

MEDICATION RISK ASSESSMENT

Please circle the answer that applies to you for each question

				<i>Office Use Only</i>	
				Female	Male
1. Has anyone in your family ever had a history of substance abuse?					
• Alcohol	Yes	No		1	3
• Illegal Drugs	Yes	No		2	3
• Prescription Drugs	Yes	No		4	4
2. Have you ever had a personal history of substance abuse?					
• Alcohol	Yes	No		3	3
• Illegal Drugs	Yes	No		4	4
• Prescription Drugs	Yes	No		5	5
3. Is your age between 16 – 45?				Yes	No
				1	1
4. Do you have a history of pre-adolescent sexual abuse?				Yes	No
				3	0
5. Have you every been diagnosed with ADD, OCD, or Schizophrenia?					
				Yes	No
				2	2
6. Have you ever been diagnosed with depression?				Yes	No
				1	1
Total Score:					

SLEEP RISK ASSESSMENT

Please mark all that apply.

- | | | |
|---|--|--|
| <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Snoring | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Apnea witnessed by partner | <input type="checkbox"/> Obesity | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypnagogic hallucinations | <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Nighttime sweating | <input type="checkbox"/> Morning headaches | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Short term memory problems | <input type="checkbox"/> Frequent arousals | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Lack of concentration | <input type="checkbox"/> Arousals with gasping | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Sexual dysfunction/impotence | <input type="checkbox"/> Arousals with SOB | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Frequent bathroom trips | <input type="checkbox"/> Arousals with choking | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cataplexy (sudden episodes of muscle weakness accompanied by full consciousness awareness) | <input type="checkbox"/> Restless sleep | <input type="checkbox"/> Moodiness |

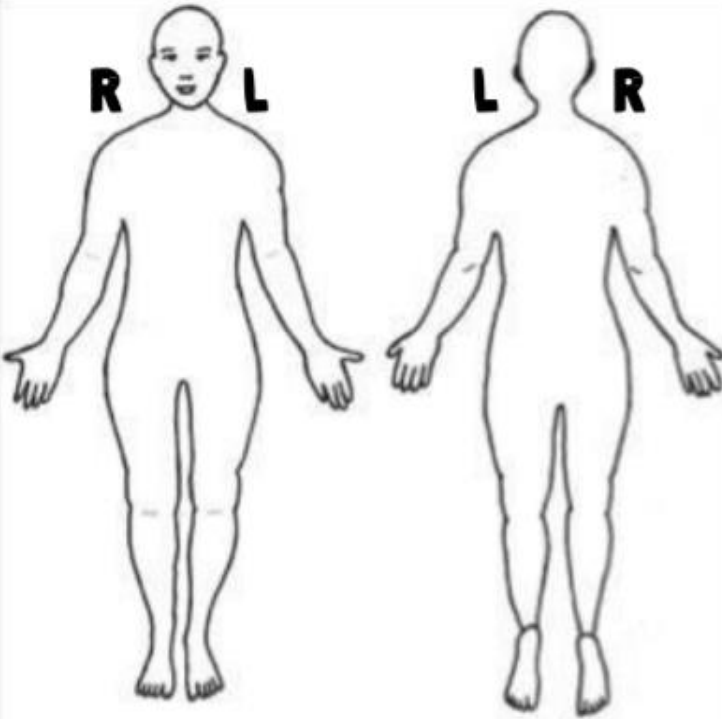
Patient Name (PRINTED)

