P: 205.208.9001
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CAHABA PAIN AND SPINE CARE

R. Brian Thoma, M.D. | T. Wade Martin, M.D

Fellowship Trained and Board-Certified in Pain Medicine

Welcome to Cahaba Pain and Spine Care. In the following pages, you will find release of records forms, insurance forms, and your clinical questionnaire. These forms are an important tool to assess your pain condition and determine appropriate treatment for you. Please fill these out before the day of your visit. This will save valuable time at the office, hopefully resulting in a timelier visit with your provider. Failure to complete the forms could result in a delay of your appointment.

In addition to the completed new patient forms, In order for our providers to give you the best care possible, you must bring the following to your appointment with us:

- ❑ Current and Valid Driver's License (or other official state/ federal ID)
- ❑ Current and Valid Insurance Card
- ❑ All Medical Records relating to your Current Pain (past 2 years)
- ❑ Any MRI's, CT Scans, or X-rays pertaining to your visit

Please see the enclosed medical records request form to enable your other doctors' office to send your records to Cahaba Pain and Spine Care. **Your outside records, especially of your care at other pain clinics, may need to be reviewed before we can prescribe certain pain medications for you. Not every patient is prescribed pain medication at their first visit.**

We encourage you to visit our website www.cahabapain.com to review key information about our practice including specific treatments we offer. An informed patient makes better decisions about treatment options offered by his or her physician. We look forward to taking care of you!

Appointments and Cancellations

Our office hours are 7:30am – 4:30pm, Monday through Friday. Please arrive on time to your appointments. We reserve the right to reschedule your appointment if you are more than 15 minutes late.

Due to the high demand for our providers' services, we ask that you provide 24 hours' notice for the cancellation of any office visit and 48 hours' notice if cancelling a procedure. This allows us to provide someone else your previously scheduled appointment time. Failure to show for a visit without proper cancellation notice will result in cancellation fees of $25 and $100 for office visits and procedures respectively.

We look forward to taking care of you!

Your appointment is schedule with

Dr. Martin/Thoma/Winkler on_____ @ _____

YOUR FIRST VISIT

Cahaba Pain and Spine Care
2010 Patton Chapel Road, Suite 200
Hoover, AL 35216

Phone: 205-208-9001
Fax: 205-208-0031

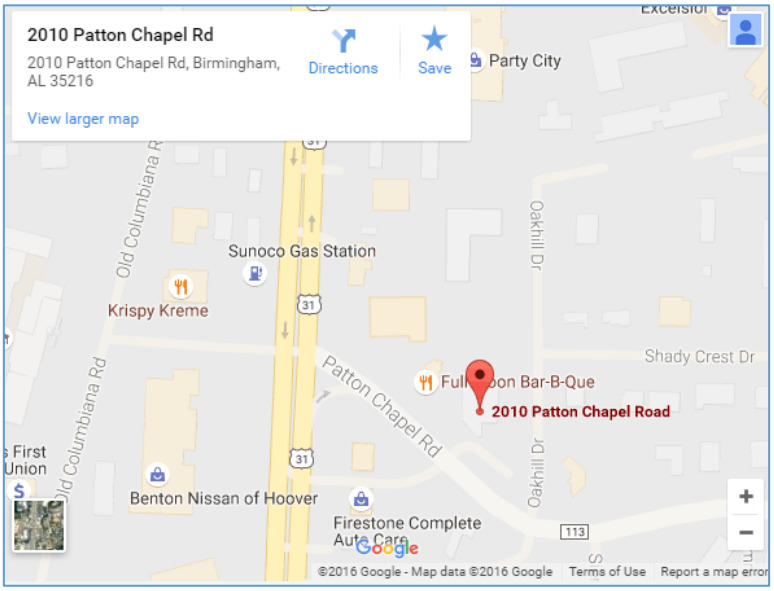
Directions

We are conveniently located just off Hwy 31 between I-65 and I-459.

From Hwy 31

Traveling South on 31: Go South on Highway 31 until you see a Nissan dealership and Krispy Kreme on the right and a Full Moon BBQ on the left. At traffic light, turn Left onto **Patton Chapel Road North.** Hoover Medical Plaza is on the left immediately after Full Moon BBQ. Turn left onto **Oakhill Drive**, and proceed to the back parking lot. There is an entrance at the back of the building directly to the second floor for easy entry. We are in Suite 200.

Traveling North on 31: Go North on Highway 31 until you see a Nissan dealership and Krispy Kreme on the left and a Full Moon BBQ and Regions Bank on the right. At the traffic light, turn Right onto **Patton Chapel Road North.** Hoover Medical Plaza is on the left immediately after Full Moon BBQ. Turn left onto **Oakhill Drive**, and proceed to the back parking lot. There is an entrance at the back of the building directly to the second floor for easy entry. We are in Suite 200.



