Innovative Pain & Spine Specialists

Today's Date:_____
Location of Care: Lincoln

Patient's Personal Information

Name:_____ Preferred Name:_____
Date of Birth: _____/_____/_____ SSN:_____
Address: _____
City: _____ State: _____ ZIP Code:_____
Home Phone: _____ Cell Phone: _____ Work Phone:_____
Email Address: _____
Preferred Method of Contact: Cell___ Home ___ Work ___ Email ___ **Preferred Language**: _____
Gender: Male ____ Female ____ **Marital Status:** Single ____ Married ____ Divorced ____ Widowed____
Race: American Indian ____ Asian ____ Black/African American ____ Native Hawaiian/Pacific Islander ____
White ____ Decline to Specify ____
Ethnicity: Hispanic or Latino ____ Non-Hispanic or Latino ____ Decline to Specify ____
Emergency Contact: _____ **Relationship:** _____
Emergency Contact Phone:_____
Does this contact have access to your medical information? Yes ____ No ____

Any other person you wish to have access to your medical information.

Name: _____ Relationship: _____ Phone: _____

Insurance Information

Primary Insurance: _____
Subscriber: _____ DOB: _____
Relationship to Patient: _____ ID #: _____ Group: _____
Secondary Insurance: _____
Subscriber: _____ DOB: _____
Relationship to Patient: _____ ID #: _____ Group:_____

PCP/Referring Provider/Other Info

Referring Provider: _____ Primary Care Provider: _____
Pharmacy & Location: _____

Please provide the front desk with and ID and all insurance, Worker's Compensation, motor vehicle accident, or attorney information

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MEDICATION CONTRACT

The following outline is a medication contract between the patient and Innovative Pain and Spine Specialists (IPSS) concerning the usage of opioid analgesics. Examples of opioid analgesics include: hydrocodone, oxycodone, fentanyl, and morphine. Opioid analgesics may not completely relieve pain symptoms. If the providers of IPSS feel that you are not responding to the therapy by showing substantial improvement in function, your medications will be tapered. **The following statements are relevant concerning opioid analgesics:**

1. There are risks associated with chronic opioid therapy including, but not limited to: constipation, itching, addiction, physical dependence, sexual dysfunction, nausea, vomiting, drowsiness, and overdose resulting in death.

2. IPSS recommends that **ALL** patients on chronic opioids not participate in the operation of motor vehicles or machinery. If the patient chooses to engage in these activities, IPSS bears no responsibility for the outcome of such events.

3. The patient will use only **ONE PHARMACY** and will notify us with the name of the chosen pharmacy.

4. Unannounced urine drug screenings will happen during the course of treatment and you are expected to comply. Positive results of illicit drugs, excessive alcohol, or negative results of a prescribed drug may result in termination from the clinic. If you are unable to provide us a urine sample, we have salivary test kits available.

5. Additionally, random pill counts may be requested. This would require you to bring in your pill bottles within 24 hours of notification by the clinic to monitor for compliance.

6. In addition, opioid analgesics will **NOT** be prescribed on your initial visit because an acceptable urine screen and review of pharmacy records must occur prior to starting these medications.

7. Our clinic must be notified at least **THREE BUSINESS DAYS** prior to the anticipated refill date(s).

8. You will only call **once** per refill request.

9. Lost or stolen medications **WILL NOT** be replaced for **ANY REASON**, including partial refills. In addition, refills will not be given for any reason after-hours or on weekends.

10. Early refills will only be given if authorized by a provider and may require a follow up visit prior to refill.

11. Patients will not seek opioid analgesics from any other physicians for the treatment of their chronic condition(s). This policy in no way prevents a patient from seeking acute care for acute problems. If patients receive opioids for an acute pain condition from another provider, they must notify our clinic who prescribed them, what they prescribed, how many they prescribed, and the reason for such.

12. By signing this contract, you are giving your medical provider permission to speak to family or members of your household about your medication usage and activity if the provider has reason to believe that medications are not being used appropriately or are not working.

The patient acknowledges that he/she has read this contract and agrees to abide by its regulations.

PATIENT SIGNATURE:_____**D.O.B.:**_____

PRINT NAME:_____ **DATE:**_____

IPSS EMPLOYEE WITNESS:_____

CLINIC POLICIES

***PLEASE INITIAL EACH LINE TO INDICATE AGREEMENT

- PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. I UNDERSTAND THAT IF I HAVE INSURANCE THAT I AM THE RESPONSIBLE PARTY AND THAT HAVING INSURANCE DOES NOT GUARANTEE PAYMENT OF THE SERVICES RENDERED TO ME. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND FULLY THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE, OR ANY COLLECTION FEES, OR INTEREST ACQUIRED.

