

**MEDICAL INFORMATION**

TODAY'S DATE \_\_\_\_\_ PATIENT NUMBER \_\_\_\_\_  
 PATIENT NAME \_\_\_\_\_ BIRTHDAY \_\_\_\_\_  
 HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ AGE \_\_\_\_\_  
 WHO REFERRED YOU? \_\_\_\_\_ RACE \_\_\_\_\_  
 FAMILY DOCTOR \_\_\_\_\_ SEX \_\_\_\_\_  
 DOCTOR ADDRESS \_\_\_\_\_

**SECTION 1: CHIEF COMPLAINT - Check all that may apply**

- |  |  |       |      |      |
|--|--|-------|------|------|
| <input type="checkbox"/> Low Back Pain   | <input type="checkbox"/> Hand Pain     | Right | Left | Both |
| <input type="checkbox"/> Neck Pain       | <input type="checkbox"/> Wrist Pain    | Right | Left | Both |
| <input type="checkbox"/> Mid Back Pain   | <input type="checkbox"/> Elbow Pain    | Right | Left | Both |
| <input type="checkbox"/> Chest Pain      | <input type="checkbox"/> Shoulder Pain | Right | Left | Both |
| <input type="checkbox"/> Abdominal Pain  | <input type="checkbox"/> Foot Pain     | Right | Left | Both |
| <input type="checkbox"/> Headache        | <input type="checkbox"/> Ankle Pain    | Right | Left | Both |
| <input type="checkbox"/> Face Pain       | <input type="checkbox"/> Knee Pain     | Right | Left | Both |
| <input type="checkbox"/> Drug Dependency | <input type="checkbox"/> Hip Pain      | Right | Left | Both |
|  | <input type="checkbox"/> Other _____   |       |      |      |

Are you presently disabled? \_\_\_\_ yes \_\_\_\_ no \_\_\_\_ unknown

If no, what is your present Occupation \_\_\_\_\_

**SECTION 2: Injury Information**

Injury occurred : \_\_\_\_ At work. Employer? \_\_\_\_\_  
 \_\_\_\_ At home  
 \_\_\_\_ In a car accident  
 \_\_\_\_ Unknown cause (it just happened or has gotten worse over time)

*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: List the order of treatment you have received for your pain problem:**

Date initiated	Treating Doctor	Type of Treatment or Test done meds, MRI, Myelogram, PT, etc.	Results of test or reponse to treatment excellent, good, fair, poor, worse	Return to work yes or no

Have you been placed at “Maximum Medical Improvement” (MMI) by any of your previous physicians?

\_\_\_\_\_ no      \_\_\_\_\_ yes      Who? \_\_\_\_\_

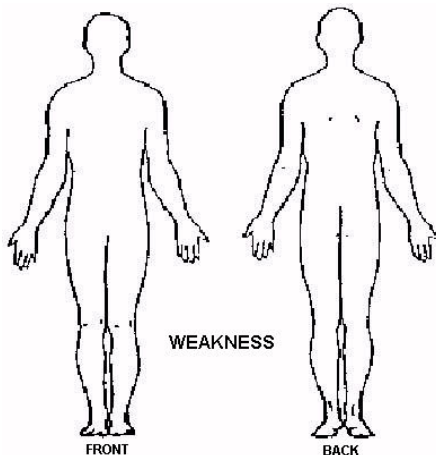
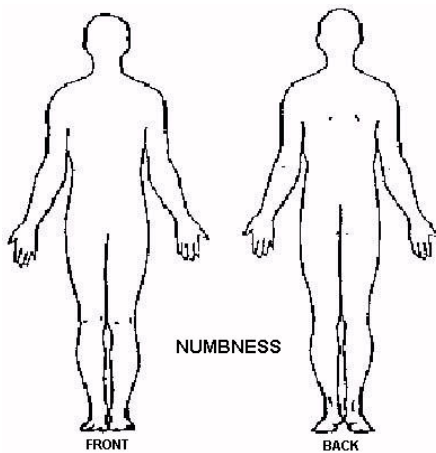
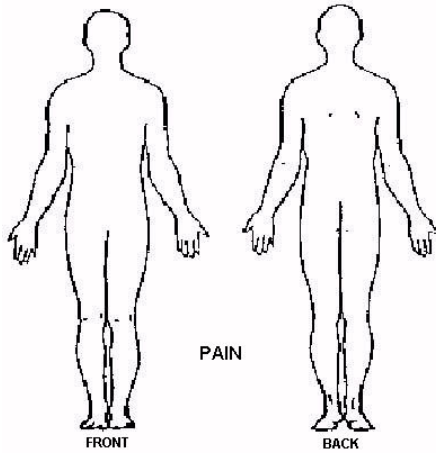
Have you been given an “Partial Permanent Impairment Rating” (PPI)?