From I-459

Take the Hoover Highway 31/Montgomery Highway Exit (Exit 13 from I-459S and Exit 13B from I-459N). Go **North on Highway 31** until you see a Nissan dealership and Krispy Kreme on the left and a Full Moon BBQ on the right. Turn Right onto **Patton Chapel Road North**. Hoover Medical Plaza is the building immediately after Full Moon BBQ on the left side. Turn left onto **Oakhill Drive**, and proceed to the back parking lot. There is an entrance at the back of the building directly to the second floor for easy entry. We are in Suite 200.

From I-65

Take the Hoover Highway 31/Montgomery Highway Exit (Exit 252). Go **South on Highway 31**. Travel approximately one mile until you see a Nissan dealership and Krispy Kreme on the right. At the traffic light, turn Left onto **Patton Chapel Road North**. Hoover Medical Plaza is the building immediately after Full Moon BBQ on the left side. Turn left onto **Oakhill Drive**, and proceed to the back parking lot. There is an entrance at the back of the building directly to the second floor for easy entry. We are in Suite 200.

What to Bring

- Insurance Card
- Valid Government-Issued Photo ID (driver's license, passport, etc.)
- Copay (if applicable)
- Completed New Patient Clinical Forms
- Outside records related to your pain (office notes, procedure notes, MRI reports) from the last two years

CAHABA PAIN AND SPINE CARE

Patient Contact Information Sheet

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

Social Security Number:_____

Any physician, staff, employee or representative of Cahaba Pain and Spine Care, LLC has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

Name	Relationship	Phone Number(s)
Name	Relationship	Phone Number(s)
Name	Relationship	Phone Number(s)
Name	Relationship	Phone Number(s)
Name	Relationship	Phone Number(s)

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Cahaba Pain and Spine Care, LLC or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to redisclosure by the individual(s).

Patient Signature: _____Date: _____

Copy available to patient upon request

CAHABA PAIN AND SPINE CARE

PATIENT INFORMATION

PATIENT NAME:
_____

LAST FIRST MIDDLE

ADDRESS:
_____

ZIP CODE: _____ **CITY:** _____ **STATE:** _____

HOME PHONE #: (_____) _____-_____ **WORK PHONE #:** (____) _____-_____ **CELL PHONE #:** (____) _____-_____

EMAIL ADDRESS: _____ **Preferred Contact Method (circle one) Home Cell Work Email**

HEIGHT: _____ **WEIGHT (lbs):** _____

DATE OF BIRTH: _____/_____/_____ **SOCIAL SECURITY NUMBER:** _____-_____-_____

MARITAL STATUS: (circle one): SINGLE MARRIED DIVORCED WIDOWED OTHER

LANGUAGE (circle one): English Arabic Chinese Polish Portuguese Russian Somali Spanish Vietnamese ☐ I decline to answer

RACE (circle all that apply): American Indian Asian Asian Indian Black or African American European Filipino Japanese Korean
Native Hawaiian or other Pacific Islander White ☐ I decline to answer

ETHNICITY (circle all that apply): Central American Cuban Dominican Hispanic or Latino/Spanish Mexican Not Hispanic or Latino Puerto Rican
South American Spaniard ☐ I decline to answer

EMERGENCY CONTACT NAME:_____ **WORK PHONE #: (_____) _____-_____**

HOME PHONE #:(____) _____-_____ CELL PHONE #: (____) _____-_____ RELATIONSHIP TO PATIENT_____

PRIMARY CARE PHYSICIAN:_____ **REFERRED BY:**_____

PREFERRED PHARMACY NAME:_____ **PHONE #:**_____

PATIENT'S EMPLOYER INFORMATION:

COMPANY: _____ **OCCUPATION**_____

CITY: _____ **PHONE #:** _____

CAHABA PAIN AND SPINE CARE

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESPONSIBLE PARTY RELATIONSHIP TO THE PATIENT: (circle one) **SEX:** (circle one)

SELF SPOUSE CHILD OTHER FEMALE MALE

RESPONSIBLE PARTY NAME:

_____

LAST FIRST MIDDLE

ADDRESS:

_____

ZIP CODE: _____ **CITY:** _____ **STATE:** _____

DATE OF BIRTH: _____/_____/_____ **SEX:** (circle one) FEMALE MALE

HOME PHONE #: (_____) _____-_____ **WORK PHONE #:** (_____) _____-_____

SOCIAL SECURITY NUMBER: _____ - _____ - _____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION:

COMPANY:_____

CITY: _____**PHONE #:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:

_____

ADDRESS: _____ **PHONE:** _____

CONTRACT (ID#) NUMBER: _____ **SUBSCRIBER'S NAME:**_____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ **GROUP NUMBER:** _____

