PATIENT REGISTRATION

FIRST NAME	MIDDLE NAME/INITIAL	LAST NAME

Preferred Name	Date of Birth	Social Security Number	Gender: Male Female

Primary Care Doctor	Name	Address	Phone	Fax
Referring Provider	Name	Address	Phone	Fax

DEMOGRAPHIC INFORMATION

Home Address				Zip code
Home Phone	Area code	Number	Work Phone	Area code / Number / Extension
Cell Phone	Area code	Number	Preferred Phone	Home Work Cellular
Email Address			Preferred communication	Phone Mail Email
Mailing Address *(if different from home address)*-				Zip code
Whom shall we contact in an emergency?		Relationship to patient?		Phone number
Race	Ethnicity:	Hispanic/Latino	Non Hispanic/Latino	Unreported/Refused
Preferred Language	English Spanish Other		Do you need an interpreter? Yes No What type of interpreter?	
Marital Status	Single Married Divorced Widowed Domestic Partner			
Employment	Full-Time Part Time Not Employed Student		Employer	

PRIMARY INSURANCE

Insurance Plan Name		Effective Date	
Subscriber ID		Group Number	
Insured's Name		Date of Birth	
Relationship to Patient	Self Spouse Parent Partner	Social Security #	

SECONDARY INSURANCE

Insurance Plan Name		Effective Date	
Subscriber ID		Group Number	
Insured's Name		Date of Birth	
Relationship to Patient	Self Spouse Parent Partner	Social Security #	

ASSIGNMENT OF BENEFITS

- I understand I am financially responsible for all charges and services provided to me, including the balance remaining after payment of potential insurance benefits. I authorize payment of medical insurance benefits to PAIN and REHABILITATION SPECIALISTS for professional services rendered.
- I authorize the release of any information necessary to process this claim.
- I certify that all the above information is true and correct to the best of my knowledge. I give my permission to the Provider and/or medical staff to administer and perform such procedures deemed necessary in the diagnosis and/or treatment of my medical condition(s).

Signature of Patient / Legal Guardian/Representative	**Relationship**	**Date**

EXTENDED INFORMATION

Date of Injury	
How were you injured?	
If you were involved in a Motor Vehicle Accident, in what state did it occur?	

WORKERS' COMPENSATION INFORMATION	
Insurance Company Name	
Claim Number	

Case Adjuster	
Office Phone	
Office Fax	
Email Address	
Mailing Address	
City / State / Zip	

Case Manager	
Office Phone	
Office Fax	
Email Address	
Mailing Address	
City / State / Zip	

ATTORNEY			
Attorney's Name			
Name of Firm			
Mailing Address			
City / State / Zip			
Office Phone		Office Fax	
Email Address			

PAIN and REHABILITATION SPECIALISTS
PRACTICE INFORMATION

Because we value open communication and mutual respect, we created this Practice Information Guide to help make your visits here convenient, pleasant, and beneficial.

Office Hours

- Our office is open from 8:00 until 4:30 Monday through Friday. The phone number is: **314-336-2570**.

After Hours and Emergency Care

- If you experience a life-threatening medical condition after office hours, call 911 or go immediately to the nearest Emergency Department, even if you are out of town.
- If you have an urgent, but not life-threatening medical concern that cannot wait until the office reopens, you may reach your doctor through our answering service: **314-771-6080.**
- Reminder: the doctors will not authorize refills of maintenance medications after office hours.

Medication Refills

- Dr. Blake and Dr. Lee authorize prescriptions for narcotic medications only during office hours.
- **Please allow 72 hours for our staff to process your refill request**. Ask the pharmacy to fax the request to **314-336-2571**.
- Your doctor may ask you to schedule an office visit before authorizing your refill request.
- We reserve the right to conduct unannounced urine or serum toxicology screens, and we require your cooperation.

Appointments

- We see our patients by appointment only.
- Our mission is to provide exceptional medical care to each patient. Dr. Blake and Dr. Lee spend as much time as needed to address each patient's individual needs. Expect the doctor to treat the primary reason for the scheduled office visit. We may ask you to schedule another appointment to address concerns other than the primary reason for your visit.
- We see patients in appointment-time order. **If you arrive after your scheduled appointment time**, we will make every effort to work you into the schedule after we treat the patients who arrived on time. Please understand, however, we may ask you to reschedule your appointment.

Personal Health Information

- Dr. Blake and Dr. Lee reserve the right to determine the type of medical-care-related forms each will complete and sign.
- **The standard fee for completion of forms (for example, FMLA, disability, etc.) is $50.00**, payable when you present the form to the office. We must receive payment, either in person or by credit card over the phone, for all requests received by fax or by mail. **Please allow up to 5 business days for completion.**
- Our practice partners with HealthPort/Ciox to process requests for medical records. We must have a signed, HIPAA-compliant authorization to release copies of your medical records.
  Please allow no less than ten (10) business days from the date we receive the request to process these requests.
  If the request is for your personal use HealthPort may charge you a fee for copying those records. We do not charge for records transferred to another physician or medical facility for the purpose of continued care.