Patient/Guarantor Signature

Date

Please identify your **worst** area of pain

Please shade the area where you feel the **worst** pain

<input type="radio"/> HEADACHES <input type="radio"/> Frontal Area (Left / Right) <input type="radio"/> Temples (Left / Right) <input type="radio"/> Back of Head (Left / Right)				
<input type="radio"/> FACIAL PAIN (Left / Right)				
<input type="radio"/> NECK <input type="radio"/> Radiates into Shoulder (Left / Right) <input type="radio"/> Radiates into Mid-Back (Left / Right) <input type="radio"/> Radiates into Arm (Left / Right) <input type="radio"/> Radiates into Hands (Left / Right)				
<input type="radio"/> UPPER BODY PAIN <input type="radio"/> Shoulders (Left / Right) <input type="radio"/> Arms (Left / Right) <input type="radio"/> Hands (Left / Right)				
<input type="radio"/> UPPER BACK PAIN <input type="radio"/> Radiates to Ribs (Left / Right)				
<input type="radio"/> ABDOMINAL PAIN <input type="radio"/> Radiates to Pelvis (Left / Right) <input type="radio"/> Radiates to Lower Back (Left / Right) <input type="radio"/> Radiates to Legs (Left / Right)				
<input type="radio"/> LOW BACK PAIN <input type="radio"/> Radiates to Hips (Left / Right) <input type="radio"/> Radiates to Buttocks (Left / Right) <input type="radio"/> Radiates to Legs (Left / Right) <input type="radio"/> Radiates to Foot (Left / Right)	How did your pain begin? <input type="radio"/> Gradually, after NO accident <input type="radio"/> Suddenly, after NO accident <input type="radio"/> Gradually, after an accident <input type="radio"/> Suddenly, after an accident	Incident Type: <input type="radio"/> Trauma <input type="radio"/> Vehicle Accident <input type="radio"/> Other: _____ _____		
<input type="radio"/> PELVIC PAIN <input type="radio"/> Coccyx <input type="radio"/> Radiates to Legs (Left / Right)	Pain Pattern: <input type="radio"/> Always Present <input type="radio"/> Sometimes Present <input type="radio"/> Present with certain activities			
<input type="radio"/> LOWER BODY PAIN <input type="radio"/> Groin (Left / Right) <input type="radio"/> Pelvis (Left / Right) <input type="radio"/> Hips (Left / Right) <input type="radio"/> Buttocks (Left / Right) <input type="radio"/> Knees (Left / Right) <input type="radio"/> Feet (Left / Right)	Describe the quality of your pain (Check all that apply) <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="radio"/> aching <input type="radio"/> burning <input type="radio"/> cramping <input type="radio"/> deep <input type="radio"/> dull </td> <td style="width: 50%; vertical-align: top;"> <input type="radio"/> pins and needles <input type="radio"/> sharp <input type="radio"/> shooting <input type="radio"/> stabbing <input type="radio"/> throbbing </td> </tr> </table>		<input type="radio"/> aching <input type="radio"/> burning <input type="radio"/> cramping <input type="radio"/> deep <input type="radio"/> dull	<input type="radio"/> pins and needles <input type="radio"/> sharp <input type="radio"/> shooting <input type="radio"/> stabbing <input type="radio"/> throbbing
<input type="radio"/> aching <input type="radio"/> burning <input type="radio"/> cramping <input type="radio"/> deep <input type="radio"/> dull	<input type="radio"/> pins and needles <input type="radio"/> sharp <input type="radio"/> shooting <input type="radio"/> stabbing <input type="radio"/> throbbing			
<input type="radio"/> DIFFUSED BODY PAIN <input type="radio"/> Face <input type="radio"/> Head <input type="radio"/> Neck <input type="radio"/> Chest <input type="radio"/> Arms (Left / Right) <input type="radio"/> Back (Left / Right) <input type="radio"/> Legs (Left / Right)	Severity of Pain: <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe Last Height: _____ Last Weight: _____ Current Pain Level: ____ / 10			