COPAYMENT AMOUNT: $ _____ **INSURED'S DATE OF BIRTH:** _____/_____/_____

CAHABA PAIN AND SPINE CARE

PATIENT NAME:_____**DATE OF BIRTH:**_____

SECONDARY INSURANCE COMPANY:_____

ADDRESS: _____ **PHONE:** _____

CONTRACT (ID#) NUMBER: _____ **SUBSCRIBER'S NAME:** _____

PATIENT RELATIONSHIP TO SUBSCRIBER (circle one): SELF SPOUSE CHILD OTHER

GROUP NAME: _____ **GROUP NUMBER:** _____

COPAYMENT AMOUNT: $ _____ **INSURED'S DATE OF BIRTH:**_____/_____/_____

WE APPRECIATE THE OPPORTUNITY TO SERVE YOU!

CAHABA PAIN AND SPINE CARE

ACCIDENT/INJURY & LITIGATION INFORMATION

IS YOUR CONDITION DUE TO:

- **WORK-RELATED INJURY OR ACCIDENT, WORKER'S COMPENSATION? ☐YES ☐NO**
- **AUTOMOBILE ACCIDENT OR OTHER ACCIDENT/INJURY? ☐YES ☐NO**

IF WORK-RELATED INJURY OR ACCIDENT, WORKER'S COMPENSATION, PROVIDE DETAILS BELOW:

DATE OF INJURY/ACCIDENT:_____

CASE MANAGER'S NAME _____ PHONE_____ FAX:_____

ADJUSTER'S NAME:_____ PHONE_____ FAX_____

WORKER'S COMPENSATION INSURANCE CO NAME:_____

CLAIM NUMBER:_____

PLEASE DESCRIBE THE DETAILS OF YOUR WORK RELATED INJURY OR ACCIDENT (WHAT HAPPENED?):

_____

IF AUTOMOBILE ACCIDENT OR OTHER ACCIDENT/INJURY, PROVIDE DETAILS BELOW:

DATE OF ACCIDENT_____

NAME OF AUTO INSURANCE COMPANY:_____

PHONE:_____ POLICY NUMBER:_____

PLEASE DESCRIBE THE DETAILS OF YOUR AUTO ACCIDENT OR OTHER ACCICENT?

IS LITIGATION (LAWSUIT) PENDING? ☐YES ☐NO

ATTORNEY'S NAME:_____

HOW DID YOU HEAR ABOUT CAHABA PAIN AND SPINE CARE (CHECK ALL THAT APPLY)**?**

- ❑ Referred by my doctor
- ❑ Google
- ❑ Facebook
- ❑ Friend
- ❑ Family
- ❑ Other_____

Clinic Policies

Consent to Treat and Authorization to Release Information to Payers

I hereby authorize treatment by **Cahaba Pain and Spine Care, LLC,** physicians and personnel. I authorize the release and disclosure of any or all of my medical and treatment records or reports to any other healthcare provider who may be of assistance, in the opinion of **Cahaba Pain and Spine Care, LLC,** and/or for assisting in any reimbursement or medical benefits to which the patient may be entitled. I allow fax transmittal of my medical records, if necessary. I further authorize and request that insurance payments be made directly to **Cahaba Pain and Spine Care, LLC**, should they elect to receive such payment. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Financial Agreement

I acknowledge full financial responsibility for services rendered by **Cahaba Pain and Spine Care, LLC** that my insurance/medicare product deems as patient responsibility or are non-covered by my insurance/medicare product. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I understand that my insurance policy is a contract between me and my insurance company. If my insurance company does not pay the practice within a reasonable period, or if my insurance plan determines a service to be "not covered," I will be responsible for the charges. I understand that payment of any deductible and coinsurance is required, based on Cahaba Pain's contract with my insurance company. I will be prepared to present my insurance card and proof of Identity (eg Driver's License) at each visit. I am will provide a change of address, phone number and/or insurance information any time a change occurs.

Medication History

I understand that my particular insurance/medicare product may allow the electronic medical record system used by **Cahaba Pain and Spine Care, LLC** to download my medication history. I understand that this medication history may be incomplete and that I am still responsible for accurately reporting my medications and dosage on the new patient clinical forms and at the new patient visit. I authorize the electronic transmission of my medication history to **Cahaba Pain and Spine Care, LLC** prior to or at the time of my visit.

Cancellation & No Show Policy

I acknowledge that I must provide a **24 hour notice of cancellation of an office visit appointment and/or a 48 hour notice of cancellation for any procedure appointment**. Failure to show for an office visit appointment without proper cancellation notice, will result in the accrual of a **No-Show Fee of $25** and failure to show for a procedure appointment, without proper cancellation notice, will result in the accrual of a **No-Show Fee of $100**.

