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.

First Name _____ Last Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Sex ☐ Male ☐ Female Date of Birth _____ Age _____ **SSN** _____

Race _____ ☐*Decline* Ethnicity _____ ☐*Decline* Primary Language _____

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

Emergency Contact _____ Relationship _____ Phone _____

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

If work-related: Adjuster/Case Manager Name _____ Phone _____

Primary Care Physician _____ Phone _____

Referring Physician _____ How did you learn about our clinic? _____

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

First Name _____ Last Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Date of Birth _____

PRIMARY INSURANCE: _____ Policy/ID # _____ Group# _____
Insured Name _____ Phone _____
Relationship to patient _____ Date of Birth _____ SSN _____
Insured's Employer _____ Phone _____

SECONDARY INSURANCE: _____ Policy/ID # _____ Group# _____
Insured Name _____ Phone _____
Relationship to patient _____ Date of Birth _____ SSN _____
Insured's Employer _____ Phone _____

INSURANCE INFORMATION 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 **may** be charged for letters, forms, depositions, and other correspondence.*

By signing below, I acknowledge that the information provided above is true and accurate. I consent to receive communication from Pain & Spine Specialists of Idaho through text messages, emails, and/ or phone calls. I acknowledge that communication will be pertaining to appointment reminder and/or education.

***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/GUARDIAN SIGNATURE: _____ DATE: _____

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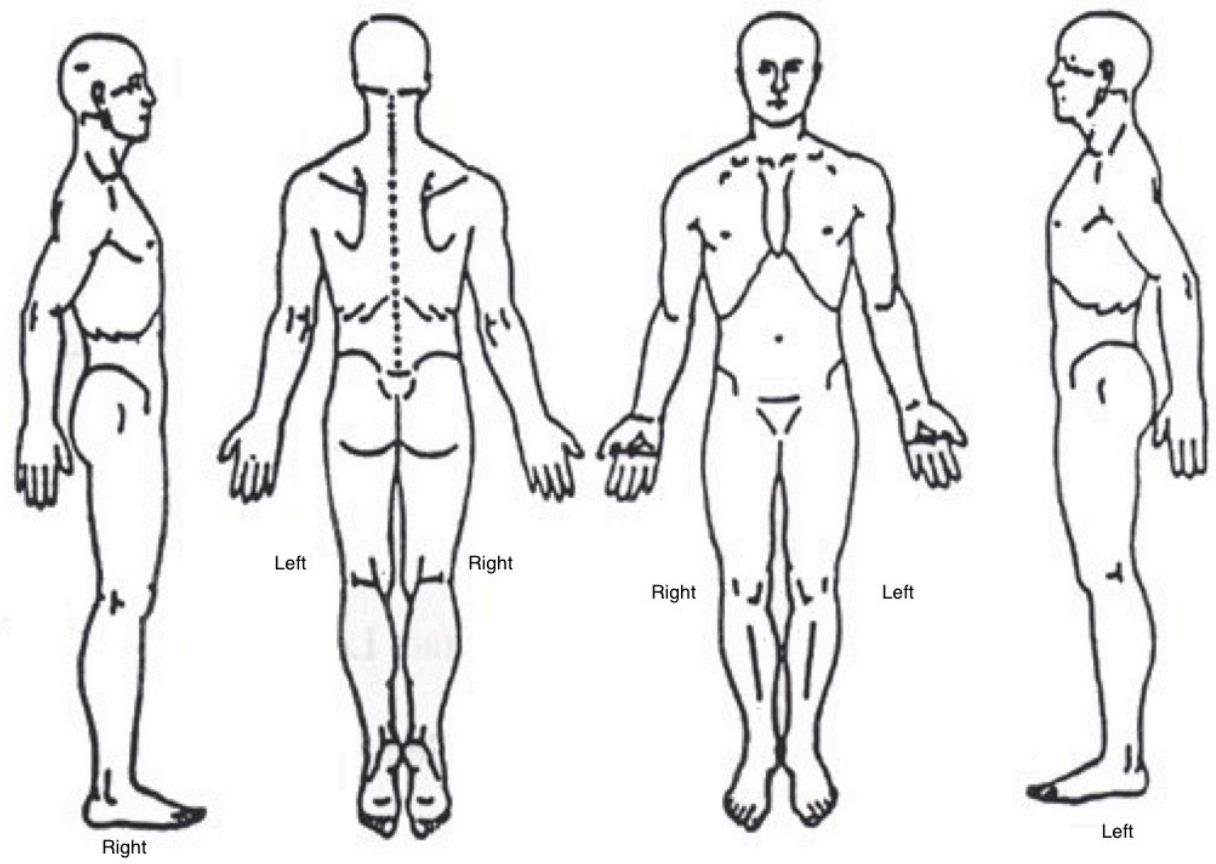
Height: _____ Weight:_____lbs. Today's Date: _____

Please indicate on the diagram below with an X where ALL your pain is located:



Goals

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. _____

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

_____

_____

_____

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

_____

_____

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History

Select all activities of daily living (ADLs) avoided or impacted due to your pain:

☐Self-care ☐Work ☐School ☐Home ☐Recreation ☐No functional impairment

Check previous treatments you have had for this condition:

☐Physical therapy/How Long?:_____ ☐Physical therapist supervised home exercise program

☐Chiropractic care ☐Acupuncture ☐Cognitive-behavioral therapy ☐Massage therapy

☐Anti-inflammatory (*eg, NSAIDs or analgesics*) ☐Gabapentin/Lyrica ☐Anti-depressants

☐Opioids (*e.g. morphine, oxycodone, hydrocodone, etc.*) How Long?: _____

☐Injections / Type?: _____ Who performed?: _____

☐Spinal cord stimulator / Date of Implant?: _____

☐Pain Pump / Date of Implant?: _____

☐Psychological therapy / Therapist_____

Patient Health Questionnaire-2

Over the **last 2 weeks**, how often have you been bothered by having little interest or pleasure in doing things?

