Elite Pain Center

Patient Registration: Circle One: **MALE** / **FEMALE**

Name: _____ Date of Birth:_____ Social Security Number:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

Mailing Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Mobile Phone:_____ Work Phone:_____

Marital Status: M, D, Single, Widow, Separated Responsible Party for this visit: Self, Spouse, Parent, Other:_____

WHAT **PHARMACY** DO YOU USE?:
_____WHERE?_____

Referring Physicians Name:_____
Phone:_____Address:_____

Primary Care Physician
Name:_____Phone:_____Address:_____

Emergency Contact Name:_____ Contact Phone:_____
Relationship:_____

Employer Name:_____ Employer Phone:_____(Ext)_____Day/hrs:_____

Employer Address:_____ City:_____ State:_____ Zip Code: _____

Insurance Name:_____ Group Number:_____
GroupName/Plan:_____

Insurance Account Number/ID:_____ Insured Person's Name:_____

Relationship to Insured Person: Self, Spouse, Parent, Other:_____ Insured Person's Date of Birth:_____

Insured Person's Social Security Number:_____ IF MEDICARE: Are you Retired? Y/N Date:_____

DO YOU HAVE ANY SPECIAL NEEDS?

_____

Elite Pain Center,LLC

Chronic Pain Controlled Substances Therapy Agreement

The purpose of this agreement is to protect your access to controlled substances and protect our ability to prescribe for you. Sometimes, after many reasonable forms of treatments have been tried for chronic pain without benefit, treatment with a controlled substance is sometimes needed for better pain control. The long-term use of controlled substances, such as opioids (narcotic analgesics), benzodiazepines, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior history of addiction. The extent of this risk is not certain. Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician at Elite Pain Center to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception.
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is: _____ phone: _____.
3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
5. You may not share, sell, or otherwise permit others to have access to these medications and appropriate safeguards will be taken by you to prevent their theft while in your possession.
6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder and/or discharge from our pain clinic.
8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
9. Original containers of medications should be brought in to each office visit because pill counts may be done.
10. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
11. **Medications may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc.**
12. I agree to follow the advice of my treating pain physician with regards to adjunctive treatments for my pain-related condition. These services may include psychological, psychiatric, physical therapy or other interventions. Failed appointments or continued noncompliance with recommended therapies may result in termination of treatment at the pain clinic.
13. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
14. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
15. Renewals of ALL medications prescribed at this clinic are contingent on keeping scheduled appointments. **Please do not call by phone for prescriptions on ANY medications after hours or on weekends as medications will not be filled except during regular office hours. Early refills will not be given under any circumstances.**

16. It should be understood that any medical treatment is initially a trial, and that continued prescriptions are at the discretion of the physician.
17. The risks and potential benefits of these therapies are explained elsewhere and you acknowledge that you have received such explanation].
18. I agree to allow my treating physician at Elite Pain Center to communicate with my referring and primary care physicians as well as my pharmacies regarding use of controlled substances and my treatment of my pain.
19. I agree to identify all physicians treating me within the last 2 year time period below.

Physician	Address	Phone	Dates Treated By Physician

20. I have disclosed fully to Elite Pain Center any use (past or present) of alcohol, controlled substances or illicit substances ever used by myself.
21. If a female of childbearing age, I certify that I am not pregnant and that I will take appropriate measures to prevent pregnancy during the course of my treatment with controlled substances.
22. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

I have read or had read to me the above information. **I understand there are risks involved with the use of controlled substances for the treatment of pain, which includes rare complications, even death, which may not have been specifically mentioned above. The risks have been explained to my satisfaction and I accept them and consent to use of these medications**. I declare the above statements to be true and complete and my treatment with controlled substances will be carried out in accordance with the conditions stated above.

Witness Signature _____ Patient Signature _____

Date _____ Patient Name (Printed) _____

Physician Declaration: I and/or my assistant have explained the risks of using opioid and other controlled substances and the pertinent contents of this document to the patient and have answered all the patient's questions. To the best of my knowledge, the patient has been adequately informed and the patient has consented to be treated with controlled substances for the treatment of pain.

Elite Pain Center
186 South Macon Street
Jesup, GA 31545
Phone: 912-530-7516 Fax: 912-559-6191

Financial Policy

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month. United Physicians Management Services (UPMS) conducts billing for this office and they may be contacted at 336-794-9616 or toll free at 866-727-3303.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, we will attempt to assist you BUT you are ultimately responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, we will attempt to assist you BUT you are ultimately responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these. Anyone not paying their co-pay will have their appointment rescheduled to another date. Self-pay patients must pay $200 for follows up and $320 for new patients when checking in with the receptionist towards charges incurred during the visit.

