100 Jim Mason Court
Warner Robins, GA 31088

230 Industrial Blvd
Dublin, GA 31021

230 Sheraton Blvd
Macon, GA 31210

Tel 478 474-AXIS (2947)
Fax 478-971-4004

APPOINTMENT DATE: _____

TIME: _____

Dear Patient:

Thank you for choosing our practice for your pain management. For your convenience, we are sending you the enclosed forms to be completed and brought with you at the time of your scheduled appointment. As a new patient, we need you to arrive 30 minutes early for your appointment in order for us to get all of the necessary paperwork completed for your chart.

Please use this check list to ensure that your visit goes smoothly:

[ ] All paperwork completely filled out
[ ] State Drivers License
[ ] Insurance Card Primary & Secondary
[ ] Prescription Card
[ ] Please bring in ALL current Medications
[ ] All co pays are due at the time service
[ ] All MRI's, CT's and X-Ray report that pertain to this office visit

If you are a patient without insurance please call the office for the amount of your visit. All self-pay patients must have his/her payment submitted to our office one week before their scheduled appointment.

Our office hours are Monday-Friday 8:00am-4:30pm. Please call our office during business hours for any additional information or questions you may have. Please remember if you are unable to keep your appointment notify us 24 hours prior to you scheduled appointment time.

Sincerely,

Pain Center Staff

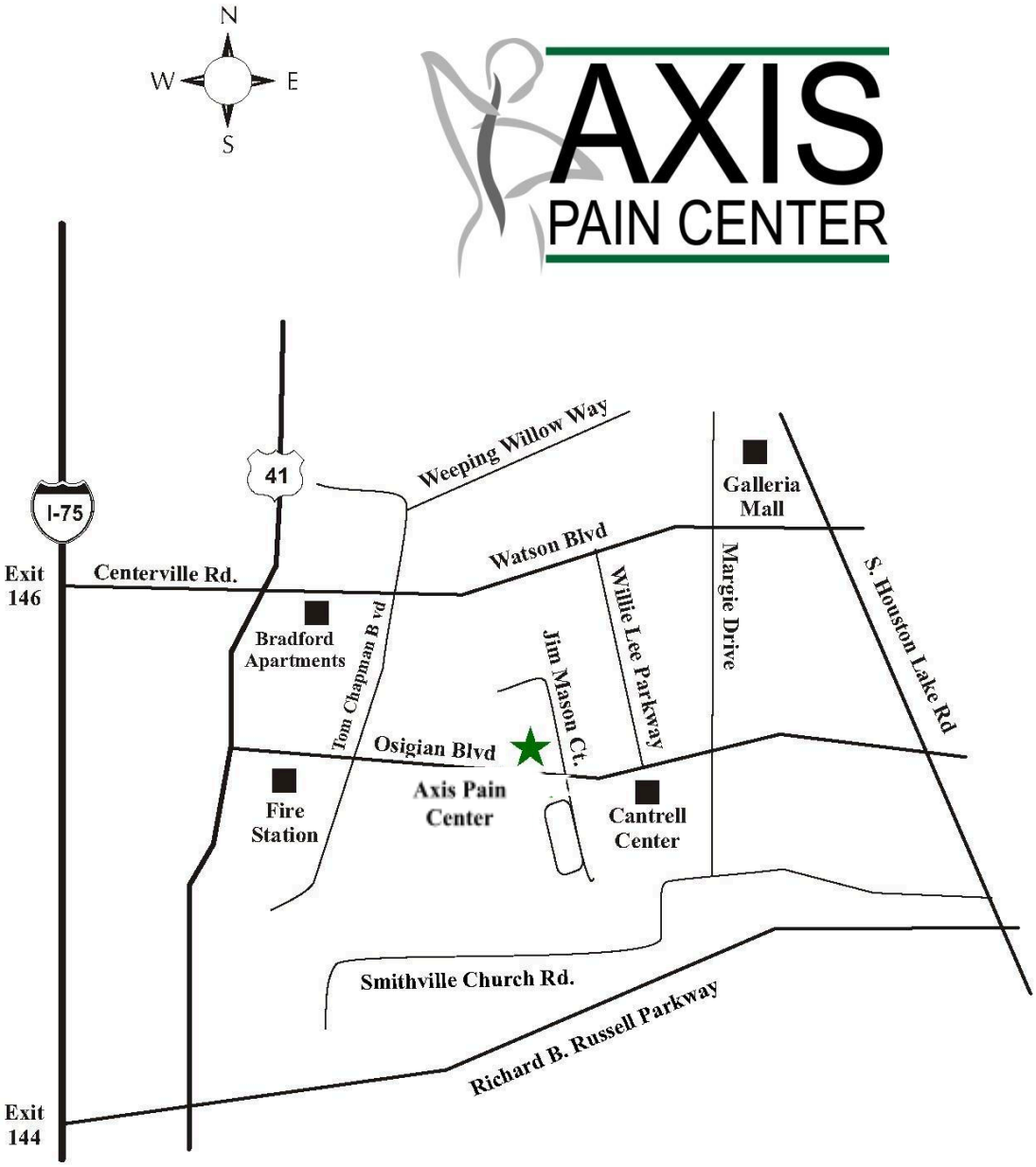
Please bring all reports from scans (ex. MRI, CT, or X-ray image), EMGs or any pertinent testing that you have had done. Include the disk or film imaging if available. If you need help obtaining these, please contact the facility where the tests were performed or the physician's office that ordered them.

