

Pain Evaluation & Management Center of Ohio, Inc.

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PATIENT INFORMATION SHEET (Please complete both pages)

FULL NAME: _____ MALE ___ FEMALE ___ DATE: _____
(Last, First, Middle)

ADDRESS: _____
(Street) (City) (State) (Zip)

HOME PHONE: ____/____ DATE OF BIRTH: _____ SSN: _____

MARITAL STATUS: ___ Single ___ Married ___ Divorced ___ Widowed

RELATIONSHIP TO INSURED: ___ Self ___ Spouse ___ Dependent ___ Other: _____

EMPLOYER: _____ WORK PHONE: ____/____

OCCUPATION: _____ REFERRING PHYSICIAN: _____
(Full Name)

EMERGENCY CONTACT: _____ / _____
(Full Name & Relationship) (Phone Number)

IF RESPONSIBLE PARTY IS OTHER THAN PATIENT, PLEASE COMPLETE THIS SECTION

FULL NAME: _____ MALE ___ FEMALE ___
(Last, First, Middle)

ADDRESS: _____
(Street) (City) (State) (Zip)

HOME PHONE: ____/____ DATE OF BIRTH: _____ SSN: _____

EMPLOYER: _____ WORK PHONE: ____/____

IF COVERED BY OTHER INSURANCE, PLEASE COMPLETE THIS SECTION

PRIMARY INSURANCE

POLICY HOLDER: _____

INSURANCE CO: _____

ADDRESS: _____

PHONE: _____

POLICY NO: _____

GROUP NO: _____

SECONDARY INSURANCE

POLICY HOLDER: _____

INSURANCE CO: _____

ADDRESS: _____

PHONE: _____

POLICY NO: _____

GROUP NO: _____

IF WORKERS' COMPENSATION OR LEGAL CASE, PLEASE COMPLETE THIS SECTION

ORIGINAL DATE OF INJURY: _____ CLAIM NO: _____

MCO: _____ / REPRESENTATIVE: _____

DOCTOR OF RECORD: _____ / _____
(Full Name) (Phone Number)

EMPLOYER AT TIME OF INJURY: _____

EMPLOYER'S ADDRESS: _____

ATTORNEY: _____ / _____
(Full Name) (Phone Number)

ATTORNEY'S ADDRESS: _____

INSURANCE AGENT: _____ / _____
(Full Name) (Phone Number)

ORIGINAL DATE OF ACCIDENT: _____ CLAIM NO: _____

CONSENT FOR TREATMENT

I understand I am responsible for payment in full in a timely manner; I authorize the release of any medical information necessary to process this claim; and, I authorize direct payment of medical benefits to the providing physician for services rendered.

Signature of Patient/Responsible Party

Date

Patients with Medicare, please read and complete the following:

I certify the information given by me, applying for payment under Title XVIII of the Social Security Act, is correct. I authorize any holder of my medical information to release any information needed for this, or a related Medicare claim, to the Health Care Financing Administration or its intermediaries or carriers. I request that payment of authorized services be made on my behalf. I assign the benefits payable for covered Medicare services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Signature of Patient/Responsible Party

Date

MEDICAL HISTORY
(please circle all that apply)

General:

Diabetes, chills, fatigue, fever, heat or cold intolerance, chronic fatigue, muscle aches, nutritional problems, sweats, recent weight change and night sweats

Eyes:

Blurred vision, color blindness, double vision, eye inflammation, eye irritation, itchy eyes, eye pain, eye trauma, visual loss, and watery eyes

Respiratory:

Asthma, bronchitis, COPD, cough, hemoptysis, orthopnea, pleurisy (pain on respiration), and wheezing

Cardiovascular:

Chest pain, discomfort, irregular rhythm, murmur, orthopnea, palpitations, rapid heart beat, shortness of breath, tightness in the chest, shortness of breath without exertion,

Gastrointestinal:

Abdominal pain, change in bowel habits, constipation, diarrhea, heartburn, rectal pain, jaundice, vomiting blood, hemorrhoids, nausea and vomiting, acid reflux, IBS

Genitourinary:

Dyspareunia (pain on sexual activity), blood in urine, incontinence, pelvic pain, vaginal discharge, renal stones and abnormal urination, kidney or bladder problems

Musculoskeletal:

Arthritis, night cramps, fractures, abnormal joints, abnormal muscles, numbness, pain, migratory pain, posture abnormalities, recent trauma or injury, swelling, tingling, wasting or atrophy, difficulty bearing weight on lower extremities, spine problems, and dislocations

Neurological:

Facial weakness, disturbance in hearing, difficulties in speech, swallowing, and taste, visual disturbance, areas of decreased sensation or hypersensitivity, lightning or shooting pains, unusual pain, periods of blackout, confusion, dizziness, headaches, trauma to head, convulsions or seizures, incoordination, motor skill loss, stroke, coma, paralysis, significant memory loss, syncope and involuntary movements

Psychiatric:

Anxiety, depression, bipolar

Cancer:

Type: _____ Onset: _____
Treatment: _____

PAIN EVALUATION AND MANAGEMENT CENTER OF OHIO

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, the Pain Evaluation & Management Center of Ohio may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to the Pain Evaluation & Management Center of Ohio's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Pain Evaluation & Management Center of Ohio reserves the right to revise its Notice of Privacy Practice at any time. A revised Notice of Privacy Practices may be obtained by forwarding a Written request to the Pain Evaluation & Management Center of Ohio Privacy Officer at 1550 Yankee Park Place, Centerville, Ohio 45458.

With my consent, the Pain Evaluation & Management Center of Ohio may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, the Pain Evaluation & Management Center of Ohio may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, the Pain Evaluation & Management Center of Ohio may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the Pain Evaluation & Management Center of Ohio restrict how it uses or discloses my PHI to carry out TPO; however, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Pain Evaluation & Management Center of Ohio's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the Pain Evaluation & Management Center of Ohio may decline to provide treatment to me.

Signature of Patient

Print Name of Patient

Date

Patient received notice of privacy practices:

Date

Employee Initials

MODIFYING FACTORS

LIST ANY CURRENT/PRIOR TREATMENTS RECEIVED FOR YOUR PAIN PROBLEMS

<u>Treatment</u>	Providing Doctor or Facility and amount or weeks of treatment if applicable	0%, 10%, 20%, etc. <u>Up to 100% Relief</u>
Physical Therapy	_____	_____
Rehabilitation Therapy	_____	_____
TENS Unit	_____	_____
Chiropractic treatment	_____	_____
Braces/support devices	_____	_____
Associated surgery	_____	_____
Nerve Block	_____	_____
Other:	_____	_____
_____	_____	_____

LIST DIAGNOSTIC TESTING RELATED TO YOUR PAIN

Please indicate which of the following, if any, tests have been completed.

MRI	Dates _____	What facility _____
CT Scan	Dates _____	What facility _____
X-rays	Dates _____	What facility _____
EMG	Dates _____	What facility _____
Myelogram	Dates _____	What facility _____
Other	Dates _____	What facility _____

ASSOCIATED SYMPTOMS

Do you have any of the following associated symptoms? (Please circle all that apply to you)

- | | | | | |
|-------------------|---------------------|---------------------|-----------------|---------|
| Diabetes | High Cholesterol | High Blood Pressure | Thyroid Disease | Obesity |
| Bowel Dysfunction | Bladder Dysfunction | Motor Loss | Sensory Loss | |

PAST HISTORY

LIST SURGERIES FOR ANY REASON

Type	Name of Surgeon	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

Are you currently working? Yes No If yes, where? _____
(Please answer below under yes or no).

- If yes,** Part time without restrictions
 Part time with restrictions (Please list) _____
 Full time without restrictions
 Full time with restrictions (Please list) _____

If no, date last worked: _____

If not working, please explain why: _____

ADDICTION(S)

Do you have a history of smoking cigarettes? Yes No *If yes, when?* _____

Do you have a history of alcohol/substance abuse? Yes No *If yes, when?* _____

Do you consume alcohol? Yes No

If yes, how much? Daily Weekly Socially Rarely

Have you ever felt you should cut down on your drinking? Yes No

Have people annoyed you by criticizing your drinking? Yes No

Have you ever felt bad or guilty about your drinking? Yes No

Have you ever had a drink first thing in the morning or to get rid of a hangover (eye-opener)?
 Yes No

Pain Evaluation and Management Center of Ohio, Inc.
1550 Yankee Park Place, Suite A
Centerville OH 45458

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby grant my permission for release of medical information to/between the following parties, including (if applicable) any information concerning treatment for psychiatric illness, alcohol and/or substance abuse, HIV test results or AIDS/ARC (AIDS related complex) diagnosis and/or other communicable diseases.