\_\_\_\_\_ no      \_\_\_\_\_ yes      Who? \_\_\_\_\_

If this is a Worker’s Compensation injury, has the Worker’s Compensation claim been settled?

\_\_\_\_\_ no      \_\_\_\_\_ yes

**SECTION 4: PRESENT SYMPTOMS - Color in all affected areas:**



**Describe your pain  
 (Check all that apply)**

- constant
- intermittent
- sharp or stabbing
- dull or aching
- pressure
- throbbing
- burning
- cramping
- numbness
- tingling
- pins and needles
- stiffness
- soreness
- tightness
- swelling
- feels like there is a "knot"
- Other - Describe:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When is your worst time of day?

\_\_\_\_\_

What makes you symptoms worse?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What makes your symptoms better?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

On a scale from 1 to 10, where 1 is mild and 10 is severe, your symptoms are:

\_\_\_\_\_ at best \_\_\_\_\_ at worst

**SECTION 5: Present Function**

I am able to walk for \_\_\_\_\_ minutes at a time. I am able to sit for \_\_\_\_\_ minutes at a time.

I am able to perform household duties/chores? \_\_\_\_\_ YES \_\_\_\_\_ NO

I am able to sleep for \_\_\_\_\_ hours at night.

**SECTION 6: Present Treatment - Check ALL that you are CURRENTLY using.**

✓	Type of Treatment	Result - (Excellent, Good, Fair, Poor, Worse)
	Medicines	
	TENS Unit	
	Chiropractic Care	
	Physical Therapy	
	Rest at Home	
	Home Exercise program	
	Work Hardening	
	Epidural Nerve Blocks/Duramorphs	
	Spinal Cord Stimulator	
	Implantable Infusion Pump	
	Other	

**If applicable:**

When was your last epidural steroid injection? \_\_\_\_\_

When were you last in any type of physical therapy? \_\_\_\_\_

Have you ever used a TENS unit? \_\_\_\_\_ yes \_\_\_\_\_ no Do you have a TENS? \_\_\_\_\_ yes \_\_\_\_\_ no

Are you currently using you TENS unit? \_\_\_\_\_ yes \_\_\_\_\_ no

What are you doing for exercise at home? \_\_\_\_\_

\_\_\_\_\_

**SECTION 7: Past Medical History - Please check or List all OTHER medical conditions:**

- Lung Disease
- Kidney Disease
- Diabetes
- Hypertension (High Blood Pressure)
- Peptic Ulcer Disease/Hiatal Hernia
- Arthritis
- Other \_\_\_\_\_
- Other \_\_\_\_\_

**SECTION 8: Past Surgical History - Please list all of your operations and/or procedures**

DATE	OPERATION	SURGEON

**SECTION 9: Social History**

Marital Status    \_\_\_\_\_ Single                      \_\_\_\_\_ Widowed  
                              \_\_\_\_\_ Married                      \_\_\_\_\_ Separated  
                              \_\_\_\_\_ Divorced                      Number of Children    \_\_\_\_\_

