THE BIRMINGHAM PAIN CENTER

7500 Hugh Daniel Drive, Suite 300
Birmingham, AL 35242
phone 205·3137246 ❖ fax 205·939·1911

MEDICAL INFORMATION

TODAY'S DATE: _____ SOCIAL SECURITY NUMBER: _____

PATIENT NAME: _____ BIRTHDAY: _____

HEIGHT: _____ WEIGHT: _____ AGE: _____

WHO REFERRED YOU? _____ RACE: _____

PRIMARY CARE PHYSICIAN: _____ SEX: _____

DOCTOR'S ADDRESS: _____

SECTION 1: Pharmacy Information

Pharmacy Name and Address: _____
Pharmacy Phone Number: _____

SECTION 2: Social History

Tobacco Use (including dip, e-cigs, vapor, cigars): Current Former Never

Tobacco-years of use: _____

How much do you smoke (i.e., 1 pack per day)? _____

Are you attempting to quit smoking? Yes No Not Applicable

If you are a former smoker, when did you quit? _____

Do you drink alcohol? Yes No How much? _____ per week/month/year

Do you use any illicit drugs? Yes No What? _____

Marital Status (circle): Single Married Widowed Divorced Separated

Number of Children: _____

Work Status: Full Time Part Time Retired On Disability Applying for Disability Unemployed

Auto related injury? Yes No

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Work related injury? Yes No

Legal Situation: Yes No PENDING

Usual Activity Level: None Limited Moderate Active Very Active

If your problem is not the result of an accident or injury, proceed to the next section.

Injury date: _____ (put specific date if known)

Were you taken off work after your injury? _____ Yes _____ No

If yes, for how long? _____ (give dates if you know them)

Describe briefly the circumstances surrounding the accident or injury - if applicable

_____
_____
_____
_____

SECTION 3: Medications

What you are currently taking and HOW MANY in an average day

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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SECTION 4: Allergies

List all allergies to MEDICATIONS

_____

_____

_____

_____

SECTION 5: Past Medical History

Please check all that apply:

☐	ADD/ADHD	☐	Heart Attack (MI)	☐	Prostate Cancer
☐	AIDS/HIV	☐	Heart Disease (CAD)	☐	Prostate Disease
☐	Addiction/Alcoholism	☐	Heart Murmur	☐	Psyhciatric/Mental Health
☐	Anemia	☐	Heart Valve Disease	☐	Seasonal Allergies
☐	Anxiety Disorder	☐	Heavy Snoring	☐	Seizures/Epilepsy
☐	Arthritis	☐	Hepatitis	☐	Sickel Cell
☐	Asthma	☐	Hernia	☐	Sleep Apnea
☐	Atrial fibrillation	☐	Hiatal Hernia	☐	Stomach Ulcers
☐	Back Injury	☐	High Cholesterol	☐	Stroke/TIA
☐	Bronchitis	☐	High Blood Pressure	☐	Substance Abuse
☐	COPD/Emphysema	☐	Hypotestosteronism	☐	Thyroid Disease
☐	Cancer	☐	Insomnia	☐	Tuberculosis
☐	Chron's disease	☐	Irregular Heart Beat	☐	Ulcerative Colitis
☐	Cirrhosis	☐	Kidney Disease	☐	Vision or Eye Problems
☐	Congenital Heart Defect	☐	Liver Disease	Please List Any Other Problems	
☐	Congestive Heart Failure	☐	Multiple Sclerosis		
☐	Decreased Hearing	☐	Muscle Weakness		
☐	Depression	☐	Muscular Disease		
☐	Diabetes	☐	Neck Stiffness		
☐	Easy bruising/bleeding	☐	Osteoporosis		
☐	Fainting	☐	Pacemaker		
☐	Fibromyalgia	☐	Pancreatitis		
☐	GERD/Acid Reflux	☐	Pneumonia		
☐	Glaucoma	☐	Poor Circulation		
☐	Gout	☐	Possibility of Pregnancy		
☐	Headaches	☐	Productive Cough		

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SECTION 6: Past Surgical History

Please check all the operations you have had:

- ☐ Heart bypass
- ☐ Heart stents
- ☐ Carotid Artery
- ☐ Low back
- ☐ Neck
- ☐ Mid back
- ☐ Gallbladder
- ☐ Appendix
- ☐ Tonsils or Adenoids
- ☐ Ear tubes
- ☐ Inginual Hernia
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ C-section
- ☐ Breast

- ☐ Knee
- ☐ Hip
- ☐ Shoulder
- ☐ Rotator Cuff
- ☐ Ankle
- ☐ Wrist
- ☐ Carpal Tunnel

List all other operations

SECTION 7: Family History

Family History: CANCER – check any that apply							
Cancer	**Mother**	**Father**	**Brother**	**Sister**	**Son**	**Daughter**	**No FHx**
Brain							
Breast							
Cervical							
Colon							
GI							
Kidney							
Lung							
Ovarian							
Prostate							
Skin							
Testicular							
Thyroid							

Family History: General – check any that apply							
Disease	**Mother**	**Father**	**Brother**	**Sister**	**Son**	**Daughter**	**No FHx**
Alcoholism							
Addiction							
Anemia							
Autoimmune							
Diabetes							
Heart Disease							

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Hypertension							
Lung Disease							
Mental Illness							
Migraine							
Heart Attack							
Kidney Failure							
Seizures							
Stroke							
Thyroid Disease							
Tuberculosis							

SECTION 8: Chief Complaint- Check all that may apply

☐	Neck Pain	☐	Wrist Pain	Right	Left	Both
☐	Mid Back Pain	☐	Elbow Pain	Right	Left	Both
☐	Low Back Pain	☐	Shoulder Pain	Right	Left	Both
☐	Chest Pain	☐	Foot Pain	Right	Left	Both
☐	Abdominal Pain	☐	Ankle Pain	Right	Left	Both
☐	Headache	☐	Knee Pain	Right	Left	Both
☐	Face Pain	☐	Hip Pain	Right	Left	Both
☐	Hand Pain	☐	Other _____			

How long have you had this pain? _____ (circle) days weeks months years

SECTION 9: Pain History

What does your pain feel like (circle all that apply)? Sharp Stabbing Shooting Dull Aching Pressure Burning Tingling Other: _____

Does it go anywhere else? _____

What time of day is it worst (circle one)? Morning Midday Evening Constant

What makes your pain worse? _____

What makes your pain better? _____

Do you have any of the following associated with your pain (circle all that apply)?
Trouble controlling your bladder Trouble controlling your bowels
Difficulty sleeping Anxiety Depression Feeling Tired

What is your pain score? Current: ____/10 Best: ____/10 Worst: ____/10

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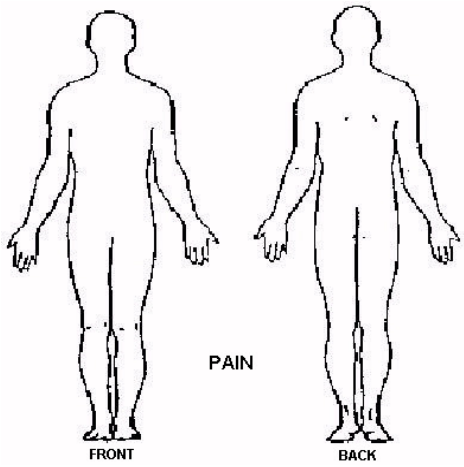
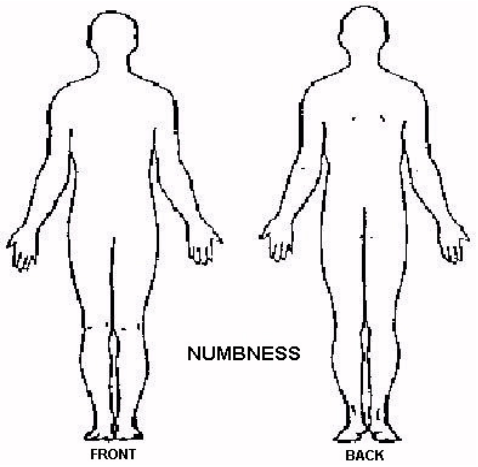
Have you tried the following treatments for your pain?

