PAIN & SPINE CENTER
of Charlottesville

Patient Registration

Date: _____

First name: _____
Middle name: _____
Last name: _____
Date of birth: _____
Social security number: _____
Street address: _____
Apartment number: _____
City/state/zip:_____

Race/ethnicity: _____
Email: _____
Mobile phone: _____
Home phone: _____
Work phone: _____
Occupation: _____
Employer: _____

Physician Information

Primary Care Physician: _____ Phone number: _____
Referring physician: _____ Phone number: _____

Emergency Contact

1. Name: _____
   Relationship to Patient: _____ Phone number: _____
2. (Optional secondary)
   Name: _____
   Relationship to Patient: _____ Phone number: _____

Preferred Pharmacy

Name: _____
Address: _____
Phone number: _____

PRIMARY INSURANCE:

Insurance name: _____
Subscriber's name: _____ Relationship: _____
Subscriber's DOB: _____ Subscriber's SSN: _____
Member ID: _____ Group #: _____
Effective Date: _____ Copay Required? □ Yes □ No Amount: $_____

SECONDARY INSURANCE:

Insurance name: _____
Subscriber's name: _____ Relationship: _____
Subscriber's DOB: _____ Subscriber's SSN: _____
Member ID: _____ Group #: _____
Effective Date: _____ Copay Required? □ Yes □ No Amount: $_____

WORKER'S COMPENSATION:

Date of Accident: _____ Claim #: _____
Representative's name: _____ Rep's phone number: _____
Workplace name and address: _____

I understand that the above information is true to the best of my knowledge. I understand I'm responsible for the charges associated with medical services. I authorize the physician and clinic to release any information requested by my insurance plan at any time for any reason, including but not limited to, claims processing or auditing. I also authorize my insurance company to pay the physician directly.

_____

(Signature of patient/guardian/representative) (Date)

Initial Pain Evaluation

CHIEF COMPLANT: List the areas of your pain

- ☐ Upper back
- ☐ Mid back
- ☐ Lower back
- ☐ Joints (list areas, specify side): _____
- ☐ Headaches
- ☐ Other: _____

Height: _____ Weight: _____

My current problem is the result of a:

☐ Car accident ☐ Work Injury ☐Other: _____

Approximately when did the problem first start (how many weeks/months/years ago)?

_____

Have you seen any other physicians for this problem? ☐ Yes ☐ No
If yes, who? _____

_____

_____

What treatments have you had for this problem?

- ☐ Physical therapy (list approximately how long ago and duration):
  _____
- ☐ Chiropractic treatment
- ☐ TENS unit
- ☐ Massage
- ☐ Acupuncture
- ☐ Surgery (list type): _____
- ☐ Nerve ablations/burning
- ☐ Epidural injections
- ☐ Other injections (list type, if known): _____

Which medications have you tried?

- ☐ Oral NSAIDs (Aspirin, Ibuprofen/Advil/Motrin, Naproxen/Aleve)
- ☐ Other over the counter (eg. Acetaminophen/Tylenol)
- ☐ Muscle relaxants (eg. Baclofen, soma, cyclobenzaprine, Metaxalone/Skelaxin, Methocarbamol, Flexeril/Tizandine)
- ☐ Prescription pain medications (eg. Codeine, Hydrocodone, Oxycodone, Methadone, Hydromorphone, Morphine, Fentanyl)
- ☐ Prescription nerve medications (eg. Tegretol/carbamazepine, Gabapentin/Neurontin, Pregablin/Lyrica, Duloxetine/Cymbalta, Topiramate/Topamax)
- ☐ Prescription topical medications (eg. Voltaren gel, Lidocaine)

Which of these medications have been helpful in the past?

_____

_____

Have you underwent any imaging related to this problem (MRIs, CTs, XRays)? ☐ Yes ☐ No

If so, which hospitals/facilities/doctors have these reports?