Axis Pain Center

SMOKING POLICY

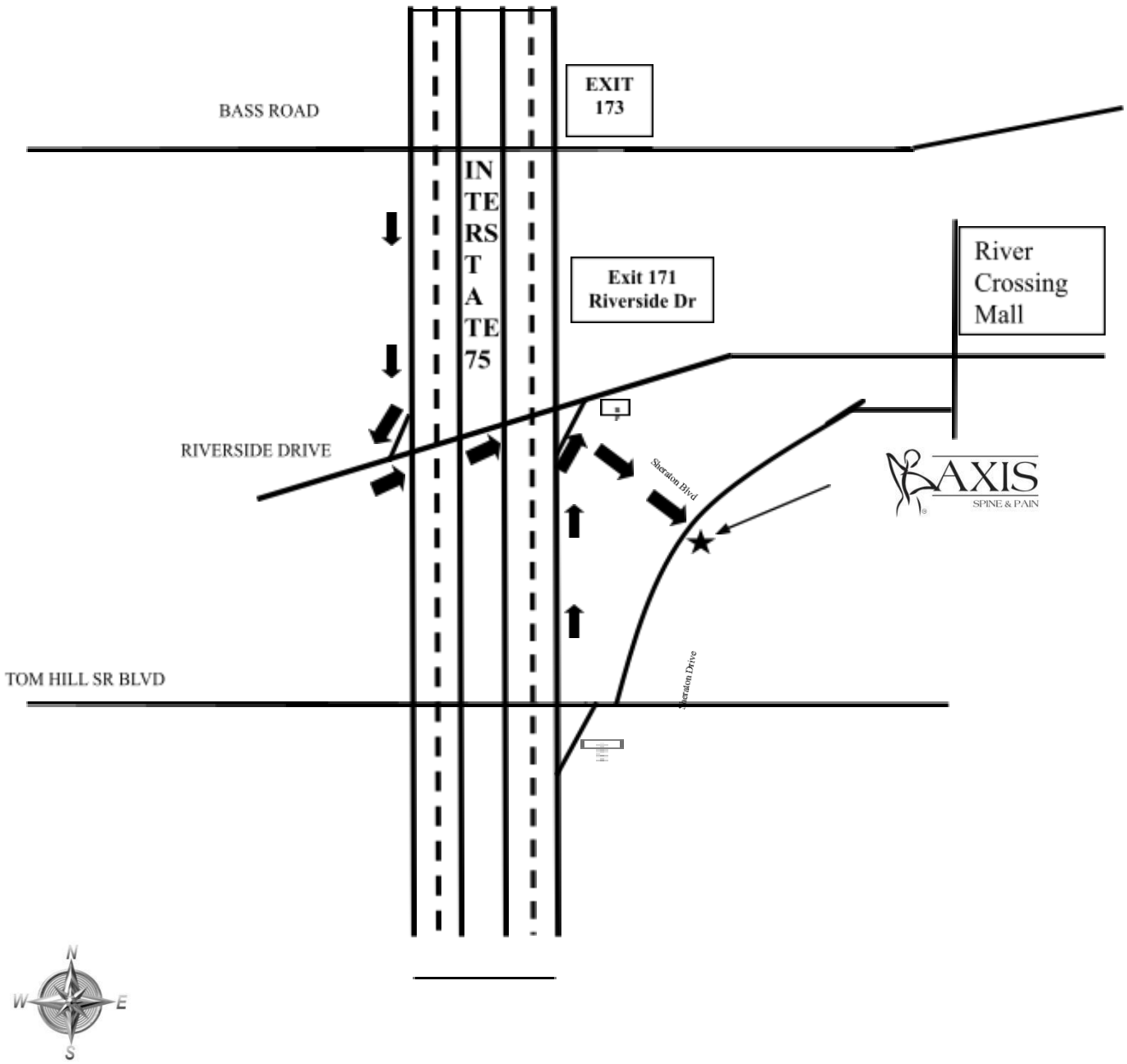
Please adhere to the above guidelines. As we are a smoke free facility, please extinguish before coming on the premises. This includes the surrounding areas and the parking lot.

DIRECTIONS (Warner Robins)



From I-75: take Centerville Road to Watson Blvd. Turn Right onto Tom Chapman Blvd. At stop sign turn Left onto Osigian Blvd. Turn Left at the first road on the Left; Jim Mason Court.

