Robert Gould, D.O.
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New Patient Intake Information

Name	DOB/Age	Date
Referring Physician/Address	Primary Care Physician/Address	

Chief Complaints (if multiple, circle the worst):

Does the pain radiate (into arm/leg)?

When did it start (Date)?
How long has it been going on (months, years)?

Do you recall a specific cause for your pain (Injury, etc.)?

Intensity (VAS): (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe)
Range: On a good day: ____/10 On a bad day: ____/10

Timing of the Pain: Rarely / Sometimes / Always / Constant / Waxes & Wanes (Good Days & Bad Days)

Describe the Pain (circle): Dull / Achy / Throbbing / Sharp / Stabbing / Burning / Lancinating / Gnawing / Numbness / Pins & Needles / Tingling / Other:

Aggravating Factors: Resting / Activity / Laying / Sitting / Standing / Walking / Positional changes / Bending / Twisting / Pushing / Pulling / Lifting / Exercise / Work
Other:

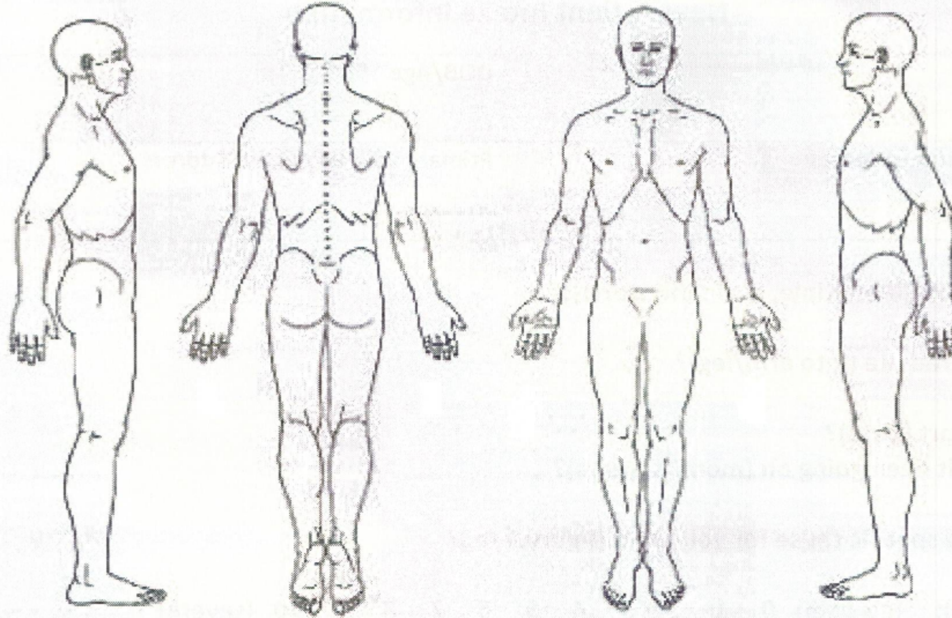
Improving Factors: Resting / Laying down / Activity / Sitting / Standing / Walking / Positional changes / Bending / Twisting / Exercise / Medication / Heat / Cold / TENS / Injections / Surgery
Other:

Low Back Pain (Circle): Left Right Middle **% of Pain:**	**Neck Pain (Circle): Left Right Middle** **% of Pain:**
Radiates into leg(s)? Yes No **Side:** Left Right Both **How far down leg?** Buttock Mid-thigh Knee Calf Ankle Foot Other:	**Radiates into arm(s)?** Yes No **Side:** Left Right Both **How far down arm?** Shoulder Upper Arm Elbow Forearm Wrist Hand Other:
Side of leg? Front Back Outside Inside	**Side of arm?** Front Back Outside Inside

PAIN DIAGRAM

Please mark the area of injury or discomfort using the appropriate symbols:

Numbness	Burning	Aching	Stabbing	Pins & Needles
+++++++	xxxxxx	ooooo	^^^^^^	////////



TREATMENTS

(Circle if Treatment effective, Mark a line through it if not effective)

General: Rest / Exercise / Physical Therapy / Occupational Therapy / Aquatic Therapy / TENS Unit / Heat
Cold / Chiropractor / Massage / Acupuncture / Counselling / Biofeedback / Behavioral Therapy
Other:

Injections/Procedures: Epidural Injections / Facet Joint Injections / Intercostal Nerve Block
Joint Injections / Peripheral Nerve Blocks / Radiofrequency Ablation / Sacroiliac Joint Injection
Spinal Cord Stimulator / Spine Surgery / Sympathetic Nerve Blocks / Trigger Point Injections
Other:

Anti-Inflammatories (NSAIDs): Arthrotec / Celebrex / Daypro / Flector / Ibuprofen / Maloxicam / Mobic /
Motrin / Naprosyn / Naproxen / Relafen / Other:

Muscle Relaxers: Baclofen / Flexeril / Norflex / Robaxin / Skelaxin / Soma / Valium / Zanaflex

Membrane Stabilizers (Anti-seizure): Depakote / Dilantin / Gabapentin / Lyrica / Neurontin / Tegretol /
Topamax / Zonegran / Other:

(continued...)

Treatments (cont.)

Opiates: Dilaudid / Duragesic / Fentanyl / Hydrocodone / Hydromorphone / Methadone / Morphine (Avinza, Kadian, MS Contin) / Norco / Nucynta / Oxycodone / Oxycontin / Percocet / Percodan / Tramadol / Vicodin / Vicoprofen / Xtampza / Other:

Sleep Aid: Amitriptyline / Elavil / Nortriptyline / Trazadone

Antidepressant: Cymbalta / Paxil / Prozac / Zoloft

Topical: Capsaicin / Compound / Flector / Lidoderm / Voltaren gel

Other: Tylenol / Herbal Medications / Ativan / Valium / Xanax / Other:

Physical Therapy:	**Injections**:
Where? When? What was done?	Who did them? When? What was done?
Surgery: Surgeon? When? What was done?	**Medications:** ***NSAIDs*** (Ibuprofen, Naproxen, Motrin, Mobic, Voltaren), Others:_______________ ***Muscle Relaxers*** (Flexeril, Norflex, Zanaflex, Baclofen, Soma), Others:_______________ ***Gabapentin /Lyrica*** ***Pain Meds*** (Norco, Percocet, Morphine, Dilaudid, Fentanyl), Others:_______________ ***Others:***

IMAGING

X-ray:	**MRI:**	**CT:**
Body part? Where? When?	Body part? Where? When?	Body part? Where? When?

WORKMANS COMP / INSURANCE

Work injury? Yes No **Date:**	**Car Accident?** Yes No **Date:**
BWC Claim #:	Attorney & Phone:

Current Medications:

Allergies:

Past Medical History: Diabetes Cancer Heart Disease Peptic Ulcers GERD Kidney Disease Bleeding Disorder Liver Disease Other:

Past Surgical History: Spinal surgery Abdominal CABG Heart Valve Peripheral Bypass Amputation Brain Surgery Other:

Family Medical History (Alive/Deceased; Age; Medical Condition):

Grandparents

Parents

Siblings

Children

Social History:

Marital Status: Single Married Separated Divorced # of Children:____________________

Living Arrangements: Residence: Home Apartment Assisted Living Other:________________

With self Spouse/Partner Caregiver Other:__________________________

Tobacco: Never Former user Cigarettes Cigar Chew Snuff Packs/day:_________________

Recreational/Street Drugs: Never Yes Former user Rehab How often?_________________

What? Marijuana Cocaine Meth Other:________________________________

Review of Systems

Circle any symptoms you're currently experiencing or have had in the past 3 years:

Constitutional
Fever
Weight Loss
Excessive Fatigue
Night Sweats

HEENT
Double Vision
Blurred Vision
Hearing Loss
Vertigo

Cardiovascular
High Blood Pressure
Palpitations
Chest Pain

Respiratory
Shortness of Breath
Coughing
Wheezing

Gastrointestinal
Loss of Appetite
Nausea
Vomiting
Abdominal Pain
Heartburn/Reflux
Diarrhea
Constipation

Genitourinary
Loss of Bladder Control
Difficult Urination
Frequent Urination

Neurological
Numbness
Lack of Coordination
Confusion
Memory Problems
Tremors
Fainting
Headaches
Dizziness

Hematological
Blood Clots
Anemia
Bleeding Tendency
Swollen Glands

Psychiatic
Anxiety
Depression
Insomnia

Skin
Rashes
Easy Bruising
Redness
Discoloration

Musculoskeletal
Spasms
Cramps
Arm Weakness
Leg Weakness
Joint Pain
Joint Swelling

Vital Signs (Clinic Staff to Fill This Out)					
Height:	Weight:	BP: /	Temp: °F	Pulse:	Resp:

The information provided above is accurate to the best of my knowledge.

