Sweetwater
Pain and Spine

PATIENT INFORMATION

Patient Name (Last, First, MI)				Birthdate	
Email	Marital Status		Gender	SSN	
Physical Address		City		State	Zip
Mailing Address (if different than above)		City		State	Zip
Home Phone	Work Phone	Cell Phone		Written Contact Preference: ☐ Email ☐ Postal Mail	
Name of Primary Care Provider			**Are you being seen today for injuries related to a motor vehicle accident or a work-related injury?** ☐ **YES** ☐ **NO**		
Primary Insurance			Secondary Insurance		

EMERGENCY CONTACT INFORMATION

Name	Relation to Patient
Address (Street, City, State, Zip)	Phone

PERSONAL RELEASE OF INFORMATION

This section is for family members/loved ones to have full access to your records and/or billing information. This is NOT a professional release intended for attorneys or other physicians. If NO NAME is designated, then information will ONLY be released to you directly.

I give my full permission to Sweetwater Pain and Spine to disclose details of my billing records and discuss my treatment/care either verbally or in written form with:

______________________________ ______________________________

Name of family member or other adult **Relation to Patient**

______________________________ ______________

Patient/Legal Representative Signature (or type name above to acknowledge policy) **Date**

INFORMED CONSENT FOR SCRIBES

At Sweetwater Pain and Spine, our medical practitioners want to provide the best care by eliminating distractions during their encounter with you. To that end, you may encounter our providers using a virtual or in-person scribe who inputs information into your medical chart that documents your medical care while our provider concentrates on providing medical care to you.

Please sign below acknowledging that you understand and agree to your provider using a virtual or in-person scribe during your encounters. If you disagree with a virtual or in-person scribe involved in your care, please do no sign below, and inform your provider.

______________________________ ______________

Patient/Legal Representative Signature (or type name above to acknowledge policy) **Date**

CANCELLATION/NO SHOW POLICY

We understand that situations arise in which you must cancel an appointment. It is therefore requested that if you must cancel an appointment, you provide more than a **48 hour notice**. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot.

With cancellations made less than a 48 hour notice, we are unable to offer that slot to other people. Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as NO SHOW. Patients who No Show two (2) or more times in a 12 month period may be dismissed from the practice and denied any future appointments.

Office appointments cancelled with less than 48 hours notification or No Show appointments will be subject to the following Cancellation/No Show fees:

$50 fee - Follow up office visits
$100 fee - Procedure appointments (EMG/Injections)

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before or at the time of the patient's next appointment. In other words, you are personally responsible for the fees and this will NOT be billed through your insurance.

In order to be a patient in our clinic you must sign that you have read, understand, and agree to this Cancellation/No Show policy.

____ ________________

Patient/Legal Representative Signature (or type name above to acknowledge policy) **Date**

ADDITIONAL INFORMED CONSENT, ACKNOWLEDGEMENTS, AND AUTHORIZATIONS

- **Patient Certification:** I certify that the above information is accurate to the best of my knowledge.
- **Patient Physician Relationship:** I understand that Sweetwater Pain and Spine is staffed by health care professionals who, although all dedicated to helping and caring for patients at Sweetwater Pain and Spine, may be independent contractors with the patient and are not necessarily employees or agents of Sweetwater Pain and Spine. Each patient is under the care and supervision of his/her attending physician and it is the responsibility of all persons involved with patient care to carry out the instructions of such physician. The relationship between the patient and the physician is at the direction of the patient. Should the patient choose to no longer accept the services of their treating physician, it is the responsibility of the patient and/or their family to obtain the services of another physician.
- **Treatment Authorization, Acknowledgment of Risk, and Promise to Cooperate:** I authorize Sweetwater Pain and Spine to evaluate and treat my medical condition. I understand there are no guarantees of expected results. I understand that every treatment has risks that cannot be reasonably avoided. I agree to be a proactive and cooperative and compliant patient in order to optimize treatment and care.
- **Medication History:** I consent to allowing Sweetwater Pain and Spine to access and review my medication history as available via prescription drug monitoring programs in determining treatment decisions and acknowledge that this will become part of my medical records.
- **HIPAA Acknowledgement:** I do hereby acknowledge that I have been made aware that Sweetwater Pain and Spine has a Privacy Policy in place in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how my protected health information may be used and disclosed, and how I may access my health records. I acknowledge that his policy is available for review in the Sweetwater Pain and Spine office as well as its website. I am informed that I am entitled to a copy of the Privacy Policy if I desire a copy for my personal file. I understand that by law (FPR 45 CPR § 164.524) my records are protected and that disclosure in most instances requires my signed permission.
- **Financial Responsibility:** I understand and acknowledge that I am personally responsible for the services rendered by Sweetwater Pain and Spine. As a courtesy, my insurance carrier will be billed and, to the extent that applicable insurance benefits exist for treatment received by me from Sweetwater Pain and Spine, said benefits are hereby assigned to be applied to my patient bill. In the event of non-payment by an insurer or any other third-party, I understand I remain responsible for any outstanding balances.
- **Communications to Patient**: I give Sweetwater Pain and Spine permission to leave a voice message on my preferred phone number voice mail.
- **A photocopy, fax, or electronic copy of this form shall be considered as effective and valid as the original.**

