APS | Atlanta Pain & Spine *Physicians*

New Patient Intake Questionnaire

NAME:_____ **DATE:**____/____/____ **BIRTHDATE:**____/____/____

REFERRED BY:_____ **AGE:**_____

REASON FOR VISIT: _____

LOCATION OF PAIN: ☐ **BACK** ☐ **HIP** ☐ **BUTTOCK** ☐ **LEG** ☐ **FOOT** ☐ **RIGHT** ☐ **LEFT**

☐ **NECK** ☐ **ARM** ☐ **SHOULDER** ☐ **HAND** ☐ **RIGHT** ☐ **LEFT**

OTHER (DESCRIBE) _____

Do you have numbness? ☐ No ☐ Yes – Where? _____

Do you have weakness? ☐ No ☐ Yes – Where? _____

How long ago did your pain start? _____

Did you have a specific injury that caused your pain? ☐ No ☐ Yes – Date _____/_____/_____

Type of injury? ☐ Fall ☐ Lifting ☐ Motor vehicle accident Other _____

Are you receiving compensation related to the injury? ☐ No ☐ Yes

Do you have litigation pending regarding the injury? ☐ No ☐ Yes

How did your pain begin? ☐ Gradually ☐ Suddenly

Is your pain constant? ☐ No ☐ Yes

Has your pain changed? ☐ Getting gradually worse ☐ Getting rapidly worse ☐ Getting better ☐ Unchanged

Have you ever had similar pain before this episode? ☐ No ☐ Yes

Which words describe the character of your pain?

☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing

☐ Cramping ☐ Shooting ☐ Stabbing ☐ Pounding ☐ Tingling

What time of day is your pain worse?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Night and interferes with sleep

What makes the pain worse?

☐ Lying ☐ Sitting ☐ Standing ☐ Walking ☐ Lifting ☐ Other _____

Lifting

What makes the pain better?

☐ Lying ☐ Sitting ☐ Standing ☐ Walking ☐

☐ Ice ☐ Heat ☐ Massage ☐ Other _____

Do you have problems with being unable to control your bowels or bladder? ☐ No ☐ Yes

Have you ever had back or neck surgery? ☐ No ☐ Yes (please describe type of surgery and when on next page)

HAVE YOU TRIED ANY OF THE FOLLOWING FOR YOUR PAIN?			**HOW MUCH PAIN RELIEF?**				
TREATMENT	*YES*	*NO*	*GOOD*	*MODERATE*	*MINIMAL*	*TRANSIENT*	*POOR*
NSAIDs (Motrin, Aleve, etc)							
Anti-depressants							
Oral Steroids							
Home Exercise							
Physical Therapy							
Electrical Stimulation							
Massage Therapy							
Trigger Point Injections							
Epidural Steroids							
Other:							

NAME:_____

CHECK IF YOU HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST:

MAJOR ILLNESSES	*YES*	*NO*	*MAJOR ILLNESSES*	*YES*	*NO*
AIDS / HIV			Heart Trouble		
Anemia			Hepatitis / Jaundice		
Anxiety			High Blood Pressure		
Arthritis / Joint pain			High Cholesterol		
Asthma			Kidney Disease		
Blood transfusions			Pneumonia		
Bowel Trouble			Reflux / GERD		
Cancer			Stroke		
Chronic Lung Disease			Tuberculosis - TB		
Depression			Thyroid Disease		
Diabetes			Ulcers		
Heart Murmur			OTHER:		

PLEASE LIST ANY PAST INJURIES OR ILLNESSES:

TYPE	*DATE*	*TYPE*	*DATE*

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:

SURGERY / REASON	*DATE*	*SURGERY / REASON*	*DATE*

CIRCLE AND CHECK IF YOUR BLOOD RELATIVES HAVE HAD:

MAJOR ILLNESSES	*YES*	*NO*	***WHAT BLOOD RELATIVE?***
AIDS/HIV			
Anemia			
Arthritis / Joint pain			
Asthma			
Bowel Trouble / Ulcers			
Breast Cancer			
Cancer			
Chronic Lung Disease			
Depression / Anxiety / Mood Disorders			
Diabetes			
Glaucoma			
Heart Trouble / Murmur			
Hepatitis / Jaundice			
High Blood Pressure			
High Cholesterol			
Kidney Infections / Stones			
Parkinson's Disease			
Stroke			
Thyroid Disease			
Tuberculosis - TB			
OTHER:			

NAME: _____

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:					
DRUG NAME	*DOSAGE*	*PHYSICIAN*	*DRUG NAME*	*DOSAGE*	*PHYSICIAN*

ALLERGIES TO MEDICATIONS OR SUBSTANCES (LATEX, X-RAY DYE, ETC.)		
DRUG OR SUBSTANCE	*DATE*	*REACTION*

SOCIAL HISTORY

Marital Status:
☐ Common Law Marriage ☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed

Exercise:
☐ None ☐ Less than 1 to 3 times per week ☐ 4 or more times per week

Occupation:

Smoke: ☐ No ☐ Yes
Packs per day: _____ Number of Years: _____

Alcohol: ☐ No ☐ Yes
Drinks per day: _____ Drink per week: _____

Drug User: ☐ No ☐ Yes
Kind: _____ Frequency: _____

History of abuse Yes No
Physical Emotional Sexual

List all "Natural" or Herbal remedies, over the counter drugs, vitamins or minerals you are taking.	List: Kind: Frequency:

NAME:_____

REVIEW OF SYSTEMS:
PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLIES TO YOU NOW.

