



NAME: _____ DATE OF BIRTH: _____

NEW PATIENT INTAKE

- Location of your pain: _____
- When did it start: _____
- What happened and when? (Car accident, falling down, nothing, etc.)

- Is your pain constant or intermittent? _____
- From scale of 0 to 10, how bad is your pain today? (0=no pain and 10= severe pain) _____
- From scale of 0 to 10, what was your average pain score throughout the last 30 days? _____
- Where does your pain start? _____
- Where does it go? _____
- **Quality** of your pain(circle all that apply)

Numbness Pins & Needles Burning Aching Stabbing Shooting

- What **aggravates** your pain? (Circle all that apply)

Sitting Bending Walking Lying down Leaning forward Leaning back Coughing/sneezing

Climbing upstairs Going downstairs

- What makes your **pain better**? (Circle all that apply)

Sitting Bending Walking Lying down Leaning Forward Leaning Back Stretching Rest Heat

Cold Medication

If medication, which ones?

- What treatments have you tried? (Circle all that apply)

Physical Therapy Chiropractor TENS Injections Massage Therapy Ibuprofen/Aleve/Motrin Hypnosis

Over-the-counter ointments (Ben-gay, Icy-Hot, Myoflex) Traction Braces Nerve Block Acupuncture

Biofeedback Ice/Heat Narcotics Religious Counseling Psychological Counseling Surgery

- Did any of the above treatments help? If so, which ones helped?

NAME: _____ DATE OF BIRTH: _____

CURRENT MEDICATIONS

Please write current medications in the table below or provide list of medications to staff

PAST MEDICAL HISTORY

Please indicate if you have suffered any of the following medical conditions. Also, state the year when these occurred.

- | | | |
|----------------------------------------------------|-------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Irregular heartbeats |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes infection | <input type="checkbox"/> Chronic skin disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Heart failure | <input type="checkbox"/> AIDS or HIV |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> Nervous breakdown | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Urinary infection |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Lupus | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Seizures/convulsions | <input type="checkbox"/> Schizophrenia/bipolar |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gall bladder issues | Other: _____ |
| <input type="checkbox"/> Menopause | <input type="checkbox"/> Panic attacks | _____ |
| <input type="checkbox"/> Hormone problems | <input type="checkbox"/> Rheumatic heart | |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Multiple sclerosis | |
| <input type="checkbox"/> Heart disease/attack | <input type="checkbox"/> Syphilis | |
| <input type="checkbox"/> Other blood abnormalities | <input type="checkbox"/> Other venereal disease | |

ALLERGIES

Please list all known allergies

Latex: YES NO Adhesive: YES NO Betadine: YES NO

Injection Dye: YES NO Steroids: YES NO Lidocaine/Marcaine: YES NO

NAME: _____ DATE OF BIRTH: _____

PAST SURGICAL HISTORY

Please list previous surgeries and the (month/year) they took place

Date (Month/Yr)	Type of Surgery

FAMILY HISTORY

Please list any disease, illness, or ailments in your IMMEDIATE FAMILY (i.e. mother-breast cancer, father-diabetic, grandfather-heart disease).

Family Member	Disease, Illness, or Ailment

SOCIAL HISTORY

Do you smoke? YES NO HOW MANY PACK/DAY? _____ YEARS? _____

Drink alcohol? YES NO IF YES HOW MUCH? _____

Do you use any other drugs (Marijuana, Cocaine, etc)? YES NO

Marital status? SINGLE MARRIED DIVORCED WIDOWED

Do you live alone? YES NO IF NO, WHO DO YOU LIVE WITH? _____

Is there an ongoing lawsuit related to your visit today? YES NO

NAME: _____ DATE OF BIRTH: _____

REVIEW OF SYSTEMS

In the past few months, have you had any of the following symptoms or difficulties? If you have any difficulty that bears further explanation, please indicate so and explain at the bottom of this page.

