Joe H. Browder, MD MBA
James E. Fox, MD

AUTHORIZATION

I hereby authorize Dr.________________________ to use or disclose my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Specific description of information that may be used or disclosed. ____ ____ ____

2. Persons/organizations authorized to receive this information.
   a. Pain Consultants of East Tennessee

3. The information will be used/disclosed for the following purposes (all purposes must be listed and described):
   b. **For treatment purposes only** Yes______ No______.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

I further understand that I may revoke this authorization at any time by notifying Pain Consultants of East Tennessee in writing. However my revocation will not be valid if: (a) Pain Consultants of East Tennessee has taken action in reliance on this authorization; or (b) If this authorization is obtained as a condition of obtaining insurance coverage.

This authorization expires on _______________.

Date of Birth ______________

Address __________________________________
____

____ ___________________
Signature of patient or patient's representative Date

____ ___________________
Printed name of patient or patient's representative Relationship to patient or authority to act for the patient

MEDICAL HISTORY INFORMATION

Name:____Birthdate:_________________Age:_________

Address: ____

Home Telephone:_________________Emergency 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:
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

Please list **all physicians** that you have seen to treat your pain, or to try to determine the cause of your pain:

Physician	Treatment dates	Location	Telephone
1. ______________________________	________________	__________	____________________
2. ______________________________	________________	__________	____________________

Have you ever been to a **PAIN CENTER** to treat your pain?

Yes No If Yes, please list____

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

Please list **surgeries** performed for this complaint to try and provide pain relief:

Surgery	Date	Physician	Hospital - Name & Telephone Number
1. ________________________	__________	__________	________________________________
2. ________________________	__________	__________	________________________________
3. ________________________	__________	__________	________________________________

Diagnostic Studies: (Please list all x-rays, CT scans, MRI scans, EMGs or other tests performed for your pain.)

TEST DATE LOCATION PERFORMED

1. ____

2. ____

3. ____

4. ____

Is your pain related to an accident? YES NO

If YES, is it: Work Related Motor Vehicle Accident Other Accident, please explain: ______________

____

Are you currently working with an attorney regarding your pain? YES NO

Pharmacy Provider, Pain Medications: ____Telephone:__________________

Thank you for providing this information. This allows us to better serve you at your new evaluation appointment. We review all of your records prior to your visit so that we can immediately begin to evaluate and treat your pain. This information also prevents duplication of tests and x-rays that you might have had previously had. If you have any questions about what we need to evaluate you, please call our office and ask to speak to one of the New Patient Coordinators.

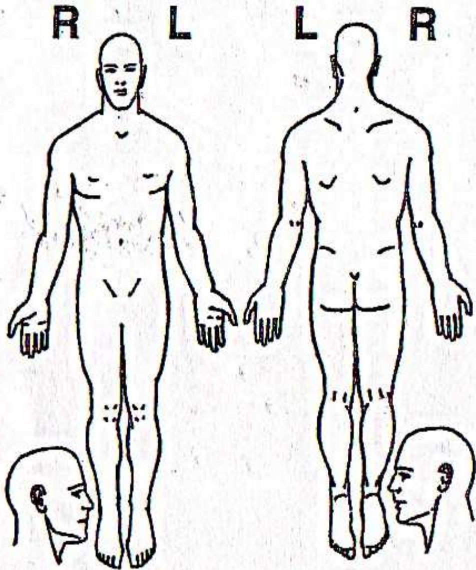
The last thing we need is for you to sign the attached medical record release, so that we can obtain your information. We look forward to meeting you. If you have any special needs or questions, please let us know at your initial appointment or call the office, and someone will be glad to assist you.

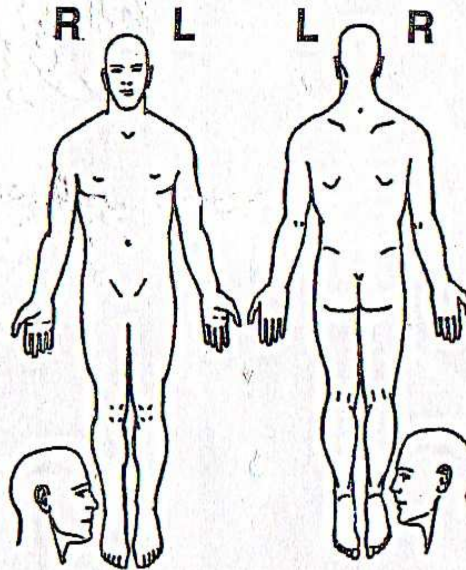
Pain Consultants of East Tennessee

PLEASE COMPLETE ALL ITEMS PRIOR TO YOUR EVALUATION. WE CANNOT PERFORM A THOROUGH EVALUATION WITHOUT A COMPLETED FORM.