Nurse Practitioner/Physician's Assistant and Other Providers Policy

I understand that Cahaba Pain and Spine Care employs nurse practitioners and physicians assistants for certain aspects of the practice that have been approved by the Alabama Board of Medical Examiners. I understand that I may be treated by a physicians assistant or nurse practitioner under the supervision of physicians who are employed by the practice. I also understand that Cahaba Pain and Spine may delegate other physicians and providers to care for me at my visit.

Communication Consent

I have provided **Cahaba Pain and Spine Care, LLC** with my contact phone number(s). I authorize **Cahaba Pain and Spine Care, LLC** to contact me via any contact phone number(s) provided, including text messaging, phone calls, voicemail messages and/or the **Cahaba Pain and Care, LLC** Patient Portal, if I have elected to participate.

Audio/Video Recording Policy

I acknowledge that it is the policy of **Cahaba Pain and Spine Care, LLC** that any and all audio or video recording is not allowed in any common spaces, exam rooms, or treatment rooms/areas. Exceptions will only be made with the prior express permission by one or both of the physicians or management and with a signed audio/video waiver. Failure to comply with this policy can result in patient dismissal from the Practice and further treatment at the Practice's discretion.

Walk-In Policy

I acknowledge that **Cahaba Pain and Spine Care** schedules patients by appointment only, and does not allow walk-in appointments. I agree to call for an appointment time before coming to the office. If I am experiencing a life-threatening emergency, I will call 911.

Late Policy

I agree to come to my office visits on time. If I am more than 15 minutes late for my appointment, I acknowledge that I may have to reschedule. Each rescheduled appointment represents a missed appointment without 24-hour notice and is subject to a **No-Show Fee of $25.**

Treatment of Staff

I understand that **Cahaba Pain and Spine Care** has a **Zero Tolerance policy for verbal abuse or threatening behavior towards our staff**. Swearing, yelling at, or threatening will result in termination from our clinic.

Disability, Life Insurance, FMLA, and other Forms

I acknowledge that it is at the discretion of the provider and/or physician to sign off, complete, and review certain types of forms. I acknowledge there may be an additional charge. I acknowledge that certain insurance companies may not cover these charges.

I HAVE READ AND UNDERSTAND THE ABOVE MENTIONED POLICIES SET FORTH BY **Cahaba Pain and Spine Care, LLC**

Signed_____
Date_____

I HAVE READ AND UNDERSTAND THE HIPAA/PRIVACY POLICY FOR **Cahaba Pain and Spine Care, LLC**

Signed_____
Date_____

CAHABA PAIN AND SPINE CARE

New Patient Clinical Forms

Welcome to Cahaba Pain and Spine Care. The following questionnaire is an important tool we use to evaluate your pain. Please read and fill out each item in this packet. Your physician will use this information to select the best treatments for you.

Patient Name:_____Date of Birth:_____

Your Physicians/Providers

Referring Physician_____

Primary Care Physician _____

Please list any of the below specialty physicians if evaluated or treated by them in the last 2 years.