Allergy/Immunology

Congestion..... Yes No Enlarged/swollen lymph glands..... Yes No

Ophthalmologic

Blurred vision..... Yes No Itching and redness..... Yes No
Diminished visual acuity..... Yes No Eye pain..... Yes No

ENT

Difficulty swallowing..... Yes No Sore throat..... Yes No
Dry mouth..... Yes No Ringing in ears..... Yes No

Endocrine

Thyroid disease..... Yes No Heat/Cold Intolerance..... Yes No

Respiratory

Shortness of breath at rest..... Yes No Coughing..... Yes No
Wheezing..... Yes No Pain with inspiration..... Yes No

Cardiovascular

Chest pain at rest..... Yes No Palpitations..... Yes No
Varicose veins..... Yes No Orthopnea..... Yes No
Dizziness..... Yes No Weight gain..... Yes No

Gastrointestinal

Hemorrhoids..... Yes No Change in bowel habits..... Yes No
Blood in stool..... Yes No Nausea..... Yes No
Constipation..... Yes No Heartburn..... Yes No

Hematology

Easy bruising..... Yes No Prolonged bleeding..... Yes No

Musculoskeletal

Significant pain/stiffness..... Yes No Joint stiffness..... Yes No
Carpal tunnel..... Yes No Weakness..... Yes No

Skin

Itching..... Yes No Skin cancer..... Yes No
Rashes..... Yes No Skin lesions..... Yes No

Neurologic

Dizziness..... Yes No Tingling/numbness..... Yes No
Seizures..... Yes No Tremor..... Yes No

Psychiatric

Anxiety..... Yes No Loss of appetite..... Yes No
Depressed mood..... Yes No Substance abuse..... Yes No
Difficulty sleeping..... Yes No Suicidal thoughts..... Yes No

ADDITIONAL NOTES



NAME: _____ DATE OF BIRTH: _____

PATIENT INFORMATION

GENDER: ___M___F ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

ETHNICITY: HISPANIC OR LATINO NOT HISPANIC OR LATIN RACE: AMERICAN INDIAN OR ALASKA NATIVE
 ASIAN NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER WHITE BLACK OR AFRICAN AMERICA

EMAIL: _____ MARITAL STATUS: ___MARRIED___ WIDOWED___ SINGLE

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT: _____ EMERGENCY PHONE#: _____

RESPONSIBLE PARTY INFORMATION

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

PHONE: _____ SSN: _____ RELATIONSHIP : _____

EMPLOYER: _____ EMPLOYER PHONE: _____

EMPLOYER ADDRESS: _____

INSURANCE INFORMATION (DO NOT complete if you have already provided this information)

INSURANCE COMPANY: _____ INS. PHONE: _____

INSURANCE ADDRESS: _____

INSURED ID #: _____ GROUP#: _____

MEDICAID #: _____ SECONDARY INSURANCE: _____

SECONDAY INS ID #: _____ SECONDARY INS GROUP #: _____

INSURED'S NAME: _____ DATE OF BIRTH: _____

INSURED'S SSN: _____ RELATIONSHIP TO PATIENT: _____

INSURED'S EMPLOYER: _____



NAME: _____ DATE OF BIRTH: _____

HIPAA Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address(s) below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment, or health care organizations.

I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it's bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's Printed Name Date of Birth

Signature of Patient Date

Legal Representative Relationship to Patient

Georgia Pain and Wellness Center, LLC 455 Philip Boulevard, Building 100, Suite 140 Lawrenceville, GA 30046

NAME: _____ DATE OF BIRTH: _____

Controlled Substance Agreement

We are committed to doing all we can to treat your chronic pain condition. In some cases controlled substances are used as a therapeutic option in the management of chronic pain and related anxiety and depression which is strictly regulated by both stated and federal agencies. This agreement is a tool to protect both you and the physician by establishing guideline, within the laws, for proper controlled substance use. The words “we” and “our” refer to the facility and the words “I”, “you”, “your”, “me”, or “my” refer to you, the patient.

