CENTRAL KENTUCKY INTERVENTIONAL PAIN MANAGEMENT CENTER

Locations:

____ Georgetown Community Hospital
1140 Lexington Road, Suite 100
Georgetown, KY 40324
502.570.3767

____ 8 Linville Drive, Suite C
Paris, Ky 40361

____ 370 Amsden Ave., Suite 504
Versailles, KY 40383
502.570.3767

Date: _____

Time: _____

If you need to cancel or reschedule, please call 502-570-3767

CENTRAL KENTUCKY
INTERVENTIONAL PAIN
MANAGEMENT CENTER

OFFICE POLICIES

Please be prepared to present your insurance card(s) at each visit.

It is essential that you provide all the necessary information about your insurance, both primary and secondary. Since changes in insurance coverage are frequent, it is our policy to obtain a copy of your card(s) for applicable insurance.

Important Information

Prescriptions for medications are NOT written. WE DO NOT TAKE OVER WRITING NARCOTIC PRESCRIPTIONS.

Any procedures needed will not be performed at the first visit. **This visit is for evaluation only**.

New Patient Paperwork

If you are a new patient please bring your new patient paperwork filled out and completed to your first office visit. If you fail to do so, you may be asked to reschedule.

No-Shows

If you are unable to make your scheduled appointment, please contact the office as soon as possible. Your cancellation allows us to serve patients who have otherwise not been seen. If you do not cancel in advance and do not present to the office for your appointment, this is considered a "No show" appointment. This office reserves the right to dismiss a patient from the practice after three consecutive missed appointments in a 12 month period.

Rescheduled Appointments

If you receive medication from our office, please keep your medication refill appointments. Our office policy states, rescheduling of the same medication refill appointment more than twice could possibly result in being discharged from medication management within the clinic.

Late Policy

If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule.

Prescription Refills

Please call your pharmacy directly for refill requests. If calling the office, please call only once. Please be aware that refills may take up to 24 HOURS to process, so please plan accordingly.

Billing

You will receive a bill for service(s) from Georgetown Community Hospital and a separate bill from Central Kentucky Interventional Pain Management Center for every visit.

I have read and fully understand the office policies of Central Kentucky Interventional Pain Management

Signature of Patient or Legal Representative

Date and Time

CONSENTT

PATIENT STICKER

Today's Date _____/_____/_____ # PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name Last	First	Middle	□ Mr □ Mrs □ Miss □ Ms	Marital Status (circle) Single/ Married / Divorced /Sep/ Widow
Is this your legal name? □ YES □ NO	If not, what is your legal name?		Birthdate / /	Age Sex □ M □ F □ T
Street or Mailing Address (circle one)	City	State Zip Code		Home Phone Number ( )
Cell Phone Number ( )	E-Mail Address			Social Security - -
Occupation	Employer		Employer Phone Number	

Employment Status: □1 – Full-Time □2 – Part-Time □3 – Not Employed □4 – Self-Employed □5 – Retired □6 – Active Military
Student Status: □F – Full-Time Student □P – Part-Time Student □N – Not a Student

Race: □American Indian/Alaska Native □Asian □Native Hawaiian/Pacific Islander □Black/African American □White □Hispanic □Other □Declined

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Declined

Language: □English □Spanish □Indian □Japanese □Chinese □Korean □French □German □Russian □Other _____

Pharmacy:	Do you have a living will? □ YES □ NO

Referred By (Please check one box)
□ Dr. _____ □ Insurance □ Hospital □ Family □ Friend □Yellow Pages □ Other _____

Other Family Members Seen Here

PCP Name Phone #

RESPONSIBLE PARTY INFORMATION

Responsible Party: □Another Patient □Guarantor □Se □Check here if information is same as patient
Name Address Home Phone Number

Birth Date / /	E-Mail Address		( )
Occupation	Employer	Employer Address	Employer Phone Number ( )

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? □ WORKERS COMPENSATION (WC)
□ OCCUPATIONAL MEDICINE (OM) □ MOTOR VEHICLE ACCIDENT (MVA) □ ACCIDENT DATE _____

Does the patient have healthcare coverage? □ YES □ NO	**Insurance Name**				
Name of Insured	Social Security Number - -	Birth Date / /	Effective Date / /	Group ID	Subscriber ID (Policy Number)

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other _____

Name of Secondary Insurance	Name of Insured	Date of Birth / /	Group ID	Subscriber ID (Policy Number)