Registration / Insurance

- Please review insurance information with our staff *prior* to receiving care to make certain your doctor is a contracted provider for your plan.
- We expect you present a valid insurance card and photo ID at each visit, even if you have an active workers' compensation claim or an active legal case.
- Please tell the staff member at check-in if you have any change in insurance, contact information, address, or pharmacy preference.

By my signature, I attest that I have read and understand the Practice Information guidelines. I received a copy for my records.

Signature of Patient / Guardian / Legal Representative	Relationship to Patient	Date

PATIENT FINANCIAL AGREEMENT

We strive to maintain a strong physician-patient relationship. Sharing our Financial Policy in advance allows for a good flow of communication and enables us to achieve our goal. If you have any questions, do not hesitate to ask a member of our staff.

Health Insurance

- Deductibles, copayment and co-insurance payments are your responsibility.
- We file claims with our contracted insurance plans only. Since the insurance contract is an agreement between you and your insurance company. It is your responsibility to understand your insurance plan benefits with regard to a covered service, if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure. If you have more than one insurance policy, it is your responsibility to inform the office which policy is **Primary** (first) coverage and which policy is **secondary** or **Tertiary**. With each policy, we require the name, birth date, address, phone number, and social security number of the individual who carries the policy.

We expect our patients to pay at time of service any copayment, co-insurance, or deductible required by the insurance company. Because this is an insurance requirement, we cannot bill the patient for these amounts.

Patient/Responsible Party Initial __________

I agree to provide a copy of my insurance card(s) at each visit with the name, address, phone number, date of birth and social security number of the individual who carries the insurance.

Patient/Responsible Party Initial __________

I agree to provide a valid authorization/referral. I understand that if I do not have a valid referral, the staff may ask me to reschedule or pay for the visit in full at check in.

Patient/Responsible Party Initial __________

General Financial Information

Returned Checks: We charge a $30.00 fee for any check returned by the bank. We expect payment by cash, credit card, or money order within 14 days of the notice that your check was returned.

Patient/Responsible Party Initial __________

Past Due Balances: We offer monthly payment plans tailored to each individual's circumstances. If your account becomes delinquent, we reserve the right to take all steps necessary to collect this debt, including referral of your account to a collection agency and/or collection attorney. If such action becomes necessary you assume responsibility for any and all related fees.

Patient/Responsible Party Initial __________

Workers' Compensation: If your employer has pre-approved treatment, we will file claims and you should not expect to have any financial liability. If your employer has not approved treatment and **you choose to receive care by our** physician, you assume full financial responsibility for costs associated with that treatment.

Patient/Responsible Party Initial __________

Personal Injury: If you are receiving treatment as part of a personal injury claim or lawsuit, we require verification from your attorney **prior to your initial visit**. In addition to this verification, we require that you allow us to bill your personal health insurance, if available. We will require you to sign a Notice of Doctor's Lien. In the absence of insurance, other financial arrangements may be available. **Payment of all charges remains the patient's responsibility. We cannot bill your attorney for charges incurred due to your personal injury.**

Patient/Responsible Party Initial __________

Completion of Forms: We charge a fee of **$50.00** to complete any forms not related to health insurance claims (disability, FMLA, injury, for example). Payment is due each time you deliver a form for completion. For forms received by fax or mail, we must receive your payment prior to returning the form to the requestor. We cannot bill you for this service.

Patient/Responsible Party Initial __________

By signing initialing and signing this form, I agree to all of the terms and conditions herein and the agreement will be in full force and effect. I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

______________________________	______________________	______________
Signature of Patient / Guardian / Legal Representative	Relationship to Patient	Date

AUTHORIZATION FOR MEDICAL TREATMENT and RELEASE OF INFORMATION

I authorize my physician and his/her employees, to provide the medical care, tests, procedures, medications, services and supplies considered advisable by my physician. These services may include pathology, radiology, emergency and other special services. In consenting to treatment, I have not relied on any statements as to results. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any of antibodies to hepatitis A, B, and C and HIV.

STORAGE AND RELEASE OF INFORMATION

I consent to the electronic storage and transmission of patient health information. I hereby authorize my treating physician, to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to:

a. Any governmental or other entity as required by law for purposes of reporting or for purposes of determining the eligibility in government sponsored benefit programs.
b. The supplier of any blood or blood products which may be administered to me for the purposes of quality control and recipient monitoring.
c. Any continuing care, residential or long-term care facility, or home health agency for the purposes of providing services for my care.
d. Another health care provider that prescribes medication electronically to provide continuity of care and quality of care issues regarding prescriptions.
e. I also authorize my physician to obtain information from other providers regarding my care and treatment including obtaining my electronic medication and prescription history from whatever source for the purpose of my continuing care and treatment.

