



Dear Sir or Madam,

We are pleased to have you as a patient at Ashford Interventional Pain Solutions. Our clinic is an interventional pain management clinic that utilizes many modalities in the treatment of chronic pain including medications, massage therapy, epidurals, a variety of nerve block procedures, as well as more advanced techniques such as implantable devices. We also have the means for referrals to neurosurgeons, orthopedic surgeons, neurologists, psychologists, and physical therapists.

On your visit, we will perform a thorough medical history and physical examination so that we may formulate an appropriate treatment plan for your specific pain problems. Some treatment plans require approval from your insurance company. Please note that this process can take several weeks to complete. We appreciate your patience and cooperation during this time.

The primary goal of our clinic is to help reduce or eliminate your pain so that you may comfortably perform routine daily activities and live a more normal life. An effective pain management strategy often requires several treatment modalities (nerve blocks, medications, massage therapy, physical therapy, etc.), but your help and motivation are essential in order for your treatment plan to be successful. Failure to comply with the advised treatment plan given to you by Dr. Ashford may result in discharge from our clinic.

Please note that we are not a walk-in clinic and you will not be seen without an appointment. If you must cancel or reschedule an appointment, please call our office 24 hours in advance of your scheduled appointment. Failure to do so will result in a no-show fee up to or equal to the fee of the scheduled visit. This fee may be anywhere from \$50 to \$150. Our time is valuable and other patients can be seen in your time slot if we have proper notice. You may be dismissed and no further appointments given if you fail to show for a scheduled appointment more than two times without reasonable cause. This decision will be made at the doctor's discretion.

We ask that you bring all of your prescribed medications or a list of all medications with you to your appointment. Please note that we will not call in medications to your pharmacy. All medications must be requested at your scheduled appointment. There will be a \$10.00 charge for any prescriptions that are requested between your scheduled appointments.

Your pharmacy's name, address, and telephone number is required at your initial consultation. No prescriptions will be written until this information is provided. If you change pharmacies, doctors, or insurance, it is your responsibility to notify our office staff. Failure to comply may result in a delay of treatment.

Thank you,  
Ashford Interventional Pain Solutions

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name (please print): \_\_\_\_\_



## POLICIES & PROCEDURES

### Appointments

- If you are greater than 15 minutes late to your scheduled appointment your appointment will be cancelled and rescheduled for a later date.
- Due to the nature of our practice, you may have an extended wait time for your appointment. We appreciate your patience and understanding.
- We require a 24-hour notice if you need to cancel or reschedule your appointment. If you fail to comply with this notice you will be charged as follows:
  - New Patient Appointment: \$350
  - Follow-up Clinic Visits: \$150
  - Procedures: \$300 - \$600
  - Massage Therapy: \$75
- Please allow a reasonable amount of time for your prescribed treatment plan to take effect by keeping your scheduled appointments.
- If you have a patient balance your balance is expected to be paid in full at the time of your clinic visit. Failure to pay will result in cancellation of your scheduled appointment.
- **We are not a walk-in clinic and will not see patients without appointments.**

### Prescriptions

- We will not call in prescriptions to your pharmacy. Please obtain all written prescriptions during your scheduled appointment.
- There will be a \$10.00 charge for any prescriptions requested between your scheduled appointments. You will be required to pick up your prescriptions at the front desk and payment will be required at the time you pick up.

### Office Eitquette

- For the safety of our elderly patients, please refrain from bringing children under the age of 12 to your appointment. Failure to comply may result in cancellation of your scheduled appointment.
- Disruptive or disrespectful behavior will not be tolerated and may result in discharge from our clinic per your Doctor's discretion.

### Office Policies:

- At times, you may be required to leave a message for the medical staff. Any messages left after 4:00 PM will be returned the following day. A \$25.00 consult fee will be charged if a call from the physician is required.
- We ask that you limit your phone calls to urgent needs only. We see a large volume of patients in our office each day and it is difficult to provide one-on-one service and still attend to a large volume of patient phone calls.
- Patients should contact the office immediately if any of the following are new or present more than 48 hours after a procedure: (1) fever greater than 101 degrees, (2) neck stiffness, (3) drainage from a procedure site, (4) weakness, numbness or tingling in arm(s) or leg(s). Patients should also call if they are having an allergic reaction to new medication prescribed. Call 911 for all emergencies.

By Signing this document, you agree to follow and adhere to the Terms and Conditions stated above.

