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.
   Pain Consultants of East Tennessee, PLLC

3. The information will be used/disclosed for the following purposes:
   For treatment purposes only

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

TO: ____

____

____

I authorize any physician, nurse, or other health professional that has attended me, or hospital at which I have been confined to furnish to:

PAIN CONSULTANTS OF EAST TENNESSEE
P.O. BOX 2665
KNOXVILLE, TN 37901-2665
FAX: 865-579-5176

Or an authorized representative, any and all information that may be requested regarding my physical illness or injury, mental condition and treatment rendered therefore and, if necessary, to allow them or any physician appointed by them to examine x-ray pictures taken of me or records regarding psychiatric or mental condition or treatment. In addition, I also authorize the release of psychiatric/psychotherapy records, mental health records, Pharmacy records, and drug and alcohol treatment information under the same terms and conditions. A photocopy of this instrument may be used instead of the original.

PATIENT NAME: ________________________________

PATIENT ADDRESS: ________________________________

____

BIRTHDATE: ________________________________

TREATMENT DATES: ________________________________

____
SIGNATURE OF PATIENT, LEGAL GUARDIAN OR PARENT

____
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? ______________________

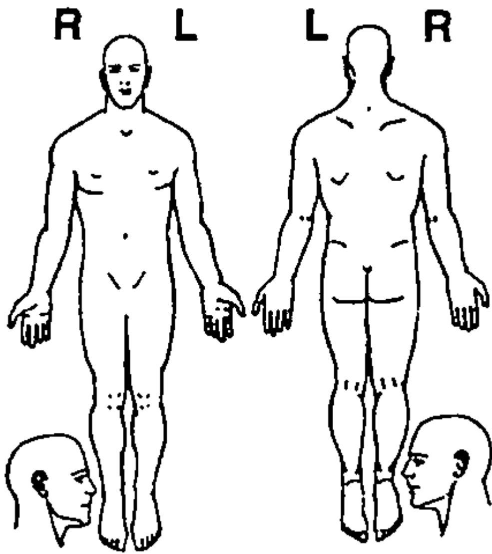
Signature: ________________________ **Date:** _____________________

You must advise PCET in writing if the above information changes in any way.

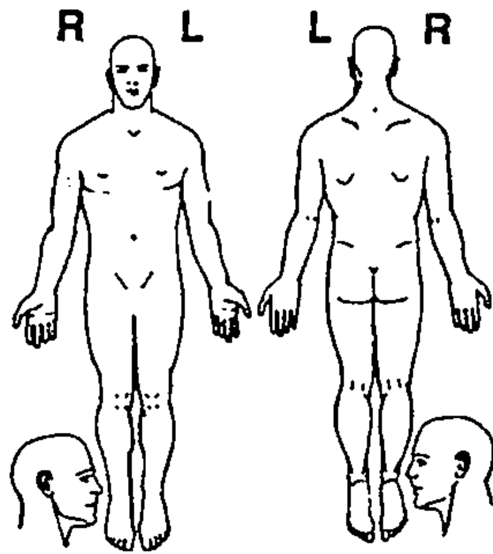
Updated 1-22-02

PAIN DIAGRAM

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 <u>chief complaint</u>? ______________________________________

PAIN SCORE: 0 = No pain; 10 = Worst pain imaginable

Today: ____ Best: ____ Worst: ____ Most Days: ____ Acceptable: ____

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

Hours slept per night: 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 **worse**:

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:

	Have not had Treatment	lasting benefit	temporary benefit	no help	made worse
1. ________________	0	1	2	3	4
2. ________________	0	1	2	3	4
3. ________________	0	1	2	3	4

PAST MEDICAL HISTORY:

SKIN: eczema, psoriasis, hives, cancer

HEAD: migraines, head injury, headaches

EYES: glaucoma, cataracts, eye surgery

ENT: hearing loss, hearing aids, tonsillectomy, sinus surgery, neck surgery

RESP: asthma, emphysema, bronchitis, pneumonia, tuberculosis, cancer

CV: heart attack, heart bypass/stents, murmur, high blood pressure, coronary artery disease, anemia, varicose veins, phlebitis, blood clots