Signature of Patient/Legal Guardian/Representative	Relationship	Date

PAIN AND REHABILITATION SPECIALIST
14825 North Outer Forty Road, Ste 365
Chesterfield, Missouri 63017
314-392-5049

NOTICE of DOCTOR'S LIEN

PATIENT NAME ______________________ Date of Birth ______________

Date of Injury/Accident ______________

- I do hereby authorize **PAIN AND REHABILITION SPECIALIST** (PRS) to furnish you, my attorney, with a full report of my examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

- I hereby authorize and direct you, my attorney, to pay directly to said entity such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said entity. I understand that the entity will not be paid in full for his services covered by my health care provider. In consideration of the entity's agreement to await payment for those services not covered by my health care provider, I agree to pay him out of my recovery against a third party the amount of all of his bills not paid by my health care provider. I hereby further give a Lien on my case to said entity against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith. In the event there is no recovery on my accident claim, I understand that I am responsible for those services rendered by the entity which were not covered by my health care provider.

- I understand and agree that in the event litigation is taken to perfect the lien granted herein, that the prevailing party will be awarded reasonable attorney's fees and costs. I further understand that I am granting to said entity all rights given to clinics, health practitioners and other institutions pursuant to R.S.Mo. 430.225 through 430.250 in addition to the rights granted herein.

- I agree to promptly notify said entity of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this Lien by signing below and returning to the entity's office.

I have been advised that if my attorney does not wish to cooperate in protecting the entity's interest, the entity will not await payment but may declare the entire balance due and payable.

______________________________ ______________

Signature of Patient / Patient's Legal Representative Date Signed

The undersigned, being Attorney of Record for the above patient, does hereby agree to observe all the terms of the above Lien and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said entity/entity above named. Attorney further agrees that in the event this Lien is litigated, that the prevailing party will be awarded attorney's fees and costs. Attorney further waives deliver of the Notice by registered mail with return receipt requested as required by R.S. MO 430.240.

______________________________ ______________

Signature of Attorney of Record Date Signed

Please date, sign and return one copy to entity's office. Also keep one copy for your records.

COMMUNICATION AUTHORIZATION

Patient Name ____

Last First MI Maiden

Date of Birth ____________________ **Social Security Number-Last 4 Digits** ____________________

I authorize the providers and staff of Pain and Rehabilitation Specialists of St Louis, LLC to discuss and disclose my Protected Health Information (PHI) to the person(s) named below.

Name	Relationship	Phone Number

I authorize the providers and staff of Pain and Rehabilitation Specialists to leave messages:

☐ ________ On my **home** answering machine / voice mail. ______________________

Initials Phone Number

☐ ________ On my **cell phone** voice mail. ______________________

InitialsPhone Number

HIPAA: NOTICE OF PRIVACY PRACTICES

I have received, and/or been provided the opportunity to receive, a copy of the "Notice of Privacy Practices" that explains when, where and why my confidential health information may be used or shared.

I acknowledge that the Pain and Rehabilitation Specialists physicians, medical assistants and other staff may use and share my confidential health information with others in order to 1) treat me, 2) to arrange for payment of my bill, and 3) for issues that concern Pain and Rehabilitation Specialists operations and responsibilities.

This authorization remains in force until revoked in writing. The purpose of this disclosure/use is for continued medical care.

______________________________ ____________ ____________

Signature of Patient, Guardian, Personal Representative Relationship Date

____

Print name of person authorized under state law to act in the patient's behalf, if the patient is deceased, or his personal representative, or if none, of his child, parent or sibling.

PAIN and REHABILITATION SPECIALISTS
14825 North Outer Forty Road, Ste 360
Chesterfield, Missouri 63017
314-392-5049

PATIENT STATEMENT OF RESPONSIBILITY

PLEASE READ CAREFULLY BEFORE SIGNING

PATIENT NAME ______________________________ Date of Birth ____________________

- I acknowledge that Pain and Rehabilitation Specialists (PRS) does not currently contract with my insurance carrier. PRS continues to negotiate with insurance carriers for appropriate reimbursement for services rendered. I understand I am using my out-of-network benefits for services rendered at this facility.
- I acknowledge that PRS will submit their bill directly to my insurance carrier for services provided by their office. My insurance company may send payment to me directly instead of sending the payment to PRS. In the event I receive a payment from my health insurance company for services rendered by PRS, I will endorse the back of the check and remit payment promptly to PRS, thereby keeping my account in current status.
- I acknowledge that any discounts negotiated with me by PRS will become null and void if I cash checks I receive from my insurance company for services rendered by PRS.
- I also acknowledge I may contact PMBA LLC (billing agent for PRS) at 314-392-5049 with questions regarding my account.

