WAKE SPINE & PAIN SPECIALISTS

First Name: _____ MI:____ Last Name: _____ Date:_____

Street Address: _____ City: _____State: _____ Zip: _____

DOB: ____/____/_____ Social Security #: _____-____-_____ [ ] Male [ ] Female

Home Phone: _____ Cell: _____ Work Phone: _____

Email: _____ *(Clinic newsletters and satisfaction surveys will be emailed periodically)*

Race: [ ] White [ ] Hispanic [ ] African American [ ] Asian [ ] American Indian [ ] Other [ ] Decline

Ethnicity: [ ] Hispanic [ ] Non-Hispanic [ ] Decline Primary Language (if not English) _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Who referred you to us? _____Phone Number: _____

Who is your Primary Care Physician (PCP)? _____ Phone Number: _____

Pharmacy:_____ Phone Number: _____

PAYMENT: [ ] Insurance [ ] Self Pay [ ] Workers Compensation

Primary insurance name: _____ Secondary insurance name: _____

Policyholder Name: _____ Policyholder DOB: _____

MARITAL STATUS: [ ] married [ ] single [ ] widowed [ ] divorced

EDUCATION: Your highest education level achieved:

[ ] Post Graduate [ ] College graduate [ ] High school graduate/GED Other_____

EMPLOYMENT: [ ] Retired [ ] Student [ ] Homemaker [ ] Disabled [ ] Unemployed [ ] Part-time

[ ] Full-time regular duty [ ] Full-time with restrictions Occupation: _____

Employer: _____ Phone Number:_____

If unemployed or employed part/full time with restrictions, is it due to your present pain condition? ____ No ____ Yes

What date did you last work (full time/without restrictions) due to your present pain condition: _____

Are you currently seeking any of the following due to your pain? [ ] Workers compensation [ ] Disability [ ]Legal help

First initial_____ Last Name_____

NEW PROBLEM QUESTIONNAIRE

Height _____ Weight _____

PAIN DESCRIPTION Where is the **worst area** of your pain located? _____

PAIN SEVERITY Please use the pain scale provided to rate your pain on a **scale of 0 – 10**

Pain Now: _____ Average pain over the last month: _____ Worst pain: _____ Least pain: _____

WHICH ACTIVITIES ARE AFFECTED BY YOUR PAIN? [ ]General activity [ ]Sleep

[ ]Overall quality of life [ ] Relationships with people [ ]Normal work [ ]Household chores [ ]Mood

Mark the drawing with the symbols that best describe your symptoms:

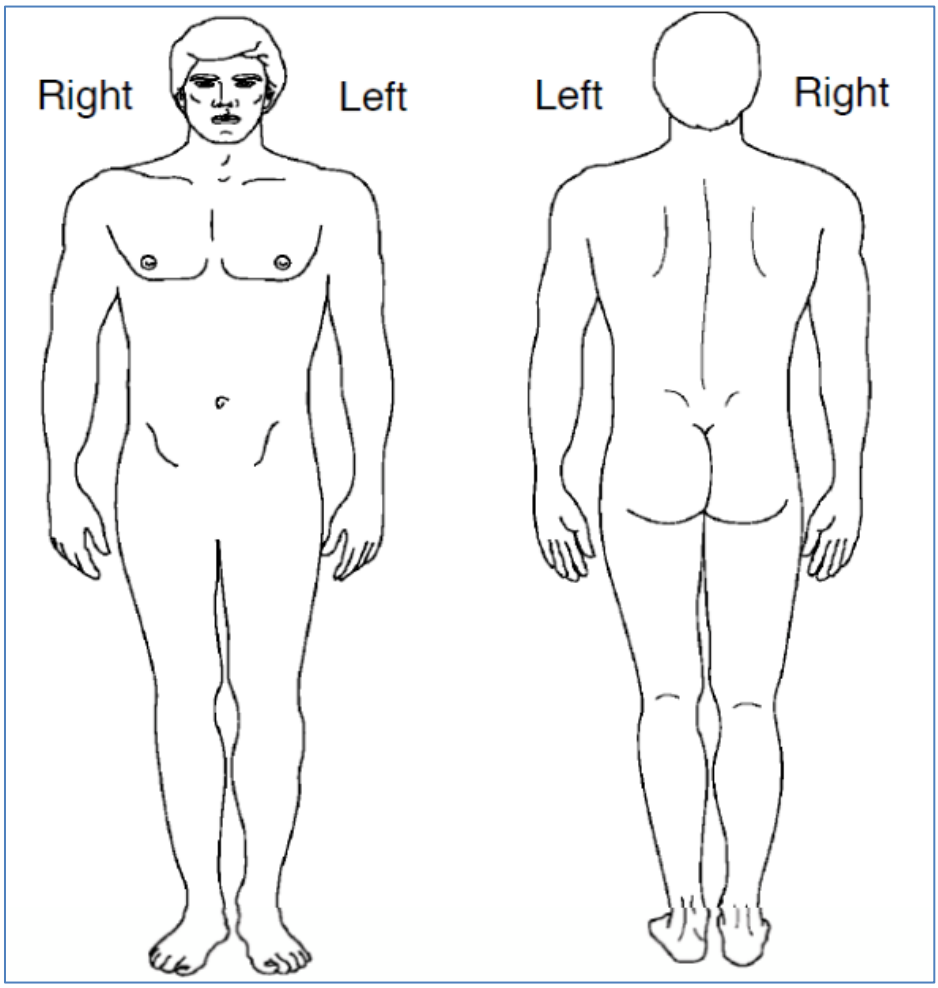
Numbness	NNN
Weakness	WWW
Ache	AAA
Pins & Needles	PPP
Burning	BBB
Radiating pain	///////

Does the pain radiate? If so, where?

_____

Neck pain % _____ Back pain % _____
Arm pain % _____ Leg pain% _____
Total % _____ Total % _____

Use this diagram to indicate the location and type of your pain.



PAIN QUALITY Check all of the below that best describes your pain

[ ]Dull/aching [ ]Numbing/Tingling
[ ]Shooting/Stabbing [ ]Stinging/Burning

WHICH ADDITIONAL SYMPTOMS ARE CAUSED BY YOUR PAIN?

[ ]Spasm [ ]Stiffness [ ]Restless legs
[ ]Itching [ ]Swelling [ ]Tenderness
[ ]Posterior headache [ ]Dropping objects

ONSET OF SYMPTOMS

Approximately when did the pain start? Month: _____Year: _____

[ ]Post fusion [ ]Post laminectomy [ ]Since a fall [ ]Since cancer

[ ] Auto Accident Date_____ [ ] Work Accident Date _____ [ ] Other_____

How did your current pain episode begin? [ ]Gradually [ ] Suddenly

How often does the pain occur? [ ] Constant [ ] Worse in the morning [ ] Worse at night
[ ] Comes and goes [ ] Worse as day goes by [ ] With activity

First initial_____ Last Name_____

Since your pain began, how has it changed? [ ] Decreased [ ] Increased [ ] Stayed the same

WHAT MAKES THE PAIN BETTER?

[ ]Rest [ ]Cold [ ]Heat [ ]Elevation of limbs [ ]Position change [ ]TENS
[ ]Medications [ ]Massage [ ]Exercise/PT

WHAT MAKES THE PAIN WORSE?

[ ]Prolonged activity [ ]Weather change [ ]Bending forward [ ]Bending backward [ ]Overhead actions
[ ]Climbing stairs [ ]Position of limb [ ]Coughing/Sneezing [ ]Arising from chair [ ]Lying down [ ]Lifting
[ ]Turning head laterally [ ]Sitting/driving [ ]Walking [ ]Standing [ ]Running [ ] Other_____

PAIN TREATMENT HISTORY

Please indicate all of the below treatment you have undergone prior to today's visit to treat your current pain:

Treatment	Year & How long	Helped (Y/N)	Facility/ Physician	Treatment	Date/Year	Helped (Y/N)	Facility/ Physician
Physical therapy				Injections (pain management.)			
Massage				TENS			
Chiropractor				Brace			
Acupuncture				Surgery			