Do you smoke?    \_\_\_\_\_ YES    \_\_\_\_\_ NO    How much? \_\_\_\_\_

Do you drink alcohol?    \_\_\_\_\_ YES    \_\_\_\_\_ NO    How much? \_\_\_\_\_

Do you use any illicit drugs?    \_\_\_\_\_ YES    \_\_\_\_\_ NO    What? \_\_\_\_\_

**SECTION 10: Current Work/Employment Situation - check all that apply**

- Unemployed
- Retired
- Early retirement secondary to disability
- Currently employed by \_\_\_\_\_
- Currently working
- Currently off work for now because of this medical condition
- Temporary Disability on Worker's Compensation
- Permanent Disability on Worker's Compensation
- Temporary Disability on personal or group disability insurance
- Permanent Disability on personal or group disability insurance
- Applying for personal or group disability benefits or early retirement
- Social Security Disability
- Applying for Social Security Disability

**SECTION 11: Legal Situation - check all that apply**

- None
- Personal Injury Case - do not have an attorney
- Personal Injury Case - attorney is \_\_\_\_\_
- Worker's Comp claim - do not have an attorney
- Worker's Comp Claim - attorney is \_\_\_\_\_
- Applying for Social Security - no attorney
- Applying for Social Security - attorney is \_\_\_\_\_
- Other legal situation/attorney \_\_\_\_\_

**SECTION 12: Medicines - What are you currently taking and HOW MANY in an average day.**

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

Pharmacy Phone Number \_\_\_\_\_

**SECTION 13: Allergies - list all allergies to MEDICATIONS**

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

**SECTION 14: Other medical complaints - check all that you FREQUENTLY have**

- headaches
- migraine headaches
- dizziness
- vertigo
- chest pain
- palpitations
- wheezing
- chronic cough
- heart burn
- difficulty urinating
- stress incontinence
- urinary retention
- fever or chills
- nausea and/or vomiting
- visual changes

- emotional difficulty
- ringing in the ears
- bleeding
- leg swelling
- constipation
- diarrhea
- sexual dysfunction
- depression
- relationship difficulty
- anxiety
- nervous condition
- drug dependancy
- fatigue
- insomnia
- poor appetite

- weight gain
- weight loss
- loss of interest
- suicidal thoughts
- hearing voices

**List all other complaints**

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

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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 doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship. If it becomes medically necessary for me to be treated with controlled medicines, my doctor 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 doctor 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."

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 doctor, 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 doctors 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 doctor.
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 doctor concerning your medications. If a dose adjustment is necessary, it can only be prescribed by your doctor.
4. We must be the only physicians prescribing pain medications for you. We will not treat any patient who receives **PAIN MEDICINES** from other doctors. 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 doctor outside of The Birmingham Pain Center to take care of your medicines, no controlled medication will be given to you from the doctors 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 doctors. Do not give your medicines to others.

6. All of your doctors should be made aware of **ALL** medications that are prescribed to you. This includes Methadone from Methadone Clinics, as well as nerve pills, sleeping pills or sedatives by other doctors. Failure to disclose your treatment (past or present) may cause you to be discharged from this clinic.
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 doctor. You must see your doctor 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 or toxic levels of medicines are present or if there are potentially dangerous drug combinations including other medications not prescribed for you and illegal drugs. 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, compliance monitoring and to help your doctor 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. Since the use of alcohol while taking pain medicines is extremely dangerous and may result in death, the use of alcohol while taking pain medicines may result in a decrease or discontinuation of your pain medicine.
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 block performed here. We will not treat patients who get interventional pain blocks 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. 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



## 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.



\_\_\_\_\_  
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



7500 Hugh Daniel Drive, Suite 300, Birmingham, AL 35242 205-313-7246, fax 205-939-1911

## 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 be made 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.

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\_\_\_\_\_/\_\_\_\_\_/20\_\_\_\_\_  
Signature of Patient Date

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\_\_\_\_\_/\_\_\_\_\_/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.)

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

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

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

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