______________________________ ____________________ ____________
Signature of Patient, Guardian, Personal Representative | Relationship | Date

____
Print name of person authorized under State law to act in the patient's behalf
If the patient is deceased, or his personal representative, or if none, of his child
parent or sibling.

PATIENT STATEMENT OF RESPONSIBILITY
MEDICAID INSURANCE COVERAGE

PATIENT NAME ______________________________ Date of Birth ____________________

PRS PROVIDER ☐ Helen M Blake, MD ☐ Thomas K Lee, MD

PLEASE READ THIS DOCUMENT CAREFULLY BEFORE SIGNING

My name is ____.

- I am completing this form to confirm my full knowledge that the doctor, whose name is checked above is not a contracted provider for the ***Medicaid insurance plan***. This means that Pain and Rehabilitation Specialists, the practice that employs this doctor, cannot, by law, bill Medicaid, and that I accept personal responsibility for any charges incurred in relation to the medical treatment I receive from this doctor, the practice, and/or any of the doctor's assistant(s).

- I understand I will be financially responsible for services provided from this date forward.

- In the event that the doctor or Pain and Rehabilitation Specialists must take legal action to pursue payment from me, I understand that I will bear financial responsibility for any cost(s) incurred by the doctor or Pain and Rehabilitation Specialists to recoup payment owed.

- I understand that I have informed Pain and Rehabilitation Specialists I am seeking medical treatment because of the effects of an accident in which I was recently involved, and that the matter is currently in litigation. I understand that Pain and Rehabilitation Specialists is willing to forego any collection attempts, and is willing to place my account on hold until this litigation matter settles, prior to proceeding with any collection attempts.

- I understand that regardless of the outcome of this litigation matter, I am fully and personally responsible for all charges accrued on my behalf.

- I understand that if I have any questions, I may contact Pain and Rehabilitation Specialists at 314-336-2570.

______________________________ ____________________
Signature, Patient or Legal Guardian Date

____
Printed Name, Patient or Legal Guardian

MEDICARE PRIVATE CONTRACT

This Contract is entered into by and between ***Helen M. Blake, MD*** *and/or* ***THOMAS K. LEE, M****D ("Physician/s") whose principal medical office is located at s14825 North Outer Forty Road, Suite 365, Chesterfield, Missouri 63017 and*

NAME: ____ *("Medicare Beneficiary"), who resides at*

ADDRESS: ____

and shall become effective on this _________________ day of _____________________________, 20_________ and shall expire on the _________________ day of _____________________________, 20_________ (the "Opt-Out Period"), unless otherwise renewed in accordance with 42 U.S.C. § 139a; 45 C.F.R. §, Subpart D.

- I, Physician, have not been excluded from Medicare under Sections 1128, 1156 or 1892 of the Social Security Act.
- I, the Medicare Beneficiary, or my legal representative, accept(s) full responsibility for payment of charges for all services furnished by Physician.
- I, the Medicare Beneficiary, or my legal representative, understand(s) that Medicare limits do not apply to what the Physician may charge for items or services furnished by the Physician.
- I, the Medicare Beneficiary, or my legal representative, agree(s) to not submit a claim to Medicare or to ask the Physician to submit a claim to Medicare.
- I, the Medicare Beneficiary, or my legal representative, understand(s) that Medicare will not pay for any items or services furnished by Physician that would have otherwise been covered by Medicare if there was no Private Contract and a proper Medicare claim had been submitted.
- I, the Medicare Beneficiary, or my legal representative, enter(s) into this Contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician/physicians who have not opted-out of Medicare, and that I am not compelled to enter into Private Contracts that apply to other Medicare-covered services furnished by other physicians who have opted-out.
- I, the Medicare Beneficiary, or my legal representative, understand(s) that Medigap plans do not, and that other supplemental plans may not elect to, make payments for items and services not paid for by Medicare.
- I, the Medicare Beneficiary, or my legal representative, understand(s) that this Contract cannot be entered into during a time when I, the Medicare Beneficiary, require emergency care services or urgent care services. (However, a physician and/or practitioner may furnish emergency or urgent care services to a Medicare Beneficiary in accordance with Chapter 15 § 40.28 of the Medicare Benefit Policy Manual (2003); 42 C.F.R. § 405.440.
- I, the Medicare Beneficiary, or my legal representative, understand(s) will receive, or have received, a copy (a photocopy is permissible) of this Contract, before items or services are furnished under the terms of this Contract.
- Medicare Beneficiary will retain the original Contract (original signatures of both parties required) for the duration of the Opt-Out Period.
- Medicare Beneficiary will supply a copy of the Contract to CMS upon request.
- Medicare Beneficiary understands that this Contract remains in effect for two (2) years. If Medicare Beneficiary again opts-out of Medicare, Medicare Beneficiary will expediently complete a new Contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