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other _____

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number ( )	Other Phone Number ( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

_____ _____
Patient/ Guardian Signature Date

CENTRAL KENTUCKY
INTERVENTIONAL PAIN
MANAGEMENT CENTER

Date_____

I HEREBY REQUEST A COPY OF THE FOLLOWING PATIENT'S MEDICAL RECORD:

Full Name of Patient: _____
Maiden Name/Alias: _____ CONTACT PHONE NUMBER_____
Patient's Birth date: _____ SOCIAL SECURITY NUMBER _____

Records Requested From:
Name/Facility _____
Facility: Phone:_____ Facility Fax:_____

INFORMATION REQUESTED (X):

( ) Discharge Summary
( ) History & Physical
( ) Operative Reports
OR date(s) _____
( ) Progress Notes
( ) Psychotherapy Notes
( ) Emergency Room
( ) Laboratory Results
( ) X-Ray Results
( ) Orders
( ) Nurses Notes
( ) Other (Specify) _____

THE ABOVE RECORD IS TO BE RELEASED TO THE FOLLOWING INDIVIDUAL:
Central Kentucky Interventional Pain Management Center
Street Address: ***1140 Lexington Road Suite 100***
City/State/Zip: ***Georgetown, Kentucky 40324***
Phone Number: ***502-570-3767***
Fax Number: ***502-570-3766***

THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON (X):

( ) Continued Medical Care
( ) Personal Interest
( ) Other (Specify) _____
( ) Legal Purposes
( ) Insurance Purposes

The authorization must be signed and dated and may be revoked in writing at any time except to the extent action has been taken prior to revocation. This consent will expire 60 days after the date below or sooner by my choice, in which case this consent will expire on _____. I will hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the medical records to the purpose and extent stated above.

REQUEST FOR RECORD COPY RELEASE WILL BE HANDLED ON A FIRST COME, FIRST SERVE BASIS.

( ) Kentucky Law directs health care providers to furnish to a patient, at the patient's request, one free copy of the patient's Medical Record.

( ) Additional requests for copies will be charged a rate of $1.00 per page.

I UNDERSTAND THAT IF THE PERSON OR ENTITY THAT RECEIVES THE INFORMATION IS NOT A HEALTH CARE PROVIDER OR HEALTH PLAN COVERED BY FEDERAL PRIVACY REGULATIONS, THE INFORMATION DESCRIBED ABOVE MAY BE REDISCLOSED AND NO LONGER PROTECTED BY THESE REGULATIONS. I HEREBY AFFIRM THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS ANDCONSENT TO THE DISCLOSURE OF THE MEDICAL RECORD FOR THE PURPOSE AND EXTENT STATED ABOVE. RELEASE OF INFORMATION FORM MUST HAVE A COPY OF PICTURE ID ATTACHED. I MAY INSPECT OR COPY ANY INFORMATION USED/DISCLOSED UNDER THIS AUTHORIZATION.

(NOTE: THIS ITEM IS NOT REQUIRED IF THE DISCLOSURE IS REQUESTED BY THE PATIENT.)

PATIENT'S SIGNATURE _____DATE_____
PARENT OR LEGAL GUARDIAN'S SIGNATURE _____
RELATIONSHIP TO PATIENT_____

CENTRAL KENTUCKY
INTERVENTIONAL PAIN
MANAGEMENT CENTER

HIPAA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY

I. CONSENT FOR TREATMENT: I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. NOTICE OF PRIVACY PRACTICES: Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

_____ The patient understands that:

Patient The practice has a Notice of Privacy Practices and that the patient has the opportunity Initials to review this notice.

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

NAME	RELATIONSHIP	CONTACT NUMBER

III. ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION: I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s),

specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence,, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

IV. PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S): Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

V. EMAIL AND TEXT COMMUNICATIONS: If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

VI. FINANCIAL POLICY: The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

• The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

• In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

• If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

• Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

VII. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS:
If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

_____ _____
Printed Name of Patient or Representative Signature of Patient or Representative

_____
Date

Relationship to Patient (if other than patient) _____

CLINIC STAFF USE ONLY

☐ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

_____ _____
Witness (Staff) Signature Witness (Staff) Printed Name

Date: _____

CENTRAL KENTUCKY
INTERVENTIONAL PAIN
MANAGEMENT CENTER

Global Pain Scale

Patient Name: _____

Instructions: For each question, please indicate your level of pain by circling a number from 0 to 10.