GI:	ulcers	appendectomy	colitis
	Crohn's disease	gallbladder surgery	pancreatitis
	hiatal hernia	irritable bowel syndrome	hemorrhoids
GU:	kidney disease	urinary tract infections	kidney stones
	prostate problems	hysterectomy	STD
MS:	rheumatoid arthritis	osteoarthritis	osteoporosis
	back surgery	multiple sclerosis	fibromyalgia
	myofacial pain	artificial joint	
NEURO:	RSD	head injury	seizures
	Parkinson's disease		
PSYCH:	depression	suicidal attempts	nervous breakdown
	panic attacks	bipolar disease	
BLOOD:	transfusions	anemia	leukemia
ENDO:	insulin diabetes	noninsulin diabetes	hyperthyroidism
	hypothyroidism		

REVIEW OF SYSTEMS:

GEN:	weight changes	fatigue	weakness
	fever	chills	night sweats
SKIN:	color changes	extreme dryness	itching
HEAD:	headaches	history of head injury	dizziness
ENT:	nose discharge	drainage from ear	glasses
	sinus pain	ear infections	double vision
	nosebleeds	dizziness	eye pain
	allergies	ringing in ears	eye redness
	change in smell	hearing problems	eye discharge
	mouth pain	frequent sore throat	toothache
	difficulty swallowing	hoarseness	sores in mouth
	voice changes		
NECK:	neck pain	limited movement	enlarged glands
	goiter		
LYMPH:	tenderness in armpits	lumps in armpits	swelling

CV:	chest pain	palpitations	swelling of feet/legs
	difficulty breathing-lying	difficulty breathing-night	heart attack
	coldness	numbness or tingling	leg discoloration
	shortness of breath with activity		
RESP:	wheezing	shortness of breath	coughing
	bloody sputum	chest pain with breathing	
GI:	difficulty swallowing	heartburn	indigestion
	constipation	nausea	vomiting
	bloody stools	rectal bleeding	
GU:	incontinence	sexual problems	frequent urination
	urination at night	flank pain	groin pain
	pain with sex	change in sexual performance	
MS:	joint pain	joint stiffness	joint swelling
	decreased movement	muscle pain	muscle cramps
	muscle weakness	difficulties walking	back pain
	back stiffness	decreased movement of back	
NEURO:	weakness	coordination problems	paralysis
	fainting	loss of consciousness	seizures
	numbness	tingling	nerve damage
PSYCH:	nervous breakdown	insomnia	mood changes
	conflicts at home	bad nerves	depression
	suicidal thoughts	anxiety	panic attacks
	hallucinations		
ENDO:	heat intolerance	cold intolerance	excessive sweating
	nervousness	abnormal hair growth	tremors
ALLER:	latex allergy	tape allergy	many allergies
ABUSE:	physical	sexual	emotional
BLOOD:	blood thinners	easy bleeder	Hepatitis
	HIV	Sickle Cell Anemia	

CURRENT WORK STATUS:

Full time employment	Medical leave of absence	How long? ___________
Part time employment	Disabled	How long?____________
Retired	Unemployed	How long? ___________

Most recent employment:________________________ How long?____________

Company name:_______________________ Job title:__________________________

Job requirements: heavy lifting, grasping, sitting, stretching, light lifting, walking, climbing, bending, no lifting, standing, repetitive movements

Job requirements:	heavy lifting	grasping	sitting	stretching
	light lifting	walking	climbing	bending
	no lifting	standing	repetitive movements	

Previous Jobs (past 5 years) ____

Highest level of school completed:

elementary school	high school/GED	associate degree	graduate school
middle school	some college	college degree	graduate degree

My income currently comes from:

salary/work	workers compensation	spouse	friends
savings	social security disability	family	private disability

My company treated my injury:

fairly	made me work harder	poorly
ignored me	compassionately	

Please list your attorney's name and telephone number if you have retained one:

<u>ATTORNEY</u> <u>TELEPHONE</u>

Current: ____________________________ ____________________

Previous: ___________________________ ____________________

SOCIAL HISTORY:

I live with:	alone	life partner	spouse	others
	friends	relatives	grown children	young children

Marital status: single divorced married widow/widower

spouse's name:_______________________________ age: ____________

# of children:________________ ages:__________________

Activities and hobbies I enjoy are:____

Effects of pain on activities: ____

Tobacco use:	none	cigars	quit _____years ago
	cigarettes	snuff/chew	____packs per day

Alcohol use:	none	____drinks per day	____drinks per week
		____drinks per month	recovering alcoholic

