Dear Patient:

Welcome to Advanced Pain Management (APM). We appreciate the confidence and trust you have placed in us by scheduling an appointment, and we look forward to seeing you. Our philosophy is to help you best manage your chronic or current pain symptom. We shall make every effort to see that your experience with our clinic is as comfortable as possible.

At your initial appointment, the provider will take a complete history. Please provide our office with copies of any reports from previous tests such as MRI, CT, EMG, bone scans, X-Rays and any other diagnostic testing for your current problem. Your physician needs this information to assist in your treatment.

Due to the amount of time that our providers may need to spend with you at your initial consultation, we cannot allow small children to accompany you into the treatment areas. Please bring a responsible adult along to watch children during your appointment. If this is not possible, we will need to reschedule your appointment to a more appropriate time.

Since all insurance company policies are different, it is advisable that you become familiar with your particular insurance coverage. This allows us to assist you in obtaining your maximum benefits. Any co-payment is due at the time of service, and we ask that you bring this with you to your appointment.

Please arrive 30 minutes prior to your scheduled appointment time. We will make every effort to maintain our schedule and yours. Please assist us by being punctual. If you are unable to keep your appointment, we ask that you give us at least 48 hour notice.

If you have any questions about APM and/or the conditions we treat, please visit our website at www.apmhealth.com. To view full animation of the procedures we offer, click on the “Conditions and Treatments” tab.

Thank you for choosing us. We welcome any questions or concerns you may have, and we look forward to seeing you.

Sincerely,

The Physicians of Advanced Pain Management
Patient Financial Statement of Information

Thank you for choosing Advanced Pain Management as your pain provider. Advanced Pain Management is a caring organization that is committed to providing patients with innovative pain management services. We are committed to providing you with quality and affordable health care.

Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have and sign in the space provided. A copy will be provided to you upon request.

Insurance and Billing

- As your provider, please remember that our relationship is with you and not your insurance company. Your benefit coverage is a contract between you and your insurance carrier. Please be aware that not all medical services are covered benefits under all insurance contracts. We encourage you to be familiar with your insurance benefits and limitations. If you have any questions about your insurance coverage, please contact your insurance carrier directly.

- Our physicians are “Preferred Providers” for many insurance plans. It is your responsibility to check with your insurance carrier to ensure that the Advanced Pain Management physician(s) and/or facility participate with your insurance network. If Advanced Pain Management is not in your carrier’s network, you may incur higher patient responsibility amounts.

- As a service to you, our office will bill your health insurance company. Providing us with accurate information at the time services are rendered will facilitate in the timely filing of claims. Changes in your information should be reported to our office in a timely manner. Your cooperation in keeping your account information current is greatly appreciated.

- You may receive multiple bills for our services. If you are having a procedure at one of our Ambulatory Surgery Centers, you will receive one (1) bill for the physician (professional) services and one (1) bill for the Ambulatory Surgery Center (facility) fees. Your benefits for each of these may be different, so please check with your insurance carrier to understand your benefits. Patient payments can be applied to outstanding balances for professional services or for the facility fees, as determined by the organization.

- If you undergo urine toxicology testing, you will receive an invoice from APM for the test. In addition, many of our lab results are also sent to a confirmatory lab for additional information on the quantitative results of the specimen. If your test is sent to a confirmatory lab, you will receive a separate bill for their services.

- If you receive services in a hospital or other inpatient setting, you will receive a separate bill for those facility charges, separately from any bills you may receive for services provided by an APM provider or facility.
Co-payments, Co-insurance and Deductibles

All copayments, coinsurance and deductibles are due at the time of service.

Co-payments are a flat fee paid each time a medical service is accessed and must be paid before any policy benefit is payable by an insurance company. Co-payments usually range from $20.00 to $50.00 depending on your coverage.

Co-insurance is a percentage of the allowed charge that the patient pays after the deductible has been satisfied.

Deductibles are amounts which must be paid out of pocket before an insurance carrier will pay any expenses. The deductible must be paid by the patient before the benefits of the insurance policy can apply.

Our providers are in-network with most insurance companies, and the insurance company will require that we collect these fees per the terms of your health care contract. Failure to pay any amounts due, including past due balances, will result in your appointment being rescheduled or other collection activity. Please speak with one of our financial counselors if you need assistance with the payments of these balances. For your convenience, we accept cash, checks, debit or credit cards (MasterCard, Visa, Discover and American Express). A fee of $35.00 will be charged for all returned checks.

