Patient information

Today's Date _____

Patient's Name _____ D.O.B _____

Street Address _____ Apt. No. _____

City / State / Zip Code _____

Home Phone # _____ Work Phone # _____

Social Security # _____ DL # _____ State _____

Sex _____ Female _____ Male Marital Status _____ Single _____ Married _____ 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 # _____

Responsible Party's Name _____

Referred By _____

Physician's Address _____

Physician's Phone # _____

Reason for Appointment _____

All Patients – Check Every Visit

Global Institute of Spine and Joint Care

PAIN PATIENT QUESTIONNAIRE DATE: _____

1. Patient's Full Name: _____
2. Patient's Age: _____DOB: _____ Sex (Circle): Male Female
3. Race (Circle one please) Caucasian black Hispanic Other (specify _____)
4. Primary Physician: _____Phone Number: _____
5. Referring Physician:_____ Phone Number: _____
6. What is the main complaint for which you are seeking treatment at the Pain Center?

   _____

   _____

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

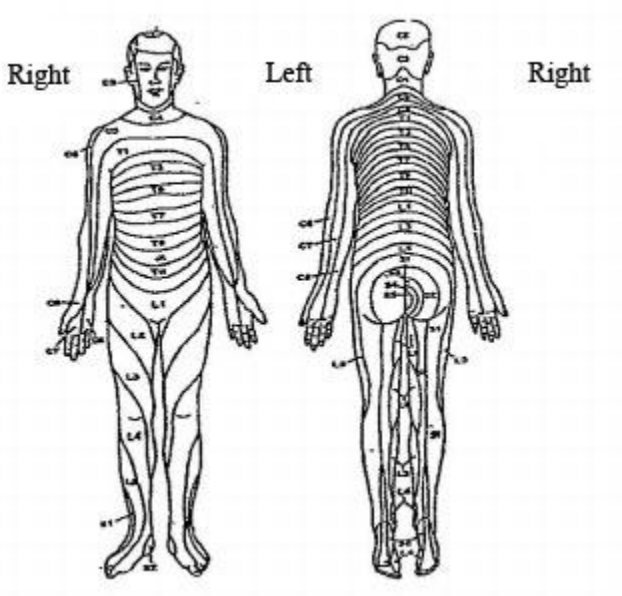
   _____
8. How did your current pain start?

   _____

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

   _____

   _____



Patient's Name _____

10. Please list all of the medications you have ever tried for your current pain problem.

_____

_____

11. 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	_____	_____
_____ Transaction	_____	_____
_____ Surgery	_____	_____
_____ Acupuncture	_____	_____
_____ TENS (Electrical Stimulator)	_____	_____
_____ Physical Therapy	_____	_____
_____ Chiropractor	_____	_____
_____ Epidural, Nerve Block, Neuroforamen injections	_____	_____

_____ Exercise – Circle: Structured program, Yoga, Tai Chi, Self gym, Pilates, Walking _____

_____ Other – Specify or circle: Therapeutic massage, aquatic therapy, etc. _____

12. How often do you have pain? _____

13. 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

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

15. Are there any factors that make your pain:

Better? (Please list) _____

Worse? (Please list) _____

16. During the past month, is your pain worse in the (Circle all that applies):

_____ Morning _____ Afternoon _____Evening _____ Night _____ No typical pattern

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

18. Have you had any CT scans or MRI for your current pain problem? (Circle) No Yes

If Yes, at what facility? _____

19. Do you have any drug allergies? (Please list) _____

_____

20. Are you allergic to seafood? (Circle) No Yes 20. Allergic to Latex? (Circle) No Yes

21. Do you have a pacemaker? (Circle) No Yes 21. Allergic to Sunscreen? (Circle) No Yes

22. Have you ever had surgery? (Please list in details)

Surgery Date Doctor or Hospital

_____

_____

_____

23. Do you have any family history of major illness? (Circle) No Yes If yes please list:

MOTHER'S SIDE FATHER'S SIDE

_____ _____

_____ _____

_____ _____

24. Are your parents deceased? (Circle) Mother: No Yes Father: No Yes

25. Do you have any siblings? (Circle) No Yes How Many? _____

Do they have a medical history? (Circle) No Yes If yes, please specify?