_____

_____

_____

Is your pain: ☐ Constant ☐ Intermittent

Was the onset of your pain: ☐ Sudden ☐ Gradual

Check the words that best describe your pain:

☐ Sharp ☐ Aching ☐ Numbness ☐ Hot/Burning ☐ Cramping ☐ Shooting
☐ Stinging ☐ Dull ☐ Tingling ☐ Stabbing ☐ Coldness

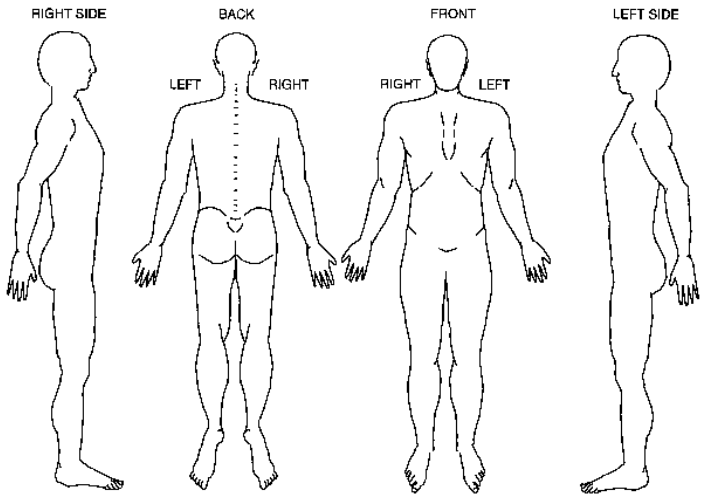
What activities make it better?

☐ Rest ☐ Stretching ☐ Ice ☐ Heat ☐ Movement ☐ Exercise
☐ Other: _____

What activities make it worse?

☐ Walking ☐ Sitting ☐ Standing ☐ Rest/lying down ☐ Riding/driving
☐ Lifting ☐ Bending forward/backwards ☐ Bending right/left ☐ Coughing/sneezing
☐ Other: _____

Shade the area(s) of your pain. If the pain radiates, describe this as well.



PAIN SCALES

(0 = no pain, 10 = worst pain)

Rate your present pain level:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Rate your worst pain level:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Rate your average pain level:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Social History

Do you smoke? ☐ Yes ☐ No If so, how much? _____

Do you drink? ☐ Yes ☐ No If so, how much? _____

Are you:

☐ Fully employed ☐ Partially employed ☐ Unemployed

Past Medical History

Do you have a pacemaker? ☐ Yes ☐ No

If yes: Brand: _____

Cardiologist name: _____

Cardiologist phone number: _____

Do you have a defibrillator? ☐ Yes ☐ No

If yes: Brand: _____

Cardiologist name: _____

Cardiologist phone number: _____

Are you on a blood thinner (ex. Coumadin, Plavix, Heparin, Aspirin)? ☐ Yes ☐ No

If yes: Medication name: _____

Prescribing doctor name: _____

Prescribing doctor phone number: _____

Have you had any complications with bleeding? ☐ Yes ☐ No

Have you had any complications with anesthesia? ☐ Yes ☐ No

Female patients only: Are you pregnant? ☐ Yes ☐ No ☐ Unsure

Please mark all that apply to you:

☐ Metal in body ☐ Pacemaker ☐ TMJ ☐ Chest pain/angina ☐ Fibromyalgia ☐ Sleep apnea ☐ High blood pressure ☐ Obesity ☐ Acid reflux / GERD ☐ High cholesterol ☐ Hypothyroidism ☐ Hyperthyroidism ☐ COPD ☐ Diabetes ☐ Kidney Disease ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ HIV/AIDS ☐ Seizures/epilepsy	☐ Asthma ☐ Emphesyma ☐ Shortness of breath ☐ Dementia ☐ Alzheimer's ☐ Memory issues ☐ Other neurological issues (list) _____ _____ ☐ Difficulty with speech ☐ Hearing loss ☐ Heart disease / CAD ☐ Past history of stroke ☐ Past history of heart attack ☐ Cardiac stent placement ☐ Cancer (list type): _____ ☐ Other chronic conditions: _____ _____ _____	☐ Anxiety ☐ Depression ☐ Bipolar disorder ☐ ADD/ADHD ☐ Other psychiatric conditions (list type): _____ _____ _____ ☐ Past history of alcohol abuse/addiction ☐ Past history of illegal drug abuse ☐ Past history of prescription drug abuse/addiction ☐ Suicidal thoughts ☐ Homicidal thoughts

List any past surgeries and approximate date:

PROCEDURE	SIDE (if applicable)	APPROXIMATE DATE

List any medication/environmental allergies:

If no known allergies, check this box: ☐

ALLERGY	REACTION	MILD/MODERATE/SEVERE?

