New Patient Intake

Welcome and thank you for choosing Mountain View Headache and Spine Institute (MVHS) for your pain management needs. Your completed intake paperwork helps our providers get to know you and your medical history better. We rely on its accuracy and its completeness to provide you with the best care possible. Please take your time and if you have any questions or are unsure how to complete any section of this form, inquire at our front desk or call **602-767-0007**.

Patient Information

Your Name: ____

DOB: ____________________ **Age:** _________ **Gender:** Male ❑ Female

Address:____

City/State/Zip:____

Preferred Phone:_________________________________❑ Home ❑ Cell ❑ Work ❑ Ok to leave message

Secondary Phone:_________________________________❑ Home ❑ Cell ❑ Work ❑ Ok to leave message

Social Security #:------------------------------**Driver's License #/State:** __________

Email address: ____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed Other: ___

Race: ❑ American Indian ❑ Asian or Pacific Islander ❑ Black ❑ White ❑ Refuse to report

Primary Language: ❑ English ❑ Spanish ❑ Other **Ethnicity:** ❑ Hispanic ❑ Non-Hispanic

Advance Directive

Do you have a: ❑ Living Will ❑ Medical Power of Attorney, if so, please provide the office a copy for your chart.

Referral and Physician Relationships

Who is your primary care physician?______________________________________Phone:____________________

Who can we thank for referring you to our clinic? ____

If you were not referred, how did you hear about us? ❑ Insurance company ❑ PCP ❑ Family ❑ Friend ❑ Yelp

❑ Internet ❑ Facebook ❑ Google ❑ Other website: ____

Emergency Contact

Name:______________________________Phone:___________________________Relationship:______________

May we leave information with your emergency contact? ❑ Yes ❑ No

Preferred Pharmacy

Pharmacy Name:____Phone:___________________________

Address:____City/State/Zip: ______________________________

Primary Insurance

Primary Insurance Company and Plan: ____________________

Policy ID #: ____________________ Group #: ____________________

Claims Address: ____________________

City/State/Zip: ____________________ Phone: ____________________

Insurance Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Complete this box if you are *not* the policy holder for your primary insurance

Policy Holder Name: ------------------------ ____________________ DOB: ____________________

Social Security #: ----------------------------- ____________ Phone: ____________________

Address: ____________________ City/State/Zip: ____________________

Policy Holder Gender: ❑ Male ❑ Female Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary Insurance

Secondary Insurance Company and Plan: ____________________

Policy ID #: ____________________ Group #: ____________________

Claims Address: ____________________

City/State/Zip: ____________________ Phone: ____________________

Insurance Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Complete this box if you are *not* the policy holder for your secondary insurance

Policy Holder Name: ------------------------ ____________________ DOB: ____________________

Social Security #: ----------------------------- ____________ Phone: ____________________

Address: ____________________ City/State/Zip: ____________________

Policy Holder Gender: ❑ Male ❑ Female Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim

Employer: ____________________ Date/Time of Injury: ____________________

Employer Address: ____________________ Phone: ____________________

Employer Insurance Carrier: ____________________ Claim #: ____________________

Insurance Address: ____________________ Phone: ____________________

Agent/Adjuster Name: ____________________ Phone: ____________________

Injury Claim

Is your pain the result of a motor vehicle accident or other accident? ❑ Yes ❑ No

Have you hired an attorney for purposes of making any claims arising from that accident? ❑ Yes ❑ No

If yes to either question, you will be required to complete additional forms.

Consent for Treatment

I certify that the above information is accurate, complete, and true.

I authorize Mountain View Headache and Spine Institute (MVHS) and its associates, assistants, and other health care providers it may deem necessary to treat my condition. I understand that no warrant or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

Patient Signature: ____________________ Date: ____________

Financial Agreement, Cancellation Policy & Notice of Privacy Practices

PLEASE READ THE FOLLOWING AGREEMENT. IT EXPLAINS YOUR FINANCIAL OBLIGATIONS WHILE UNDER OUR CARE, OUR POLICIES REGARDING CANCELLATIONS AND NOTICE OF PRIVACY PRACTICES.