Patient Signature: \_\_\_\_\_ Patient Name (please print): \_\_\_\_\_



**AUTHORIZATIONS, RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS**

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize Ashford Interventional Pain Solutions, to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to the following:

- a. Any person or entity responsible for payment for the medical services rendered to me at the Facility, including third party payors, self-insurers, worker's compensation carriers and government agencies or any person or entity acting as the agent or contractor of such party responsible for payment, in connection with obtaining payment for the medical services rendered to me at the Hospital by employees of the Facility or any person providing services at the Facility.
- b. Federal, State or other governmental or quasi-governmental agencies or such other parties required by law for reporting purposes or for purposes of determining eligibility in government sponsored benefit programs.
- c. Any person or entity participating in quality studies, utilization review or similar studies of the care rendered by the Facility and /or its physicians.
- d. Any health professionals involved in my care for the purpose of facilitating the continuity of my medical care.
- e. To persons authorized by the Facility in connection with the performance of supervised research in compliance with the rules and procedures of the Facility. I also understand that an authorized researcher may contact me at some future date.
- f. I acknowledge that the above authorization has no expiration date and is valid to authorize the release of medical records and billing information at any time a valid request is received. This includes information relative to alcohol abuse, drug abuse, psychological or psychiatric conditions and Acquired Immune Deficiency Syndrome (AIDS).

MEDICAL LIFETIME SIGNATURE ON FILE: (if applicable) I request that payment of authorized Medicare benefits be made to APS for any services furnished by a member of this group, I authorize the holder for medical information about me to release the finance administration and its agents any information needed to determine these benefits or benefits payable for related services.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize my Medicare and/or medical insurance benefits to be paid directly to Ashford Interventional Pain Solutions, separately from other Facility or professional bills. I understand that I am financially responsible for non-covered services as well as any deductibles, coinsurance or amounts in excess of insurance benefits. If coverage is denied, I give my express consent to appeal to the insurance on my behalf.

FINANCIAL RESPONSIBILITY: In consideration of services rendered or to be rendered to the patient designated herein at my request for this occasion of service, I guarantee and agree to pay charges for those services rendered including any amount not paid in my insurance plan, Medicare, health service plan or health maintenance organization. Members of health maintenance organizations (and preferred provider organizations) are generally required to comply with certain policies and procedures requiring use of participating providers and compliance with plan requirements for primary referral, emergency admission, pre-certification and utilization review. These are conditions to payment of benefits by the health maintenance organizations (and preferred provider organizations). OR Ashford Interventional Pain Solutions, may not participate with your health care coverage plan and their charges may not be covered.

By signing the financial responsibility statement, the patient and guarantor(s) acknowledge and agree they are responsible for payment of billed charges rendered in any case in which payment may be denied by the health maintenance organization (or preferred provider organization) because of a failure to comply with such coverage requirements or for any other reason.

I acknowledge that I have read and understand its contents fully. The undersigned is the patient, the patient's legal representative or is authorized by the patient to execute this form and accepts its terms. I authorize the use of email to contact me.

\_\_\_\_\_  
Signature of patient, parent or legal guardian of patient

\_\_\_\_\_  
Date signed



**PLEASE READ AND SIGN THIS FORM  
PATIENT HIPAA PRIVACY AUTHORIZATION FORM  
ASHFORD INTERVENTIONAL PAIN SOLUTIONS**

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I understand that my health information is private and confidential. I understand that Ashford Interventional Pain Solutions works very hard to protect my privacy and preserve my confidentiality of the personal health information. Some information can be relayed by telephone. In this instance, we will call your telephone we have on file that you have provided. For more pertinent information it is necessary to send a letter. In this case we will send a letter addressed only to you at the address you have provided.

I understand that Ashford Interventional Pain Solutions may use and disclose my personal health information (PHI) to help provide health care to me, to handle billing and payment, and to take care of the other health care operations. In general, there will be no other used and disclosures of this information unless I authorized it in writing. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual.

Ashford Interventional Pain Solutions has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting our patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement. SCWH may update this "Notice of Privacy Practices" at any time. If I ask, Ashford Interventional Pain Solutions will provide me with the most current "Notice of Privacy Practices". I have been provided a copy of this at my first visit.

Our Notice of Privacy Practices states that we may disclose your PHI to others who may assist in your care, such as your spouse, children, parents, or caregiver. **Please list any family members and caregivers with whom we are authorized to discuss your medical care or to whom we may release medical records.**

No Release to family/caregivers. If you wish to RESTRICT use/disclosure to TPO in other ways, please request a form.

