

Frederick
196 Thomas Johnson Dr
Suite 215
Frederick, MD 21702
Phone (301) 668-9988
Fax (301) 668-9977

Prince Frederick
80 Sherry Lane
Suite 101
Prince Frederick, MD 20678
Phone (410) 414-9229
Fax (410) 414-9339

Waldorf
3581 Old Washington Rd
Suite F
Waldorf, MD 20602
Phone (301) 638-4400
Fax (301) 638-2200

Leesburg
161 Ft. Evans Rd, NE
Suite 340
Leesburg, VA 20176
Phone (703) 443-8000
Fax (703) 443-8100



Welcome to Newbridge Spine & Pain Center

Thank you for choosing Newbridge Spine & Pain Center to manage your medical care. Our specialists are dedicated to providing you with the latest pain management treatments and procedures to aid in the relief of your chronic pain. We appreciate the trust you have given us and will continually strive to exceed your expectations.

To prepare for your first visit, please **complete the enclosed New Patient Packet** and take a moment to read through and **complete the last page of the Patient Handbook**. Please use only *blue or black ink* to complete these forms. This handbook features helpful information about our practice and the care we will be providing to you at our office.

Be sure to bring the following items with you to your first appointment:

- Your **entire signed and completed New Patient Packet**
- The **last page of your Patient Handbook** (please sign and date)
- Medical insurance card (*Our pre-authorization specialist will verify your insurance coverage prior to your first visit.*)
- Any copay and/or deductible payment
- Driver's license or photo identification
- Referral documentation from your referring physician
- All previous written reports of x-rays, MRIs, CT scans and/or EMGs

If you have any questions please feel free to contact us anytime. We look forward to meeting you soon.

Best Regards,

Jay Gonchigar

Jay Gonchigar, M.D.



Please complete using only blue or black ink

NEW PATIENT INFORMATION

NAME (Last, First, Middle Initial)			SUFFIX EG: Jr. Sr., II, III	
STREET ADDRESS/ MAILING ADDRESS (PO BOX)			CITY	
COUNTY	STATE	ZIP CODE	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> SEPARATED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		SOCIAL SECURITY #	DATE OF BIRTH	
PHONE: HOME <input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY	PHONE: WORK <input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY	PHONE: CELL <input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY		

HOW DID YOU HEAR ABOUT US?

PRIMARY CARE
 OTHER PHYSICIAN
 FAMILY/ FRIEND
 PRINT AD
 RADIO AD
 BROCHURE
 SOCIAL MEDIA
 SEARCH ENGINE / WEBSITE
 OTHER INTERNET
 OTHER _____

REFERRING PHYSICIAN (IF APPLICABLE)

REFERRING PHYSICIAN NAME (IF APPLICABLE) (Last, First)			PHONE	
STREET ADDRESS	CITY	STATE	ZIP CODE	

PRIMARY CARE PHYSICIAN (IF APPLICABLE)

PHYSICIAN NAME (Last, First)			PHONE	
STREET ADDRESS	CITY	STATE	ZIP CODE	

OTHER PERSONAL INFORMATION

EMPLOYMENT STATUS <input type="checkbox"/> EMPLOYED <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> RETIRED <input type="checkbox"/> DISABLED		OCCUPATION	EMPLOYER NAME
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PLEASE PROVIDE YOUR EMAIL ADDRESS TO ACCESS / REVIEW YOUR MEDICAL INFORMATION/ PATIENT PORTAL ONLINE:

RACE <input type="checkbox"/> NATIVE AMERICAN/ALASKAN NATIVE <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> NATIVE HAWAIIAN/ PACIFIC ISLANDER <input type="checkbox"/> ASIAN <input type="checkbox"/> WHITE/CAUCASIAN <input type="checkbox"/> OTHER _____ <input type="checkbox"/> DECLINED <input type="checkbox"/> MULTIRACIAL - SPECIFY _____		ETHNICITY <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> NON-HISPANIC OR LATINO <input type="checkbox"/> DECLINE TO PROVIDE INFORMATION
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PRIMARY LANGUAGE