____ ________________

Patient/Legal Representative Signature (or type name above to acknowledge policy) **Date**

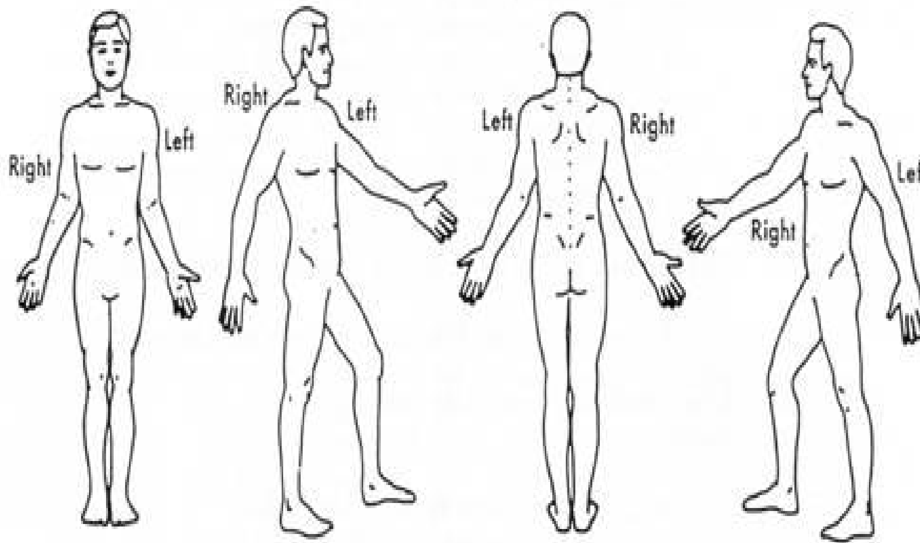
MEDICAL INFORMATION

Name: ____

Reason for visit: ___________________________ How long ago did your pain start? ________________________________

Where is your pain located? ☐ Head ☐ Neck ☐ Shoulder ☐ Mid Back ☐ Low Back
☐ Hip ☐ Arm ☐ Leg Other: ____

Please shade/click in the area of your pain below



What number best describes your pain on average in the past week?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

How long ago did your pain start? _________________________ How did your pain begin? ☐ Suddenly ☐ Gradually

Check all that describe your pain: ☐Achy ☐ Burning ☐ Cramping ☐ Dull ☐ Sharp
☐ Shooting ☐ Stabbing ☐ Stiff ☐ Throbbing ☐ Other

What makes your pain better? ____

What makes your pain worse? ____

Does your pain radiate?	☐ Yes	☐ No
Do you have numbness/tingling in your limbs?	☐ Yes	☐ No
Do you have weakness in your limbs?	☐ Yes	☐ No
Is your pain constant or does it come and go?	☐ Constant	☐ Comes and goes
Did your pain begin after a trauma?	☐ Yes	☐ No
Does your pain affect your ability to work or go to school?	☐ Yes	☐ No
Does your pain affect your daily activities?	☐ Yes	☐ No
Do you have osteoporosis?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No (not applicable)
Have you had cancer?	☐ Yes	☐ No
Have you ever had similar symptoms/injury before	☐ Yes	☐ No
If yes, describe briefly:		

Are you being seen for a work-related injury? ☐ **YES** ☐ **NO**

Have you recently been injured in a Motor Vehicle Accident? ☐ **YES** ☐ **NO** **If yes:** **Date of Injury** ____________________________ **Name of Attorney** ________________________

What treatments have you had for your pain? ____

____

Have you had any of the following diagnostic studies? ☐ X-ray ☐ CT scan ☐ MRI ☐ EMG (nerve study)

Where were the studies performed? ____

ALLERGIES:

Name	Describe reaction:

CURRENT MEDICATIONS

Name	Dosage	How often do you take?

