LIBERTY PAIN ASSOCIATES™

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NEW PATIENT WELCOME LETTER

Welcome to LIBERTY PAIN ASSOCIATES, the office of Dr. Sathya P. Bhandari, M.D. specializing in interventional pain management.

Decreasing your pain and its impact on your personal and professional life is our first and foremost concern. We deliver a complete program of unique, state-of-the-art pain control techniques to help you:

- Advance your functional ability
- Improve your emotional well being
- Optimize your quality of life

Our team employs a caring and responsive attitude at all times. All patients are treated with dignity and respect for privacy, and we will not release any information about you unless we have a signed release to do so. We are committed to providing you with quality pain management services and the highest standards of medical care in a cost-effective manner.

A THOROUGH APPROACH FOR THE BEST RESULTS
We work closely with your referring and primary care doctors. We continuously monitor and measure the effectiveness of your therapies and, on a regular basis, deliver telephone and written updates of your progress to your referring physician and all others that you request.

Optimum pain management begins with an accurate diagnosis of the origin of your pain. We request that referring physicians send us a complete medical history, including results of radiology and laboratory tests and any previous approaches to pain management that have been taken. Before we can develop a comprehensive, individualized treatment plan for you, you must receive a thorough medical evaluation.

Your first visit includes:

- A detailed medical history and physical examination
- Review of all past diagnostic and treatment data
  - Medication History
  - Radiologic Tests: X-ray, CT, MRI, and Bone Scans (bring pertinent x-rays or MRIs)
  - Neurologic Tests: EMG, NCV, and QST
  - Laboratory Tests
  - Surgical Reports

TREATMENT OPTIONS
These established and innovative therapies provide a significant reduction or complete elimination of pain in most patients. Your individualized treatment plan may include one or more of the following:

- Nerve Blocks and Nerve Lesioning
- Spinal Cord Stimulation
- Joint Injections
- Regenerative Medicine

PRIOR TO YOUR VISIT
In order to expedite your first visit and serve you best please print and complete the attached forms prior to your appointment. We accept completed forms via: **mail**, **fax to (844) 221-1862** or drop off at our **office Monday-Thursday 8am-5pm and Friday 8am-12pm.** In accordance with HIPPA Privacy Rule our office does not communicate Protected Health Information via email and as such cannot accept the completed forms via email.
Please ensure that you have a valid form of government i.d. and all insurance card(s) with you for your first appointment.

Thank you. We look forward to seeing you.

LIBERTY PAIN ASSOCIATES™

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PATIENT CONSENT TO TREATMENT

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following:

1. **INDEPENDENT CONTRACTORS:** LIBERTY PAIN ASSOCIATES may utilize independent contractors for office, outpatient or inpatient treatment/ procedures. These include, but are not limited to, surgical assistants, physical therapists, and consulting and referral physicians. Healthcare professionals that are independent contractors are not agents or employees of LIBERTY PAIN ASSOCIATES are responsible for their own actions. I understand that LIBERTY PAIN ASSOCIATES shall not be liable for the acts or omissions of independent contractors. This Consent to Treatment also applies to any independent contractor utilized by my physician(s).
2. **VALUABLES:** LIBERTY PAIN ASSOCIATES assumes no responsibility for, and I hereby release LIBERTY PAIN ASSOCIATES from liability for, loss or damage to any of my personal property while on the premises and/or receiving treatment.
3. **AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD PARTY PAYMENTS:** I hereby expressly authorize LIBERTY PAIN ASSOCIATES and all healthcare professionals providing care to release all necessary information to LIBERTY PAIN ASSOCIATES any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to LIBERTY PAIN ASSOCIATES and all professionals (including independent contractors) providing for such care, and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to LIBERTY PAIN ASSOCIATES and the third party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.
4. **PAYMENT FOR SERVICES:** In return for services to be provided by LIBERTY PAIN ASSOCIATES I promise to pay for services rendered by LIBERTY PAIN ASSOCIATES to me or for my benefit. If the services I receive from LIBERTY PAIN ASSOCIATES are covered by a third party payor, LIBERTY PAIN ASSOCIATES may elect to bill and accept payment from such third party. I will pay the portion of these bills which the third party payor determines are my responsibility. In the case of services which I agree to receive but which are not covered by the third party, I will pay the amount due upon receipt of services. If no third party is involved in paying for my services, I agree to pay in full for such services at the time the services are received.
5. **AUTHORIZATION AND RELEASE FOR PHOTOGRAPHS**: I authorize and release LIBERTY PAIN ASSOCIATES and its employees and agents to take photographs, videos, x-rays, and/or other photographic, electronic or other images of me and to use them as may be medically appropriate. Such images may be used for educational or other purposes as necessary and appropriate. These images may be maintained as a permanent part of my medical record. I understand and acknowledge that LIBERTY PAIN ASSOCIATES may use cameras for security and patient monitoring, and patient confidentiality will be maintained for all such images.
6. **NO GUARANTEE OF RESULTS:** LIBERTY PAIN ASSOCIATES physicians and healthcare professionals cannot guarantee any specific result(s) of any examination, treatment, procedure or medical care. I release LIBERTY PAIN ASSOCIATES, its physicians and healthcare professionals from any liability for any accident or injury that is not directly caused by the negligence of LIBERTY PAIN ASSOCIATES or its employees, agents, representatives or assigns.
7. During the course of my care and treatment, I understand that various types of examinations, tests, diagnostic or treatment procedures ("procedures") may be necessary. These procedures may be performed by physician(s), nurses, technicians, physician assistants, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.
8. I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