Your Pain:

- My current pain is …….No pain: 0 1 2 3 4 5 6 7 8 9 10 : Extreme pain
- During the *past week*,

  the **best** my pain has been is ……..No pain: 0 1 2 3 4 5 6 7 8 9 10 : Extreme pain

  the **worst** my pain has been is ……No pain: 0 1 2 3 4 5 6 7 8 9 10 : Extreme pain

  my **average** pain has been ……..No pain: 0 1 2 3 4 5 6 7 8 9 10 : Extreme pain
- During the *past 3 months*,

  my **average** pain has been ……..No pain: 0 1 2 3 4 5 6 7 8 9 10 : Extreme pain

Your Feelings: During the ***past week***, I have felt:

- Afraid ..……Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 : Strongly Agree
- Depressed ……....Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 : Strongly Agree
- Tired ……....Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 : Strongly Agree
- Anxious ……...Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 : Strongly Agree
- Stressed ……...Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 : Strongly Agree

Your Clinical Outcomes: During the ***past week***:

- I had trouble sleeping ……..….Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 : Strongly Agree
- I had trouble feeling comfortable …...…Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 : Strongly Agree
- I was less independent .....Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 : Strongly Agree
- I was unable to work

  (or perform normal tasks) .....Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 : Strongly Agree
- I needed to take more medication ……Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 : Strongly Agree

Your Activities: During the ***past week***, I was ***NOT*** able to:

- Go to the store ……..…Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 : Strongly Agree
- Do chores in my home ……....Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 : Strongly Agree
- Enjoy my friends and family …….…...Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 : Strongly Agree
- Exercise (including walking) ……..….Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 : Strongly Agree
- Participate in my favorite hobbies ……...Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 : Strongly Agree

Total: _____ *(Please total your scores)*

CENTRAL KENTUCKY
INTERVENTIONAL PAIN
MANAGEMENT CENTER

Name: _____ **DOB:** _____

Who is your referring physician? _____

Who is your Primary Care Physician? _____

Have you ever been to another pain clinic? ☐ No ☐ Yes, please specify: _____

- If female, please choose which of the following apply:
  ☐ Hysterectomy ☐ Child-Bearing Age (no contraception)
  ☐ Post-Menopausal ☐ Child-Bearing Age (Use of contraception)
- Where is your pain located? _____
- How long have you had your pain? _____
- What is the main cause of your pain?
  ☐ Unknown ☐ Normal Aging ☐ Fall ☐ Sporting Accident ☐ Motor Vehicle Accident ☐ Work Injury
- What is the frequency of your pain? ☐ Constant ☐ Fluctuating
- Describe your pain *(check all that apply)*: ☐ Aching ☐ Burning ☐ Cramping ☐ Dull ☐ Numb
  ☐ Sharp ☐ Stabbing ☐ Stinging ☐ Throbbing ☐ Tingling
- What makes your pain worse? *(check all that apply)*
  ☐ Bending/Stooping ☐ Carrying heavy loads ☐ Laying on back ☐ Laying on side ☐ Sitting ☐ Standing
- What makes your pain better? *(check all that apply)*
  ☐ Exercise ☐ Laying on back ☐ Laying on side ☐ Sitting ☐ Standing ☐ Stretching ☐ Walking ☐ Nothing
- Your pain interferes with? *(check all that apply)*
  ☐ Daily chores ☐ Employment ☐ Exercise ☐ Mood ☐ Relationships ☐ Sleep ☐ Walking
- Have you had any of the following? *(check all that apply)*
  ☐ Bone Density ☐ MRI / CT Scan ☐ Nerve Conduction / EMG ☐ Ultrasound ☐ Vascular Studies ☐ X-Rays
- Have you had any of the following injections in the past to help with your pain? *(check all that apply)* ☐ Botox ☐ Joint ☐ Muscle ☐ Spinal
- Have you had any of the following surgeries? *(check all that apply)*
  ☐ Back ☐ Hip ☐ Knee ☐ Neck ☐ Shoulder ☐ Intrathecal Pain Pump Implant ☐ Spinal Cord Stimulator
- Have you tried any of the following to assist with your pain? *(check all that apply)*
  ☐ Cane ☐ Chiropractic Therapy ☐ Exercise Program ☐ Physical Therapy ☐ TENS Unit ☐ Walker
  If so, how long have you tried the above? _____
  _____
  _____

CENTRAL KENTUCKY
INTERVENTIONAL PAIN
MANAGEMENT CENTER

Please answer the following questions and provide address and phone number if known.

