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Sweetwater
Pain and Spine

PATIENT INFORMATION

Patient Name (Last, First, MI)				Birthdate	
Email	Marital Status		Gender	SSN	
Physical Address		City		State	Zip
Mailing Address		City		State	Zip
Home Phone	Work Phone	Cell Phone		Written Contact Preference (Click): ◯ **Email** ◯ **Postal Mail**	

Race: (Click): ◯ American Indian ◯ Alaska Native ◯ Asian ◯ Hawaiian ◯ Pacific Islander ◯ Black or African American ◯ Hispanic or Latino ◯ White or Caucasian ◯ Refuse to Report ◯ Other:	**Ethnicity (Click):** ◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Refuse to Report
Have you recently been injured in a Motor Vehicle Accident? ◯ **YES** ◯ **NO**	**If yes:** **Date of Injury**_____ **Name of Attorney**_____

EMPLOYMENT INFORMATION

Employment Status (Click): ◯ Employed ◯ Unemployed ◯ Full-Time Student ◯ Part-Time Student / Other		
Employer Name	Employer Address	Employer Phone

EMERGENCY CONTACT INFORMATION

Name	Relation to Patient
Address (Street, City, State, Zip)	Phone

GUARANTOR/RESPONSIBLE PARTY

Name	Relationship ◯ SELF ◯ OTHER: (specify)	
DOB	Phone	Address

INSURANCE INFORMATION

PRIMARY Insurance Name	Policy Holder Name	DOB
ID #	Group # Name	Relationship to Policy Holder
SECONDARY Insurance Name	Policy Holder Name	DOB
ID#	Group #	Relationship to Policy Holder
TERTIARY Insurance Name	ID #	Group #

REFERRING PROVIDER/PRIMARY CARE PHYSICIAN

Name of Referring Provider	Phone Number
Name of Primary Care Provider	

Informed Consent, Acknowledgements and Authorizations

- **Patient Certification:** I certify that the above information is accurate to the best of my knowledge.
- **Patient Physician Relationship:** I understand that Sweetwater Pain and Spine is staffed by health care professionals who, although all dedicated to helping and caring for patients at Sweetwater Pain and Spine, may be independent contractors with the patient and are not necessarily employees or agents of Sweetwater Pain and Spine. Each patient is under the care and supervision of his/her attending physician and it is the responsibility of all persons involved with patient care to carry out the instructions of such physician. The relationship between the patient and the physician is at the direction of the patient. Should the patient choose to no longer accept the services of their treating physician, it is the responsibility of the patient and/or their family to obtain the services of another physician.
- **Treatment Authorization, Acknowledgment of Risk, and Promise to Cooperate:** I authorize Sweetwater Pain and Spine to evaluate and treat my medical condition. I understand there are no guarantees of expected results. I understand that every treatment has risks that cannot be reasonably avoided. I agree to be a proactive and cooperative and compliant patient in order to optimize treatment and care.
- **Medication History:** I consent to allowing Sweetwater Pain and Spine to access and review my medication history as available via prescription drug monitoring programs in determining treatment decisions and acknowledge that this will become part of my medical records.
- **HIPAA Acknowledgement:** I hereby acknowledge that I have been made aware that Sweetwater Pain and Spine has a Privacy Policy in place in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how my protected health information may be used and disclosed, and how I may access my health records. I acknowledge that his policy is available for review in the Sweetwater Pain and Spine office as well as its website. I am informed that I am entitled to a copy of the Privacy Policy if I desire a copy for my personal file.
- **Financial Responsibility:** I understand and acknowledge that I am personally responsible for the services rendered by Sweetwater Pain and Spine. As a courtesy, my insurance carrier will be billed and, to the extent that applicable insurance benefits exist for treatment received by me from Sweetwater Pain and Spine, said benefits are hereby assigned to be applied to my patient bill. In the event of non-payment by an insurer or any other third-party, I understand I remain responsible for any outstanding balances.
- **Authorization to Verify Information:** I hereby authorize verification of employment history, banking accounts, credit history and any other information deemed necessary in conjunction with accounts owed Sweetwater Pain and Spine.
- **Communications to Patient**: I give Sweetwater Pain and Spine permission to leave a voice message on my preferred phone number voice mail.
- **A photocopy, fax or electronic copy of this form shall be considered as effective and valid as the original.**