Returned checks: There is a fee (currently $40) for any checks returned by the bank. Once a check has been returned for non-sufficient funds the returned check fee and amount of the check that was returned must be paid in full before another appointment will be scheduled. In addition, we will no longer accept checks and payment must be paid in cash or by credit card.

Missed appointment fee: Patients who miss an appointment or cancel an appointment with less than 24 hours notice will be charged a $50 fee. This fee must be paid before a new appointment is scheduled. The reason for this fee is that another could have been scheduled in your place. Patients with three missed appointments will be asked to transfer their records to another doctor.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Wayne County, Georgia. Once your account goes to collections you will be discharged as a patient and asked to transfer your records to another physician. Your delinquent account will also be reported to all three credit bureaus.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case. If a letter is required on your behalf for your attorney, a fee will be charged based on the time needed for the physician to complete the letter.

Court Related: Court related letters produced will be charged based on the time required for the physician to produce the letter.

Court Appearances and Depositions: An hourly rate will be charged for any court appearances and depositions.

Insurance Papers and Letters: A fee of $30 will be charged to you for letters the physician produces on your behalf.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained heroin and the agreement will be in full force and effect.

Patient's Name: (Print) _____

Responsible party: (Print)
(if not the patient) _____

Signature: _____ Date: _____

Co-Signature: _____ Date: _____

Elite Pain Center, LLC
186 South Macon Street
Jesup, GA 31545
(912) 530-7516 • Fax (912) 559-6191

HEALTH CARE CONSENT & AUTHORIZATION FORM

FINANCIAL RESPONSIBILITY: I do hereby expressly agree to pay and guarantee payment in full of any charges for services rendered or to be rendered to the above-named ("Patient") by Elite Pain Center, LLC (EPC) and by licensed healthcare providers or their professional entities who may provide services during this patient visit or stay (a "Provider"). Payment is due in full within 30 days of services. In the event of nonpayment, the undersigned guarantees payment of late charges not to exceed 1.5% per month for bills 30 days past due and all costs of collections, including reasonable attorney's fees. In addition, I authorize the transfer of monies paid to EPC by or on behalf of the Patient and otherwise refundable to the Patient or Guarantor, to other accounts at EPC for which the Patient or Guarantor is responsible.

Signature:_____ Witness:_____

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of medical benefits payable to me directly to EPC. The rates will not exceed regular charges for similar services. I understand that BILLING OF INSURANCE IS A SERVICE ONLY AND NOT A GUARANTEE OF PAYMENT. If my insurance requires pre-certification for services, I realize it may be my responsibility to get the necessary approvals. I understand that I am personally responsible to EPC for charges not covered by insurance, including charges for health care services determined to be non-medically necessary by a private insurer's utilization review program. I understand that I may choose to continue services that are not covered by the Patient's insurance carrier at my own expense so long as EPC has notified me in advance that the insurance carrier may not cover or continue to cover all services.

MEDICARECERTIFICATION: The information given by me in applying for payment under Titles V, XVIII, and/or XIX of the Social Security Act is correct. I request that payment of benefits under Title XVIII (Medicare) and XIX (Medicaid) of the Social Security Act for any services furnished by EPC be made on my behalf. I authorize any holder of medical or other information about me to release to Medicare and their respective agents any information needed for this or a related claim.

PERSONAL VALUABLES: EPC is not responsible for the personal property or valuables of patients. I release EPC of all responsibility for personal property and for valuables.

AUTHORIZATION FOR CARE AND/OR TREATMENT: I hereby consent to outpatient treatment and give permission to EPC to provide the services deemed necessary or advisable in the diagnosis and treatment of this patient. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatment or examination in EPC. I understand that the patient has the right to withhold consent to a medical service that is deemed necessary or advisable by the provider. I understand that physicians in training (residents) and student in health related training programs may participate in the care for the patient or observe special procedures.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I understand that I may revoke or amend the following authorizations at any time except to the extent that action has already been taken:

RELEASE FOR PAYMENT PURPOSES: I authorize EPC to furnish any information relating to this hospitalization or treatment to representatives of any party financially responsible for the Patient's care or to any governmental or charitable agencies. I understand that only that information that is necessary for payment purposes will be disclosed.

