INTERSPINE
PAIN & WELLNESS CENTER

NEW PATIENT REGISTRATION

PATIENT INFORMATION

First & Last Name: _____ Preferred Name: _____ DOB: _____

Address: _____ Email: _____

Preferred Phone: _____ Alternative Phone: _____ Primary Care Physician: _____

Pharmacy: _____ Emergency Contact (Relation): _____

Marital Status: _____ Preferred Language: _____ Race: _____ Ethnicity: _____

SOCIAL HISTORY

Smoking Status: ☐ Never ☐ Former ☐ Current (# PPD, Years): _____

Alcohol Use: ☐ Never ☐ Occasionally ☐ Moderate ☐ Heavy Illicit Drug Use: ☐ Never ☐ Former: _____ ☐ Current: _____

Exercise Level: ☐ Never ☐ 1-2 days/week ☐ 3-4 days/week ☐ 5-7 days/week

Employment: ☐ Retired ☐ Disabled ☐ Not working ☐ Part or Full-time: Occupation _____

Have an Advanced Directive? ☐ Yes ☐ No Medical Power of Attorney? ☐ Yes ☐ No Code Status: ☐ DNR ☐ DNI ☐ Full Code

MEDICAL HISTORY

Allergies & Reactions: _____ ☐ No Known Drug Allergies

Please indicate all current and former medical conditions below:

☐ Hypertension	☐ Hyperthyroid	☐ HIV/AIDS	☐ Osteoarthritis
☐ High Cholesterol	☐ Hypothyroid	☐ Hepatitis	☐ Osteoporosis
☐ Heart Disease	☐ Diabetes	☐ Insomnia	☐ Fibromyalgia
☐ Heart Attack	☐ COPD	☐ Sleep apnea	☐ Rheum. Arthritis
☐ DVT/PE	☐ Cancer: _____	☐ Anxiety	☐ Migraines
☐ Liver Disease	☐ Acid Reflux	☐ Depression	☐ Neuropathy
☐ Kidney Disease	☐ IBS/Crohn's	☐ Seizures	☐ Scoliosis
☐ Stroke/TIA	☐ Vision Loss	☐ Bipolar Disorder	☐ Gout
☐ Heart Failure	☐ Hearing Loss	☐ Dementia	☐ Other: _____

Family History: _____

Surgical History:

☐ Tubal Ligation	☐ Spine: _____	☐ Cardiac Bypass Surgery
☐ Hysterectomy	☐ Knee: _____	☐ Cardiac Stent Placement
☐ Gastric Bypass	☐ Hip: _____	☐ Foot/Ankle: _____
☐ Hernia Repair	☐ Shoulder: _____	☐ Other: _____

Please list all medications, vitamins, and supplements you take below, continue on back of page if needed:

Medication & Dose	Frequency	Indication

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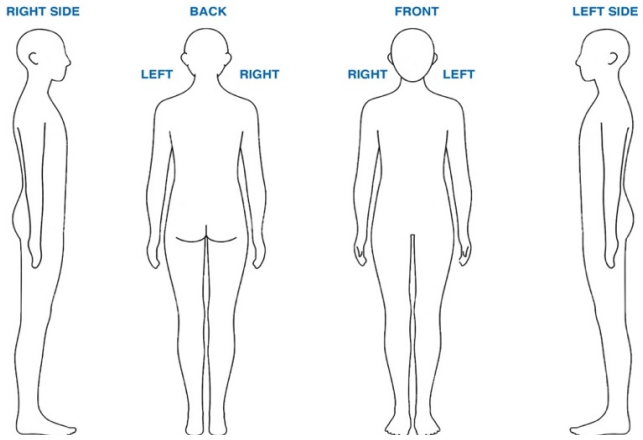
Please mark the areas where your pain is located:



Circle the terms that best describe your pain:

Acute Chronic Aching Dull Sharp
Stabbing Numbness Tingling Weakness
Throbbing Shooting Radiating Burning
Constant Intermittent Stiffness Heaviness
Severe Hot Cold Sore Pressure
Other: _____

When did your problems with pain begin:
_____

How did your problems with pain begin? (i.e, accident, fall, work-related, etc.):
_____

What have you tried to treat the pain? (i.e, physical therapy, medication, injections, etc.):
_____