_____ _____

Type PATIENT NAME above to acknowlege polcies **Date**

Personal Release of Information

***This is NOT a professional release intended for attorneys or other physicians.**

***This form is for family members/loved ones to have full access to your records and/or billing information**

If NO NAME is designated, then information will ONLY be released to YOU directly.

I,_____give my full permission to Sweetwater Pain and Spine to disclose details of my billing records and discuss my treatment/care either verbally or in written form with:

_____ _____

Name Relation to Patient

_____

Date

Acknowledgment of Receipt of Privacy Notice

Applies to Guarantor of Account or spouse only

I do hereby acknowledge that I have been made aware that Sweetwater Pain and Spine has a Privacy Policy in place in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how my protected health information may be used and disclosed, and how I may access my health records. I acknowledge that his policy is available for review in the Sweetwater Pain and Spine office as well as its website. I am informed that I am entitled to a copy of the Privacy Policy if I desire a copy for my personal file.

I understand that by law (FPR 45 CPR § 164.524) my records are protected and that disclosure in most instances requires my signed permission.

_____ _____

Type PATIENT NAME above to acknowledge policy/policies **Date**

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel an appointment. It is therefore requested that if you must cancel an appointment you provide more than a **48 hour notice**. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot.

With cancellations made less than a 48 hour notice, we are unable to offer that slot to other people. Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as NO SHOW.

Office appointments cancelled with less than 48 hours notification or No Show appointments will be subject to the following Cancellation/No Show fees:

$25 fee - Follow up office visits
$50 fee - Procedure appointments (EMG/Injection)

Patients who No Show two (2) or more times in a 12 month period may be dismissed from the practice and denied any future appointments.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before or at the time of the patient's next appointment. In other words, you are personally responsible for the fees and this will NOT be billed through your insurance.

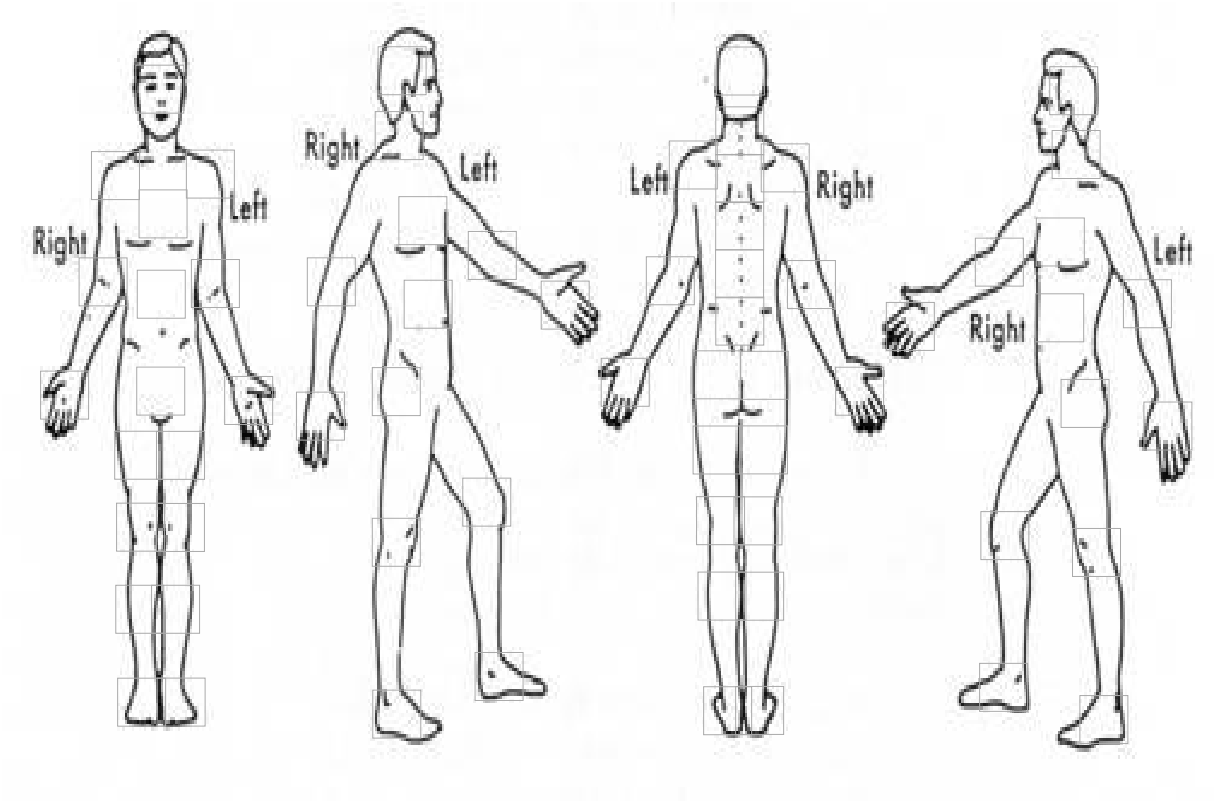
In order to be a patient in our clinic you must sign that you have read, understand, and agree to this Cancellation/No Show policy.