Self-Pay

If you are uninsured and are in need of care, we can see you on a self pay-basis. Payment is due at the time services are rendered.

Referrals/Authorizations

Many of the services we provide require referrals, authorization and pre-authorization. Your insurance company may require documentation prior to authorizing services and we will do our best to comply in a timely fashion with their requests. This process can take time. We appreciate your patience while we work with your insurance company. We reserve the right to refuse or reschedule services to any patient who does not have a valid referral in our office at the time of their appointment.

Hardship

A Hardship Discount may be available to our patients who do not have the ability to pay their bills. We will require that you complete a financial statement and provide information including your last year’s tax filings. Please contact us at 1-877-276-6997, if you believe you may qualify for this program.

Non-Payment

If your account is over 120 days past due, your account will be referred to our outside collection agency. This may include listing your information with the credit bureau. Your account will also be reviewed for possible discharge from care.

Overpayment

Patients agree that if they have a credit balance after paying for a service, Advanced Pain Management can apply this credit to any outstanding balance on their account, including balances related to professional or facility fees. Patients will be refunded any amounts paid in excess after all outstanding amounts have been credited.
Cancellation of Services

Advanced Pain Management reserves the right to charge a $25 fee if the patient fails to provide at least 24 hours cancellation notice. This fee will be paid by the patient regardless of insurance.

Patient Payment Options

There are several outlets for paying your balance in a secure environment. Each patient statement you receive includes a unique web address which will direct you to an online patient payment portal or you can call a dedicated patient account number and payment may be made over the phone.

**On-line Patient Payment Portal:** This portal allows you to make your payment online, enables you to manage your account online as well as sign up to receive electronic statements.

https://pay.instamed.com

**Interactive Voice Response Payment Portal:** You will receive an automated phone call prior to your scheduled visit as well as after services are rendered, informing you of your current balance. These calls will also allow you the option to pay over the phone, or connect with a patient financial service representative to discuss your account. You can reach our patient accounts department Monday – Friday between the hours of 8:00 a.m. – 5:00 p.m. C.T. by calling 1-877-276-6997 or by pressing Option 1 to make a Credit Card payment.

You may see balances on your statement(s) that are related to previous services performed at Advanced Pain Management or one of its Ambulatory Surgery Centers. Please be advised that these balances must be paid immediately. You may pay by using the payment portal, the interactive voice response portal, or by speaking with one of our customer service representatives.

It is our goal to provide our patients with the best possible customer service. We hope that these features will allow you to easily obtain the balance/status of your account and provide you with the most convenient method for paying your bill(s).

I have read and understand the above credit/payment policy.

I hereby authorize Advanced Pain Management to file claims on my behalf and for payment to be rendered directly to Advanced Pain Management for benefits otherwise payable to me by any third party. The above authorization is in effect permanently or until canceled by myself in writing.

Patient Signature: ___________________________ Date: _____/_____/______
NOTICE OF PRIVACY PRACTICES

Advanced Pain Management ("APM") is committed to ensuring that your health information is kept private in accordance with federal and state law. This information is called “protected health information” or “PHI.” We are required by law to maintain the privacy of your PHI and to provide you with this Notice of Privacy Practices ("Notice"). We are also required by law to follow the terms of this Notice or any revision to it that is in effect. This Notice covers the privacy practices of all health care professionals, employees and staff at our APM clinics and Ambulatory Surgery Centers.

This Notice is effective as of July 27, 2013. We reserve the right to make changes to this Notice as permitted by law. Changes to our privacy practices as reflected in our Notice will apply to all PHI that we maintain. If we change this Notice, you can access the revised Notice using these options:

• From the APM website (www.apmhealth.com)

• From the receptionist at any APM clinic or Ambulatory Surgical Center.

If you want more information about the privacy practices of APM, please contact Advanced Pain Management Privacy Officer:

4131 W. Loomis Road, Suite 300, Greenfield, WI 53221
or email: privacyofficer@apmhealth.com.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe the ways that we may use and disclose your PHI without your written authorization:

Treatment. We will use PHI about you to provide you with medical treatment or services. We will disclose your PHI to other health care professionals so that they can evaluate your health, diagnose your medical conditions and provide your treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may need the information to provide you with treatment.

