PATIENT INFORMATION

Please take a few moments to complete this form in its entirety. All information will be considered confidential, and will be released only as allowed through HIPAA regulations, and as considered necessary for treatment, payment, or other health care operations.

PATIENT INFORMATION

First Name _____ Last Name_____MI_____

Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____Email_____

Sex ❑ M ❑ F Date of Birth_____ Age_____ SSN _____

Race _____ ❑ *Decline* Ethnicity _____ ❑ *Decline* Primary Language _____

Marital Status (check one) ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Employer_____ Work Phone_____

Employer Address_____City_____State_____Zip_____

Emergency Contact_____Relationship_____Phone_____

Accident Related? ❑ Yes ❑ No Type ❑ Auto ❑ Work ❑ Other Date of Injury _____

How did this injury occur?_____

If work-related: Adjuster/Case Manager Name_____ Phone_____

Referring Physician_____Primary Care Physician_____

How did you learn about our clinic? _____

RESPONSIBLE PARTY/GUARANTOR INFORMATION *(If parent or legal guardian/conservator of patient)*

Name of person responsible for this account_____Relationship to patient_____

Daytime Phone_____Home Phone_____

Address_____City_____State_____Zip_____

Employer_____Employer Phone_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____	**SECONDARY INSURANCE: _____**
Insured Name_____	Insured Name_____
Phone_____	Phone_____
Policy/ID# _____Group #_____	Policy/ID# _____Group #_____
Relationship to patient_____	Relationship to patient_____
Date of Birth _____SSN _____	Date of Birth _____SSN _____
Insured's Employer _____	Insured's Employer _____
Phone_____	Phone_____

DISABILITY INSURANCE/FORMS

As a pain specialist practice ***WE DO NOT COMPLETE DISABILITY FORMS*** or work release forms. These forms should be completed by your primary care doctor. Please do not request, nor expect, our office to perform this service for you. Additional fees of up to $1,000 an hour ***may*** be charged for letters, forms, depositions, and other correspondence.

***Consent to treat*:** I, the undersigned, authorize medical treatment for myself or my minor child, _____, as deemed necessary and provided by Pain & Spine Specialists of Idaho physicians and medical staff.

PATIENT PRINTED NAME:_____

PATIENT OR PARENT/GUARDIAN SIGNATURE: _____ **DATE:**_____

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GOALS OF PAIN MANAGEMENT

1. Please list your most important reasonable or attainable goal(s) that you hope to achieve, as a result of your pain management treatment.

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

HISTORY OF PRESENT CONDITION

Height: _____ Weight: _____

2. Please tell us your pain story. Where do you hurt? What happened?

_____
_____
_____
_____
_____
_____
_____
_____

3. Please answer questions A-E below using a 0-10 scale:

0 1 2 3 4 5 6 7 8 9 10

No Pain **Worst Imaginable Pain**

A. _____ Your **pain on average** in the past week?

B. _____ During the past week, how has pain interfered with your **enjoyment of life?**

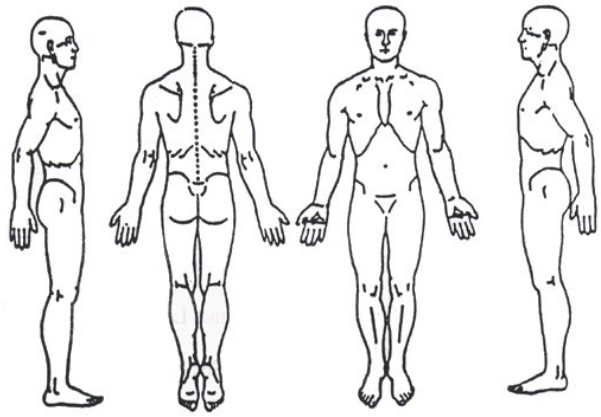
C. _____ During the past week, how has pain interfered with your **general activity**?

Clinic Use Only (Sum/3) = PEG Score: _____

D. _____ Your pain **with medications?**

E. _____ Your pain **without medications?**

4. Please indicate on the diagram below where your pain is located:



5. When did your symptoms begin? _____
(Please indicate a specific date if possible.)

6. Which of the following best describes how your pain/injury occurred?

☐ lifting ☐ degenerative process ☐ unknown
☐ car accident ☐ recreation/sports ☐ throwing
☐ a fall ☐ post surgical pain ☐ overuse
☐ crush injury ☐ illness ☐ other_____

7. Check all of the following that describe your pain:

☐ burning ☐ sharp ☐ shooting
☐ dull/aching ☐ constant ☐ cramping
☐ throbbing ☐ tingling ☐ spasm

8. As the day progresses, do your symptoms:

☐ worsen ☐improve ☐ remain the same

9. How does your pain affect your sleep?

_____
_____

10. How does your pain affect your mood?

_____
_____

11. What aggravates your symptoms?

☐ sitting ☐ standing ☐ up/down stairs
☐ walking ☐ sleeping ☐ sitting to standing
☐ squatting ☐ stress ☐ standing to sitting
☐ coughing/sneezing ☐ changes in weather
☐ taking a deep breath ☐ bending
☐ household activities ☐ looking overhead
☐ reaching across/behind/overhead/back ☐ other_____

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12. What relieves your symptoms?