DIRECTIONS (Macon)



If you are coming from 75 South:

- Take 75 North
- Take exit 171- Riverside Drive
- Make an immediate right between the interstate and the BP gas station.
- Cross over Sheraton Drive and the office is the first building on the right will

If you are coming from 75 North:

- Take 75 South
- Take exit 171 – Riverside Drive
- Turn right immediately after I-75 onto Sheraton Blvd (between I-75 and the BP gas station)
- Cross over Sheraton Drive and the office is the first building on the right will

AXIS SPINE AND PAIN – NEW PATIENT CONSULTATION

WELCOME

The physicians and staff of the Axis Pain Center want to welcome you to our facility for Pain Management Consultation. Our center accepts patients by REFERRAL ONLY from either a local primary care physician, specialist or surgeon.

We would like to outline what to expect during the INITIAL CONSULATION visit to avoid any misunderstandings.

Notice of Consultation

I understand that my appointment today at The Axis Pain Center is for consultation only. I understand that receiving prescription medication(s) and/or refills is under the discretion of the attending physician.

INITIAL VISIT

All initial visits are considered CONSULTATION only. The physicians will review your complete medical history and any outside records AFTER the nurse brings you back to the consultation room. The provider does not review your records until after you are taken back to the room. We may also need to REQUEST more complete medical records if your referring physician did not send all your records. If we did not have the MEDICAL RECORDS from previous doctors, lab tests or IMAGING, we may review them at your subsequent appointment. We generally request records (3) THREE times. The patient will then be responsible for obtaining the records.

EXPECTATIONS

The physicians at Axis Pain Center are all BOARD CERTIFIED & FELLOWSHIP TRAINED in Pain Management. The majority (>90%) of the pain our providers focus on is SPINAL PAIN. Below is an outline of what you can expect from your initial visit:

1. We believe that pain medication is to be used as a LAST RESORT OPTION only, and may recommend other modalities of treatment.

2. Alternative treatments may include, nerve blocks (epidurals, facets, RFA, etc.), acupuncture, weight loss/nutritional counselling, physical therapy, psychological co-management, and surgical evaluation.

3. **Pain medication (both narcotic and non-narcotic) prescriptions should NOT be expected on the first visit.**

4. If you are currently on pain medication, please notify your previous prescribing physician they will need to continue prescribing as we may not prescribe medication on your first visit.

**** OUR PHYSICIANS ARE UNDER NO OBLIGATION TO WRITE YOUR NARCOTIC PAIN MEDICATIONS DURING THE FIRST or ANY SUBSEQUENT VISIT. ****

5. If, after the first CONSULATION VISIT, the provider feels we are unable to help you long term, then we may provide RECOMMENDATIONS and refer you back to your referring physician, or to another specialist that may be able to provide the care that you need.

FUTURE VISIT:

A. FOLLOW UP AFTER CONSULT

After the initial consolation, we may schedule you for a nerve block at our one of our facilities. This is typically done after we have received insurance approval, any outside evaluations or tests (MRI, CT, etc) psychological and/or blood thinner clearances.

If you are referred to an outside facility and do not get a phone call within ONE WEEK of you visit, please call us back ASAP as we are not notified by outside centers after we send out a referral.

B. GUIDELINE FOR AN INJECTION VISIT AFTER FOLLOW UP:

- If you have financial constraints, please discuss this with our billing office PRIOR to your injection to discuss options. As a courtesy, we will bill your insurance if you choose (both in and out of network)
- If you cannot wait on insurance verification to have your procedure done, you have the option of paying billed charges, and we will provide you an insurance claim to file the insurance on your own.
- Because of our agreements with your insurance, we CANNOT WRITE OFF the patient's FINANCIAL OBLIGATIONS such as copays, deductibles, coinsurance (not the same as copay) or no show fees. As part of your contract with your health insurance – you may be paying for OUT OF NETWORK COVERAGE. It is the PATIENTS RESPONSIBILITY to verify if the SURGERY CENTER is in-network with your insurance. If you need clarification, please ask our billing office prior to your procedure.
- Generally, our in network facility fees for the Ambulatory Surgery Center are LOWER COST than those of the HOSPITAL OUTPATIENT DEPARTMENT for your procedures. Please call your insurance carrier for specific rates.

Patient Information and Expectations

Welcome to Axis Pain Center. Enclosed is a packet of information that you should complete in its entirety prior to your appointment. If you have any questions, a member of our staff will be available to help you at the time of your appointment.

What you need on your first visit:

- The New Patient Packet completely filled out.
- A copy of medical records from any other physicians that you have seen regarding your current complaint(s).
- All of the medication(s) you are currently taking. (Please bring the actual bottles with you; this is only for your first visit with us).
- All insurance cards. All Co-payments and deductibles will be due at time of service. Failure to pay your bill can result in discharge from the practice.