PHYSICIAN / PHYSICIAN'S REPRESENTATIVE	**PATIENT or LEGAL REPRESENTATIVE**
______________________________ Signature	______________________________ Signature
______________________________ Printed Name	______________________________ Printed Name
______________________________ Date	______________________________ Date

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name ____

Last First MI Maiden

Date of Birth ____________________ Social Security Number ____________________

I Authorize and Request: ____

____

____

____________________ ____________________

Office Phone Office Fax

To Release to: **Pain and Rehabilitation Specialists**
14825 N Outer 40 Road, Suite 360
Chesterfield, MO 63017
Office Phone: 314-336-2570
Office Fax: 314-336-2571

Medical Records covering the periods of health care from ____________ to ____________

Date Date

Please check, and initial, the types of records you do not want released.

☐ HIV Testing/Treatment Records ☐ Substance Use/Abuse History ☐ Psychiatric Evaluation

☐ Other (please specify) ____

The Medical Information is needed for: ____

ATTENTION: Once this information has been released pursuant to the Authorization, it may no longer be protected by Federal, and/or State law/regulations and may no longer be deemed "confidential."

I understand that neither Pain and Rehabilitation Specialists, or any of its affiliated healthcare providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization, if so requested.

I understand that I may revoke the Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will **expire one (1) year** from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax, or bring a letter in person stating that I want to cancel this Authorization. I understand that I need to mail, fax or bring the letter to the address or fax number at the top of the page.

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's Death Certificate.

______________________________ ____________ ____________

Signature of Patient (if the patient is incompetent, of his guardian or other) ***Relationship*** ***Date***

____

Printed name of person authorized under State Law to act in the patient's behalf, if the patient is deceased, or his personal representative or if none, of his child, parent or sibling.

PAIN and REHABILITATION SPECIALISTS

UNITED PHYSICIANS GROUP

TELEMEDICINE PATIENT CONSENT/REFUSAL FORM

Patient Name ______________________________ DOB ________________

PHYSICIAN ☐ Helen M. Blake, MD ☐ Thomas K. Lee, MD

1. **PURPOSE**: The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with follow up appointments/continuing medical care.
2. **NATURE OF TELEMEDICINE CONSULT*:*** During the telemedicine consultation, details of your medical history, examinations, x-rays, and/or tests will be discussed through the use of interactive video, audio, and telecommunication technology.
3. **MEDICAL INFORMATION & RECORDS:** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, no telecommunications are recorded or stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to other entities shall not occur without your consent.
4. **CONFIDENTIALITY:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and state law apply to information disclosed during this telemedicine consultation.
5. **RIGHTS**: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment.
6. **RISKS, CONSEQUENCES & BENEFITS**: You have been advised of all the potential risks, consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.
7. **FINANCIAL RESPONSIBILITY**: Your financial responsibility will be determined individually and governed by your private health insurance carrier(s), workers compensation carrier(s), or Doctor's Lien arrangement. It is your responsibility to check with your insurance carrier to determine coverage.

I agree to participate in a telemedicine consultation

Signature, Patient or Legal Representative	Relationship to Patient	Date

I refuse to participate in a telemedicine consultation.

Signature, Patient or Legal Representative	Relationship to Patient	Date

HELEN BLAKE, MD.
HEALTH HISTORY
PAIN MANAGEMENT

Date of Visit ______________________

Name ______________________ DOB ______________ Gender ☐ M ☐ F

Email address ______________________ Height __________ Weight __________

Spouse ______________________ Are you pregnant? ☐ No ☐ Yes ☐ Unknown

Primary Care Physician ______________________ Phone ______________

Preferred Pharmacy ______________________ Phone ______________

PAST MEDICAL HISTORY: *Please check if you have now, or have had in the past, any of these medical conditio*

- ☐ **NO PAST MEDICAL PROBLEMS**
- ☐ Acid Reflux
- ☐ Adverse Reaction to Anesthesia
  - Describe ______________________
- ☐ Alzheimer's/Significant Memory Loss
- ☐ Anemia
- ☐ Angina or Chest Pain
- ☐ Asthma
- ☐ Atrial Fibrillation/Erratic Heartbeat
- ☐ Bladder Problems
- ☐ Bleeding Ulcer
- ☐ Blood Clot
  - ☐ Legs ☐ Lungs ☐ Other
- ☐ Cancer Type: ______________________
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Dental Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Hemophilia/Excessive Bleeding
- ☐ Hepatitis or Liver Disease
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ HIV or AIDS
- ☐ Infections: ______________
  - MRSA? ☐ Yes ☐ No
- ☐ Kidney Disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Psychiatric Disorder
- ☐ Rheumatoid Arthritis
- ☐ Sickle Cell
- ☐ Sleep Apnea
- ☐ Use CPAP Machine
- ☐ Stroke (CVA)
- ☐ Thyroid Disease
- ☐ Other (Explain)

Have you ever passed out/lost consciousness at the time of a blood draw, IV or medical procedure?

