

Account # _____

Date _____

MEDICAL HISTORY INFORMATION

Name: _____ Birthdate: _____ Age: _____

Address: _____

Home Telephone: _____ Cell Telephone: _____ Work Telephone: _____

Social Security Number: _____ Marital Status: Single Married Divorced Widowed

Spouse's Name: _____ Birthdate: _____ Social Security Number: _____

Primary Insurance:

Name: _____

Address: _____

Insured's Name: _____

Group #: _____

ID: _____

Telephone: _____

Employer: _____

Secondary Insurance:

Name: _____

Address: _____

Insured's Name: _____

Group #: _____

ID: _____

Telephone: _____

Employer: _____

ASSIGNMENT OF BENEFITS

I request that payment of authorized benefits be made to Pain Consultants of East Tennessee on my behalf for any services rendered to me. I understand that I am financially responsible for all charges incurred regardless of insurance coverage.

PATIENT SIGNATURE

DATE

MEDICARE PATIENTS ONLY

PATIENT NAME: _____ MEDICARE NUMBER: _____

I request that payment of authorized Medicare benefits be made on my behalf to PAIN CONSULTANTS OF EAST TENNESSEE, PLLC for any services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services.

PATIENT SIGNATURE

DATE

Account #: _____

Date: _____

Please indicate below where your chronic pain is located (body part / area of pain).

#1 Pain Complaint: _____

- When did this pain first begin (month / year)? _____
- Event, injury, or surgery that may have caused this pain: _____

#2 Pain Complaint: _____

- When did this pain first begin (month / year)? _____
- Event, injury, or surgery that may have caused this pain: _____

#3 Pain Complaint: _____

- When did this pain first begin (month / year)? _____
- Event, injury, or surgery that may have caused this pain: _____

Conservative Treatments Previously Tried

Instructions: Check the box next to any of the conservative treatments listed below that you have tried for your worst pain complaint listed above.

- | | | |
|--|---|--|
| <input type="checkbox"/> Activity Modification | <input type="checkbox"/> Opioid Medications | <input type="checkbox"/> Topical Creams / Gels |
| <input type="checkbox"/> Ice | <input type="checkbox"/> Lyrica / Pregabalin | <input type="checkbox"/> Topical patches |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Neurontin / Gabapentin | <input type="checkbox"/> Brace / Splint |
| <input type="checkbox"/> TENS Unit | <input type="checkbox"/> Muscle Relaxers | <input type="checkbox"/> Chiropractic Care |
| <input type="checkbox"/> Home Exercise Program | <input type="checkbox"/> OTC Tylenol | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> OTC Ibuprofen / NSAIDs | <input type="checkbox"/> Massage |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Oral Steroid Dosepak | <input type="checkbox"/> Injections |

When did you attend Physical Therapy for this pain? (month / year) _____

How long did you attend PT? _____ Name of Facility: _____

Functional Limitations

Instructions: Circle any activities that are difficult due to your pain.

Bathing/Grooming • Dressing • Eating • Household chores • Laundry • Bending
Twisting • Lifting • Carrying • Standing • Walking • Climbing stairs • Sleeping
Prolonged sitting • Driving/Traveling • Lying down • Transfers • Working • Exercise
Shopping • Social Activities • Childcare/Caregiving • Cooking/Preparing meals

Other: _____

Account # _____

Date _____

REVIEW OF SYSTEMS: (please circle any health problems you have now)

GEN:	fever	chills	weight changes	fatigue
CV:	chest pain swelling of feet/legs	palpitations	cyanosis	
RESP:	bloody sputum shortness of breath	cough	wheezing	
HEENT:	eye pain ringing in ears toothache	double vision change in smell	sinus pain mouth pain	
GI:	abdominal pain Constipation	vomiting bloody stools	diarrhea rectal bleeding	
MS:	muscle pain neck pain joint swelling	muscle weakness back pain stiffness	muscle cramps joint pain	
ALLERGY:	latex allergy	tape allergy	environmental allergies	
ABUSE:	physical	sexual	emotional	
GU:	painful urination urination at night	incontinence flank pain	frequent urination sexual problems	
HEM/ LYMPH:	blood thinners sickle cell anemia extremity swelling	HIV lymph node tenderness	hepatitis lymph node swelling	
NEURO:	headaches tremors numbness/tingling	dizziness paralysis coordination problems	seizures difficulty walking	
PSYCH:	nervous breakdown anxiety/nervousness suicidal plan	hallucinations insomnia	depression/mood changes suicidal thoughts	
ENDO:	heat intolerance excessive sweating	cold intolerance	abnormal hair growth	
SKIN:	rash	redness	itching	bruising

MEDICATION ALLERGIES: (rash, swelling, itching): _____

Account # _____

Date _____

PAST MEDICAL HISTORY: (please circle any health problems you have ever had. Think of things you take medications for)

Diabetes COPD Sleep Apnea Heart Attack Atrial Fibrillation Stomach Ulcers/GI Bleed
 GERD Hypertension Kidney Disease Multiple Sclerosis Fibromyalgia Stroke/TIA
 Cancer HIV Seizures Blood Clots Osteoporosis Depression Anxiety
 Panic Attacks Bipolar Insomnia Suicide Attempts Alcohol Abuse Drug Abuse
 Other: _____

