Advanced Interventional Pain Management
New Patient Intake Form

Name: _____ Age: _____ Date of Birth: _____ Gender: _____
Height: _____ Weight: _____ Phone Number: _____
Employer: _____
Referring Provider: _____ PCP: _____

PAIN LOCATION: (Please check **only one** location you would like to address first)
☐ Head ☐ Neck ☐ Mid-back ☐ Low-back ☐ Shoulder ☐ Hip ☐ Knee ☐ Abdomen

☐ Hand ☐ Foot ☐ Chest wall ☐ Groin ☐ Vagina ☐ Anus ☐ Scrotum

PAIN DESCRIPTION: (check all that apply)
☐ Sharp/Stabbing ☐ Aching ☐ Burning ☐ Throbbing

PAIN ONSET:
☐ <1 month ago ☐ 1 month ago ☐ 3 months ago ☐ 6 months ago ☐ 1 year ago ☐ __ years ago

ASSOCIATED FEATURES: (check all that apply)
☐ Numbness/Tingling ☐ Worsening Weakness ☐ Unable to control bowel/bladder

☐ Changes in skin color of involved extremity ☐ Change in nail/hair growth of involved extremity

PAIN WORSENED BY: (check all that apply)
☐ Walking ☐ Standing ☐ Sitting ☐ Leaning backward ☐ Leaning forward ☐ Looking down

☐ Looking up ☐ Reaching for objects overhead ☐ Changes in Weather ☐ Touching the area

☐ Loud Noises ☐ Bright Light

FREQUENCY OF SYMPTOMS:
☐ Constant ☐ Intermittent

PAIN SCORE: (over the last week)
Worse Pain Score : ____/10
Average Pain Socre: ____/10

0 = no pain 10= worst pain imaginable

PREVIOUS CONSERVATIVE TREATMENTS TRIED & FAILED:
☐ Physical Therapy x 6 weeks ☐ Unable to tolerate PT ☐ Home Exercises/Stretching

☐ Chiropractor ☐ Acupuncture ☐ TENS Unit ☐ Voltaren Gel ☐ Lidocaine Cream ☐ CBD Oil

PREVIOUS INTERVENTIONAL MANAGEMENT:
☐ Radiofrequency Ablation (Date: _____) ☐ Epidural Steroid Injection (Date: _____)

☐ Joint Injections ☐ Trigger Point Injections

Current Pain Medications:

Current (non-pain) Medications:

☐ **Blood Thinners:** _____

PREVIOUS IMAGING:
(Please list location and year obtained)

☐ MRI _____
☐ CT _____
☐ X-RAY _____
☐ Myelogram _____
☐ Ultrasound _____
☐ EMG/NCS _____

PAST MEDICAL HISTORY:

☐ AIDS
☐ Alcohol Use Disorder
☐ Anemia
☐ Anorexia
☐ Anxiety
☐ Aortic Regurgitation
☐ Aortic Stenosis
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Bipolar Disorder
☐ Breast Cancer
☐ Bulimia
☐ Carpal Tunnel Syndrome
☐ Cervical Cancer
☐ Chronic Kidney Disease
☐ Chronic Pancreatitis
☐ Cirrhosis
☐ Cluster Headaches
☐ Colon Cancer
☐ CRPS
☐ Congestive Heart Failure
☐ COPD
☐ Coronary Artery Disease
☐ Crohn's Disease
☐ Cubital Tunnel Syndrome
☐ Depression
☐ Diabetes Type I
☐ Diabetes Type II
☐ Diabetic Neuropathy
☐ Enlarged Prostate (BPH)
☐ Epilepsy
☐ Factor V Leiden Mutation
☐ Fibromyalgia
☐ Gastric Reflux
☐ Glaucoma
☐ Gout
☐ Hemophilia
☐ Hepatitis B
☐ Hepatitis C
☐ Herpes Simplex Virus
☐ High Cholesterol
☐ High Blood Pressure
☐ HIV Positive
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Lung cancer
☐ Lupus
☐ Malignant Hyperthermia
☐ Migraines
☐ Mitral Regurgitation
☐ Mitral Stenosis
☐ Myasthenia Gravis
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Ovarian Cancer
☐ Prostate Cancer
☐ Scoliosis
☐ Shingles
☐ Substance Use Disorder
☐ Ulcerative Colitis
☐ Von Willebrand Disease

