INTERVENTIONAL PAIN CARE

60 Business Park Dr, Ste A
Troy, MO 63379
636-728-9460

REGEN ORTHO SPINE & PAIN

407 Meramec Blvd
Eureka, MO 63025.
636-333-3700

Patient Registration

Last Name:	First Name: MI:
Home Address:	City/State/Zip:
DOB:	Social Security #:
Home Phone: Cell #:	Email:
Sex: ☐ Male ☐ Female	Phone #:
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Employment: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled
Referring Physician:	Office Phone Number:
Primary Care Doctor:	Office Phone Number:

Pharmacy Information

Pharmacy name:	Address:
Phone #:	

I authorize IPC/ROSP to view all available RX History from an external source. I am aware that IPC/ROSP uses a secure connection to Sure Scripts to send and receive prescriptions. This authorization remains in effect until revoked in writing.

Signature of Patient: _____ *Date:* __/___/20___

Insurance Information

Primary Insurance:	Secondary Insurance:
ID#	ID#

I authorize the assignments of benefits (payments) directly to IPC/ROSP for all my insurance claims related to services received. I will pay all charges that exceed or are not covered by my insurance. I understand that co-payments, deductibles, and non-covered services are due at the time of service. I authorize release of my medical information for the purpose of processing claims with my insurance company. I permit this authorization to be used in place of the original. This authorization remains in effect until revoked in writing.

Signature of Patient: _____ *Date:* __/___/20___

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Accident Information (if applicable)

Date of Accident:	Type of Claim: **WORKERS COMP AUTO OTHER**
Name of Insurance:	Claim#
Name of Claim Adjuster:	Adjuster Phone#

Acknowledgment of Receipt of HIPPA Notice

Interventional Pain Care/Regen Ortho Spine & Pain is concerned about the privacy of our patient's healthcare information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your healthcare service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and healthcare operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for: Interventional Pain Care/Regen Ortho Spine & Pain.

_____ _____
(Signature of Patient or Legal Guardian) (Date)

Authorization to Discuss Your Medical Information

In accordance with the HIPAA guidelines Interventional Pain Care/Regen Ortho Spine & Pain/Regen Ortho Spine & Pain is authorized to discuss my medical information with the following individuals.

Please list up to 3 people we may leave messages withinthe event we are unable to contact you.

HIPAA Authorized Person's Name	Relationship to Patient	Telephone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Which of the above listed HIPPA Released contacts is your Emergency Contact?

_____

(If left blank, your 1st listed HIPPA Released person above will be considered your emergency contact)

Patient Evaluation

Patient Name: _____DOB: ___/___/_____

Referring Provider (full name): _____ Primary Provider (full name): _____

If female, what is your current pregnancy status?
□Hysterectomy □Post Menopause □Unable to get pregnant □Child bearing age-No contraceptive
□Child bearing age-Birth Control Medication □ Child bearing age-Other Contraceptive

Where is your pain located? _____ **Began:** ___/___/_____

What's the main cause of the pain? □Unknown □Normal Aging □Fell down
□Sports injury □Car Accident □Work Injury

What's the frequency of your pain? □Constant □Fluctuates/Always present
□Fluctuates/usually present □Fluctuates /rarely present

What best describes your pain? □Aching □Burning □Cramping □Dull □Numb
□Sharp □Stabbing □Stinging □Throbbing □Tingling

What's your pain level most of the time?
□ No Pain □1 □2 □3 □4 □ 5 □6 □7 □8 □9 □ Unbearable Pain

What makes the pain worse?
□Bending/Stooping □Changing from standing to sitting □Sitting □Lifting/Carrying heavy loads
□Lifting/Carrying small loads □Lying on back □Lying on side □Nothing

What makes the pain better? □ Lying on side □ Lying on back □Sitting □Standing
□Walking □Stretching □Exercise □Nothing

What does your pain interfere with?
□ Daily chores □ Employment □Exercise □Grooming □House chores
□Mood □ Relationships □Sleep □Walking □Nothing

Mark any of the following tests you've had performed to evaluate your pain:
□ MRI □ CT scan □ X-ray □ EMG/Nerve Conduction

Mark any of the following tests performed to evaluate your pain: □ Blood work □ Drug Screening
□ Bone Scan □ Bone Density □ Vascular Studies □ Functional Capacity Evaluation □ Depression Screening

Mark any of the following injections you've had to assist in your pain: □ Spinal □ Joint □ Muscle □ None

Mark any you've had to assist in your pain: □ Back Brace □ Neck Brace □ Tens Unit □ None

Mark any surgeries you've had: □ Low Back □ Mid Back □ Neck □ Hip □ Knee □ Shoulder □ None

Mark any therapies you've had to assist your pain: □ Physical □ Chiropractic □ Aquatic □ None