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT: I authorize treatment of the person named above and agree to pay all fees and charges for such treatment promptly upon presentation of statement unless prior credit arrangements have been agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date. Although this office may assist me in filing an insurance claim, I understand that I am fully responsible for the balance and agree that payment will not be delayed because of any pending insurance claim. In the event legal action should become necessary to collect an unpaid balance, I agree to pay all reasonable attorney's fees or other costs the court may determine proper.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION: I authorize all insurance benefits, unless previously paid by myself, to be paid directly to this physician/facility and authorize the physician/facility to release any information required in the processing of the insurance claim. I authorize the physician/facility to release medical information to my referring physician, primary care physician, spouse, children, parents, and any physician he/she may refer me to.

ALL MEDICARE PATIENTS MUST SIGN THE FOLLOWING STATEMENT: I request that payment under the medical insurance program be made on my behalf to Mountain View Headache and Spine Institute (MVHS) Center for any services furnished me by its physician(s) and/or practitioners. 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 permit a copy of this authorization to be used in place of the original.

Name:____ Signature: ___________________________________

Insurance Benefits

Arizona State Law (HB2600) requires that medical claims be paid by insurance carriers within 90 days. If your insurance carrier has not appropriately paid the submitted claim within 90 days, I understand that outstanding balances will become the responsibility of the policy holder.

Insurance Co-Payments

In accordance with my insurance contract, I understand that **co-payments are due at time of service**.

Deductible

If my insurance deductible has not been met, I understand that outstanding deductible amounts will be collected at the time of service unless other payment arrangements have been made.

Co-insurance

I understand that co - insurance amounts may be collected at time of service, and at the time interventional procedures are scheduled.

Private Pay

If I have no insurance coverage, or insurance with which Mountain View Headache and Spine Institute (MVHS) does not participate, or Mountain View Headache and Spine Institute (MVHS) is unable to verify current insurance coverage, I understand **full payment is expected at time of service**. We do accept SELF-PAY patients (i.e. Patients with NO insurance), Initial consultation is $400.00 that is due at the time of service. Follow up visits are $150.00 due at time of service, if a urinalysis is required it will be $200.00. If a procedure is scheduled- a fee schedule will be discussed with you prior to the appointment day. The amount discussed will be due at the time of service.

Verification of Benefits and Non-Covered Services

Insurance policies are individualized per patient plan. Mountain View Headache and Spine Institute (MVHS) may provide services that my insurance plan excludes. I understand that it is my responsibility to verify coverage benefits and exclusions. I understand that all non-covered services are my responsibility.

Notice to Medicare Patients

If we are unable to verify from Medicare that there is automatic submission of claims to the secondary insurance carrier, you may be responsible for secondary insurance balances at the time of service and at the time interventional procedures are scheduled.

Refund Policy

I understand that amounts collected from me (including co-payments, co-insurance, and deductibles) are based on information received by Mountain View Headache and Spine Institute from my insurance carrier. Refunds are to be requested from your insurance company. MVHS is not responsible for reimbursements.

Collections

I understand that once an account is placed in a collection status, all future services must be paid in full at time of service (no checks accepted). If my account is placed into collections, I will be responsible for all collection and interest costs.

Returned Checks

Returned checks will be subject to a $30.00 returned check fee.

NO SHOW, LATE CANCELLATIONS OR RESCHEDULING

Regretfully, we have been forced to institute this policy due to a large volume of last-minute cancellations, scheduling changes, and "no-shows."

- We have a very busy practice. Assuring that all our established patients have access to their doctor when necessary is a constant challenge. When you cancel or reschedule at the last minute, or fail to show for your appointment, you are depriving another patient of the care they need. **You must cancel or reschedule within 24 hours.**
- New patient visits require our doctor to block out large time slots, making last minute cancellations and rescheduling of visits even more problematic. We provide a large amount of time and attention with each one of our new patients because we are committed to providing the highest quality care.

