THE BIRMINGHAM PAIN CENTER

4515 Southlake Pkwy, Suite 200
Hoover, AL 35242
phone 205·313·7246 ❖ 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: 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 2: Pharmacy Information

Pharmacy Name and Address: ____
Pharmacy Phone Number: ____

SECTION 3: Allergies

List all allergies to MEDICATIONS

____

____

____

____

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SECTION 4: Medications

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

____
____
____
____
____
____
____
____
____
____
____
____
____
____

SECTION 5: 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							

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Family History: General – check any that apply							
Disease	**Mother**	**Father**	**Brother**	**Sister**	**Son**	**Daughter**	**No FHx**
Alcoholism							
Addiction							
Anemia							
Autoimmune							
Diabetes							
Heart Disease							
Hypertension							
Lung Disease							
Mental Illness							
Migraine							
Heart Attack							
Kidney Failure							
Seizures							
Stroke							
Thyroid Disease							
Tuberculosis							

SECTION 6: 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 7: Past Surgical History

Please check all the operations you have had:

				List all other operations
☐	Heart bypass	☐	Knee	____________
☐	Heart stents	☐	Hip	____________
☐	Carotid Artery	☐	Shoulder	____________
☐	Low back	☐	Rotator Cuff	____________
☐	Neck	☐	Ankle	____________
☐	Mid back	☐	Wrist	____________
☐	Gallbladder	☐	Carpal Tunnel	____________
☐	Appendix	☐		____________
☐	Tonsils or Adenoids	☐		____________
☐	Ear tubes	☐		____________
☐	Inginual Hernia	☐		____________
☐	Hysterectomy	☐		____________
☐	Tubal Ligation	☐		____________
☐	C-section	☐		____________
☐	Breast	☐		____________

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SECTION 8: Past Medical History

Please check all that apply:

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

Please List Any Other Problems

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

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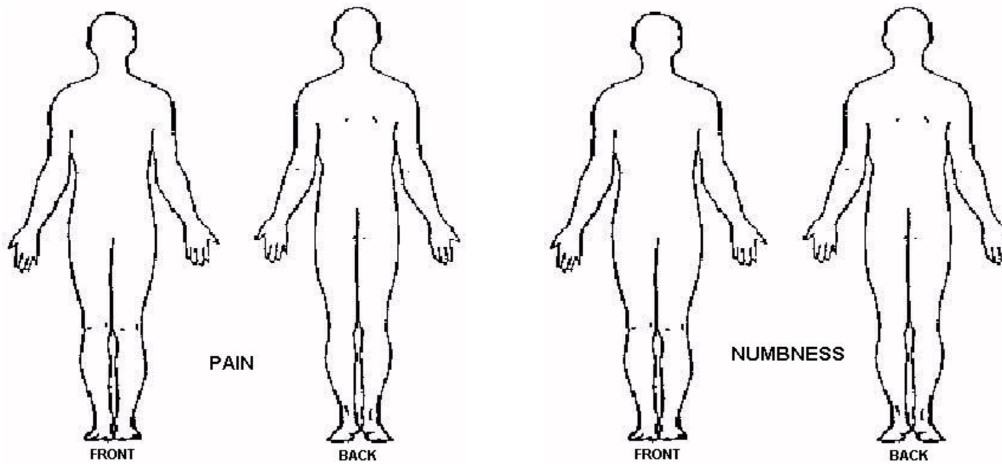
What is your pain score? Current: ____/10 Best: ____/10 Worst: ____/10

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?	○	○	○	○	○

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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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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 for patient listed above.
(*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.

☐ Please initial

NONCOVERED SERVICES STATEMENT:

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 processed monthly:

CHOOSE ONE OF THE FOLLOWING OPTIONS

☐ I choose to take advantage of The BPC's offer to process and create interim prescriptions between my quarterly follow-up appointments, to be transmitted or 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.

☐ My prescriptions are covered by Workers' Compensation, and I elect to use The BPC's in-house pharmacy (only available to WC patients), and my interim prescription medications will be mailed to me with no extra fee.

☐ I do not want to pay the $10.00 processing fee or use The BPC's pharmacy, 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.

________________________________ Guarantor Signature

________________________________ Signature of Patient or Personal Representative

_____/_____/20________ 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:

____

________________________ Printed Name

__________ Title

________________________ Signature

_____/_____/20_________ 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.***)