Shade all painful areas in red.
Indicate the worst areas of pain in black.

Shade all areas of numbness in blue.





ETIOLOGY:

What is your chief complaint? ____

TIMING: Circle all items that describe your pain:

Pain is worst:	awakening	morning	afternoon	evening	night
Pain is best:	awakening	morning	afternoon	evening	night
I sleep:	soundly	well	uninterrupted	little	none
	2 hours	4 hours	6 hours	8+hours	
Pain wakes me up:		never	occasionally		frequently
I fall asleep:	easily	after an hour	only with medicine	with difficulty	

QUALITY:

Circle all items that describe your pain:

dull	aching	tingling	weakness
sharp	burning	pulling	give away
stabbing	throbbing	cramping	lose balance
stinging	electrical shock	shooting	numbing
itching	squeezing	radiating	pounding

DURATION:

My pain is: constant comes and goes occasional work related

My pain occurs when I ____

CONTEXT:

Circle all activities that make your pain **<u>better</u>:**

bedrest	weather changes	position changes	sex
worry/stress	physical activity	coughing/sneezing	sitting
standing	bending	lying flat on back	driving
walking	lifting	lying on side	alcohol
eating	heat	distraction (TV, etc.)	cold
massage	bright lights	loud noises	pressure

Circle all activities that make your pain **<u>worse</u>**:

bedrest	weather changes	position changes	sex
worry/stress	physical activity	coughing/sneezing	sitting
standing	bending	lying flat on back	driving
walking	lifting	lying on side	alcohol
eating	heat	distraction (TV, etc.)	cold
massage	bright lights	loud noises	pressure

My painful condition has made me lose control of:

my bowels: ☐ Yes ☐ No
my bladder: ☐ Yes ☐ No

TREATMENTS:

	Have not had Treatment	lasting benefit	temporary benefit	no help	made worse
Physical therapy	0	1	2	3	4
TENS unit	0	1	2	3	4
Chiropractic	0	1	2	3	4
Pain Center	0	1	2	3	4
Relaxation techniques	0	1	2	3	4
Nerve blocks-specify site and date:					
1. ________________	0	1	2	3	4
2. ________________	0	1	2	3	4
3. ________________	0	1	2	3	4

Please list surgeries you have had performed for this complaint for pain relief:

Surgery	Date	Physician	Hospital
1. ___________________	___________	___________	___________
2. ___________________	___________	___________	___________
3. ___________________	___________	___________	___________
4. ___________________	___________	___________	___________

Diagnostic Studies: (Please list all x-rays, CT scans, MRI scans, EMGs or other tests performed for your pain.)

TEST DATE LOCATION PERFORMED

1. ____
2. ____
3. ____
4. ____
5. ____

REVIEW OF SYSTEMS:

CV:	chest pain	blocked arteries	heart attack
	high blood pressure	phlebitis	pacemaker
	murmur	angina	
RESP:	asthma	cough	tuberculosis
	emphysema	bronchitis	
GI:	ulcer	hiatal hernia	heartburn
	diarrhea	irritable bowel	pancreatitis
	ulcerative colitis	Crohn's disease	constipation
GU:	hysterectomy	sexual problems	kidney stones
	urinary tract infections	urination at night	
MS:	rheumatoid arthritis	degenerative arthritis	artificial joint
	fibromyalgia	myofascial pain	muscle spasms
NEURO:	neuropathy	nerve damage	RSD
PSYCH:	nervous breakdown	bipolar disease	insomnia
	conflicts at home	bad nerves	depression
	suicidal thoughts	anxiety	panic attacks
ENDO:	insulin diabetes	noninsuling diabetes	thyroid problems
ALLER:	latex allergy	tape allergy	many allergies

MEDICATIONS:

Drug allergies: (rash, swelling, itching) ______________________________

____

List all current medications and dosage:

1. ____________________________ 5. ____________________________

2. ____________________________ 6. ____________________________

3. ____________________________ 7. ____________________________

4. ____________________________ 8. ____________________________

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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.

Updated 1-22-02