Mark any of the following you've used to assist in your pain:
□ Spinal Cord Stimulator □ Spinal Traction □ Cane □ Walker
□ Exercise Program □ Weight Loss Program □ Intrathecal Pain Pump □ None

What Medications have helped? _____

_____

What Medications have NOT helped? _____

_____

Have you tried creams or ointments? ☐ No ☐ Yes; _____

All Current Medications:

List all medications, dosage, and instructions: ☐ Medications were provided separately

_____

_____

_____

Allergies/Intolerance: ☐ Penicillin ☐ Sulfa ☐ IV Dye/Contrast ☐ Other:_____

Diagnostic Studies Date

X-rays: _____

MRI: _____

CT Scan: _____

Myelogram: _____

Bone Scan: _____

List all surgeries and dates: ☐ Surgery history were provided separately

_____

_____

_____

Your Personal Medical History (mark all that apply):

☐ Addiction
☐ Alcoholism
☐ Anxiety
☐ Arthritis OA/RA
☐ Asthma
☐ Bowel Disease
☐ Cancer
☐ Cirrhosis
☐ Coronary Artery
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Fibromyalgia
☐ Gallbladder Disease
☐ Head Injury
☐ Heart Arrhythmia
☐ Heart Attack (MI)
☐ Hepatitis
☐ Hiatal Hernia
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV
☐ Kidney Disorder
☐ Migraine
☐ Multiple Sclerosis
☐ Muscle Disorder Disease
☐ Osteoporosis
☐ Pancreatitis
☐ Peripheral Nerve
☐ Reflux
☐ Seizures
☐ Sleep Apnea
☐ Spine Disorder
☐ Stroke
☐ Ulcers
☐ None

Your Family's Medical History (mark all that apply):

□ Addiction
□ Alcoholism
□ Anxiety
□ Arthritis OA/RA
□ Asthma
□ Bowel Disease
□ Cancer
□ Cirrhosis
□ Coronary Artery
□ Depression
□ Diabetes
□ Emphysema
□ Fibromyalgia
□ Gallbladder Disease
□ Head Injury
□ Heart Arrhythmia
□ Heart Attack (MI)
□ Hepatitis
□ Hiatal Hernia
□ High Blood Pressure
□ High Cholesterol
□ HIV
□ Kidney Disorder
□ Migraine
□ Multiple Sclerosis
□ Muscle Disorder Disease
□ Osteoporosis
□ Pancreatitis
□ Peripheral Nerve
□ Reflux
□ Seizures
□ Sleep Apnea
□ Spine Disorder
□ Stroke
□ Ulcers
□ None

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

Who resides with you or helps provide you care?
□ Alone □ Friends □ Spouse □ Children □ Parents □ Hospice □ Nursing Facility

Employment Status: □ Full-Time □ Part-Time □ Retired □ Unemployed □ Disability: Short or Long (circle one)

Alcohol Use: □ None □ Rarely □ Occasionally □ Regularly □ Previously Addicted □ Currently Addicted

Nicotine Use: □ Never □ Former Smoker □ Current Smoker: Sometimes or Everyday (circle one)

Street Drug Use: □ No □ Yes □ Previously Overdosed

Review of Symptoms (Mark all that apply)

General: □ Weight Loss □ Weight Gain □ Fever □ Night Sweats □ Fatigue □ Many Infections

HEENT: □ Headache □ Facial Pain □ Sinusitis □ Loss of Vision □ Hearing Loss □ Teeth/Gum Problems

Respiratory: □ Chronic Cough □ Wheezing □ Shortness of Breath □ Sleep Apnea □ Home Oxygen Use □ C-PAP

Cardiology: □ Chest Pain □ Murmur □ Congestive Failure □ Abnormal EKG

Gastroenterology: □ Appetite Loss □ Chronic Nausea □ Heartburn
□ Constipation □ Diarrhea □ Bowel Control Loss

Genitourinary: □ Painful Urination □ Blood in Urine □ Bladder Control Loss □ Enlarged Prostate
□ Testicular Pain □ Irregular Bleeding □ Pregnancy

Endocrine/Hematological: □ Abnormal Blood Sugars □ Easy Bruising/Bleeding

Musculoskeletal: □ Joint Pain □ Muscle Spasms □ Neck Pain □ Back Pain

Neurology: □ Drowsiness □ Dizziness □ Blackouts □ Tremors

Psychiatric: □ Panic Attacks □ Insomnia □ Depression

Vascular: □ Poor Circulation □ Current Blood Clot □ Swelling in Legs **Skin:** □ Rash

Preventative Medicine-Fall Risk Screening (age 65 & older only): □ No falls - last year
□ 1 fall without injury – last year □ 1 fall with injury – last year
□ 2+ falls without injury – last year □ 2+ falls with injury – last year

Opioid Risk Tool

Please mark each question as either Yes or No depending on if the question applies to you.

