INTERSPINE
PAIN & WELLNESS CENTER

NEW PATIENT PAPERWORK

PATIENT INFORMATION

Legal Name: _____ Preferred Name: _____ DOB: _____

Address: _____ Primary Care Physician: _____

Email: _____ ☐ May we email medical information when necessary?

Phone: _____ Alternative Phone: _____ ☐ May we leave a detailed voicemail at either number?

Emergency Contact Name: _____ Phone: _____ Relation: _____

Pharmacy: _____ Pharmacy Address and/or Phone: _____

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

SOCIAL HISTORY

1. Tobacco Use: ☐ Never ☐ Former ☐ Current cigarettes: _____ PPD for _____ years ☐ Current chewing tobacco use ☐ Current vape use
2. Alcohol Use: ☐ Not at all ☐ Daily ☐ Few per week ☐ Once per week ☐ Once per month
3. Illicit Drug Use: ☐ Never ☐ Former : Type _____ for _____ years ☐ Current: Type _____ for _____ years
4. Employment: Occupation: _____ ☐ Full Time ☐ Part Time ☐ Retired ☐ Not working ☐ Legally disabled
5. Advance Care Planning: ☐ Yes, I have an Advance Directive / Living Will ☐ No, I do NOT have an Advance Directive / Living Will

MEDICAL HISTORY

If you do not have any allergies to medication, foods, etc., please indicate here: ☐ No known allergies

Allergy	Reaction(s)	Allergy	Reaction(s)

Please indicate ALL current and former medical conditions by checking the boxes below:

☐ Hypertension	☐ Cancer (Type): _____	☐ Sleep Apnea	☐ Neuropathy	☐COPD
☐ High Cholesterol	☐ Hyperthyroid	☐ Anxiety	☐ Scoliosis	☐ Hepatitis
☐ Heart Disease	☐ Hypothyroid	☐ Depression	☐ Gout	☐ Migraines
☐ Heart Failure	☐ Diabetes	☐ Bipolar Disorder	☐ Fibromyalgia	☐ Osteoporosis
☐ Heart Attack	☐ Acid Reflux (GERD)	☐ Seizures	☐ Shingles	☐ HIV/AIDS
☐ DVT/PE	☐ IBS/Crohn's/GI Disorder	☐ Dementia	☐ Lupus	☐ Stroke/TIA
☐ Liver Disease	☐ MRSA/Sepsis	☐ Arthritis	☐ Multiple Sclerosis	☐ Vision Loss
☐ Kidney Disease	☐ Blood Clots	☐ Rheumatoid Arthritis	☐ CRPS	☐ Hearing Loss

☐ Other: _____

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

Medication	Dose	How Often	Medication	Dose	How Often

Please list ANY surgical procedures you've had in the past including an approximate date:

Type of Surgery	Date	Type of Surgery	Date

If any of your family members have any of the above conditions, please list the condition and the individual's relationship to you:

_____

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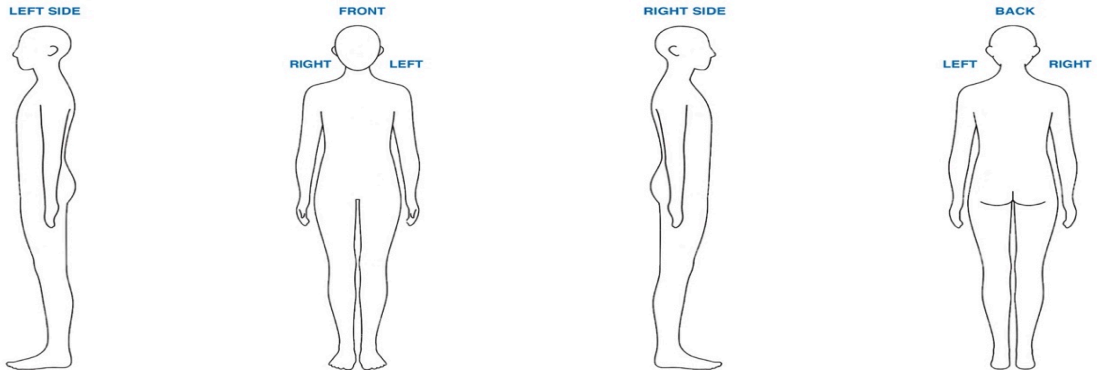
Please indicate where your pain is located by marking the diagram below:



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)

When did your problems with this pain begin? _____

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

Circle the following terms that best describe your pain:

Acute Chronic Aching Dull Sharp Sore

Stabbing Numbness Tingling Weakness Cold

Burning Radiating Shooting Throbbing Hot

Constant Intermittent Stiffness Pressure

Other: _____

What have you tried to treat the pain?