CONSTITUTIONAL **NOTES**
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fever

EYES
- ☐ Yellow color

HENT
- ☐ Headaches
- ☐ Dizziness
- ☐ Thyroid Problem
- ☐ Neck Pain

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Irregular Heart Beats
- ☐ Rapid Heart Rate
- ☐ Fainting
- ☐ Swelling of legs
- ☐ Leg pain with walking

RESPIRATORY
- ☐ Wheezing
- ☐ Cough
- ☐ Shortness of breath

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Bloody / Black Stool
- ☐ Jaundice

GENITOURNARY
- ☐ Urgency of urination
- ☐ Frequency of urination
- ☐ Inability to urinate
- ☐ Leakage of urine
- ☐ Impotence
- ☐ Possible Pregnancy

SKIN
- ☐ Rashes
- ☐ Itching

NEUROLOGICAL
- ☐ Muscular Weakness
- ☐ Numbness or Tingling
- ☐ Difficulty Concentrating
- ☐ Memory Difficulties
- ☐ Seizures
- ☐ Loss of Balance

MUSCULOSKELETAL
- ☐ Joint Pain or Swelling
- ☐ Muscle Cramps
- ☐ Back Pain
- ☐ Limited joint motion

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Confusion
- ☐ Suicidal Thoughts
- ☐ Excessive Anger
- ☐ Homicidal thoughts
- ☐ Difficulty Sleeping
- ☐ Physical Abuse
- ☐ Sexual Abuse

HEMATOLOGIC
- ☐ Bruises, frequent or easily
- ☐ Cuts do not stop bleeding

OTHER
1.
2.
3.
4.
5.
6.
7.

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Patient Information Form

Please **print** all information in the spaces provided.

Last Name: _____ First Name: _____ M.I.: ____
Date of Birth: _____ SSN: _____

Home Address:_____
_____

Phone: (Home) _____ (Work) _____ (Cell) _____
Email:_____

Employer Name and
Address:_____
_____

Emergency Contact Name and Phone Number: _____
Referring Physician Name and Phone Number: _____
Primary Care Physician Name and Phone Number: _____
Pharmacy Name and Address:
_____

Primary Insurance
Company Name and Phone Number: _____
Address: _____
Policy Holder: _____Policy Holders Date of Birth:_____
ID Number: _____ Group Number: _____

Secondary Insurance
Company Name and Phone Number: _____
Address: _____
Name of Insured: _____
ID Number: _____ Group Number: _____

Assignment of Benefit/Consent for Treatment do hereby assign all medical and /or surgical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all my charges not paid by my insurance. I authorize this office to release all information necessary to secure payment, transmit and process claims electronically or through any other reasonable and customary means; including, but not limited to Medicare. I hereby voluntarily consent to my treatmrent6 at this office and authorize such treatment, examination, medications, anesthesia, surgical operations and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by my attending physicians. I have read this consent, am aware of its contents and fully understand the same. I acknowledge that no assurance or promises have been given to the patient concerning the results which may be obtained by such treatments and procedures hereby affirmed by the signature of the undersigned.

PATIENT SIGNATURE:_____**DATE:**_____

NOTICE OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Atlanta Pain and Spine Physicians, we are committed to treating and using protected health information about your responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected heath information. This Notice is effective April 1, 2003 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Atlanta Pain and Spine Physicians a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionally who contribute to your care
- Legal document describing the care your received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and the nation
- A source of data for our planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Atlanta Pain and Spine Physicians, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health record
- Amend your health record
- Obtain an accounting of disclosures of your health information

- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Atlanta Pain and Spine Physicians is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have any questions and would like additional information, you may contact the practice's Privacy Officer, Julissa Swim at 770-436-4450.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

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CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPEATIONS

I, _____, understand that as part of my health care, Atlanta Pain and Spine Physicians originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry our treatment, payment or health care operations.

I understand that Atlanta Pain and Spine Physicians is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the code of Federal Regulations.

I further understand that Atlanta Pain and Spine Physicians reserves the right to change their notice and practice and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Atlanta Pain and Spine Physicians change their notice, they will send a copy of any revised notice to the address I've provided.

I wish to have the following restriction to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures vial fax.

I fully understand and accept / decline the terms of this consent.

_____

Print Patient's Name

_____

Patient's Signature

_____

Date

FOR OFFICE USE ONLY

[ ] Consent received by_____on_____.

[ ] Consent refused by patient, and treatment refused as permitted.

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Patient Authorization to Disclose Protected Health Information

I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient of that information. I specifically authorize any current employee or owner of_____ to release or disclose my protected health information to the medical practice named below. I understand that I retain the right to revoke this authorization in writing at any time.

Description of the information to be used or disclosed:

[**X**] The patient's last three office visit progress notes

[**X**] All notes in the last 2 years pertaining to any pain management procedures.

[**X**] The patient's complete medication profile

[**X**] Any MRI, CT or X-ray Reports pertinent to the patients pain condition

Please fax or mail the above information to:

Atlanta Pain and Spine Physicians
3200 Highlands Parkway, SE Suite 420
Smyrna, Georgia 30082
Phone: 770-436-4450
Fax: 770-790-4811

_____ _____
Patient's Signature Patient's Date of Birth

_____ _____
Print Patient's Name Today's Date