

PATIENT FACE SHEET

Patient Name: _____

DOB: _____ **Gender:** **Female** **Male**

Race: **African American** **Hispanic or Latino** **White** **Other**

SSN: _____

Address: _____

Marital Status **Single** **Married** **Divorced** **Widowed**

Employment Status **Employed** **Unemployed** **Retired** **Disabled**

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Emergency Contact:

Name: _____

Phone: _____

Relationship: _____

Primary Care Provider: _____

Pharmacy Name: _____

Location: _____

Phone: _____

Primary

Insurance: _____

Effective Date: _____

Policy Holder: _____

Policy Holder Date of Birth: _____

Relationship: _____

Secondary

Insurance: _____

Effective Date: _____

Policy Holder: _____

Policy Holder Date of Birth: _____

Relationship: _____

Group No: _____

Insured ID: _____



INFORMATION RELEASE AND INSURANCE ASSIGNMENT—ALL PATIENTS

I hereby authorize Southern Pain Specialists, P.C., to release medical information to any insurance company or any public agency that may be assisting in payment of benefits to which I am entitled. In addition, I authorize the payment of any insurance benefits directly to Southern Pain Specialists, P.C. This signature shall suffice for all insurance forms on a continuing basis.

SIGNED: _____ DATE: _____
(Signed by patient or person legally authorized to sign for patient.)

MEDICARE ASSIGNMENT—MEDICARE PATIENTS ONLY

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER
(Extended Payment Request for Physician Services Applicable to Current and Future Treatment)

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made either to me or on my behalf to P.C. and/or Physicians, for any services furnished me by or in the name of such providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services. I recognize that this one-time authorization will permit P.C. and/or Physicians to submit any Medicare claim, on either an assigned or an unassigned basis, without obtaining any additional signature from me, and will remain in the files of P.C. for inspection by the Medicare carrier, and will continue in full force and effect unless cancelled by my request.

SIGNED: _____ DATE: _____
(Signed by patient or person legally authorized to sign for patient.)

FINANCIAL ASSIGNMENT—ALL PATIENT

I understand that I am directly responsible to Southern Pain Specialists, P.C., for all charges for medical services rendered to me regardless of insurance coverage. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.

SIGNED: _____ DATE: _____
(Signed by patient or person legally authorized to sign for patient.)

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION TO

SPECIFIED INDIVIDUALS

Southern Pain Specialists is committed to the protection of our patient's personal health information. However, we recognize that individuals other than themselves attend to many of our patient's healthcare needs. In accordance with new HIPAA regulations, we ask that you take a moment to give us the names of individuals with whom we are able to discuss your medical appointments, condition, treatment options, insurance/private payment information, or other information necessary to our responsibility in your treatment. Please list the names (and phone numbers, if readily available) of any individuals with whom we may have communication, which may include all, or part of your personal health information. If you fail to list any names, we will not discuss your medical information

Examples include: spouse, parent, child, brother/sister, friend, etc.

Patient's Signature: _____ Date: _____

Contact/Relationship to patient:

Telephone number:

1. _____

2. _____

3. _____

CONSENT FOR THE USE OF NON-IDENTIFYING PATIENT INFORMATION

It is the practice of Southern Pain Specialists to gather non-specific patient data for such purposes as teaching, marketing, and research. This data does not include any identifying information that would compromise the privacy of your identity, health condition, insurance or payment information. Examples include (but are not limited to): age, sex, race, treatment options, response to treatment and/or a non-identifying photograph or x-ray. Southern Pain Specialists is bound by the conditions of the Health Insurance Portability and Accountability Act and will not disclose further Personal Health Information beyond such non-identifying information without the express written consent of the patient. However, we request your permission to use your non-identifying patient information for such purposes as listed above.

I, (print name) _____, grant permission to Southern Pain Specialists to use non-identifying patient information about me (exclusive of Personal Health Information) for such purposes that may include, but are not restricted to, teaching, marketing and/or research.