PAST MEDICAL HISTORY

☐ Alcoholism	☐ Anxiety	☐ Arthritis	☐ Asthma	☐ Cancer
☐ Claustrophobia	☐ Dementia	☐ Depression	☐ Diabetes	☐ Epilepsy
☐ Headache	☐ Heart Attack	☐ High Cholesterol	☐ Lung Disease	☐ Organ Transplant
☐ Osteoporosis	☐ Parkinson's	☐ Shingles	☐ Stroke	☐ Thyroid Disease
☐ Ulcers (GI)	☐ MRSA	☐ HIV / AIDS	☐ Hepatitis (If yes, what type):	☐ A ☐ B ☐ C

Other Conditions: ____

PAST SURGICAL HISTORY

Have you had any surgeries? ☐ No ☐ Yes

If yes, please list type of surgery and approximate date:

1. ______________________ 2. ______________________ 3. ______________________ 4. ______________________
5. ______________________ 6. ______________________ 7. ______________________ 8. ______________________

FAMILY HISTORY

Please check box for any medical condition that a blood relative has a history of:

☐ Anxiety	☐ Arthritis	☐ Asthma	☐ Autoimmune Disease	☐ Back Problems
☐ Cancer	☐ Dementia	☐ Depression	☐ Diabetes	☐ Epilepsy
☐ Gout	☐ Headache	☐ Heart Attack	☐ Heart Failure	☐ High Cholesterol
☐ Hypertension	☐ Kidney Stones	☐ Lung Disease	☐ Stroke	☐ Thyroid Disease

Other: ____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Other ______________________

Number of Children: __________ Ages: ______________________

Do you smoke?	☐ No	☐ Yes	How much per day? ______________________
Previous Smoker?	☐ No	☐ Yes	When stopped? ______________________
Do you drink alcohol?	☐ No	☐ Yes	How much per day? ______________________
Coffee, tea, cola beverages?	☐ No	☐ Yes	How much per day? ______________________
Do you use recreational drugs?	☐ No	☐ Yes	What type? How often? ______________________
Are you currently employed	☐ No	☐ Yes	If yes, type of job: ______________________

REVIEW OF SYMPTOMS: Please mark those items which you currently experience

GENERAL

☐ Chills ☐ Fatigue ☐ Fever ☐ Night sweats ☐ Weakness

☐ Weight gain ☐ Weight loss Other:

SKIN

☐ Easy bruising ☐ Itching ☐ Jaundice ☐ Lesions ☐ Rashes

HEAD/EYES/EARS

☐ Dizziness ☐ Head injury ☐ Headaches ☐ Blurry vision ☐ Double vision ☐ Eye pain

☐ Light sensitivity ☐ Vision loss ☐ Ear pain ☐ Hearing loss ☐ Ringing in ears ☐ Sound sensitivity

RESPIRATORY

☐ Asthma ☐ Bronchitis ☐ Coughing blood ☐ Wheezing ☐ Shortness of breath

CARDIOVASCULAR

☐ Chest pain ☐ Palpitations ☐ Swelling of legs

GASTROINTESTINAL

☐ Abdominal pain ☐ Bloody/dark stool ☐ Constipation ☐ Diarrhea ☐ Nausea

GENITOURINARY

☐ Blood in Urine ☐ Urinary Frequency/Urgency ☐ Incontinence ☐ Urinary pain/burning ☐ Retention

☐ Kidney Stones ☐ Discharge ☐ Irregular Menstruation ☐ Menstrual Pain ☐ Sexual dysfunction

MUSCULOSKELETAL

☐ Arthritis ☐ Joint swelling ☐ Muscle cramps ☐ Trauma

NEUROLOGICAL

☐ Numbness/tingling ☐ Seizures ☐ Unsteady gait ☐ Weakness

PSYCHIATRIC

☐ Anxiety ☐ Depression ☐ Disturbing thoughts ☐ Disorientation ☐ Mood Changes ☐ Stress

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Name: ____________________ **Date of Birth:** ____________________

MENTAL HEALTH QUESTIONAIRE

Click/Check the box that applies below:

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling asleep, staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, feeling that you are a failure, or that you have let yourself or your family down				
Trouble concentrating on things such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
Thinking that you would be better off dead or that you want to hurt yourself in some way				
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it's hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

For Office Use
5-14 (10)

For Office Use
10-14

In your life, have you ever had any experience so frightening, horrible, or upsetting that, in the past month, you:	**Yes**	**No**
Have had nightmares about it or thought about it when you did not want to?		
Tried hard not to think about it or went out of our way to avoid situations that reminded you of it?		
Were constantly on guard, watchful, or easily startled?		
Felt numb or detached from others, activities, or your surroundings?		

For Office Use
3

Do you have a family history of substance abuse of:	**Yes**	**No**
Alcohol		
Illegal Drugs		
Prescription Drugs		
Do you have a personal history of substance abuse of:		
Alcohol		
Illegal Drugs		
Prescription Drugs		
Are you between the ages of 16 and 45?		
Do you have a history of preadolescent sexual abuse?		
Do you have any of these psychological conditions:		
ADD/ADHD, OCD, Bipolar, or Schizophrenia		
Depression		

For Office Use	
1	3
2	3
4	4
3	3
4	4
5	5
1	1
3	0
2	2
1	1
M 4-7	