Patient Signature: Date:

Name ______________________________ DOB ____________ Date ____________

Modified Oswestry Low Back Pain Questionnaire

This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. We realize that you may feel that more than one statement may relate to you, but please just circle the **one** number that most closely describes your problem.

1. Pain Intensity
   - 0 The pain comes and goes, and is very mild.
   - 1 The pain is mild and does not vary much.
   - 2 The pain comes and goes and is moderate.
   - 3 The pain is moderate and does not vary much.
   - 4 The pain comes and goes and is severe.
   - 5 The pain is severe and does not vary much.
2. Personal Care
   - 0 I do not have to change my way of washing or dressing to avoid pain.
   - 1 I do not normally change my way of washing or dressing, even though it causes me pain.
   - 2 Washing and dressing increase the pain, but I manage not to change my way of doing it.
   - 3 Washing and dressing increases the pain, and I find it necessary to change my way of doing it.
   - 4 Because of the pain, I am unable to do some washing and dressing without help.
   - 5 Because of the pain, I am unable to do any washing and dressing without help.
3. Lifting (skip if you have not attempted lifting since the onset of your low back pain)
   - 0 I can lift heavy weights without extra low back pain.
   - 1 I can lift heavy weights but it causes extra pain.
   - 2 Pain prevents me from lifting heavy weights off the floor.
   - 3 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (ex: on a table).
   - 4 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
   - 5 I can only lift light weights at the most.
4. Walking
   - 0 I have no pain walking.
   - 1 I have some pain on walking, but I can still walk my required to normal distances.
   - 2 Pain prevents me from walking long distances.
   - 3 Pain prevents me from walking intermediate distances.
   - 4 Pain prevents me from walking even short distances.
   - 5 Pain prevents me from walking at all.
5. Sitting
   - 0 Sitting does not cause me any pain.
   - 1 I can sit as long as I need, provided I have my choices of sitting surfaces.
   - 2 Pain prevents me from sitting more than 1 hour.
   - 3 Pain prevents me from sitting more than ½ hour.
   - 4 Pain prevents me from sitting more than 10 minutes.
   - 5 Pain prevents me from sitting at all.

Name ______________________________________

6. Standing
   - 0 I can stand as long as I want without pain.
   - 1 I have some pain while standing, but it does not increase with time.
   - 2 I cannot stand for longer than 1 hour without increasing pain.
   - 3 I cannot stand for longer than ½ hour without increasing pain.
   - 4 I cannot stand for longer than 10 minutes without increasing pain.
   - 5 I avoid standing because it increases the pain immediately.

7. Sleeping
   - 0 I have no pain while in bed.
   - 1 I have pain in bed, but it does not prevent me from sleeping well.
   - 2 Because of pain, I sleep only ¾ of normal time.
   - 3 Because of pain, I sleep only ½ of normal time.
   - 4 Because of pain, I sleep only ¼ of normal time.
   - 5 Pain prevents me from sleeping at all.

8. Social Life
   - 0 My social life is normal and gives me no pain.
   - 1 My social life is normal, but increases the degree of pain.
   - 2 Pain prevents me from participating in more energetic activities (ex: sports, dancing, etc).
   - 3 Pain prevents me from going out very often.
   - 4 Pain has restricted my social life to my home.
   - 5 I hardly have any social life because of pain.

9. Traveling
   - 0 I get no pain while traveling.
   - 1 I get some pain while traveling, but none of my usual forms of travel make it any worse.
   - 2 I get some pain while traveling, but it does not compel me to seek alternative forms of travel.
   - 3 I get extra pain while traveling that requires me to seek alternative forms of travel.
   - 4 Pain restricts all forms of travel.
   - 5 Pain prevents all forms of travel, except that done lying down.

10. Employment/Homemaking
   - 0 My normal job/homemaking duties do not cause pain.
   - 1 My normal job/homemaking duties cause me extra pain, but I can still perform all that is required of me.
   - 2 I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities (ex: lifting, vacuuming, etc).
   - 3 Pain prevents me from doing anything but light duties.
   - 4 Pain prevents me from doing even light duties.
   - 5 Pain prevents me from performing any job or homemaking chore.