Signature

Date



POLICY REGARDING MISSED PROCEDURE/OFFICE APPOINTMENTS

PROCEDURE APPOINTMENTS

If you are scheduled for a procedure we want you to be aware of our cancellation and no-show policy.

If you need to cancel your scheduled procedure appointment, please call us at least **48 business hours** in advance, and we will be happy to reschedule your procedure to a more convenient time. This time period allows us to schedule another waiting patient in the time slot.

Should you fail to show up the day of your scheduled procedure, and you have not notified us at least **48 business hours** in advance of the scheduled time, you will be charged **\$150.00**. This charge is not billable to your insurance and must be paid by you.

OFFICE APPOINTMENTS

Please call our office if you need to cancel an office visit at least **24 hours** in advance. If you do not show up for an office appointment or if you cancel with less than 24 hours notice, you will be charged **\$25.00**. This charge is not billable to your insurance and must be paid by you.

Please call our office if you have any questions (205) 995-9967.

Thank you!

Patient Signature

Date



Authorization for Release of Medical Information

Date: _____

To: _____

Patient Name	Date of Birth	Social Security #

This is to authorize and request that you furnish all medical or hospital information, including any radiology reports, concerning your examination, treatments, and care of the patient listed above.

Southern Pain Specialists. P. C.

7500 Hugh Daniel Drive, Suite 360

Birmingham, Alabama 35242

Attention: Medical Records

(205) 995-9967

FAX: (205) 995-0635

(888) 436-4560

WWW.SOUTHERNPAIN.COM

Patient (or Guardian) Signature: _____



7191 Cahaba Valley Rd, Suite 204,
 Birmingham, Alabama 35242-6402
 Phone: (205) 995-9967 FAX: (205) 995-0635
 1-888-436-4560
<http://www.southernpain.com>

For Office Use Only	
Wt: _____	T: _____
P: _____	R: _____
BP: _____ / _____	
Ht: _____	

PAIN PATIENT QUESTIONNAIRE

It is very important that this form be filled out completely before coming for your visit!

Today's Date: _____ Ref. MD: _____

I. IDENTIFICATION:

_____ (Last Name) _____ (First Name) _____ (MI)

Date of Birth: _____ Age: _____ Weight _____ lbs Height @ age 25 : _____

II. CHIEF COMPLAINT

1. Please list your pain site in order of importance (rank the worst problem, as "a" the next as "b", etc.)

a. _____ b. _____ c. _____

III. HISTORY OF PRESENT ILLNESS

2. Date when your pain began? _____ Did this pain begin: → Gradually or → Suddenly

3. How did this pain begin? (check)

Accident? At Work At Home Auto Other _____
 Following an Illness? Following Surgery

