Welcome to Pain Relief Solutions.

Your care and comfort are most important to us. In order to better serve our patients, please review and complete this packet, in its entirety, prior to your consultation.

Your first appointment will be a consultation, please bring the following items:

- Picture ID Card
- Insurance Card
- A list of all medications the patient is taking
- This packet completed in its entirety

Disclosure of insurance and other information is necessary

- If the patient's injury is due to any type of personal injury, accident or malicious conduct for which the patient is seeking damages, the patient must notify us and sign a lien in our favor.
- Your failure to make necessary disclosures will result in patient's responsibility for all charges incurred for services rendered by us.

Abusive Patient Policy

- For the safety of our patients and staff, Pain Relief Solutions has a ZERO TOLERANCE POLICY for any harassing, threatening or abusive behavior, verbal or physical, against anyone in this facility. Such behavior may result in the immediate termination of the Provider-Patient relationship.

I hereby consent to the patient's evaluation and treatment by Pain Relief Solutions ("PRS") and their health care providers.

Patient's Signature: _____ Date: _____

Patient's Name: _____ Date of Birth: _____

Representative's Name: _____ Date: _____

Representative's Signature_____ Rel. to Pt.: _____

Patient Demographic Information Page

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____

City:_____ State: _____ Zip Code: _____

Patient Phone Number: _____ Patient Cell Phone Number: _____

Patient Email: _____

Patient Emergency Contact Name: _____ Phone Number: _____

Patient Primary Insurance Company: _____ Policy Number: _____

Patient Secondary Insurance Company: _____ Policy Number: _____

Patient Signature: _____ Date Signed: _____

Patient Financial Responsibility Policy

Co-Payments are due when services are rendered

- If the patient is unable to pay the copayment at the time of the appointment, said appointment will be rescheduled.
- Any deductible, copayment, or balance not paid by a patient's insurance is the patient's financial responsibility. Insured patients are responsible for all charges not paid by their insurance within 45 days after the date of service.
- There is a $25 service fee on all returned checks.
- Always bring your insurance card and ID to your appointment. If your coverage cannot be verified, you will be responsible for any payments at the time of service.
- It is your responsibility to notify us if there are any changes to your insurance, address or phone number.
- Pain Relief Solutions will bill the insurance on your behalf.
- Payment of insurance benefits will be paid directly to Pain Relief Solutions.

If you have:	You are responsible for:	Our staff will:
PPO/HMO	Payment of copay, deductible and non-covered services for office visits, procedures and other charges.	Check your insurance coverage to determine co-pays. File your insurance claim
Worker's Compensation	If we have verified the claim with your carrier, no payment is necessary at the time of visit. If we are not able to verify your claim, the appointment will be rescheduled until authorization is obtained.	Verify your claim and obtain authorization. File your claim.

I have read and understand the Patient Financial Responsibility Policy and I agree to all of the terms and conditions contained herein.

_____ _____

Patient's Signature Date

Cancellation/No Show Policy

We kindly request that you give our office at least 24 hours advance notice if you need to reschedule or cancel your appointment.

- To cancel/ reschedule your appointment, call us directly. If you reach our voicemail, please leave a message with your name, date of birth, and date and time of your appointment.
- In the event you fail to give at least 24 hours advance notice to reschedule/cancel your appointment or fail to follow procedure instructions causing a reschedule, you may be charged a $50 fee for any office visit, $100 fee for an in-office procedure or $150 for a Spinal Cord Stimulator Trial. This fee will not be billed to the insurance company.
- If you are ten (10) minutes late to your appointment, it may result in a cancelled appointment and, as determined by Pain Relief Solutions, you may be responsible for the cancellation fee.
- If you No show 3 or times it can result in a discharge from the practice.

I have read and understand the Patient Cancellation Responsibility Policy. I also understand that Pain Relief Solutions may amend such terms at any time.

_____ _____

Printed Name of Patient Your Name and Relationship to Patient

_____ _____

Patients Signature Date

HIPPA Compliance Requirement Form
Notice of Pain Relief Solutions Privacy Practices

THIS DOCUMENT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO SUCH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to ask each of our patients to acknowledge receipt of our Notice of Privacy Practices. Pain Relief Solutions must take steps to protect the privacy of your Protected Health Information ("PHI") in accordance with HIPAA. PHI includes information that we have created or received regarding your health care, including payment and billing for your health care. In addition to your medical records, PHI includes personal information such as your name, social security number, address and phone number.