☐ Physical Therapy ☐ Dry Needling

☐ Home Exercises ☐ Brace

☐ Chiropractic Care ☐ TENS Unit

☐ Massage Therapy ☐ Medications: _____

☐ Ice/Heat _____

Please list any procedures you've had relative to this pain if any:

	Approximate Date	Location/Performing Facility	Helpful?
☐ Medial Branch Block/Radiofrequency Ablation:	_____	_____	Yes / No
☐ Epidural Steroid Injection:	_____	_____	Yes / No
☐ Spinal Cord Stimulator:	_____	_____	Yes / No
☐ Kyphoplasty:	_____	_____	Yes / No
☐ Peripheral Nerve Stimulator:	_____	_____	Yes / No
☐ Joint Injection: Hip / Knee / Shoulder:	_____	_____	Yes / No
☐ OTHER: _____	_____	_____	Yes / No

Please list the most recent imaging studies you've had relative to this pain if any:

	Approximate Date	Location/Imaging Facility
☐ X-RAY:	_____	_____
☐ MRI:	_____	_____
☐ CT SCAN:	_____	_____
☐ EMG/NERVE CONDUCTION:	_____	_____
☐ OTHER: _____	_____	_____

Modified Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement that best applies to you. We realize you may consider two or more statements in any one section as applicable, but please select the ONE statement which most closely describes your problem.

Section 1 - Pain Intensity

☐ I can tolerate the pain I have without having to use pain medication.
☐ The pain is bad, but I manage without having to take pain medication.
☐ Pain medication provides me complete relief from pain.
☐ Pain medication provides me with moderate relief from pain.
☐ Pain medication provides me little relief from pain.
☐ Pain medication has no effect on the pain.

Section 2 - Personal Care

☐ I can take care of myself normally without causing increased pain.
☐ I can take care of myself normally but it increases my pain.
☐ It is painful to take care of myself, and I am slow and careful.
☐ I need help, but I am able to manage most of my personal care.
☐ I need help every day in most aspects of my care.
☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

☐ I can lift heavy weights without increased pain.
☐ I can lift heavy weights, but it causes increased pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, etc.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift only very light weights.
☐ I cannot lift or carry anything at all.

Section 4 - Walking

☐ Pain does not prevent me from walking.
☐ Pain prevents me walking more than 1 mile.
☐ Pain prevents me walking more than ½ mile.
☐ Pain prevents me walking more than ¼ mile.
☐ I can only walk using a cane, walker, etc.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

☐ I can sit in any chair as long as I like.
☐ I can only sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting more than 1 hour.
☐ Pain prevents me from sitting more than ½ hour.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting at all.

Section 6 - Standing

☐ I can stand as long as I want without increased pain.
☐ I can stand as long as I want, but it increases my pain.
☐ Pain prevents me from standing for more than 1 hour.
☐ Pain prevents me from standing for more than ½ hour.
☐ Pain prevents me from standing for more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 - Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using pain medication.
☐ Even when/if I take pain medication, I sleep less than 6 hours.
☐ Even when/if I take pain medication, I sleep less than 4 hours.
☐ Even when/if I take pain medication, I sleep less than 2 hours.
☐ Pain prevents me from sleeping at all.

Section 8 - Employment/Homemaking

☐ My normal homemaking/job activities do not cause pain.
☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful duties (ex. vacuuming).
☐ Pain prevents me from doing anything but light duties.
☐ Pain prevents me from doing even light duties.
☐ Pain prevents me from performing any job/homemaking activities.

Section 9 - Traveling

☐ I can travel anywhere without increased pain.
☐ I can travel anywhere, but it increases my pain.
☐ Pain restricts travel over 2 hours.
☐ Pain restricts travel over 1 hour.
☐ Pain restricts my travel to short necessary journeys under ½ hour.
☐ Pain prevents all travel except visits to the doctor/therapist/hospital.