1. I understand that chronic opioid therapy has been associated with not only addiction and abuse but also multiple medical problems including the suppression of endocrine function resulting in low hormonal levels in men and women which may affect mood, stamina, sexual desire, and physical and sexual performance.
2. For female patients, if I plan to become pregnant or believe that I have become pregnant while taking this medication, I am aware that, should I carry the baby to delivery while taking these medications, the baby will be physically dependent upon opioids. I will immediately call my obstetrician and this office to inform them of my pregnancy. I am also aware that opioids may cause a birth defect even though it is extremely rare.
3. I have been informed that long term and/or high doses of pain medications may also cause increased levels of pain known as opioid induced hyperalgesia (pain medicine causing more pain) where simple touch will be predicted as pain and pain gradually increases in intensity and also the location with hurting all over the body. I understand that opioid induced hyperalgesia is a normal expected result of using these medicines for a long period of time. This is only treated with addition of non-steroidal anti-inflammatory drugs such as Advil, Ibuprofen, etc. or by reducing or stopping opioids. I understand that I should not operate any heavy machinery while under the influence of narcotics.
4. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine uses is markedly decreased, stopped, or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.
5. I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain, however it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment, reduce the dose, or stop it.
6. I: All controlled substances must come from the physician whose signature appears below or during his/her absence, by the covering physician unless specific authorization is obtained for an exception.
7. I understand that I must tell the physician whose signature appears below or during his/her absence the covering physician, all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death.
8. I may not seek prescriptions or controlled substances from any other physician, healthcare provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physician's knowledge.
9. I also understand that it is unlawful to obtain or to attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician or his/her staff or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed).
10. All controlled substances must be obtained at the same pharmacy when possible. Should the need arise to change pharmacies, our office must be informed.



NAME: _____ DATE OF BIRTH: _____

11. You may not share, sell, or otherwise permit others, including your spouse or family members, to have access to any controlled substances that you have been prescribed.
12. Early refills will not be given; all patients will be seen every 30 days to receive refills on medications. Renewals are based upon keeping scheduled appointments ONLY during working hours. Please DO NOT make excessive phone calls for prescriptions on early refills and do not phone for refills after hours or on weekends. Georgia Pain and Wellness Center has hours of operation between 8:30 am and 5:00 pm on Monday through Friday. Medication refill requests made via telephone have 24 BUSINESS HOURS to be returned.
13. Unannounced pill counts (random or planned) urine or serum adherence monitoring may be requested from you and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from the facility and its physicians and staff.
14. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose signature appears below or during his/her absence by the covering physician, as set forth in Section 2 above. I will not use, purchase, or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance or any combination of substances (e.g. alcohol and prescription drugs), which impairs my driving ability may result in DUI charges.
15. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen, it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told the authorities is not enough.
16. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol) refills on controlled substances will not be given.
17. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at the facility and that law enforcement officials may be contacted
18. I also understand that the prescribing physician has permission to discuss all diagnostic and treatment details, including medications, with dispensing pharmacists, other professionals who provide your healthcare, or appropriate drug and law enforcement agencies for the purposes of maintaining accountability.
19. I am aware that it is a felony in Georgia for a patient to fail to disclose to his physician that he has received a controlled substance of a similar therapeutic use from another practitioner.
20. I affirm that I have full right and power to sign and to be bound by this agreement, that I have read it and understood and accept all of its terms.

My signature below acknowledges that I have read and received the Controlled Substance Agreement and the policies concerning prescription of dependence producing drugs.

Patient's Full Name Date

Patient's Signature Date

Supervising Provider Signature Date

Witness Date



NAME: _____ DATE OF BIRTH: _____

Clinic Policies

Initials _____ Payment is due at the time services are rendered. I understand that if I have insurance that I am the responsible party, and that having insurance does not guarantee payment of the services rendered to me. I authorize submission of my claim to the insurance company listed above.

Initials _____ If you are unable to make an appointment please call within 24 hours prior to your appointment time to reschedule. If you fail to notify our office prior to missing your scheduled appointment you will be charged a NO SHOW fee of \$25 for an office visit and \$50 for a procedure. Frequent NO SHOWS may result in a release from the practice.

Initials _____ Permission for treatment: I hereby authorize physician and assistants for the care of the patient named on this record to administer treatment as may be deemed necessary including examinations of treatments that may be ordered to be performed by the clinical personnel. I acknowledge that no guarantees have been made to me to the result of examinations or treatments to be performed.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office’s notice of privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature

Date