PAST SURGICAL HISTORY: (please list any surgeries that you have had in the past) _____

FAMILY HISTORY:

heart disease	lung disease	cancer	diabetes	arthritis
nervousness	chronic pain	disability	alcoholism	
drug abuse or addiction		emotional/psychiatric illness		

SOCIAL HISTORY:

Employment: unemployed disabled full time part time odd jobs
 retired worker's compensation working/on medical leave

Occupation: _____

Marital Status: single married separated divorced widowed

Tobacco use: none cigars quit _____ years ago
 cigarettes snuff/chew _____ packs per day never smoked

Alcohol use: none _____ drinks per day _____ drinks per week Beer Wine Liquor
 _____ drinks per month _____ recovering alcoholic

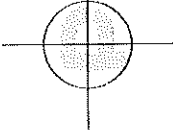
Street drugs currently used: _____ none

Used in the past: _____ Used to help with pain? Yes No

How often do you use recreational drugs? Frequently Sometimes Rarely Never

Have you ever been in rehab or treatment for drug or alcohol abuse? Yes No
 When? _____

Have you ever been discharged from any **PAIN CENTER OR MEDICAL PRACTICE**? Yes No



Pain Consultants
BEST PAIN RELIEF

James Choo, MD
Kathryn Schott, MD
Martha J. Smith, MD

PCET MEDICATION LIST

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

Prescription Medications:

Name	Dosage	Formulation <small>Tablet, Capsule, Cream or Inhaler</small>	Frequency	How <small>(ex. Oral)</small>
Sample- Cartia XL	120 MG	Tablet	1x per day	Oral
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Comments: _____

SIGN: _____ DATE: _____

PLEASE PRINT NAME: _____ (office use only) ACCT #: _____

PATIENT NAME: _____

ACCOUNT #: _____

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How often have you felt a need for higher doses of medication to treat your pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. How often have you felt impatient with your doctors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. How often have you felt that things are just too overwhelming that you can't handle them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. How often is there tension in the home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. How often have you counted pain pills to see how many are remaining?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. How often have you been concerned that people will judge you for taking pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. How often do you feel bored?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. How often have you taken more pain medication than you were supposed to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. How often have you worried about being left alone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. How often have you felt a craving for medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. How often have others expressed concern over your use of medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. How often have any of your close friends had a problem with alcohol or drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PATIENT NAME: _____

ACCOUNT #: _____

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
14. How often have others told you that you had a bad temper?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. How often have you felt consumed by the need to get pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. How often have you run out of pain medication early?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. How often have others kept you from getting what you deserve?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. How often, in your lifetime, have you had legal problems or been arrested?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. How often have you attended an AA or NA meeting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. How often have you been in an argument that was so out of control that someone got hurt?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. How often have you been sexually abused?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. How often have others suggested that you have a drug or alcohol problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. How often have you had to borrow pain medications from your family or friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. How often have you been treated for an alcohol or drug problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SCORE: _____

PCET PROVIDER INITIALS: _____

DATE: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself--or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite -- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)

TOTAL:

10. If you checked off <i>any</i> problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____
---	---

PCET #: _____

(For internal use only):

PHQ-9 INTERPRETATION:

- **0-4:** No depression or minimal depression, typically not requiring further treatment.
- **5-9:** Mild depression, may warrant monitoring and further assessment.
- **10-14:** Moderate depression, likely requiring treatment options like therapy or medication.
- **15-19:** Moderately severe depression, usually requiring active treatment with therapy and/or medication.
- **20-27:** Severe depression, often requiring comprehensive treatment with medication and psychotherapy.

PLAN: Already on antidepressants as managed by another provider. Patient instructed to follow up with that provider for additional evaluation/treatment. Patient verbalized understanding of effects of pain and depression.

Instructed to follow up with primary care (and/or psychiatry, psych NP) for formal depression evaluation, diagnosis and treatment

No suicidal thoughts/plan.

Suicidal thoughts/plan. RESPONSE:

Provider signature: _____

Date: _____

AUDIT-C Questionnaire

Patient Name _____

Date of Visit _____

1. Within the past year, how often did you have a drink of alcohol?

- a. Never
- b. Monthly (e.g. Special occasions/Rare)
- c. 2-4 times a month (e.g. 1x on weekend - "Fridays only" or "every other Thursday")
- d. 2-3 times a week (e.g. weekends - Friday-Saturday or Saturday-Sunday)
- e. 4 or more times a week (e.g. daily or most days/week)

2. Within the past year, how many standard drinks containing alcohol did you have on a typical day?

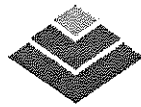
- a. 1 or 2
- b. 3 or 4
- c. 5 or 6
- d. 7 to 9
- e. 10 or more

3. Within the past year, how often did you have six or more drinks on one occasion?

- a. Never
- b. Less than monthly
- c. Monthly
- d. Weekly
- e. Daily or almost daily