Required by Law. We may disclose your PHI when required by law to follow the terms of this Notice or any revision to it that is in effect. Changes to our privacy practices as reflected in our Notice will apply to all PHI that we maintain.

Payment. We may use and disclose your PHI to obtain payment for the services we provide to you. For example, we may disclose your PHI to seek payment from your insurance company, or from another third party. We may need to give your insurance company information about a procedure you underwent so that your insurance company will pay for the procedure. We may also inform your insurance company about a treatment you are going to receive so that we obtain prior approval for the treatment, or in order to find out if your insurance company will cover the treatment.

Health Care Operations. We may use and disclose your PHI in order to conduct certain of our business activities, which are called health care operations. For example, health care operations activities include performing activities that allow us to improve the quality of care we provide. We may use and disclose PHI about you for the following health care operations activities: (i) cooperating with outside organizations that assess the quality of care that we provide; (ii) cooperating with outside organizations that evaluate, certify or license health care providers; (iii) cooperating with various people who review our activities, such as our accountants. We may also disclose your PHI to other health care professionals that you have seen so that they may improve their quality or performance.

Appointment Reminders and Information Sharing. We may use or disclose your PHI to provide you with appointment reminders. We may call you on the telephone about surgical appointment reminders and also to communicate necessary information about your appointment. We may also use your PHI to tell you about treatment options or other health-related products or services that may be of interest to you.

Fundraising. We may use your PHI (for example, your name, address, phone number and treatment dates) to contact you about supporting our fundraising efforts. You may opt-out of receiving any further fundraising communications from us by notifying us of your name, address and request.

OTHER WAYS WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe other ways we may use and disclose your PHI without your written authorization:

Patient Directory. We may keep brief information about you in our directory. Unless you tell us otherwise, we may disclose where you are in our facility and your general health condition (for example “stable” or “good”) to anyone who asks for you by name.

Family Members and Friends for Care and Payment and Notification. Unless you make a request to the contrary, we may disclose to a family member, relative or another person identified by you as being involved in your health care or payment for your health care, your PHI that is directly relevant to such person’s involvement with your care or payment for your care. We may also use or disclose your PHI to provide such individuals with general information about you, such as your location or condition. In an emergency situation or in the event of your incapacity, we may exercise our professional judgment to determine whether a disclosure to a particular person is in your best interest.

Disaster Relief Efforts. We may disclose your PHI to organizations for the purpose of disaster relief efforts in accordance with the law.

Preferred Method of Communication. We may use your PHI to communicate with you about your appointment and payments.

HOW WE USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe the ways that we may use and disclose your PHI in order to conduct certain of our business activities, which are called health care operations.

Payment. We may use and disclose your PHI to obtain payment for the services we provide to you. For example, we may disclose your PHI to seek payment from your insurance company, or from another third party. We may need to give your insurance company information about a procedure you underwent so that your insurance company will pay for the procedure. We may also inform your insurance company about a treatment you are going to receive so that we obtain prior approval for the treatment, or in order to find out if your insurance company will cover the treatment.

Required by Law. We may disclose your PHI when required by law to follow the terms of this Notice or any revision to it that is in effect. Changes to our privacy practices as reflected in our Notice will apply to all PHI that we maintain.

Payment. We may use and disclose your PHI to obtain payment for the services we provide to you. For example, we may disclose your PHI to seek payment from your insurance company, or from another third party. We may need to give your insurance company information about a procedure you underwent so that your insurance company will pay for the procedure. We may also inform your insurance company about a treatment you are going to receive so that we obtain prior approval for the treatment, or in order to find out if your insurance company will cover the treatment.
related illnesses and injuries to your employer for workplace safety purposes.

**Reporting Victims of Abuse or Neglect.** If we reasonably believe you have been a victim of abuse or neglect, we may disclose your PHI to a government authority in accordance with law.

**Health Care Oversight.** We may disclose your PHI to authorities and agencies for oversight activities allowed by law, including audits, investigations, inspections, licensure and disciplinary actions, or civil, administrative and criminal proceedings, as necessary for oversight of the health care system, government programs and civil rights laws.

**Legal Proceedings.** We may disclose your PHI in the course of certain administrative or judicial proceedings. For example, we may disclose your PHI in response to a court order.

**Law Enforcement.** We may disclose your PHI to a law enforcement official for certain specific purposes, such as reporting certain types of injuries.

