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:_____

Spouse's Employer:_____ Work Telephone:_____

Referring Physician:_____Telephone:_____

Primary Care Physician:_____ Telephone:_____

Please list who you want our office notes sent to:

1. _____ 2. _____

_____ _____

Primary Insurance:	Secondary Insurance:
Name:_____	Name:_____
Address: _____	Address:_____
_____	_____
Insured's Name:_____	Insured's Name:_____
Group#: _____	Group #:_____
ID: _____	ID: _____
Telephone: _____	Telephone:_____
Employer: _____	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_____

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	

FLU SHOT THIS SEASON? Yes No

TETANUS SHOT IN PAST 10 YEARS? Yes No

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

Account # _____ Date_____

IF YOU ARE AGE 60 OR OLDER: Have you ever received the pneumonia vaccine (shot)? Yes No

IF YOU ARE AGE 50 OR OLDER: Have you ever received a shingles vaccine (shot)? Yes No

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

_____

PAST MEDICAL HISTORY: (please circle any health problems you have ever had)

SKIN:	eczema	psoriasis	hives
		other:_____	
HEAD:	migraines	head injury	headaches
	trigeminal neuralgia	other: _____	
EYES:	glaucoma	cataracts	other:_____
ENT:	hearing loss	hearing aids	other:_____
RESP:	asthma	emphysema / COPD	bronchitis
	pneumonia	tuberculosis	other:_____
	sleep apnea		
CV:	heart attack	murmur	varicose veins
	high blood pressure	coronary artery disease	lower extremity edema
	blood clots	other:_____	
GI:	ulcers	colitis	Crohn's disease
	pancreatitis	constipation	GI bleed
	hiatal hernia	irritable bowel syndrome	hemorrhoids
	cirrhosis	GERD	other: _____
GU:	kidney disease	urinary tract infections	kidney stones
	prostate problems	STD	interstitial cystitis
	erectile dysfunction	low testosterone	other:_____
MS:	rheumatoid arthritis	osteoarthritis	osteoporosis
	multiple sclerosis	fibromyalgia	myofascial pain
		other:_____	
NEURO:	Parkinson's disease	CRPS	head injury seizures
	stroke/TIA	shingles	other:_____
PSYCH:	depression	anxiety	panic attacks
	suicidal attempts	nervous breakdown	bipolar disease
		other:_____	
BLOOD:	transfusions	anemia	leukemia

Account # _____ Date_____

sickle cell HIV hepatitis
blood thinners other:_____

ENDO: diabetes thyroid problems other:_____

ABUSE: alcohol abuse drug abuse type:_____

CANCER: Type_____

Treatment (circle all that apply) chemotherapy radiation surgery

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

_____

_____

_____

FAMILY HISTORY: (Has anyone in your family (blood relatives only), besides yourself, had problems with any of the following)

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: _____

Military Service: yes: past service current service no

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

Account # _____ Date_____

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 RELATED HISTORY:

Where do you hurt? _____

Rate your pain 0-10 (10 = worst imaginable) at times: _____

How would you describe your pain: (Circle all items that apply)

dull	aching	sharp	burning	stabbing	throbbing
cramping	stinging	shooting	squeezing	pounding	electrical shock

Is your pain? constant comes and goes

What things make your pain <u>better</u>? (Circle all items that apply)

bedrest	standing	sitting	walking	physical activity
coughing/sneezing	bending	heat	cold	position changes
lying flat on back / stomach		lying on right / left side		distraction (TV, etc.)
alcohol	eating	weather changes		

What things make your pain <u>worse</u>? (Circle all items that apply)

bedrest	standing	sitting	walking	physical activity
coughing/sneezing	bending	heat	cold	position changes
lying flat on back / stomach		lying on right / left side		distraction (TV, etc)
alcohol	eating	weather changes	worry/stress	sex
lifting	driving			

What activities of daily living do you have difficulty performing? (Circle all items that apply)

bathing	dressing	eating	sleeping	cooking
cleaning	walking	transferring	driving	

Account # _____ Date_____

ORT ASSESSMENT INSTRUMENT:

PATIENT NAME: _____

ORT ASSESSMENT INSTRUMENT:

		MARK EACH BOX THAT APPLIES
1. Family History of Substance Abuse	• Alcohol • Illegal Drugs • Prescription Drugs	□ □ □
2. Personal History of Substance Abuse	• Alcohol • Illegal Drugs • Prescription Drugs	□ □ □
3. Age	Mark box if age 16-45 years)	□
4. Personal history of Preadolescent Sexual Abuse	Mark box if yes	□
5. Psychological Disease	• ADHD, OCD, Bipolar disorder, Schizophrenia • Depression	□ □

□ None of the above apply to me

ORT SCORE: _____ LOW MOD HIGH

PCET PROVIDER INITIALS: _____

DATE: _____

This assessment is a screening tool only. Patients have or will have a 45 minute face to face interview with one of our Behavioral Medicine Institute psychologist for their formal risk assessment given finding of the following publication.

Jones T and Passik SD (2011). "A Comparison of Methods of Administering the Opioid Risk Tool." *Journal of Opioid Management*. 7(5): 347-352.

CONSERVATIVE TREATMENT CHECKLIST

PATIENT NAME: _____ PCET #: _____

These questions are extremely important to **ANSWER COMPLETELY** so that we can get your procedure scheduled without having to repeat treatments you have already tried because of tighter insurance restrictions.

CONSERVATIVE TREATMENT:

☐ PHYSICAL THERAPY IN THE PAST 6 MONTHS

Body part treated: _____

Start date: _____ End date: _____ * doesn't have to be exact

How many times did you go? _____

Why did you stop (if you did)? Increased pain | No relief | MD said to stop | finished sessions

Relief: (circle 1 or more) None Some Temporary Good Complete

☐ HOME EXERCISE PROGRAM WITHIN THE LAST 6 MONTHS (includes any stretching, walking, yoga, etc.)

Relief: (circle 1 or more) None Some Temporary Good Complete

Currently Doing Any Active HEP: YES NO

How many days per week? _____

☐ ACTIVITY MODIFICATION (Circle items you are having problems doing)

Bathing Dressing Grooming Eating Bending Lifting Traveling Laundry Exercise Walking

Carrying things Prolonged sitting Prolonged standing Sleeping Other _____

☐ OTHER CONSERVATIVE TREATMENTS IN THE PAST 6 MONTHS:

(CHECK IF YOU HAVE TRIED): Relief: (circle 1 or more)

☐ TENS	None	Some	Temporary	Good	Complete
☐ Occupational therapy	None	Some	Temporary	Good	Complete
☐ Chiropractic therapy	None	Some	Temporary	Good	Complete
☐ Bracing	None	Some	Temporary	Good	Complete
☐ Heat	None	Some	Temporary	Good	Complete
☐ Ice	None	Some	Temporary	Good	Complete

☐ MEDICATIONS TRIED

(CHECK IF YOU HAVE TRIED): Relief: (circle 1 or more)

☐ Ibuprofen/Aleve	None	Some	Temporary	Good	Complete
☐ Tylenol	None	Some	Temporary	Good	Complete
☐ Prescription pain medication	None	Some	Temporary	Good	Complete
☐ Muscle relaxers	None	Some	Temporary	Good	Complete
☐ Steroids (dosepak, injections)	None	Some	Temporary	Good	Complete
☐ Nerve pain medications (Pregabalin, Gabapentin)	None	Some	Temporary	Good	Complete

Patient signature _____ PCET Provider _____

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 figety 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 *any 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 _____

A2663B 10-04-2005

Pain Consultants
OF EAST TENNESSEE

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

PCET MEDICATION LIST

PLEASE LIST **ALL MEDICATIONS** YOU ARE CURRENTLY TAKING

Prescription Medications:

Name	Formulation Tablet, Capsule, Cream or Inhaler	Dosage	Frequency	How (ex. Oral)
Sample– Cartia XL	Tablet	120 MG	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 #:_____

***** Please complete the other side →

Pain Consultants
OF EAST TENNESSEE

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

PCET MEDICATION LIST

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

Over-the-counters, Herbals, and Vitamin/mineral/dietary (nutritional) supplements:

Name	Formulation Tablet, Capsule, Cream or Inhaler	Dosage	Frequency	How (ex. Oral)
1.				
2.				
3.				
4.				
5.				

Comments:_____

SIGN:_____DATE:_____

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

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? _____