Have you ever been considered to be a problem drinker at any point in your life?
Yes No Not Sure

Have you ever had any legal trouble due to your drinking?
Yes No

Have you ever been in alcohol treatment for your drinking?
Yes No

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

Have you ever had any legal trouble due to your drug use?
Yes No

Have you ever been treated for drug or alcohol dependence? Yes No
Please give details:____

Are you "in recovery" from alcohol or drug abuse? Yes No

Do you think that you take too much pain medication? Yes No

Have any family or friends ever told you that you are taking too many pain pills?
Yes No
Has a physician ever told you that you take too much medication? Yes No

Are there any other crises going on in your life that affect your pain? Yes No
If yes, please explain____

Have you ever been discharged from another medical practice due to medication use or abuse issues? Yes No

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

MEDICATIONS:

Drug allergies: (rash, swelling, itching) ______________________________
____

List all current medications and dosage:

1. ____________________________ 5. _____________________________

2.____________________________ 6. _____________________________

3. ____________________________ 7. _____________________________

4. ____________________________ 8. _____________________________

List all previous pain medications tried and dosages:

1. ____________________________ 4. _____________________________

2.____________________________ 5. _____________________________

3. ____________________________ 6. _____________________________

Pharmacy: ______________________ Telephone:____________________

List three things that you cannot do now that you would like to be able to do after treatment by PCET (Goals):

____

____

____

____

____

____

Emotional and Quality of Life Checklist

Name:___________________________ Date:______________

1. How depressed would you say you have felt in the last few months (circle one)?
    a. Not at all depressed
    b. A little depressed
    c. Somewhat depressed
    d. Very depressed
2. Do you feel you are being punished?
    a. No
    b. Yes
3. Do you feel as though your future is hopeless and will never get better?
    a. No
    b. Yes
4. How often do you have pleasure in your life these days?
    a. Often
    b. Every once in a while
    c. Never
5. Do you have any major stressors in your life right now in addition to your pain?
    a. No
    b. Yes, If so, briefly explain________________________________
6. How are you and your family getting along since you have had your pain?
    a. Better than ever
    b. The same as ever
    c. A little worse than ever
    d. Much worse than ever
7. How nervous or anxious would you say you have felt in the last few weeks or months (circle one)?
    a. Not at all anxious
    b. A little anxious
    c. Somewhat anxious
    d. Very anxious
8. Have you had any anxiety "attacks" in the last few weeks or months?
    a. No
    b. Not sure
    c. Yes
9. Have you had thoughts of harming yourself recently?
    a. No
    b. Yes
10. Have you had a traumatic event, such as an accident, which continues to bother you still, either through nightmares or strong memories?
    a. No
    b. Yes

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

NEW URINE DRUG SCREEN POLICY

EFFECTIVE 10/1/03, PAIN CONSULTANTS OF EAST TENNESSEE WILL BEGIN CHARGING FOR URINE DRUG SCREENS.

ALL PATIENTS ARE SUBJECT TO RANDOM DRUG SCREENS. THE METHOD OF BILLING FOR THE URINE DRUG SCREEN DEPENDS ON YOUR INSURANCE CARRIER. MOST INSURANCE CARRIERS USUALLY DO NOT COVER THE COST OF ROUTINE SCREENINGS. THE COST OF THE URINE DRUG SCREEN IS THE PATIENT'S RESPONSIBILITY REGARDLESS OF METHOD OF BILLING OR INSURANCE COVERAGE. YOU WILL EITHER RECEIVE A BILL FROM PCET OR THE OUTSIDE LAB. IF YOU SIGN A PAYMENT AGREEMENT LETTER WITH PCET, YOU ARE RESPONSIBLE FOR MAKING THE AGREED UPON PAYMENTS AS STATED. IF YOU RECEIVE A BILL FROM THE OUTSIDE LAB, YOU MUST CONTACT THEM DIRECTLY TO MAKE PAYMENT ARRANGEMENTS.

RANDOM URINE DRUG SCREENS ARE AN INTEGRAL PART OF EVERY PATIENTS TREATMENT PLAN. REFUSAL TO COMPLY COULD RESULT IN DISCHARGE FROM THE PRACTICE.

PLEASE DISCUSS THIS POLICY WITH YOUR PHYSICIAN OR NURSE PRACTITIONER IF YOU HAVE ANY QUESTIONS.