PAIN & SPINE SPECIALISTS
an affiliate of Mountain View Hospital

PATIENT INFORMATION

Please take a few moments to complete this form in its entirety. All information is confidential, and will be released only as allowed through HIPAA regulations, and as 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

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

_____
_____
_____
_____
_____
_____
_____

PAIN DESCRIPTION

3. What number best describes your pain **with medications?**

0 1 2 3 4 5 6 7 8 9 10
No Pain **Your Worst Pain**

4. What number best describes your pain **without medications?**

0 1 2 3 4 5 6 7 8 9 10
No Pain **Your Worst Pain**

5. 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 **Your Worst Pain**

6. 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**

7. 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**

Clinic Use Only (Sum(5-7) / 3) = PEG Score: _____

Height: _____Weight:_____

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

9. **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_____

10. **Check all of the following that describe your pain:**

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

11. **As the day progresses, do your symptoms:**

☐ worsen ☐improve ☐ remain the same

12. **How does your pain affect your sleep?**

_____
_____

13. **How does your pain affect your mood?**

_____
_____

14. **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_____

15. **What relieves your symptoms?**

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

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

_____
_____
_____
_____

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17. **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_____

HOSPITALIZATIONS/SURGERIES

18. **List any hospitalizations/surgeries that you have had:**

Date	Facility/Procedure	Reason for Stay/Surgical Procedure

PAST MEDICAL HISTORY

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

1. _____
2. _____
3. _____
4. _____
5. _____
6. **Are you diabetic?** ☐yes ☐no Type: _____

If yes, do you take insulin or metformin? ☐yes ☐no

FAMILY HISTORY

20. Has an ***immediate family member*** ever been diagnosed with any of the following conditions?

Father ☐*Alive* ☐*Deceased*

☐ heart problems ☐ cancer ☐ diabetes ☐ headaches
☐ fibromyalgia ☐ stroke ☐ arthritis ☐ chronic pain

Mother ☐*Alive* ☐*Deceased*

☐ heart problems ☐ cancer ☐ diabetes ☐ headaches
☐ fibromyalgia ☐ stroke ☐ arthritis ☐ chronic pain

Sister ☐*Alive* ☐*Deceased*

☐ heart problems ☐ cancer ☐ diabetes ☐ headaches
☐ fibromyalgia ☐ stroke ☐ arthritis ☐ chronic pain

Brother ☐*Alive* ☐*Deceased*

☐ heart problems ☐ cancer ☐ diabetes ☐ headaches
☐ fibromyalgia ☐ stroke ☐ arthritis ☐ chronic pain

WORK HISTORY

21. **Occupation**_____

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

SOCIAL HISTORY

22. **Please check your current living situation.**

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

23. **Do you currently smoke**? □yes □no *Packs/day*_____
If no, are you a former smoker? □yes □no
If yes, have you tried to quit? □yes □no *#/times*_____

24. **Do you currently, or have you in the past, used recreational drugs?** ☐ yes ☐ no
If yes, w*hen, what kind, and for how long?*

_____

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

PATIENT HEALTH QUESTIONNAIRE

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

☐ yes ☐ no

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

☐ yes ☐ no

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ORT

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

			Clinic Use Only F	Clinic Use Only M
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
	Illicit Drugs		4	4
	Prescription Drugs		5	5
3. Age (If between 16 to 45)			1	1
4. History of Preadolescent Sexual Abuse			3	0
5. Psychological Disease	ADD, OCD, Bipolar, Schizophrenia		2	2
	Depression		1	1
TOTAL Score				

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 □ irregular heartbeat □ lightheadedness

□ pacemaker □swelling in the feet

Gastrointestinal

□ abdominal pain □ constipation □ diarrhea □ nausea

Musculoskeletal

□ neck pain □ back pain □ hip pain □ arm/leg pain

□ joint pain □ muscle spasms □ muscle stiffness

Neurological

□ dizziness □ headaches □ numbness □ seizures

□ stroke □ tingling □ weakness

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*

_____ _____

_____ _____

_____ _____

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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 I become 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,** and any other resources available to my provider 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_____

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

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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