Circle your **current** pain level: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable)

Circle your **worst** pain level: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable)

PQRS Depression Questionnaire:
Over the last two weeks, how often have you experienced or been bothered by…

	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things?				
2. Feeling down, depressed, or hopeless?				
3. Trouble falling or staying asleep, or sleeping too much?				
4. Feeling tired or having little energy?				
5. Poor appetite or overeating?				
6. Feeling bad about yourself or that you are a failure?				
7. Trouble concentrating on things?				
8. Moving or speaking so slowly that people could have noticed?				
9. Thoughts of hurting yourself in some way?				
10. If you selected any of these problems, how difficult have they made it to carryout day to day tasks?	☐ Not at all	☐ Somewhat difficult	☐ Moderately difficult	☐ Extremely difficult

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☐ ***Check here if you do NOT currently take/wish to discuss taking opioid medications as part of your treatment plan. In this case, you may skip BOTH of the following questionnaires.***

Please complete the patient screening questionnaires below if you are currently prescribed opioid medications or wish to discuss opioid medications as a potential part of your treatment plan. Please answer each question as honestly as possible. This information will remain confidential, and your answers alone will not determine your treatment.

Opioid Risk Tool – Revised (ORT-R): check each box that applies.

Family history of alcohol abuse		Personal history of alcohol abuse	
Family history of illegal drug abuse		Personal history of illegal drug abuse	
Family history of Rx drug abuse		Personal history of prescription drug abuse	
Current age between 16-45 years old		Diagnosed with ADD, OCD, Bipolar or Schizophrenia	
History of preadolescence sexual abuse		Diagnosed with Depression	

Screener and Opioid Assessment for Patients with Pain (SOAPP-R): check the box that applies.

	Never	Seldom	Sometimes	Often	Very Often
How often do you have mood swings?					
How often have you felt a need for higher doses of medication to treat your pain?					
How often have you felt impatient with your doctors?					
How often have you felt that things are just too overwhelming that you can't handle them?					
How often is there tension in the home?					
How often have you counted pain pills to see how many are remaining?					
How often have you been concerned that people will judge you for taking pain medication?					
How often do you feel bored?					
How often have you taken more pain medication than prescribed?					
How often have you worried about being left alone?					
How often have you felt a craving for medication?					
How often have others expressed concern over your use of medication?					
How often have any of your close friends had a problem with alcohol or drugs?					
How often have others told you that you had a bad temper?					
How often have you felt consumed by the need to get pain medication?					
How often have you ran out of pain medication early?					
How often have others kept you from getting what you deserve?					
How often, in your lifetime, have you had legal problems or been arrested?					
How often have you attended an AA or NA meeting?					
How often have you been in an argument that was so out of control that someone got hurt?					
How often have you been sexually abused?					
How often have others suggested that you have a drug or alcohol problem?					
How often have you had to borrow pain medications from your family or friends?					
How often have you been treated for an alcohol or drug problem?					

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Authorization and Consent for Medical Treatment

Chronic opioid therapy is prescribed for a clearly defined anatomical pain generator causing moderate to severe refractory pain as well as malignant cancer pain. Short-term opioid therapy is prescribed for acute pain related to an injury, surgery, or for adequate pain control during the treatment of a painful condition. Due to the potential for abuse or diversion associated with these drugs, strict accountability is necessary. We intend for this document and the communication process associated with it to improve the relationship between you and our providers and staff and to ensure you have the necessary information to help with your healthcare decisions. Review this document carefully and talk to your provider if you have any questions.

InterSpine Pain and Wellness Center practices a multidisciplinary approach to pain management. I understand and agree to referrals for evaluation and or treatment of behavioral health, physical therapy, or other related programs and agree to attend the appointments as scheduled. I understand that I will inform my pain management provider of any treatments or procedures that I receive. I also understand that I am required to attend all scheduled appointments with my pain management provider. In the event you need to cancel or reschedule your appointment, please follow the guidelines as detailed in InterSpine Pain and Wellness Center's No-Show / Missed Appointment Policy. Prescriptions may not be renewed if the patient cancels or no-shows for an appointment.