IF YOU ARE HERE AS A RESULT OF A WORKER'S COMPENSATION OR AUTO INJURY COMPLETE BELOW

<input type="checkbox"/> WORKERS COMPENSATION <input type="checkbox"/> AUTO INSURANCE	DATE OF INJURY
CLAIM #	CLAIM ADJUSTER NAME
WORKERS COMP OR AUTO INSURANCE CARRIER NAME	PHONE

PRIMARY INSURANCE CARRIER	SECONDARY INSURANCE CARRIER
INSURANCE CARRIER NAME	INSURANCE CARRIER NAME
INSURANCE PHONE #	INSURANCE PHONE #
INSURANCE ID#	INSURANCE ID #
GROUP #	GROUP #
SUBSCRIBER (POLICY HOLDER) NAME	SUBSCRIBER (POLICY HOLDER) NAME
BIRTHDATE (POLICY HOLDER)	BIRTHDATE (POLICY HOLDER)
POLICY HOLDER ADDRESS IF DIFFERENT FROM PATIENT	POLICY HOLDER ADDRESS IF DIFFERENT FROM PATIENT
PATIENT-SUBSCRIBER RELATIONSHIP <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT <input type="checkbox"/> OTHER	PATIENT-SUBSCRIBER RELATIONSHIP <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT <input type="checkbox"/> OTHER

Medical Billing Policy

- Payment is required when services are rendered. Accepted forms of payment include cash, checks, money orders, VISA and MasterCard.
- Rescheduling or canceling an appointment or procedure must be done at least 24 hours prior. If 24-hour advance notice is not provided, the patient will be assessed a \$25 fee for office visits and \$100 fee for procedures.
- Deductibles, co-payments and co-insurance amounts must be paid in full prior to receiving medical care and/or seeing a physician. Patients are responsible for verifying the amount of their deductible with their insurance company prior to their initial visit. Deductibles are due in full at the time of initial and subsequent visits.
- Insurance claims are filed on behalf of patients, however, patients are financially responsible for paying their own personal deductible and/or insurance co-payment.
- Patients are responsible for providing current primary and secondary insurance information at the time of their initial visit. Otherwise patients are financially responsible for any charges not covered by their insurance.
- Patients are responsible for providing any insurance changes and/or updates. If a patient's bill is incorrectly submitted to an insurance company due to a lack of updated information, the patient will be charged a \$25 service fee and held financially responsible for charges not covered by their insurance.
- Patients without insurance and those unable to pay their deductible and/or co-payments are required to schedule and attend a meeting with the practice billing manager during which a payment plan must be arranged. At each appointment the payment plan must be current prior to receiving medical care or seeing a physician.
- If a patient's check is returned unpaid for any reason by the issuing bank, patients are liable for the amount of each returned check plus a \$25 service charge.
- If a collection agency is required to collect a past due amount, the patient remains financially responsible and will be charged for the collection agency's fee in addition to the past due amount.
- This medical practice complies with Stark Law in regards to governing physician referrals and payments for those practices.

Medical Billing Policy (Page 2)