RELEASE FOR TREATMENT/QUALITY REVIEW PURPOSES: I authorize release of medical information about the patient to the referring physician, any health care facility or physician to whom the patient may be referred and any extended care facility considered for placement. I understand that a separate consent form is necessary for disclosure of information regarding treatment of alcohol or substance abuse. **I specifically consent to the disclosure of information related to AIDS, HIV infection or other communicable diseases.**

MY SIGNATURE BELOW INDICATES APPROVAL OF THE ABOVE

Signature:_____ Date:_____ Witness;_____

(If patient is unable to consent or is a minor, complete the following)

Signature_____ Date:_____ Witness:_____

Elite Pain Center, LLC

Notice of Privacy Practices (9/18)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective SEPTERMBER 14, 2018, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. [If there are other such disclosures that you might make, list them here.] These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.
Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative

functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in

your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to PRACTICE MANAGER, 186 South Macon Street, Jesup, GA. 31545

Elite Pain Center
186 South Macon Street
Jesup, GA 31545

This signature page is in reference to the forms entitled:

Notice of Privacy Practices

If you did not receive these documents, or have misplaced them, please ask for another copy. This signature page is in reference to the Federal HIPPA Privacy Regulations requirements.

The undersigned certifies that he/she has received a copy of the **Notice of Privacy Practices (HIPPA),** and is the client, or is duly authorized by the client as the client's representative. If a more detailed verbal explanation is needed, in addition to the one you received, please request one now and we would be pleased to assist you

_____
Print Name

_____ _____
Client Signature (or Client's Representative) Date

Phone: (912) 530-7516
Fax: (912) 559-6191

Elite Pain Center

186 South Macon Street
Jesup, GA 31545

Date: _____

I _____give authorization to Elite Pain Center to disclose all of my personal information to:_____ as it directly effects my care. This information may include scheduling appointments, prescription refills, medical information, procedure or patient care notes, and any financial information. I understand that this information shared to the above named individual is confidential and I assume all responsibility for any information disclosed to this individual.

You may contact:

1) Name: _____ Relationship to Patient:_____

Phone: _____ Alternate Phone: _____

2) Name: _____ Relationship to Patient:_____

Phone: _____ Alternate Phone:_____

Patient Name:_____

DOB:_____

I agree to all the above:

Patient Signature:_____ **Date:**_____

Witness:_____ **Date:**_____

(Relationship to Patient):_____

Elite Pain Center Staff as Witness:_____ **Date:**_____

Elite Pain Center
Patient Initial Review of Systems

Constitutional

Chills	O Yes O No
Fever	O Yes O No
Weight Loss	O Yes O No
Weakness	O Yes O No
Fatigue	O Yes O No
Weight Gain	O Yes O No

Head

Headaches	O Yes O No
Fainting	O Yes O No

Eyes

Blurred Vision	O Yes O No
Double Vision	O Yes O No
Eyeglasses	O Yes O No
Eye Pain	O Yes O No
Redness	O Yes O No
Vision Changes	O Yes O No

ENT

Nasal Discharge	O Yes O No
Hearing Aide	O Yes O No
Ear Pain	O Yes O No
Throat Tenderness	O Yes O No

Respiratory

Asthma	O Yes O No
Shortness of Breath	O Yes O No
Respiratory Infections	O Yes O No

Cardiovascular

Chest Pain	O Yes O No
Palpatations	O Yes O No
Leg Pain-Walking	O Yes O No
Swelling Legs	O Yes O No

Gastrointestinal

Abdominal Pain	O Yes O No
Heartburn	O Yes O No
Nausea	O Yes O No
Vomiting	O Yes O No
Constipation	O Yes O No
Rectal Bleeding	O Yes O No
Diarrhea	O Yes O No
Black Tarry Stools	O Yes O No

Musculoskeletal

Joint Pain	O Yes O No
Muscle Cramps	O Yes O No
Weakness	O Yes O No

Psychiatric

Depression	O Yes O No
Memory Loss	O Yes O No
Easy Brusing	O Yes O No
Rashes	O Yes O No

Neurological

Dizziness	O Yes O No
Tremors	O Yes O No
Numbness	O Yes O No
Fainting	O Yes O No
Strokes	O Yes O No
Headaches	O Yes O No
Mood Changes	O Yes O No
Memory Changes	O Yes O No