Under the terms of this consent, I can ask Ashford Interventional Pain Solutions to limit how my personal health information is used or disclosed to carry our treatment, payment, or healthcare options. I understand that Ashford Interventional Pain Solutions does not have to agree to my request. If Ashford Interventional Pain Solutions does agree to my request, I understand that they would follow the agreed limits.

I may cancel this consent in writing at any time by writing, signing, and dating a letter to Ashford Interventional Pain Solutions. The letter must say that I want to revoke my consent to authorize the use and disclosure of my personal health information for treatment, payment, and health care operations. If I revoke this consent, Ashford Interventional Pain Solutions does not have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of Ashford Interventional Pain Solutions "Notice of Privacy Practices". My signature means that I agree to allow Ashford Interventional Pain Solutions to use and disclose my patient's personal health information to carry out treatment, payment, and healthcare operations.

\_\_\_\_\_  
Signature of patient, parent or legal guardian of patient

\_\_\_\_\_  
Date signed



**ASHFORD INTERVENTIONAL PAIN SOLUTIONS  
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I hereby authorize to release all medical records including history, finding, and prognosis to Ashford Interventional Pain Solutions. A copy shall be valid as the original document. I understand that when my PHI is disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and my no longer be protected by the federal HIPAA privacy rule. I have the right to revoke this authorization in writing, except (i) to the extent that the practice has acted in reliance upon this authorization; or (ii) to the extent that the authorization was obtained as a condition of obtaining insurance coverage claim under the policy. I understand that my revocation must be submitted in writing to the practice's privacy official/committee at 1000 Hawthorne Avenue Suite J, Athens, GA 30606, by sending a written request stating that I wish to revoke this authorization to the attention of the privacy official/committee. I understand that the practice may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. By signing this authorization, I authorize Ashford Interventional Pain Solutions (the "practice") to use and/or disclose certain protected health information (PHI) to or for the party or parties listed below.

**Records From: Facility Name(s):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Sent From: \_\_\_\_\_ Job Title: \_\_\_\_\_

**Ashford Interventional Pain Solutions**  
**1000 HAWTHORNE AVE.**  
**SUITE J**  
**ATHENS, GA 30606**  
**(P): (706) 286-8344**  
**(F): (706) 286-8346**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date Signed

If signed by legal representative, please check one:

- \_\_\_\_\_ Relationship to this patient: \_\_\_\_\_
- \_\_\_\_\_ Custodial Guardian
- \_\_\_\_\_ Durable Power of Attorney for Healthcare



## ASHFORD INTERVENTIONAL PAIN SOLUTIONS PATIENT PAYMENT POLICY

Ashford Interventional Pain Solutions strives to ensure a clear understanding of your financial responsibility with respect to the medical services we provide. These policies apply to all procedures and dates of service.

**Co-Pays:** We require payment of co-pays at the time of service, and reserve the right to refuse treatment.

**No Insurance:** If you have no insurance, we collect the office visit before the visit and the remainder at checkout. Self-pay patients may receive additional bill for services rendered.

**Payments:** Your insurance company will determine what amount, if any, you owe to Ashford Interventional Pain Solutions. Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. If there is a balance due to your account, we will mail a detailed statement which is due upon receipt. Do not assume that any statement you receive will be paid by your insurance company. For your convenience, we accept cash, money orders, Visa, MasterCard, American Express, and Discover. If a check is returned for insufficient funds, we reserve the right to add a penalty charge of \$45.00 to your account.

**Outstanding Account Balances:** Any patient with an outstanding balance will be required to pay that balance in full before being authorized to see your doctor. Failure to comply will result in cancellation of your scheduled appointment.

**Claim Filing:** We happily file your claim with your insurance company as a courtesy. We bill insurance in accordance with all federal, state, and other contractual requirements in cases where we have an agreement or we are a participating provider. Please keep in mind that payment remains your responsibility. We are happy to help aid to get your claims paid, but from time to time your insurance company may need you to supply certain information directly. We expect payment in full from you if your insurance company delays processing of your claim for over 90 days. You agree to pay any portion of the charges not covered by insurance. If your insurance company sends payments directly to you, send or drop-off the payment to Ashford Interventional Pain Solutions, and we will apply it to your account.

**Preauthorization:** Most insurance companies require preauthorization before you have a surgical procedure. Failure to obtain preauthorization may result in your insurance company refusing to pay your claim. Any refusal of payment by insurance for this reason is your responsibility.

