ALLAY SPINE & PAIN MANAGEMENT

New Patient Medical History Questionnaire

Please complete this form to provide information regarding your medical condition. Feel free to ask your primary care physician for assistance. All information will be kept confidential. Please return the completed questionnaire with the following:

- ☐ Current insurance authorization for an initial surgical consultation.
- ☐ Photocopy of the front and back of your insurance card.

Name: _____ Date of Birth: _____ Age: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Primary Language: _____

Address: _____ City/State/Zip: _____

Social Security Number: _____ Driver's License Number: _____ State: _____

Occupation: _____ Employer's Name: _____

Employer's Address: _____ Business Phone: _____

Marital Status: _____ Number Dependents: _____

Spouse's Name: _____ Spouse's Employer: _____

Spouse's Employer Address: _____ Spouse's Business Phone: _____

Emergency Contact (other than above): _____

Relationship: _____ Phone Number: _____

Medical Insurance Information

Primary Insurance Company: _____ Policy Holder and DOB: _____

Subscriber Number: _____ Group Number: _____

Insurance Company Address: _____

Secondary Insurance Company: _____ Policy Holder and DOB: _____

Subscriber Number: _____ Group Number: _____

Insurance Company Address: _____

Is the reason for this consultation work related? Y/N

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Consent to Treat

I authorize the doctor to perform such examinations, treatments, laboratory tests, and to administer such medications as, in his opinion, are necessary or advisable for myself.

Patient's Signature: _____ Date: _____

Consent to Treat Minors

This section is to be completed by the parent or guardian for all patients whom wish to be examined or treated that are under the age of 18.

I authorize the doctor to perform such examinations, treatments, laboratory tests, and to administer such medications as, in his opinion, are necessary or advisable for the minor patient:

Print patient's name: _____

Patient's Signature: _____ Date: _____

Release of Information

I authorize the release of any medical information necessary to process any claims and request payment of insurance proceeds including any major medical benefits to the undersigned physician or clinic. This will also serve as authorization for this office to obtain insurance information from Medicare or any other insurance company regarding any claims submitted in my behalf. A copy of these signatures are as valid as the original.

Patient Signature: _____ Insured's Signature: _____

Date: _____ Date: _____

Consent to Payment

I understand that I am responsible for payment of all charges incurred on behalf of myself and my families regardless of insurance benefits.

Patient's Signature: _____ Insured's Signature: _____

If patient is not the responsible party for this bill, please indicate who is responsible:

Name: _____ Relationship to Patient: _____

Address: _____ City/State/Zip: _____

Contact Phone: _____ Email Address: _____

Employer: _____ Occupation: _____

Employer's Address: _____ City/State/Zip: _____

Responsible Party Social Security Number: _____ Responsible Party Date of Birth: _____

ALLAY SPINE & PAIN MANAGEMENT

Consent to Use and Disclose Protected Health Information

How We May Use and Disclose Your Health Information
Your protected health information will be used by Allay Spine and Pain to disclose to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

The Notice of Privacy Practices
The physicians are required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" that is located in our office. **Please review it carefully**.

You May Place Restrictions on the Use or Disclosure of Your Health Information
You may request a restriction on the use or disclosure of your protected health information. However, Allay Spine and Pain may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative or the Privacy Officer if you would like additional information or clarification.

It is a violation of the federal privacy standards if Allay Spine and Pain agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the notice of Privacy Policies, please consult with a practice representative or **Shanda Scifres, Practice Manager and Privacy Officer**.

You May Revoke This Consent at Any Time
You may revoke this consent at any time; however, Allay Spine and Pain requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of the request.

Changes to Privacy Practices
The physicians reserves the right to change or modify the privacy practices outlined in the Notice of Privacy Policies. Allay Pain and Spine will notify you of any changes of privacy practices either by mail, at your next appointment, or any other pre-approved method of request.

Signature
I have reviewed this consent form, received the brochure entitled "Notice of Privacy Policies and Practices" and give my permission to Allay Spine and Pain to disclose my health information in accordance with this consent and the notice provided.

Patient Name (Print): _____

Patient Representative (Print): _____

Signature of Patient or Representative: _____

Date: _____

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Providers

Names of the doctors who referred you, your primary care doctor, and any other doctor from whom you are receiving care

Doctor who referred you: _____ Phone Number: _____ Fax Number (if known): _____

Primary care physician: _____ Phone Number: _____ Fax Number (if known): _____

Other pertinent physician: _____ Phone Number: _____ Specialty: _____

Have you seen a Pain Management Physician in the past? YES NO

Name of Physician	Dates of Treatment	Reason for Leaving

Have you ever been evaluated by a surgeon for your main pain complaint? YES NO

Name of Surgeon	Date	Was surgery recommended? YES NO

Please list any diagnostic imaging and include body location and date:

X-ray: _____

MRI: _____

CT: _____

How did you find this practice?