☐ heat ☐ sitting ☐ standing
☐ cold/ice ☐ rest ☐ stretching
☐ walking ☐ medication ☐ massage
☐ exercise ☐ lying down ☐ nothing
☐ other _____

13. Check previous treatments you have had for this condition.

☐ NSAIDS/Ibuprofen ***Duration of Therapy?:***_____
☐ Acetaminophen/Tylenol ***Duration of Therapy?:***_____
☐ Gabapentin/Lyrica ***Duration of Therapy?:***_____
☐ Anti-depressants ***Duration of Therapy?:***_____
☐ Opioids (e.g. morphine, oxycodone, hydrocodone, etc.) ***Duration of Therapy?:***_____
☐ TENS unit ***Who Prescribed?:***_____
☐ physical therapy ***Duration of Therapy?:***_____
Physical Therapist? _____
☐ injections ***Duration of Therapy?:***_____
Who performed injections?_____
☐ chiropractic care ***Duration of Therapy?:***_____
Chiropractor? _____
☐ spinal cord stimulator ***Date of Implant?:***_____
☐ psychological therapy ***Duration of Therapy?:***_____
Therapist? _____
☐ other_____

14. Have you been to a pain clinic before? If so, where and who treated your pain?

_____
_____

HOSPITALIZATIONS/SURGERIES

15. List any hospitalizations/surgeries that you have had:

Date	Facility/Procedure	Reason for Stay/Surgical Procedure

PAST MEDICAL HISTORY

16. Please list all medical conditions you have been diagnosed with:

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

FAMILY HISTORY

17 . Has an ***immediate family member*** ever been diagnosed with any of the following conditions? **Please specify which family member on the line provided.** (Check all that apply)

☐ cancer _____ (type)_____
☐ heart problems _____ ☐ stroke _____
☐ diabetes_____ ☐ arthritis_____
☐ headaches_____ ☐ chronic pain_____
☐ fibromyalgia_____ ☐ other_____

WORK HISTORY

18. Occupation_____

☐ employed full time ☐ employed part time
☐ self-employed ☐ homemaker ☐ disabled
☐ student ☐ retired ☐ unemployed

SOCIAL HISTORY

19. Please check your current living situation.

☐ live alone ☐ live with family members/others
☐ assisted living complex ☐ live with caregiver
☐ other_____

20. Are you, or could you be, pregnant? ☐ yes ☐ no

21. Do you currently smoke? ☐yes ☐no P***acks/day***_____

If no, are you a former smoker? ☐yes ☐no

If yes, have you tried to quit? ☐yes ☐no ***#/times***_____

22. Do you currently, or have you in the past, used recreational drugs? ☐ yes ☐ no

If yes, *when, what kind, and for how long?*

_____
_____

23. Do you drink alcohol? ☐ yes ☐ no
How many drinks per (circle) day/week/month _____

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MEDICATIONS

Please list ***ALL*** prescriptions and over-the counter medications that you are currently taking/using.
You may attach a separate sheet.

Medication	Strength	Reason for Taking	Dosing (i.e. 1 a day)	Prescribing Physician

Have you ever taken anti-coagulants (blood thinners) such as Coumadin, Heparin, Lovenox, Plavix or Warfarin, Pradaxa, Eliquis, Xarelto Aspirin, Ibuprofen, Exedrin?

☐ Yes, currently (listed above) ☐ Yes, previously (Date last taken _____) ☐ No, never

ALLERGIES

List any allergies and adverse responses (hives, etc.) to medications, iodine, x-ray contrast, latex or topical agents:

Medication/Substance Response/Reaction

_____ _____

_____ _____

_____ _____

ORT

Please check each box that applies to you.
Leave blank if not applicable.