Skin

Itching	O Yes O No
Headaches	O Yes O No

Endocrine

Thyroid Problems	O Yes O No
Sweats	O Yes O No

Hematologic

Anemia	O Yes O No
Bleeding	O Yes O No
Blood Clots	O Yes O No

Allergic

Hives	O Yes O No

Urinary

Urinary Changes	O Yes O No
Urinary Retention	O Yes O No

Date:_____

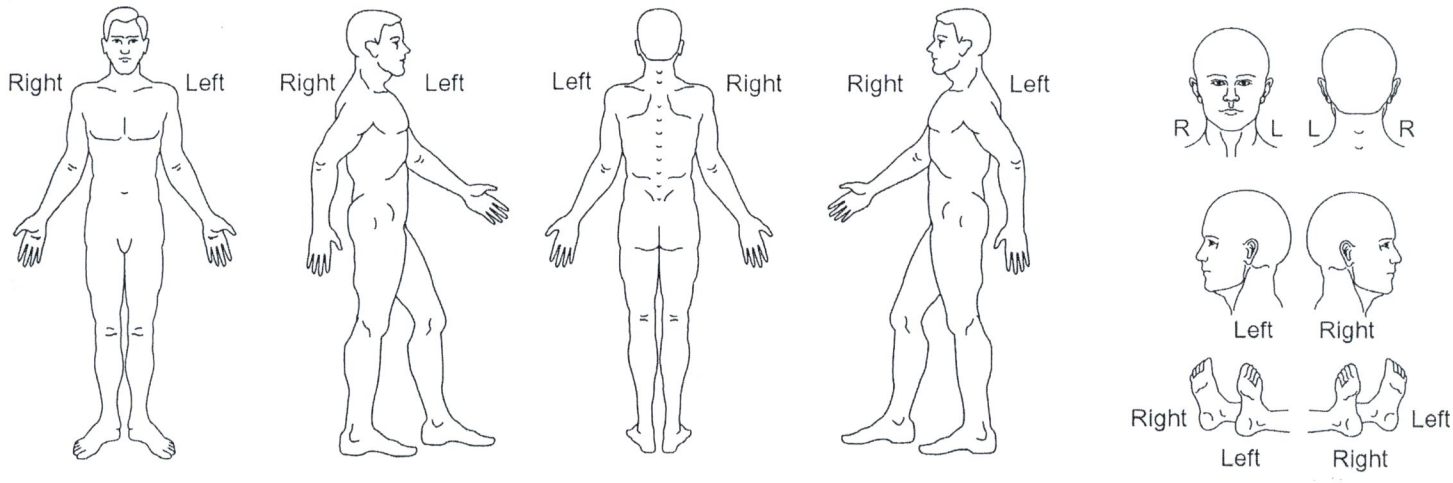
Patient: _____

DOB:_____ MR#: _____

Elite Pain Center

Dr. Patrick Karl/ Alana Waters FNP

In what areas of your body is your pain located?
PLEASE USE A PEN AND SHADE IN WHERE YOUR PAIN IS TODAY



Please Circle Your Average Pain Level Below:

0 1 2 3 4 5 6 7 8 9 10

Little pain Moderate pain Worst pain ever

0 Absent (No pain); **1-2** Tolerable (tolerate without medications); **3-4** Bearable (some activities restricted/prevented, requires medication); **5-6** Nearly intolerable (sedentary, only able to watch TV, read, etc.); **7-8** Intolerable (Can't read, watch TV, use the phone, need to visit ER for pain killers); **9-10** Devastating (need hospitalization for pain control)

Pain Area #1 (WORST PAIN)

Worst Pain Area (Example, list things like low back, headache, neck pain) _____

When did your pain begin?_____

Did anything cause your back pain? (Car accident, Fall, lifting heavy object, after surgery etc.):

_____

Circle words that describe your pain:

aching burning cramping dull electric sharp stabbing throbbing sore stiff

What makes your pain better? (circle all that apply)

Accupuncture activity chiropractics heat ice lying down massage pain medications physical therapy position change rest sitting standing steroid injections TENS unit walking sleep local pressure

What makes your pain worse? (Circle all that apply)

Activity bending cold heat everything lifting moving neck looking down looking up lying down standing movement physical therapy sitting change in position stress walking working touch light sexual activity bad weather twisting straining sneezing sidebending riding in car coughing

Have any physicians treated you for this pain in the past? Who?_____

_____

Have you seen any surgeons for a surgical consultation for your pain? If yes, please list surgeons below:

_____

IF YOU HAVE MORE THAN ONE MAIN PAIN YOU LISTED ABOVE, THEN FILL OUT THE OTHER PAINS BELOW.