**Dependents:** You are responsible for payment of services rendered to your dependents on your account. In cases where a written court order allows payment for medical costs associated with a dependent, it is the responsibility of you to obtain reimbursement from the other party involved.

### **Attestation Statement:**

*I have read, understand, and agree to the above Ashford Interventional Pain Solutions Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I acknowledge that these policies do not obligate Ashford Interventional Pain Solutions to extend credit.*

*I authorize my insurance benefits to be paid directly to Ashford Interventional Pain Solutions.*

*I authorize Ashford Interventional Pain Solutions to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim in compliance with HIPAA regulations.*

Patient Name (please print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_



### PATIENT DEMOGRAPHICS

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Sex:  Female  Male Ethnicity:  White/Caucasian  Black/African-American  Asian  Hispanic/Latino

Marital Status:  Single  Married  Divorced  Widowed

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Employer Name: \_\_\_\_\_

#### Responsible Party (if other than patient):

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

#### Emergency Contact Information:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

#### How did you hear about Ashford Interventional Pain Solutions?

Google  Healthgrades  Family/Friend  Facebook  Mail  Other: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Preferred Pharmacy Name: \_\_\_\_\_ Address: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_



Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please shade in the chart below areas where you feel pain.  
Put an X on the area that hurts the most.

**FRONT**                      **BACK**

Right                      Left                      Left                      Right

What are your activity goals for your pain treatment?

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

How long have you had chronic pain?

\_\_ Month(s) \_\_ Year(s) \_\_ Week(s) \_\_ Day(s)

Please describe events surrounding the onset of your pain. (Date of injury, activities that made it worse?)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE CIRCLE: In the last year, how many emergency room visits have you had for pain?**

0 1 2 3 4 5 6 7 8 9 10 other: \_\_\_\_\_

**Which words describe the QUALITY of your pain? (check)**

- Throbbing  Cramping  Heavy/Pressure
- Tingling/Pins & Needles  Cold/Freezing  Sharp/Shooting
- Hot/Burning  Stabbing  Electric-Shock  Itching

**Please circle all ACTIVITIES that MAKE YOUR PAIN WORSE:**

rest touch sitting standing bending lifting walking light exercise sex warm compresses cold compresses relaxation techniques other: \_\_\_\_\_

**Please circle all ACTIVITIES that MAKE YOUR PAIN BETTER:**

rest touch sitting standing bending lifting walking light exercise sex warm compresses cold compresses relaxation techniques other: \_\_\_\_\_

**Please circle RELIEF(%) YOU HAVE HAD IN THE LAST 24 HOURS from medications & treatments:**

No Relief    10%    20%    30%    40%    50%    60%    70%    80%    90%    100% Complete Relief

**WHEN YOU TAKE YOUR MEDICATION how many HOURS OF RELIEF do you get?**

\_\_\_\_ Hours    \_\_\_\_ No help at all    \_\_\_\_ I do not take pain medications

Does your pain affect your sleep? \_\_\_\_\_ yes \_\_\_\_\_ no

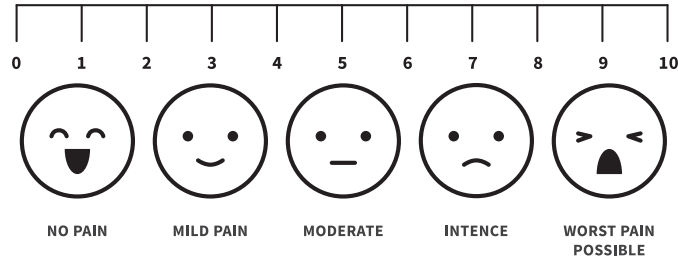
Does your pain cause anxiety? \_\_\_\_\_ yes \_\_\_\_\_ no

Does your pain cause depression? \_\_\_\_\_ yes \_\_\_\_\_ no





### PAIN MEASUREMENT SCALE



Please circle the number that indicates your **WORST PAIN LEVEL** over the last week:

No Pain    0    1    2    3    4    5    6    7    8    9    10 Worst Pain You Can Imagine

Please circle the number that indicates your **LEAST PAIN LEVEL** over the last week:

No Pain    0    1    2    3    4    5    6    7    8    9    10 Worst Pain You Can Imagine

Please circle the number that indicates your **AVERAGE PAIN LEVEL** over the last week:

No Pain    0    1    2    3    4    5    6    7    8    9    10 Worst Pain You Can Imagine

Please circle the number that indicates your **CURRENT PAIN LEVEL RIGHT NOW** over the last week:

No Pain    0    1    2    3    4    5    6    7    8    9    10 Worst Pain You Can Imagine

Please help us understand **HOW PAIN HAS INTERFERED WITH** your:

**A. General Activity**

Does Not Interfere 0    1    2    3    4    5    6    7    8    9    10 Completely Interferes

**B. Mood**

Does Not Interfere 0    1    2    3    4    5    6    7    8    9    10 Completely Interferes

**C. Ability To Walk**

Does Not Interfere 0    1    2    3    4    5    6    7    8    9    10 Completely Interferes

**D. Ability To Perform Tasks At Home Or Work**

Does Not Interfere 0    1    2    3    4    5    6    7    8    9    10 Completely Interferes

**E. Relations With Other People**

Does Not Interfere 0    1    2    3    4    5    6    7    8    9    10 Completely Interferes

**F. Sleep**

Does Not Interfere 0    1    2    3    4    5    6    7    8    9    10 Completely Interferes

**A. Enjoyment Of Life**

Does Not Interfere 0    1    2    3    4    5    6    7    8    9    10 Completely Interferes



**CHECK THE BOX IF YOU HAVE ANY OF THE FOLLOWING SYMPTOMS:**

**General/ Constitutional:**

- Weakness
- Chills
- Fatigue
- Fever
- Night Sweats
- Weight Gain
- Weight Loss

**Allergy/ Immunology:**

- Increased thirst
- Bleeding easily
- Blistering of skin
- Seasonal Allergies

**Ophthalmologic:**

- Sensitivity to Light
- Double Vision
- Blurred Vision
- Eye Drainage
- Eye Pain
- Itching and redness

**ENT:**

- Congestion
- Headache
- Ear pain
- Ear problems
- Nosebleed
- Ringing in the ears

**Cardiovascular:**

- Chest pain
- Irregular heartbeat
- Palpitations
- Shortness of breath
- Swelling of hands/feet
- Weakness

**Gastrointestinal:**

- Black stool
- Abdominal pain
- Blood in stool
- Constipation
- Diarrhea
- Heartburn
- Nausea
- Vomiting

**Genitourinary:**

- Urgency
- Flank pain
- Blood in urine
- Frequent urination
- Painful urination

**Musculoskeletal:**

- Neck pain
- Falls
- Low back pain
- Back problems
- Muscle aches
- Painful joints

**Neurologic:**

- Change in sensation
- Focal weakness
- Changes in alertness
- Difficulty speaking
- Dizziness
- Tremor

**Psychiatric:**

- Memory problems
- Irritability
- Anxiety
- Auditory/visual hallucinations
- Depressed mood
- Suicidal thoughts

**Respiratory:**

- Coughing blood
- Cough
- Blood in urine
- Shortness or breath
- Sputum production
- Wheezing

**Skin:**

- Itching
- Rash

**Have you ever had (currently or in the past):**

- Yes  No Treatment for mood, anxiety, and/or sleep disorder?
- Yes  No Nightmares or flashbacks from prior traumatic experiences?
- Yes  No Alcohol, illicit drug, or prescription medication misuse/addiction?
- Yes  No Problems with compulsive behaviors such as gambling, eating disorder, etc.?
- Yes  No Hospitalization for anxiety or depression?

If yes, please explain: \_\_\_\_\_

**How many physicians have been involved in the treatment of your pain?** Please circle the number and then write who you have seen on the line: 1-3 4-5 6-10 11-15 16-20 \_\_\_\_\_



**PLEASE CHECK ALL OF THE PAIN MANAGEMENT PROCEDURES THAT YOU HAVE HAD.**

	How Many	Date(s) performed (approximate)
<input type="checkbox"/> Trigger Point Injections	_____	_____
<input type="checkbox"/> Medial Branch Nerve Blocks	_____	_____
<input type="checkbox"/> Radiofrequency Nerve Ablation or Rhizotomy	_____	_____
<input type="checkbox"/> Epidural Steriod Injection	_____	_____
<input type="checkbox"/> Caudal Steroid Injection	_____	_____
<input type="checkbox"/> Spinal Cord Stimulator	_____	_____
<input type="checkbox"/> Facet Joint Injection	_____	_____
<input type="checkbox"/> Sacroiliac Joint Injection	_____	_____
<input type="checkbox"/> Stallate Ganglion Block	_____	_____
<input type="checkbox"/> Lumbar Sympathetic Block	_____	_____
<input type="checkbox"/> Intercostal Nerve Block	_____	_____
<input type="checkbox"/> Knee Genicular Nerve Block	_____	_____
<input type="checkbox"/> Occipital Nerve Block	_____	_____
<input type="checkbox"/> Botox Injections	_____	_____
<input type="checkbox"/> Kyphoplasty/Vertebroplasty	_____	_____

