REGENERATIVE
SPINE & JOINT
INSTITUTE

Name____________________________ Age ____________________________
Marital Status ____________________ Place of Residence _______________
Occupation ______________________ Phone Number __________________
Referring Doctor__________________ Primary Care Doctor______________
Date______________________________

Current Pain Problem

1. Date of onset of pain: ____
   Date of diagnosis: ____
2. Under what circumstances did the pain begin: Work accident_______________
   Home accident______ Auto accident_____ After surgery____________
   Describe briefly ____
3. In what part of the body is the pain localized? Describe_____________________
   ____
4. Describe your pain. The following words may help you. Aching [ ] Throbbing [ ]
   Stabbing [ ] Shooting [ ] Burning [ ] Penetrating [ ] Sharp [ ] Numb [ ]
   Tingling [ ] Constant [ ] Intermittent [ ]
5. Intensity of the pain: Mild [ ] Moderate [ ] Severe [ ] Excruciating [ ]
6. What makes the pain worse? ____
   Sitting____ Standing____ Walking____ Coughing___ Bending over_____
   Exercise____ Lying on your back____ Lifting____ Deep breathing______
7. What eases the pain? (Massage, rest, medication, etc.) ______________________
   ____
8. If you take any pain medication, describe the effect:
   I do not take pain medications_____ It does not help______
   How long does the pain relief last? (Hours)______________
   How many times a day do you take it? __________________
   In the last two weeks, are you taking: more_____ same_____ less _____ pain medications?
9. Has the pain caused depression or other emotional problems?________________
   If so, have you sought medical care?
10. Has the pain affected your ability to work? Yes [ ] No [ ] For how long?____________
11. Does the pain interfere with your sleep?_ Yes [ ] No [ ]
12. Has the pain affected your ability to enjoy life, personal relationships, other?____
    ____
13. In the last 24 hours, how much relief has treatments and medications provided?
    0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100

    In the last 24 hours how would you rate your average pain?
    Pain Level – 0 1 2 3 4 5 6 7 8 9 10

    In the last 24 hours how would you rate your worst pain?
    Pain Level – 0 1 2 3 4 5 6 7 8 9 10

In the last 24 hours how would you rate your least pain?
Pain Level – 0 1 2 3 4 5 6 7 8 9 10

14. Describe any previous treatment for your pain:

Treatment	**Location**	**Date**	**Response**
Physical Therapy			
Work Hardening			
Pain Program			
Injections/ Nerve blocks			
Others(Surgery, TENS, Acupuncture, Chiropractor, Biofeedback)			

15. What is your current occupation or last job?____________________
16. If not working currently, when did you work last?____________________
17. What prevents you from returning to work?____________________
18. Do you receive compensation or disability payments?____________________
    Do you have an application for compensation or disability payments?__________
19. Are you in active litigation because of pain or injury?____________________
20. Do you enjoy your work?____________________
21. Last grade completed? (High school, College, Masters, Professional)____________________
22. Are you R or L handed?

PAST MEDICAL HISTORY

1. Please **circle** any of the following illness, which you have or had in the past:

High Blood Pressure	Stomach Ulcer	Asthma
Angina	Gallbladder Disease	Tuberculosis
Heart Attack	Colon Disorder	Gout
Heart Murmur	Heart Surgery	Cancer
Hepatitis	Rheumatoid Arthritis	Diabetes Mellitus
Osteoarthritis	Vascular Disease	Thyroid Disease
Kidney Disease	Anemia	Glaucoma
Bleeding Disorder	Seizures	Drug abuse
Recent weight loss	Change in bladder or bowel habits	

Depression Other____________________

Chronic Pain Syndrome ____________________

2. Please list all previous hospitalizations:

Diagnosis/Reasons	Date

3. List any previous injuries:

____

____
____
____

4. List Medications you are taking now:

Medication	Dose	Frequency (Times a day)	**Medication**	Dose	Frequency (Times a day)

5. List medications to which you are **allergic**:

Medication **Type of reaction** (rash, itching, swelling, etc)
____
____
____
____