Released From: (Dr) or (Other Entity)

Released To: (Dr)/(Other Entity)/Self

For the purpose of: _____

Information Requested:

Progress Notes X-rays/MRI's Other (Please Specify)
 Consults Immunizations _____
 Lab tests Complete

You must completely fill out your name, address, date of birth and phone number Below or the records may not get copied.

Patient's Name

Date of Birth

Patient's Address

Phone #

City, State, Zip

This consent expires 6 months from date signed and is subject to revocation by the patient at any time prior to the expiration date.

Signature of Patient, or legal guardian

Date

ANY REDISCLOSURE OF MEDICAL INFORMATION BY RECIPIENT IS PROHIBITED. PLEASE NOTE: All matters relating to alcohol or drug abuse records are considered privileged and confidential and are regulated by Federal Law sect.2.31 of PL.93.282, 42 CFR, and part 2. This prohibits further disclosure without specific written consent of the patient. A general authorization for release of information is not sufficient.

Drug Use Questionnaire

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then circle the appropriate response beside the question.

In the following statements "drug abuse" refers to:

1. the use of prescribed or over-the-counter drugs in excess of the directions, and
2. any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These Questions Refer to the Past 12 Months

1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop using drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Brief Pain Inventory (Short Form)

Study ID# _____ Hospital# _____

Do not write above this line

Date: _____ Time: _____

Name: _____

Last

First

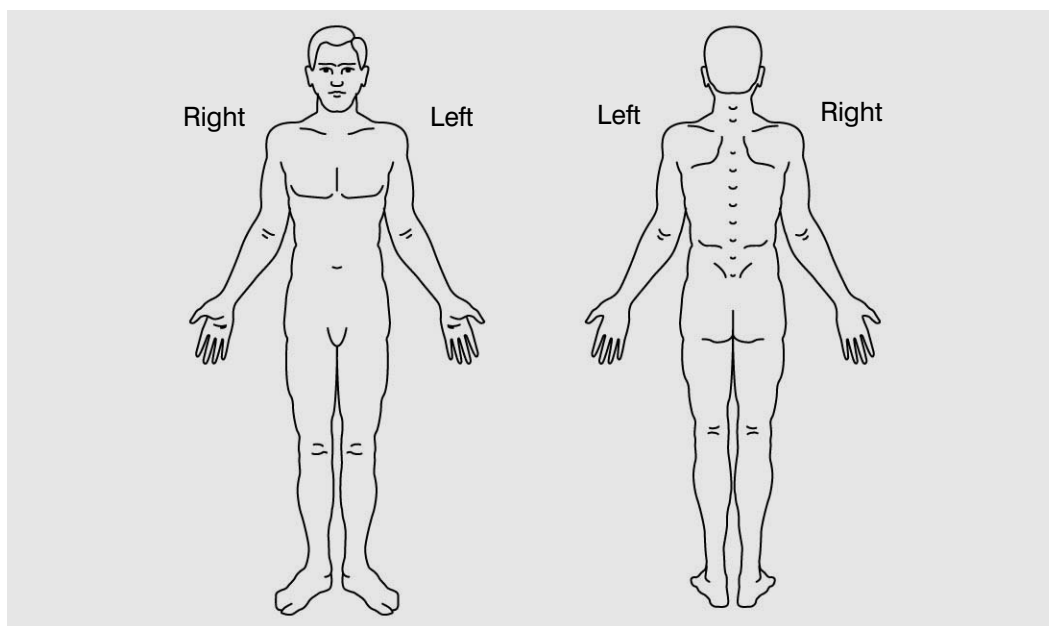
Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes

2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain									Pain as bad as you can imagine	

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain									Pain as bad as you can imagine	

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	4	5	6	7	8	9	10
No pain									Pain as bad as you can imagine	

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10
No pain									Pain as bad as you can imagine	

7) What treatments or medications are you receiving for your pain?

8) In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much RELIEF you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No relief									Complete relief	

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes	

B. Mood:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes	

C. Walking ability:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes	

D. Normal work (includes both work outside the home and housework):

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

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