Pain Area #2

Where is pain? (Example, list things like low back, headache, neck pain) _____
When did your pain begin?_____
Did anything cause your back pain? (Car accident, Fall, lifting heavy object, after surgery etc.):

_____

Circle words that describe your pain:
Aching burning cramping dull sharp stabbing throbbing sore stiff
What makes your pain better? (circle all that apply)
Accupuncture activity chiropractics heat ice lying down massage pain medications physical therapy position change rest sitting standing steroid injections TENS unit walking sleep local pressure
What makes your pain worse? (Circle all that apply)
Activity bending cold heat everything lifting moving neck looking down looking up lying down standing movement physical therapy sitting change in position stress walking working touch light sexual activity bad weather twisting straining sneezing sidebending riding in car coughing
Have any physicians treated you for this pain in the past? Who?_____

_____

Have you seen any surgeons for a surgical consultation for your pain? If yes, please list surgeons below:

_____

Pain Area #3

Where is pain? (Example, list things like low back, headache, neck pain) _____
When did your pain begin?_____
Did anything cause your back pain? (Car accident, Fall, lifting heavy object, after surgery etc.):

_____

Circle words that describe your pain:
aching burning cramping dull sharp stabbing throbbing sore stiff
What makes your pain better? (circle all that apply)
Accupuncture activity chiropractics heat ice lying down massage pain medications physical therapy position change rest sitting standing steroid injections TENS unit walking sleep local pressure
What makes your pain worse? (Circle all that apply)
Activity bending cold heat everything lifting moving neck looking down looking up lying down standing movement physical therapy sitting change in position stress walking working touch light sexual activity bad weather twisting straining sneezing sidebending riding in car coughing
Have any physicians treated you for this pain in the past? Who?_____

_____

Have you seen any surgeons for a surgical consultation for your pain? If yes, please list surgeons below:

_____

Pain Area #4

Where is pain? (Example, list things like low back, headache, neck pain) _____
When did your pain begin?_____
Did anything cause your back pain? (Car accident, Fall, lifting heavy object, after surgery etc.):
_____
Circle words that describe your pain:
Aching burning cramping dull sharp stabbing throbbing sore stiff

What makes your pain better? (circle all that apply)
Accupuncture activity chiropractics heat ice lying down massage pain medications physical therapy position change rest sitting standing steroid injections TENS unit walking sleep local pressure
What makes your pain worse? (Circle all that apply)
Activity bending cold heat everything lifting moving neck looking down looking up lying down standing movement physical therapy sitting change in position stress walking working touch light sexual activity bad weather twisting straining sneezing sidebending riding in car coughing
Have any physicians treated you for this pain in the past? Who?_____
_____
Have you seen any surgeons for a surgical consultation for your pain? If yes, please list surgeons below:
_____

Following Questions Relate To All Your Pain Areas

What do you hope we can accomplish today?_____ _____

Please rate your ability to cope with pain. (0 = Not able 10 = Very able)
❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Please rate your ability to perform activities of daily living such as hygiene, household chores, transportation, etc. (0 = Not able 10 = Very able)
❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Please rate your ability to function and interact well with family and friends. (0 = Not able 10 = Veryable) ❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Please rate your ability to work in your usual occupation. (0 = Not able 10 = Very able)
❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Do you have any pending litigation with the courts or with a job injury? ❑Yes ❑No
If Yes, please explain:_____

Do your pain medications provide relief? ❑Yes ❑No ❑I do not take pain medications
a. If yes, how much relief do you receive?
❑10% ❑20% ❑30% ❑40% ❑50% ❑60% ❑70% ❑80% ❑90% ❑100%

Do your pain medications improve your function? ❑Yes ❑No ❑I do not take pain medications
a. If yes, how much improvement in function do you receive?
❑10% ❑20% ❑30% ❑40% ❑50% ❑60% ❑70% ❑80% ❑90% ❑100%

SLEEP BEHAVIOR
Do you have difficulty falling asleep? ❑Yes ❑No
Do you have difficulty remaining asleep? ❑Yes ❑No
Are you ever awakened by your pain? ❑Yes ❑No
How many hours do you sleep, on average, per night?
❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 ❑More than 10

What treatments have you tried below?

Accupuncture: Never tried Made Pain Better Made Pain Worse Notes: _____
Biofeedback: Never tried Made Pain Better Made Pain Worse Notes: _____
Chiropractic Therapy: Never tried Made Pain Better Made Pain Worse Notes: _____
Massage Therapy: Never tried Made Pain Better Made Pain Worse Notes: _____
Physical Therapy: Never tried Made Pain Better Made Pain Worse Notes: _____
Counseling: Never tried Made Pain Better Made Pain Worse Notes: _____
TENS Unit: Never tried Made Pain Better Made Pain Worse Notes: _____
Back Brace: Never tried Made Pain Better Made Pain Worse Notes: _____
Heating Pad: Never tried Made Pain Better Made Pain Worse Notes: _____