NEW PATIENT APPOINTMENTS:

- IF YOU FAIL TO SHOW FOR YOUR APPOINTMENT, YOU MAY BE CHARGED $50.
-

FOLLOW- UP VISITS:

- IF YOU FAIL TO SHOW FOR YOUR APPOINTMENT WITHOUT NOTIFICATION YOU MAY BE CHARGED $50.
- IF YOU CONTINUE TO CANCEL, RESCHEDULE, OR FAIL TO SHOW FOR YOUR SCHEDULED APPOINTMENTS YOU MAY BE DISCHARGED FROM OUR PRACTICE.

PROCEDURE APPOINTMENTS:

- IF YOU NO SHOW FOR YOUR PROCEDURE APPOINTMENT YOU MAY BE CHARGED $100.00

**** PAYMENT FOR THESE CHARGES MUST BE MADE IN FULL PRIOR TO BEING SEEN FOR YOUR NEXT APPOINTMENT ****

ADDITIONALLY, I ACKNOWLEDGE THAT IF I HAVE 3 OR MORE "NO SHOW" OR "LATE CANCELLATIONS" FOR ANY SERVICE, I MAY BE REFERRED FOR TREATMENT TO ANOTHER CLINIC.

Medical Records

We are happy to provide you with copies of your medical records upon request. However, because of time restrictions, please allow up to 30 business days to fulfill this request. Please note there is a charge for personal use, however, medical records sent to another medical provider will be done free of charge.

Other Forms

We will respond (at the provider's discretion) to requests for the completion of certain medical forms (FMLA, Short Term Disability & **Temporary** Disability Parking Permit) assuming the patient is in good standing and has been active with the SPM for six (6) months consecutively. Other forms not listed may be considered for completion. In these cases, the fee will be determined by the office manager.
All requests require an office visit.

Notice of Privacy Practices

I have been given the option to review Mountain View Headache and Spine Institute (MVHS)'s "Notice of Privacy Practices" that explains how my personal health information will be used. I am also aware that I may request a copy of the "Notice of Privacy Practices" at any time.

I HAVE READ AND AGREE TO ABIDE BY THIS FINANCIAL AGREEMENT, CANCELLATION POLICY AND NOTICE OF PRIVACY PRACTICES. By signing this, you are indicating that you understand and agree to the terms of service explained above.

Name:____DOB: ____________________________

Signature:____Date: ____________________________

Office Policies and Procedures

PLEASE READ AND **INITIAL** ALL SECTIONS BELOW:

_______**1).** A cordial and cooperative tone will facilitate communication with our staff and providers. Mountain View Headache and Spine Institute (MVHS) has a very strict **ZERO** tolerance for abusive and aggressive behavior toward its staff; we do not permit patients to swear at our staff, nor be rude, aggressive, belligerent or disruptive. Thank you for remaining calm and friendly.

_______**2).** All patients with pain perceive their symptoms to be special and urgent. We acknowledge that you may be experiencing physical and emotional distress. However, all the patients referred to this clinic feel this same urgency to obtain treatment. Extra-special consideration cannot routinely be granted in scheduling your visits and treatments due to time, space, and staff limitations. Please know that we will do everything possible to serve you in a timely and effective manner within our limitations. Occasionally, a medical emergency arises which may delay the day's schedule – we appreciate your patience in these situations.

_______**3).** Chronic pain is **NOT** considered to be a medical emergency. Therefore, emergency access to our clinic is rarely indicated. You may be referred back to your primary care physician or to an emergency facility if we cannot accommodate your urgent needs. Please do not wait until the last minute to seek care for an escalating problem.

_______**4).** Arriving late for your appointment is very disruptive and makes it nearly impossible to maintain our commitment to serve you in a timely manner. Therefore, our office has a 10-minute late policy. If you arrive 10 minutes after your scheduled appointment, we will usually not be able to see you that day. We will reschedule your appointment for the next available time. Arriving late on a routine basis for your scheduled appointments may be reason for dismissal from our clinic. ***THERE ARE NO EXCEPTIONS.*** Please keep in mind this rule ***DOES NOT*** apply for the last appointment before lunch, nor the last appointment of the day, there is ***NO*** leeway for these appointments. Out of courtesy, if you are running late please call the office to confirm we are still able to see you. ***PLEASE REMEMBER THAT ANY LEEWAY IS A COURTESY AND NOT A GUARANTEE.*** We make every effort to give reminder calls for upcoming appointments, but it is ultimately the patients' responsibility to keep all scheduled appointments or give appropriate notice for rescheduling or cancelling.