			Clinic Use Only Score If Female	Score If Male
1. Family History of Substance Abuse	*Alcohol*	☐	1	3
	Illegal Drugs	☐	2	3
	Prescription Drugs	☐	4	4
2. Personal History of Substance Abuse	*Alcohol*	☐	3	3
	Illegal Drugs	☐	4	4
	Prescription Drugs	☐	5	5
3. Age (Mark box if 16-45)		☐	1	1
4. History of Preadolescent Sexual Abuse		☐	3	0
5. Psychological Disease		☐	2	2
Attention Deficit Disorder,Obsessive Compulsive Disorder, Bipolar, Schizophrenia				
	Depression	☐	1	1
			Total	**Total**
		LR = 0-3		
		MR = 4-7		
		HR = ≥ 8		

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REVIEW OF SYSTEMS

Do you currently have any of the following medical symptoms? Check all that apply.

Constitutional:	❑ Difficulty Sleeping	❑ Fatigue	❑ Fever	
Eyes:	❑ Recent Vision Changes			
Ears/Throat:	❑ Hearing Problems	❑ Ringing in Ears	❑ Difficulty Swallowing	
Respiratory:	❑ Cough	❑ Shortness of Breath	❑ Snoring	❑ Wheezing
Cardiovascular:	❑ Chest Pain ❑ Swelling in the feet	❑ Irregular Heartbeat	❑ Lightheadedness	❑ Pacemaker
Gastrointestinal:	❑ Abdominal Pain ❑ Vomiting	❑ Constipation	❑ Diarrhea	❑ Nausea
Musculoskeletal:	❑ Joint Pain ❑ Arm/Leg Pain	❑ Muscle Spasms	❑ Back Pain	❑ Neck Pain
Psychiatric:	❑ Feeling Anxious	❑ Depressed Mood		
Neurological:	❑ Dizziness ❑ Stroke	❑ Headaches ❑ Tingling	❑ Numbness ❑ Weakness	❑ Seizures
Hematologic/Lymphatic:	❑ Easy Bruising	❑ Hepatitis	❑ HIV/AIDS	
Genitourinary:	❑ Painful Urination	❑ Urinary Frequency	❑ Urinary Retention	

PATIENT HEALTH QUESTIONNAIRE (PHQ-2)

1. During the past month, have you often been bothered by feeling down, depressed, or hopeless?

☐ Yes ☐ No

2. During the past month, have you often been bothered by little interest or pleasure in doing things?

☐ Yes ☐ No

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INFORMED CONSENT AND 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; these substances are strictly regulated by both state and federal agencies. This agreement is a tool to protect you and your health care provider by establishing guidelines, 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.

a. Opioids and other controlled substances during pregnancy are associated with multiple effects on the baby including birth defects and physical dependency for the baby on opioids upon delivery. I will immediately contact my obstetrician and this office to inform them of my pregnancy.

b. 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). Simple touch will be felt as pain and pain gradually increases in intensity and the pain's location is 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 the addition of nonsteroidal anti-inflammatory drugs such as Advil, Aleve, etc., or by reducing or stopping opioids.

c. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use 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, can cause severe anxiety, rapid heart rate, and profound blood pressure changes, and could even result in heart attack, stroke, or death.

d. 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 happen to me. I have been informed that tolerance and physical dependence go hand in hand. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment, reduce the dose, or stop them.

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INFORMED CONSENT AND CONTROLLED SUBSTANCE *AGREEMENT(continued)*

2. I understand that all of my controlled substances must come from one of the health care providers from this practice, by the covering physician, unless specific authorization is obtained for an exception.

a. I understand that I must inform this office, of 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.

b. I will not seek prescriptions for controlled substances from any other physician, health care provider, or dentist, except for unrelated emergencies, trauma, and surgery. I understand it is unlawful to be prescribed the same controlled substance medication by more than one health care provider at a time without each provider's knowledge. Opioid-based cough suppressants, sleeping pills including sedatives, when combined with other prescribed medications utilized in pain management could result in toxicity including death.

c. 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 health care provider or his/her staff or knowingly withholding facts from a health care provider or his/her staff (including failure to inform the health care provider or his/her staff of all controlled substances that I have been prescribed).

3. I understand that all controlled substances must be obtained at the same pharmacy if possible. Should the need arise to change pharmacies, our office must be informed. The preferred pharmacy that I have selected is: _____

4. I will not share, sell, or otherwise permit others, including my spouse or family members, to have access to any controlled substances that I have been prescribed.

a. Early refills will not be given. I will not consume excessive amounts; I will follow prescribed instructions, and remain compliant to all aspects of treatment. Renewals are based upon keeping scheduled appointments. Please do not call for refills after hours or on weekends.

b. Medication changes will not be made between appointments except in emergency situations, which will be determined by the health care provider.