Consults	Physician	Date/year	Consults	Physician	Date/year
Ortho surgeon			Neurologist		
Spine surgeon			Rheumatologist		
Pain specialist			Podiatrist		
Psychologist			Sleep specialist		

MEDICATIONS TRIED FOR PAIN

Check all the medications that you have tried for your pain:

NSAIDS	[ ]Acetaminophen (Tylenol) [ ] Aspirin [ ]Ibuprofen
Neuro/Psych	[ ]Amitriptyline (Elavil) [ ]Gabapentin (Neurontin) [ ]Pregabalin (Lyrica) [ ]Duloxetine (Cymbalta)
Antispasmodics	[ ]Cyclobenzaprine (Flexeril) [ ]Tizanidine (Zanaflex) [ ]Baclofen [ ]Methocarbamol (Robaxin)
Opiates	[ ]Codeine(Tylenol 3) [ ]Tramadol (Ultram) [ ]Hydrocodone (Vicodin) [ ]Oxycodone (Percocet) [ ]Oxycontin [ ]MS Contin [ ]Morphine [ ]Hydromorphone (Dilaudid) [ ]Oxymorphone(Opana) [ ]Opana ER [ ]Nucynta ER

DIAGNOSTIC TESTS AND IMAGING

Mark all the tests below that you have had that are related to your current pain complaint. [ ] **None**

Test	Body part	Date	Facility	Test	Body part	Date	Facility
MRI				EMG/NCV			
CT Scan				Ultrasound			
X-Ray				Other			

First initial_____ Last Name_____

PATIENT MEDICAL HISTORY

CURRENT MEDICATIONS

Please indicate which (if any) of the following **blood-thinners** you are taking: [ ]**Not on blood thinners**

[ ]Aggrenox [ ]Coumadin [ ]Effient [ ]Eliquis [ ]Lovenox [ ]Plavix [ ]Pletal [ ]Pradaxa
[ ]Ticlid [ ]Warfarin [ ]Xarelto [ ]Other _____

Please list **ALL** medications you are **CURRENTLY** taking. Attach an additional sheet, if required.

Medication name	Dose	Frequency	Medication name	Dose	Frequency

MEDICAL HISTORY

Have you had any of the following? [ ] No pertinent past medical history

General	[ ] High thyroid	[ ] Low thyroid	[ ] HIV/AIDS	[ ]Diabetes type _____
	[ ]Cancer type_____	[ ]Prior chemotherapy	[ ]Prior radiation therapy	
Cardiovascular	[ ]High blood pressure	[ ]Coronary artery disease/Heart failure	[ ]High cholesterol	
	[ ]Heart attack: when_____			
Musculoskeletal	[ ]Osteoporosis	[ ]Gout	[ ]Fibromyalgia	[ ]Vertebral compression fracture
	[ ]Joint disease	[ ]Lupus	[ ] Rheumatism	[ ]Connective tissue disease
Neuro	[ ]Stroke	[ ]Headache	[ ]Seizure	[ ]Neuropathy
Respiratory	[ ]Asthma	[ ]Sleep apnea	[ ]Emphysema	
Genitourinary	[ ]Kidney disease	[ ]Kidney stones	[ ]Dialysis	[ ]Prostate enlargement
Gastrointestinal	[ ]Acid reflux/Ulcer	[ ]GI bleeding	[ ]Crohn's disease	
Blood	[ ]Bleeding disorder	[ ]Blood thinners	[ ]Anemia	[ ]Blood clot: when_____
	[ ]Peripheral vascular disease			
Psych	[ ]Anxiety	[ ]Depression	[ ]Dementia	[ ]Bipolar disorder [ ]Substance abuse
Liver	[ ] Liver disease	[ ]Hepatitis C		
Other (Please list)				

ALLERGIES [ ] No known drug allergies

Medication name	Reaction	Medication name	Reaction

Skin allergies [ ] None [ ]Latex [ ]Iodine [ ]Shellfish [ ]Tape Other _____

PAST SURGICAL HISTORY

Please list any surgeries you have had. [ ] I have never had any surgical procedures