What to expect from your visit with:

- Prompt, professional, and courteous service from all employees.
- A thorough history of your pain will be obtained, as well as treatments you may have received in the past. You will then be examined by the physician.
- As a courtesy to our patients, your insurance will be filed for you. You will then be responsible for any and all charges not paid by your insurance company. Workers Compensation will be filed for the full amount of your bill.
- There will be a $50.00 NO SHOW fee charged to your account if you fail to cancel or reschedule your appointment 24 hours prior to your appointment time.
- Patient privacy is of great concern to our practice. We therefore prohibit the use of audio and/or video recording devices during patient visits and/or in patient waiting area. Video/audio recording of patient encounters could lead to discharge from the practice and up to a $25,000 fine per occurrence. This includes but not limited to the patient, patient representatives/adjuster, family members, friends, etc. If you need a copy of your visit summary we would be happy to provide a copy of your plan of care.

The Axis Pain Center is NOT a primary care facility.

You must obtain a referral to make an appointment with Axis Pain Center. Once you have reached maximum medical improvement, you will follow up with your primary care physician for continued care.

The NEXus Pain Center of Houston County, LLC / d.b.a Axis Pain Center

PAYMENT AUTHORIZATION PRIVACY REGULATIONS

I request that payment of authorized benefits be made to The NEXus Pain Center of Houston County, LLC / d.b.a Axis Pain Center. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine the benefits or the benefits payable for related services.

I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any health care related to utilization review or quality assurance activities or to any healthcare professional requiring this information in order to treat me.

I hereby assign and authorize payment to The NEXus Pain Center of Houston County, LLC / d.b.a Axis Pain Center for all medical and/or surgical benefits, including major medical policies, to which I am entitled under any insurance policy or policies, any self-insurance program, or any other type of benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf. I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to The NEXus Pain Center of Houston County, LLC / d.b.a Axis Pain Center by any insurance policy, self-insurance program, or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

NOTICE OF PRIVACY PRACTICES

I have been offered a copy of the “NOTICE OF PRIVACY PRACTICES” for my records.

ACKNOWLEDGEMENT OF MID-LEVEL PROVIDER SERVICES

I understand that Axis Pain Center employs a team approach to care for its patients. This team may include physicians, nurse practitioners or physician assistants. I understand that the mid-level providers provide care under the supervision of the physicians and that they may be a part of my healthcare team. This team approach allows my care to be followed by both the doctors and the mid-level providers. Prescriptions issued during a visit with a mid-level provider are subject to physician review and approval prior to being issued.

Axis Pain Center

APPOINTMENT NO SHOW POLICY

Our schedules stay very full and often times we have a waiting list. Our No Show Policy is designed to encourage our patients to give us an opportunity to offer appointment times to others if they are unable to make their appointment. Patients who do not cancel or reschedule 24 hours prior to their appointment time or who fail to show up for their scheduled appointment will be charged $50.00 for their missed appointment. This charge is *NOT* covered by insurance. This charge must be paid before your next visit with the physician.

If you fail to show up for 3 appointments, you are subject to discharge from the practice.

Please be considerate of our other patients and call our office if you are not able to keep or make your appointment. For your convenience, we have initiated an automated reminder system. The reminder system will call you 48 hours in advance of your appointment.

Your cooperation in this matter is greatly appreciated.

Re: Concurrent use of Benzodiazapine or sleep aids with Opioids and bringing pain medications at every appointment

- ***You must bring your pain medication with you to every appointment (this includes empty bottles if you are out of medication). If you do not have your pain medication with you, please advise the front desk so your appointment can be rescheduled.**
- Please be advised that due to recent changes in State, Federal, and CDC guidelines and recommendations, as well as insurance guidelines (https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf), your insurance company may not approve your medication if you are concurrently prescribed opioid based pain medications and benzodiazapines or sleep aids(examples: Xanax, Ativan, Ambien).
- You will need to decide which of these medications you wish to continue or discuss alternative anti-anxiety medications and/or sleep aids with your primary care provider or psychiatrist.
- If you have any questions regarding these guidelines, please discuss them with your provider today.

MEMO : Rx Medication / Pill Count Policy

Please be advised that ALL PATIENTS are required to bring their medications to EACH VISIT for their PILL COUNT.

Patients should RESCHEDULE their appointment for another date at CHECK IN if they forgot to bring any medications –i.e. they left them at home, in a "pill box", travel container, safe etc.

Once a patient is brought back by the nurse, only the medications in their DATED Prescription Bottle (NOT IN PILL COUNTER) will be counted, and patients will NOT be permitted to leave the office to get the rest of their medication.

If the patient is SHORT on their pain medication (> 1 pill short), then provider may DISCONTINUE all Pain Medication, and the patient may possibly be DISCHARGED from the PRACTICE.

Patient Financial Policy

Effective July 1, 2019

This policy supersedes any previous financial policies and remains in effect until revised or replaced.

Purpose: To inform patients of Axis Pain Center and its affiliated surgery centers (Axis Surgery Center and Lakeview Surgery Center) financial policies.