Under federal law, we are required to: (i) protect the privacy of your PHI (Pain Relief Solutions therefor requires our employees to maintain the confidentiality of PHI); (ii) provide you with this Notice of Pain Relief Solution's Privacy Practices explaining our duties and practices regarding your PHI; and (iii) follow the practices and procedures set forth in this Notice of Pain Relief Solution's Privacy Practices.

I, _____, understand that as a part of my healthcare, Pain Relief Solutions originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care and treatment. I understand that this information serves as follows:

- A basis for planning my care and treatment
- A means of communication among health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment to my bill
- A means by which a third-party payer can verify services billed were provided
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

Email: You are advised that email is not a secure method of communication. If you email us you agree to our communication by use of email and you agree to the risks.

Telephone: You are advised that telephonic communication is not a secure form of communication. You understand and agree that such communication may include calls, voicemails and/or test messages.

My PHI may be discussed with the following people:

1. _____ 3. _____
2. _____ 4. _____

I hereby agree to the above and consent for Pain Relief Solutions to obtain my past, present and future medication and medical information as well as all other PHI.

_____ _____

Patient's Signature Date

A more detailed list of our Privacy Practices is available upon request.

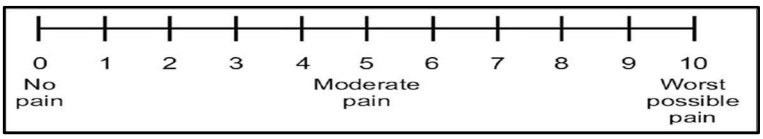
EVALUATION FOR CURRENT TREATMENT

Name: _____ **Phone Number:** _____

Date of Birth: _____ **Date:**_____ **Height:** _____ **Weight:** _____

PAIN ASSESSMENT

On a scale from 0 to 10, please rank your pain today:



Where does it hurt the worst?_____ **Where else does it hurt?**_____

Does the pain radiate? Yes / No **Where?** _____

Is this a new problem? Yes / No **How long have you had this problem? (circle one)** 1-3 4-7 > 8 days/months/years

Describe your pain: (circle all) Sharp Stabbing Dull Aching Burning Electrical Throbbing Shooting

What is the severity? Mild / Moderate / Severe **Is the pain (circle one):** constant or intermittent

What makes your pain worse? (circle all) Walking Sitting Bending Extension Twisting Working Exercise Cold

What makes your pain better? (circle all) Heat Ice Laying Down Rest Stretching Medication Procedures/Injections

How did your pain begin? (circle all) Injury at Work Illness Motor Vehicle Accident Undetermined Other _____

How long have you been in pain? (circle all) 0-3Mos 4-6Mos 7-9Mos 10-12Mos Yrs _____

How often does your pain increase above average? (circle all) Never 1-2 times a month 1-2 times a week Daily

Associated Symptoms: (circle all) Numbness Tingling Weakness Incontinence Depression Fatigue Anxiety

MEDICATIONS/ THERAPIES/ IMAGING

Current Medications: _____

_____

_____

What is your preferred pharmacy?_____

Pain relief from the current medication regimen? _____ **%**

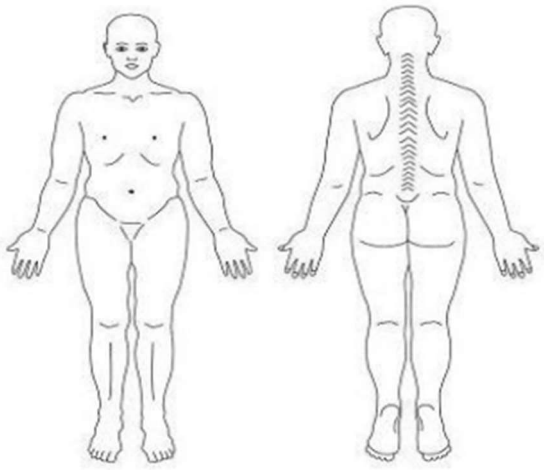
How long have you been on the same medication regimen? _____

Any side effects? Yes / No **Do you need refills?** Yes / No

What were the side effects? _____

Previous tried and failed medications:_____

_____



Type of last procedure: _____**Date of procedure:**_____

Pain relief? _____% **Length of Relief**_____

Recent imaging? Yes / No **Facility?** _____

Other treatments? (circle all) Physical Therapy(PT) Home Exercise Acupuncture Chiropractor