Surgery	**Date**	**Hospital/Physician**	**Surgery**	**Date**	**Hospital/Physician**

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FAMILY MEDICAL HISTORY

	Chronic pain	Depression	Arthritis	Substance abuse
Mother	[ ]	[ ]	[ ]	[ ]
Father	[ ]	[ ]	[ ]	[ ]
[ ] I am adopted (No family medical history available)				

SOCIAL HISTORY

Are you capable of becoming pregnant? [ ] Yes [ ] No If so, are you currently pregnant? [ ]Yes [ ]No

Alcohol Use: [ ]Never [ ]Occasionally/Socially [ ]Daily-limited [ ]Current alcoholism [ ]History of alcoholism

Tobacco Use: [ ]Current Tobacco User [ ]Former Tobacco User [ ]Never Used Tobacco

[ ]Current Everyday Tobacco User [ ]Current Someday Tobacco User [ ]Unknown Tobacco Use Status

Illegal Drug Use: [ ]Denies [ ]Currently Using [ ]Formerly Used (Drug: _____)

[ ]Currently Uses Marijuana [ ]Currently Using Someone Else's Prescription Medications

Have you ever abused narcotic or prescription medications? [ ]Yes [ ]No (Medication: _____)

Have you ever been in a detoxification program? [ ]Yes Name of program_____ When_____

REVIEW OF SYSTEMS

Check all that have occurred in the past twelve months. [ ] **None**

General	[ ]Weight gain [ ] Weight loss [ ]Fever [ ]Insomnia [ ]Infections
Psychology	[ ]Hallucinations [ ]Anxiety [ ]Suicidal ideation [ ]Depression
Neurology	[ ]Headaches [ ]Seizures [ ]Loss of balance/dizziness [ ]Numbness/tingling [ ]Memory loss [ ]Paralysis [ ]Disorientation [ ]Loss of consciousness
Cardiology	[ ]Chest pain [ ]High blood pressure [ ]Irregular heartbeat [ ]Swelling in feet
Gastrointestinal	[ ]Constipation [ ]Nausea [ ]Diarrhea [ ]Reflux [ ]Vomiting
Respiratory	[ ]Shortness of breath [ ]Cough [ ]Wheezing
Hematology/Lymph	[ ]Bleeding [ ]Swollen lymph nodes [ ]Bruising
Head/Ear/Nose/Throat	[ ]Change in vision [ ]Loss of hearing [ ]Glaucoma
Endocrinology	[ ]Excessive sweating [ ]Frequent thirst [ ]Low sex drive
Urinary	[ ]Incontinence [ ]Frequent urination [ ]Hesitancy

First initial_____ Last Name_____

FINANCIAL POLICY

- **FINANCIAL RESPONSIBILITY:** Insurance billing is a service provided as a courtesy and you are at all times financially responsible to Wake Spine & Pain Specialists and/or its affiliated entities for **ANY** charges not covered by your health care benefits except as limited by our contract (if any) with your insurance carrier.
- **PAYMENT DUE AT TIME OF SERVICE:** Any self-pay charges (if not insured), co-pays, deductibles, co-insurances, non-covered services and any past due balances are due at time of service. Wake Spine & Pain reserves the right to reschedule your appointment until a time that you are able to pay any balance due at time of service.
- **REASSIGNMENT OF BALANCE:** If your insurance does not pay Wake Spine & Pain Specialists for services rendered within 90 days, the balance will be transferred to you. A refund will be issued upon receipt of insurance payment.
- **BOUNCED CHECKS:** You will be charged a $35.00 fee for any bounced checks.
- **REBILLING FEE:** You will be charged a monthly $5.00 rebilling fee for any outstanding balance if payment is not received within 30 days of each statement date until balance is paid in full.
- **COLLECTION OF UNPAID ACCOUNTS:** If you have an outstanding balance over 120 days old and have failed to make payments, your account will be transferred to an independent collection agency. You agree to pay Wake Spine & Pain Specialists for any expenses we incur to collect on your account, including reasonable attorneys' fees and collection costs.
- **COVERAGE CHANGES & TIMELY SUBMISSION:** It is your responsibility to notify Wake Spine & Pain Specialists (WSPS) immediately of any changes in your health care coverage or demographic changes. If WSPS is unable to submit your claim within the insurance time limit because we have not been supplied with the correct insurance information or demographic information, you will be responsible for these charges.