**Deceased Persons.** We may disclose your PHI to coroners, medical examiners or funeral directors so that they can carry out their duties.

**Research.** Under certain circumstances, we may disclose your PHI to researchers who are conducting a specific research project. These researchers must agree not to disclose information that would allow you to be identified, except as allowed by law.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose your PHI if we believe it is necessary to prevent a serious and imminent threat to the health or safety of a person or to the public.

**Military, National Security, or Incarceration/Law Enforcement Custody.** If you are or were involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your PHI to the proper authorities so they may carry out their duties under the law.

**Workers’ Compensation.** We may disclose your PHI as necessary to comply with laws related to workers’ compensation or other similar programs.

Please be aware that state and other federal laws may have additional requirements that we must follow, or may be more restrictive than HIPAA on how we use and disclose your PHI. If there are specific more restrictive requirements, even for some of the purposes listed above, we may not disclose your PHI without your written permission as required by such laws. For example, we will not disclose your HIV test results without obtaining your written permission, except as permitted by state law. We may also be required by law to obtain your written permission to use and disclose your information related to treatment for a mental illness, developmental disability or alcohol or drug abuse.

**OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION**

Disclosure of your PHI or its use for any purpose other than those listed above requires your specific written authorization. For example, your written authorization is typically required if your attorney requests your PHI. If you change your mind after authorizing a use or disclosure of your PHI, you may withdraw your permission by revoking the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of your PHI that occurred before you notified us of your decision, or any actions that we have taken based upon your authorization. To revoke an authorization, you must notify us in writing at Advanced Pain Management, ATTN: Privacy Officer, 4131 W. Loomis Road, Suite 300, Greenfield, WI 53221.

**YOUR PROTECTED HEALTH INFORMATION RIGHTS**

As an APM patient, you have the following rights:

**Right to Read and Copy.** You have the right to read and receive a copy of your PHI. We may charge you a reasonable fee if you want a copy of your PHI. Requests for copies of PHI must be made in writing. To request a copy of your PHI, please contact our Medical Records Department at 414-325-7246 to obtain a request form. In certain circumstances, you may obtain your PHI in an electronic format and may request that we transmit such copy to any person or entity you designate. If you wish to make such requests, please contact Medical Records Department at 414-325-7246.

**Right to Request to Correct Your PHI.** You have a right to request that we amend or correct your PHI that you believe is incorrect or incomplete. For example, if your date of birth is incorrect, you may request that the information be corrected. To request a correction or amendment to your PHI, you must make your request in writing to Medical Records Department, Supervisor, Advanced Pain Management, 4131 W. Loomis Road, Suite 300, Greenfield, WI 53221 and provide a reason for your request. Under certain circumstances we may deny your request. If your request is denied, we will provide you with information about our denial and how you can disagree with the denial.

**Right to Request Restrictions on Certain Uses and Disclosures.** You have the right to request restrictions on how your PHI is used or disclosed for treatment, payment or health care operations activities. However, we are not required to agree to your requested restriction, unless that restriction is regarding disclosure to your health insurance company of PHI if: (1) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (2) the PHI pertains solely to a health care item or service for which you or another person (other than your health insurance company) paid in full. If you would like to make a request for a restriction, you must submit your request in writing to Medical Records Department, Supervisor, Advanced Pain Management, 4131 W. Loomis Road, Suite 300, Greenfield, WI 53221.

**The Right to Request Confidential Communications.** You have the right to request that we communicate your PHI to you in different ways or at different locations. For example, you may wish to receive information about your health status through a written letter sent to a private address. We will grant reasonable requests. To request confidential communications, you must make your request in writing. You may obtain a request form by contacting our Medical Records Department at 414-325-7246.

**Right to an Accounting of Disclosures.** You have the right to receive a list of certain disclosures of your PHI that we have made during the past six years. This list will include the date of each disclosure, who received the disclosed PHI, a brief description of the PHI disclosed, and why the disclosure was made. However, the list will not include disclosures for the following purposes: treatment, payment, health care operations, and certain other limited purposes. In addition, the list will not include information that was disclosed to you and to others with your authorization, incidental disclosures and disclosures of PHI that has been stripped of your identifiers to create a limited data set or de-identified PHI. We must provide you the list within 60 days of your request, unless you agree to a 30-day extension. You will not be charged for this list, unless you request more that one list per year. To request this list of disclosures, submit your request in writing to our Medical Records Department. Your request must state a time period, which may not go back further than six years.