- Patients are required to present insurance cards for re-verification at each visit.
- Patients are assessed a \$25 fee if additional paperwork, such as disability forms and/or secondary insurance forms, must be completed by our office staff.
- Patients are assessed a fee according to current state law if medical records are provided to an authorized party.
- It is the policy of Newbridge to extend "in-network benefits" to all our patients. Patients will be responsible for payments based on their in-network benefits. Payment of their in-network benefit amount is due at the time of service unless prior arrangements are approved by management.
- Patients are required to sign a copy of this billing policy agreement to be placed in the patient's medical file prior to their initial consultation.
- **Referrals:** If a patient's insurance company requires a referral be obtained prior to services rendered at a specialist, it is the patient's responsibility to obtain the referral from their primary physician and present it during their initial visit in order to be seen by the physician. If a patient inadvertently receives medical care or visits with the physician without a required referral, the patient will be financially responsible for the visit. If subsequent referrals are required, it remains the patient's responsibility to obtain and present the referrals at each applicable visit.
- **HMO:** Accepted providers must be verified by the patient and applicable referral paperwork must be provided to our office prior to receiving medical care.
- **Personal Injury Protection (PIP):** A pre-authorization specialist will verify the amount of PIP coverage available. Personal health insurance information is required so charges not covered by PIP can be submitted to the patient's personal health insurance company. If a patient's health insurance company requires a referral, it *must* be obtained and presented during the patient's first visit, even if a claim is being filed to PIP.
- **Worker's Compensation:**
 - Worker's compensation patients are required to provide correct case and financial coverage information prior to their first visit related to the case. Otherwise a \$25 service fee will be charged to update medical and financial records as needed.
 - Worker's comp medical claims cannot be filed with personal insurance companies because treatment related to a worker's comp case is not covered under personal insurance plans. If submission of worker's comp charges to a personal insurance company is attempted, the worker's comp patient is then personally responsible for all charges.
 - Worker's comp patients are responsible for securing approval from their case worker for treatment prior to the patient's *initial* visit. Approval for subsequent visits will be obtained by the medical staff.
 - Worker's comp patients must bring the following to their first appointment: date of injury, claim number, name of worker's comp insurance company, name of case worker, case worker's phone and fax numbers.

Patient Acknowledgement

I have received, read, fully understand and agree to abide by the terms of this billing policy.

PATIENT SIGNATURE	DATE
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Notice

As required by state and federal regulations, this notice serves to inform you that Newbridge Spine & Pain Center, LLC, Newbridge Spine & Pain Center of Virginia, LLC, Newbridge Surgery Center at Frederick, LLC, Newbridge Surgery Center at Waldorf, LLC, and Newbridge Surgery Center at Prince Frederick, LLC, are solely owned by Jay Gonchigar, MD.

Treatment Consent and Assignment of Benefits

I hereby authorize the physicians of Newbridge Spine & Pain Center, LLC, Newbridge Spine & Pain Center of Virginia, LLC, Newbridge Surgery Center at Frederick, LLC, Newbridge Surgery Center at Waldorf, LLC, Newbridge Surgery Center at Prince Frederick, LLC, to provide medical treatment and release information pertaining to treatment, as deemed necessary, to my insurance companies, attorney, referring physician, primary care physician and any other medical professionals from which I am receiving treatment including pharmacies and other physicians not listed. I agree to allow Newbridge Spine & Pain Center, LLC, Newbridge Spine & Pain Center of Virginia, LLC, Newbridge Surgery Center at Frederick, LLC, Newbridge Surgery Center at Waldorf, LLC, Newbridge Surgery Center at Prince Frederick, LLC, to receive direct payments, for professional treatment of me, which would otherwise be payable to me for services rendered. My insurance carrier or I may revoke this authorization at any time in writing. In any case where insurance payment for services at Newbridge is sent directly to me I agree to endorse payment and mail this to Newbridge.

I hereby authorize direct medical benefit payments issued by my insurance company or companies be provided to the above named entities. I understand and agree to be financially responsible for all charges incurred as a result of my decision to be treated by Newbridge Spine & Pain Center, LLC, Newbridge Spine & Pain Center of Virginia, LLC, Newbridge Surgery Center at Frederick, LLC, Newbridge Surgery Center at Waldorf, LLC, Newbridge Surgery Center at Prince Frederick, LLC. I understand I am financially responsible for payment of deductibles, co-pays and non-covered charges as outlined by my healthcare insurance policy contract.

I indicate with my signature below that I have read, fully understand and accept the above statements.