By signing this document, I certify that I have read and understand its contents and the information provided by me is accurate and complete (including insurance information and current eligibility for benefits).

A copy of this document may be utilized the same as the original.

_____ Date:_____

Patient/Parent/Guardian/Authorized Representative

If not signed by the patient, please indicate relationship to the patient on the line below:

_____

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HIPAA Form Part 1/2

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES PURSUANT TO 45 C.F.R. S 164.520 and 42 C.F.R. Part 2

1. Our Duties

We are required by law to maintain the privacy of your Protected Health Information ("Protected Health Information"). We must also provide you with notice of our legal duties and privacy practices with respect to Protected Health Information. We are required to abide by the terms of our Notice of Privacy Practices currently in effect. However, we reserve the right to change our privacy practices in regard to Protected Health Information and make new privacy policies effective for all Protected Health Information that we maintain. We will provide you with a copy of any current privacy policy upon your written request, addressed to our Privacy Officer, at our current address.

2. Your Complaints

You may complain to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with us by sending a certified letter addressed to "Privacy Officer" at our current address, stating what Protected Health Information you believe has been used or disclosed improperly. You will not be retaliated against for making a complaint. For further information you may contact our Privacy Officer, at telephone number 972-355-9038.

3.Description and Examples of Uses and Disclosures of Protected Health Information

Here are some examples of how we may use or disclose your Protected Health Information. In connection with treatment, we will, for example, allow a physician associated with us to use your medical history, symptoms, injuries or diseases to treat your current condition. In connection with payment, we will, for example, send your Protected Health Information to your insurer or to a federal program, such as Medicare, that pays for your treatment. This allows us to obtain payment for the services we rendered on your behalf. In connection with health care operations, we will, for example, allow our auditors, consultants, or attorneys' access to your Protected Health Information to determine if we billed you accurately for the services we provided to you.

4.Uses and Disclosures Which Require Your Written Authorization

Uses and disclosures other than those involving treatment, payment, and health care operations, as well as those described in the following sections of this Notice, will only be made by obtaining a written authorization from you. You may revoke this authorization in writing at any time, except to the extent that we have taken action in reliance upon your authorization.

5. Uses and Disclosures Not Requiring Your Written Authorization

The privacy regulations give us the right to use and disclose your Protected Health Information if: (I) you are an inmate in a correctional institution; (ii) we have a direct or indirect treatment relationship with you, (iii) we are so required or authorized by law. The purposes for which we might use your Protected Health Information would be to carry out treatment, payment, and health care operations similar to those described in Paragraph 1.

6. Uses of Protected Health Information to Contact You

We may use your Protected Health Information to contact you regarding appointment reminders or to contact you with information about treatment alternatives or other health-related benefits and services that, in our opinion, may be of interest to you. We may use your Protected Health Information to contact you in an effort to raise funds for our operations.