**Right to a Paper Copy of Notice.** You have the right to receive a printed copy of this Notice and may ask for a copy of this Notice at any time. This Notice can be obtained from the receptionist at any APM site or surgery center. This Notice is also available at our website at www.apmhealth.com.

**Complaints.** You have the right to file a complaint if you believe your privacy rights have been violated. If you would like to file a complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: Advanced Pain Management, Attention: Privacy Officer, 4131 W. Loomis Road, Suite 300, Greenfield, WI 53221

You may also file a complaint by contacting our Privacy Officer at 414-325-7246. You have the right to complain to the United States Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

**CONTACT INFORMATION, QUESTIONS OR CONCERNS**

If you have questions or concerns about your privacy rights, or the information contained in this Notice, please contact Privacy Officer, Advanced Pain Management, 4131 W. Loomis Road, Suite 300 Greenfield, WI 53221 or email: privacyofficer@apmhealth.com.
Please review the following list and check any that apply to you.

**CONSTITUTIONAL**  □ Normal □ Abnormal
- Weight Loss Amount: 
- Weight Gain Amount: 
- Fever □ No □ Yes
- Chills □ No □ Yes
- Insomnia □ No □ Yes
- Fatigue □ No □ Yes

**EYES**  □ Normal □ Abnormal
- Vision □ Normal □ Abnormal
- Dryness □ No □ Yes
- Pain □ No □ Yes

**ENT**  □ Normal □ Abnormal
- Hearing Loss □ No □ Yes
- Tinnitus (ringing in ears) □ No □ Yes
- Vertigo □ No □ Yes
- Dizziness □ No □ Yes

**Nose**
- Nasal Congestion □ No □ Yes
- Facial Pain □ No □ Yes
- Decreased Smell □ No □ Yes
- Epistaxis (nose bleeds) □ No □ Yes

**Throat**
- Sore Throat □ No □ Yes
- Dysphagia (difficulty swallowing) □ No □ Yes

**RESPIRATORY**  □ Normal □ Abnormal
- Shortness of Breath □ No □ Yes
- Cough □ No □ Yes
- Sputum □ No □ Yes
- Hemoptysis (bloody sputum) □ No □ Yes
- Wheezing □ No □ Yes
- Chest Pain □ No □ Yes
- Snoring □ No □ Yes

**MUSKULOSKELETAL**  □ Normal □ Abnormal
- Joint Pain □ No □ Yes
- Neck Pain □ No □ Yes
- Mid Back Pain □ No □ Yes
- Low Back Pain □ No □ Yes
- Weakness □ No □ Yes

**NEURO**  □ Normal □ Abnormal
- Headache □ No □ Yes
- Fainting □ No □ Yes
- Seizures □ No □ Yes
- Paralysis □ No □ Yes
- Uncoordinated (Clumsiness) □ No □ Yes
- Memory Loss □ No □ Yes
- Numbness □ No □ Yes

**PSYCHIATRIC**  □ Normal □ Abnormal
- Depression □ No □ Yes
- Anxiety □ No □ Yes
- Suicidal □ No □ Yes
- Hallucinations □ No □ Yes

**GENITOURINARY**  □ Normal □ Abnormal
- Incontinence □ No □ Yes
- Dysuria (pain w/urination) □ No □ Yes
- Urgency □ No □ Yes
- Hematuria (blood in urine) □ No □ Yes
- Erectile Dysfunction □ No □ Yes
- Loss of Sexual Drive □ No □ Yes

**ALLERGIC/IMMUNOLOGIC**  □ Normal □ Abnormal
- Food Allergies □ No □ Yes
- Environmental Allergies □ No □ Yes

**HEMATOLOGIC/LYMPHATIC**  □ Normal □ Abnormal
- Easy Bruising □ No □ Yes
- Easy Bleeding □ No □ Yes
- Lymphadenopathy (swollen glands) □ No □ Yes

**SKIN/DERMATOLOGIC**  □ Normal □ Abnormal
- Rash □ No □ Yes
- Dryness □ No □ Yes
- Alopecia (hair loss) □ No □ Yes
- Nail Changes □ No □ Yes
- Color Changes □ No □ Yes