_____ _____

Type PATIENT NAME above to acknowledge policy Date

Patient Name _____DOB_____

Please CLICK in the area of your pain below:



What number best describes your pain on average in the past week?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Have you received an influenza shot? ◯Yes ◯No If yes, when_____

Have you received a pneumonia shot? ◯Yes ◯No If yes, when_____

Sweetwater
Pain and Spine

CHIEF COMPLAINT INFORMATION

Please fill out this form to your best ability so that we may be able to address your pain condition to the best of our ability.

Name: _____

Reason for visit:_____How long ago did your pain start? _____

Where is your pain located? ☐ Head ☐ Neck ☐ Shoulder ☐ Mid Back ☐ Low Back
☐ Arm ☐ Leg ☐ Other: _____

Did it start suddenly or gradually? ☐ Suddenly ☐ Gradually

How would you describe your pain? ☐ Achy ☐ Burning ☐ Cramping
☐ Dull ☐ Sharp ☐ Shooting
☐ Stabbing ☐ Stiff ☐ Throbbing

What makes your pain better? _____

What makes your pain worse? _____

Does your pain radiate?	☐ Yes	☐ No
Do you have numbness/tingling in your limbs?	☐ Yes	☐ No
Do you have weakness in your limbs?	☐ Yes	☐ No
Is your pain constant or does it come and go?	☐ Constant	☐ Comes and goes
Did your pain begin after a trauma?	☐ Yes	☐ No
Does your pain affect your ability to work or go to school?	☐ Yes	☐ No
Does your pain affect your daily activities?	☐ Yes	☐ No
Do you have osteoporosis?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Have you had cancer?	☐ Yes	☐ No
Have you had surgery for your pain?	☐ Yes	☐ No
Have you ever had similar symptoms/injury before	☐ Yes	☐ No
If yes, describe briefly:		

Have you recently been injured in a Motor Vehicle Accident? ◯ **YES** ◯ **NO**	**If yes:** **Date of Injury**_____ **Name of Attorney**_____

Do you have any of the following? ☐ Fever ☐ Bowel Problems ☐ Bladder Problems

What treatments have you had for your pain? _____

_____

Have you had any of the following diagnostic studies? ☐ X-ray ☐ CT ☐ MRI
☐ EMG (nerve condition studies)

Where were the studies performed? _____

MEDICATION ALLERGIES: ◯ No ◯ Yes (If yes, please list below)

Name	Describe reaction:

CURRENT MEDICATIONS

Name	Dosage	How often do you take?