7. Disclosures of Protected Health Information for Billing Purposes

We may disclose your billing information to any person that calls our billing staff or agents with billing questions after we verify the identity of the person by requesting information such as your social security number or health plan number.

(continued next page)

Patient/Guardian Signature Date

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HIPAA Form Part 2/2

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES PURSUANT TO 45 C.F.R. S 164.520 and 42 C.F.R. Part 2

8. Disclosures for Directory and Notification Purposes

If you are incapacitated or not present at the time, we may disclose your Protected Health Information (a) for use in a facility directory, (b) to notify family or other appropriate persons of your location or condition, and (c) to inform family, friends or caregivers of information relevant to their involvement in your care or payment for your treatment. If you are present and not incapacitated, we will make the above disclosures, as well as disclose any other information to anyone you have identified, only upon your signed consent, your verbal agreement, or the reasonable belief that you would not object to such disclosure(s).

9. Individual Rights

(i) You may request us to restrict the uses and disclosures of your Protected Health Information, but we do not have to agree to your request. (ii) You have the right to request that we communicate with you regarding your Protected Health Information in a confidential manner or pursuant to an alternative means, such as by a sealed envelope rather than a postcard, or by communicating to a specific phone number, or by sending mail to a specific address. We are required to accommodate all reasonable requests in this regard. (iii) You have the right to request that you be allowed to inspect and copy your Protected Health Information as long as it is kept as a designated record set, and as long as you pay in advance for the administrative time and costs to make arrangements to have the records inspected and copied. Certain records are exempt from inspection and cannot be inspected or copied, so each request will be reviewed in accordance with the standards published in 45 C.F.R. S 164.524. (iv) You have the right to amend your Protected Health Information for as long as the Protected Health Information is maintained in the designated record set. We may deny your request for an amendment if the Protected Health Information was not created by us, or is not part of the designated record set, or would not be available for inspection as described under section 45 C.F.R. S 164.524, or if the Protected Health Information is already accurate and complete without regard to the amendment. (v) You have the right to request, and thereafter receive, an accounting of the disclosures of your Protected Health Information for six years before the date on which you request the accounting. An exception to this accounting are those disclosures not allowed by law pursuant to section 164.528. Each request for an accounting will be reviewed pursuant to the rules of section 164.528. (vi) You also have a right to receive a copy of this Notice upon request.

10. 42 CFR Part 2 – Confidentiality of Substance Use Disorder Patient Records

You are hereby notified that the records released may contain information pertaining to psychiatric and/or treatment for alcohol and/or drug and/or substance dependency (substance use disorder). You are notified that that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of the records from making further disclosures to third parties without express consent of the patient. In signing below you acknowledge that you have been notified of your rights pertaining to the confidentiality of your treatment information/records under 42 CFR Part 2, and you further acknowledge that you understand those rights.

TO THE PARTY RECEIVING THE INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by Federal confidentiality rules (Title 4242, Part 2, Code of Regulations [42 C.F.R. Part 2]). The Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains, or as otherwise permitted by 42 C.F.R. Part 2. A general authorization of the release of medical or other information is NOT sufficient for this purpose.

11. Effective Date

The effective date of this Notice is September 1, 2015.

Patient/Guardian Signature Date

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HIPAA Release Form

Patient Name: _____ **Date of Birth** _____/_____/_____

RELEASE OF INFORMATION

( ) I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

( ) Spouse/Parent:_____ Phone:_____

( ) Child(ren):_____Phone:_____

( ) Other(s):_____ Phone:_____

( ) I DO NOT authorize the release of information including the diagnosis, records, examination rendered to me and claims information, other than to parties are already disclosed and/or required per the NOTICE OF PRIVACY PRACTICES PURSUANT TO 45 C.F.R. S 164.520 and 42 C.F.R. Part 2 or by law.

This Release of Information [HIPPA Release Form] will remain in effect until terminated by me in writing.