Have you had any radiographic imaging results in the last 5 years (MRI, CT Scans, x-rays)? If so please list below:

_____

Have you had any NEW bowel or bladder problems? ❑Yes ❑No If yes, please explain:_____

Are you on any Blood Thinners? (Coumadin-Warfarin, Plavix, Lovenox):_____

Have you ever had any of the following treatments? If yes please circle below:

Trigger Point Injections: Never tried Made Pain Better Made Pain Worse Notes: _____
Botox Injections: Never tried Made Pain Better Made Pain Worse Notes: _____
Lumbar Epidural Injections: Never tried Made Pain Better Made Pain Worse Notes: _____
Cervical Epidural Injections: Never tried Made Pain Better Made Pain Worse Notes: _____
Cervical Facet Injections: Never tried Made Pain Better Made Pain Worse Notes: _____
Knee Injections: Never tried Made Pain Better Made Pain Worse Notes: _____
Shoulder Injections: Never tried Made Pain Better Made Pain Worse Notes: _____
Lumbar Facet Injections: Never tried Made Pain Better Made Pain Worse Notes: _____
Cervical Radiofrequency Ablation: Never tried Made Pain Better Made Pain Worse Notes: _____
Lumbar Radiofrequency Ablation: Never tried Made Pain Better Made Pain Worse Notes_____
SI Joint Injections: Never tried Made Pain Better Made Pain Worse Notes: _____
Intrathecal Pump: Never tried Made Pain Better Made Pain Worse Notes: _____
Spinal Cord Stimulator: Never tried Made Pain Better Made Pain Worse Notes: _____

Please list all previous surgeries below:

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

Please list ALL CURRENT Medications Below:

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

Please list any Medication Allergies:

_____

Family History:

Please list any medical illnesses for the following blood relatives:

Father:_____

Mother: _____

Brothers/Sisters:_____

Social History:

Alcohol Use: ❑Yes ❑No

If yes, how many drinks per day or per week?_____

Cigarette Use: ❑Yes ❑No

If yes, how many packs per day_____ How Many years have you smoked _____

Are you currently working? ❑Yes ❑No

If yes, what is your current occupation?_____ What is past occupation?_____

If working, are you working with restrictions ❑Yes ❑No If yes, what restrictions:_____

If employed, how many hours do you work each week?

❑Less than 10 ❑11-20 ❑20-30 ❑30-40 ❑More than 40

What level education did you obtain?_____

Are you officially disabled? ❑Yes ❑No

If yes, what year did you become disabled?_____

Are you retired? ❑Yes ❑No If yes, how many years have you been retired? _____

Do you have any children? ❑Yes ❑No How many Children?_____

Are you currently married? ❑Yes ❑No

Are you divorced? ❑Yes ❑No

Do you exercise regularly? _____

Do you engage in any recreational drug use? ❑Yes ❑No

If yes, which drugs have you used? _____

Please circle below ALL medications that you have tried in PAST and list next to them if they worked to treat your pain, if they did not work, if they lost effectiveness or if you had side effects to the medication:

Amerge:_____
Amrix:_____
Avinza:_____
Axert:_____
Baclofen:_____
BC Powders:_____
Goody Powder:_____
Celebrex:_____
Clonidine:_____
Cymbalta:_____
Darvocet:_____
Demerol:_____
Dilaudid:_____
Elavil (Amitripyline) :_____
Embeda:_____
Endocet:_____
Fentanyl Patch:_____
Fentora:_____
Flexeril:_____
Gabitril:_____
Ibuprofen:_____
Keppra:_____
Lexapro:_____
Lidoderm:_____
Lorcet:_____
Lortab:_____
Lyrica:_____
Maxalt:_____
Methadone:_____
Mobic:_____
Morphine:_____
MS Contin:_____
Naproxen:_____
Neurontin:_____
Nucynta:_____
Opana:_____
Oxycodone:_____
Oxycontin:_____
Percocet:_____
Pristiq :_____
Relafen:_____
Robaxin:_____
Savella:_____
Skelaxin:_____
Soma:_____
Topamax:_____
Toradol:_____
Ultram:_____
Vicodin:_____
Voltaren Gel:_____
Zanaflex:_____
Zomig:_____

OTHER MEDS NOT LISTED:_____

We require you use ONE pharmacy while being a patient at the clinic, please list pharmacy below you will use:

_____

Please circle any physicians you have been treated by below:

CARDIOLOGY
Dr Willie Bell
Dr. Joel Ferree
Dr. John Madonna
Dr Timothy Catchings
Dr. Darrel Collins