_______**5).** Missed appointments will be rescheduled at the next available time (possibly up to 3-4 weeks). We will not refill medications in the interim, so try not to miss your scheduled appointment. Missing several appointments may be reason for dismissal from our clinic.

_______**6).** When you call our clinic, you may be routed to a voice mailbox. Please leave your message. We listen to our messages daily and will return your call within 24-48 business hours. Multiple phone calls on the same day for the same problem are very disruptive and may cause delay in a call back. If you do this, you will be given a warning to desist. If this behavior continues, you may be dismissed from our clinic.

_______**7).** If narcotics or other potent medications to treat your pain are prescribed, you will be asked to enter into a formal narcotic agreement that outlines rules, risks, and conditions of continued access to these medications. Please remember, it is up to the physician's discretion if opiate medications are prescribed on the first visit.

_______**8).** Pain medication prescriptions are written for a 30-day supply. Medications are refilled once a month during a scheduled office visit. As a rule, we do not call or fax narcotic prescription refills to the pharmacy. Lost or stolen medication will **NOT** be replaced with a new prescription. Pain medication should be taken as directed as we do **NOT** provide early refills. Six months of pharmacy records may be required before a narcotic prescription can be issued. Non-urgent calls regarding medication may be returned within 72 hours. Medication changes are addressed during scheduled office visits, not during/between procedure series. Before leaving the office, it is recommended that patients schedule their next appointment to avoid any last-minute requests for an appointment which we may not be able to accommodate.

_______**9).** Obtaining pain medications elsewhere without our specific written or verbal approval may be considered a sign of possible narcotic addiction and may be reason for dismissal from our clinic.

_______**10).** It is your responsibility as the patient to inquire if you are due for a urine drug screen (UDS). Please ask the front desk upon arrival if you are due for one **BEFORE** using the restroom. If a UDS is required, you may **NOT** leave the lobby/office once you have checked in. If you do leave the office your urine is considered a fail and you may not receive your prescription and you may be discharged from the practice. Furthermore, if we find reason you may be given a specific time limit to complete your UDS.

_______**11). For female patients only:** To the best of my knowledge I am **NOT** pregnant. If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is MY responsibility to inform my physician immediately if I become pregnant. If I am pregnant or am uncertain, **I WILL NOTIFY MY PHYSICIAN IMMEDIATELY**. All the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and **DO NOT** hold my physician liable for injuries to the embryo/fetus/ baby.

Following these guidelines is important for continued success in managing your pain. If our clinic guidelines are unacceptable to you, you may choose to seek care from another source more suited to your desires. Thank, you for your understanding. We consider it a privilege to serve you. We look forward to a happy and productive working relationship.

Patient Name:____ DOB: ______________________

Signature:____ Date: ______________________

Agreement for Chronic Pain Medication Administration

PLEASE READ AND **INITIAL** ALL SECTIONS BELOW:

________I understand the purpose of this agreement is to prevent misunderstandings about certain medications that I will be taking for pain management. This is to help me, and my doctor comply with the law regarding controlled medications.

________I understand that if I break this agreement, Mountain View Headache and Spine Institute (MVHS) will stop prescribing my pain medications.

________I agree that I will not mix alcohol with pain medication.

________I agree that I will not use any illegal substances, including marijuana.

________I agree that driving or operating any type of machinery will not be allowed while I am being prescribed opioid medication as this could be considered "driving under the influence" by law.

I will not increase or decrease the dosage of my medication without the consent of the prescribing physician. If I feel that adjustments in the medication dosage is required, I agree to contact the prescribing provider at Mountain View Headache and Spine Institute (MVHS) for an appointment.

________I will not share or sell my medications with anyone, nor will I take another person's medication.

________I will not receive any pain medications from any other doctors. If I am given a prescription for a controlled substance, I agree not to fill the prescription until I have contacted the office and have discussed it with a provider at Mountain View Headache and Spine Institute (MVHS).

________I understand that it is my responsibility to safeguard my prescription and medications. Should my prescription or medication be lost, stolen, or destroyed, under no circumstances will it be replaced.