SUMMARY:

The purpose of the policy is to inform patients of their need to remain in good standing with the practice financially in order to continue as a patient of the facilities. This policy will also outline what constitutes "good standing" with the organizations as well as what arrangements can be made by a patient with a financial responsibility.

POLICY:

Axis Pain Center will make a best effort to contact patients prior to their visit should it have the potential to incur a charge of more than the patient's standard co-pay or their deductible amount. Patients who have appointments with the affiliated surgery centers will be contacted in the same reasonable fashion. Please note that when this occurs this may be an "estimate of responsibility" and could differ once insurance has been processed.
While Axis Pain Center is in network with MOST insurance carriers there are several carriers that are Out of Network with Axis Surgery Center and Lakeview Surgery Center. However, should you have a procedure performed in one of the surgery centers, we do not want to "penalize" you for your out of network insurance and will apply your in-network benefits to your out of network patient responsibility. This is being done as a courtesy to our patients in an effort to ease the patients' financial burden but please note this will still be applied to your out-of-network plan.

PAYMENTS:

All co-pays and office visit deductibles shall be due at the time of service. Other patient financial responsibility will be looked at on a case by case basis but the general rule is that a minimum of 10% will be due at the time of service and the patient will need to fill out a recurring payment form for the remainder of the estimated balance to be paid off within 12 months of the date of service. Should the patient be unwilling to set-up the payment plan or make the 10% down payment the billing department must approve the appointment. Payment plans longer than 12 months must be approved by the Administrator and/or Medical Director, and must be approved PRIOR to the patient's visit. Payment plans of longer than 24 months will not be accepted.

COLLECTIONS:

Patients who for whatever reason fail to make acceptable payments towards their financial responsibility for a period of greater than 90 days are subject to being turned over to collections. Once an account has been turned over to collections, financial arrangements must be made with the collection agency. All patients who have been turned over to collections are subject to discharge from the practice.

By signing below, I (patient name) _____, acknowledge that I have been provided with the information listed below.

Initial

_____ Notice of New Patient Consultation
_____ Notice of Consultation Only
_____ Patient Information and Expectations
_____ Payment Authorization Privacy Regulations
_____ Notice of Privacy Practices
_____ Acknowledgement of Mid-Level provider Services
_____ No Show Policy
_____ Notice of Concurrent Use of Benzos or Sleep Aids
_____ Pill Count Policy
_____ Financial Policy

_____ _____/_____/_____

Patient Signature Date

_____/_____/_____

D.O.B

Axis Pain Center

Patient Demographics

Last Name: _____ Primary Care Dr. _____

First Name: _____ Referring Dr. _____

Address: _____ Date of Birth: _____ Gender: M / F

_____ Email Address: _____

Circle One:

City: _____ Single / Married / Divorced / Separated / Widowed

State: _____ Zip _____ Social Security Number _____-_____-_____

Home Phone: (_____)_____ Cell: (_____)_____

Work Phone: (_____)_____ Ext. _____ Employer: _____

Spouse Name: _____ SS#: _____-____-_____ DOB: _____

* Phone: (_____)_____ (required)

Emergency Contact (NOT living with you): _____ Phone:(_____)_____

Insurance(s): (Please bring ALL Ins. card(s) to every appt with you)

Primary: _____ Cardholder name: _____

Subscriber Number: _____ Group Number: _____

Secondary: _____ Cardholder name: _____

Subscriber Number: _____ Group Number: _____

Other: _____ Cardholder name: _____

I understand Nexus Pain Center is doing business as Axis Pain Center and my insurance will be billed as Axis Pain Center. I verify that all the above information is correct. I hereby authorize payment of medical benefits billed to my insurance by The NEXus Pain Center of Houston County, LLC / d.b.a Axis Pain Center. I accept responsibility for any/all payments not made by

my insurance company for services rendered by The NEXus Pain Center of Houston County, LLC / d.b.a Axis Pain Center. I understand that payment is due at time of service for all co-pays, deductibles, coinsurance, or out of network fees. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information in this packet and have completed the answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____/_____/_____

Patient or Guardian Signature Date

Axis Pain Center

RELEASE OF INFORMATION

Health Insurance Portability and Accountability Act requires us to have your permission to discuss your treatment, personal information or anything pertaining to you with anyone other than yourself. If a person's name is not listed on this form, we cannot discuss your information with anyone unless in an emergency situation.

Choose and Complete One of the Options Below

Option 1☐

I hereby give my consent to Axis Pain Center and their staff to review or discuss my medical treatment, lab results, pathology reports, medication changes, personal or financial information etc. to the following persons OTHER THAN MYSELF and/or my emergency contact (i.e. spouse, parent, child etc)

1._____Relationship_____ Phone_____

2._____Relationship_____Phone_____

3._____Relationship_____Phone_____

Patient Signature_____Date_____

OR

Option 2 ☐

I do not want any type of information discussed with anyone other than myself.

