreement answered satisfactorily, and I agree to all of its elements.

Patient Signature: _____ **Date:** _____

Witness: _____ **Title:** _____

SOAPP-R

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
(Circle the answer that most applies to you)					
1. How often do you have mood swings?	0	1	2	3	4
2. How often have you felt a need for higher doses of medication to treat your pain?	0	1	2	3	4
3. How often have you felt impatient with your doctors?	0	1	2	3	4
4. How often have you felt that things are just too overwhelming that you can't handle them?	0	1	2	3	4
5. How often is there tension in the home?	0	1	2	3	4
6. How often have you counted pain pills to see how many are remaining?	0	1	2	3	4
7. How often have you been concerned that people will judge you for taking pain medication?	0	1	2	3	4
8. How often do you feel bored?	0	1	2	3	4
9. How often have you taken more pain medication than you were supposed to?	0	1	2	3	4
10. How often have you worried about being left alone?	0	1	2	3	4
11. How often have you felt a craving for medication?	0	1	2	3	4
12. How often have others expressed concern over your use of medication?	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
14. How often have others told you that you had a bad temper?	0	1	2	3	4
15. How often have you felt consumed by the need to get pain medication?	0	1	2	3	4
16. How often have you run out of pain medication early?	0	1	2	3	4
17. How often have others kept you from getting what you deserve?	0	1	2	3	4
18. How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4
19. How often have you attended an AA or NA meeting?	0	1	2	3	4
20. How often have you been in an argument that was so out of control that someone got hurt?	0	1	2	3	4
21. How often have you been sexually abused?	0	1	2	3	4
22. How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
23. How often have you had to borrow pain medications from your family or friends?	0	1	2	3	4
24. How often have you been treated for an alcohol or drug problem?	0	1	2	3	4
TOTAL					

Name:_____ Signature:_____ Total:

DOB:_____ Date:_____ MD Signature:

Today's Date:_____

THE NEXus PAIN CENTER OF COLUMBUS, LLC

NAME:_____
First Middle Last

DOB:_____ REFERRING PHYSICIAN:_____

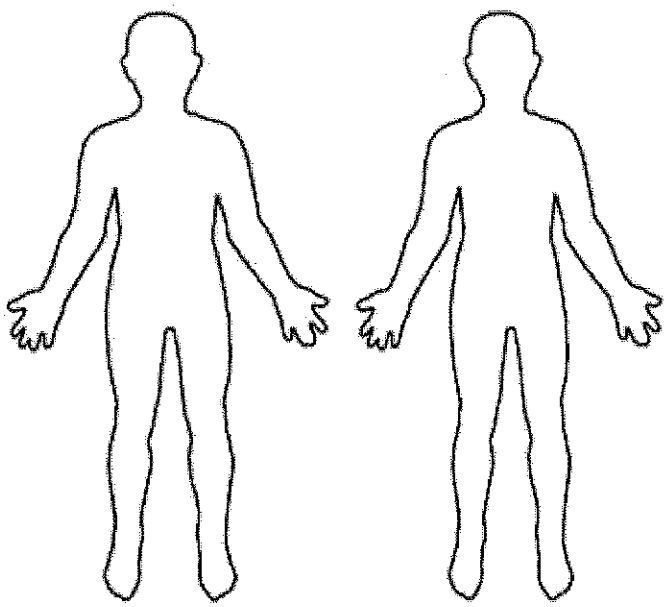
PRIMARY CARE PHYSICIAN:_____

PAIN HISTORY:

LOCATION: Use the figures below to shade in the area where you have pain. If your pain moves around, put an "X" where it starts and draw an arrow to where it spreads.

FRONT **BACK**

RIGHT **LEFT** **LEFT** **RIGHT**



CHIEF COMPLAINT: **Check mark the boxes below and circle R/L**

Where is/are your chief area (s) of Pain? Describe, or check below_____

	Head		Upper back		Legs R L
	Neck		Lower back		Arms R L
	Chest		Groin		Hands R L
	Abdomen		Buttocks		Feet R L

MEDICATIONS:

Please list all of your current medication, including both prescription and "over-the-counter" medications. **LIST PAIN MEDICATION FIRST.**

MEDICATION	STRENGTH	TIMES PER DAY	EFFECTIVENESS

Please list any other **pain medication** you have **tried in the past.**

MEDICATION	STRENGTH	TIMES PER DAY	EFFECTIVENESS

I AUTHORIZE NEXus PAIN CENTER TO OBTAIN A PRESCRIPTION HISTORY REPORT ON MY BEHALF AS PART OF MY ONGOING TREATMENT.