To be completed by provider: Score ____________________ (points/possible score [max 50] x 100 = %)

OPIOID RISK TOOL

Name: ______________________ Date: ______________

DOB: ______________

		Mark each box that applies	For Female Patients	For Male Patients
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Rx Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Rx Drugs	[ ]	5	5
3. Age (Mark box if 16-45 yo)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Bipolar Disease Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
		TOTAL:	______	______

<u>Total Score Risk Category</u>: (circle)

Low Risk	**0 - 3**
Moderate Risk	**4 - 7**
High Risk	**≥ 8**

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

07/24/19

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Confidential Patient Information

Referred By (location/phone):

Primary Physician (location/phone):
(if different)

Pharmacy (location/phone):

Patient Name: ______________________________ Date of Birth: ______________

Address: ______________________________ Home Phone: ______________

City/State: ______________________ Zip: __________ Cell Phone: ______________

Address of Insured: [ ]Same as above ______________________________

SS#: ______________________

Sex: [ ]Female [ ]Male Marital Status: [ ]Single [ ]Married [ ]Divorced [ ]Widow [ ]Separated

Occupation: ______________________ Employer/School: ______________________

Emergency Contact: ______________________ Relationship: ______________

Emergency Contact Phone #: ______________________

Insurance Information

Insurance Company: ______________________ Insur. Phone #: ______________________

ID#: ______________________ Group #: ______________________

Policy Holder Name: ______________________ Date of Birth: ______________________

Address (if different from above): ______________________________

Employer: ______________________ SS#: ______________________

Patient's Relationship to Policy Holder: [ ] Self [ ] Spouse [ ] Child [ ] Significant Other

Secondary Insur. Company: ______________________ Insur. Phone #: ______________________

ID#: ______________________ Group #: ______________________

Name of Policy Holder: ______________________ Date of Birth: ______________________

Employer: ______________________ SS#: ______________________

LEGAL ASSIGNMENT AND RELEASE

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the captioned, and hereby assign at clinic's request, and convey directly to Spine Muscles Nerves all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefits payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care, including but not limited to, my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.
I understand I may be billed $50 for missed or cancelled appointments when I do not provide 24 hours notice.

I have read and fully understand this agreement.

Signature of Insured/Guardian: ______________________________ Date: ______________

Agreement for Chronic Opioid Therapy

Patient Name: ______________________________ DOB: _____________ Date: ______________

Spine Muscles Nerves (SMN) may consider prescribing opioid medications for chronic pain. This decision was made because my condition is serious or other more conservative have not helped.

It is understood that us of opioid medications have risks associated with them, including: drowsiness, constipation, nausea, vomiting, itching, dizziness, allergic reactions, slowed breathing, slowed reflexes or reaction time, physical dependency, tolerance, addiction, and that the medicine may not provide complete relief. I am aware of the possible risks and benefits other types of treatments that may be used for my benefit.

I will tell my doctor about all other medicines and treatments that I am receiving.

I will not involve myself in any activity that may be dangerous to me or someone else if I feel drowsy or I am not thinking clearly, and if my reflexes and reaction time might be slowed. I will avoid activities that may put me or others in danger, such as: using heavy equipment or machinery, operate a motor vehicle, working at dangerous heights, or being responsible for another individual who depends on me for his or her care.

I am aware that other medications, such as Naloxone (Narcan), Naltrexone (Vivitrol), Buprenorphine (Subutex), Buprenorphine/Naloxone (Suboxone, Zubsolv) may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms that will make me feel like I have the flu, called **Withdrawal Syndrome.** I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid for pain control and cannot take any of the medicines listed above.

I am aware that **Addiction** is defined as the use of medicine even if it causes harm, having cravings for a drug, feeling the need to obtain and use a drug to control those cravings, even with the risk of decreased quality of life. I am aware that the chance of becoming addicted to pain medicine is low. I am aware that the development of addiction has been reported in medical journals and is much more common in a person who has a family member or personal history of addiction. To the best of my ability, I agree to tell my doctor my complete and honest personal and family drug history.