Physical Therapy:	Yes	No
Chiropractor:	Yes	No
Pain Medications:	Yes	No
Steroids:	Yes	No
TENS/muscle stimulator:	Yes	No
Heat/Ice:	Yes	No
Surgery:	Yes	No
Pain Procedures (Epidurals, Nerve blocks, etc.):	Yes	No

Please shade the painful and numb areas in the diagrams below:





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SECTION 10: Other medical complaints

Check all that you FREQUENTLY have

☐ Fever	☐ Pounding Heart Beat	☐ Jaundice	☐ Hallucinations
☐ Night Sweats	☐ Heart Murmur	☐ Rash	☐ Suicidal Thoughts
☐ Weight Changes	☐ Leg Swelling	☐ Laceration	☐ Drug Dependency
☐ Fatigue	☐ Cough	☐ Loss of conciousness	☐ Increased Thirst
☐ Chills	☐ Wheezing	☐ Weakness	☐ Cold Intolerance
☐ Appetite Changes	☐ Coughing up bloood/sputum	☐ Numbness	☐ Increased Hunger
☐ Vision Changes	☐ Nausea	☐ Seizures	☐ Heat Intolerance
☐ Hearing Changes	☐ Vomiting	☐ Dizziness	☐ Swollen Glands
☐ Nose Problems	☐ Constipation	☐ Migraines	☐ Easy Bruising
☐ Sore Throat	☐ Diarrhea	☐ Headaches	☐ Excessive Bleeding
☐ Dry Mouth	☐ Heartburn	☐ Tremor	☐ Runny Nose
☐ Chest Pain	☐ Incontinence	☐ Depression	☐ Sinus Pressure
☐ Shortness of Breath (SOB)	☐ Difficulty Urinating	☐ Sleep Disturbances	☐ Itching
☐ SOB when walking	☐ Blood in Urine	☐ Addiction	☐ Hives
☐ SOB when lying down	☐ Urinary Frequency	☐ Anxiety	☐ Frequent Sneezing

Any other pertinent information you think we need to know._____

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?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

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

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	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?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

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

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Controlled Substances Agreement and Informed Consent

The purpose of this Agreement is to prevent misunderstandings about certain medicines you may be taking for pain management. This is to help both you and your physician to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a physician/patient relationship. If it becomes medically necessary for me to be treated with controlled medicines, my physician will do so only based on this Agreement. I also understand that my physician is prescribing these medications in good faith for legitimate medical purposes.

I understand that if I do not adhere to this Agreement, my physician will stop prescribing controlled pain medicines and that I might be discharged from his/her care. Also, a drug-dependence/addiction treatment program may be recommended.

I understand that there is a risk of addiction with controlled pain medicines. The State of Alabama defines addiction as follows. Addiction is a neurobehavioral syndrome with genetic and environmental influences that result in psychological dependence on the use of substances for their mind-altering effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as 'drug dependence' and 'psychological dependence.' **Physical dependence and tolerance** are normal physiological consequences of taking pain medicines for extended periods of time and should **not** be considered addiction."

I understand that opiate medications may have side effects, including but not limited to; nausea, vomiting, constipation, itching, sedation, respiratory depression, decreased sex drive, dental decay, slurred speech, impaired thinking, slow reflexes, overdose, and **DEATH**. For this reason, the physicians of The Birmingham Pain Center reserve the right to change or discontinue opiate medications at any time.

Withdrawal symptoms such as a flu-like syndrome, irritability, diarrhea, and muscle soreness are natural consequences of the abrupt discontinuation of pain medicine. Therefore, if you, or your physician, decide to discontinue your pain medicines, these medicines will need to be tapered off to avoid or diminish these withdrawal symptoms.

The State of Alabama and the Federal Drug Enforcement Agency place very strict guidelines for prescribing controlled medicines. Therefore, the following policies must be adhered to in order to receive controlled medications from the physicians of The Birmingham Pain Center:

1. The Physicians and Physician Assistants of The Birmingham Pain Center **ARE NOT OBLIGATED TO REPLACE PRESCRIPTIONS OR REFILL MEDICATIONS THAT ARE LOST, STOLEN OR DAMAGED IN ANY WAY**. It is your responsibility to take care of your medication. If you fear that withdrawal from your medication will occur, then call the Birmingham Pain Center and notify your physician.