Duration of Pain: <input type="radio"/> _____ weeks / months / years <input type="radio"/> Other: _____	Assisted Devices: <input type="radio"/> None <input type="radio"/> Cane <input type="radio"/> Walker <input type="radio"/> Brace <input type="radio"/> Corset <input type="radio"/> Wheelchair
Course of Pain: <input type="radio"/> Without Change <input type="radio"/> Improving <input type="radio"/> Worsening	Intensity of Pain at Best: ____ / 10 Intensity of Pain at Worst: ____ / 10 Intensity of Pain on Average: ____ / 10
Pain Relieved By: <input type="radio"/> Rest <input type="radio"/> Ice <input type="radio"/> Changing Position <input type="radio"/> Sitting <input type="radio"/> Exercise <input type="radio"/> Standing <input type="radio"/> Pain Medication <input type="radio"/> Bending Forward <input type="radio"/> Heat <input type="radio"/> Physical Therapy <input type="radio"/> Other: _____ <input type="radio"/> Nothing	Previous Evaluations: <input type="radio"/> Primary Care <input type="radio"/> Psychologist <input type="radio"/> Urgent Care <input type="radio"/> Pain Management <input type="radio"/> Emergency Room <input type="radio"/> Orthopedic Surgeon <input type="radio"/> Rheumatologist <input type="radio"/> Neurologist <input type="radio"/> Physiatrist <input type="radio"/> Neurosurgeon <input type="radio"/> Chiropractor <input type="radio"/> None
Pain Worsened By: <input type="radio"/> Sneezing <input type="radio"/> Lifting <input type="radio"/> Coughing <input type="radio"/> Sitting <input type="radio"/> Bowel Movements <input type="radio"/> Standing <input type="radio"/> Bending <input type="radio"/> Walking <input type="radio"/> Twisting <input type="radio"/> Lying Down <input type="radio"/> Other: _____ <input type="radio"/> Nothing	Physical Therapy: <input type="radio"/> None <input type="radio"/> TENS unit <input type="radio"/> Ice <input type="radio"/> Massage <input type="radio"/> Heat <input type="radio"/> Aquatic <input type="radio"/> Stretching Exercises <input type="radio"/> Other: _____ <input type="radio"/> Strengthening Exercises _____
Associated Factors: <input type="radio"/> None <input type="radio"/> Hip Pain <input type="radio"/> Tingling: _____ <input type="radio"/> Flank Pain <input type="radio"/> Numbness: _____ <input type="radio"/> Incontinence of Stool <input type="radio"/> Leg Weakness (L / R) <input type="radio"/> Incontinence of Urine <input type="radio"/> Arm Weakness (L / R) <input type="radio"/> Chills <input type="radio"/> History of Malignancy <input type="radio"/> Fever	Previous Spine Surgery: <input type="radio"/> None <input type="radio"/> Type: _____ Date: _____ Surgeon: _____ <input type="radio"/> Type: _____ Date: _____ Surgeon: _____
Daily Activities Impaired by Pain: <input type="radio"/> Work <input type="radio"/> Dressing <input type="radio"/> Sleeping <input type="radio"/> Bathing <input type="radio"/> Leisure <input type="radio"/> Intimacy <input type="radio"/> Chores <input type="radio"/> None	Previous Injection Therapy: <input type="radio"/> None <input type="radio"/> Vertebroplasty <input type="radio"/> Joint Injection: _____ <input type="radio"/> Kyphoplasty <input type="radio"/> Facet Injection <input type="radio"/> Other: _____ <input type="radio"/> Epidural Steroid Injection _____
Accident / Injury: 1. Are you currently involved in a litigation regarding your injury? Y / N 2. Is your pain a work-related injury? Y / N 3. Is workman's compensation involved? Y / N 4. Date of injury/ accident? _____	Previous Imaging Studies: <input type="radio"/> X-RAY: _____ <input type="radio"/> CT: _____ <input type="radio"/> MRI: _____ <input type="radio"/> Bone Scan: _____ <input type="radio"/> EMG Study: _____