Explain: _____

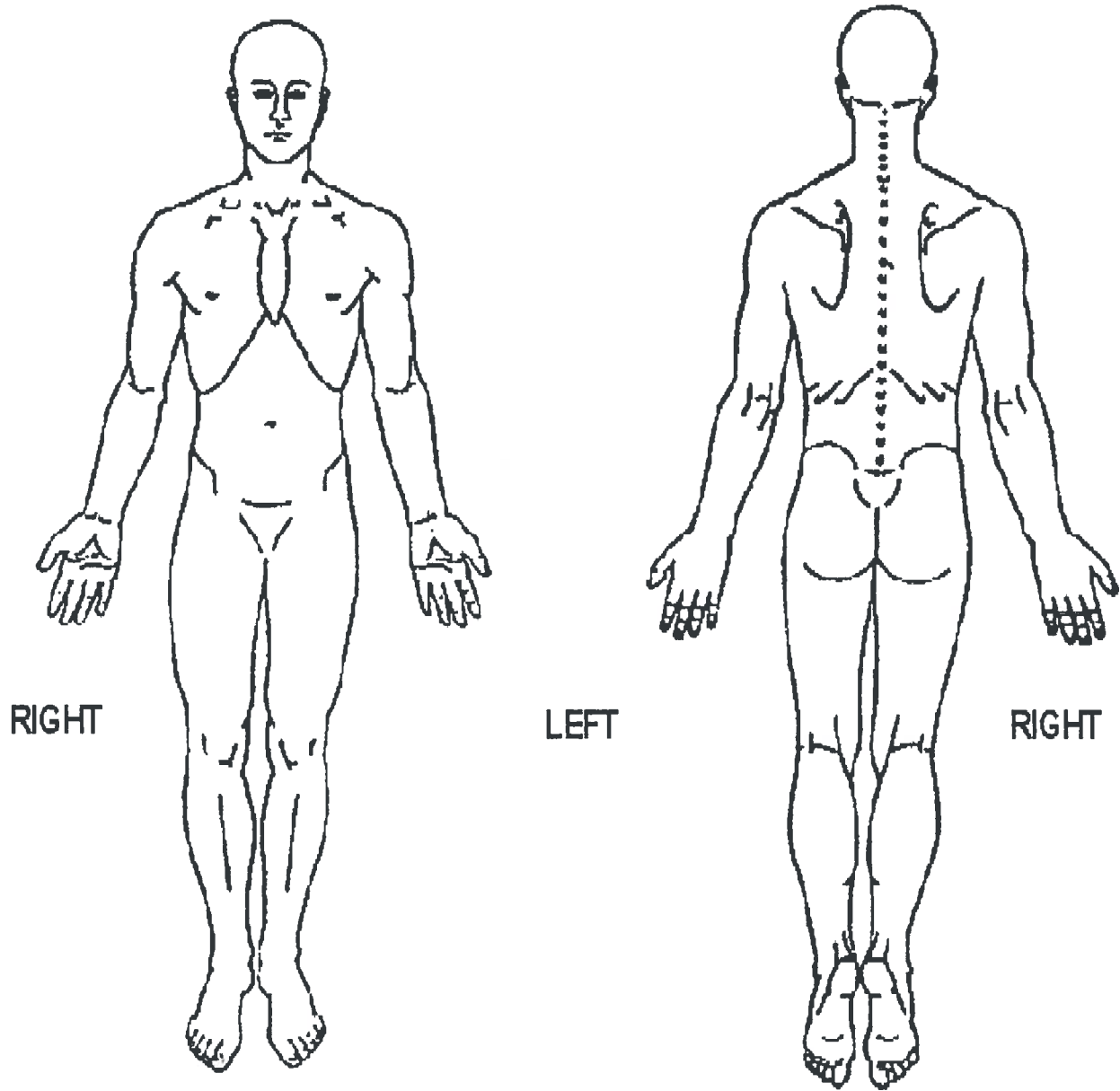
4. Is the pain the same now as it was when it began? SAME BETTER WORSE

5. Is there a time of day that your pain is worse Morning Noon Afternoon Evening
 Wakes you at night

6. PLEASE INDICATE WHICH *DIAGNOSTIC PROCEDURES (TESTS)* YOU HAVE HAD FOR THIS PAIN PROBLEM

<input type="checkbox"/> X-Ray	Date: _____	Where: _____
<input type="checkbox"/> CT Scan	Date: _____	Where: _____
<input type="checkbox"/> Myelogram	Date: _____	Where: _____
<input type="checkbox"/> EMG	Date: _____	Where: _____
<input type="checkbox"/> Discogram	Date: _____	Where: _____
<input type="checkbox"/> Bone Scan	Date: _____	Where: _____
<input type="checkbox"/> MRI	Date: _____	Where: _____
<input type="checkbox"/> Bone Mineral Density (BMD) (Test for Osteoporosis)	Date: _____	Where: _____
<input type="checkbox"/> Vertebral Fracture Assessment (VFA)	Date: _____	Where: _____