Patient Signature_____Date_____

Authorization for Release of Medical Records

(To obtain records from another Professional Medical Facility)

I, _____, authorize the following protected health information
Person Authorizing Release

released from the medical record of:

Patient's Last Name	First Name	MI
Street Address		
City	State	Zip
Patient's Date of Birth	SSN	

Medical Records Released to:

Axis Pain Center
100 Jim Mason Court
Warner Robins, GA 31088
Phone: (478) 474-AXIS (2947)
Fax: (478) 971-4004

Reason for release of information:_____
Please note specific dates or information to be obtained:

_____

I understand that this authorization is valid for one year unless I notify Axis Pain Center otherwise. I may revoke this authorization in writing at any time except to the extent that Axis Pain Center has already relied on this authorization. I may revoke it by mailing or faxing a written notice to Axis Pain Center to the address/fax number above stating my intent to revoke this authorization. I understand that the records released may include information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"): treatment for history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand my treatment will not be conditioned by my completion of this form. I understand that I may be billed per the fee schedule for medical records with the exception of records directly released from Axis Pain Center to another Professional Medical Facility. This information will be requested in a prompt manner according to the standards of Axis Pain Center provided all information has been supplied to Axis Pain Center correctly.

) on behalf

Name: _____

Date of Birth: _____

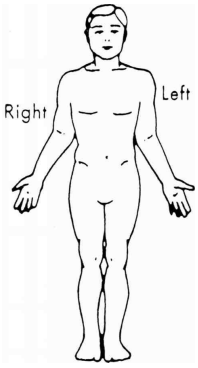
Today's Date: _____

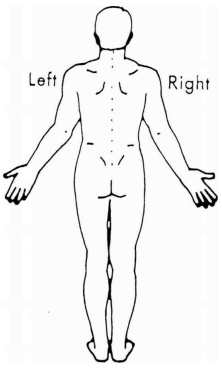
Referring Physician: _____

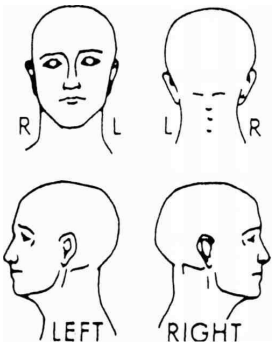
Primary Care Physician: _____

HISTORY OF PRESENT ILLNESS:

Location: Use the figures below to shade in the area where you have pain. If your pain moves around, put an "X" where it starts and draw an arrow to where it spreads.







Duration:

- When did your current pain problem begin? (be specific) Approx. Date: _____/_____/_____

Onset:

- How did your pain problem first start? : ( ) Sports Injury ( ) Car Accident ( ) Disease ( ) Cancer ( ) Unknown ( ) Other_____ : ( ) Job Injury

  If so, are you being treated under Worker's Compensation? ( ) Yes ( ) No
- Describe the speed of onset of your pain. ( ) Sudden/Abrupt ( ) Gradual

Frequency:

- How often do you have this pain? ( )Constantly ( )Daily ( )Weekly ( )Monthly
- What time of day is your pain the worst? ( )Morning ( )Afternoon ( )Evening ( )Night
- What time of day is your pain the least? ( )Morning ( )Afternoon ( )Evening ( )Night

Severity:

- Rate the severity of your pain right now by circling the corresponding number below.

(No Pain) *(Worst Pain Imaginable)*

0 1 2 3 4 5 6 7 8 9 10

0 1 2 3 4 5 6 7 8 9 10

- Rate the severity of your pain on average by circling the corresponding number above

Character:

- Describe in your own words what your pain is like. (i.e. sharp, dull, burning etc.)_____
- Does your pain travel to different parts of your body? _____Yes _____ No
- If yes, where?_____

Patient Name: _____

Associated Signs and Symptoms:

- Are you experiencing any of the following?

	Yes	No	Location or Description
Muscle Weakness			
Numbness or Tingling			
Bladder or Bowel Dysfunction			
Rash			
Fever			
Visual Disturbance			
Other:			

Are you currently seeing a surgeon? ( )Yes ( )No If so, who _____

Aggravating and Alleviating factors:

- What activities or factors improve or worsen your pain? *(Please check all that apply.)*

Activity	Worsens	Relieves	No Change	Activity	Worsens	Relieves	No Change
Exercise				Bright Lights			
Climbing Stairs				Cold			
Walking				Heat			
Standing				Noise			
Sitting/Driving				Emotion			
Lifting				Weather Change			
Cough/Sneeze				Rest			
Lying Down				Touch			
Eating				Ot			

Effects on Activities of Daily Living:

Are there areas of your life that have been adversely affected by your pain problem? *(Check below all those applicable and describe)*

( ) Sleep
( ) Relationships
( ) Work
( ) Finances
( ) Physical Activity
( ) Use of Alcohol, or Recreational Drugs
( ) Other

_____
_____
_____
_____
_____
_____
_____

Have you had physical therapy? ( ) Yes ( ) No

When? _____ Where?_____ How long?_____

Have you ever been treated by another pain specialist? ( ) Yes ( ) No Where/Dates: _____

Patient Name: _____

Treatments:

- What Treatments have you received for your pain in the past? *(Please check if helpful or not helpful.)*

Treatment	Helpful	Not Helpful	Approx. Date	Comments
Surgery				
Nerve Blocks				
Steroid Injections/Epidurals				
Trigger Point Injection				
Acupuncture				
TENS Unit				
Heat/Ice Treatment				
Biofeedback				
Hypnosis				
Relaxation Training				
Counseling				
Traction				
Chiropractic Treatment				
Occupational Therapy				
Physical Therapy				
Other (Explain)				

Diagnostic Testing:

- Have you had any of the following tests performed within the past 24 months?