Review of Systems

Please mark all that apply

<u>Constitutional</u>	<u>Eyes</u>
<input type="checkbox"/> Fatigue <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss	<input type="checkbox"/> Redness <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Pain <input type="checkbox"/> Double Vision <input type="checkbox"/> Vision Change <input type="checkbox"/> Dry
<u>E.N.M.T</u>	<u>Cardiovascular</u>
<input type="checkbox"/> Decreased Hearing <input type="checkbox"/> Earache <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Sinus Pain <input type="checkbox"/> Sore Throat	<input type="checkbox"/> Chest Heaviness <input type="checkbox"/> Chest Pain <input type="checkbox"/> Chest Tightness <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Palpitations <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Leg Swelling
<u>Respiratory</u>	<u>Gastrointestinal</u>
<input type="checkbox"/> Short of Breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Pain with Breathing	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Bloody Stool <input type="checkbox"/> Tarry Stool <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Abdominal Pain
<u>Genitourinary</u>	<u>Musculoskeletal</u>
<input type="checkbox"/> Burning Urination <input type="checkbox"/> Painful Urination <input type="checkbox"/> Incontinence – urine <input type="checkbox"/> Incontinence - stool	<input type="checkbox"/> Back Pain <input type="checkbox"/> Neck Pain <input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Limited range of motion <input type="checkbox"/> Gout
<u>Skin</u>	<u>Neurological</u>
<input type="checkbox"/> Dry <input type="checkbox"/> Itchy <input type="checkbox"/> Lesions <input type="checkbox"/> Sores <input type="checkbox"/> Lump <input type="checkbox"/> Rash <input type="checkbox"/> Brittle Nails <input type="checkbox"/> Pigmentation Change	<input type="checkbox"/> Dizziness <input type="checkbox"/> Trouble Walking <input type="checkbox"/> Headache <input type="checkbox"/> Migraine <input type="checkbox"/> Restless Legs <input type="checkbox"/> Tingling <input type="checkbox"/> Speech Difficulty <input type="checkbox"/> Fainting
<u>Psychiatric</u>	<u>Endocrine</u>
<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Mood Changes <input type="checkbox"/> Memory Disturbances <input type="checkbox"/> Stressed	<input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Thyroid Problems

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy note; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e., electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14, 2003**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Patient Name (PRINTED)

Patient/Guarantor Signature

Date

Patient Payment Policy

Thank you for choosing Idaho Pain Clinic, LLC. We are committed to providing you with the highest quality of healthcare and strive to keep healthcare affordable in our office. As such, we provide this document to ensure your understanding of the payment policies. Please read the following office payment policy carefully and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

Payment Policy

- At the time of service, and before you are seen by the practitioner, you are required to pay any applicable co-pay or balance.
- Payment for service is due in full at the time of service provided you have no insurance. Please ask our front office staff for a fee schedule.
- We accept cash, check, Visa, MasterCard and Discover. Any returned check is subject to a \$35.00 return check fee.
- Unless canceled **two business days** in advance, your account will be charged \$25.00 for a missed appointment. Three no show or three canceled appointments will result in a discharge from the facility.
- Please note that your insurance company will not cover any of the additional fees listed above.
- If a patient has a balance of \$500 or greater, the patient will not be seen without payment on the account.
- If you are in need of a payment plan, you can discuss options with the office staff.
- Patient Statement will be mailed to you if you have an outstanding balance after we have billed your insurance. If your account is overdue for longer than 90 days, it may be referred to a collection agency.

As a courtesy, we file your insurance claims. It is your responsibility to notify us of any changes to your insurance coverage. It is your responsibility to know your policy in regards to benefits, maximums, waiting periods, benefits, and patient coverage. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays.

Patient Name (PRINTED)

Patient/Guarantor Signature

Date

Thank you for your time!

Please give completed paperwork to the front desk receptionists



Disclosure to Family Members and Friends

The new government HIPAA regulations require permission from the patient in order for any healthcare professional to speak with family, friends, or caregivers regarding your protected health information (PHI), with the exception of cases of emergency.

Please list your choice of individuals for us to disclose and/or discuss your private health information.

Please list those you authorize (ex: spouse, children, sibling, or caregiver) and remember that even your spouse needs to be listed if you authorize us to speak with them.

Name: _____ DOB: _____ Phone: _____ Relationship: _____

Name: _____ DOB: _____ Phone: _____ Relationship: _____

Name: _____ DOB: _____ Phone: _____ Relationship: _____

Name: _____ DOB: _____ Phone: _____ Relationship: _____

Name: _____ DOB: _____ Phone: _____ Relationship: _____

Please tell us where to call you, leave messages, and appointment reminders: Home Cell Work

Phone: _____

Can we leave messages on the phone number you have provided? Yes No

If yes, may we leave brief messages with NO clinical information? Yes No

May we leave extended messages with some clinical information? Yes No

Patient Signature: _____ Date: _____

Patient Name, printed: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____
=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>