________I will not contact the office to schedule for an earlier appointment if I have over-taken my medication.

________I understand that there may be risks associated with the use of pain medication, including risk of death, respiratory depression, bowel and bladder dysfunction, sexual dysfunction, change of appetite with possible weight gain or loss, change of coordination (which may interfere with driving, operating machinery and fine motor movement) and others.

________I understand that the continuous use of pain medication may result in dependence, addiction, change in personality, and sleep changes.

________I will report any changes in my mental state, as well as possible side effects from my medication.

________I understand and agree that I will not receive anti-anxiety medications known as benzodiazepines, or Soma, unless decided jointly by myself and my pain provider.

________I agree to submit to random urine drug testing and/or pill counts at the request or need of the providers on an as needed basis to monitor medication compliance with recommended treatment.

________I understand that sudden stopping of pain medication can lead to rebound pain, withdrawal symptoms, seizures and other symptoms. I have been informed not to stop any pain medication suddenly unless decided jointly by myself and my pain provider.

________I agree to allow my pain provider to review any of my past medical or psychological records.

________I agree that when I have any contact with Dr. Gupta or any staff member, I will not be rude, aggressive, swear and/or be disruptive with any member of the office or other patients.

________I have read and understand the above information. I agree and understand that non-compliance with the above will result in formal discharge with notification to my primary care physician and other treating physicians.

Patient name:____DOB:

Signature:____DATE: ______________________________

PATIENT INFORMATION

____
Date

Name (Last, first, middle initial) , DOB: Social Security # or Patient ID:

Street address: City: State ZIP Code:

I AUTHORIZE THE FOLLOWING INFORMATION TO BE RELEASED

❏ MEDICAL RECORDS ❏ TEST RESULTS ❏ APPOINTMENTS

❏ PHONE MESSAGES ❏ MEDICATION INFORMATION ❏ ALL INFORMATION

______I authorize Mountain View Headache and Spine Institute (MVHS) to leave confidential information on my provided home/cell phone, answering machine/voicemail and/or email

Primary phone number Other phone number E-mail address

I authorize Mountain View Headache and Spine Institute (MVHS) (providers and staff) permission to discuss and/or disclose my health information with the following person/persons listed below:

Name: Relationship: Phone:

Name: Relationship: Phone:

Name Relationship Phone

______**I DO NOT** authorize any medical information to be released to any other individuals

Signature____ Date ________________________

No information will be released to any persons without the permission of the patient. All authorized persons receiving any information will need to show proper identification before any information will be released. HIPAA Privacy Rights Form

MOUNTAIN VIEW
HEADACHE AND SPINE
INSTITUTE

Medical/Clinical History

Your Name: ____ Date of Birth: _________________

Primary reason for today's visit: ________________________ Height: _______ Weight: _______

Preferred Pharmacy:________________________________ Address: _______________________