Section 10 - Social Life

☐ My social life is normal and does not increase my pain.
☐ My social life is normal, but it increases my level of pain.
☐ Pain prevents me from participating in more energetic activities.
☐ Pain prevents me from going out very often.
☐ Pain has restricted my social life to my home.
☐ I have hardly any social life because of my pain.

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PQRS Depression Screening Questionnaire: circle or mark the number that corresponds with your response.

Over the last two weeks, how often have you experienced or been bothered by any of the following problems?	Not at all	Several days	More than half of 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 or staying sleep, 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 members down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper/watching TV	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed	0	1	2	3
9. Thoughts of hurting yourself or others in some way	0	1	2	3
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐ Not at all	☐ Somewhat difficult	☐ Very difficult	☐ Extremely difficult

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

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

Screener and Opioid Assessment for Patients with Pain (SOAPP-R): circle or mark the number that corresponds with your response.

	Never	Seldom	Sometimes	Often	Very Often
1. How often do you have mood swings?	0	1	2	3	4
2. How often have you felt a need for higher doses of medication to treat your pain?	0	1	2	3	4
3. How often have you felt impatient with your doctors?	0	1	2	3	4
4. How often have you felt that things are just too overwhelming that you can't handle them?	0	1	2	3	4
5. How often is there tension in the home?	0	1	2	3	4
6. How often have you counted pain pills to see how many are remaining?	0	1	2	3	4
7. How often have you been concerned that people will judge you for taking pain medication?	0	1	2	3	4
8. How often do you feel bored?	0	1	2	3	4
9. How often have you taken more pain medication than prescribed?	0	1	2	3	4
10. How often have you worried about being left alone?	0	1	2	3	4
11. How often have you felt a craving for medication?	0	1	2	3	4
12. How often have others expressed concern over your use of medication?	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
14. How often have others told you that you had a bad temper?	0	1	2	3	4
15. How often have you felt consumed by the need to get pain medication?	0	1	2	3	4
16. How often have you run out of pain medication early?	0	1	2	3	4
17. How often have others kept you from getting what you deserved?	0	1	2	3	4
18. How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4
19. How often have you attended an AA or NA meeting?	0	1	2	3	4
20. How often have you been in an argument that was so out of control that someone got hurt?	0	1	2	3	4
21. How often have you been sexually abused?	0	1	2	3	4
22. How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
23. How often have you had to borrow pain medications from your family or friends?	0	1	2	3	4
24. How often have you been treated for an alcohol or drug problem?	0	1	2	3	4

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AUTHORIZATION AND CONSENT TO MEDICAL TREATMENT

I consent to medical care and procedures while I am a patient at InterSpine Pain and Wellness Center ("Practice"). This includes but is not limited to non-invasive testing or procedures, such as routine exams, finger pricks, physical assessments and treatments, referrals for evaluation and treatment of behavioral health, imaging procedures or physical therapy ("Procedures") recommended by my physician or other provider. If I have any questions or concerns regarding my care, I will ask my provider for more information. If I do not consent to a procedure, I will tell my provider when they recommend the procedure. The Practice may download my medication history from pharmacies, health plans, and other healthcare providers and include it in my electronic medical record to improve the coordination of my medical care. This may include information about medications prescribed to me for mental health conditions, sexually transmitted diseases, substance abuse disorders, and HIV/AIDS. If I do not want the Practice to obtain this information, I will notify the Practice in writing. I understand that my written revocation of consent will not be effective until received and acknowledged by the Practice in writing and it will not have any effect on actions taken prior to such revocation. Refusal to allow downloading prescription records does not prevent my physician from viewing records under the Georgia Prescription Drug Monitoring Program. Georgia law allows testing for blood-borne pathogens in certain situations. If a healthcare worker is exposed to my blood (e.g., suffers a needle stick), my blood may be tested for diseases including HIV/AIDS. Additional information about this test is available. I will be informed of test results. The Practice is engaged in health care education. At times care, examination, and treatment may be delivered by students under the direct supervision of authorized Practice personnel. Students will never have primary responsibility for my care; there will always be fully licensed health care providers supervising the students. If I do not want students to participate or observe my care, I will notify my care provider at the time of service. I understand that, unless I request confidentiality, the privacy laws allow the Practice to communicate with family members or others who may be involved in my care. I agree that the providers can communicate with me in the presence of family members or others who come with me to my appointment. If I object, I will notify my provider and ask others to leave when the provider is discussing care with me. I agree to notify my provider about any treatments or procedures I have or medicines (including supplements and herbal products) that I am taking and to follow the provider's instructions. I affirm that no guarantees have been made to me as to the result of any treatment or examination in the Practice. The health care professionals participating in my care will rely on my medical history and other information obtained from me, my family, or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions. I consent to participation in and assistance with the Procedures by Practice employees, medical personnel under the direct supervision and control of the provider, and other medical personnel involved in my care.