I affirm that I have full right and power to sign and be bound by this agreement. I have read, understand, and voluntarily agreed to the treatment consisting of opioid pain medicines and other treatment modalities for my pain control. The use of pain medication is not an exclusive treatment remedy and will be used in conjunction with other treatment modalities. The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my day-to-day function. I understand medication will be discontinued if deemed unsafe or not the best treatment option for my complaint. Permission is hereby given for any medical/surgical procedures, X-rays, drug or laboratory test, medication, or exam as may be deemed necessary by the physician, physician assistant, or nurse practitioner. In the case of an unemancipated minor, the consent below is being given on his or her behalf.

_____

Patient / Agent / Guardian Signature Date

Consent to Take Videos or Photograph

InterSpine Pain and Wellness Center may choose to take medical or educational videos and/or medical photographs of me to be part of my medical record for purposes of comparison before and after certain treatments, to track certain types of lesions, for proper identification, educational purposes, instructional purposes, medical teaching, and for radiographic imaging. I agree that videos and/or photographs may be taken during the procedure and these videos and/or photographs remain the property of InterSpine Pain and Wellness Center. In the case of an unemancipated minor, the consent below is being given on his or her behalf.

_____

Patient / Agent / Guardian Signature Date

No-Show/Missed Appointment Policy

We at InterSpine Pain and Wellness Center understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your scheduled appointment due to an emergency, please call us as soon as possible. For all non-emergent cancellations, please contact our office at least 24 hours in advance. To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder email, call, and/or text to you will be made/attempted before your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

Please review the following policy:

- Please cancel your appointment with at least 24 hours' notice.
- If less than 24-hour cancellation is given, this will be documented as a no-show appointment.
- If you do not present to the office for your appointment, this will be documented as a no-show appointment.
- If you arrive 15 minutes late or more for your scheduled appointment, you will be considered a no show
- If you no-show a regular office visit appointment with InterSpine Pain and Wellness Center, we will apply a $50 no show fee to your account. If you no-show a surgery or procedure, we will apply a $250 no show fee to your account. These fees will have to be paid in full before we schedule you for any additional appointments.
- If you have three no show appointments within a 12-month period, you may be subject to dismissal from our practice. You will be notified by letter if dismissal occurs.

I have read and understand InterSpine Pain and Wellness Center's no-show appointment policy and understand my responsibility to plan appointments accordingly and notify InterSpine Pain and Wellness Center appropriately if I have difficulty keeping my scheduled appointments. In the case of an unemancipated minor, the consent below is being given on his or her behalf.

_____

Patient / Agent / Guardian Signature Date

Financial Responsibility

I understand it is the responsibility of each patient to arrange for payment for the medical services received in this office. I hereby authorize any insurance benefits to be paid directly to InterSpine Pain and Wellness Center and recognize my responsibility to pay for all non-covered services. I also authorize the release of any information necessary to process an insurance claim. Charges for all minors are the responsibility of the parent, guardian, or individual presenting the child for treatment.

I hereby authorize InterSpine Pain and Wellness Center or any of its affiliates, agents, contractors, or business associates, to contact me (by any telephone numbers, e-mail addresses, or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by prerecorded forms of voice messaging systems, by electronic mail owned or used by the guarantor/responsible party, by text messages, by telephone or by cell phone for reasons related to the services I have received at InterSpine Pain and Wellness Center or payment for the services I received at InterSpine Pain and Wellness Center including but not limited to, debt collection purposes. In the case of an unemancipated minor, the consent below is being given on his or her behalf.

_____

Patient / Agent / Guardian Signature Date

Acknowledgment of Privacy Rights

By signing below, I acknowledge that I am aware of InterSpine Pain and Wellness Center's notice of privacy practices and individual rights. We may use or share your medical information with personnel involved in your care at IPWC. We may also disclose your medical information to people outside of the system, such as health information exchanges. IPWC Notice of Privacy Practices contains more information about the policies and practices protecting the patient's privacy. I acknowledge that I have read the above, I am going to give my consent to the above and am acknowledging that I have been informed of my rights to privacy. In the case of an unemancipated minor, the consent below is being given on his or her behalf.