IV. Please Draw the LOCATION and the TYPE of your pain on the figure below:



Use this legend to draw your pain

OOOOO

●●●●●
XXXXXX

Pins and Needles
Dull Aching Pain
Burning, sharp, shooting
Unbearable

/////////
▽▽▽▽▽
=====

Spasm: Tension Type
Excruciating
Numbness
Other: _____

7. Please check those words that describe your pain, as mild, moderate, or severe:

- | | | |
|------------------------------------|--------------------------------------|---------------------------------|
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Cramping | <input type="checkbox"/> Heavy |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Gnawing | <input type="checkbox"/> Tender |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Hot-Burning | |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Aching | |

8. You will be using the **MANKOSKI Pain Scale** to estimate the level of your pain. Please note that the subjective experience of pain varies from person to person. In order to make your pain rating more valid, **please read the following descriptions** of the various pain levels and physical responses. Please be realistic in your pain rating, so we can help you better.

- 0 – Pain free
- 1 – Minor annoyance
- 2 – Annoyance
- 3 – Distracting; mild painkillers needed (aspirin, Tylenol).
- 4 – Cannot be ignored; Mild painkillers remove pain for 3-4 hours.
- 5 – Cannot be ignored for more than 30 minutes. Mild painkillers decrease pain for 3-4 hours.
- 6 – Cannot be ignored for any length of time. Stronger painkillers (codeine, narcotics) reduce pain for 3-4 hours.
- 7 – Cannot concentrate; interferes with sleep. Stronger painkillers are only partially effective.
- 8 – Physical activity is severely limited. Nausea and dizziness set in as factors in pain.
- 9 – Unable to speak. Crying out or moaning uncontrollably; near delirium.
- 10 – Unconscious. Pain makes you pass out.

Using the above definitions, enter the number that describes your **pain level right now here:** →

and also **circle it** on the scale below:



On the same scale (0 = no pain; 10 = the worst), rate your pain at its **WORST:** _____ At its **LEAST (best):** _____

9. PAIN MODIFIERS. How is your pain **changed**? For each of the following please check (X) the appropriate box:

The following make your pain....

	Worse	Better	Same		Worse	Better	Same
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold Weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shifting Position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting – prolonged time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep, Rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat/Heating Pads	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Standing - prolonged time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot Weather or Room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Twisting/Turning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice Packs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liquor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Labor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Please list **ALL the treatments** you have had and are currently having **for your pain**. Include operations, hospitalizations, anesthetic procedures, nerve blocks, physiotherapy, and psychological treatments.

Did it Help?

	YES	NO	YES	NO
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steroid Injections (I.e. epidural, facet, other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1. Did you have any **surgeries** for this pain condition? YES NO

If YES, what kind? _____

Dates of the surgeries, if any: _____

Did they/it help? YES NO

If YES for how long? _____

2. List **ANY** other treatment you have had for this pain condition: _____

3. How many times have you been to the **emergency room**, this year, because of present pain? _____

4. How many times have you been **admitted to the hospital** because of the present pain problem? _____

5. How many times have you seen a **medical doctor** in the past **six (6) months**: _____

6. How many of these visits were for a **pain-related** problem? _____

V. CURRENT MEDICATIONS. Please list **ALL medications** or drugs you **are taking NOW** for any reason, whether PRESCRIBED by a doctor or not (include home remedies; painkillers; over-the-counter medications; birth control pills).

Name of the Medication	Dosage/ Strength	How many a day/how often	Who prescribed it

VI. PREVIOUS MEDICATIONS. Please list **ALL medications** or drugs you have tried in the past for any reason, whether PRESCRIBED by a doctor or not (include home remedies; painkillers; over-the-counter medications; birth control pills).

Name of the Medication	Dosage/ Strength	How many a day/how often	Who prescribed it

Your PHARMACY: _____
(Name of pharmacy)

_____ (Phone)

Check this box if you used the back for extra room for your medications.