		Yes	No	Score (Office use only)
1	Has there been family history of alcohol abuse?	Yes	No	
2	Has there been family history of illegal drug use?	Yes	No	
3	Has there been family history of recreational drug use?	Yes	No	
4	Has there been personal history of alcohol abuse?	Yes	No	
5	Has there been personal history of illegal drug use?	Yes	No	
6	Has there been personal history of recreational drug use?	Yes	No	
7	Aged between 16 - 45 years?	Yes	No	
8	Has there been a history of preadolescent sexual abuse?	Yes	No	
9	Has there been a personal history of Attention Deficit Disorder (ADD or ADHD), bipolar or schizophrenia?	Yes	No	
10	Has there been a personal history of depression?	Yes	No	

Total Score:

Developer Reference:

Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. Pain Medicine. 2005;6(6):432-442. Used with permission.

Have you used any of the following in the last two months?

Cocaine:	☐ Yes	☐ No	Marijuana:	☐ Yes	☐ No
Methamphetamine:	☐ Yes	☐ No	Suboxone/Subutex:	☐ Yes	☐ No
Opana:	☐ Yes	☐ No	Insomnia (Sleeping) Pills:	☐ Yes	☐ No
Anxiety Medications:	☐ Yes	☐ No	Morphine:	☐ Yes	☐ No
Hydrocodone (Lortab), Norco, Vicodin):	☐ Yes	☐ No	Oxycodone (Percocet, Oxycontin, Roxicodone):	☐ Yes	☐ No
Heroin:	☐ Yes	☐ No	Medications not prescribed to you:	☐ Yes	☐ No

Oswestry Pain Disability Questionnaire

I have pain that has bothered me for 3 months or more: □ Yes □ No

Mark ONLY ONE per section that fits you the best currently.

1: Pain Intensity:
□ I tolerate the pain without having to use painkillers
□ The pain is bad, but I manage without taking pain killers.
□ Pain killers give complete relief.
□ Painkillers give moderate relief.
□ Painkillers give very little relief.
□ I don't use painkillers because they don't help.

2: Personal Care:
□ Self-care doesn't cause extra pain.
□ It causes extra pain.
□ I'm slow & careful since it's painful.
□ I need some help but mostly do it on my own.
□ I need help in most aspects of self-care.
□ It hurts too much to perform self-care activities.

3: Lifting:
□ I can lift heavy objects without added pain.
□ Lifting heavy objects gives extra pain.
□ I can only lift heavy objects off the table.
□ I can only lift light objects if conveniently placed.
□ I can lift very light weights.
□ I can't lift or carry items.

4: Walking:
□ I can walk any distance.
□ Pain prevents me from walking over a mile.
□ Pain prevents me from walking more than a ½ mile.
□ Pain prevents me from walking more than a ¼ mile.
□ I can only walk with aids, cane, crutches, etc.
□ I avoid walking at all times.

5: Sitting:
□ I can sit as long as like.
□ I can sit in my favorite chair as long I like.
□ I can't sit longer than 1 hour.
□ I can't sit longer than ½ hour.
□ I can't sit longer than 10 minutes.
□ Pain prevents me from sitting at all.

6: Standing:
□ I can stand as long as I want.
□ I can stand as long as I want with some pain.
□ I can't stand for longer than 1 hour.
□ I can't stand longer than ½ hour.
□ I can't stand longer than 10 minutes.
□ Pain prevents me from standing at all.

7: Sleeping:
□ Pain doesn't prevent me from getting good sleep.
□ I sleep well while on medication.
□ I get less than 6 hours sleep while on medication.
□ I get less than 4 hours sleep while on medication.
□ I get less than 2 hours sleep while on medication.
□ Pain prevents me from getting any sleep.

8: Sex Life:
□ Pain does not affect my sex life.
□ Some pain while I have a normal sex life.
□ It's very painful while having a normal sex life.
□ Sex life is restricted due to severity of pain.
□ Sex life is nearly absent due to pain.
□ Sex life is completely absent due to pain.

9: Social Life:
□ My social life is normal with no pain.
□ My social life is normal, but it causes some pain.
□ Pain only decreases my social life in high energy activities.
□ I do not go out as often which decreases my social life.
□ Pain has restricted my social life to only at home activities.
□ I have no social life due to pain.

10: Traveling:
□ I can travel anywhere without pain.
□ I can travel anywhere with some pain.
□ Due to the pain, I restrict traveling to under 2 hours.
□ Due to the pain, I restrict traveling to under 1 hour.
□ Due to the pain, I restrict traveling to under ½ hour.
□ I only travel to doctor's appointments.