1. Who is your primary care giver (family doctor)? _____

   _____

2. What pharmacies have you used in the last 4 months? _____

   _____

3. Have you **ever** done physical therapy? If yes, list the facility? _____

   _____

4. What surgeries have you had? Please list **surgeon** and **year.** _____

   _____

   _____

5. Have you had any imaging done? (CT, MRI, X-ray) Please list facility. _____

   _____

   _____

6. Have you been to any other pain clinics in the past? Please list facility. ____

   _____

   _____

7. Have you been to a Chiropractor? If so, who did you see? _____

   _____

8. Any other specialty doctor that you have seen? (Neurologist, Orthopedic) _

   _____

Patient Name: _____

Date of Birth: _____

Female or Male: _____

Opioid Risk Tool (ORT)

Mark each box that applies

1. **Family** History of Substance Abuse:
   - Alcohol..... ☐ (1, 3)
   - Illegal Drugs ..... ☐ (2, 3)
   - Prescription Drugs..... ☐ (4, 4)
2. **Personal** History of Substance Abuse:
   - Alcohol..... ☐ (3, 3)
   - Illegal Drugs (including Marijuana)..... ☐ (4, 4)
   - Prescription Drugs..... ☐ (5, 5)
3. Age (Mark the box if you are between ages 16-45)..... ☐ (1, 1)
4. Personal History of Preadolescent Sexual Abuse..... ☐ (3, 0)
5. Psychological Disease (Do you have any of the following):
   - ADD (Attention Deficit Disorder), OCD (Obsessive-Compulsive Disorder)
   - Bipolar Disorder, Schizophrenia..... ☐ (2, 2)
   - Depression..... ☐ (1, 1)

This Section to Be Filled Out By Staff *Scoring Total:* ☐

CENTRAL KENTUCKY
INTERVENTIONAL PAIN
MANAGEMENT CENTER

1140 Lexington Road
Georgetown, KY 40324
Phone: 502-570-3767
Fax: 502-570-3766

PATIENT NAME: _____

DATE/TIME: _____

The Patient Health Questionnaire (PHQ-9)

Over the past 2 weeks, how often have you been bothered by any of the following problems.	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 asleep, 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		3
COLUMN TOTALS				
ADD COLUMN TOTALS TOGETHER				

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1140 Lexington Road
Georgetown, KY 40324
Phone: 502-570-3767
Fax: 502-570-3766

PATIENT NAME: _____

DATE/TIME: _____

CAGE QUESTIONNAIRE

1. Have you ever felt that you ought to cut down on your drinking?	YES	NO
2. Have people annoyed you by criticizing your drinking?	YES	NO
3. Have you ever felt bad or guilty about drinking?	YES	NO
4. Have you ever had a drink the first thing in the morning (eye opener) to steady your nerves or get rid of a hangover?	YES	NO

NOTES:

CENTRAL KENTUCKY
INTERVENTIONAL PAIN
MANAGEMENT CENTER

Date:_____ Patient Name:_____ DOB:_____

Review of Systems: Please mark each of the following symptoms/problems that you currently have.

General	HEENT	Respiratory	Cardiology	Gastroenterology
O Weight loss	O Headache	O Chronic cough	O Chest pain (angina)	O Appetite loss
O Weight gain	O Facial pain	O Wheezing	O Murmur	O Chronic nausea
O Fever	O Sinusitis	O Shortness of breath	O Congestive failure	O Heartburn
O Night sweats	O Loss of vision	O Sleep apnea	O Abnormal EKG	O Constipation
O Fatigue	O Hearing loss	O Home oxygen use		O Diarrhea
O Many infections	O Teeth/gum problems	O C-PAP		O Bowel control loss
O Drowsiness				

Genitourinary	Endocrine/Hematological	Musculoskeletal	Neurology	Psychiatric
O Painful Urination	O Abnormal blood sugars	O Joint pain	O Dizziness	O Panic attacks
O Blood in urine	O Easy bruising/bleeding	O Muscle spasm	O Blackouts	O Insomnia
O Bladder control loss		O Neck pain	O Tremors	
O Enlarged prostate		O Back Pain	O Numbness	
	Vascular		Skin	
O Testicular pain	O Poor circulation		O Rash	
O Irregular bleeding	O Current blood clot O Pregnancy			
	O Swelling in legs			