☐Not at all ☐Several Days ☐More than half the days ☐Nearly every day

Over the **last 2 weeks**, how often have you been bothered by feeling down, depressed, or hopeless?

☐Not at all ☐Several Days ☐More than half the days ☐Nearly every day

Fall Screening

How many times have you fallen within the past year?

☐None ☐One fall without injury ☐One fall with injury

☐Two or more falls without injury ☐Two or more falls with injury

Do you feel unsteady when standing or walking? ☐Yes ☐No

Do you have a fear of falling? ☐Yes ☐No

Medications

Please attach a list with ALL prescriptions and over the counter medication that you are currently taking/using.

Are you currently taking any **blood-thinners** or anticoagulants? ☐Yes ☐No

(e.g. Aspirin, Ibuprofen/Motrin Aleve, Advil, Excedrin, Clopidogrel, Plavix, Coumadin, Warfarin, Lovenox, Pradaxa, Heparin, Eliquis, Xarelto,) **If yes, please list which ones**._____

Allergies

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

Medication / Substance	Response / Reaction

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Medical History

Please list all medical conditions you have been diagnosed with:

_____ _____

_____ _____

_____ _____

_____ _____

Are you diabetic? ☐Yes ☐No Type:_____ If yes, do you take insulin? ☐Yes ☐No

Do you have a condition that affects blood clotting, such as Von Willebrand disease, hemophilia, or liver disease?

☐Yes ☐No **If yes, please list them here.** _____

Do you currently smoke cigarettes? ☐Yes ☐No *Packs per day#*____ If no, are you a former smoker? ☐Yes ☐No

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

Do you drink alcohol? ☐Yes ☐No. If yes, how many drinks per (circle) day/week/month _____

If yes, which kind? ☐Beer ☐Wine ☐Hard Liquor

Do you currently, or have in the past, used recreational drugs? ☐Yes ☐No

If yes, what kind and for how long? _____

List any hospitalizations/surgeries that you have had:

Date	Facility/Procedure	Reason for Stay/Surgical Procedure

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

Are you, or could you be, pregnant? ☐Yes ☐No ☐N/A

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The following questions are for our records and will remain confidential.

Does anyone in your family struggle with any of the following? Check all that apply

☐Alcohol ☐Illegal Drugs ☐Prescription Drugs

Do you struggle with any of the following? Check all that apply

☐Alcohol ☐Illegal Drugs ☐Prescription Drugs

Have you ever been sexually abused? ☐Yes ☐No

Have you been diagnosed with any of the following psychological diseases? Check all that apply

☐ADD/ADHD ☐Bipolar ☐PTSD ☐Depression ☐Obsessive Compulsive Disorder ☐Schizophrenia

Pain Scores

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

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

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

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

3. 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*

4. 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*

5. 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*

Mountain View Hospital
Getting you back to what you Love
A Physician Owned Hospital

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MVH Continuing Care Release of Information

I, _____ *(Patient/Patient Representative)*, authorize **Pain & Spine Specialists an affiliate of Mountain View Hospital** to obtain protected health information (medical records) for the individual named below:

_____ _____
Name of Patient *Date of Birth*

_____ _____
Street Address *Phone Number*

_____
City, State, Zip Code

The Purpose of this disclosure is:
☐ Continuity of Care

Date(s) of Service Requested: *from* _____ *thru* _____

Information Requested:
☐ Lab Reports ☐ Radiology Reports ☐ EKG's/ECG's ☐ Emergency Room Records

☐ Medical Record Abstract (Face sheet, History & Physical, Operative Report, Discharge Summary, Consultations, and Discharge Instructions)

☐ Entire Medical Record

I understand that if my medical or billing record contains information in reference to the conditions described below, I must agree to the release by initialing on each applicable line:

_____ HIV/AIDS testing or treatment

_____ Psychiatric treatment (excluding psychotherapy notes)

_____ Genetic testing records

_____ Sexually transmitted diseases

_____ Drug or Alcohol Abuse Records (diagnosis, treatment, or referral)

_____ Hepatitis B or C testing

Information to be released to:

Mountain View Hospital/ Pain & Spine Specialists
3385 Potomac Way, Idaho Falls, ID 83404
O: (208)522-7246
F: (208)529-2620

This authorization will expire in one (1) year unless an earlier date is specified: _____

I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

I understand that I may revoke this authorization at any time by giving written notice to the Director of Health Information Management, 2325 Coronado St., Idaho Falls, ID 83404. I understand that revocation will not affect any action Mountain View Hospital took by relying on this authorization before they received my written notice.

I understand that this authorization to use or disclose protected health information is voluntary and Mountain View Hospital cannot deny or withhold health care services if I do not sign the authorization, except if the authorization is required for a research study in which I am enrolled, or if the service is solely for a third-party (pre-employment physical, etc.).

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

_____ _____

Signature of Patient or Patient Representative *Date*

_____ _____

Relationship of Patient Representative *Description of Authority*

Patient Label