PAST MEDICAL HISTORY

- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Claustrophobia
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Headache
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Lung Disease
- ☐ Organ Transplant
- ☐ Parkinson's
- ☐ Shingles
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcers(GI)

Hepatitis (If yes, click:) ◯ A ◯ B ◯ C

- ☐ MRSA
- ☐ HIV / AIDS

☐ Other Conditions: _____

PAST SURGICAL HISTORY

Have you had any surgeries? ◯ No ◯ Yes

If yes, please list type of surgery and approximate date:

1._____ 2._____ 3._____ 4._____

5._____ 6._____ 7._____ 8._____

FAMILY HISTORY

Please CLICK box for any medical condition that a blood relative has a history of:

☐ Anxiety	☐ Arthritis	☐ Asthma	☐ Autoimmune Disease	☐ Back Problems
☐ Cancer	☐ Dementia	☐ Depression	☐ Diabetes	☐ Epilepsy
☐ Gout	☐ Headache	☐ Heart Attack	☐ Heart Failure	☐ High Cholesterol
☐ Hypertension	☐ Kidney Stones	☐ Lung Disease	☐ Stroke	☐ Thyroid Disease
☐ Other: _____				

SOCIAL HISTORY

Marital Status: (Click one)

◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ "Living Together" ◯ Separated

Number of Children: _____ Ages: _____

Do you smoke?	◯ No	◯ Yes	How much per day? _____
Previous Smoker?	◯ No	◯ Yes	When stopped? _____
Do you drink alcohol?	◯ No	◯ Yes	How much per day? _____
Coffee, tea, cola beverages?	◯ No	◯ Yes	How much per day? _____
Do you use recreational drugs?	◯ No	◯ Yes	What type? How often? _____
Are you currently employed	◯ No	◯ Yes	If yes, type of job

REVIEW OF SYMPTOMS: Please CLICK those items which you currently experience

GENERAL

☐ Chills	☐ Fatigue	☐ Fever	☐ Night sweats	☐ Weakness
☐ Weight gain	☐ Weight loss	☐ Other:		

SKIN

☐ Easy bruising	☐ Itching	☐ Jaundice	☐ Lesions	☐ Rashes

HEAD/EYES/EARS

☐ Dizziness	☐ Head injury	☐ Headaches	☐ Blurry vision	☐ Double vision
☐ Eye pain	☐ Eyeglass use	☐ Light sensitivity	☐ Vision loss	☐ Ear pain
☐ Hearing loss	☐ Ringing in ears	☐ Sound sensitivity		

RESPIRATORY

☐ Asthma	☐ Bronchitis	☐ Coughing blood	☐ Shortness of breath	☐ Wheezing

CARDIOVASCULAR

☐ Chest pain	☐ Palpitations	☐ Swelling of legs

GASTROINTESTINAL

☐ Abdominal pain	☐ Bloody/dark stool	☐ Constipation	☐ Diarrhea	☐ Nausea

GENITOURINARY

☐ Blood in Urine	☐ Frequency/Urgency with urination	☐ Incontinence	☐ Pain/burning on urination
☐ Retention	☐ Stones	☐ Discharge	☐ Irregular Menstruation
☐ Menstrual Pain	☐ Sexual problems	☐ Venereal disease	

MUSCULOSKELETAL

☐ Arthritis	☐ Joint swelling	☐ Muscle cramps	☐ Trauma

NEUROLOGICAL

☐ Numbness/tingling	☐ Seizures	☐ Unsteady gait	☐ Weakness

PSYCHIATRIC

☐ Anxiety	☐ Depression	☐ Disturbing thoughts	☐ Disorientation	☐ Mood Changes	☐ Stress

Sweetwater
Pain and Spine

Name:_____ Birth date:_____

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

Click/Check the box that applies below

	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling asleep, staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
Trouble concentrating on things such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
Thinking that you would be better off dead or that you want to hurt yourself in some way				
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it's hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

For Office Use

5-14 (10)

For Office Use

10-14

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

	YES	NO
Have had nightmares about it or thought about it when you did not want to?		
Tried hard not to think about it or went out of our way to avoid situations that reminded you of it?		
Were constantly on guard, watchful, or easily startled?		
Felt numb or detached from others, activities, or your surroundings?		