- ☐ Referred by a friend/relative
- ☐ Referred by a physician or other provider
- ☐ Referred by my insurance
- ☐ Website/Internet: _____
- ☐ Magazine: _____

New Patient Intake Form

ALLAY SPINE & PAIN MANAGEMENT

Name:_____DOB:_____

Pain History Background

What is your main pain complaint?

How long has this pain been present?

Years Months

Pain History

Work related injury Date:_____

Motor vehicle accident Date:_____

Fall or other trauma Date:_____

Following Surgery Date:_____

Following illness Date:_____

Unknown reason

Other_____

Does your pain radiate?

Arms L / R Legs L / R None

What words best describe how the pain feels?

Sharp Burning Shooting Deep Tender

Stabbing Throbbing Aching Pressure Shocking

Dull Tingling Sore Other_____

How often is the pain present? Constant

Frequent (several times per hours} Sporadic (several times per day}

Occasional (several Times per week} Rare (sever times per month}

/s the pain associated with any other symptoms?

None Difficulty walking

Numbness: Where _____

Weakness: Where_____

Bladder incontinence Bowel incontinence

Other: _____

Does the Pain affect your sleep? Yes, significantly Occasionally No

What makes your pain better?

Rest Heat Cold Medication ⌀ercise

Other_____

What makes your pain worse?

Heat Cold MedicaΘon Bending/TwisΘng

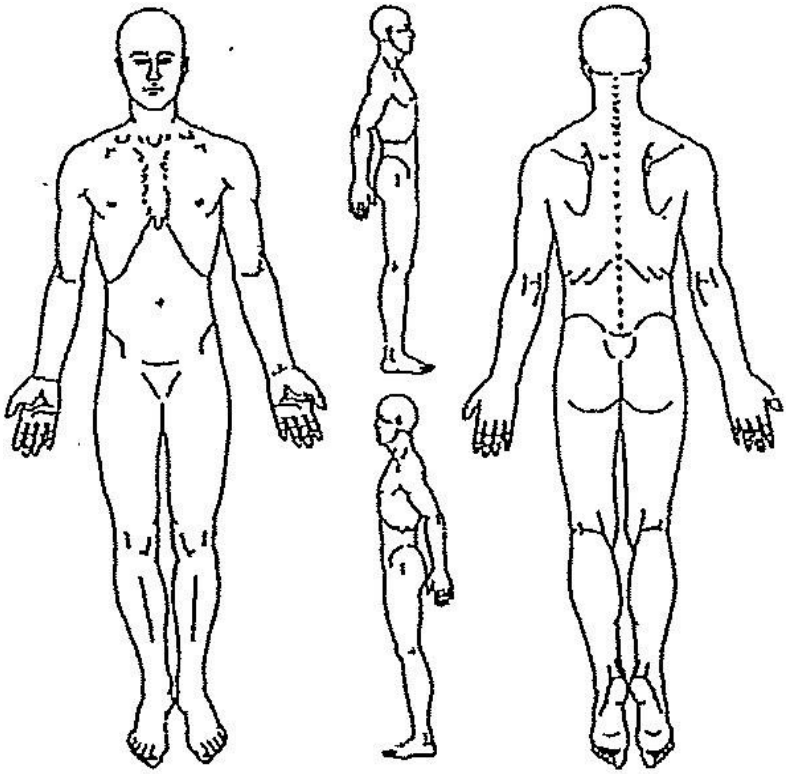
Sitting Standing Lying down Coughing/Sneezing

Stress Exercise Nothing Standing from sitting

Other:----------

Pain locations (please circle)

Numbness and Tingling (mark with X)



Please indicate your current pain										
0	1	2	3	4	5	6	7	8	9	10
Please rate your worst pain in the last week										
0	1	2	3	4	5	6	7	8	9	10
Please rate your least pain in the last week										
0	1	2	3	4	5	6	7	8	9	10

Review of Systems

Fever	Nausea/Vomiting	Insomnia
Night sweats	Constipation	Diarrhea
Rash	Vision Loss	Bleeding
Chest Pain	Difficulty Walking	Cough
Incontinence	Muscle Weakness	Leg Swelling
Anxiety/Depression	Myalgias (muscle pains)	Memory Loss/Confusion
Fatigue	Sensory Changes	Abdominal Pain/cramping

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Past Medical History

Please check any illnesses you have had in the past.