_____

Patient / Agent / Guardian Signature Date

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Authorization for Controlled Substance Therapy for the Treatment of Chronic Pain

1. I have discussed my complete medical history, and I do not have any history of substance abuse, dependency, or addiction that I have not discussed with Dr. Hemani.
2. All controlled substances must be obtained through the same pharmacy. Should the need arise to change your pharmacy, our office MUST be notified within 48 hours.
3. You are required to take opioid medication ONLY as prescribed to you by Dr. Hemani. You may not take more than prescribed. You may not obtain pain medication, benzodiazepines, or stimulants, from other sources or providers without the knowledge and consent of InterSpine Pain and Wellness Center and Dr. Hemani. You may not share, sell, or otherwise permit any other person to access these medications. It is expected that you take the highest possible degree of care with your medications. Since these drugs may be hazardous or lethal to a person who is not tolerant of the effects, you must keep them out of reach of such people.
4. InterSpine Pain and Wellness Center has a "No Replacement" policy. Lost, destroyed, or stolen medications will not be replaced. It is your responsibility to keep your medications in a safe and secure location.
5. Physical dependence and/or tolerance can occur with the use of opioid medications. The use of alcohol, benzodiazepines, and sedatives with opioid medications is contraindicated. Do not use opioid medication while performing meaningful tasks, driving, or operating heavy machinery. You should not use any illicit substances such as cocaine, methamphetamines, etc. while taking these medications. This will be considered a violation of this agreement and may result in termination from the practice.
6. Unannounced urine toxicology screenings are required for compliance at the provider's discretion. If requested to provide a urine sample, you agree to cooperate fully. Failure to do so may constitute a safe titration of medication dosage and/or dismissal from the practice. The presence of unauthorized substances may result in a referral for assessment for opioid use disorder and/or discharge from InterSpine Pain and Wellness Center. Urine toxicology screenings are performed for your safety, as a diagnostic tool, and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.
7. I understand that I may be randomly asked to bring my medications in for a pill count. All medications should be in their original bottles as received from the pharmacy and brought to our practice within 24 hours of the request.
8. Your prescribing provider has the authorization to discuss all diagnostic and treatment details with the dispensing pharmacist, your referring and/or primary care provider, or other healthcare professionals for the purpose of maintaining patient safety and accountability.
9. Prescriptions may be renewed from Monday through Friday. You are responsible for providing the practice with a notice of at least 48 hours prior to running out of medication. No refills of medications will be completed during the evening or on weekends. If you are unable to contact InterSpine Pain and Wellness Center within normal business hours, or if our office is closed, please go to the nearest emergency room.
10. I understand that if I am pregnant or plan to become pregnant, I must notify my provider immediately. If pregnant, I am ineligible for certain treatment plans including the use of opioid medications, as these medications can cause developmental and life-threatening effects on the fetus.
11. Treatment with opioids may be terminated if your pain management provider determines they are no longer effective in managing your pain or if there is no improvement in your functional activity level. Failure to comply with any part of the treatment agreement may result in the immediate termination of your opioid regimen and possible discharge from InterSpine Pain and Wellness Center. In the event of the termination of opioid treatment, you may be given a titration dose. In the event of discharge from InterSpine Pain and Wellness Center, you will be given a reasonable opportunity to obtain treatment from another healthcare provider.
12. If I do not follow these guidelines, I understand that my treatment plan may be terminated. I understand that non-compliance with the program or inability to comply with the voluntary guidelines and treatment plan will result in a change in the plan and discontinuation of the medications used as part of that program.
13. I understand that daily use of narcotics increases certain risks, which include but are not limited to, addiction, respiratory depression, dizziness, developing tolerance, impaired ability to operate machines or drive motor vehicles, impaired judgment, sleepiness, confusion, nausea, vomiting, constipation, allergic reactions, overdose, and death.

I affirm that I have full right and power to sign and be bound by this agreement. I have read, understood, and voluntarily agreed to the treatment consisting of opioid pain medication and other treatment modalities for my pain control. The use of pain medication is not an exclusive treatment method and will be used in conjunction with other treatment modalities. I understand medication will be discontinued if deemed unsafe or not the most effective and appropriate form of treatment for my pain.

***Please note: if you do NOT currently receive or do not wish to discuss and potentially receive controlled medication as part of your comprehensive treatment regimen for chronic pain, no signature is required, and you may skip this form. ***

_____

Patient / Agent / Guardian Signature Date