Pain Physician_____

Spine Surgeon (Surgery or Orthopedics)_____

Psychiatrist/Psychologist_____

Rheumatologist_____

Orthopedics (other than spine)_____

Neurologist_____

Chiropractor: _____

Physiatrist/Rehabilitation Specialist_____

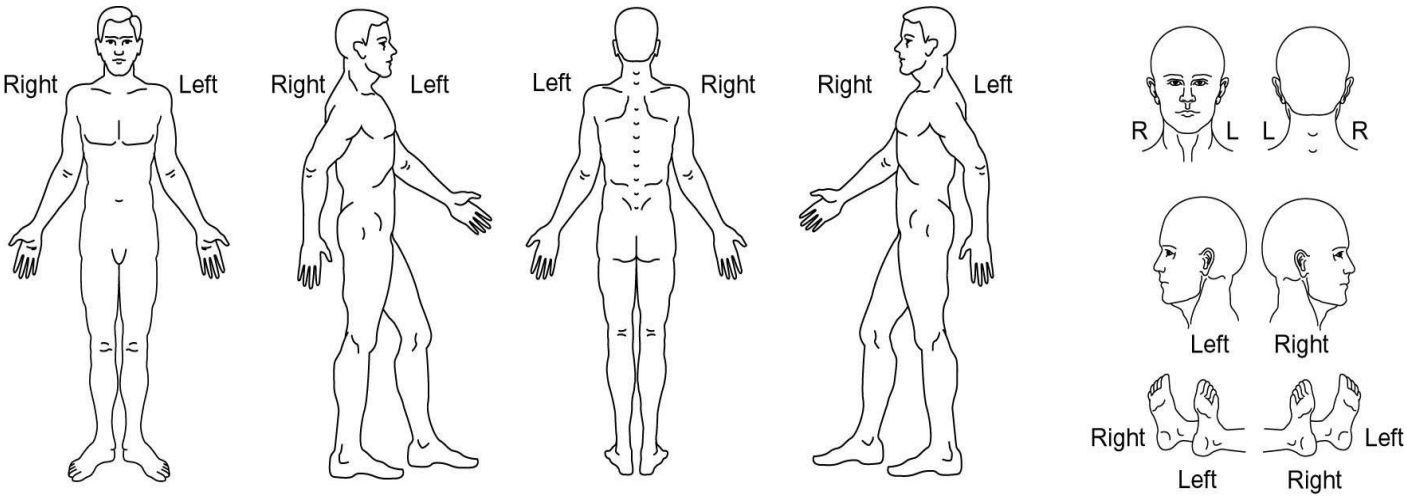
Hematologist/Oncologist_____

Gastroenterologist _____

Cardiologist_____

Patient Name:_____Date of Birth:_____

Circle or shade in your areas of pain:



What painful areas are you seeking treatment for?

□ Lower Back □ Mid Back □ Neck □ Knee (R, L, or both) □ Hip (R, L, or both) □ Shoulder

Other_____

When did the pain start/date?_____

How did the Pain Start? (Check all that apply)

- ❑ Just Started by Itself
- ❑ Suddenly
- ❑ Gradually
- ❑ Lifting
- ❑ Twisting
- ❑ Bending
- ❑ Pulling
- ❑ At Work
- ❑ Motor Vehicle Accident
- ❑ Following Surgery
- ❑ Fall
- ❑ Sports Injury
- ❑ Direct Blow to the Spine
- ❑ Other Reason (specify):_____

How would you rate your pain? (0= No Pain, 10= The Worst Pain Imaginable)

Pain today	0	1	2	3	4	5	6	7	8	9	10
Pain most days	0	1	2	3	4	5	6	7	8	9	10
Lowest pain last 7 days	0	1	2	3	4	5	6	7	8	9	10
Worst Pain last 7 days	0	1	2	3	4	5	6	7	8	9	10

How would you describe your pain? (check all that apply)

- ❑ Sharp
- ❑ Burning
- ❑ Electricity
- ❑ Shooting
- ❑ Stabbing
- ❑ Throbbing
- ❑ Cramping
- ❑ Crushing
- ❑ Dull
- ❑ Aching
- ❑ Sore
- ❑ Heavy
- ❑ Sickening
- ❑ Terrifying
- ❑ Punishing
- ❑ Numb
- ❑ Tingling
- ❑ Penetrating
- ❑ Tight,
- ❑ Squeezing
- ❑ Cold
- ❑ Nauseating
- ❑ Dreadful
- ❑ Agonizing

Does your pain radiate into arms or legs? Yes No

When does your pain occur (check all that apply)? ☐Constant ☐ Intermittent ☐ Worse at night

☐ Worse at daytime ☐ Episodes lasting how long?_____

What WORSENS your pain (check all that apply)?

- ❑ Sitting
- ❑ Standing
- ❑ Lifting
- ❑ Pulling
- ❑ Walking
- ❑ Running
- ❑ Twisting
- ❑ Bending forward
- ❑ Bending Backwards
- ❑ Using Arms
- ❑ Coughing/Sneezing
- ❑ Bowel Movement
- ❑ No apparent reason

What IMPROVES your pain? (check all that apply.)

☐ Rest ☐ Medication ☐ Injections ☐ Sitting ☐ Lying down ☐Prayer

☐ Other (describe):_____

Does your pain awaken you at night? ☐YES ☐NO If Yes, can you go back to sleep? ☐YES ☐NO

How many hours do you sleep on average at night? 3/4/5/6/7/8/9/10/11/12

Do you take medicine to help you sleep? ☐YES ☐NO

Do you have trouble controlling your bladder or bowels? ☐YES ☐NO

What other symptoms do you experience with your pain? (Check all that apply.)

- ❑ Weakness in the arms ☐ Right ☐ Left ☐ Both
- ❑ Weakness in the legs ☐ Right ☐ Left ☐ Both
- ❑ Hypersensitive skin
- ❑ Headache
- ❑ Fatigue
- ❑ Nausea/Vomiting
- ❑ Other_____

Do you have cramping, fatigue, or tightness in your legs with walking, that is relieved by rest? ☐YES ☐NO

How has pain impacted your life? (Check all that apply.)

- ❑ I rarely experience pain, and I'm never limited by it.
- ❑ Pain is a regular annoyance, but it doesn't limit my activity.
- ❑ I am able to do the things I need to, but pain limits my doing the things I want to do.
- ❑ Pain limits my ability to do mild housework.
- ❑ Pain keeps me from taking care of my daily needs.

Previous Treatments

Have you tried any of the therapies below? If so were they helpful? When did you try them?