- ☐ Allergies, Seasonal (hay fever)
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Bleeding or clotting disorder
- ☐ Blood Transfusion (history of)
- ☐ Cancer
- ☐ Chronic Bronchitis/COPD
- ☐ Congestive Heart Failure
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Drug / Alcohol Abuse
- ☐ Fibromyalgia
- ☐ Gallstone or gallbladder disease
- ☐ GERD/heartburn/acid reflux
- ☐ Headache/Migraine
- ☐ Heart Arrhythmia
- ☐ Heart Disease
- ☐ Hepatitis / Fatty Liver
- ☐ High blood pressure (Hypertension)
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Intestinal / Inflammatory Bowel Disease
- ☐ Kidney disease
- ☐ Liver disease / Hepatitis
- ☐ Mental health condition
- ☐ Myocardial infarction (heart attack)
- ☐ Obstructive Sleep Apnea
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's disease
- ☐ Seizures
- ☐ Spinal Stenosis
- ☐ SLE / Lupus
- ☐ Stroke
- ☐ Sciatica
- ☐ Thyroid disease
- ☐ Other (please list):_____

_____

_____

Past Surgical History

Please check any operations you have had.

- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Breast surgery
- ☐ Carpal Tunnel Release
- ☐ Coronary artery bypass surgery
- ☐ Neck Surgery
- ☐ Cholecystectomy (gallbladder removal)
- ☐ Gastric Bypass
- ☐ Colon surgery
- ☐ Pacemaker
- ☐ Cosmetic surgery
- ☐ Spinal Stimulator
- ☐ Caesarean section (C-section)
- ☐ Tonsillectomy
- ☐ Eye surgery
- ☐ Thyroidectomy
- ☐ Joint Surgery
- ☐ Hysterectomy (uterus removal)
- ☐ Joint replacement
- ☐ Prostate surgery
- ☐ Small intestine surgery
- ☐ Tubal ligation
- ☐ Valve replacement
- ☐ Transplant
- ☐ Other (please list): _____

_____

Hospitalizations

Have you ever been hospitalized? If YES, please list:

Date:	Reason:
_____	_____
_____	_____

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Medications (you may attach a list)

Medication	Dose	How Often	Reason	Prescriber

Allergies

Have you ever had a reaction to any of the following? (Please select either **YES** or **NO** for each)

Latex Yes _____ No _____

Iodine Yes _____ No _____

IV Contrast Yes _____ No _____

Are you allergic to any medications? If so, list the medication and the reaction that you had. Examples of reactions include anaphylaxis/shock, rash, itching, nausea/vomiting, and shortness of breath.

Medication	**Reaction**

Consent for Medication History

I authorize the doctor to access my medication history via an online portal from participating pharmacies.

Patient's Signature: _____ Date: _____

Primary Pharmacy

Pharmacy Name: _____ Pharmacy Number: _____

Secondary Pharmacy

Pharmacy Name: _____ Pharmacy Number: _____

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What are your goals besides pain relief?

Please select 1 (one) or more

- ☐ Return to work or be more productive at work
- ☐ Improve ability to interact with family and friends
- ☐ Reduce medication usage
- ☐ Improve Quality of Life
- ☐ Other:_____

Social History

Do you live alone?	Y / N
Do you have difficulty dressing yourself?	Y / N
Are you receiving any special help at home?	Y / N
History of falls?	Y / N
Have you ever had thoughts of hurting yourself or someone else?	Y / N
History of Alcoholism?	Y / N
History of Drug Abuse?	Y / N
History of Physical / Sexual Abuse?	Y / N

Do you drink alcohol? Yes _____ No _____

If yes, what is your average number of:

_____glasses of wine/week

_____cans of beer/week

_____shots of liquor/week

Do you use drugs recreationally? Yes ____No____

If yes, which drugs: _____

Smoking History (please circle):

Current Former Passive Never

How many packs per day do you smoke? _____

How many years have you smoked? _____

Marital Status (please circle):

Single Married Divorced Widowed

Children:

How Many? _____Ages: _____

Highest Level of Education (please circle): GED High School College Vocational Graduate None

Work Status (please circle):

Fulltime Part time Disability Worker Compensation Retired

Family History

Please list any significant medical problems in your family: ADOPTED

Mother: _____ Living? Y / N

Father: _____ Living? Y / N

Sibling: _____ Living? Y / N

Grandparent: _____ Living? Y / N

Aunt/Uncle: _____ Living? Y / N

Child: _____ Living? Y / N

ALLAY SPINE & PAIN MANAGEMENT

SCREEN AND OPIOID ASSESSMENT FOR PATIENTS WITH PAIN—REVISED (SOAPP®-R)

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.	0	1	2	3	4
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in the home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					

ALLAY SPINE & PAIN MANAGEMENT

PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

The purpose of this agreement is to give you information about the medications you may be taking for pain management and to ensure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. Controlled substances can be considered for moderate to severe pain with the intent of reducing pain and improving function. The goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician-patient relationship and full agreement and understanding of the risks and benefits of using controlled substances to treat pain.