SIGNATURE:_____ DATE:_____

Patient Name:_____

PAST MEDICAL HISTORY: Please check nay of the following medical problems you have had or presently have:

- Sleep Apnea
- Cancer
- Head Injury
- Migraines
- High Blood Pressure
- Heart Problems ( )Heart Stent ( )Heart Disease ( )Pacemaker/ICD
- Arthritis
- Ulcer
- Neurologic Disease
- Seizures
- Stroke
- Respiratory Problems ( )COPD ( )Asthma ( )Emphysema ( ) Bronchitis ( )Acute Respiratory Distress Syndrome (ARDS)
- Kidney Problems ( )Kidney Failure ( )Kidney Disease ( )Kidney Stones
- Bleeding Problems ( )Deep Vein Thrombosis (DVT) ( )Blood Clots ( )Bloodthinners
- Infectious Disease ( )HIV/AIDS ( )MRSA ( )Hepatitis ( )Cirrhosis ( )Other
- Diabetes ( )Insulin Dependent ( )Insulin Pump ( )Medication Only ( )Both Insulin & Medications

PLEASE NOTIFY OUR OFFICE BEFORE YOUR APPOINTMENT IF YOU ARE COMING IN FOR A PROCEDURE.

Have you ever been under the care of Psychiatrist or mental health professional? YES OR NO

If yes, please list diagnosis and dates of treatment (ex. Bipolar, Depression, Schizophrenia, etc):
Diagnosis:_____ Date:_____
Diagnosis:_____ Date:_____

ALLERGIES: Please list all mediation allergies below with reactions:

Have you ever had a reaction to Iodine, Shellfish or Contrast Dye? **YES** or **NO**

Are you allergic to Latex? **YES** or **NO**

PATIENT NAME:_____

PAST SURGICAL HISTORY:

Please list all past surgeries and hospitalizations.

DATE	PROCEDURE/ILLNESS	DATE	PROCEDURE/ILLNESS

FAMILY HISTORY:

Please check below if you have a family history of any of the following:

	Brother	Sister	Mother	Father	Aunt	Uncle	Grandfather	Grandmother
Diabetes								
Cancer								
Heart Disease								
Stroke								
Hypertension								
Migraines								
Chronic Pain								
Anesthetic Problems								
Other								

SOCIAL HISTORY:

Marital Status:

What is your current marital status?

	Single		Living with significant other		Married		Divorced		Widowed

Has your marital status changed since your pain problem began? **Circle your answer**: YES NO

Number of Children living with you:_____

What is the highest level of education you've finished?_____

PATIENT NAME:_____

Employment:

Are you currently working? **Circle your answer:** YES NO RETIRED Occupation_____

If yes, where?_____ Does it involve heavy lifting? YES NO

Is this the same occupation you had before your pain started? YES NO

If you are not working, has pain forced you to stop working? YES NO

If you are not working, what was your occupation before your pain became a problem?_____

Is there pending litigation? YES NO

Is your claim being filed under your private insurance? YES NO

Are you currently receiving disability **benefits**? YES NO

If yes, when did your disability start?_____

For what reason was your disability granted (diagnosis on your disability)_____

Are you being treated under Worker's Compensation? YES NO

Have you been to any other pain clinics in the past? YES NO If yes, please list_____

I verify that all the above information is correct. I hereby authorize payment of medical benefits billed to my insurance by **The NEXus Pain Center of Columbus, LLC**. I accept responsibility for any/all payments not made by my insurance company for services rendered by **The NEXus Pain Center of Columbus, LLC**. I understand that payment is due at time of service for all co-pays, deductibles, coinsurance, or out of network fees. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information in this packet and have completed the answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Patient Signature:_____ Date:_____

PATIENT NAME:_____

Habits:

Are you a: Check **the boxes below**

	Current smoker		Unknown if ever smoked
	Former smoker		Light tobacco
	Non Smoker		Heavy tobacco smoker
	Current every day smoker		Uses tobacco in other forms
	Current some day smoker		
	Smoker, current status unknown		

Additional Findings: Tobacco - Are you: **Check the boxes below**

	Chain smoker		Moderate cigarette smoker (10-19 cigs/day)
	Chew fine cut tobacco		Pipe smoker
	Chews loose leaf tobacco		Rolls own cigarettes
	Chews plug tobacco		Snuff user
	Chews twist tobacco		Trivial cigarette smoker (less than one cigarette/day)
	Heavy cigarette smoker (20-30 cigs/day)		User of moist powdered tobacco
	Light cigarette smoker (1-9 cigs/day)		Very heavy cigarette smoke (40+ cigs/day)

	Aggressive non-smoker		Ex-trivial cigarette smoker (<1/day)
	Current non-smoker		Ex-user of moist powdered tobacco
	Current non-smoker, but past smoking history unknown		Ex-very heavy cigarette smoker (40+/day)
	Does not use moist powdered tobacco		Intolerant ex-smoker
	Ex-cigar smoker		Intolerant non-smoker
	Ex-cigarette smoker		Never chewed tobacco
	Ex-cigarette smoker amount unknown		Never used moist powdered tobacco
	Ex-heavy cigarette smoker (20-30/day)		Non-smoker for medical reasons
	Ex-light cigarette smoker (1-9/day)		Non-smoker for personal reasons
	Ex-moderate cigarette smoke (10-19/day)		Non-smoker for religious reasons
	Ex-pipe smoker		Tolerant ex-smoker
			Tolerant non-smoker

PATIENT NAME:_____

Do you drink alcohol?