For Office Use

3

Name:_____ Birth date:_____

Sweetwater Pain and Spine

Please answer the following questions by clicking/checking the appropriate box :

		Yes	No
1. Do you have a family history of substance abuse of:			
	Alcohol		
	Illegal Drugs		
	Prescription Drugs		
2. Do you have a personal history of substance abuse of:			
	Alcohol		
	Illegal Drugs		
	Prescription Drugs		
3. Are you between the ages of 16 and 45 years?			
4. Do you have a history of preadolescent sexual abuse?			
5. Do you have any of these psychological conditions:			
	ADD/ADHD, OCD, Bipolar, or Schizophrenia		
	Depression		
6. Have you ever been arrested?			

For Office Use Only	
1	3
2	3
4	4
3	3
4	4
5	5
1	1
3	0
2	2
1	1
+	+
M 4-7	

IMPORTANT: If you are NOT interested in opioid treatment through our clinic, then you may skip this form. Otherwise, this form is mandatory.

PATIENT CONTROLLED SUBSTANCE AGREEMENT FOR CHRONIC PAIN

Sweetwater Pain and Spine

Date: _____

Patient Name: _____ DOB: _____

The purpose of this Agreement is to prevent misunderstandings about certain medicines you may be taking or are prescribed at Sweetwater Pain and Spine. This is to help both you and your provider to comply with regulations regarding controlled substances.

Controlled substances are being used because I have a persisting pain condition, and other treatments have not helped or resolved the condition.

I understand that this agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this agreement.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepines, tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit, as well as their risks. There is also the risk of an addictive disorder developing, or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the treatment is helping to relieve the pain and influence my function. I will inform my provider of any adverse effects I am experiencing with the medicine or treatment.

It is understood that any treatment is a trial, and that continued treatment is contingent on evidence of benefit. There is a risk the medication or treatment will not provide pain relief or improve my function.

Because these drugs have potential for abuse or diversion, strict accountability is necessary. For this reason, I, the patient, agree to the following policies as a consideration for and a condition of the willingness of the provider to prescribe the initial and/or continued prescription of controlled substances to treat my pain.

I will tell my provider about all other medicines, treatments, and studies that I am receiving from all other providers. If requested, I will assist with obtaining records of previous medical care.

I understand that my provider may order additional diagnostic tests or recommend additional treatments or consultations as part of the management. I agree to make a good faith effort to comply with these recommendations.

I give the prescribing provider permission to discuss all diagnostic and treatment details with dispensing pharmacists or other providers who are involved in my care.

I am advised that certain other medications such as nalbuphine (Nubain), pentazocine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol), may reverse the action of the medication I am using for pain control. Taking any of these other medicines while I am taking my medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid; I understand I cannot take any of the medicines listed above without permission.

I am advised that addiction is defined as the use of a medication even if it causes harm, having cravings for a drug, feeling the need to use a drug, and a decreased quality of life or function. I am advised that there is a risk of becoming addicted to the medicine prescribed. I

am advised that the development of addiction has been reported in medical journals, and is more common in a person who has a family or personal history of addiction. I agree to tell my provider my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medications for a period of time. I understand that physical dependence is not the same as addiction. I am advised that physical dependence means that if my medication use is markedly decreased, stopped, or reversed by some of the agents mentioned above, I may experience a withdrawal syndrome. This means that 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 flu-like feelings. I am advised that opioid withdrawal is uncomfortable, but the life-threatening risk is very low.

I am advised that tolerance to analgesia means that I may require more medication over time to get the same amount of pain relief. I am advised that tolerance to analgesia can occur with patients treated for chronic pain. If it occurs, increasing doses may not help, and may cause unacceptable side effects. Tolerance or failure to respond to controlled substances may cause my provider to choose another form of treatment.

(Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire, and physical and sexual performance. I understand that my provider may order tests to assess my testosterone/endocrine levels.