FAMILY HISTORY

Circle condition and describe as follow (**F**-father, **M**-mother, **S**-sibling **GF**-grandfather, **GM**-grand mother, **O**-other)

High blood pressure _____________ Heart attack __________________
Diabetes _____________ Cancer __________________
Bleeding disorder _____________ Seizures __________________
Neurological Disorders _____________ Chronic Pain _________________
Problems with anesthesia _____________ Depression __________________
Other ____

SOCIAL HISTORY

1. Do you drink **alcoholic beverages**: Yes____ No____
   If yes, what type and on the average, how much per week:
   ____
2. **Smoking habits**: No____Yes____Past_____

If yes, who much do you smoke and for how long:___________________________

3. History of substance abuse? Yes_____No____

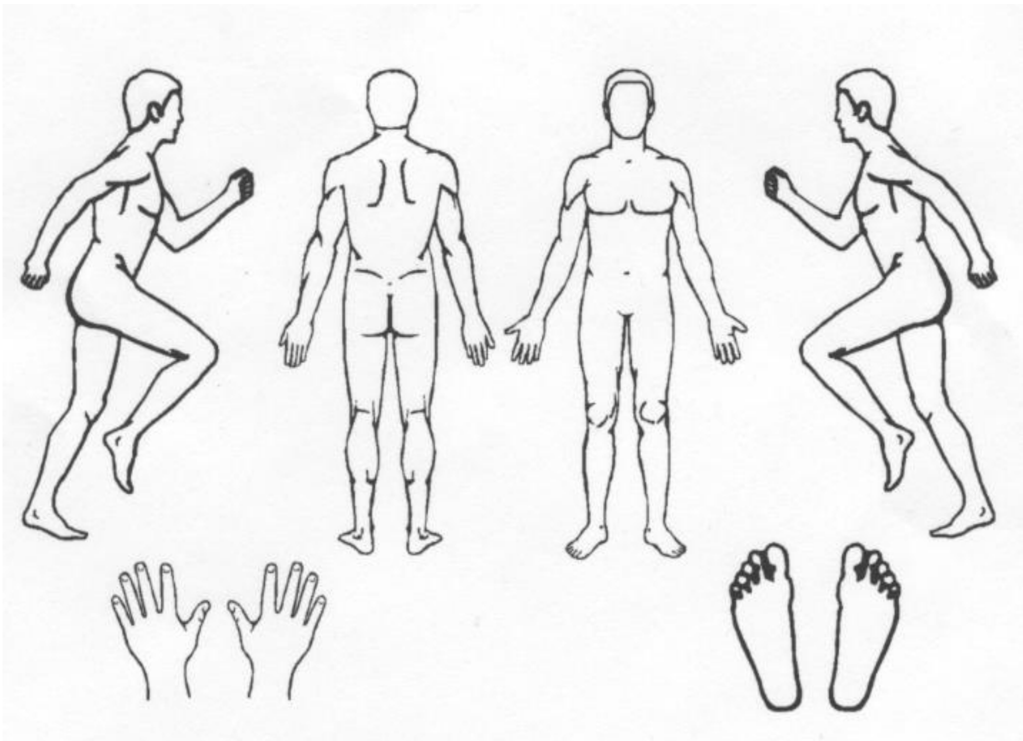
. History of Drug Detoxification Program? Yes_____No____

Explain ____

What are your treatment goals?

Pain reduction	☐ 100%	☐ 75%	☐ 50%	☐ 25%
Decrease medication intake	☐ 100%	☐ 75%	☐ 50%	☐ 25%
Avoid surgery	☐ yes	☐ no		
Increase activities of daily living	☐ **Sitting**	☐ **Walking**	☐ **Standing**	☐ **Sports**
Return to work with	☐ Minimal discomfort	☐ Manageable pain		
Improvement in quality of life	☐ Significant	☐ Moderate		

Pain Drawing



XXXX painful areas
00000 numbness
======= burning
▲▲▲ pins and needle

Thank you for completing this evaluation form. It will assist us in providing an individualized treatment plan.