PATIENT SIGNATURE	DATE
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Disclosure of Medical Records and Medical Information

Patient records may be audited by health insurance companies, Medicare or the Office of Inspector General of the United States, for compliance with regulations. Medical records may also be seen by accrediting organizations, including Joint Commission for Accreditations of Healthcare Organizations, AAAHC or AAAASF. Patients have the right to receive a list of any and all entities receiving copies of their medical records and the reasons for disclosure. Patients must provide written notice if they do not want their records reviewed by regulatory agencies.

I understand it is Newbridge Spine & Pain Center, LLC, Newbridge Spine & Pain Center of Virginia, LLC, Newbridge Surgery Center at Frederick, LLC, Newbridge Surgery Center at Waldorf, LLC, Newbridge Surgery Center at Prince Frederick, LLC, policy to maintain patient privacy and confidentiality as mandated by the HIPPA Act of 1996. A patient's medical information will only be disclosed to previously unauthorized outside parties with the patient's written permission and verbal acknowledgment to a staff member that they are giving up their right to patient privacy and confidentiality. Patients are asked to make their family and friends aware of this patient confidentiality policy.

I understand I may be referred to Newbridge Spine & Pain Center, LLC, Newbridge Spine & Pain Center of Virginia, LLC, Newbridge Surgery Center at Frederick, LLC, Newbridge Surgery Center at Waldorf, LLC, Newbridge Surgery Center at Prince Frederick, LLC, for a procedure to be performed at said location. I acknowledge I am aware of the financial interest held by above said physician in said facilities.

I indicate with my signature below that I have read, fully understand and accept these policies

PATIENT SIGNATURE	DATE
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Privacy Act Statement

This statement gives notice as required by the Healthcare Portability & Accountability Act of 1996.

Sections 1102(a), 1861(o), 1861(z), 1863, 1864, 1865, 1866, 1871, 1891(b) of the Social Security Act of 1974 provides our office with the authority to collect your information, including your social security number, for assessment.

- Patients have the right to have their personal healthcare information kept confidential.
- Every patient's personal health information is kept confidential and only provided to authorized parties.
- No information will be shared with a spouse, family member, friend or significant other without a signed release from the patient.
- No medical records will be released to an unauthorized third party without a signed release from the patient with the exception of the patient's referring and primary care provider.
- Safeguards are in place with passwords for all employees to guard against illegal entry into our computer system by unlawful users. Users are restricted to only the information needed to perform duties for the office. No employee is allowed to take work home.
- If a chart must be removed from the office, it will be signed out only by a physician solely responsible for safeguarding and returning the records as soon as possible.
- A locked fireproof box is required for transport of medical records from this office.
- All employees and vendors sign a confidentiality agreement to protect patient information.
- All patient charts are locked in a file cabinet when the office is not occupied.

Reasons for collecting information from patients:

- A complete assessment must be done to accurately reflect a patient's current health. This includes information that can be used to show progress toward a patient's health goals.
- Information must be received from each patient to document quality standards are being met and appropriate health care is being provided to patients.
- Personal and demographic information is collected and utilized for patient identification and insurance verification purposes.
- Patients have the right to refuse to provide information. If patients refuse to provide or provide inaccurate information, the information will be completed as best as possible. However, if a patient does not provide enough information to provide proper treatment, providers have the right to deny services to the patient.
- Patient information is protected under HIPAA's privacy and security provisions.
- Patients have the right to see, copy, review, and request correction of their information at any time.

Purposes for which a patient's information is intended to be used:

- To file insurance claims on the patient's behalf for reimbursement for services rendered.
- To supply documentation on the patient's behalf for disability claims or litigation brought by the patient for injuries involving Worker's Compensation or PIP.
- To supply information to primary or referring physicians documenting the patient's treatment progress.
- To support regulatory and policy functions.
- To assess the effectiveness and quality of care.
- For survey and certification by Health Care Financing Administration (HCFA), State of Maryland, Commonwealth of Virginia and Joint Commission of Healthcare Organizations.
- To provide information to a patient's insurance provider for payment of the patient's claim.

Purposes for which patient information is intended to be used (*continued*):

- To provide information for disability claims by the patient.
- To provide information on a patient's condition for Worker's Compensation.
- For any litigation by the Department of Justice involving HCFA.