**GASTROINTESTINAL**  □ Normal □ Abnormal
- Dysphagia (difficulty swallowing) □ No □ Yes
- Heartburn □ No □ Yes
- Abdominal Pain □ No □ Yes
- Vomiting □ No □ Yes
- Diarrhea □ No □ Yes
- Constipation □ No □ Yes
- Fecal Incontinence □ No □ Yes
- Bloody Stool □ No □ Yes
- Nausea □ No □ Yes

**ENDOCRINOLOGY**  □ Normal □ Abnormal
- Intolerance to heat □ No □ Yes
- Intolerance to cold □ No □ Yes
- Diaphoresis □ No □ Yes

**CARDIOVASCULAR**  □ Normal □ Abnormal
- Chest Pain □ No □ Yes
- Shortness of Breath □ No □ Yes
- Palpitations □ No □ Yes
- Ankle Swelling □ No □ Yes
- Claudication □ No □ Yes
Section 1 - Pain Intensity
☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

Section 2 - Personal Care
☐ I can look after myself normally without causing extra pain.
☐ I can look after myself, but it is very painful.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help, but can manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 - Lifting
☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights, but it gives me extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on the table).
☐ 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 any distance.
☐ Pain prevents me from walking more than 1 mile.
☐ Pain prevents me from walking more than 1/4 mile.
☐ I can walk only using a stick or crutches.
☐ 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 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 1/2 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 extra pain.
☐ I can stand as long as I want, but it gives me extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 1/2 hour.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 - Sleeping
☐ My sleep is never disturbed by pain.
☐ My sleep is occasionally disturbed by pain.
☐ Because of pain, I have less than 6 hours of sleep.
☐ Because of pain, I have less than 4 hours of sleep.
☐ Because of pain, I have less than 2 hours of sleep.
☐ Pain prevents me from sleeping at all.

Section 8 - Sex Life (if applicable)
☐ My sex life is normal and causes no extra pain.
☐ My sex life is normal, but causes some extra pain.
☐ My sex life is nearly normal, but is very painful.
☐ My sex life is severely restricted by pain.
☐ My sex life is absent because of pain.
☐ Pain prevents any sex life at all.

Section 9 - Social Life
☐ My social life is normal and causes me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., sports, etc.)
☐ Pain has restricted my social life and I don’t go out often.
☐ Pain has restricted my social life to home.
☐ I have no social life because of pain.

Section 10 - Traveling
☐ I can travel anywhere without extra pain.
☐ I can travel anywhere, but it gives me extra pain.
☐ Pain is bad, but I manage journeys over 2 hours.
☐ Pain restricts me to journeys of less than 1 hour.
☐ Pain restricts me to short journeys under 30 minutes.
☐ Pain prevents me from traveling except to receive treatment.

Please complete this questionnaire. It has been designed to give us information as to how your pain has affected your ability to manage in everyday life. Please answer every section. Mark only ONE number in each section that most closely describes you today.
**NEW PATIENT EVALUATION FORM**

**INITIAL PATIENT DATABASE** In order to help us provide the best possible care for you at Advanced Pain Management, we ask for your cooperation in providing the following information. Please bring this form with you to your first appointment.

**GENERAL INFORMATION**

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date form completed: <em><strong>/</strong></em>/____</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Date of birth: <em><strong>/</strong></em>/____</td>
</tr>
</tbody>
</table>

| Height: ___ ft. ___ in. | Weight: ___ | Age: ___ |

| Referred By: | Family Physician: |

| Date onset of pain: ___/___/____ | Cause of pain: |

Was this injury: □ At Work □ Auto Accident □ Other □ After Surgery

Onset of pain: □ Sudden □ Gradual

<table>
<thead>
<tr>
<th>On a scale of 1-10 your pain is at its worst:</th>
<th>Pain at its best:</th>
<th>Pain right at this moment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = no hurt</td>
<td>1-2 hurts a little bit</td>
<td>3-4 hurts a little more</td>
</tr>
</tbody>
</table>

**LOCATION OF YOUR PAIN**

On the picture, color in all your areas of pain.