Pain Scale

Where is your **worst area** of pain centered? ____

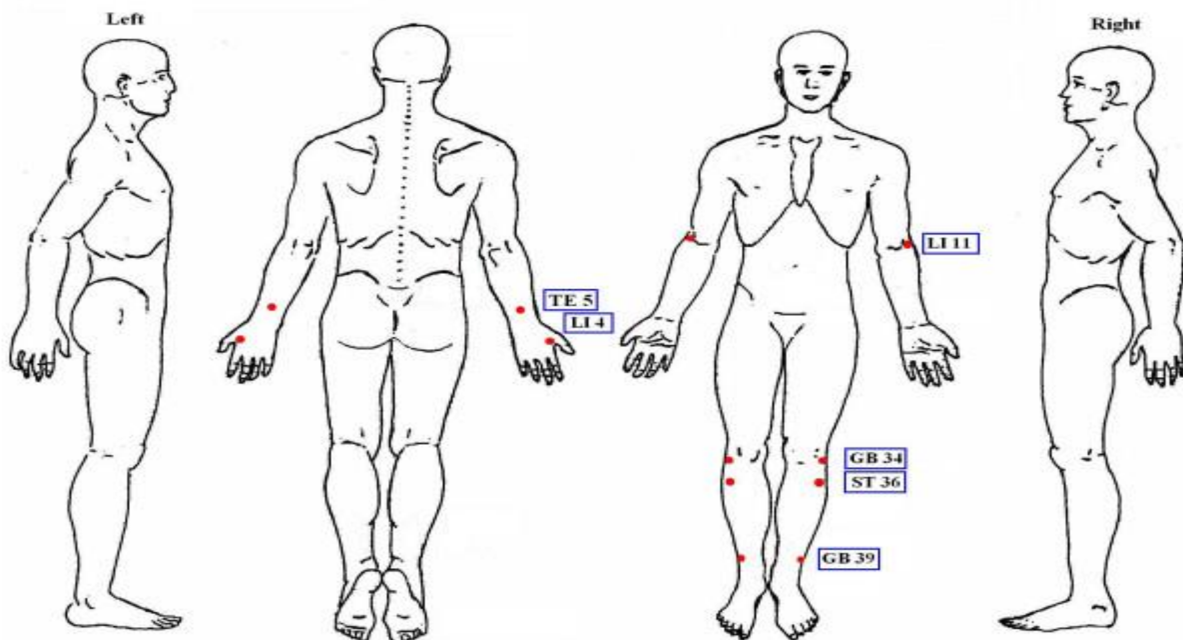
What number on the pain scale (0-10) best describes your **pain right now**?

What number on the pain scale (0-10) best describes your **worst pain?**

What number on the pain scale (0-10) best describes your **least pain?**

Pain Location

Use this diagram to circle the location of your pain.



Onset of Symptoms

Approximately when did the pain begin? ____

What caused your current pain episode? ____

Is your pain the result of a Motor Vehicle Accident or Personal Injury? YES / NO

How did your current episode begin? GRADUALLY / SUDDENLY

Since your pain began, has it changed? DECREASED / INCREASED / REMAINED THE SAME

Pain Description

What aggravates your pain? (Circle all that apply.)

Bending/ change in weather/ driving/ going downstairs/ going upstairs/ increased activity/ lifting objects/ lying flat/ movement/ sitting/ standing/ walking/ stretching/ other:

____

What helps alleviate your pain? (Circle all that apply.)

Bending/ change in weather/ driving/ going downstairs/ going upstairs/ increased activity/ lifting objects/ lying flat/ movement/ sitting/ standing/ walking/ stretching/ other:

____

Circle all the following that describe your pain:

Numbness, Burning/hot, Cramping, Dull, Shooting, Stabbing/sharp, Tingling/pins, Throbbing, Aching, Shock-like, Spasming, Squeezing.

Pain Frequency

What word best describes the frequency of your pain? CONSTANT / INTERMITTENT

When is your pain at its worst? MORNING / DURING THE DAY / EVENINGS / NIGHTTIME

Diagnostic Tests and Imaging

- MRI of the __________________ Date: _____________ Facility: ______________________
- X-ray of the _________________ Date: _____________ Facility: ______________________
- CT of the ___________________ Date: _____________ Facility: ______________________
- EMG/NVC study of the _______ Date: _____________ Facility: ______________________
- Ultrasound of the ___________ Date: _____________ Facility: _______________________
- Other diagnostic testing: ____

Current Medications

Are you currently taking any aspirin, blood thinners or anticoagulants? YES / NO

If yes, which ones? COUMADIN / PLAVIX / LOVENOX / AGGRENOX / OTHER:

Please list all medications you are **CURRENTLY** taking. Attach an additional sheet if necessary.

Medication name	Dose	Frequency

PREVIOUS Medications Tried

Circle any medications tried in the **PAST**

Over the counter medication:

ASPIRIN - ACETAMINOPHEN/TYLENOL - ADVIL/MOTRIN/IBUPROFEN - ALEVE/NAPROXEN EXCEDRIN

Prescription Anti-Inflammatories:

IBUPROFEN - NAPROXEN - DICLOFENAC/VOLTAREN - MELOXICAM/MOBIC - CELECOXIB/CELEBREX - KETOROLAC/TORADOL - ETODOLAC - INDOMETHACIN - PIROXICAM

Muscle Relaxers:

FLEXERIL/CYCLOBENZAPRINE - ROBAXIN/METHOCARBAMOL - TIZANIDINE/ZANAFELX – SOMA/CARISOPRODOL – BACLOFEN – SKELAXIN/METAXALONE – ORPHENADRINE/NORFLEX – LORZONE/CHLORZOXAZONE

Nerve Pain medications:

GABAPENTIN/NEURONTIN – PREGABLIN/LYRICA – DULOXETINE/CYMBALTA – AMITRIPTYLINE/ELAVIL – NORTRIPTYLINE/PAMELOR – OXCARBAZEPINE/TRILEPTAL – TOPIRAMATE/TOPAMAX

Opiates: Short acting:

TRAMADOL/ULTRAM – TYLENOL W/ CODEINE – HYDROCODONE/VICODIN – OXYCODONE/PERCOCET – DILAUDID/HYDROMORPHONE – IMMIDIATE RELEASE MORPHINE – OPANA IR **Extended Release:** BUTRANS PATCH – FENTANYL/DURAGESTIC PATCHES – MS CONTIN/MORPHABOND/MORPHINE ER – OXYCONTIN – OPANA ER – METHADONE

Opiate included constipation:

MIRALAX – DOCUSATE – SENOKOT – COLACE – MOVANTIK – AMITIZA – LINZESS – RELISTOR

Pain Treatment History

Mark all the following pain treatments you have undergone **prior** to today's visit:

CHIROPRACTIC / NEUROSURGEON / PAIN MANAGEMENT / PHYSICAL THERAPY / RHEUMATOLOGY / ACUPUNCTURE / MASSAGE

- Discogram – (circle all levels that apply) Cervical/ Thoracic/ Lumbar
- Epidural Steroid Injection – (circle all levels that apply) Cervical/ Thoracic/ Lumbar
- Joint Injection- Joint(s) ____
- Medial Branch Blocks or Facet Injections- (circle all levels that apply) Cervical/Thoracic/Lumbar
- Nerve Blocks – Area/Nerve(s) ____
- Radiofrequency Ablation- (circle all levels that apply) Cervical/ Thoracic/ Lumbar
- Spinal Column Stimulator- (circle one) Trial Only/ Permanent Implant- Which company ____
- Trigger Point Injection- Where? ____
- Vertebroplasty/ Kyphoplasty- Level(s) ____________________________________
- Other: ____
- Other: ____
- **I have NOT had any prior treatments for my current pain complaints**

Allergies

Do you have any known allergies? YES / NO

If so, please list all medications you are allergic to:

Medication Name	Allergic Reaction Type

Past Medical History/ Problem List

Cardiovascular/Hematologic

- Anemia
- Heart Attack
- Hypertension
- Mitral Valve Prolapse
- Pacemaker/Defibrillator
- Coronary Artery Disease
- High Cholesterol
- Poor Circulation
- Stroke

Musculoskeletal

- Amputation/ Phantom Limb Pain
- Bursitis
- Carpal Tunnel Syndrome
- Chronic Low Back Pain
- (CRPS)
- Spinal Cord Injury
- Traumatic Brain Injury (TBI)
- Chronic Joint Pain
- Chronic Neck Pain
- Fibromyalgia
- Joint Injury ________________
- Osteoarthritis
- Osteoporosis
- Rheumatoid Arthritis
- Tennis Elbow
- Schizophrenia
- Seizures
- Reflex Sympathetic Dystrophy (RSD) /Chronic Reginal Pain Syndrome
- Vertebral Compression Fracture

General Medical

- Cancer- Type _______
- Diabetes- Type _______
- HIV/AIDS

Respiratory

- Asthma
- Bronchitis
- COPD
- Pneumonia
- Tuberculosis
- Valley Fever

Gastrointestinal

- Bowel Incontinence
- Constipation
- GERD

Head/Eyes/Ears/Nose/Throat

- Glaucoma
- Migraines
- Head Injury

- Hyperthyroidism
- Hypothyroidism

Other: ________________

Hepatic- list:

Hepatitis **A / B / C ACTIVE/INACTIVE/UNSURE**

- **I HAVE NO SIGNIFICANT MEDICAL HISTORY**

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type or other pertinent details:

Abdominal Surgery

❑ Gallbladder removal ________________________
❑ Appendectomy __________________________
❑ Other __________________________

Joint Surgery

❑ Hip __________________________
❑ Knee __________________________
❑ Shoulder __________________________

Female Surgeries

❑ Caesarean section __________________________
❑ Hysterectomy __________________________
❑ Laparoscopy __________________________
❑ Ovarian __________________________
❑ Other __________________________
❑ Other __________________________

Spine/Back Surgery

❑ Discectomy (levels) ___________________
❑ Laminectomy_________________________
❑ Spinal Fusion (levels) __________________
❑ Other _______________________________
❑ Other _______________________________

Other Common Surgeries

❑ Hemorrhoid surgery__________________

Heart Surgery

❑ Aneurysm repair __________________________
❑ Stent placement __________________________
❑ Valve replacement __________________________
❑ Other __________________________

❑ Thyroidectomy _______________________
❑ Tonsillectomy ________________________
❑ Vascular surgery _____________________
❑ Hernia repair_________________________

Please list any other surgeries and dates

____
____
____
____

❑ I HAVE **NOT** HAD ANY SURGICAL PROCEDURE DONE

Hospitalizations

Please list any **RECENT** hospitalizations:

Month/Year Reason

____

____

____

Family History

Mother alive / deceased illnesses:

____

____

Father alive / deceased illnesses:

____

____

❑ **NO SIGNIFICANT FAMILY HISTORY / I AM ADOPTED**

Social History

Tobacco use: Current smoker? Yes/ No Start? ______ How often? Everyday / Somedays

How many a day? 5 or less / 6-10 / 11-20 / 21-30

Former smoker? Yes / No Start? _______________ Stop? ___________________

Nonsmoker? Yes / No

Illegal Drug Use: Yes / No If yes, please list:____

Caffeine intake? None / 1-2 cups a day / 2-3 / 3-4 / more than 4 cups a day

Current Marijuana use? Yes / No

Do you drink alcohol? Yes / No / Daily / Socially / Rarely

Occupation: ____

Marital Status (circle one): Single / Married / Divorced / Widowed

Review of Systems

General: Change in appetite / Chills / Fatigue / Fever / Headache / Lightheadedness / Night sweats / Sleep disturbance / Weight gain / Weight loss

Ophthalmologic: Blurry vision / Change in vision / Double vision / Eye pain

ENT: Decreased hearing / Decreased sense of smell / Difficulty is swallowing / Dry mouth / Ear pain / Nasal congestion / Nosebleed

Endocrine: Cold intolerance / Dizziness / Excessive sweating / Excessive thirst / Frequent urination / Hair loss / Heat intolerance / Hot flashes / Weakness

Respiratory: Chest pain / Chest tightness / Chronic cough / pain with inspiration / shortness of breath

Cardiovascular: Chest pain / Chest pain at rest / Difficulty laying flat / Dizziness

Gastrointestinal: Abdominal pain / Blood in stool / Constipation / Decreased appetite / Diarrhea / Heartburn / Nausea / Vomiting

Hematology: Anemia / Easy bleeding / Easy bruising / Fever / Prolonged bleeding

Musculoskeletal: Arthritis / Back pain / Joint stiffness / Leg cramps / Muscle spasms / Neck pain / Pain in shoulder(s) / Painful joints / Sciatica / Swollen joint(s) / Trauma to arm(s) / Trauma to hip(s) / Trauma to knee(s) / Trauma to ankle(s) / Weakness

Neurologic: Balance difficulty / Difficulty speaking / Dizziness / Fainting / Headache / Irritability / Loss of strength / Low back pain / Memory loss / Paralysis / Seizures / Stroke / Tic / Tingling / Numbness / Tremor

Psychiatric: Anxiety / Delusions / Depressed mood / Difficulty sleeping / eating disorder / Loss of appetite / Mental or physical abuse / Mood disorder / Nervous breakdown

Medical History and Authorization to Proceed with Treatment

I certify that the above is true and accurate to the best of my knowledge.

Signature: ________________________________ Date: _________________________