Privacy Act Statement (Continued)

- For contractors or consultants working for the HCFA to assist in the performance of a service related to this system of records and who need to access these records to perform their activities.
- For an agency of the state for developing and operating Medicaid reimbursement systems.
- For Federal or State agencies to contribute to the accuracy of HCFA's health insurance operations.
- For peer review organizations for the purpose of assessing and improving care.
- For any congressional office in response to a constituent inquiry made at the written request of the constituent about whom the record is maintained.
- Patients must provide written notice if they do not want their records reviewed by regulatory agencies.

Effects on a patient if a patient does not provide requested information:

- As correct and complete information is needed to give patients high quality of care, incorrect or false information may compromise a patient's quality of care
- Incorrect or incomplete information may result in billing errors
- If a patient does not provide enough information to provide proper treatment, providers have the right to deny services to the patient.

Patient health information rights:

While patient medical records remain the physical property of the office, the information belongs to the patient. Patients have a right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy their health record as provided for in 45 CFR 164.524.
- Amend their health record as provided in 45 CFR 164.528.
- Obtain an accounting of disclosures of their health information as provided in 45 CFR 164.528.
- Request communications of their health information by alternative means or at alternative locations
- Request restriction on certain uses and disclosures of information as provided by 45 CFR 164.522.
- Revoke authorization to use or disclose information except to the extent of action already taken.

AUTO-REMIND	
NAME (Last, First, Middle Initial)	DOB:
PLEASE INDICATE IF YOU WISH TO RECEIVE REMINDERS REGARDING YOUR APPOINTMENT	
<input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, PLEASE INDICATE HOW YOU PREFER TO RECEIVE REMINDERS	
<input type="checkbox"/> TEXT <input type="checkbox"/> EMAIL PHONE: <input type="checkbox"/> HOME <input type="checkbox"/> CELL OR <input type="checkbox"/> ALTERNATE	
CELL NUMBER FOR TEXT REMINDERS	NUMBER FOR PHONE REMINDERS
EMAIL ADDRESS FOR REMINDERS	

STATEMENTS ON PATIENT ADVANCE DIRECTIVES
PLEASE READ AND CHECK THE APPLICABLE STATEMENTS

AN ADVANCE HEALTH DIRECTIVE IS A SET OF WRITTEN DOCUMENTS SPECIFYING WHAT ACTIONS SHOULD BE TAKEN FOR A PATIENT IF THAT PATIENT IS NO LONGER ABLE TO MAKE HEALTH DECISIONS DUE TO THEIR OWN ILLNESS OR INCAPACITY. AN ADVANCE DIRECTIVE APPOINTS AN AGENT TO MAKE SUCH DECISIONS ON THE PATIENT'S BEHALF. PLEASE INDICATE BELOW IF YOU HAVE AN ADVANCE DIRECTIVE AND THEN SELECT A STATEMENT TO BEST DESCRIBE YOUR ADVANCE DIRECTIVE STATUS.

I HAVE AN ADVANCE DIRECTIVE

- I AM PROVIDING A COPY OF MY ADVANCE DIRECTIVE TODAY TO BE PLACED IN MY MEDICAL FILE.
- I WILL PROVIDE A COPY OF MY ADVANCE DIRECTIVE AT A LATER DATE TO BE PLACED IN MY MEDICAL FILE.
- I DO NOT WISH TO PROVIDE A COPY OF MY ADVANCE DIRECTIVE TO BE PLACED IN MY MEDICAL FILE.

I DO NOT HAVE AN ADVANCE DIRECTIVE

- I WOULD LIKE INFORMATION ABOUT ADVANCE DIRECTIVES (OFFICE USE: DISTRIBUTED MATERIALS INITIAL)
- I DO NOT WISH TO RECEIVE INFORMATION ABOUT ADVANCE DIRECTIVES.