2. ALTERING PRESCRIPTIONS IS A FELONY. If you alter or forge or call in any prescriptions you may be prosecuted. We will not treat any patient engaged or implicated in such criminal activities.

3. Chronic pain should rarely be treated with large amounts of opiates. It is your responsibility to exercise self-control. If you feel that your medication is not helping, or feel that you need something stronger or different, **DO NOT INCREASE YOUR MEDICATIONS YOURSELF**. You must call and make an appointment to talk with the physician concerning your medications. If a dose adjustment is necessary, it can only be prescribed by your physician. Failure to comply, may results in serious consequences, including **DEATH**.

4. We must be the only physicians prescribing pain medications for you. We will not treat any patient who receives **PAIN MEDICINES** from other physicians. However, we understand that another physician might prescribe pain medicine for an unexpected surgical or dental procedure, trauma, or an acute medical emergency. If that should occur, the Birmingham Pain Center requires that you call to notify us of the circumstance, the medication and amount prescribed. If you desire another physician outside of The Birmingham Pain Center to take care of your medicines, no controlled medication will be given to you from the physicians at this clinic. **You should continue to see your other physicians for all of your other medical problems.**

5. Do not take any medications other than those prescribed by your physicians. Do not give your medicines to others.

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6. All of your physicians should be made aware of **ALL** medications that are prescribed to you. This includes Methadone from Methadone Clinics and Suboxone from Suboxone Clinics, as well as nerve pills, sleeping pills or sedatives by other physicians. Please let us know of all the medications you are prescribed.

7. Do not drive, operate heavy machinery, work at unprotected heights or any potentially dangerous activity until you have taken the medications for a while and know how your body reacts to the medications. If you feel impaired or appear impaired to others in any way, **DO NOT DRIVE. DO NOT OPERATE HEAVY MACHINERY. DO NOT PUT YOURSELF OR OTHERS IN A DANGEROUS SITUATION**. If you feel impaired or appear impaired to others in any way, contact your physician immediately.

8. If you fail to keep your follow-up appointment and run out of your medication, we will only give you enough medication to get you through to your make-up appointment. If you fail to keep this make-up appointment, no more medicines will be given to you until you see your physician. You must see your physician in order to get your medications refilled if you missed two appointments.

9. Periodic blood and/or urine tests may be required to determine if liver or kidney function is being harmed. Urine drug testing is also required to monitor for potentially dangerous drug combinations, medications not prescribed for you, illegal drugs, and compliance with your medication regimen. Any of these conditions could be potentially life threatening to you. These tests are not for legal purposes such as worker's compensation, employment, or other legal drug screens but are performed for your safety and to help your physician better treat your problems. The results of these tests are held confidential as are the rest of your medical records and in compliance with all regulatory agencies concerning medical records.

10. The Birmingham Pain Center physicians are not obligated to treat any patient who takes any illegal drugs (street drugs including marijuana) or any other controlled drugs not prescribed for that patient. Therefore, do not use any illegal drugs or any medicines that are not prescribed for you.

11. The use of alcohol while taking pain medicines, especially extended release medications, is extremely dangerous and may result in death. Do not use alcohol if you are taking pain medications or other sedating medications.

12. If we are prescribing your controlled pain medicines, your entire pain care needs to be done by the physicians and staff of The Birmingham Pain Center. This includes interventional procedures such as epidural steroid injections, joint injections, or any other "blocks" or procedures that we perform. Almost all physicians are capable of writing pain medications, however many choose not to do so. Since we are a comprehensive pain center, our physicians have specialty training in performing a wide variety of procedures as well as medication management. If your surgeon or another physician recommends a "block," you must have that procedure performed here. We will not treat patients who get interventional pain procedures elsewhere. Remember, the same physician that recommended or performed your block, is also capable of writing your pain medications, and you are always free to transfer your entire care to that physician's clinic.