5. Unannounced pill counts, random urine or serum tests, or planned drug screening may be requested from you and your cooperation is required. The presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from treatment by the facility and its health care providers and staff.

6. I am advised that after beginning opioid treatment, or after a dose increase a patient should not drive for at least 4–5 days, possibly longer based on individual response. I am also being advised that with prescribed chronic opioids, I am being warned not to drive or engage in potentially dangerous work or other activities until a patient becomes tolerant to any sedative properties of the medications prescribed and have had enough time to understand the medications ability to impair or not impair my driving abilities.

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INFORMED CONSENT AND CONTROLLED SUBSTANCE *AGREEMENT(continued)*

7. 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 health care provider, as set forth in Section 1 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.

8. 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, such as a police report. **A statement narrating what you told the authorities is not enough.**

9. Respiratory depression can occur and can be fatal if not treated immediately by calling 911 or going to an emergency room. A patient will be provided based on medical necessity or upon request with an opioid antagonist prescription **EVZIO 0.4MG/0.4ML AUTO INJECTOR 2PK or Narcan Nasal Spray**. (**Opioid Overdose Antidote Naloxone**) to inject if experiences signs or symptoms of overdose.

10. I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the **Prescription Drug Monitoring Programs web site** periodically throughout my treatment period.

11. In the event I am arrested or incarcerated in relation to legal or illegal drugs (including alcohol), or overdosed on controlled substances, controlled substances will be withheld for an appropriate period.

12. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this health care provider and other health care providers at the facility and that law enforcement officials may be contacted.

13. I also understand that the prescribing health care provider(s) has permission to discuss all diagnostic and treatment details, including medications, with dispensing pharmacists, other professionals who provide my healthcare, or appropriate drug and law enforcement agencies for the purpose of maintaining accountability.

14. I affirm that I have full right and power to sign and to be bound by this agreement, that I have read it, and understand and accept all of its terms.

I _____ have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy & acknowledge receipt of this document.

This Agreement is entered into on this _____ day of _____, _____

Patient name_____Patient/Representative Signature_____

MEDICATION REFILL PROCESS

Patient Name: _____ DOB: _____ Date: _____

Dear Patient,

Current practice and regulatory requirements require frequent office visits for medication management. Therefore, medication refills can ***only*** be provided at office visits.

New prescriptions and changes to existing prescriptions also ***require*** an office visit.

Thank you for your understanding of this process.

Sincerely,

Jason Poston, MD
Jake Poulter, MD
Timothy Snell, MD
Daric Russell, DO
Richard Runyan, MD
Christy Taylor, NP-C
Matt Nelson, PA-C
Travis Allen, PA-C
Ryan Williams, PA-C
Jed Willardson, PA-C
Weldon Richardson, PA-C
Tyler Hepworth, PA-C

My signature below acknowledges I understand medication refills and medication changes both require and can ***only*** be completed at an office visit.

Patient Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

ACCOUNT #_____

Patient's Name at Time of Visit: _____

Attending Physician: _____

Date of Birth: _____ Date(s) of Treatment: _____

Please Initial:

____ I hereby authorize Mountain View Hospital to furnish the named individual or company below with all medical data and information they may request, as listed below, concerning my illness or injury.

____ This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate **six months** from the date of consent without express revocation.

____ I hereby consent to the release of any and all records containing alcohol and/or drug medication abuse and/or psychiatric diagnosis under the same consideration as outline above. I understand that such information cannot be released without my specific consent, except in accordance with a court order.

____ I further understand that I have a right to receive a copy of this authorization upon request.

Medical Information to be Released to: Pain & Spine Specialists of Idaho

Address: 3385 Potomac Way Idaho Falls, ID 83404 208-522-7246

City *State* *Zip Code* *Telephone Number*

Reason for Release: _____

- ❑ *I hereby authorize the above named individual access to my medical records.*
- ❑ *I do not require a copy for myself at this time.*

Medical Information Requested: ***A copy fee of $1.00 per report will be charged as applicable.***

❑ **Discharge Summary**	❑ **History & Physical**	❑ **Operative Report**	❑ **X-ray**
❑ **Consultation**	❑ **Clinical Laboratory**	❑ **EKG, EEG**	❑ **Outpatient Clinic**
❑ **Other: _____**	❑		

I hereby authorize the above named individual access to my medical records. I do/ don't require a copy for myself at this time.

Signature: _____ Date: _____

Patient, Parent/Legal Guardian

Witness: _____ Date: _____

MVH Employee

❑ Verified ID: _____ ❑ Records issued: Initial _____ Date: _____

***** I understand this request may take up to 2 weeks to process. *****

Mountain View Hospital
Getting you back to what you Love