  X _____

- IF YOU ARE UNABLE TO MAKE AN APPOINTMENT, PLEASE CALL 24 HOURS PRIOR TO YOUR APPOINTMENT TIME TO RESCHEDULE**. IF YOU FAIL TO NOTIFY OUR OFFICE PRIOR TO MISSING YOUR SCHEDULED APPOINTMENT, YOU WILL BE CHARGED A 'NO SHOW' FEE OF $25 FOR AN OFFICE VISIT AND $50 FOR A PROCEDURE. **FREQUENT 'NO SHOWS' MAY RESULT IN A RELEASE FROM THE PRACTICE.**

  X _____

- PERMISSION FOR TREATMENT: I HEREBY AUTHORIZE PHYSICIANS AND ASSISTANTS FOR THE CARE OF THE PATIENT NAMED ON THIS RECORD TO ADMINISTER TREATMENT AS MAY BE DEEMED NECESSARY, INCLUDING EXAMINATIONS OR TREATMENTS THAT MAY BE ORDERED TO BE PERFORMED BY THE CLINICAL PERSONNEL. I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE OF THE RESULTS OF EXAMINATIONS OR TREATMENTS TO BE PERFORMED.

  X _____

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES (HIPPA)

I HAVE READ AND REVIEWED THIS OFFICE'S NOTICE OF PRIVACY PRACTICES (LOCATED AT THE FRONT DESK), WHICH EXPLAINS HOW MY MEDICAL INFORMATION WILL BE USED AND DISCLOSED. I UNDERSTAND THAT I AM ENTITLED TO RECEIVE A COPY OF THIS DOCUMENT.

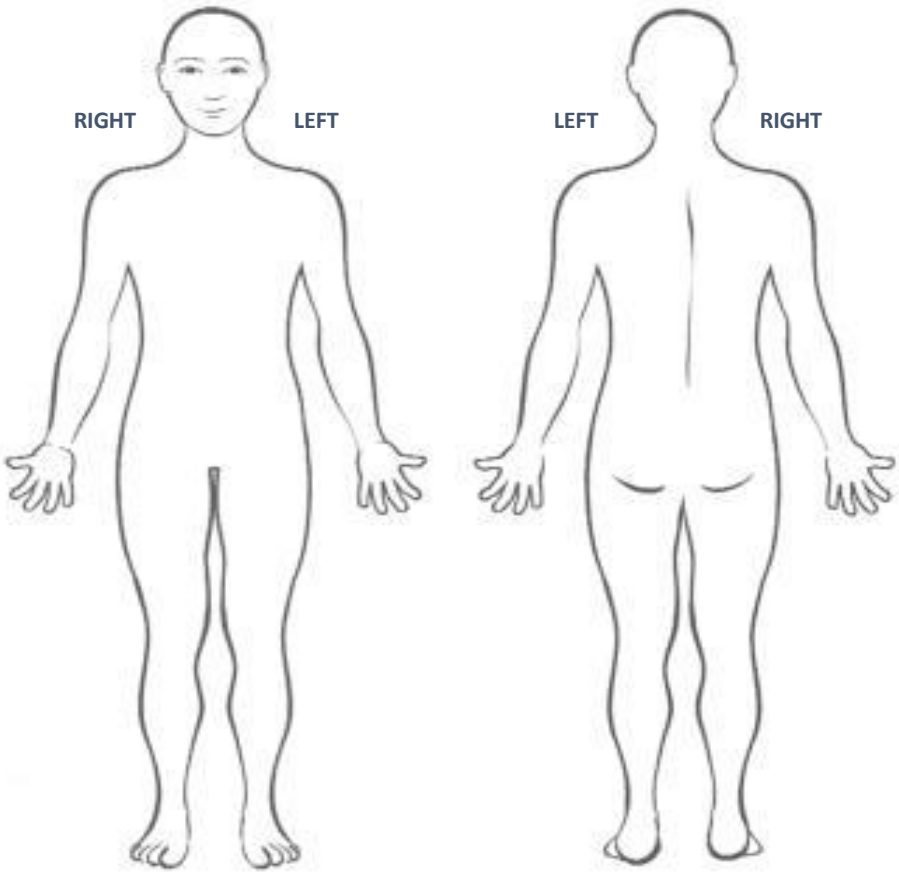
PATIENT SIGNATURE: ______ **DATE:**_____