☐ NO ☐ YES Briefly explain. ______________________________________

Do you have a FAMILY history of any of these conditions?

- ☐ Alcohol Abuse
  - ☐ Father
  - ☐ Mother
  - ☐ Sibling
  - ☐ Child
- ☐ Illegal Drug Use
  - ☐ Father
  - ☐ Mother
  - ☐ Sibling
  - ☐ Child
- ☐ Prescription Drug Abuse
  - ☐ Father
  - ☐ Mother
  - ☐ Sibling
  - ☐ Child

Do you have a PERSONAL history of any of these conditions?

☐ Alcohol Abuse ☐ Illegal Drug Use ☐ Prescription Drug Abuse

Did you seek Professional Treatment or Detoxification? ☐ NO ☐ YES

Do you have a PERSONAL Diagnosis of any of these conditions?

☐ ADD / ADHD ☐ OCD ☐ Bipolar

☐ Schizophrenia ☐ Depression ☐ Other:

Are you taking medication for any of the above conditions?

☐ NO ☐ YES What medication? ____________________

Are you allergic to any of the following?

☐ Iodine ☐ Shellfish ☐ Latex

Are you CURRENTLY Taking any of the following medications?

☐ *Coumadin* (Warfarin)	☐ *Plavix (Clopidogrel)*	☐ Aspirin	☐ *Brillinta* (Ticagrelor)
☐ *Pradaxa* (Dabigatran)	☐ *Lovenox* (Enoxaprin)	☐ *Aggrenox*	☐ *Ticlid* (Ticlopidine)
☐ *Xarelto* (Rivaroxaban)	☐ Eliquis (Apixaban)		

Why are you taking this medication? ____________________

What is the Prescribing Physician? ____________________

Contact phone number? ____________________

SURGICAL HISTORY: *Please check if you have had any of these surgeries.*

☐ **NO PREVIOUS SURGERY**	☐ Breast Surgery	☐ Prostate Surgery
☐ Abdominal Surgery	Type ____________	☐ Other (explain)
Type: ____________	☐ Carotid Surgery	____________
☐ Aneurysm	☐ Colon Surgery	____________
☐ Angioplasty/Stents	☐ Coronary Bypass (CABG)	____________
☐ Artery Bypass of Arm or Leg	☐ Heart Valve Replacement	____________
☐ Bone/Joint Surgery	☐ Hysterectomy	____________
Type ____________	☐ Pacemaker/Defibrillator	____________

☐ Back/Neck Surgery

- ☐ Cervical (neck) Level(s) ____________ When? ____________
- ☐ Thoracic Level(s) ____________ When? ____________
- ☐ Lumbar (low back) Level(s) ____________ When? ____________

☐ Implanted Devices *(If YES, check all that apply.)*

☐ Screws, Pins, Plates	☐ Pacemaker	☐ IUD	☐ Venous Access
☐ Aneurysm Clip(s)	☐ AICD	☐ Breast Implant	☐ Spinal Cord Stimulator
☐ Intrathecal Pump			

Patient Name: ____________________ DOB ____________ Date of Visit ____________

FAMILY HISTORY:

*Please check below if any immediate relatives have had any of these conditions: **F**–father, **M**–mother, **S**-sibling, **C**-child.*

- ☐ **NO FAMILY HISTORY TO REPORT**
- ☐ **I AM ADOPTED**
- ☐ Aneurysm
- ☐ Adverse Reaction to Anesthesia
- ☐ Bleeding Disorders
- ☐ Blood Clots/ Pulmonary Embolism
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke (CVA)
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Other (Explain) ______________________ ______________________ ______________________

SOCIAL HISTORY:

Marital Status ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widow/Widower

Hobbies ______________________

Please indicate your employment status

- ☐ Unemployed because of my Pain
- ☐ Unemployed, currently looking
- ☐ Homemaker
- ☐ On Disability
- ☐ Retired
- ☐ (Other) ______________________
- ☐ Employed, Part Time
- ☐ Employed, Full Time

Smoking ☐ Never Smoked ☐ Former Smoker ☐ Current Smoker? How may packs /day? __________

Do you dip or chew tobacco? ☐ No ☐ Yes How much per day? ______________________

Do you drink alcoholic beverages? ☐ No ☐ Yes How many drinks per week? ______________________

