0219

Global Institute of Spine and Joint Care

Today's Date_____

Patient's Name_____DOB_____

Street Address_____ Apt. No._____

City / State / Zip Code_____

Home Phone#_____ Work/Cell Phone#_____

☐ Leave message on Voice Mail

Social Security # _____ DL#_____ State_____

Sex: _Female _Male Marital Status: _Single _ Married _Divorced Widowed

Spouse's Name _____ Spouse's Telephone#_____

Your Employer_____

Employer's Address_____

City / State / Zip Code_____

Employer's Phone#_____ Position_____

Emergency Contact_____ Relationship_____

Home Phone#_____ Work Phone#_____

Primary Care Physician _____ Office Phone#_____

Referred By _____ Office Phone#_____

Reason for Appointment_____

Global Institute of Spine and Joint Care

PAIN PATIENT QUESTIONNAIRE

1. What is the main complaint for which you are seeking treatment?

_____

_____

_____

2. How long have you had the pain problem you are currently experiencing?

_____

3. How did your current pain start?

_____

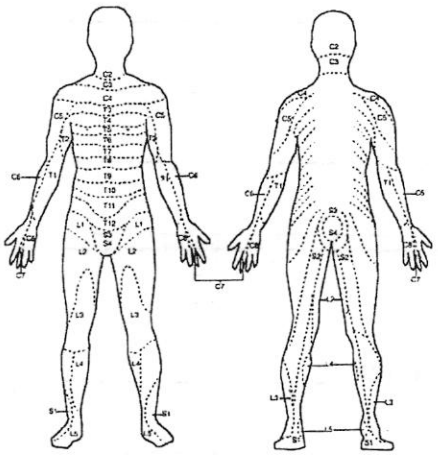
_____

4. Have any other Health Care Professionals and/or Specialist been involved in the evaluation and treatment of your current pain? (Please specify)

_____

_____

Please mark the areas of your pain in the diagram below:



5. Please list all medications you have tried for your **current pain problem.**

_____

_____

_____

6. Please check all of the treatments you have tried for your pain from the list below, and complete the appropriate columns at the right.

TREATMENT	DATES	RESULTS
__Hospital Bed Rest	_____	_____
__Traction	_____	_____
__Surgery	_____	_____
__Acupuncture	_____	_____
__TENS(Electrical Stimulator)	_____	_____
__Physical Therapy	_____	_____
__Chiropractor	_____	_____
__Epidural, Nerve Block, Neuroforamen Inj	_____	_____
__Exercise: Structured Program, Yoga, Tai Chi, Self Gym, Pilates, walking		_____
__Other- Specify or circle: Therapeutic massage, aquatic therapy, etc.		_____

7. How often do you have pain? _____

8. Check any symptoms and adjectives associated with your pain:

__Numbness	__Weakness	__Urinary Incontinence
__Redness	__Swelling	__Tenderness of affected area
__Cool, Pale skin	__Burning	__Pain with only a light touch
__Mild	__Shooting	__Prevents family duties
__Moderate	__Stabbing	__Prevents social duties
__Strong	__Tingling	__Affects appetite
__Dull	__Cramping	__Throbbing
__Aching	__Squeezing	__Sexual Dysfunction

9. Does your pain affect your sleep? (Circle) Yes No Falling asleep? Yes No

10. Are there any factors that make your pain:
Better? (Please List) _____
Worse? (Please List) _____

11. During the past month, is your pain worse in the (circle all that applies) :
___ Morning ___Afternoon ___Evening ___Night ___No typical pattern

12. Have you ever had psychiatric or psychological evaluation or treatment for the problems including your current pain? (circle) Yes No

13. Have you had any radiology done(MRI's , Xrays, etc) in the last 24 months for your current pain problem
Yes/No: Locations_____
14. Do you have any drug allergies? (Please List) _____
_____