☐ Other Diagnosis not listed _____

PAST SURGICAL HISTORY:

- ☐ Above Knee Amputation
- ☐ ACDF
- ☐ Aortic Valve Replacement
- ☐ AV Fistula Creation
- ☐ Appendectomy
- ☐ Below Knee Amputation
- ☐ CABG
- ☐ Carotid Endarterectomy
- ☐ Carpal Tunnel Release
- ☐ Cholecystectomy
- ☐ Colon Resection
- ☐ Craniotomy
- ☐ Cubital Tunnel Release
- ☐ Gastric Bypass
- ☐ Hemorrhoidectomy
- ☐ Hip Replacement
- ☐ Hysterectomy
- ☐ Kidney Transplant
- ☐ Knee Replacement
- ☐ Kyphoplasty
- ☐ Lumbar Laminectomy
- ☐ Lumbar Fusion
- ☐ Mitral Valve Replacement
- ☐ Nephrectomy
- ☐ Pacemaker Implantation
- ☐ Parathyroidectomy
- ☐ Posterior Cervical Fusion
- ☐ Prostatectomy
- ☐ Rotator Cuff Repair
- ☐ Shoulder Replacement
- ☐ Spinal Cord Stimulator
- ☐ Thyroidectomy
- ☐ TURP
- ☐ Other Surgery not listed: _____

FAMILY HISTORY:

- ☐ AIDS
- ☐ Alcohol Use Disorder
- ☐ Anemia
- ☐ Anorexia
- ☐ Anxiety
- ☐ Aortic Regurgitation
- ☐ Aortic Stenosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bipolar Disorder
- ☐ Breast Cancer
- ☐ Bulimia
- ☐ Carpal Tunnel Syndrome
- ☐ Cervical Cancer
- ☐ Chronic Kidney Disease
- ☐ Chronic Pancreatitis
- ☐ Cirrhosis
- ☐ Cluster Headaches
- ☐ Colon Cancer
- ☐ CRPS
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Cubital Tunnel Syndrome
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Diabetic Neuropathy
- ☐ Enlarged Prostate (BPH)
- ☐ Epilepsy
- ☐ Factor V Leiden Mutation
- ☐ Fibromyalgia
- ☐ Gastric Reflux
- ☐ Glaucoma
- ☐ Gout
- ☐ Hemophilia
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes Simplex Virus
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Lung cancer
- ☐ Lupus
- ☐ Malignant Hyperthermia
- ☐ Migraines
- ☐ Mitral Regurgitation
- ☐ Mitral Stenosis
- ☐ Myasthenia Gravis
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Ovarian Cancer
- ☐ Prostate Cancer
- ☐ Scoliosis
- ☐ Shingles
- ☐ Substance Use Disorder
- ☐ Ulcerative Colitis
- ☐ Von Willebrand Disease

Social History:

- ☐ Current Smoker
- ☐ Former Smoker
- ☐ Never Smoked
- ☐ Alcohol Use
- ☐ Illicit Drug Use
- ☐ Medical Marijuana Card

Marital Status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Work History

- ☐ Currently Employed
- ☐ Unemployed
- ☐ Retired
- ☐ Disabled
- ☐ Short Term Disability

Last Day Worked: _____

Review of Systems:

General
- ☐ Weight Loss
- ☐ Weakness
- ☐ Fatigue
- ☐ Fever

Eyes
- ☐ Vision Loss
- ☐ Double Vision
- ☐ Pain/Tearing
- ☐ Redness

ENT
- ☐ Hearing Loss
- ☐ Dizziness
- ☐ Runny Nose
- ☐ Sore Throat

Skin
- ☐ Itching
- ☐ Redness
- ☐ Swelling

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular Heartbeat

Respiratory
- ☐ Cough
- ☐ Shortness of Breath

Musculoskeletal
- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Muscle Spasms
- ☐ Stiffness

Hematology
- ☐ Easily Bruised
- ☐ Prolonged Bleeding
- ☐ Spontaneous Bleeding

GU
- ☐ Blood in Urine
- ☐ Loss of bladder control
- ☐ Pain with urination

Neurological
- ☐ Numbness/tingling
- ☐ Difficulty holding objects
- ☐ Frequent falls
- ☐ Headache
- ☐ Seizures