STATEMENTS OF EMERGENCY CARE
PLEASE READ AND CHECK THE APPLICABLE STATEMENTS

IF AN EMERGENCY ARISES DURING MY TREATMENT, I UNDERSTAND ALL EMERGENCY MEASURES WILL BE TAKEN UNTIL I AM TRANSPORTED TO THE NEAREST EMERGENCY ROOM. I ALSO UNDERSTAND ANY ADVANCE DIRECTIVES IN MY FILE WILL BE SENT WITH ME TO THE EMERGENCY ROOM.

IN CASE OF EMERGENCY, I UNDERSTAND THE EMERGENCY CONTACT PERSON I AM NOTING BELOW WILL BE NOTIFIED:

EMERGENCY CONTACT PERSON NAME

ADDRESS

CITY

STATE

ZIP

PRIMARY PHONE

SECONDARY PHONE

OTHER PHONE

I INDICATE WITH MY PRINTED NAME AND SIGNATURE BELOW THAT I HAVE READ, UNDERSTAND AND ACCEPT THE ABOVE STATEMENTS ON EMERGENCY CARE:

PATIENT PRINTED NAME

PATIENT SIGNATURE

DATE

YOUR HEALTH HISTORY

NAME (LAST, FIRST)	DATE OF BIRTH	TODAYS DATE
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FEMALES – DATE OF LAST MENSTRUAL PERIOD (IF APPLICABLE)

CURRENT MEDICATIONS - COMPLETE THE CHART BELOW FOR ALL CURRENT MEDICATIONS AND INCLUDE ANY HERBAL MEDICATIONS OR OVER-THE COUNTER MEDICATIONS. ATTACH AN ADDITIONAL LIST IF NEEDED.

MEDICATIONS: PLEASE INDICATE IF YOU TAKE ANY OF THE FOLLOWING MEDICATIONS (CHECK ALL THAT APPLY)

NONE
 AGGRENOX
 ASPIRIN
 COUMADIN
 EFFIENT
 HEPARIN
 LOVENOX
 PLAVIX
 PRADAXA
 TICLID
 ANTI-INFLAMMATORY DRUGS
 OTHER BLOOD THINNERS (*please describe*)

Please specify dosage below

MEDICATION	DOSAGE	FREQUENCY OF DOSAGE	PRESCRIBING PHYSICIAN

YOUR PHARMACY (If Applicable)

PHARMACY NAME	LOCATION	PHONE #
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ALLERGIES: INDICATE IF YOU HAVE ALLERGIES TO ANY OF THE FOLLOWING MEDICATIONS AND/ OR FOODS (CHECK ALL THAT APPLY)

NONE
 ASPIRIN
 CODEINE
 ERYTHROMYCIN
 HYDROCODONE
 IODINE
 LATEX
 MORPHINE
 MOTRIN/NSAIDS
 PENICILLIN
 SULFA
 TETRACYCLINE
 KEFLEX/CEPHALOSPORIN
 OTHER (*please describe*): _____

DESCRIBE YOUR ALLERGIC REACTION(S) TO THE ABOVE CHECKED MEDICATIONS AND/OR FOODS:

PLEASE COMPLETE THE CHART BELOW IF YOU HAVE HAD ANY OF THE FOLLOWING TESTS FOR YOUR CURRENT PAIN

X-RAY FILM, CT SCAN, MRI, EMG/NERVE STUDIES

TEST PERFORMED	DATE	FACILITY WHERE TEST WAS PERFORMED	RESULTS

IMPORTANT: PLEASE BRING ALL REPORTS INCLUDING X-RAYS, CT SCANS, MRIS, LABORATORY, EMGS, DISCOGRAM, MYELOGRAM AND/OR ANY RELATED RESULTS TO YOUR FIRST APPOINTMENT. **PLEASE ONLY BRING REPORTS** - FILMS ARE NOT NECESSARY UNLESS SPECIFICALLY REQUESTED.