Preventative Medicine: Falls Risk Screening: If you are 65 or older, please check all that apply to you O No Falls in the past year

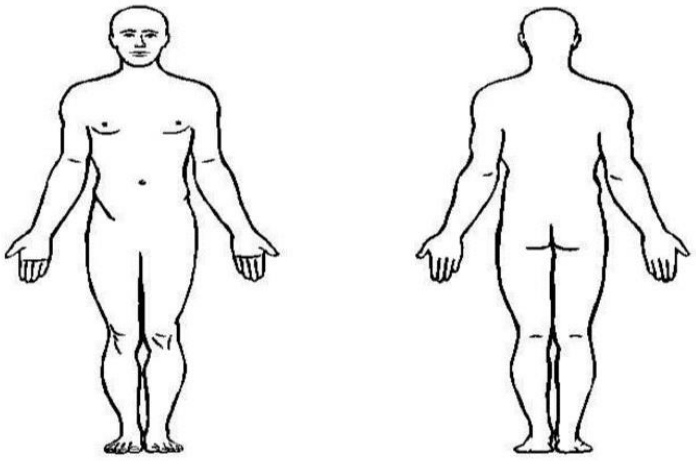
O One Fall with injury in the past year

O One Fall without injury in the past year

O Two or more falls with injury in the past year

O Two or More Falls without injury without injury in the past year

Draw small X's where your pain is located.
Draw small O's where any numbness is located



CENTRAL KENTUCKY
INTERVENTIONAL PAIN
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Date _____ PATIENT NAME: _____ PT DOB: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (Add additional page if needed):

Medication	Dosage	Instructions

Have you tried any of the following medications?

Medicine	Helpful	Not Helpful	Medicine	Helpful	Not Helpful
Aspirin			**Norflex**		
Celebrex			**Parafon Forte (Lorzone)**		
Diclofenac			**Skelaxin (Metaxolone)**		
Daypro			**Tizanidine (Zanaflex)**		
Etodalac(Lodine)			**Morphine ER (MS Contin, Avinza,Kadian)**		
Ibuprofen (Motrin,Advil)			**Hydrocodone (Lortab, Lorcert,Norco)**		
Indomethacin (Indocin)			**Opana**		
Vimovo			**Oxycodone (Percocet, Roxicodone, OxyIR)**		
Ketroprofen			**MSIR**		
Mobic (Meloxicam)			**Methadone**		
Naproxen			**Tramadol (Ultracet)**		
Relafen			**Kadian**		
Toradol			**Oxycontin**		
Duexis			**Duragesic**		
Baclofen			**Codeine**		
Cyclpbenzaprine (Flexeril)			**Dilaudid(Hydromorphone)**		
Carisoprodol (Soma)			**Biofreeze**		
Diazepam (Valium)			**Icy Hot**		
Methocarbamol (Robaxin)			**Bengay**		
Avinza			**Aspercreme**		

Allergies/ Reaction(list): _____

Tobacco Use: How much:_____ How many Yrs:_____

Have you ever tried prescription creams such as EMLA cream, Voltaren Gel or ECT. Yes or No

CENTRAL KENTUCKY
INTERVENTIONAL PAIN
MANAGEMENT CENTER

Date:_____ Patient Name:_____ DOB:_____

Have you ever tried a Compound Pain of Scar cream from a Specialty Pharmacy? _____

Please check all medical conditions that <u>you</u> have had.

Peripheral Nerve Disease_____	Muscle Disorder_____	Sleep Apnea_____
High blood pressure_____	Fibromyalgia_____	Arthritis_____
Breathing Problems_____	Heart Problems_____	HIV_____
Head Injury_____	Spine Disorder_____	Osteoporosis_____
Multiple Sclerosis_____	Migraines_____	Stroke_____
Seizures_____ _____	Cholesterol_____	Reflux_____
Anxiety_____	Depression_____	Pancreatitis_____
Diabetes_____	Gallbladder_____	Prostate_____
Bowel Disease_____	Liver Problems_____	Kidney _____
Cancer_____	Hepatitis_____	Hernia_____

Alcohol / Drug Use_____

List All Surgeries:_____

_____

Social and Family History:

Marital Status:_____ **Lives with:_____**

Biological Mother- Alive_____ Deceased_____ Age_____

Any known medical conditions:_____

_____

Biological Father- Alive_____ Deceased_____ Age_____

Any known medical conditions:_____

_____