FAMILY PRACTICE
Jesup
Dr Sandra Bohnstengel
Dr. Kevin Brown
Dr Paul Elliott
Dr. William Headley
Dr. Kevin Keown
Dr. Robert Phillips
Dr. Ross Goehring .
Baxley
Dr. Harrison Carter
Dr. Tonya Fordham
Dr Evelyn Johnson
Dr. John Mann
Dr. Garland Martin
Dr Saul Weinstein
Dr. Teresa Cezar
Dr. Orlando Fernando
Dr Evelyn Johnson
WAYCROSS
Dr Linda Harper
Dr. Ronald Lynch
Dr. David Walters
Dr. Gregory Prohaska
Dr. Alan Morton
Dr Jaya Krishna
Dr Celestine Stiles
Dr. Muhammad Akram
Dr Tannis Alligood
Dr. Clay Lee
Dr. George Wheeler
Dr. Peter Wrobel
Dr. Susan Brickle
Dr. James Blasko
Dr Ramzi Tawil
Dr. Mitzi Clayton
Dr. Brent Waters
Dr. Donald Waters
Dr. Earl Martin
HINESVILLE
Dr. Christopher Blasy
Dr Glen Carter
Dr Stacie Wong
Dr. Adewunmi Sobowale
Dr. Daniel Green
Dr Michael Sharkey
Dr James A Mcquown
Dr. William Robertson
Dr Grace Bautista
Dr. Bennie Johnson
Dr W. P. Carr
DOUGLAS
Dr Steve Anderson
Dr. Lydia Tanner
Dr Charles Miller
Dr Challori Reddy
Dr Gordon Boone

GASTROENTEROLOGY
BAXLEY
Dr Khalid Magsood
WAYCROSS
Dr. S. A. Choudhri
Dr. Craig Kubik
Dr. Maria Castellano
Dr. Ahmad Irfan

INTERNAL MEDICINE
JESUP
Dr. Pumpelly
Dr Lance Hendrix
BAXLEY
Dr. Orlando Fernando
Dr. Teresa Cezar
Dr Errol Graham
Dr. James Graham
Dr Harrison Carter
WAYCROSS
Dr Mukesh Agarwal
Dr Nishi Agarwal
Dr Muhammad Akram
Dr. Ric Zarzuela
Dr. Alan Morton
Dr Nirmala Amaram
Dr Chandrakanth Amaram
Dr. Pauline Bellecci
Dr. Robert Lee
Dr. Thomas Campen
Dr. Thomas Cliatt
Dr. Roberto Garcia
Dr Jill Goggans
Dr. Rhonda Williams
Dr. Robert Packer
HINESVILLE
Dr Robert Carter
Dr Adewunmi Sobowale
Dr. Sabin Tomus
Dr Tomus
Dr. Bobby L Herrington
Dr Firas Bannout
Dr Raymond Cruz
Dr Calin Badea

NEPHROLOGY
WAYCROSS
Dr. C Amaram
Dr. P. Maramreddy

NEUROSURGERY
Dr. Gary Kaufman MD
Dr. Mark A Gold MD
Dr John Shutack MD
Dr. Suzanne Fix
SAVANNAH
Dr. Roy Baker
Dr. Louis Horn
Dr. Jay Lindley
Dr. Willard Thompson
Dr Jay Howington
Dr Cliff Cannon
Dr. Fremont Wirth
Dr Randolph Bishop
Dr. Kevin Ammar
Dr Daniel Suh

OB/GYN:
Dr Jeffrey L Harris
Dr Sandra Mager
BAXLEY
Dr Patty Henry
Dr. Catherine Jackson
BRUNSWICK
Dr. Henry Flournoy MD
WAYCROSS
Dr Joel Higgins
Dr Dan Lott
Dr. Robert Stark MD
Dr Robert Stark MD
Dr. John Malmborg
HINESVILLE
Dr Cinar Aksu
Dr. Seth Borquaye
Dr Zorana Sifford
Dr Cliphane McLeod
Dr. David Ostman
Dr victor Ramos

ORTHOPEDIC SURGERY
JESUP
Dr. Douglas Hein
Dr J Lex Kenerly
BRUNSWICK
Dr Ralph Morales
Dr. Michael Dunn
Dr. Larry Dyal
Dr. Kevin Brooks
WAYCROSS
Dr. John Cope
Dr. Randall O'Brien
Dr. Robert Lykens
Dr S.R. Adcock
HINESVILLE
Dr. William Tankersley
Dr Christopher Mark Vaughn