List any current medications (including strength and dosage):

MEDICATION	STRENGTH	DOSAGE

Family History

Please list any serious health problems or important notes concerning your mother's medical history:

_____

_____

If deceased, at what age? _____

Please list any serious health problems or important notes concerning your father's medical history:

_____

_____

If deceased, at what age? _____

By signing below, I agree that I have completed this entire form and I have provided the correct information.

_____

(Signature of patient/guardian/representative) (Date)

Pain Management Agreement

The purpose of this agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This agreement will help you and your provider comply with the law regarding controlled pharmaceuticals.

- I understand that this agreement is essential to the trust and confidence necessary in a provider/patient relationship, and that my provider undertakes my treatment based on this agreement.
- I understand that if I break this agreement, my provider, on his sole discretion, will stop prescribing these pain/control medicines, switch me to non-opioid only medications, or may discharge me from his care. A drug-dependence treatment program may also be recommended.
- I understand that there is a risk of psychological and/or physical dependence, serious interactions with other medications/substances, risks of addiction, respiratory depression, organ damage, and death associated with use of opioid/narcotic medication.
- I will fully cooperate and comply with other recommendations including referrals to physical therapy or other providers and to interventional procedures including injections or nerve blocks as may be deemed necessary by my provider as part of my treatment plan.
- I would also be amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems it necessary.
- I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.
- I will not use alcohol or any illegal controlled substances (including marijuana, cocaine, etc.) or misuse or self-prescribe/medicate with legal controlled substances.
- I will not share my medication with anyone.
- I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.
- I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced. A police report may be requested by my provider if this happens.
- I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.
- I agree to use only this pharmacy for filling all of my pain medicine prescriptions:

  Pharmacy name: _____

  Pharmacy address: _____

  Pharmacy phone number: _____

- I authorize the provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my provider to provide a copy of this agreement to my pharmacy, primary care provider, and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorization.
- I agree to submit to a blood, saliva, or urine test if requested by my provider to determine my compliance with my program of pain control medications.
- I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and one pharmacy by checking the Prescription Monitoring website periodically throughout my treatment period.
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater care will result in no medication for a period of time.
- I will bring unused pain medication to every office visit.
- I agree to follow these guidelines that have been fully explained to me.

All of my questions and concerns regarding treatment have been adequately answered. I may request a signed copy of this document at any time.

This agreement is entered onto this date: _____

Patient signature: _____

Patient name (printed): _____

Provider signature: _____

Provider name (printed): _____

Witnessed by: _____

Signature: _____

Opioid Risk Tool (ORT)

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

MARK EACH BOX THAT APPLIES	FEMALE	MALE
FAMILY HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 1	☐ 3
Illegal drugs	☐ 2	☐ 3
Rx drugs	☐ 4	☐ 4
PERSONAL HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 3	☐ 3
Illegal drugs	☐ 4	☐ 4
Rx drugs	☐ 5	☐ 5
AGE BETWEEN 16–45 YEARS	☐ 1	☐ 1
HISTORY OF PREADOLESCENT SEXUAL ABUSE	☐ 3	☐ 0
PSYCHOLOGIC DISEASE		
ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
SCORING TOTALS		

ADMINISTRATION

- On initial visit
- Prior to opioid therapy

SCORING (RISK)

0–3: low

4–7: moderate

≥8: high

Patient Health Questionnaire

Over the last two 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
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, and hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure and have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

[For doctor only: calculate total] _____

10. If you have checked any problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult

Dr. Akhtar Purvez
Pain & Spine Center of Charlottesville
1807 Seminole Trail, Suite 201, Charlottesville, VA 22901
PH: 434-328-2774, FAX: 434-328-2776

RELEASE OF INFORMATION

Patient name: _____

Date of Birth: _____

This document authorizes Dr. Akhtar Purvez and the Pain & Spine Center of Charlottesville to provide or receive a copy, summary, or narrative of my medical records, or otherwise release confidential information.

Release to the following person(s):

Akhtar Purvez, MD
Pain & Spine Center of Charlottesville
1807 Seminole Trail, Charlottesville VA 22901
Phone: (434) 328-2774, Fax: (434) 328-2776

I understand the information may include information related to HIV/AIDS status.

I understand that I may revoke this authorization in writing. Doing so will not affect uses or disclosures of my confidential information that occurred prior to revoking.

I understand that refusal to sign this authorization will in no way affect my treatment.

I understand that confidential information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law.

Signature: _____ Date: _____