Score: _____ Unhealthy Alcohol Use: Yes No Counselor _____

Signature: _____ Date: _____



PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Name: _____

Date: _____

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

Yes	No	I choose not to answer this question
-----	----	--------------------------------------

2. Which race(s) are you? Check all that apply

Asian	Native Hawaiian
Pacific Islander	Black/African American
White	American Indian/Alaskan Native
Other (please write):	
I choose not to answer this question	

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

Yes	No	I choose not to answer this question
-----	----	--------------------------------------

4. Have you been discharged from the armed forces of the United States?

Yes	No	I choose not to answer this question
-----	----	--------------------------------------

5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you currently live with? _____

I choose not to answer this question

7. What is your housing situation today?

I have housing
I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
I choose not to answer this question

8. Are you worried about losing your housing?

Yes	No	I choose not to answer this question
-----	----	--------------------------------------

9. What address do you live at?
Street: _____
City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

Less than high school degree	High school diploma or GED
More than high school	I choose not to answer this question

11. What is your current work situation?

Unemployed	Part-time or temporary work	Full-time work
Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:		
I choose not to answer this question		

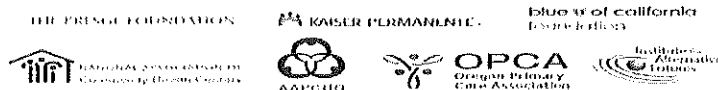
12. What is your main insurance?

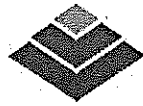
None/uninsured	Medicaid
CHIP Medicaid	Medicare
Other public insurance (not CHIP)	Other Public Insurance (CHIP)
Private Insurance	

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

I choose not to answer this question

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PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences Paper Version of PRAPARE® for Implementation as of September 2, 2016

14. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
I choose not to answer this question					

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

<input type="checkbox"/>	Yes, it has kept me from medical appointments or
<input type="checkbox"/>	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
<input type="checkbox"/>	No
I choose not to answer this question	

Social and Emotional Health

16. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

<input type="checkbox"/>	Less than once a week	<input type="checkbox"/>	1 or 2 times a week
<input type="checkbox"/>	3 to 5 times a week	<input type="checkbox"/>	6 or more times a week
I choose not to answer this question			

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

<input type="checkbox"/>	Not at all	<input type="checkbox"/>	A little bit
<input type="checkbox"/>	Somewhat	<input type="checkbox"/>	Quite a bit
<input type="checkbox"/>	Very much	<input type="checkbox"/>	I choose not to answer this question

Optional Additional Questions

18. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	I choose not to answer this
--------------------------	-----	--------------------------	----	--------------------------	-----------------------------

19. Are you a refugee?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	I choose not to answer this
--------------------------	-----	--------------------------	----	--------------------------	-----------------------------

20. Do you feel physically and emotionally safe where you currently live?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unsure
I choose not to answer this question					

21. In the past year, have you been afraid of your partner or ex-partner?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Unsure
I have not had a partner in the past year					
I choose not to answer this question					

Account # _____

Date _____

COMMUNICATION SHEET

NAME: _____

DOB: _____

HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

E-MAIL: _____

How do you prefer we contact you? _____

May we leave private information on your answering machine? _____

May we give private information to your spouse/family? _____

(Please specify name, relationship, and phone number) _____

May we e-mail private information to you? _____

Signature: _____

Date: _____

You must advise PCET in writing if the above information changes in any way.

IF YOU ARE AGE 65 OR OLDER:

Do you have (circle all that apply): Living will Power of attorney DNR directive None of them

Who is your surrogate decision maker? _____



James J. Choo, MD
Martha Smith, MD
Kathryn R. Schott, MD

1540 Member Lane, Suite 100, Knoxville, TN 37909
575 Oak Ridge Turnpike, Oak Ridge, TN 37830

Account# _____
NP _____

Provider Request for Protected Health Information

Requesting from: _____
Name of doctor or facility

_____ Phone
Fax _____

Purpose of Disclosure: () evaluation/care () payment () operations

Patient Information:

Last name First Middle Maiden (if available)

Date of Birth XXX-XX- Social Security Number

Information requested

- Radiology
- Labs
- Office notes
- DC summary
- ER notes
- Operative report
- Special requests _____

By signing this authorization, I authorize Pain Consultants of East Tennessee to use/disclose certain protected health information (PHI) about me from/to the parties listed above. *Expires 60 days from date signed.*

Patient Signature: _____ Date: _____

Note: Additional authorization may be required for mental health, alcohol/drug, HIV/AIDS and any other sensitive information. Requestor should abide by the minimum necessary regulation of HIPAA if requesting information for reasons other than patient care. In compliance with the Health Insurance Portability and Accountability Act of 1996 regarding the release of protected health information, the records listed above will be released in good faith that the requesting provider is a current treatment provider.

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Requested by: _____ Phone (865) 579-0552 ext. _____ Need before _____

FAX RECORDS TO (865) 579-1154

If more than 50 pages, please contact us before faxing. Thank you.