Therapy	**Was it helpful?**	**% Relief (10/20/30/40/50/60/70/80/90/100)**	**When?**
❑ Surgery	☐YES ☐NO		
❑ Physical therapy	☐YES ☐NO		
❑ TENS unit	☐YES ☐NO		
❑ RF Nerve Ablation	☐YES ☐NO		
❑ Epidural injections	☐YES ☐NO		
❑ Other injections/blocks	☐YES ☐NO		
❑ Chiropractic therapy	☐YES ☐NO		
❑ Acupuncture	☐YES ☐NO		
❑ Psychotherapy	☐YES ☐NO		
❑ Biofeedback	☐YES ☐NO		
❑ Prayer	☐YES ☐NO		
❑ Bracing/Splints	☐YES ☐NO		
❑ Spinal Cord Stimulation	☐YES ☐NO		

Have you had any of the following diagnostic tests in the last 2 years for your pain? If so, when and where?

Diagnostic Test	**When?**	**Where?**
❑ MRI		
❑ CT Scan		
❑ Xray		
❑ EMG/Nerve Conduction		
❑ Bone Scan		
❑ Other_____		

Medications tried previously (Please indicate if you have taken any of the below medications and their benefit)

Medication	Helpful	Somewhat Helpful	Not Helpful
❑ Acetaminophen (Tylenol®)	☐	☐	☐
❑ Amitriptylene (Elavil)	☐	☐	☐
❑ Baclofen	☐	☐	☐
❑ Belbuca	☐	☐	☐
❑ Buprenorphine (Suboxone®)	☐	☐	☐
❑ Butalbital (Fioricet)	☐	☐	☐
❑ Butorphanol (Stadol)	☐	☐	☐
❑ Butrans	☐	☐	☐
❑ Capsaicin	☐	☐	☐
❑ Carbamazepine (Tegretol)	☐	☐	☐
❑ Carisoprodol (Soma)	☐	☐	☐
❑ Celecoxib (Celebrex)	☐	☐	☐
❑ Chlorzoxazone (Parafon Forte, Lorzone)	☐	☐	☐
❑ Codeine (Tylenol #3, #4)	☐	☐	☐
❑ Cyclobenzaprine (Flexeril, Amrix)	☐	☐	☐
❑ Diclofenac (Arthrotec®)	☐	☐	☐
❑ Divalproex Sodium (Depakote)	☐	☐	☐
❑ Duloxetine (Cymbalta®)	☐	☐	☐
❑ Etodolac (Lodine)	☐	☐	☐
❑ Fentanyl (Duragesic)	☐	☐	☐
❑ Gabapentin (Neurontin®, Gralise®, Horizant)	☐	☐	☐
❑ Hydrocodone (Lortab, Norco)	☐	☐	☐
❑ Hydromorphone (Dilaudid)	☐	☐	☐
❑ Ibuprofen (Advil®)	☐	☐	☐
❑ Indomethacin (Indocin)	☐	☐	☐
❑ Ketorolac (Toradol)	☐	☐	☐
❑ Lidocaine Topical (Lidoderm, ZT Lido)	☐	☐	☐
❑ Meloxicam (Mobic®)	☐	☐	☐
❑ Meperidine (Demerol)	☐	☐	☐
❑ Metaxolone (Skelaxin)	☐	☐	☐
❑ Methadone	☐	☐	☐
❑ Methocarbamol (Robaxin)	☐	☐	☐
❑ Morphine (MS Contin, Kadian®)	☐	☐	☐
❑ Nabumetone (Relafen)	☐	☐	☐
❑ Naproxen (Aleve®)	☐	☐	☐
❑ Naproxen Topical (Flector, Pennsaid)	☐	☐	☐
❑ Notriptylene (Pamelor)	☐	☐	☐
❑ Orphenadrine (Norflex)	☐	☐	☐
❑ Oxycodone (Oxycontin®,Percocet®)	☐	☐	☐
❑ Oxymorphone (Opana)	☐	☐	☐

Medication	Helpful	Somewhat Helpful	Not Helpful
❑ Pentazocine (Talwin)	☐	☐	☐
❑ Pregabalin (Lyrica®)	☐	☐	☐
❑ Tapentadol (Nucynta)	☐	☐	☐
❑ Tizanidine (Zanaflex)	☐	☐	☐
❑ Topirimate (Topamax®)	☐	☐	☐
❑ Tramadol (Ultram®)	☐	☐	☐
❑ Venlafaxine (Effexor)	☐	☐	☐

Medications

Please list all medications you are currently taking. Include dose and number of times taken per day.

_____
_____
_____
_____
_____
_____

If you are taking opioid pain medications, do you have constipation? ☐YES ☐NO

Allergies ☐ I have no known drug or medication allergies

Please list any **drugs or medications** that you are allergic to and include the reaction you have to each.

Are you allergic to any of the following? (Check all that apply.)