**Associated with (check all that apply):**

- □ Numbness/Tingling
- □ Night Pain
- □ Weakness
- □ Loss of Control of Bowel
- □ Loss of Control of Bladder
- □ Fever/Chills
- □ Sexual Dysfunction
- □ Unexplained Weight Loss

How many pounds: ___

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NP_07_2013
COMPLETE THIS BOX ONLY IF YOU WERE INVOLVED IN AN AUTO ACCIDENT

Were you wearing a seat belt?  □ Yes  □ No
Were you the passenger?  □ Yes  □ No
Were you the driver?  □ Yes  □ No
Did you lose consciousness?  □ Yes  □ No  If yes, for how long?  
Briefly describe the accident:

How much damage was done to your vehicle?  $

How long after the incident did the pain occur?  

When did you first seek medical attention?  ____ / ____ / ______

Did you experience pain in the same location previous to this accident?  □ Yes  □ No  If yes, explain:

COMPLETE THIS BOX ONLY IF YOU WERE INVOLVED IN A WORK INJURY

Describe injury:

How long after the incident did the pain occur?  

When did you first seek medical attention?  ____ / ____ / ______

Have you had the pain in the same location prior to your work injury?  □ Yes  □ No  If yes, explain:

Is your current injury through your current employer?  □ Yes  □ No
If it is not through your current employer, please list the name of the employer that it is through, along with a phone number.
Employer name:  Phone:

SYMPTOMS The questions below refer only to the area of pain that you are coming to our clinic for at this time.

My pain is:  □ Mild  □ Mild-Moderate  □ Moderate  □ Moderate-Severe  □ Severe

Check the boxes that best describe what your pain feels like.

□ Throbbing □ Shooting □ Stabbing □ Burning □ Sharp □ Tingling
□ Numb □ Tender □ Pressure □ Deep □ Aching □ Cramping
□ Heaviness □ Diffuse □ Dull □ Gnawing □ Localized □ Superficial

What makes your pain worse?

□ Bending □ Coughing □ Daily Activities □ Driving □ Everything □ First Steps
□ Going Downstairs □ Going Upstairs □ Kneeling □ Lifting □ Lying Down □ Neck Movement
□ Nothing □ Reaching □ Sitting □ Sneezing □ Squatting □ Standing
□ Stretching □ Twisting □ Weather Changes □ Walking □ Work Activities
□ Other, Explain

The pain is:  □ At Rest □ Continuous □ In the Night □ In the Morning □ Intermittent □ On Activity □ Spontaneous

Does your pain make you: (check all that apply)  □ Depressed □ Angry □ Frustrated
□ Helpless/Hopeless  □ Sleep □ Daily Activities □ Work
Please check any previous treatments for current pain:

- No Prior Modalities
- Acupuncture
- Biofeedback
- Hypnosis
- Manipulation/Chiropractor
- Physical Therapy
- Traction
- Work Hardening
- Herbal Remedies
- Herbal Remedies
- Tens Unit
- Physical Therapy
- Traction
- Work Hardening
- Herbal Remedies
- Tens Unit
- Physical Therapy
- Traction
- Work Hardening
- Herbal Remedies
- Tens Unit

List any tests for your pain:

- X-ray
- CT scan
- MRI
- Mylogram
- Bone Scan
- EMG
- Blood Tests

PAST MEDICAL HISTORY
Please check all that apply

- AIDS/HIV
- Aneurysm
- Arthritis
- Asthma
- Bleeding Disorder
- Cancer
- Chem. Dependency
- CA Colon
- CA Lung
- CA Breast
- CA Prostate
- CA Cervical
- COPD
- Depression
- Diabetes
- Fibromyalgia
- Heart Attack
- Heart Disease
- Hepatitis
- Hypercholesterolemia
- Hypertension
- Hypothyroidism
- Jaundice
- Kidney Disease
- Liver Disease
- Murmur
- Osteoarthritis
- Pacemaker
- Peptic Ulcer Disease
- Peripheral Neuropathy
- Peripheral Vascular Disease
- Post-op Nausea/Vomiting
- Reflux
- Rheumatic Fever
- Seizure Disorder
- Sleep Apnea
- Stroke
- Other, please list:

PAST SURGICAL HISTORY
List all previous surgeries:

<table>
<thead>
<tr>
<th>DATE (MONTH/YEAR)</th>
<th>PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
FAMILY HISTORY

Check if any of your BLOOD relatives have had any of the following:

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>RELATIONSHIP TO YOU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Chemical Dependency</td>
<td></td>
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<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Heart Disease, stroke</td>
<td></td>
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<tr>
<td>High Blood Pressure</td>
<td></td>
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<tr>
<td>Kidney Disease</td>
<td></td>
</tr>
<tr>
<td>Neurologic Condition</td>
<td></td>
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<tr>
<td>Bleeding disorder</td>
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<tr>
<td>Other, please list</td>
<td></td>
</tr>
</tbody>
</table>