	Yes
	No

If yes:

How often did you have a drink containing alcohol in the past year?

	Never
	Monthly or less
	Two to four times a month
	Two to three times per week
	four or more times a week

How many drink did you have on a typical day when you are drinking in the past year?

	1 or2
	3 or 4
	5 or 6
	7 to 9
	10 or more

How often did you have six or more drinks on one occasion in the past year?

	Never
	Less than montly
	Monthly
	Weekly
	Daily or almost daily

PATIENT NAME_____

DIRECTIONS: PLEASE CHECK THE BOX THAT CORRESPOINDS WITH YOUR ANSWER.

CONSTITUTIONAL (PHYSICAL OR MENTAL CONDITION)

Have you had any of these symptoms within the last 3 month?

excessive weight gain		Yes		No
loss of appetite		Yes		No
fever		Yes		No
weight loss		Yes		No
fatigue (excessive tiredness)		Yes		No

MUSCOLOSKELETAL

Do you currently experience any?

joint pain		Yes		No
joint swelling		Yes		No
joint stiffness		Yes		No
muscle cramps		Yes		No

NEUROLOGY

Do you currently experience?

headaches		Yes		No
tingling or numbness		Yes		No
seizures		Yes		No
recent memory loss		Yes		No
tremors		Yes		No
imbalance		Yes		No
weakness in arms		Yes		No
weakness in legs		Yes		No
loss of feeling (one side)		Yes		No
loss of feeling in legs		Yes		No

PATIENT NAME_____

OPOID MANAGEMENT

Do you currently experience?

myclonus (twitching)		Yes		No
Nausea/vomiting		Yes		No
itching rash		Yes		No
constipation		Yes		No
sedation		Yes		No
Diaphoresis (profuse sweating)		Yes		No
Edema (swelling)		Yes		No
dry mouth		Yes		No
blurred vision		Yes		No
hallucination, weird dreams		Yes		No
headaches				

ALLERGY

Do you currently experience?

runny nose		Yes		No
sinus congestion		Yes		No
stuffy nose		Yes		No

CARDIOLOGY

Do you currently experience?

dizziness		Yes		No
chest pain (angina)		Yes		No
irregular heartbeats		Yes		No
leg swelling		Yes		No

ENDOCRINOLOGY

Do you currently experience?

excessive sweating		Yes		No
heat intolerance		Yes		No
excessive thirst		Yes		No
excessive urination		Yes		No
cold intolerance		Yes		No
heat intolerance		Yes		No

PATIENT NAME_____

ENT

Have you experienced any of these symptoms within the last 3 months?

cold		Yes		No
cough		Yes		No
nose bleed		Yes		No
hearing loss		Yes		No
change in voice		Yes		No
sore throat		Yes		No
ringing in ears		Yes		No
ear pain		Yes		No

GASTROENTEROLOGY

Do you currently experience?

vomiting		Yes		No
abdominal pain		Yes		No
diarrhea		Yes		No
constipation		Yes		No
change in bowel habits		Yes		No
blood in stool		Yes		No
nausea		Yes		No
constant heartburn		Yes		No

HEENT

Have you experienced any of these symptoms within the last 3 months?

change in vision		Yes		No
loss of hearing		Yes		No
loss of smell		Yes		No
trouble swallowing		Yes		No

HEMATOLOGY/LYMPH

Have you experienced any of these symptoms within the last 6 months?

abnormal bruising		Yes		No
abnormal bleeding		Yes		No
varicose veins		Yes		No
enlarged lymph nodes		Yes		No

PATIENT NAME_____

FEMALE REPRODUCTIVE (IF YOU ARE MALE, DO NOT ANSWER)

Do you currently experience?

heavy periods		Yes		No
Are you sexually active?		Yes		No
painful periods		Yes		No
post menopausal		Yes		No

MALE REPRODUCTIVE (IF YOU ARE FEMALE, DO NOT ANSWER)

Do you currently experience?

difficulty with erection		Yes		No
diminished sexual drive		Yes		No
impotence		Yes		No
difficulty urinating		Yes		No

PSYCHOLOGY

Do you currently experience?

depression		Yes		No
high stress level		Yes		No
sleep disturbances		Yes		No
suicidal ideations		Yes		No
been hospitalized for psychiatric conditions		Yes		No
are you receiving counseling		Yes		No