Did the Therapy help? Yes / No **Length of Therapy?**_____ **Are you still doing therapy?** Yes / No

When did therapy start?(year and month): _____**When did therapy end?(year and month):** _____

Why was therapy stopped? :_____

Diabetes? Yes / No **Smoker** Yes / No **Allergies?** Yes / No _____

********** *for office use only* **********

Description	Description Blood Pressure_____/_____ Pulse_____ EPCS? YES or NO
Med Management	UDS ODS Med Management ORT BIOMARKER
Insurance	PPO HMO MPMG SRS SCMG CCIPA VMG CHG Molina Care1st Medicare Medical VA Tricare WC

MA Notes:_____

Patient Name: _____ Date:_____ Age:_____ DOB:_____

General Health History

1. Please indicate any illness/medical conditions which you may have:

Y/ N	Arthritis	Y/ N	Eye disorder	Y/ N	Obesity
Y/ N	AIDS/HIV	Y/ N	Headache (specify)	Y/N	Organ Transplant
Y/ N	Bladder/Urinary disorder	Y/ N	Heart attack/myocardial infarction	Y/ N	Pacemaker
Y/ N	Bleeding problems	Y/ N	Heart disease	Y/ N	Peripheral vascular disease
Y/ N	Blood disease (Sickle cell, Anemia, Leukemia)			Y/ N	Stomach problems
Y/ N	Cancer	Y/ N	Hepatitis(Peptic ulcer disease)	Y/ N	Thyroid problems
Y/ N	Chemical dependency	Y/ N	**High cholesterol**	Y/ N	Stroke /CVA
Y/ N	Chronic pain	Y/ N	**Hypertension** (high blood pressure)	Y/ N	Congestive heart failure
Y/ N	Kidney problems (Renal disease)			Y/ N	TIA
Y/ N	**Diabetes**	Y/ N	Liver disease	Y/ N	TMJ
Y/ N	Epilepsy	Y/ N	Lung disease	Y/ N	Other

2. Past Surgical History*(Please list all surgeries and dates):*

Surgery	Physician	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Indicate the various treatments you have received in the past FOR YOUR CURRENT PAIN CONDITION.
(indicate as many as apply)

Date	Results (Good, Fair, Poor)
_____acupuncture	_____
_____aerobic conditioning	_____
_____biofeedback or relaxation therapy	_____
_____counseling/psychotherapy	_____
_____cranial electrotherapy (e.g. Alpha-Stim)	_____
_____drug detoxification	_____
_____educational classes about pain, how to better manage stress, etc.	_____
_____exercise quotas (i.e. gradually working towards specific exercise goals)	_____
_____heat	_____
_____hypnotherapy	_____
_____ice/cold	_____
_____manipulation (e.g. orthopedic, osteopathic, chiropractic, etc)	_____
_____massage	_____
_____medication	_____
_____myotherapy	_____
_____nerve blocks (i.e. administration of pain blocking drugs to block the nerve transmission of pain)	_____
_____oral dental therapy (e.g. appliances, dentures, splints, orthodontics, etc.)	_____
_____orthotics (e.g. corrective foot inserts)	_____
_____patient controlled anesthesia (PCA)	
_____percutaneous electrical nerve stimulation (*PENS: electrical stimulation of nerve/muscle*	_____
through insertion of a needle)	_____
_____pool/hydrotherapy	_____
_____prosthetics (e.g. braces, supports, etc.)	_____
_____radiation treatment	_____
_____range of motion exercises	_____
_____relaxation/imagery	_____
_____spinal column stimulation *(i.e. surgically implanting an electrical stimulation device near your spinal column to help control pain)*	_____
_____stabilization exercises	_____
_____surgery	_____
_____traction	_____
_____transcutaneous electrical nerve stimulation (TENS)	_____
_____trigger point injections (i.e. a needle is inserted into tender areas-anesthetics may or may not be injected)	_____
_____weights	_____
_____work hardening and work simulation	_____
_____ultrasound	_____