Test	Date	Facility Where Test Was Done	Results
X-ray film			
CT Scan			
MRI			
Laboratory			
EMG/ Nerve Conduction			
Discogram			
Myelogram			
Other			

Patient Name_____

MEDICATIONS

● Please list all of your current medication, including both prescription and "over-the-counter" medication. List PAIN medication FIRST. (If you need more room, please use the back of this page)

Medication	Strength	Times Per Day	Effectiveness

● Have you been on any Blood Thinners recently? *(I.e. Coumadin, Warfarin, Heparin, Aspirin, Plavix, Clopidogrel, Pradaxa, Aggrenox, Lovenox, Pletal, Effient, Eliquis, Xarelto)* ( ) Yes ( ) No *(If so, please list)*

**** If you are coming in for a procedure, please notify our office before your appointment to inform us about your blood thinner. ****

ALLERGIES:

● Please list all medication allergies below.

Medication	Reaction

● Have you ever had a reaction to Iodine, Shellfish or Contrast Dye? ( )Yes please explain

_____

( )No

● Are you allergic to Latex? ( ) Yes ( ) No

● Have you ever been treated by psychiatrist, mental health professional, or addictionologist? ( ) Yes ( ) No
If yes, please list diagnosis and dates of treatment (ex. depression, alcohol abuse, drug abuse, bipolar disorder, schizophrenia, etc.):

Diagnosis: _____ Date: _____/_____/_____

Where were you treated? _____

Patient Name: _____

PAST MEDICAL HISTORY:

Please check any of the following medical problems you have had or presently have:

( ) Diabetes _____
( ) Cancer _____
( ) Heart Problems _____
( ) Respiratory Problems _____
( ) Depression _____
( ) High Blood Pressure _____
( ) Migraines _____
( ) HIV/AIDS _____
( ) Other _____

( ) Arthritis _____
( ) Ulcer _____
( ) Kidney Problems _____
( ) Bleeding Problems _____
( ) Seizures _____
( ) Neurologic Disease _____
( ) Head Injury _____
( ) Hepatitis/Cirrhosis _____

PAST SURGICAL HISTORY:

● Please list all past surgeries and hospitalizations.

Date	Procedure/Illness	Date	Procedure/Illness

FAMILY HISTORY:

● Please check below if you have a family history of any of the following:

	Brother	Sister	Mother	Father	Aunt		Uncle		Grandfather		Grandmother	
					Paternal	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal	Maternal
Diabetes												
Cancer												
Heart Disease												
Stroke												
Hypertension												
Migraines												
Chronic Pain												

Anesthetic Problems												
Other:												
LIVING (Yes/No)												

Patient Name: _____

SOCIAL HISTORY:

Marital Status:

- What is your current marital status?
  ( ) Single ( ) Living with significant other ( ) Married ( ) Divorced ( ) Widowed
- Number of Children living with you:_____
- Sons _____ Daughters _____

Education:

- What is the highest level of education you have completed?

_____

Employment:

- Are you currently working? ( ) Yes ( ) No ( ) Retired Occupation

_____

- Is this the same occupation you had before your pain started? ( ) Yes ( ) No
- If you are not working, has pain forced you to stop working? ( ) Yes ( ) No
- If you are not working, what was your occupation before your pain became a problem?_____
- Are you currently receiving disability benefits? ( ) Yes ( ) No
- Does your spouse work? ( ) Yes ( ) No Occupation?_____

Habits:

- Are you sexually active? ( ) Yes ( ) No
- Do you exercise? ( ) Yes ( ) No
- Do you smoke? ( ) Yes ( ) No How many packs per day? _____ #Years?_____
  - Are you interested in quitting ( ) Yes ( ) No
- Former Smoker? ( ) Yes ( ) No When did you quit? _____
- Do you drink alcoholic beverages? ( ) Yes ( ) No How many drinks per day? ___ Beer ( ) Wine ( ) Liquor ( )
- Do you use any "recreational" or "street" drugs? ( ) Yes ( ) No *(If yes, please list.)*

Workman's Compensation:

- Is your claim being filed under your private insurance? ( ) Yes ( ) No
- Are you being treated under Worker's Comp? ( ) Yes ( ) No Is there pending litigation? Yes ( ) No ( )
- Have you been treated under Worker's Comp in the past? ( ) Yes ( ) No Has litigation been settled? Yes ( ) No ( )
- Claim Number? _____ ● Date of Injury? _____