PAIN PHYSICIANS
RICHMOND HILL
Dr. Amy Pearson
Jesup
Dr Sandra Bohnstengel
Dr Carl Shenkman
WAYCROSS
Dr. Kevin Coyle
Dr. Michael Lupi
BRUNSWICK
Dr. Gary Kaufman
Dr. Mark A Gold
Dr John Shutack
SAVANNAH
Dr. Wayne Woodbury
Dr Keith Kirby
Dr. Ortello Bosch

PODIATRY
JESUP
Dr. Rob Spinola
Ronald Reagin
Waycross
Dr Emily Via-Bowers
Dr. Lisa Panthel
Dr. Robert Phipps
Dr. David Murphy
HINESVILLE
Dr Paul Bodamer Dr Newsome

RHEUMATOLOGY
WAYCROSS
Dr Charles Galea
Dr Boswell

SURGERY
JESUP
Dr Dennis Davis
Dr. Donald Kennedy
BAXLEY
• Dr. William Cantey
BRUNSWICK
• Dr Turner Rentz
HINESVILLE
Dr. Stephen Weiss
WAYCROSS
Dr Du Bose Medlock
Dr. David Wykstra
Dr. Thomas Wehmann
Dr. Sigismund Lee
Dr Najam Azmat
Dr Victor Bondar
Dr. Daniel Terry

UROLOGY
JESUP
Dr. Mark Byron MD
Dr. Rudolf Nunnemann MD
Dr. David Kranc MD
WAYCROSS
Dr. James (Wade) Dye
Dr Ron Tomlinson

VASCULAR SURGERY
WAYCROSS
Dr Najam Azmat
Dr. Thomas Wehmann

HEMATOLOGY/ONCOLOGY
JESUP
Dr. Duane P. Moores
Dr. Abraham Cheong
WAYCROSS
Dr Marco Ayulo
Dr. Asit Jha
Dr Negrea George
Dr. Barjinder Singh
Dr Sridhar Srinivasan

CHIROPRACTORS
Dr Edwin Davis
Dr. Ren Halverson
Dr. Nick Nicholson
Dr Brett Mizell
Dr. Anna Bodnar
Dr. R. B. Carswell
Dr Lyle Donald
Dr. Daniel Cooke
Dr. Jerry Nolan

NEUROLOGY
JESUP
Dr. Stephen Pappas
WAYCROSS
Dr. Michael Baker
Dr. Michael Singh
Dr. Maneul Cuesta
Dr Mellick
Brunswick
Dr. Carl Shenkman

If physicians not included above, please list:_____

Past Medical History (Please circle all medical problems):

abdominal aneurysm
adrenal disorder
allergic rhinitis
anemia
angina
ankle pain
acid reflux
anxiety disorder
arthritis
arthritis-Osteoarthritis
arthritis-Rheumatoid
asthma
atrial fibrillation
avascular necrosis
Bell's Palsy
bipolar
bladder problems
bleeding disorder
blood clots
brain aneurysm
bursitis
cancer (Type: _____)
carotid stenosis
carpal tunnel
cataracts
chiari malformation
cellulitis
cervical pain
chest pain
chronic bronchitis
cirrhosis
Congestive Heart Failure
COPD
Crohn's disease
degenerative joint disease
degenerative disc disease
depression
diabetes type I
diabetes type II
diverticulosis
deep vein thrombosis
endometriosis
gallbladder disease
gastritis
glaucoma
emphysema
epilepsy
facet arthropathy
fibromyalgia
fractures of bones:_____
GERD
Gout
headaches
heart murmur
heart disease
heart attack
hemophilia
hernias
hepatitis B
hepatitis C
high cholesterol
high blood pressure
HIV/AIDS
hypothyroidism
hyperthyroidism
insomnia
interstitial cystitis
irritable bowel syndrome
leg pain
leukemia
lung disease
lumbar pain
lupus
kidney disease
kidney stones
knee pain
mirgraine headaches
motor vehicle accident
muscle disease
osteoarthritis
osteoporosis
pacemaker
pancreatitis
panic attacks
parkinsons
eripheral neuropathy
peripheral vascular disease
plantar fasciitis
pneumonia
polymyaglia rheumatica
post-herpetic neuralgia
pulmonary embolism
renal problems
restless leg syndrome
rib pain
rotator cuff problems
sacral pain
sciatic pain
scoliosis
schizophrenia
seizure disorder
shingles
shoulder pain
sleep apnea
stroke
thoracic pain
TMJ problems
trigeminal neuralgia
thyroid problems
tonsillectomy
ulcers
vascular problems
vertebral fracture
whiplash injury

Other things not listed:

_____

_____