VII. MEDICAL HISTORY

1. ALLERGIES YES NO ASPIRIN LATEX

Drug allergies: _____

Other Allergies: _____

2. Have you recently taken **YES** **NO** **Date last taken**

Coumadin, _____

Plavix _____

Aspirin, Goody's powder _____

Cortisone or steroids _____

3. Have you ever had a history of malignancy (**cancer**)? Yes No

If Yes, please provide the following: Type: _____

Approximate date discovered: _____ Treating physician: _____

Currently receiving treatments (such as chemotherapy or radiation)? Yes No

4. Have you had or do you presently have any of the following problems:

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Attack; Angina | <input type="checkbox"/> Seizures, Convulsions | <input type="checkbox"/> TMJ Dysfunction |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma in the past year | <input type="checkbox"/> Thyroid Dysfunction |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Strokes (CVAs) | <input type="checkbox"/> Interstitial Cystitis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Emphysema of the lungs | <input type="checkbox"/> Irritable Bowel / Crohn's Disease |
| <input type="checkbox"/> Kidney Failure; stones | <input type="checkbox"/> Stomach ulcer or duodenal ulcer | <input type="checkbox"/> Hepatitis Type <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C |

5. List any **surgeries** you have had and when: _____

6. List any **injuries** or **accidents** you have had/date of injury: _____

VIII. HABITS

1. Do you smoke **cigarettes**? YES NO If YES, how many a day? _____

2. Do you use **other tobacco** products? YES NO If, YES, what? _____

3. Please indicate the number of **caffeinated beverages** (including coffee, tea, and sodas) you drink each day; specify type: _____

4. Do you drink **alcohol**? YES NO

Type: _____ Glasses / cans Per day _____ Per week: _____

5. Recreational drug use? YES NO

IX. WORK AND LIFE STYLE:

1. Education:

Finished ___th grade GED HS Graduate College _____ (yrs) Post-Graduate _____

2. Are you presently working? YES NO Date last worked: _____

3. What type of work do you do or did you do last? (include housewife): _____

4. If you are not working presently:

a. Is your pain preventing you from working? YES NO

b. Have you applied for **Social Security Disability** or **Disability Retirement**? YES NO

6. Do you exercise regularly? YES NO

7. Do you own any type of exercise equipment? YES NO If YES, what kind: _____

8. HOME ENVIRONMENT

a. Are there any others who are regular members of the household? YES NO

b. Is there anybody in the household who has special care needs? YES NO

If, YES, describe: _____

c. Is anybody in your household on **disability**? YES NO

d. Is anybody in your household **applying for disability**? YES NO

e. Are you in charge of the person needing **special care**? YES NO

If, YES, what is expected of you: _____

f. Are you **getting any help**? YES NO

X. FAMILY HISTORY

1. ORIGINAL FAMILY

a. Have any immediate family members died? YES NO

If YES, who? _____

Cause of death? _____

b. Has anybody in your family had back or neck surgery? YES NO

If YES, who? _____

2. MARRIAGE Single Married Separated Divorced Widowed

What is your partner's occupation? _____

3. CHILDREN living (ages, sex, living at home, or not): _____

a. Any children deceased? Date: _____ Age: _____ Reason: _____

Patient Name: _____ Date of birth: _____

REVIEW of SYSTEMS: Check the box for EACH symptom you have):

General/Constitutional

- Fever/ Chills Fatigue Weight loss Decline in Health
Weight gain Weakness

Head / ENT

- Headaches Dizziness Fainting Pain
Head Injury Sweats

Eyes

- Blurry Vision Pain with light excessive tearing Vision Loss Infection
Double Vision unusual sensations Glaucoma Discharge Redness
eyeglass use Cataracts Recent Injury Eye pain