MESSAGES

Please call ( ) my home ( ) my work ( ) my cell number: _____

If unable to reach me:

( ) You may leave a detailed message

( ) Please leave a message asking me to return your call

( ) Other: _____

The best time to reach me is (day) _____ between (time) _____

_____

Patient/Guardian Signature Date

_____

Witness Date

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PATIENT RESPONSIBILITY DISCLOSURES
CANCELLATION / NO SHOW POLICY

PATIENT RESPONSIBILITY DISCLOSURES

Patient Financial Responsibility: In order to provide the highest quality of care, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful and encourage you to discuss it with us and to ask questions. Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be financially responsible for this bill after services have been rendered. It is your responsibility as the patient to pay the denied amounts in full. **You must pay at the time of service, unmet deductible amounts/co-pays and co-insurance percentages for in-network or out-of network coverage unless other arrangements have been made with our office.** Credit card payment plans are available and further information can be obtained by calling the main office at 972-355-9038. The remainder of your bill will be sent to your health plan for direct payment to our office. If, by mistake, your health plan remits payment to you, you will send it to us along with all documentation which accompanied it. Your health plan may refuse payment of a claim for some of the following reasons, among others: (i) You have not met your deductible for the full calendar year (ii) The type of medical service required is not covered by your plan (iii)The health plan was not in effect at the time of the service and/or (iv) You have other insurance which must be filed first. If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF) or Account Closed (AC), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $20.00 Service Charge.

Non-Payment On Account: Accounts that are over 90 days past due may be placed with an outside collection agency for recovery. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the Patient's Responsible Party, understands that Liberty Pain Associates has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the Patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, collection fees, all court costs and Attorney fees.

Prescriptions and/or Refills: **For medical emergencies we advise you to go the nearest emergency room or to call 911**. For non-emergency questions, clinical information, or prescription refills, please call us during office hours. Urgent messages will be relayed to the physician on call. As a reminder, there are no medication refills after office hours or on Fridays after 1pm. If you do not have an appointment and are requesting a refill to be called to your pharmacy on allowable medications, please allow 48-72 hours to process your request. On all refills, please call your pharmacy and request your refill and your pharmacy will then notify us with the appropriate information needed to handle your request. Note specific controlled substances require a prescription to be picked up in person from the office. We recommend calling a week in advance. New prescription requests, if possible, should be discussed during an office visit. Please note that we DO NOT refill prescriptions on the weekends or holidays. Weekends begin at 1:00 PM on Fridays and a holiday begins at 4:00 PM on the day prior to a National Holiday. In person drug testing/ screening is required in specific instances as per your physician.

Authorization/Referral Policy: Please understand that it is your responsibility to obtain an authorization and/or referral through your primary care physician's office, if required by your insurance company. Failure to do so may result in charges being billed directly to you or your appointment being cancelled and rescheduled once you have obtained the appropriate authorization and/or referral.

Medicaid: Liberty Pain Associates is not in network with Medicaid. Patients with Medicaid will be responsible for the amount that is covered by Medicaid. Sorry for the inconvenience that this may cause.

_____ **(patient initial Medicaid Patients)** I understand Liberty Pain Associates is accepting me as a private pay patient for the period that I choose to come to this office, and I will be responsible for paying for any services I receive. The provider will not file a claim to Medicaid for serviced provided to me.

CANCELLATION / NO SHOW POLICY

As a speciality physician office we reserve your appointment time for you and we expect you to keep all your appointments with the exception of serious emergencies. If you need to re-schedule or cancel an appointment we require 24 hours notice. **There is a automatic $50.00 (office appointment) or $100.00 (EMG testing) or $200.00 (surgery/procedure) fee for late cancellation and no-shows which must be paid prior to seeing us at your re-scheduled appointment in addition to any of your insurance deductible and co-payment obligations immediately due.**

I certify that information on these forms, in partial and entirety, has been answered truthfully and completely to the best of my knowledge. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier. I have READ and AGREE to the Patient Responsibility Disclosure and the Cancellation/No Show Policy.

Patient/Guardian Signature Date

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PATIENT INFORMED CONSENT FOR TELEMEDICINE SERVICES

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose another physician or form of treatment at any time. I understand that this is NOT intended to be used in the case of a medical emergency. In a medical emergency I should call 911 and/or go to an emergency room.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
5. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Liberty Pain Associates' use of telemedicine in the course of my diagnosis and treatment.