Do you use recreational drugs ☐ No ☐ Yes What and how often? ______________________

REVIEW OF SYSTEMS: *Please check if you have now, or recently experienced any of these medical conditions.*

- ☐ Leg Swelling
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Fever/Chills/Night Sweats
- ☐ Vision Problems
- ☐ Dental Problem
- ☐ Chest Pain
- ☐ Skin Wounds/ Rash
- ☐ Shortness of Breath
- ☐ Abdominal Pain
- ☐ Black, Tarry Stools
- ☐ Arm/Leg Pain
- ☐ Urinating at Night
- ☐ Incontinence
- ☐ Seizures
- ☐ Psychological Problems
- ☐ Depression
- ☐ Anxiety
- ☐ Easy Bleeding/Bruising
- ☐ Swollen Glands
- ☐ Irregular Heart Beat

MEDICATION ALLERGIES

☐ **NO KNOWN MEDICATION ALLERGIES**

Are you allergic to Contrast Dye? ☐ NO ☐ YES	Reaction?
Are you allergic to Latex? ☐ NO ☐ YES	Reaction?
Are you allergic to Tape? ☐ NO ☐ YES	Reaction?
Other	Reaction?
Other	Reaction?
Other	Reaction?

CURRENT MEDICATION: *Please include herbal and over-the-counter medications. List all medications with dosage.*

☐ NOT CURRENTLY TAKING ANY MEDICATIONS-PRESCRIPTION OR OVER-THE-COUNTER, OR HERBAL SUPPLEMENTS

DRUG	**DOSAGE**	**DRUG**	**DOSAGE**

Patient Name: ______________________ DOB ____________ Date of Visit ____________

HELEN BLAKE, MD.
PAIN MANAGEMENT
PATIENT QUESTIONNAIRE

DATE ______________________

Patient Name ______________________ **DOB** ______________ **Gender** M ☐ F ☐

Reason for today's visit: ☐ Back Pain ☐ Neck Pain ☐ Shoulder Pain
☐ Knee Pain ☐ Other ______________________

How did this Pain begin? ☐ Auto Accident ☐ At Home ☐ Following an Illness
☐ At Work ☐ Following Surgery ☐ Other/Unknown

Please briefly describe how your Pain began. ______________________

____

____

When did the Pain begin? ______________________

What was the date of your Injury? ______________________

Have you ever had this Pain before? ☐ NO ☐ YES How long ago? ______________________

Since the Pain began, my symptoms have: ☐ Gotten Worse ☐ Stayed the Same ☐ Improved

How often do you have the Pain? ☐ Constant (100% of the time) ☐ Intermittent (50% of the time)
☐ Frequent (75% of the time) ☐ Occasional (25% of the time)

Have you ever seen any other physician, or had other treatment, for this Pain? ☐ NO ☐ YES

If **YES**, what is the Physician's name? ______________________ Specialty ______________

If **YES**, what treatment did you receive? ______________________

Have any Legal Claims been filed related to your Pain? ☐ NO ☐ YES

If **YES**, what is the Attorney's name? ______________________ Phone# ______________

Have you had any of the following Imaging Studies to evaluate the Pain?

☐ MRI ☐ X-Ray ☐ CT Scan ☐ Bone Scan
☐ Myelogram ☐ Discogram ☐ EMG/NCV ☐ Other ______________________

What Treatments have you previously tried for the Pain?

- ☐ Steroid/Cortisone Injection
- ☐ Acupuncture
- ☐ Chiropractic Visits
- ☐ Biofeedback
- ☐ Rest/Activity Modification
- ☐ Heat Therapy
- ☐ Physical Therapy
- ☐ Psychotherapy
- ☐ Electrical Stimulation (TENS)
- ☐ Nerve Block
- ☐ Massage Therapy
- ☐ Other ______________________________

What Medications have you previously tried for the Pain?

- ☐ Gabapentin (*Neurontin*)
- ☐ Ibuprofen (*Advil*)
- ☐ Opioid/Narcotic *Type* ______________________
- ☐ Pregablin (*Lyrica*)
- ☐ Acetaminophen (*Tylenol*)
- ☐ Antidepressant *Type* ______________________
- ☐ Oral Steroids (*Medrol Dose-Pak*)
- ☐ Naproxen (*Aleve*)
- ☐ Other *Type* ______________________

Do you have any of the following symptoms? ☐ NO ☐ YES

If **YES**, check all that apply.

- ☐ Numbness
- ☐ Bladder Incontinence
- ☐ Weakness in Arm/Leg
- ☐ Tingling
- ☐ Bowel Incontinence
- ☐ Joint Swelling

What makes the Pain better? (Check all that apply.)