SOCIAL HISTORY

Educational Background

☐ None  ☐ Home-Schooling  ☐ Elementary School  ☐ High School  ☐ College Graduate
☐ GED  ☐ Grad School  ☐ Some College  ☐ Trade School  ☐ Technical School
☐ Post-College  ☐ Medical School  ☐ Law School

CHECK APPROPRIATE ANSWERS:

Marital Status:  ☐ Married  ☐ Single  ☐ Divorced  ☐ Widowed  ☐ Separated

How many children do you have?  

Do you use tobacco?  ☐ Current  ☐ Former  ☐ Never  ☐ Unknown

Type:  
Units/day:  
Years used:  
Pack Years:  

Ever tried to quit?  ☐ Yes  ☐ No  
Year quit:  
Longest tobacco free:  

Relapse reason:  
Passive smoke exposure?  ☐ Yes  ☐ No

Smoker Status (Meaningful Use)

☐ Current Every Day Smoker  ☐ Smoker, Current Status Unknown  ☐ Former Smoker
☐ Current Some Day Smoker  ☐ Never Smoker  ☐ Unknown if Ever Smoked

Do you drink alcohol?  ☐ Yes  ☐ No  ☐ Former

How frequently do you drink alcohol?

☐ Daily  ☐ Weekly  ☐ Monthly  ☐ Yearly  ☐ Occasionally  ☐ Rarely  ☐ Socially  ☐ Never

Do you use recreational drugs?  ☐ Yes  ☐ No  ☐ Former

☐ Never  ☐ Rarely  ☐ Occasionally  ☐ Often

What:  
How often:  

Exercise?

☐ Never  ☐ Rarely  ☐ Occasionally  ☐ Often  ☐ 2-3 Times/Week  ☐ 3-4 Times/Week  ☐ Daily
### WORK HISTORY

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you employed?</td>
<td></td>
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<tr>
<td>Occupation:</td>
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<tr>
<td>If yes, where:</td>
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<tr>
<td>Are you on worker’s compensation?</td>
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<tr>
<td>Is your employer contesting?</td>
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<tr>
<td>Do you have an attorney?</td>
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<tr>
<td>If yes, attorney name:</td>
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<tr>
<td>When did you last work?</td>
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<tr>
<td>Are you currently working?</td>
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<tr>
<td>Do you have work restrictions?</td>
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<tr>
<td>Would you return to work with restrictions?</td>
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<tr>
<td>Have you missed work because of your pain?</td>
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<tr>
<td>Do you want to go back to work?</td>
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<tr>
<td>Do you want permanent disability?</td>
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</table>

### PSYCHOLOGICAL HISTORY

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Have you ever been treated for emotional/behavioral disorder?</td>
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<tr>
<td>Have you ever been treated for depression?</td>
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<tr>
<td>If yes, when:</td>
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<tr>
<td>Do you currently have ACTIVE suicidal thoughts?</td>
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<tr>
<td>Do you have a history of suicidal attempts?</td>
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<tr>
<td>Do you have a history of drug abuse?</td>
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<tr>
<td>Do you have a history of alcohol abuse?</td>
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</table>
### ALLERGIES

<table>
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<tr>
<th>ALLERGY</th>
<th>REACTION</th>
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### MEDICATION HISTORY

**Pharmacy Name:**

**Phone #:**

Please provide a list of current prescription medication and over the counter medication:

<table>
<thead>
<tr>
<th>MEDICATION NAME</th>
<th>DOSE</th>
<th>FREQUENCY</th>
<th>PHARMACY</th>
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</table>

Have you taken any medications in the past for your current pain problem, even if they didn’t work?  □ Yes  □ No

If yes, please list (be sure to include any nonprescription medications such as Tylenol, Bengay, etc.):  

<table>
<thead>
<tr>
<th>NAME</th>
<th>WHY STOPPED</th>
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I, the undersigned, have completed this form to the best of knowledge. The information that I have provided is true and accurate to the best of my knowledge. I understand that this information is used in the care and treatment plan while under the care of all physicians and staff of Advanced Pain Management.

**Patient/Guardian Signature**

**Date:**  

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**NP_07_2013**