_____ _____

PATIENT'S SIGNATURE **DATE**
(OR AUTHORIZED PERSON TO SIGN FOR PATIENT)

_____

IF AUTHORIZED SIGNER, RELATIONSHIP TO PATIENT

_____ _____

WITNESS **DATE**

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NEW PATIENT REGISTRATION

Please arrive with valid ID and insurance card(s) at least 15 minutes prior to your appointment

Basic Information

Patient Name (First, MI, Last) Sex: ☐M ☐F		Social Security #		DOB (MM/DD/YY)
Address		Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Age	Height / Weight
City, State & Zip		Mobile Phone #		Home Phone #
eMail Address		Referring Physician (if applicable)		
Emergency Contact Name	Emergency Contact Phone(s) #		Relation to Emergency Contact	

Employment Information

☐ Employed: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Student ☐ Retired

Employer Name	Employer Phone #	Professional Title
Address	City, State & Zip	

Health Insurance Information

Primary Insurance

Insurance Company Name	Claims Mailing Address		Insurance Company Phone #
Primary Insured Name	Primary Insured Social Security #	Relationship to Patient	Primary Insured DOB (MM/DD/YY)
Policy #		Group #	

Secondary Insurance

Insurance Company Name	Claims Mailing Address		Insurance Company Phone #
Primary Insured Name	Primary Insured Social Security #	Relationship to Patient	Primary Insured DOB (MM/DD/YY)
Policy #		Group #	

Assignment & Authorization For Release Of Information For Insurance Benefits

I certify that if I, and/or my dependent(s), have insurance coverage, I shall assign to Liberty Pain Associates and/or its affiliates/agents all authorized Medicare and other insurance 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 authorize the use of my signature or all insurance submissions. I appoint Liberty Pain Associates to act as my authorized representative in requesting an appeal from my insurance plan regarding services or denial of payment. Liberty Pain Associates and its affiliates/agents may use my health care information and may disclose such information to the health care insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services. I understand that this authorization may include release of your Protected Health Information ("Protected Health Information") pursuant to 45 C.F.R. S 164.520. I intend this consent to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment. Unless I request to the contrary, in writing, I will receive appointment reminders on my home or cell telephone answering system and/or other information regarding my treatment or invoices by mail to my home address. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due. The duration of this authorization is indefinite and continues until revoked in writing.
(Patient initial) _____ I hereby certify that the reason for my visit is NEITHER an injury/ilness due to a motor vehicle accident NOR is related to current/potential ligitation. Furthermore I certify that I have not met with/retained a personal injury lawyer in this regard.

Patient/Guardian Signature Date

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NEW PATIENT REGISTRATION (cont'd)

Accident Information
Is this illness/injury the result of an accident? ☐ Yes ☐ No

If "Yes" where did the accident occur? ☐ Work ☐ Auto ☐ Other

Date of accident: _____

If this is work related did you report the illness/injury to your employer? ☐ Yes ☐ No

Primary Care Physician

Physician Name	Physician Address	City, State and Zip
Date of Last Physician In-Office Visit	Physician Phone #	

Pharmacy Information Prescriptions may be electronically sent excluding specific controlled substances as prohibited by law

Pharmacy Name	Pharmacy Address	Pharmacy City, State and Zip
Pharmacy Cross Streets	Pharmacy Phone #	

Allergies – List any foods, drugs, or medications and include reaction

Medications – List any prescription and non-prescription medications, dosage, frequency and prescribing physician that you are currently taking

Medication	Dosage	Frequency	Prescribing Physician

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HEALTH HISTORY

If female, are you pregnant? ☐Y ☐N

If yes, # of weeks _____

Previous Surgeries

Please list each occurrence separately with date, surgery/procedure and physician

Date (Approx.)	Surgery/Procedure Performed	Physician

Family History

Mother	
Father	
Siblings	

Lifestyle

Habits

Illicit Drug Use? ☐ Y ☐ N

Type(s) _____

Smoker? ☐ Y ☐ N

Packs per Day / Years _____

Alcoholic Drinks Per Day _____

Coffee - Cups per Day _____

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Work Activity: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Check all that you have had:

☐ Alcoholism
☐ Anemia
☐ Asthma
☐ Cancer
☐ Diabetes
☐ Drug Addition
☐ Emphysema
☐ Epilepsy
☐ Gout
☐ Heart burn
☐ Heart disease
☐ Hepatitis
☐ High blood pressure
☐ HIV/AIDS
☐ Kidney Disease
☐ Liver Disease
☐ Multiple sclerosis
☐ Numbness/tingling
☐ Pace maker
☐ Osteoporosis
☐ Stroke
☐ Suicide Attempt
☐ Thyroid disease
☐ Ulcers
☐ Other(s) _____

Check any of the below symptoms that you currently are experiencing or have experienced in the past 3 months:

☐ Weight loss (more than 10 lbs.)
☐ Visual loss
☐ Sore throat
☐ Shortness of breath
☐ Headache
☐ Loss of Balance
☐ Cannot Tolerate Cold or Heat
☐ Fever
☐ Chills
☐ Rash
☐ Cough
☐ Diarrhea
☐ Numbness
☐ Anxiety
☐ Blurred Vision
☐ Double Vision
☐ Itching
☐ Phlegm
☐ Stomach Pain
☐ Tingling
☐ Sweating
☐ Weakness
☐ Yellow Eyes
☐ Chest Pain
☐ Asthma
☐ Blood in Urine
☐ Bleeding
☐ Fatigue
☐ Hearing Loss
☐ Chest Pressure
☐ Hives
☐ Burning upon Urination
☐ Bruising
☐ Fainting
☐ Sneezing
☐ Nausea
☐ Eczema
☐ Dizziness
☐ Depression
☐ Chest Discomfort
☐ Stuffy Nose
☐ Palpitations
☐ Seasonal Allergies
☐ Loss of Appetite
☐ Low Blood Count
☐ Change in Bowel or Bladder Control
☐ Runny Nose
☐ Leg Swelling
☐ Vomiting
☐ Permament Weakness
☐ Frequent Urination or Drinking

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HEADACHE QUESTIONAIRRE

Please ***describe*** your headaches as best you can, for example: sensation types such as "throbbing, stabbing, numbness, shooting, aching" and location areas such as "in the front of my head, sides of my head, back of my head, left side, right side"

Current Headache Level – 1 = No Pain, 10 = Most Pain

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

When did symptom(s) appear?	Headaches are getting: ☐ Better ☐ Worse ☐ Same ☐ Don't know	Have the headaches occurred before? ☐Y ☐N If yes, when they first occur?

What percentage of time do you experience headaches?	What relieves the headache?	What makes the headache worse?	What other symptoms do you have during a headache?	What routines does your headache interfere with?
☐ <25% ☐ 75% ☐ 25% ☐ 100% ☐ 50%	☐ Sleep ☐ Quiet Room ☐ Medications	☐ Weather ☐Smells ☐ Light ☐Sound	☐ Light Sensitivity ☐ Vomiting ☐ Sound Sensitivity ☐ Nausea	☐ Work ☐ School ☐ Daily Life ☐ Interpersonal relationships

1. How many days in the past month did you spend with a headache/migraine? _____
(Include all days with any headache pain of any kind, even those you didn't feel you needed to take any medications for the headache or took an over the counter medication)

2.Did any of your headaches/migraines last more than 4 consecutive hours if you didn't treat them? ☐ Yes ☐ No

3. Have you ever been diagnosed as having chronic headaches? ☐ Yes ☐ No
(Including chronic tension-type or chronic sinus headaches)

4. Have you ever been diagnosed as having migraines? ☐ Yes ☐ No

5. How do your headaches/migraines impact your daily life?

1 = Not At All, 10 = Completely Debilitating

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

6. Have you had to take days off from work or school due to headaches? ☐ Yes ☐ No

7.How many days in the past month have your headaches/migraines severely affected your daily life? _____

8. In the past month did you take anything to treat your headaches/migraines? ☐ Yes ☐ No

If Yes, how many days in the past month did you take something to treat your headaches/migraines? _____

Please check all medications listed below that you have tried:

☐ Fiorcet	☐ Maxalt	☐ Diclofenac (Cambria, Zipsor)	☐ Esgic
☐ Imitrex	☐ Aleve (Naprosyn, Naproxen)	☐ Fiorinal	☐ Amitryptyline (Elavil)
☐ Relpax	☐ Zomig	☐ Frova	☐ Nortriptyline (Pamellor)
☐ Butalbital-Acetaminophen-Caffeine Oral	☐ Sumatrptan	☐ Excedrin Migraine	☐ Topamax
☐ Treximet	☐ Axert	☐ Sumavel	☐ Depakote
☐ Keppra			

LIBERTY PAIN ASSOCIATES™

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COMPREHENSIVE PAIN QUESTIONAIRRE

Please check all previous pain management procedures ONLY you have had and indicate approximate dates

Procedure	Date	Procedure	Date	Procedure	Date
☐ Cervical epidural ☐ Cervical Rhizotomy ☐ Cervical Facet Injection ☐ Discogram ☐ Joint Injection: Knee ☐ Joint Injection: Hip ☐ Joint Injection: Shoulder ☐ Joint Injection: Other		☐ Intrathecal Pump ☐ Lumbar Epidural ☐ Lumbar Rhizotomy ☐ Lumbar Facet Injections		☐ Nerve Block ☐ Occipital Nerve Block ☐ Platelet Rich Plasma (PRP) Injection ☐ Regenerative Medicine Injections ☐ RSD/CPRS Injections ☐ Spinal Cord Stimulator: Trial ☐ Spinal Cord Stimulator: Permanent ☐ Spinal Cord Stimulator: Removal	

Please check all medications that you have tried in the past

Opiods

☐ Fentanyl (Actiq, Fentora, Duragesic)
☐ Morphine (Avinza, Kadian, Embeda, MS Contin)
☐ Oxycodone (Oxycontin, Percocet)
☐ Propoxyphene (Darvocet, Darvon)
☐ Tramadol (Ultram ER Ultram)
☐ Demerol
☐ Oxymorphone (Opana, Opana ER)
☐ Oxycodone (Oxycontin, Percocet)
☐ Hydromorphone (Dilaudid, Exalgo)
☐ Other(s) _____
☐ Buprenorphine (Suboxone, Subutex, Butrans Patch)
☐ Hydrocodone (Lortab, Norco, Vicodin, Vicoprofen)
☐ Tapentadol (Nucynta)
☐ Codeine

Anti-inflammatories & Tylenol

☐ Diclofencac (Arthrotec, Voltaren, Voltaren Gel)
☐ Aspirin
☐ Celecoxib (Celebrex)
☐ Indomethacin (Indocin)
☐ Etodolac (Lodine)
☐ Meloxicam (Mobic)
☐ Ibuprofen (Motrin, Advil)
☐ Naproxen (Naprosyn)
☐ Other(s) _____
☐ Nabumetone (Relafen)
☐ Acetaminophen (Tylenol)
☐ Flector patch

Muscle Relaxants

☐ Baclofen
☐ Cyclobenzaprine (Flexeril, Amrix)
☐ Methocarbamol (Robaxin)
☐ Metaxalone (Skelaxin)
☐ Other(s) _____
☐ Carisoprodol (Soma)
☐ Tizanidine (Zanaflex)

Antidepressants

☐ Cymbalta
☐ Effexor
☐ Amitriptyline
☐ Zoloft
☐ Nortriptyline (Pamelor)
☐ Paxil
☐ Pristiq Fluoxetine (Prozac)
☐ Wellbutrin
☐ Other(s) _____
☐ Remeron
☐ Serzone Imipramine
☐ (Tofranil) Trazodone

Sleep Aids

☐ Zolpidem (Ambien, Ambien CR)
☐ Melatonin
☐ Lunesta
☐ Restoril
☐ Other(s) _____
☐ Benedryl
☐ Sonata

Other

☐ Buspar
☐ Gabitril
☐ Tegretol
☐ Zomig
☐ Vistaril
☐ Imitrex
☐ Keppra
☐ Lidoderm Patch
☐ Topamax
☐ Lyrica
☐ Maxalt
☐ Gabapentin (Neurontin)
☐ Other(s) _____