Respiratory

- Asthma Sputum Recent Chest X-Ray Pleurisy
Coughing blood Bronchitis Tuberculosis Short of Breath
Positive TB test Pain Cough Wheezing

Heart & Circulation

- Chest Pain Palpitations History of Heart Attack Heart Tests(not EKG)
hair loss on legs Extremity(s) Cool Recent electrocardiogram Leg Pain- walking
high blood pressure Heart Murmur Extremity(s) discolored Rheumatic fever
Short of Breath-exertion Swelling of legs Varicose veins Short of breath lying flat
Thrombophlebitis ulcers on legs Short of breath-sleeping

Gastrointestinal

- Abdominal pain Abdominal X- Ray Tests Antacid Use
Black Tarry Stools Change in Frequency of BM change in stool caliber
Change in stool color Change in stool consistency Constipation
Decreased appetite Diarrhea Excessive hunger
Excessive Thirst Gallbladder Disease Heartburn
Hemorrhoids Hepatitis Infections
Jaundice Laxative Use Liver Disease
Nausea Rectal Bleeding Rectal Pain
Swallowing Problem Vomiting Vomiting Blood

Musculoskeletal

- Arthritis Restricted motion Muscle stiffness Joint stiffness
Gout Back problems weakness Paralysis
Muscle Cramps Joint pain deformities

Psychiatric

- Behavioral change Psychiatric Disorders Mood changes Nervousness
Disturbing Thoughts Depression Disorientation
Memory Loss Excessive Stress Hallucinations

Breasts

- Discharge Lumps Pain Self-Examination Tenderness

Skin

- Dryness
- Hair dye
- Itching
- Nail appearance change
- Skin color change
- Easy Bruisability
- Hair texture change
- Lumps
- Nail texture change
- Eczema
- Rashes
- Hives
- Mole increase size

Neurological

- Blackouts
- Fainting
- Loss of Consciousness
- Paralysis
- Tingling
- Burning
- Head Injury
- Memory Loss
- Speech disorders
- Tremors
- Dizziness
- Headaches
- Numbness
- Strokes
- Unsteady gait

Endocrine

- Cold Intolerance
- Goiter
- Neck Pain
- Weakness
- Excessive Urination
- Heat Intolerance
- Sweats
- Weight Gain
- Fatigue
- Increased Thirst
- Thyroid Trouble
- Weight Loss

Hematologic

- Anemia
- Easy Bruisability
- Swollen Glands
- Bleeding Easily
- Lumps
- Transfusion reaction
- Blood Clots
- Radiation Exposure

Genitourinary

- Difficulty Starting stream
- change in color of urine
- loss of bladder control
- discharge
- nighttime urination
- painful urination

Allergic/Immunologic

- Coughing
- Itchy Eyes
- Runny Nose
- Watery Eyes
- Coughing with exercise
- Itchy Nose
- Sneezing
- Wheezing
- Hives
- Recurrent Infections
- Stuffy Nose
- Wheezing with exercise

Urinary

- Awakening to Urinate
- Burning
- Flank Pain
- Infections
- Stones
- Urine Odor
- Bed-Wetting
- Difficulty Starting Stream
- Frequency
- Pain on Urination
- Urgency
- Blood in Urine
- Excessive Urination
- Incontinence
- Retention
- Urine Discoloration

Male Genitalia

- Discharge
- Impotence
- Prostate problems
- venereal disease
- Fertility problems
- Lesions
- Scrotal Masses
- Hernias
- Pain
- Sexual Problems

Female Genitalia

- Birth control
- Change in Periods-Flow
- Difficult Pregnancy
- Hernias
- Menopause
- Postmenopausal Bleeding
- Sexual Problems
- Bleeding between periods
- Change in Periods-Interval
- Discharge
- Itching
- Menstrual Pain
- Recent Pap Smear
- Venereal Disease
- Change in periods-duration
- DES Exposure
- Fertility Problems
- Lesions
- Pain on Intercourse
- Recent Pregnancy