☐ Betadine/Iodine ☐ IV Contrast Dye ☐ Eggs ☐ Latex ☐ Adhesives or tape

Review of systems (Have you had any of these in the last 30 days? Check all that apply)

Constitutional

☐ Excess weight loss/gain ☐ Fever ☐ Fatigue ☐ Loss of appetite

☐ Other_____

Head Ears Eyes Nose Throat (HEENT)

☐ Recent head trauma ☐ Vision changes ☐ Dry Eyes ☐ Hearing loss

☐ Ear lesions ☐ Nose lesions ☐ Mouth lesions ☐ Sore throat ☐ Difficulty swallowing

☐ Other_____

Cardiovascular

☐ Fainting (syncope) ☐ Chest pain ☐ Palpitations

☐ Other_____

Pulmonary

☐ Cough ☐ Shortness of Breath ☐ Coughing up blood ☐ Pain with deep breaths

☐ Other_____

Gastrointestinal

☐ Abdominal pain ☐ Nausea/Vomiting ☐ Constipation ☐ Blood in stool ☐ Diarrhea

☐ Other_____

Genitourinary

☐ Pain with urination ☐ Blood in urine ☐ Genital pain ☐ Bladder spasms ☐ Incontinence

☐ Other_____

Musculoskeletal

☐ Joint pain ☐ Soft tissue swelling ☐ Joint swelling ☐ Recent trauma

☐ Other_____

Skin

☐ Rash ☐ Skin lesions ☐ Skin sensitivity ☐ Healing wounds

☐ Other_____

Neurologic

☐ Weakness ☐ Numbness ☐ Tingling ☐ Headache ☐ Loss of Consciousness

☐ Balance problems ☐ Falls ☐ Other_____

Psychiatric

☐ Depression ☐ Anxiety ☐ Suicidal thoughts ☐ Homicidal thoughts ☐ Poor sleep

☐ Other_____

Endocrine

☐ Heat intolerance ☐ Cold Intolerance ☐ Increased thirst

☐ Other_____

Past Medical History (Please indicate if you have been diagnosed with or treated for any of the following.)

Spine ☐ Degenerative disc disease ☐ Spinal stenosis ☐ Herniated disc ☐ Discitis
☐ Sacroiliac joint pain ☐ Facet syndrome ☐ Postlaminectomy syndrome
☐ Other_____

Neurologic ☐ Seizure ☐ Stroke ☐ Brain mass/tumor ☐ Migraines
☐ Neuropathy ☐ MS ☐ Hearing or vision loss ☐ Muscle problems
☐ Other_____

Psychiatric ☐ Depression ☐ Bipolar disorder ☐ Suicidal thoughts/attempts ☐ Schizophrenia
☐ Anxiety ☐ Post-traumatic Stress Disorder ☐ Panic Disorder
☐ Other_____

Cardiac ☐ Chest pain ☐ Heart attack ☐ Abnormal heart rhythm ☐ Valve disease
☐ Heart failure ☐ Pacemaker or AICD implantation ☐ High Blood Pressure/ Hypertension
☐ Other_____

Pulmonary ☐ Asthma ☐ COPD ☐ Lung cancer ☐ Chronic bronchitis
☐ Pneumonia ☐ Sarcoidosis ☐ Tuberculosis
☐ Other_____

Abdominal ☐ Liver disease ☐ Cirrhosis ☐ Hepatitis ☐ Ulcers/GI bleed
☐ Pancreatitis ☐ Diverticulitis ☐ Appendicitis ☐ Crohn's disease
☐ Ulcerative Colitis ☐ Colon cancer ☐ Gallbladder disease
☐ Other_____

Urinary ☐ Kidney disease/failure ☐ Renal cancer ☐ Kidney failure ☐ Bladder cancer
☐ Interstitial cystitis ☐ Kidney stones ☐ Other_____

Endocrine ☐ Hypothyrodism ☐ Hyperthyroidism ☐ Diabetes (Non-insulin dependent)
☐ Diabetes (requiring insulin) ☐ Thyroid cancer ☐ Adrenal tumors
☐ Low testosterone ☐ Other_____

Musculoskeletal ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Gout ☐ Fibromyalgia
☐ Myopathy ☐ Avascular Necrosis ☐ Osteomyelitis
☐ Other_____

Hematologic ☐ Anemia ☐ Low Platelets ☐ Sickle Cell Anemia ☐ Blood clot or DVT

☐ Hypercoagulable state (blood clots abnormally well) ☐ Hemophilia ☐ Lupus

☐ Leukemia/Lymphoma ☐ Bleeding Disorder

☐ Other_____

Immunologic: ☐ Cancer (type):

☐ HIV or AIDs

Skin ☐ MRSA infection ☐ Cellulitis ☐ Foot ulcers ☐ Infected surgical wound

☐ Skin cancer (e.g. melanoma, squamous cell carcinoma, basal cell carcinoma)

Reproductive ☐ Infertility ☐ Cancer of reproductive organs ☐ Impotence ☐ Loss of sex drive

ENT ☐ Obstructive sleep apnea ☐ Chronic sinusitis ☐ Oral or throat cancer

Have you ever been hospitalized for psychiatric reasons? ☐YES ☐NO

If Yes, please explain._____

Surgical History (Please list surgery and approximate year it was done.)