Psychological
- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal thoughts
- ☐ Homicidal thoughts

GI
- ☐ Heart Burn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Loss of bowel control
- ☐ Blood in stool

Endocrine
- ☐ Sweating
- ☐ Frequent Thirst
- ☐ Always Hot
- ☐ Always Cold

Medication Allergies:

_____

_____

_____

_____

_____

I understand that as part of my healthcare, Advanced Interventional Pain Management 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 or treatment. I understand that this information serves as:

A basis for planning my care and treatment,

A means of communication among the many health professionals who contribute to my care,

A source of information for applying my diagnosis and surgical information to my bill,

A means by which a third-party payer can verify that services billed were actually provided, and

A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing the this consent,

The right to object to the use of my health information for directory purposes, and

The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that Advanced Interventional Pain Management is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Advanced Interventional Pain Management reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Advanced Interventional Pain Management change their notice, they will send a copy of any revised notice to the address I've provided (weather U.S. Mail or, If I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I grant the clinic's staff and physician's permission to discuss my protected health information and other personal information with the following persons:

NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER

I { } do { } do not
Authorize Advanced Interventional Pain Management to forward/fax Return to Work excuses to employer or school.

I { } do { } do not
Authorize Advanced Interventional Pain Management to leave appointment information on my answering machine.

I understand that as part of this organization's treatment, payment or health care operation, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures, via fax.

I fully understand and accept the terms of this consent.

Patient's Signature: _____ Date: _____

BASIC POLICY:

Payment for services is due in full at the time the service is provided in our offices unless we are a member of your insurance group. Please contact your insurance company regarding covered members, or prior arrangements must be made with this office.

FOR PATIENTS WITH INSURANCE:

If we are members of your insurance group, we will bill the insurance carrier for payment to come directly to us. You will be responsible for co-payment and deductibles. All co-payments and deductibles are due and payable at the time the service is provided.

If we are not members of your insurance group, we will bill most insurance carriers for you if the proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Payment for these claims will come directly to us. If our office can be of any assistance with your insurance carrier, please let us know.

MEDICARE PATIENTS:

Our office accepts Medicare assignments. We will also bill secondary insurances for you. All co-payments and deductibles are due and payable at the time service is provided.

NON-COVERED SERVICES:

Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of an insurance claim denial.

ASSIGNMENT AND RELEASE:

I, the undersigned patient, have insurance coverage and assign directly to Advanced Interventional Pain Management all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the office of Advanced Interventional Pain Management to release all information necessary to secure the payment of benefits or to pre-certify their services as required by my insurance company. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made to Advanced Interventional Pain Management for any services furnished me by any member of this clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or if electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown in Medicare, assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the determination of the Medicare carrier.

_____ _____

Signature of Insured/Guardian/Beneficiary Date

I have read, understand and agreed to the above financial policy for payment of professional fees. I understand that I, the patient, am ultimately responsible for all professional fees.

_____ _____

Patient Signature Date

Prescription Policy and Procedures

If your prescription is to be called to your pharmacy or picked up at the office, please notify us 72 business hours in advance.

Prescriptions will not be mailed to your home.

You will not be notified of when your prescription is ready. We ask that you refrain from making numerous calls to see if your prescription is ready. Please call your pharmacy to check to see if your prescription is ready. Prescriptions may not be filled prior to due date.

When leaving a message for a refill, please speak slowly and clearly. Please spell your last name and list a phone number where you can be reached. Please list the names of your medications you will need refilled.

If the pharmacy fills your medication early, it will not change your due date the next month.

Refills will not be given early if you take more medication than prescribed.

You are responsible for your prescriptions and medication. If lost, stolen, or misplaced, we will not give a replacement prescription.

For prescription refills, you may call 501-321-4772 and leave a message on the clinical staff's line.

Pharmacy_____ Phone Number _____.

You will use only the pharmacy listed above for filling all medications.

If you do not keep your appointments or follow your plan of treatment, you are at risk of your medication being stopped or being terminated as a patient from the clinic.