●Insurance Provider

Information:_____

●Are you currently under the age of 65 and receiving social security? ( ) Yes ( ) No

● If yes, what was your determining diagnosis? _____ When did you start receiving benefits?_____

I verify that all the above information is correct. I have read all the information in this packet and have completed the answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____/_____/_____

Patient or Guardian Signature Date

Printed Name: _____

Patient Name: _____

For continuity of care, please complete the following information:

1. PRIMARY CARE DOCTOR PHONE#/ADDRESS

2. PHARMACY (where you will be getting medications filled)
Per regulations, you must use **ONE** pharmacy for all pain medications.

Pharmacy PHONE#/ADDRESS

3. SPECIALISTS PHONE#/ADDRESS
(Surgeon, Cardiologist, Psychiatrist, Previous Pain Physicians)

Patient Name: _____

Axis Pain Center

REVIEW OF SYSTEMS

Please darken the circle that corresponds with your answer

Constitutional

Have you had any of these symptoms within the last 3 months?

excessive weight gain	O Yes O No	
loss of appetite	O Yes O No	
fever	O Yes O No	
weight loss	O Yes O No	
fatigue(excessive tiredness)	O Yes O No	

Musculoskeletal

Do you currently experience any:

joint pain?	O Yes O No	What joint(s):_____
joint swelling?	O Yes O No	What joint(s):_____
joint stiffness?	O Yes O No	What joint(s):_____
muscle cramps?	O Yes O No	

Neurology

Do you currently experience:

headaches?	O Yes O No	
tingling or numbness?	O Yes O No	Where:_____
seizures?	O Yes O No	
recent memory loss?	O Yes O No	
tremors?	O Yes O No	
imbalance?	O Yes O No	
weakness in arms?	O Yes O No	
weakness in legs?	O Yes O No	
loss of feeling (one side)?	O Yes O No	
loss of feeling in legs?	O Yes O No	

Allergy

Do you currently experience:

runny nose?	O Yes O No
sinus congestion?	O Yes O No
stuffy nose?	O Yes O No

Cardiology

Do you currently experience:

dizziness?	O Yes O No
chest pain (angina)?	O Yes O No
irregular heartbeats?	O Yes O No
leg swelling?	O Yes O No

Patient Name: _____

ENT

Have you experienced any of these symptoms with in the last 3 months?

cold	O Yes O No
cough	O Yes O No
nose bleed	O Yes O No
hearing loss	O Yes O No
change in voice	O Yes O No
sore throat	O Yes O No
ringing in ears	O Yes O No

Female Reproductive (if you are Male do not answer)

Do you currently experience:

abnormal vaginal discharge?	O Yes O No
heavy periods?	O Yes O No
pain during sex?	O Yes O No
Are you sexually active?	O Yes O No
painful periods?	O Yes O No
post-menopausal?	O Yes O No

Gastroenterology

Do you currently experience:

vomiting?	O Yes O No
difficulty swallowing?	O Yes O No
abdominal pain?	O Yes O No
diarrhea?	O Yes O No
constipation?	O Yes O No
change in bowel habits?	O Yes O No
blood in stool?	O Yes O No
nausea?	O Yes O No
constant heartburn?	O Yes O No

HEENT

Have you experienced any of these symptoms within the last 3 months?

change in vision	O Yes O No
loss of hearing	O Yes O No
loss of smell	O Yes O No
trouble swallowing	O Yes O No

Patient Name: _____

Hematology/Lymph

Have you experienced any of these symptoms within the last 6 months?

abnormal bruising?	O Yes O No
abnormal bleeding?	O Yes O No
varicose veins?	O Yes O No
enlarged lymph nodes?	O Yes O No

Male reproductive (If you are female, do not answer)

Do you currently experience:

difficulty with erection?	O Yes O No
diminished sexual drive?	O Yes O No
impotence?	O Yes O No
difficulty urinating?	O Yes O No

Psychology

Do you currently experience:

serious depression?	O Yes O No
high stress level?	O Yes O No
sleep disturbances?	O Yes O No
suicidal thoughts?	O Yes O No
psychiatric hospitalization?	O Yes O No
are you receiving counseling?	O Yes O No

Respiratory

Do you currently experience:

shortness of breath?	O Yes O No
excessive sputum?	O Yes O No
wheezing?	O Yes O No
cough ?	O Yes O No

Endocrinology

Do you currently experience:

excessive sweating? O Yes O No
heat intolerance? O Yes O No
excessive thirst? O Yes O No
excessive urination? O Yes O No
cold intolerance? O Yes O No

Opioid Management (These questions pertain to medications)
side effects? O Yes O No
What effects: _____
more functional with your activities of daily living? O Yes O No
do you drink alcohol? O Yes O No
do you receive pain relief? O Yes O No