15. Are you allergic to seafood? (Circle) Yes No 16. Allergic to Latex? Yes No

17. Do you have a pacemaker? (Circle) Yes No 18. Allergic to sunscreen? Yes No

19. Have you ever had surgery? (Please list in detail)

Surgery	Date	Doctor or Hospital

20. Do you have any family history of major illnesses? (circle) Yes No If yes, please list:

MOTHERS SIDE	FATHERS SIDE

21. Aside from your current pain problem, how is your general health? (Please check one)

__Excellent __Minor health problems __ Major health problems

22. Height: _____ Weight: _____

23. Have you had any of the following health problems? (Please check all that apply)

General

__Hearing Loss __Eye Disorders __Skin Disorders/Type_____

__Cancer – Location:_____ Treatment:_____

Cardiovascular Health

__Chest Pain __Heart Attack __Irregular Heartbeats __Stroke

__High Blood Pressure __Phlebitis __High Cholesterol __Dizziness

__Fainting

Pulmonary

__Chronic Cough __Asthma __Tuberculosis __COPD __Pneumonia

__Emphysema __Oxygen Use __CPAP use __Snoring __Bronchitis

__Shortness of Breath __Wheezing

Gastrointestinal

__Ulcers __Pancreatis __Jaundice __Constipation __Colostomy

__Diverculitis __GERD __Hepatitis(Type__) __ Gallbladder Disease

Endocrine

__Diabetes __Thyroid Disorder

Hematology

__Bleeding disorder __Anemia

Neurological

__Memory Deficit __Paralysis __CVA/TIA __Seizures __Meningitis

__Headaches __Depression __Anxiety __Numbness/Tingling-arms, legs, fac

Genitourinary

__Sexually Transmitted Disease (Specify:_____) __Impotence
__Urination difficulty __Prostate Disease __Kidney disease __HIV/AIDS __Incontinence

Bone/Joint

__Arthritis __Gout __Swollen Joints __Osteoporosis

Others not listed:

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24. Do you smoke? (Circle) Yes/No –If yes, how many packs per day?_____ How many years?_____
25. Do you drink alcoholic beverages? (Circle) Yes/No If yes, how often? _____
26. Do you use any recreational drugs? (Circle) Yes/No If yes, what? _____
27. Are you actively involved in any recovery, treatment and/or monitoring programs if yes what?
    _____
28. Currently working? Yes/ No If no, why? _____
    Is your current work status considered FULL DUTY? Yes/ No If no, please explain_____
    What is your occupation? _____
    Please describe:_____
29. Would you return to work if you and no pain problem? (Circle) Yes/No Full time/Part Time

I assume full responsibility for the accuracy of the above information provided.

Patients Name_____ Patients Signature_____

Authorization for Pharmacy release of Prescription Information

List Pharmacies used in the last 12 months:

Pharmacy	Phone#/Location
_____	_____
_____	_____
_____	_____

Purpose of this request: For Provision of continuing medical care

_x_ Records of Prescription Medications

Patient Name_____ Patient Signature_____ _____ Date_____

Current Pharmacy (This will be the pharmacy used in case we need to call in a RX for you) :

Pharmacy	Phone#/Location
_____	_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____)_____ **ALT. PHONE** (____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____)_____ Fax (____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____)_____ Fax (____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

Global Institute of
Spine and Joint Care

PATIENT SIGNATURE PAGE **Todays date** _____

Name: _____ **D.O.B.**_____

Acknowledgement of receipt of **NOTICE OF PRIVACY PRACTICES**
I have been provided with a Notice of privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand the **Global Institute of Spine and Joint Care** reserves the right to change their notice of Privacy practices and prior to implementation will provide an updated copy in the clinic. I may request a copy of the updated Notice of Privacy Practices by calling the office or requesting a copy in person at my appointment.

_____ _____Date_____
Patient/Legal Representative Signature

_____
Relationship to patient

_____ Date _____
Witness

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Global Instititue of Spine and Joint Care to share my protected health information with:

_____ _____
Name Relationship Name Relationship

_____ _____
Name Relationship Name Relationship

ACKNOWLEDGEMENT OF FINANCIAL POLICY
Full payment and Co-Pays are due at the time of service. We accept cash or Credit cards. I have read and understand this Financial Policy.

_____ Date_____
Signature of Responsible Party

CONSENT FOR TREATMENT
By signing this consent, I am authorizing Dr. Mehta and or other individuals he deems appropriate to perform and/or exams, tests, procedures, and any other care deems necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid each visit I make to GLOBAL INSTITUTE OF SPINE AND JOINT CARE unless revoked by me in writing.

_____Date_____
Patient/ legal Represntive Signature

_____
Relationship to Patient

_____Date_____
Witness

INSURANCE AUTHORIZATION AND ASSIGNMENT
I authorize global Institute of Spine and Joint Care to release to my insurance carrier and/or their agents any information necessary to determine benefits payable to related services. I authorize the payment of medical benefits to Global Institute of Spine and Joint Care I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician, based on his discretion to acess my chart for utilization management review.

Signature_____Date_____