PATIENT AUTHORIZATION & CONSENT

The Regenerative Spine and Joint Institute is committed to fulfilling all the requirements of the Health Insurance Portability and Accountability Act (HIPPA) of 1996.

Section A: ***AUTHORIZATION***

Must be completed for all authorizations. The patient or the patient's representative must read and initial the following statements:

1. I authorize Premier Pain Care to release any of my medical or insurance information necessary to process my medical claims and coordinate or manage my health care. **Initials:________**

2. I understand that I may revoke this authorization any time by notifying Premier Pain Care in writing. But, if I do revoke this authorization, my revocation will not have an effect on any actions Premier Pain Care took before they received my revocation**.** **Initials:________**

You may revoke this authorization by signing a Revocation Authorization form and returning it to Premier Pain Care. To request a Revocation Authorization form, you may ask the reception desk or contact our office at: Privacy Contact, Premier Pain Care, 1108 Dallas Drive, Suite 310 Denton, Tx 76205, (940) 323-9404.

3. Premier Pain Care will not base condition for treatment or payment for health care services on your completing and signing this authorization. **Initials:_______**

For additional information regarding disclosures of uses of my health information, I acknowledge I may obtain a copy of Premier Pain Care **" Notice of Privacy Practices"** at any time from the reception desk or by contacting the above business office. **Initials:________**

Section B: ***CONSENT***

In the event a family member or care giver attends my office visit and is in the exam room at the time of evaluation and/or treatment, I give Premier Pain Care and it's physicians or employees my permission to discuss freely my condition, treatment, diagnosis or insurance/payments issues with that person.

Initials:_________

May we leave a message on your HOME Phone: (provide #) ____________________ ☐YES ☐NO
May we leave a message on your WORK Phone: (provide #) ____________________ ☐YES ☐NO
May we leave a message on your CELL Phone: (provide #) ____________________ ☐YES ☐NO
May we leave a message on your PAGER (if applicable) ____________________ ☐YES ☐NO

May we leave a message at one of the numbers listed above about appointments with this office?
☐YES ☐NO

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6160 Windhaven Parkway, Suite 200
Plano, TX 75093
Ph:940-323-9404 Fax: 940-323-9422
www.rsjinstitute.com

We address our patients by name in our office and reception area. If you do not wish us to do this please note here.____

With whom may we discuss or release information about your care, treatment, or diagnosis?
____ Relationship_______________________

____ Relationship_______________________

Print Name____________________________Signature____________________________Date_______

Financial Policy

We would like to thank you for the opportunity to participate in your medical care. The following information is provided for your consideration. It contains information concerning payment for our services.

If our office participates with your insurance company, it is your responsibility to:

Bring your insurance card to every visit.

Be prepared to pay your co-pay and deductible in full (if applicable) at each visit. Cash, check, VISA or MasterCard, are accepted.

Referrals: If your plan requires a referral for treatment, the referral must be presented at or prior to your visit. If you do not have your referral, your visit may need to be rescheduled or you will be financially responsible. It is the patient's responsibility to confirm that any necessary referrals or pre-authorizations are obtained.

Any non-covered services that are rejected by your insurance plan will be billed directly to you and will be your responsibility.

When scheduled for a procedure, payment for your co-pay and deductible is expected in full prior to the procedure.

If you have any questions about your specific insurance coverage issues, please contact your insurance company member services department. This number should be listed on your insurance card.

If you do not have insurance coverage or have coverage with a company that we do not participate with, payment is expected in full at the time of your visit.

If the patient is a minor (18 years and younger), or dependent, then the parent or legal guardian must sign below. The parent or guardian of an unaccompanied minor is responsible for any payment due at time of service. They are responsible for bringing any necessary referrals and insurance verification.

Cancellations of office appointments should be made at least 24 hours before schedule time, unless there are attenuating circumstances.

When undergoing biologic procedures in which special tissues or stem cell products are ordered, if there is a cancellation, the procedure will be re-scheduled. If the procedure is cancelled indefinitely, the cost of the biologics is non-refundable.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to our billing office. Please sign that you have read and agree to this policy.

______________________________ ________________

Signature of Patient or Responsible Party Date