I have read and understood the above financial policy and agree to be bound by its terms. **Initial Here**:_____

ASSIGNMENT OF BENEFITS

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Wake Spine & Pain Specialists (WSPS) for all covered medical services and supplies provided to me during all courses of treatment and care provided by WSPS and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by WSPS, and will constitute a continuing authorization for direct payment to WSPS of all applicable insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by WSPS.

Initial Here:_____

OTHER CLINIC POLICIES

- **CONSENT FOR CARE**: I voluntarily consent to receive medical and health care services (including procedures, diagnostic and laboratory tests) provided by Wake Spine & Pain Specialists health care providers, employees and associates that Wake Spine & Pain Specialists deems necessary, acknowledge that no warranty or guarantee has been made to me as to result or cure. I agree to actively participate in my care to maximize its effectiveness.
- **PRESCRIPTION HISTORY:** I grant permission to Wake Spine & Pain Specialists to obtain my prescription history from external sources for better coordination of my health care.
- **CANCELLATION POLICY:** I will be charged a **$50.00** for follow-up appointments and **$100.00** for procedure appointments if I fail to cancel within 48 hours of my scheduled appointment.
- **CODE OF CONDUCT:** I will treat the staff with courtesy and respect at all times. I understand that Wake Spine & Pain Specialists has a zero-tolerance policy regarding rude, profane, threatening or harassing comments or actions to any staff member. If I exhibit this type of behavior, I will be terminated from the practice immediately.

Initial Here:_____

By signing below, I affirm that I have read and understood the above policies and agree to abide by the terms.

Patient signature: _____ **Date:** _____

Patient Name: _____

First initial_____ Last Name_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I understand that Wake Spine & Pain Specialists may use and disclose my personal health information for coordinating my medical care, to handle billing and payment, and to take care of other related health operations.

Wake Spine & Pain Specialists has provided me with the "HIPAA Notice of Privacy Practices. I understand that I have the right to read the "Notice" before signing this acknowledgement. I acknowledge that I have been offered a copy of this office's notice of privacy practices.

Initial Here:_____

HIPAA CONSENT TO DISCLOSE INFORMATION

Entity authorized to receive information	**Information to be disclosed**		
	Appointment reminder	Medical information	Billing/Financial information
[ ]Patient phone/voicemail [ ]Patient email [ ]Patient text message	**[ ]**	**[ ]**	**[ ]**
[ ]Spouse/Partner Name _____ Phone number_____	**[ ]**	**[ ]**	**[ ]**
[ ]Parent Name _____ Phone number_____	**[ ]**	**[ ]**	**[ ]**
[ ]Child Name _____ Phone number_____	**[ ]**	**[ ]**	**[ ]**
[ ]Other Name _____ Phone number_____	**[ ]**	**[ ]**	**[ ]**

I authorize Wake Spine & Pain Specialists (WSPS) to contact me by the methods indicated above, which could result in charges to me, without reimbursement from Wake Spine & Pain Specialists for charges that may be incurred.

By signing below I authorize Wake Spine & Pain Specialists to disclose my protected health information with the above individuals. This authorization will be in effect until revoked in writing.

Patient signature: _____ **Date:** _____

Patient Name: _____

First initial_____ Last Name_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name (please print)_____ Date of Birth_____/_____/_____

Persons/Organizations Providing the Information:

Name_____

Phone _____

Fax _____

Name_____

Phone _____

Fax _____

Persons/Organizations Receiving the Information:

Name: **Wake Spine & Pain Specialists, PC**

Address: 3001 Edwards Mill Rd, Suite 203

Raleigh, NC 27612

Telephone #: 919-787-7246

Fax #: 919-787-7247

I hereby authorize disclosure of my protected health information to Wake Spine & Pain Specialists. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation.

_____ _____

Signature of Patient or Guardian **Date**