IPSS EMPLOYEE WITNESS_____

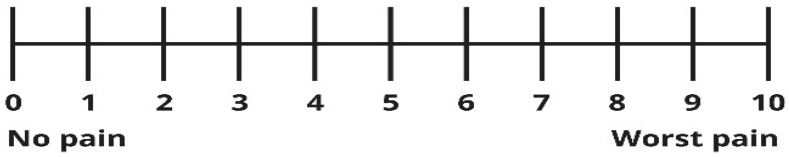
Patient Name: _____

LOCATION OF PAIN

PLEASE SHADE IN THE AREA OF PAIN THAT YOU ARE BEING TREATED FOR TODAY:



ON A SCALE OF 0 TO 10, HOW WOULD YOU RATE YOUR PAIN **TODAY?** (0=NO PAIN, 10=SEVERE PAIN)



DO YOU TAKE ANY BLOOD THINNING MEDICATIONS? ☐ YES ☐ NO

IF YES, WHAT IS THE NAME OF THE MEDICATION?_____

PLEASE LIST THE PHYSICIAN WHO MANAGES YOUR BLOOD THINNER: _____

ABOUT YOUR HEALTH

IN THE PAST FEW MONTHS, HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DIFFICULTIES? IF SO, PLEASE ADD FURTHER EXPLANATION IN THE ADDITIONAL NOTES SECTION. **PLEASE CIRCLE ANY & ALL THAT APPLY:**

GENERAL:
LOSS OF APPETITE
FEVER
CHILLS
RECENT WEIGHT LOSS
LOW ENERGY/FATIGUE

EYES:
BLURRED VISION
LOSS OF VISION
DOUBLE VISION
EYE PAIN

HEAD/EARS/NOSE/THROAT:
HOARSENESS
TROUBLE SWALLOWING
HEARING LOSS
EAR PAIN

CARDIOVASCULAR:
CHEST PAIN
LEG SWELLING
VARICOSE VEINS
PALPITATIONS
SHORTNESS OF BREATH (WHILE LYING FLAT)

RESPIRATORY:
WHEEZING
CHRONIC COUGH
SHORTNESS OF BREATH

GASTROINTESTINAL:
NAUSEA OR VOMITING
BLOOD IN STOOL
CHANGE IN BOWEL HABITS
HEARTBURN
CONSTIPATION
HEMORRHOIDS

KIDNEY/BLADDER/URINE:
PAINFUL URINATION
FREQUENT URINATION
BLOOD IN URINE
CHANGE IN URINARY PATTERN

MUSCLES & JOINTS:
SIGNIFICANT PAIN/STIFFNESS

SKIN:
RASH
FREQUENT RASHES
ITCHING

NEUROLOGICAL:
TREMOR
SEIZURES
DIZZINESS
TINGLING/NUMBNESS

PSYCHIATRIC:
DEPRESSION
DRUG/ALCOHOL ADDICTION
DIFFICULTY WITH SEXUAL ACTIVITIES
SUICIDAL THOUGHTS
TROUBLE SLEEPING (INSOMNIA)

ENDOCRINE:
THYROID DISEASE
HEAT/COLD INTOLERANCE

HEMATOLOGIC/LYMPHATIC:
EASY BRUISING
EASY BLEEDING

IMMUNOLOGIC:
ENLARGED/SWOLLEN LYMPH GLANDS

ADDITIONAL NOTES:

_____

_____

PAST MEDICAL HISTORY

PLEASE INDICATE IF YOU HAVE SUFFERED ANY OF THE FOLLOWING MEDICAL CONDITIONS. **PLEASE CIRCLE ALL THAT APPLY:**

AIDS OR HIV
ANXIETY
AUTOIMMUNE DISORDER
OSTEOARTHRITIS
ASTHMA
BIPOLAR DISORDER
CANCER
CHRONIC SKIN DISEASE
COPD
DEPRESSION
DIABETES
FIBROMYALGIA
GOUT
HEADACHES/MIGRAINES
HEART DISEASE
HEART FAILURE
HEPATITIS
HIGH BLOOD PRESSURE
HIGH CHOLESTEROL
HYPOTHYROIDISM
HYPERTHYROIDISM
KIDNEY DISEASE
KIDNEY STONES
LIVER DISEASE
MRSA INFECTION
MULTIPLE SCLEROSIS
PARKINSONS DISEASE
PEPTIC ULCER DISEASE
PERIPHERAL VASCULAR DISEASE
PROSTATE ENLARGEMENT
RHEUMATOID ARTHRITIS
SEIZURE DISORDER
SHINGLES/HERPES ZOSTER
STROKE
VENEREAL DISEASE/STDs
OTHER: _____

PRIOR SURGERIES:

_____

_____

_____

IMMEDIATE (PARENTS/SIBLINGS/CHILDREN) **FAMILY MEDICAL HISTORY:**

_____

_____

_____

ALLERGIES: NO KNOWN ALLERGIES LATEX IODINE CONTRAST DYE ADHESIVE/BANDAGES
OTHER:_____

_____

_____

SOCIAL HISTORY:

DO YOU USE NICOTINE PRODUCTS? _____

IF SO, HOW MUCH PER DAY? **(PACK /CAN /CIGAR /GUM /PATCH/E-CIGARETTE):** _____

DO YOU DRINK ALCOHOL? _____ IF SO, HOW OFTEN? _____
DO YOU USE OTHER RECREATIONAL OR STREET DRUGS? _____
IF YES, PLEASE LIST:_____

EMPLOYER AND OCCUPATION: _____
ARE YOU WORKING WITH ANY RESTRICTIONS? IF SO, PLEASE SPECIFY: _____
_____

MUSCLE & JOINT PAIN EVALUATION

LOCATION(S) OF PAIN:_____
WHEN DID THE PAIN START (MONTH/DAY/YEAR)? _____
HOW DID YOUR PAIN BEGIN (ACCIDENT/FALL/NOTHING/ETC.)? _____

PLEASE CIRCLE YOUR PAIN CHARACTERISTICS:

CONSTANT	SUPERFICIAL	NUMBNESS	BURNING	ACHING
INTERMITTENT	DEEP	PINS/NEEDLES	PRESSURED	STABBING

PLEASE CIRCLE WHAT AGGRAVATES YOUR PAIN:

SITTING	WALKING	COUGHING/SNEEZING
STANDING	WALKING STAIRS	OTHER: _____
BENDING	POSITION CHANGES	
LEANING FORWARD	HEAT	
LEANING BACK	COLD	

PLEASE CIRCLE WHAT RELIEVES YOUR PAIN:

SITTING	WALKING	MEDICATION
STANDING	WALKING STAIRS	STRETCHING
BENDING	POSITION CHANGES	OTHER: _____
LEANING FORWARD	HEAT	
LEANING BACK	COLD	

CURRENT MEDICATIONS (PLEASE LIST OR PROVIDE PERSONAL LIST)

NAME	STRENGTH/DOSE	HOW OFTEN TAKEN

COMPLETE THIS SECTION IF YOU ARE BEING SEEN FOR MIGRAINES/HEADACHES ONLY*:*

HEADACHE LOCATION:_____ PAIN DESCRIPTION:_____
ASSOCIATED SYMPTOMS:_____
FREQUENCY (HOW OFTEN: _____DURATION (HOW LONG): _____
HEADACHE TRIGGERS: _____
CURRENT HEADACHE MEDICATIONS (PRESCRIBED OR OVER THE COUNTER): _____
_____
PLEASE LIST ALL PREVIOUSLY TRIED HEADACHE MEDICATIONS: _____
_____

PAST PAIN TREATMENT

☐ **PHYSICAL THERAPY:**

WHEN/OFFICE: _____DURATION: _____WAS IT HELPFUL? **Y** OR **N**

☐ **AQUATIC THERAPY:**

WHEN/OFFICE: _____DURATION: _____ WAS IT HELPFUL? **Y** OR **N**

☐ **CHIROPRACTIC CARE:**

WHEN/OFFICE: _____DURATION: _____ WAS IT HELPFUL? **Y** OR **N**

OTHER TREATMENTS:

BRACE TENS UNIT ACUPUNCTURE PSYCHOLOGICAL COUNSELING BIOFEEDBACK

PLEASE LIST ANY **INJECTIONS OR SURGERIES** YOU'VE HAD FOR THIS PAIN, INCLUDING WHAT KIND, HOW MANY, WHEN, AND IF RELIEF WAS FOUND:

_____
_____
_____
_____

PLEASE CIRCLE ANY MEDICATIONS THAT YOU HAVE TRIED FOR THIS PAIN:

GABAPENTIN/NEURONTIN
PREGABALIN/LYRICA
TOPIRAMATE/TOPAMAX

DULOXETINE/CYMBALTA
VENLAFAXINE/EFFEXOR

CYCLOBENZAPRINE/FLEXERIL
TIZANIDINE/ZANAFLEX

TRAMADOL
HYDROCODONE
OXYCODONE

NUCYNTA
MORPHINE
BUTRANS
BELBUCA
FENTANYL
DILAUDID

NSAIDS (IBUPROFEN, ALEVE/NAPROXEN, ETC.)
TYLENOL/ACETAMINOPHEN

OTHERS:_____
_____
_____

WERE THEY HELPFUL?:
_____