RESPIRATORY

Do you currently experience?

shortness of breath		Yes		No
excessive sputum		Yes		No
wheezing		Yes		No
cough		Yes		No

PATIENT NAME:_____

Depression Screening: Check below

Little interest or pleasure in doing things:

_____Not at all
_____Several Day
_____More than half the day
_____Nearly every day

Feeling down, depressed, or hopeless

____Not at all
____Several Day
____More than half the day
____Nearly every day

Trouble falling or staying asleep, or sleeping too much

_____Not at all
_____Several Day
_____More than half the day
_____Nearly every day

Poor appetite or overeating

____Not at all
____Several Day
____More than half the day
____Nearly every day

Feeling tired or having little energy

_____Not at all
_____Several Day
_____More than half the day
_____Nearly every day_____

Feeling bad about yourself or that you are a failure or have let yourself or your family down

_____Not at all
_____Several Day
_____More than half the day
_____Nearly every day

Trouble concentrating on things, such as reading the newspaper or watching television

_____Not at all
_____Several Day
_____More than half the day
_____Nearly every day

Moving or speaking so slowly that other people could have noticed. Or the opposite of being fidgety

_____Not at all
_____Several Day
_____More than half the day
_____Nearly every day

Thoughts that you would be better off dead, or of hurting yourself in some way

_____Not at all
_____Several Day
_____More than half the day
_____Nearly every day

PATIENT NAME:_____

DURATION:

When did your pain start? Date:_____

ONSET:

Under what circumstances did your pain begin?

_____Accident/Injury at work
_____Accident/Injury
_____Motor vehicle accident
_____Following illness
_____At work, but not an accident
_____Secondary to repetitive activity
_____Following surgery
_____Pain began unrelated to activity

FREQUENCY: Check mark the boxes below

How often do you have this pain?

	Constantly		Daily		Weekly		Monthly

What time of day is your pain the worst?

	Morning		Afternoon		Evening		Night

What time of the day is your pain the least?

	Morning		Afternoon		Evening		Night

RADIATION OF PAIN:

Does your pain travel anywhere? **Circle your answer: YES NO If yes, where?**_____

SEVERITY: Circle the numbers below

Rate the severity of your pain **right now** by circling the corresponding number below.

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10**(Worst Pain)**

Rate the severity of your pain on **average** by circling the corresponding number below.

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10**(Worst Pain)**

Character

What is your pain like? **Please circle** Aching Throbbing Burning Pulsating Shooting Stabbing

Associated Signs & Symptoms:

Are you experiencing any of the following?

	YES	No	Location or Descriptions
rash			
tingling			
numbness or muscle weakness			
bladder or bowel dysfunction			
fever			
visual disturbance			

PATIENT NAME_____

Aggravating and alleviating factors:

What activities or factors improve or worsen your pain? **Please check all that apply**.

Activity	Worse	Relieves	No Change
exercise			
climbing stairs			
walking			
standing			
sitting/driving			
lying down			
lifting weight			
bright lights			
cold			
heat			
noise			
stress			
weather change			
rest			
touch			
pressure			
other (please list)			

Effects on Activities of Daily Living:

Are their areas of your life that have been adversely affected by your pain problem? **Check below all those that apply and please describe.**

_____Sleep _____

_____Appetite _____

_____Relationships _____

_____Work _____

_____Finances _____

_____Physical Activity _____

Use of Alcohol, or Recreational Drugs _____

Have you had physical therapy? **Please Circle** Yes No

If yes, When?_____ Where?_____ How long?_____

PATIENT NAME_____

Treatments:

What treatments have you received for your pain in the past? **Please check if helpful or not helpful**

Treatment	Helpful	Not Helpful	Comments
Surgery			
Never Blocks			
Steroid Injection/Epidurals			
Trigger Point Injection			
Acupuncture			
TENS Unit			
Heat/Ice Treatment			
Biofeedback			
Physical Therapy			
Chiropractic Treatment			
Relaxation Training			
Counseling			
Pain Medications			
Other (explain)			

Diagnostic Testing:

Have you had any of the following tests performed within the past 24 months?

Test	Date	Facility where test was done
X-ray film		
CT scan		
MRI		
EMG		
Nerve Conduction		
Laboratory		
Discogram		
Myelogram		
Other (explain)		

PATIENT NAME_____

PRIMARY CARE DOCTOR	PHONE	ADDRESS

	SPECIALISTS NAME	PHONE	ADDRESS
Neurologist			
Rheumatologist			
Surgeon (s)			
Surgeon (s)			
Orthopaedic (s)			
Orthopaedic (s)			
Psychiatrist/Psychologists			
Cardiologist			
Others (Please List)			

PHARMACY	PHONE	ADDRESS