Random urine or blood drug screens will be performed to document the proper use of your medication, as well as to confirm your compliance.

The physician has the right to refer you to your Primary Care Physician for Med Management.

Due to circumstances beyond the control of the Physician, appointment times are estimates, not exact times that you will be seen. If you have not been seen within one hour of your appointment time, please see the receptionist.

Patient's Signature: _____ Date: _____

Nurse's Signature: _____ Date: _____

Advanced Interventional Pain Management
ONE MERCY LANE, SUITE 304 • HOT SPRINGS, AR 71913
(501) 321-4772 • Fax (501) 321-2945

Authorization for Release of Protected Health Information (PHI)

Name: _____ DOB: _____ Phone #: _____

PLEASE OBTAIN INFORMATION FROM:	PLEASE SEND INFORMATION TO:
_____	Advanced Interventional Pain Management
Name of Provider/Clinic/Organization	
_____	One Mercy Lane, Suite 304
Street Address	
_____	Hot Springs, AR 71913
City, State, Zip Code	
Phone: _____ Fax: _____	Phone: 501-321-4772 Fax: 501-321-2945

I AUTHORIZE the following information to be disclosed: (Please check all that apply)

____ Entire Medical Record	____ Consultation	__X__ Radiology/Imaging Reports/Films
__X__ Progress Notes	____ Immunizations Record	____ Billing Records
__X__ Most Recent History & Physical	____ Laboratory Reports	____ Other _____

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

REASON for disclosure of health information: (Please check one)

____ Continuing Care	____ Legal Purposes	____ SS/Disability (provide SSA letter)
____ Consultation	____ Insurance	____ Job/School
____ Second Opinion	____ Personal Use	____ Other _____

EXPIRATION of this Authorization: (Please check one)

____ 180 days after signature date ____ On this date _____ ____ After this event _____

This authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying Advanced Interventional Pain Management. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date tat is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

ADDITIONAL PATIENT INFORMATION:

- I understand that I have the right to withdraw this authorization as indicted in the above paragraph.
- I understand that I do not have to sign this authorization to get treatment.
- I understand that once my health care information is disclosed as I have authorized, it could be re-disclosed by the recipient and is no longer protected by Advanced Interventional Pain Management.
- I understand that signing this authorization does not cancel any rights I have under other state or federal laws.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed Name of Patient or Patient's Representative

_____ or _____
Relationship to Patient Legal Authority (attach supporting documentation

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	o	o	o	o	o
2. How often have you felt a need for higher doses of medication to treat your pain?	o	o	o	o	o
3. How often have you felt impatient with your doctors?	o	o	o	o	o
4. How often have you felt that things are just too overwhelming that you can't handle them?	o	o	o	o	o
5. How often is there tension in the home?	o	o	o	o	o
6. How often have you counted pain pills to see how many are remaining?	o	o	o	o	o
7. How often have you been concerned that people will judge you for taking pain medication?	o	o	o	o	o
8. How often do you feel bored?	o	o	o	o	o
9. How often have you taken more pain medication than you were supposed to?	o	o	o	o	o
10. How often have you worried about being left alone?	o	o	o	o	o
11. How often have you felt a craving for medication?	o	o	o	o	o
12. How often have others expressed concern over your use of medication?	o	o	o	o	o

 The SOAPP®-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	o	o	o	o	o
14. How often have others told you that you had a bad temper?	o	o	o	o	o
15. How often have you felt consumed by the need to get pain medication?	o	o	o	o	o
16. How often have you run out of pain medication early?	o	o	o	o	o
17. How often have others kept you from getting what you deserve?	o	o	o	o	o
18. How often, in your lifetime, have you had legal problems or been arrested?	o	o	o	o	o
19. How often have you attended an AA or NA meeting?	o	o	o	o	o
20. How often have you been in an argument that was so out of control that someone got hurt?	o	o	o	o	o
21. How often have you been sexually abused?	o	o	o	o	o
22. How often have others suggested that you have a drug or alcohol problem?	o	o	o	o	o
23. How often have you had to borrow pain medications from your family or friends?	o	o	o	o	o
24. How often have you been treated for an alcohol or drug problem?	o	o	o	o	o

Please include any additional information you wish about the above answers. Thank you.

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