1. You should use one physician to prescribe and monitor all controlled substances.
2. You should use one pharmacy to obtain all controlled substances prescribed by your physician. Should the need arise to change pharmacies, please notify us.
3. You should inform your physician of ALL medications you are currently taking, including herbal medicines, since controlled substances can interact with over-the-counter medications and other prescribed medications, e.g. cough syrup that contains codeine. *Please bring an updated medication list with you to each appointment*.
4. You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment. You are to take the medications as prescribed.
5. Prescriptions will be refilled during appointments only.
6. You may be asked to bring medication bottles to your appointments for pill counts.
7. You are responsible for keeping your pain mediation in a safe and secure place, such as a locked cabinet or safe. Stolen medications should be reported to the police and to your physician immediately. *Lost or stolen prescriptions will not be refilled*.
8. It is against the law to give, share, or sell your medications to any other person.
9. The use of alcohol and controlled substances is not advised and could result in death.
10. There are side effects with controlled substances which may include skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, swelling, sedation, or the possibility of impaired cognitive function and/or motor ability. *Overuse of opioid medications can diminish your drive to breathe.*
11. If you have a history of alcohol or drug misuse/addiction, you must notify the physician of such history since the treatment with controlled substances for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for treatment for pain with controlled substances but starting or continuing a program for recovery is mandatory.
12. You agree to allow your physician to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions, if the physician feels it is necessary. If the responsible legal authorities have questions concerning your treatment, as might occur, for example if you obtained medications at several pharmacies, all confidentiality is waived and these authorities may be given full access

Patient Initials:_____

to your Allay Spine and Pain Management records. In the event that you are arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given to you.

13. You also agree to a family conference or a conference with a close friend or significant other, if the physician feels it is necessary.
14. You agree and understand that your physician reserves the right to perform random or unannounced urine drug testing. If requested to provide a urine sample, you agree to cooperate. If you decide not to provide a urine sample, you understand that your doctor may change your treatment plan, including safe discontinuation of your controlled substances when applicable or complete termination of the physician-patient relationship. The presence of a non-prescribed drug or illicit drug in the urine can be grounds for termination of your physician-patient relationship. Urine drug testing is not forensic testing, but is done for your benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain. You accept responsibility for the cost of the urine drug test in the event that your healthcare coverage will not cover the cost of this test.
15. You may be required to participate in remote monitoring for medication compliance as part of your treatment plan.
16. You should not use any illicit substances, such as cocaine, heroin, methamphetamines, marijuana, etc. while taking these medications. This may result in a change in your treatment plan, including safe discontinuation of your prescribed controlled substances when applicable or complete termination of the physician-patient relationship.
17. Any evidence of drug hoarding, acquisition of any controlled substances from other physicians (which includes emergency rooms and urgent care centers), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the physician-patient relationship.
18. If it is discovered that a history of alcohol, medication, or substance abuse has been withheld or denied, the medications may be discontinued or the physician-patient relationship may be discontinued.

I understand that if I violate any of the above conditions, my prescription for controlled substances may be terminated immediately. If the violation involves obtaining controlled substance medications from another individual, or the use of non-prescribed illicit drugs, I may also be reported to all of my physicians, medical facilities, and appropriate authorities. I have read this agreement and the same has been explained to me by Allay Spine and Pain Management staff. In addition, I fully understand the consequences of violating this agreement may include cessation of therapy with controlled substances and/or discharge from Allay Spine and Pain Management.

_____ _____

Patient Signature Date

ALLAY SPINE & PAIN MANAGEMENT

Name of Individual:_____
Other Names used: _____
Date of Birth: _____
Address: _____
Phone: _____ Email: _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:
Person/Organization:_____
Address:_____
Phone: _____ FAX: _____

WHO CAN RECEIVE AND USE THIS HEALTH INFORMATION?
Person/Organization: Allay Spine and Pain Management PLLC
Address: 3725 S LAKE FOREST DR #114 MCKINNEY, TX 75070
Phone: 469-545-1082 FAX: 469-545-1083

Reason for disclosure (circle one)

Treatment/continuity of care	Personal Use	Billing or Claim
Disability Determination	Insurance	Legal Purposes
School	Employment	Other

SIGNATURE_____ DATE_____

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of either the death of the individual; the individual reaching age of majority; the permission is withdrawn; or the following specified date:
_____

* By signing I understand that the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also understand that my health records may include information relating to AIDS, HIV, and/or sexually transmitted disease.