(Females only) If I plan to become pregnant or believe I have become pregnant while taking these medications, I will immediately call my obstetric physician and this office to inform them. I am advised that should I carry a baby to delivery while taking these medications the baby will be physically dependent to these medications. I am advised that the use of opioids is not generally associated with birth defects. However, birth defects can occur whether or not the mother is taking medication, and there is always the possibility that my child will have a birth defect while I am taking controlled substances.

I understand that if I break this agreement, my provider may stop prescribing these medicines. In this case, my provider may taper off the medicine in an effort to minimize withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

Please check each box to show you understand the requirements below:

☐ I have been apprised of the possible risks and benefits of other types of treatments that do not involve the use of controlled substances.

☐ I will not share, sell, or trade my medication with anyone.

☐ I will comply, if asked, to bring all unused medicines to an office visit.

☐ I agree that prescriptions for medicine will be made only at the time of an office visit during regular office hours. No prescriptions for controlled substances are provided by phone/fax to the pharmacy. No prescription will be written in the evenings or on weekends.

☐ I will not use any federal illegal substances, including marijuana, cocaine, etc. I will abstain from alcohol while on controlled substances. If I have a history of substance use, abuse or psychiatric care, I will inform my doctor. Additionally, I agree to participate in psychological and/or psychiatric consultation treatment, if recommended by my provider.

☐ I agree that I will use my medicine at a rate no greater than the prescribed rate. I understand that use of my medicine at a greater rate will result in my being without medication for a period of time and an abstinence syndrome will develop (withdrawal symptoms).

☐ I agree that I will submit to unannounced blood, oral swab or urine tests if requested by my provider to determine my compliance with treatment. The test may also be used to detect illegal substances. If I am found to have illegal substances, my provider may stop prescribing medications and may refer me to a drug-dependence treatment program.

☐ I will not attempt to obtain any opioid medicines from any other provider without authorization from Sweetwater Pain and Spine.

☐ I understand that prescriptions and bottles of these medications may be sought by others and should be closely safeguarded. I will safeguard my medicine and prescriptions from loss or theft. Lost or damaged medicines will not be replaced. Stolen medications may be replaced with a verified police report at the provider's discretion.

☐ Since the medicines may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, I must keep them out of reach of such people.

☐ I am advised that the use of such medications has certain risks associated with it, including, but not limited to: constipation, nausea, itching, sleepiness or drowsiness, vomiting, dizziness, allergic reaction, osteoporosis, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, increased pain, addiction, slowing of breathing rate, overdose and death. As is true of all medications in medical treatment, there is always the possibility of a new or unexpected risk.

☐ I will not be involved in any activity that may be dangerous to me or anyone else if I feel drowsy or am not thinking clearly. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights, or being responsible for another individual who is unable to care for him or herself. I am advised that even if I do not notice it, my reflexes/reaction time might be slowed.

☐ I authorize my provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including State's Board of Medicine or Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my medicine. I authorize my provider to provide a copy of this agreement to my pharmacy or other providers. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

☐ I understand that certain medications including but not limited to benzodiazepines, sedatives, and Soma impose a greater risk of overdose when taken alongside opioid medications. I will abstain from taking these medications while prescribed opioids.

☐ I understand that alcohol can interact with opioid medications and can increase the risk for overdose. I will abstain from drinking alcohol while prescribed opioid medications.

I agree to only use (Pharmacy name) _____for filling prescriptions for all of my controlled substance medicines.
(Pharmacy location): _____

I agree to follow this agreement that has been fully explained to me. All of my questions and concerns regarding this agreement have been adequately answered. I affirm that I have the full right and power to sign and be bound by this agreement, and that I have read, understood, and accepted all of its terms. By signing this agreement voluntarily, I give my consent for the treatment of my pain with controlled substances.

A copy of this agreement has been given to me at my request.

This Agreement is entered into on: _____

☐ By clicking this box, your electronic signature will be applied to this Agreement and will have the same legal effect as a handwritten signature.

_____

Type PATIENT NAME above to acknowledge agreement