What surgeries have you had related to your pain?_____

_____

Please list all other surgeries you have had._____

_____

_____

Family History (Please limit to your parents, siblings, or children)

Do any family members suffer from the following conditions? If so, who?

☐ Autoimmune disease (Rheumatoid arthritis, Lupus)_____

☐ Substance abuse (Alcoholism, Opiate/heroin addiction)_____

☐ Bleeding disorders_____

☐ Heart disease (e.g. heart attack, vascular disease)_____

Social History

	Yes	No	If so, how much/how often?
Do you drink alcohol?	☐	☐	Never/ Daily / Less than once a week / Several Times per Week/ Once a Week/ I am a Heavy Drinker
Do you smoke?	☐	☐	Packs per day: (1/4, ½, 1, 2, 2+)
	☐	I quit	When?_____

Have you ever been treated for drug or alcohol abuse? ☐YES ☐NO

Have you ever used illicit drugs? ☐YES ☐NO If yes, what drug and when was last use?_____

_____

Have you had any legal problems related to drugs, alcohol, or prescription medication? ☐YES ☐NO

If Yes, please explain._____

What is your current work status? ☐ Employed ☐ Unemployed ☐ Retired

☐ Disabled ☐ Homemaker ☐ Student ☐ Self-employed

If you are currently working, what is your occupation/Job Title?_ _____

If you are not working, is it due to your initial onset of pain/injury or a new pain/injury? ☐YES ☐NO

Any pending litigation associated with your pain? (check)

- ❑ Worker's Compensation
- ❑ Personal Injury
- ❑ Other
- ❑ None

Have you applied for disability? ☐YES ☐NO

Are you currently… ☐ Married ☐ Single ☐ Divorced ☐ Separated

With whom do you live? (indicate more than one if appropriate)

☐ Spouse ☐ Children ☐ Alone ☐ Friends/other family

☐ Assisted living facility ☐ Other_____

Recent Major Changes/ Stressors (check all that apply):

- ❑ Loss of loved one
- ❑ Financial Change
- ❑ Family Changes
- ❑ Sleep disturbance
- ❑ Divorce

Have you ever been the victim of the following? ☐YES ☐NO

☐ Sexual abuse ☐ Domestic abuse ☐ Other_____

If so, are you in need of any counseling services or social work related to the above? ☐YES ☐NO

Have you ever been dismissed from a medical practice or had your pain medication stopped by a physician?

☐YES ☐NO If Yes, please explain._____

What are your goals/expectations from your pain Management Program? Check all that apply

- ❑ Pain Reduction % (40/50/60/70/80/90)
- ❑ Pain Relief
- ❑ Return to Work
- ❑ Increase Work Hours
- ❑ Increase in activities of daily living
- ❑ Increase in hobbies/ physical activity
- ❑ Reduce use of pain medications
- ❑ Other_____

For Females Only: Gynecologic History:

Last Menstrual Period?

Could you be Pregnant? ☐YES ☐NO

Birth Control Method:_____

CAHABA PAIN AND SPINE CARE

OTHER DOCTORS' RECORDS ☐ SEND TO CAHABA PAIN AND SPINE CARE

Authorization to Disclose Health Information

Patient Name: _____ Social Security Number:_____

1. I authorize _____to disclose
(*Physician and/or Practice name you are coming FROM*)
the above named individual's health information as described below.

2. This information may be disclosed to and used by the following individual or organization:

Name: Cahaba Pain and Spine Care, LLC

Address: 2010 Patton Chapel Road, Suite 200 Birmingham, AL 35216

Office phone: (205)-208-9001 Office fax: (205)-208-0031

For the purpose: Medical evaluation and/or treatment

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

☐ Office Visit Notes_____ ☐ Patient Account Statement/Billing Records

☐ Medication list ☐ Procedure Notes_____

☐ List of allergies

☐

☐ Most recent history and physical

☐ Most recent discharge summary

☐ Laboratory results From (date) _____ to (date) _____

☐ X-ray and imaging reports From (date) _____ to (date) _____

☐ Consultation reports From (doctors' names) _____

☐ Entire record

☐ Other:_____

_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to our Privacy/Security Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: .

_____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact the Privacy/Security Officer.

Signature of Patient or Legal Representative	Date
If signed by Legal Representative, Relationship to Patient	Signature of Witness