Medical History _____

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

_____ Excellent _____ Minor health problem only _____ Major health problems

27. Marital Status: _____

28. Height: _____ Weight: _____

29. Have you had any of the following heath 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 ____ Irregular heartbeat (Type :_____)

Pulmonary

____ Chronic Cough _____ Asthma _____ Tuberculosis _____COPD ____ Pneumonia
____ Emphysema _____ Oxygen use _____ CPAP use _____ Snoring ____ Bronchitis
____ Shortness of breath _____ Wheezing

Gastrointestinal

____ Ulcers _____ Pancreatitis _____ Jaundice _____ Constipation ____ Colostomy
____ Diverticulitis _____ GERD _____ Hepatitis (Type___) _____ Gallbladder Disease

Endocrine

____ Diabetes _____ Thyroid Disorder

Hematology

____ Bleeding disorder _____ Anemia

Neurological

____ Memory deficit _____ Paralysis _____CVA/TLA _____Seizures ____Meningitis
____ Headaches _____ Depression _____Anxiety _____ Numbness/Tingling- arms, legs, face

Genitourinary

____ Sexually Transmitted Disease (Specify: _____) ____ Impotence
____ Urination difficulty _____ Prostate disease _____ Kidney disease _____HIV/AIDS ____ Incontinence

Bone/Joint

_____ Arthritis ____Gout _____Swollen Joints _____Osteoporosis

Other Not Listed:

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30. Do you smoke? (Circle) No/Yes – If yes, how many packs per day? _____ How many years? _____
31. Do you drink alcoholic beverages? (Circle) No/Yes If yes, how often? _____
32. Do you use any recreational drugs? (circle) No/Yes If yes, what? _____
33. Are you actively involved in any recovery, treatment and/or monitoring programs if yes what?
    _____
34. Currently working? No/Yes If no why? _____
    Is your current work status considered FULL DUTY? No/Yes
    If no, please explain? _____
    What is your occupation? _____
    Please describe? _____
35. Would you return to work if you had no pain problem? (Circle) No/Yes Full Time Part Time
36. I assume full responsibility for the accuracy of the above information provided.

Patient's Signature _____

Patient's Name _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please select either Option A or Option B

Option A:

I, _____, authorize Global Institute of Spine and Joint Care to release or discuss information related to my medical condition (including information related to my treatment plan, test results, medication information and billing information) to the
Following named person(s)*:

1. _____ _____ _____
   Name Social Security # Date of Birth

2. _____ _____ _____
   Name Social Security # Date of Birth

3. _____ _____ _____
   Name Social Security # Date of Birth

***Only person(s) listed above will be able to receive information related to my care, such as treatment and billing information, co-payments, appointment times and test results. This office will not be able to disclose information to any other person(s). (NOTE: you do not have to list anytime.)**

I may change, expand or restrict this list at any time.

OR:

Option B:

I, _____, do not authorize Global Institute of Spine and Joint Care to release or discuss information related to my medical condition (including information related to my treatment plan, test results, medication information and billing information) to anyone but me personally.

Date _____ Patient Signature _____

Global Institute of Spine and Joint care
201 W Randol Mill Rd. Arlington, TX 76011
Tel # 817-987-1805 Fax # 817-987-1807

Authorization for Pharmacy release of Prescription Information

Patient Name: _____ Date of Birth _____

Address: _____

Phone #: _____ Social Security #: _____

I authorize _____
_____
_____

to release any and all medical information relating to my treatment from _____ to _____. This is to include all the records, if any, concerning HIV or AIDS, mental behavioral health or psychiatric care and drug or alcohol abuse.

Purpose of this request: For provision of continuing medical care_____

__x__ Records of Prescription Medications

Send information via Mail, Fax to: or Hold for pick-up by authorized Representative of:

Dr. Vivek Mehta
201 W Randol Mill Rd.
Arlington, TX 76011
Tel #817-987-1805

I understand that this consent can be revoked at any time except to the extent that action has been taken prior to revocation. If not previously revoked, this consent will terminate one year after the date of my signing this consent.

_____ _____
Signature of Patient or legal Guardian Date

_____ _____
Printed Name of Patient or Legal Guardian Relationship to Patient

OFFICE PAYMENT POLICY

Payment for services is due at each office visit. If you are not prepared for this, please see receptionist immediately. Your insurance policy and plan is a contractual agreement between you and your insurance carrier. Each patient is responsible for payment for medical care, regardless of the status claim. Because this practice accepts Medicare, those patients on this plan need to make arrangements at time of appointment to cover their 20% responsibility as set forth by Medicare guidelines.

I have read and understand the previous statement and agree.

Signature _____ Date _____

AUTHORIZATION OF TREATMENT

I, the undersigned, hereby authorize any Global Institute of Spine and Joint Care healthcare provider to perform necessary treatment/surgery in the event of an emergency.

Signature _____ Date _____

INSURANCE INFORMATION

Insurance Carrier _____
Policy No. _____ Group No. _____

I attest that the information that I have provided is true and correct. I authorize the release of medical information necessary to forward claims to my insurance company(ies) and/or their agencies, including Medicare, and/or other physicians requesting records for the purpose of filling and/or receiving payment for medical claims. I permit a photocopy of this original to serve as an original signature.

Signature of Insured _____ Date _____