4. **Do you have any of the following symptoms? (please circle)**

Headache	Dizziness	Vision Problems	Hearing Problems	Neck Pain
Chest Pain	Cough	Shortness of Breath	Nausea	Vomiting
Diarrhea	Constipation	Blood in stool	Dark Tarry Stool	Abdominal Pain
Pelvic Pain	Pain on Urination	Urinary Problems	Rash	Itching
Tender muscles	Back Pain	Stiff Joints	Swollen Joints	Loss of Balance
Weakness of Limbs	Numbness of hand	Numbness of arm	Numbness of Leg	Numbness of feet
Fever	Chills	Poor Sleep	Weight Loss	Weight Gain
Additional Comments:				

5. **Does your pain cause you to suffer any of the following?** ☐ Frustration ☐ Anxiety ☐ Depression ☐ Insomnia/Sleeplessness

6. **Suicidal Thoughts: When was the last time?**_____

7. **Have you ever attempted suicide?**_____

8. **Social History**

Do you use tobacco? Yes / No Freq:_____Type:_____

Did you quit? Yes / No How long ago?_____How long ago?_____

Do you drink alcohol? Yes / No How often:_____ Type:_____

Do you use illicit drugs? Yes / No Have you ever used illicit drugs? Yes / No

If so please specify type: ☐ Cocaine ☐ Heroin ☐ Methamphetamine ☐ Other:_____

Do you see now or have you seen a psychiatrist/psychologist? Yes / No

9. **Family History**

When applicable, please indicate which family member has been affected.

Disease	**Relationship to you**
Y/N Cancer	_____
Y/N Diabetes	_____
Y/N **Heart disease**	_____
Y/N Hypertension	_____
Y/N Liver disease	_____
Y/N Mental illness	_____
Y/N Respiratory disease	_____
Y/N Renal disease	_____

Review of Systems (x), (i+ii) abnormal findings & pertinent negatives • **General**: *(Circle "Y" or "N")*

Y / N Recent **Wt. Loss**_____lbs. Wt. Gain_____lbs. Y / N **Fever**

(Circle "Y" or "N" for any abnormalities, and then circle appropriate symptom if applicable) • **HEENT (ENT/mouth):**

Y / N Head: headaches, head injury, migraines

Y / N Ears: discharge, hearing changes, ringing in the ear

Y / N Nose: Chronic sinusitis, decreased smell, excessive rhinorrhea, nosebleeds, nasal fracture

Y / N Throat: Oral cavity tenderness/lesion, frequent sore throats, trouble swallowing, hoarseness

Y / N Neck: Injury, masses, pain, stiffness

• **Eyes:**

Y / N Blurriness, cataracts, double vision, other **visual changes**_____

• **Cardiovascular**:

Y / N **Chest pain,** Angina, **palpitations,** dizziness

Y / N CHF, **edema in feet**, **shortness of breath with exertion**, orthopnea, PND

Y / N Phlebitis, TIA's, CVA (stroke), hypertension, claudication, cyanosis

• **Respiratory:**

Y / N Asthma, bronchitis, COPD,

Y / N **Wheeze**, **chronic cough**, shortness of breath, rapid breathing, sleep apnea Y / N Bloody sputum, tuberculosis,

• **Gastrointestinal:**

Y / N Constipation, clay stools, diarrhea, trouble swallowing, gallbladder disease, vomiting blood, bloody stools, hemorrhoids, hepatitis, hernias, indigestion, jaundice, nausea, vomiting, pancreatitis, rectal bleeding

• **Genito-urinary**:

Y / N painful urination, blood in urination, urgency discharge, frequency, hesitancy, incontinence, chronic urinary tract infections, STD, prostatitis, kidney stones

• **Musculoskeletal:**

Y / N joint swelling, joint redness, joint pain, gait (walking problems)

• **Integumentary (skin) or breast:**

Y / N rash, itching, sores, abscess, discharge, breast enlargement, pain, prior surgery or biopsy

• **Neurology:**

Y / N Numbness, tingling, joint pain, muscle spasms, tremors, nervousness, **syncope**, **dizziness**, vertigo, weakness

• **Psychiatric:**

Y / N **Depression**, anxiety disorder, panic disorder

• **Endocrine:**

Y / N Hot/cold intolerance, extreme thirst, frequent urination, anemia, excessive bruising or bleeding, diabetes, thyroid problems

• **Hematology/lymphatic:**

Y / N Bleeding tendency, easy bruising, lymph node swelling

• **Allergic/Immunologic:**

Y / N Allergies to medicine, food, seasonal allergies, other?