NO-SHOW/MISSED APPOINTMENT POLICY

We at InterSpine Pain and Wellness Center ("Practice") 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 a 24-hour notice is given, this will be documented as a no-show.
- If you do not present to the office for your appointment, this will be documented as a no-show.
- Please call our office at 404-593-0090 if you will be late to your appointment, as we have a 15 minute grace period.
- If you are 15 minutes late or more for your scheduled appointment, you will be considered a no show, and a $50 fee will be added to your account.
- If you no-show/same day cancel a regular office visit appointment, we will apply a $50 no show fee to your account.
- If you no-show/same day cancel a surgery or procedure, we will apply a $100 no show fee to your account.
- For new patients that no show/same day cancel, a $50 rebooking deposit will be required in order to reschedule an appointment.

Failure to keep your appointments may result in dismissal from the practice. These fees will have to be paid in full before we schedule your next appointment. Three no show appointments within a 12-month period will be subject to dismissal from our practice. You will be notified by email or letter if dismissal occurs. I have read and understood the Practice's no-show appointment policy and understand my responsibility to plan appointments accordingly. I will notify the Practice appropriately if I have difficulty keeping my scheduled appointments.

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 ("Practice") 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 the Practice 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, or by phone for reasons related to the services I have received or payment for the services I received at the Practice including but not limited to debt collection purposes.

ACKNOWLEDGEMENT OF PRIVACY RIGHTS

I acknowledge receipt of the Notice of Privacy Practices ("Notice") from InterSpine Pain and Wellness Center ("Practice") and its medical staff. The Notice provides information about how the Practice and its medical staff members may use and disclose my health information. I have been encouraged to read the Notice in full. Although the Practice and its medical staff members have policies and procedures for purposes of complying with privacy laws, some or all of the health care professionals performing services are not employees or agents of the Practice and remain independent contractors. Independent contractors are responsible for their own actions and the Practice shall not be liable for the acts or omissions of any such independent contractors. I understand that the Notice is subject to change. If the Practice changes the Notice, I may obtain a copy of the revised Notice by request or at the website (www.interspinecenter.com).

I affirm that I have read or had all pages of this form read to me and understand its contents. I understand I may request a copy of this agreement at any time. I understand that I may be declined treatment if I refuse to sign this authorization. If I am signing this form on behalf of another person, to the best of my knowledge, I am legally authorized to consent on that person's behalf. In the case of an unemancipated minor, the consent below is being given on his or her behalf.

_____ _____

Signature of Patient or Legal Representative Date

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CONSENT TO PHOTOGRAPHY/VIDEO

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.

_____ _____

Signature of Patient or Legal Representative Date

☐ Check here if you do NOT wish to provide consent to photography/video.

AUTHORIZATION TO 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. If you need 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 ("Practice") 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. The Practice 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/or 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 would be 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 the Practice. 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 the Practice 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 the Practice. In the event of the termination of opioid treatment, you may be given a titration dose. In the event of discharge from the Practice, 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 read or had all pages of this form read to me and understand its contents. I understand I may request a copy of this agreement at any time. I understand that I may be declined treatment if I refuse to sign this authorization. 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. If I am signing this form on behalf of another person, to the best of my knowledge, I am legally authorized to consent on that person's behalf. In the case of an unemancipated minor, the consent below is being given on his or her behalf.

_____ _____

Signature of Patient or Legal Representative Date

☐ Check here if you do NOT wish to discuss any controlled substance therapy as part of your comprehensive treatment regimen. No signature is required.