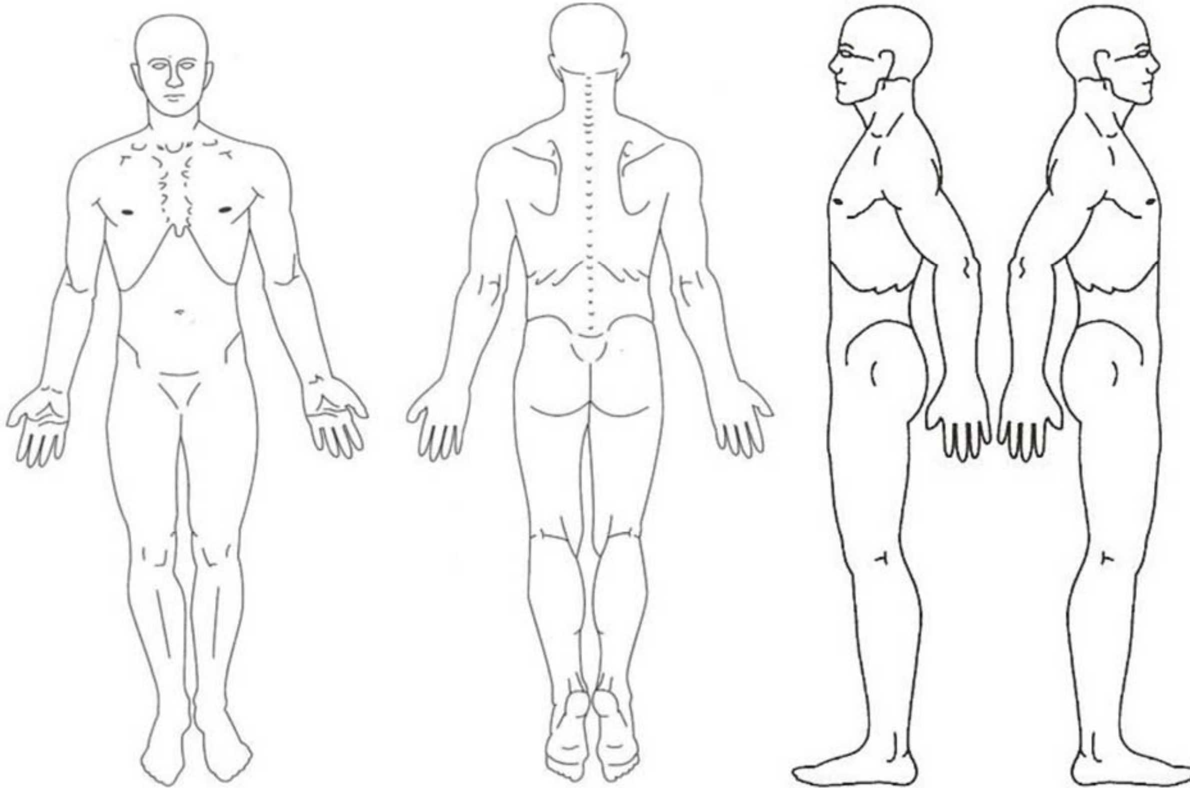
- ☐ Walking
- ☐ Leaning Forward
- ☐ Relaxation
- ☐ Heat
- ☐ Lying Flat
- ☐ Lying with Hips/Knees Bent
- ☐ Rest
- ☐ Medication ______________________________

What makes the Pain worse? (Check all that apply)

- ☐ Standing
- ☐ Laying Down
- ☐ Bowel Movements
- ☐ Sitting
- ☐ Lifting
- ☐ Coughing/Sneezing
- ☐ Getting up out of bed
- ☐ Bending Forward
- ☐ Damp Weather
- ☐ Walking
- ☐ Bending Backward
- ☐ Rising out of a chair
- ☐ Cold
- ☐ Urination
- ☐ Exercise ______________________________

Please mark **WHERE** you feel The Pain. Use the symbols to indicate **THE TYPE OF PAIN** you experience in each area.

Aching	Burning	Numbness	Pins and Needles	Stabbing
ΔΔΔΔΔΔΔ	XXXXXXXX	=========	ooooooo	/////////



In the past 30 DAYS, please indicate your Pain Level based on the scale below:

TODAY	0 1 2 3 4 5 6 7 8 9 10
At its BEST	0 1 2 3 4 5 6 7 8 9 10
At its WORST	0 1 2 3 4 5 6 7 8 9 10

Scale
0 = No Pain
1 = Very Mild Pain: You are aware of the pain but it doesn't bother you
2 = Mild Pain that you can tolerate without taking medication
3 = Mild to Moderate pain that requires medication to tolerate
4-5 = Moderate Pain that sometimes is not controlled and causes you to feel antisocial
6 = Fairly Severe Pain that Interferes with daily life.
7-9 = Intensely Severe Pain
10 = Worst Pain Imaginable