**List any allergies and the reaction:**

Are you allergic to **iodine** or **IV contrast dye**?     YES     NO

**Past Medical History (please check all that apply):**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> CVA/Stroke       | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Anemia         | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoarthritis       |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Ulcers         | <input type="checkbox"/> Thyroid Disease  | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Sleep Apnea    | <input type="checkbox"/> Depression       | <input type="checkbox"/> Fibromyalgia         |
| <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Reflux         | <input type="checkbox"/> Seizures         | <input type="checkbox"/> COPD                 |
| <input type="checkbox"/> Other               |   |   |   |

If other, please explain: \_\_\_\_\_

**Past Surgical History:**

**Have you ever been hospitalized for more than 7 days (please circle):**    YES    NO

If yes, what for? How long? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**FAMILY HISTORY:**

Family Member	Alive	Deceased	Health Status or Cause of Death
Father			
Mother			
Sister(s)			
Brother(s)			
Grandmother(s)			
Grandfather(s)			
Other (please specify)			

Yes  No Do you have any family members with a history of **substance abuse**? If yes, please specify:

Alcohol    Illegal Drugs    Prescription Medications

Yes  No Problems with **compulsive behaviors** such as gambling, eating disorder, etc.?

Yes  No Does **anyone in your household take prescription pain medications**?

Yes  No Does **anyone in your household use illicit drugs**?

**SOCIAL HISTORY**

Marital Status: Single    Married    Separated    Divorced    Widowed

Who Lives at home with you? \_\_\_\_\_

**Family Support:** Strong    Average    Minimal    None

What are your Sources of Support? \_\_\_\_\_

What are your sources of stress? \_\_\_\_\_

**Employment:**

Working?     Yes  No    Occupation: \_\_\_\_\_ Full Time? \_\_\_\_ Part Time? \_\_\_\_

Retired?     Yes  No    What took you out of work? \_\_\_\_\_ Last Day Worked? \_\_\_\_\_

Disabled?     Yes  No    (if yes, since when?): \_\_\_\_\_

Are you involved with **workers compensation**?  Yes  No    If YES, is there **litigation pending**?  Yes  No

**Education:**

Please check the highest level of education you have completed:

\_\_\_ Grade School    \_\_\_ High School    \_\_\_ Junior College    \_\_\_ Trade School  
 \_\_\_ Some College    \_\_\_ Graduated College    \_\_\_ Graduate/ Professional School



**Substance Use:**

**Do you use tobacco products?**

No, Never     No, but I used to    Quit date: \_\_\_\_\_  
 Yes    If yes, form of tobacco? \_\_\_\_\_ Packs/day? \_\_\_\_\_  
How Long? \_\_\_\_\_

**Do you drink Alcohol?**

No, Never     No but I used to  
 Yes    If yes: \_\_\_Daily    \_\_\_Weekly    \_\_\_Monthly    \_\_\_Rarely    \_\_\_Socially    \_\_\_Occasionally  
How Long? \_\_\_\_\_

**Do you use illegal drugs?**

No, Never     No but I used to  
 Yes    If YES, please list: \_\_\_\_\_

**HAVE YOU EVER:**

- Yes  No    Had prescription pain medication lost or stolen?
- Yes  No    Shared your prescription pain medications with others?
- Yes  No    Taken more prescription pain medication than prescribed, or run out early?
- Yes  No    Taken prescription pain medications to relieve non-pain symptoms (anxiety, sleep)?
- Yes  No    Consumed prescription pain meds that were not prescribed to you?
- Yes  No    Altered a prescription pain pill for enhanced effect (such as crushing a time-release tab)?
- Yes  No    Been in a treatment program for alcohol and/or drug abuse?
- Yes  No    Attended a 12-step meeting such as alcoholics anonymous (AA) or Narcotics Anonymous (NA)?
- Yes  No    Had a DUI or been arrested for using or selling illicit drugs?
- Yes  No    Had a drug overdose?
- Yes  No    Had someone express concern about your overuse of prescription pain meds, drugs or alcohol?
- Yes  No    Been discharged from a pain clinic for any reason?

If you listed YES to any of the above, please explain:

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