I understand that **Physical Dependency** is a normal and expected result of using these medicines over a long period of time. I understand that physical dependency is not the same as addiction. I am aware that physical dependency means that if my pain medicine use is markedly decreased or stopped, I will experience Withdrawal Syndrome, which tends to present with any of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, nausea, vomiting, diarrhea, irritability, body aches, and flu-like symptoms. I am aware that opioid withdrawal is uncomfortable but not life threatening.

Agreement for Chronic Opioid Therapy (continued)

The following pertains to receiving opioid medicines from SMN:

- Changes to opioid medications require an office visit before a new prescription may be given. It will be required for you to bring in unused medications to the office before a new prescription will be given.
- Opioid medications may not be refilled early.
- If medication is lost or stolen, a new prescription will not be given until your next scheduled refill date.
- I will need to protect my medications from being lost/stolen, which may require use of a lock box.
- If prescribed by SMN, I agree to receive opioid medications from **only** this practice.
- To avoid possession of multiple opioid prescriptions, I will discard all previously prescribed opioid medications, because if future testing shows old prescriptions in my system, then that will be deemed a failed screen.
- **Urine Drug Screens** will be done as part of an evaluation of compliance. If a urine sample cannot be given, then a cheek swab may be done.
- **Random Pill Counts** may be requested to ensure compliance with medication prescribed.

I understand that I may be dismissed due to any of the following:

- Use of illegal drugs/substances.
- Taking medication that is not part of the SMN treatment plan.
- Obtaining medications from other providers. If you do not notify other practices you are receiving opiates and subsequently receive opiates from them, then that will be a violation of your Agreement.
- Refusal to provide a drug screen sample.
- Pill counts being refused, or not done on the requested date/time.
- Pill counts resulting in having overtaken, thus having less medication than should be present.

I understand that I will:

- **NOT** adjust the dose or frequency of my medication(s) without consulting the provider FIRST.
- **NOT** give my medications to others.
- **NOT** take pain medications for any other purpose than pain relief.
- **NOT** alter my medication in any way and I will only consume my medications as directed and in the form received from my pharmacy.

I have read this form or it has been read to me. I understand my responsibilities as outlined above. I understand that violating any of the above policies in the Agreement may lead to my dismissal from the practice. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines. This Agreement will remain in effect as long as I am being prescribed controlled substances (ex, pain medication) by my provider at Spine Muscles Nerves.

Patient Signature: ______________________________ Date: ______________

Printed Name: ______________________________

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Phone: (614) 918-9808   Fax: (614) 918-9807

FINANCIAL POLICY

Welcome to Spine Muscles Nerves!

We are dedicated to you, our patient, with our goal to give you the best care available. We know that dealing with the financial side of your care may be confusing and stressful.

Like all businesses, our practice must collect payments for our services in order to remain financially viable. However, unlike other businesses, medical practices typically receive payment from businesses (health insurance carriers) other than the individuals to whom they provide services, which can take up to 30 days or more to receive after those services are rendered. In order to provide patients with high standards of care and expertise they come to expect, it is important that we work together to ensure accurate billing and timely payments for the services we provide.

Patient Demographic and Insurance Information

It is critical that we have correct demographic (personal) information about you and your health insurance coverage in order for us to bill accurately for the services we provide to you. This information includes:

- Your complete name, address, social security number, and phone number.
- If different, the subscriber's complete name, address, social security number, and phone number.
- The name of your insurance company, the group and subscriber number, or other identifying numbers.
- A copy of your insurance card, which also shows important information about your plan.
- The name, address and phone number of the physician (usually your primary care physician, or other specialist) who is referring you to our office.

Please bring a valid I.D. to each visit so we can verify and update your demographic information, and for patients with insurance, please bring your current insurance card for your primary and (if applicable) secondary insurance. This is to ensure accurate billing information and to protect you by confirming that we are providing services to the correct individual. This is no different than when you check into a hospital or urgent care center. Please understand that our staff will ask for this information and these documents even if you have recently been seen in our office. We rely on the information you provide in order to bill third parties for your medical services. Please be sure to report all potential third party sources of payment (auto, work comp, supplements, etc). If you do not provide us with the needed information in a timely manner, you may be responsible for payment for services rendered. ***Balances that are not paid due to errors or omissions in the information you provide may result in the entire balance becoming your responsibility.***