If so, what? And please describe reaction:_____

• **Sleep:**

Total # of hours of sleep/night_____Number of sleep interruptions_____

What wakes you up? _____

What do you do when unable to return to sleep? _____

• **Appetite:**

What is your appetite like? _____ Is this a change for you? Yes / No How long has it been this way?

The Corrado-Gottlieb TOPS

Name: _____ Date: _____ Age: _____ Gender: _____

Please mark one response for each of the following questions or statements:

1. What is your highest level of education?

☐ Did not complete high school ☐ Completed high school/GED ☐ Some college ☐ College degree or higher

2. What is your marital status?

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Living with Partner

3. On a scale from 0 to 10 (with O being an absence of pain and 10 being the most intense pain), what is the lowest your pain has been during the past six months?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

4. On a scale from 0 to 10 (with O being an absence of pain and 10 being the most intense pain), rate your average pain level over last six months.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

5. I feel like giving up because things will not get better for me.

☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

6. I believe that I will be happier in the future than I am now.

☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

7. I believe I will be able to return to work and/or successfully perform the activities of daily living.

☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

8. I lack interest or pleasure in the things I used to enjoy.

☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

9. I feel tired, fatigued, run down, and/or lethargic.

☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

10. I have trouble thinking and concentrating.

☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

11. I feel incapable of managing my pain.

☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your pain is affecting your ability to manage in everyday life. Please answer by checking one box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please shade out the spot that indicates the statement which most clearly describes your problem.

Section 1: Pain Intensity

☐ I have no pain at the moment
☐ The pain is very mild at the moment
☐ The pain is moderate at the moment
☐ The pain is fairly severe at the moment
☐ The pain is very severe at the moment
☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)

☐ I can look after myself normally without causing extra pain
☐ I can look after myself normally but it causes extra pain
☐ It is painful to look after myself and I am slow and careful
☐ I need some help but can manage most of my personal care
☐ I need help every day in most aspects of self-care
☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

☐ I can lift heavy weights without extra pain
☐ I can lift heavy weights but it gives me extra pain
☐ Pain prevents me lifting heavy weights off the floor but I can
☐manage if they are conveniently placed, e.g. on a table
☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
☐ I can only lift very light weights
☐ I cannot lift or carry anything

Section 4: Walking

☐ Pain does not prevent me walking any distance
☐ Pain prevents me from walking more than 1 mile
☐ Pain prevents me from walking more than 1/2 mile
☐ Pain prevents me from walking more than 100 yards
☐ I can only walk using a stick, crutches or walker
☐ I require a wheelchair
☐ I am in bed most of the time

Section 5: Sitting

☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than one hour
☐ Pain prevents me from sitting more than 30 minutes
☐ Pain prevents me from sitting more than 10 minutes
☐ Pain prevents me from sitting at all

Section 6: Standing

☐ I can stand as long as I want without extra pain
☐ I can stand as long as I want but it gives me extra pain
☐ Pain prevents me from standing for more than 1 hour
☐ Pain prevents me from standing for more than 30 minutes
☐ Pain prevents me from standing for more than 10 minutes
☐ Pain prevents me from standing at all

Section 7: Sleeping

☐ My sleep is never disturbed by pain
☐ My sleep is occasionally disturbed by pain
☐ Because of pain I have less than 6 hours of sleep
☐ Because of pain I have less than 4 hours of sleep
☐ Because of pain I have less than 2 hours of sleep
☐ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

☐ My sex life is normal and causes no extra pain
☐ My sex life is normal but causes some extra pain
☐ My sex life is nearly normal but is very painful
☐ My sex life is severely restricted by pain
☐ My sex life is nearly absent because of pain
☐ Pain prevents any sex life at all

Section 9: Social Life

☐ My social life is normal and gives me no extra pain
☐ My social life is normal but increases the degree of pain
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports
☐ Pain has restricted my social life and I do not go out as often
☐ Pain has restricted my social life to my home I have no social life because of pain

Section 10: Traveling

☐ I can travel anywhere without pain
☐ I can travel anywhere but it gives me extra pain
☐ Pain is bad but I manage journeys over two hours
☐ Pain restricts me to journeys of less than one hour ☐ Pain restricts me to short necessary journeys of under 30 minutes
☐ Pain prevents me from traveling except to receive treatment