13. Abusive behavior towards the staff will not be tolerated.

14. Failure to comply with any and all of the above may result in discontinuation of treatment with controlled substances and/or termination from the clinic

15. **The physicians and staff of The Birmingham Pain Center will not treat any patient with controlled pain medicines without this signed agreement in place.**

I have read, understand and agree to abide by these policies,

_____ _____

Patient Signature Date

THE BIRMINGHAM PAIN CENTER

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Ph: 205-313-7246, Fax: 205-939-1911

Acknowledgment of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

☐ Please initial

Therefore, I, _____ (printed name of patient or personal representative), acknowledge that **The Birmingham Pain Center** has provided a written copy of its Notice of Privacy Practices for Protected Health Information to:
(specify patient name):_____.
(*If signing as a personal representative, documentation of your legal right to do so must be provided and attached.*)

☐ Please initial

I hereby authorize The Birmingham Pain Center to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. A copy of this authorization shall be valid as the original.

NONCOVERED SERVICES STATEMENT:

☐ Please initial

The services I receive from The BPC will be performed when felt necessary for maintenance of my good health and I will be responsible for payment in full of **all** services that may not be covered by my insurance, including (but not limited to) non-payments or take-backs, including coordination-of-benefit issues if I have not submitted to The BPC updated, current and correct insurance coverage information in a timely manner.

☐ Please initial

The undersigned, in consideration of services rendered to the patient, agrees to pay all sum due the physician(s), waives all claims of exemption, and agrees to pay a reasonable collection fee if referred to an attorney or collection agency, whether a suit is filed or not.

If my treatment plan is stable and I am on controlled medications for which the prescription must be hardcopy:

☐ Please initial

I choose to take advantage of The BPC's offer to process and create interim prescriptions between my quarterly follow-up appointments, to be mailed directly to my pharmacy, for which I will be charged and agree to pay the minimal fee of $10.00 each month, allowing me the opportunity to save transportation costs, time, and office visit fees.

☐ Please initial

I do not want to take advantage of this offer or do not want to pay the $10.00 processing fee, and understand that monthly follow-up clinic visits will be scheduled instead of quarterly in order for prescriptions to be written.

☐ Please initial

If I do not cancel my appointment 24 hours or more in advance, I agree to pay $35.00 for each missed office visit and $100.00 for each missed procedure appointment.

⇨

_____ _____ _____/_____/20_____
Guarantor Signature | Signature of Patient or Personal Representative | Date:

To be completed by The Birmingham Pain Center:

☐ We made a good faith attempt to provide the above named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:

_____

_____ _____ _____ _____/_____/20_____
Printed Name | Title | Signature | Date

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Consent to Use Protected Health Information

To provide for your healthcare, **The Birmingham Pain Center** collects information about your medical history, physical examinations and test results, diagnoses, and treatments. Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare may decide to obtain your consent to use personal health information for treatment, payment, or healthcare operations, but are not required to do so.

Therefore, I, _____ (printed name of patient or personal representative), consent that **The Birmingham Pain Center** may use and request the health information of

(check one) ☐ myself or ☐ (specify): _____ for the following purposes:

1. Treatment (to perform actions required to help diagnose, maintain, or improve health);
2. Payment (to obtain reimbursement from third party payers);
3. Healthcare operations (to carry out, analyze, or improve business processes related to healthcare).

The Birmingham Pain Center has privacy practices that are summarized in our Notice of Privacy Practices for Protected Health Information ("Notice"). This Notice describes the use and disclosure of protected health information, patients' rights relevant to examining medical records, requesting corrections and additions to these records, requesting restrictions to the use of health information, finding out to whom their protected health information has been disclosed, and registering any complaints relevant to privacy issues. The Notice also describes how to receive these rights. I have been provided with or have previously received a copy of this Notice and given the opportunity to review it prior to signing this consent. I understand that if I decide not to sign this consent, **The Birmingham Pain Center** may decline to provide healthcare to me.

The consent I am signing today covers this and all future healthcare activities performed for me by **The Birmingham Pain Center** with respect to treatment, payment, and operations. This consent replaces and supercedes any previous consents I may have signed with **The Birmingham Pain Center** for such use of my healthcare information. If I wish to revoke this consent, such a request must made be in writing. However, a revocation does not cover actions that have already been taken in reliance upon the consent previously in force. In addition, I understand that if I revoke this consent, then **The Birmingham Pain Center** may discontinue taking care of me.

_____ _____/_____/20_____
Signature of Patient Date

_____ _____/_____/20_____ _____ _____/_____/20_____
Signature of Patient Personal Representative Date Witness Date
(***If signing as a personal representative, documentation of your legal right to do so must be provided.***)