YOUR FAMILY HISTORY

IS THERE A HISTORY OF DIABETES IN YOUR FAMILY? <input type="checkbox"/> YES <input type="checkbox"/> NO	RELATIONSHIP
IS THERE A HISTORY OF HEART DISEASE IN YOUR FAMILY? <input type="checkbox"/> YES <input type="checkbox"/> NO	RELATIONSHIP
IS THERE A HISTORY OF CHRONIC PAIN IN YOUR FAMILY? <input type="checkbox"/> YES <input type="checkbox"/> NO	RELATIONSHIP

NAME (LAST, FIRST)		DATE OF BIRTH	TODAYS DATE
YOUR HABIT HISTORY			
DO YOU USE ALCOHOL? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, HOW MUCH & HOW OFTEN?	
DO YOU USE TOBACCO? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> QUIT		DATE OF LAST TOBACCO USE IF QUIT	
WHAT TYPE OF TOBACCO DO YOU USE? <input type="checkbox"/> CIGARETTE <input type="checkbox"/> CIGAR <input type="checkbox"/> CHEWING/SNUFF <input type="checkbox"/> OTHER			
HOW OFTEN DO YOU USE TOBACCO?	NUMBER (I.E. PACKS)	PER (I.E. WEEK)	
DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE? <input type="checkbox"/> YES <input type="checkbox"/> NO (PLEASE EXPLAIN)			

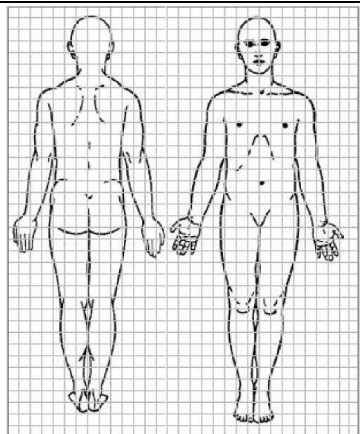
MEDICAL HISTORY (CHECK ALL THAT APPLY)					
<input type="checkbox"/>	ARTHRITIS (OSTEO OR RHEUMATOID)	<input type="checkbox"/>	FIBROMYALGIA	<input type="checkbox"/>	NEUROLOGIC PROBLEMS
<input type="checkbox"/>	ASTHMA/LUNG DISEASE	<input type="checkbox"/>	HEADACHES/MIGRAINES	<input type="checkbox"/>	PANCREATITIS
<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	HEART DISEASE	<input type="checkbox"/>	PERIPHERAL VASCULAR DISEASE
<input type="checkbox"/>	BLEEDING DISORDER	<input type="checkbox"/>	HEPATITIS	<input type="checkbox"/>	SEIZURES
<input type="checkbox"/>	CANCER (TYPE _____)	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	STROKES/TIAS
<input type="checkbox"/>	DIABETES <input type="checkbox"/> INSULIN OR <input type="checkbox"/> NON-INSULIN	<input type="checkbox"/>	KIDNEY DISEASE	<input type="checkbox"/>	THYROID DISEASE
<input type="checkbox"/>	DVT/PULMONARY EMBOLISM	<input type="checkbox"/>	LUPUS	<input type="checkbox"/>	TREATMENT FOR DEPRESSION OR ANXIETY
<input type="checkbox"/>	EASY BRUISING/BLEEDING	<input type="checkbox"/>	MULTIPLE SCLEROSIS	<input type="checkbox"/>	ULCERS
<input type="checkbox"/>	SLEEP APNEA	ON AVERAGE, HOW MANY HOURS OF SLEEP DO YOU GET/ NIGHT? (_____)			
<input type="checkbox"/>	OTHER: _____				

CURRENT LEVEL OF PAIN	
WHAT IS YOUR PAIN LEVEL TODAY? MINIMAL <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 SEVERE	
DESCRIBE THE LOCATION AND CHARACTERISTICS OF YOUR PAIN	
HOW LONG HAVE YOU HAD THIS PAIN? (APPROXIMATE DATE)	
WHAT MAKES THE PAIN FEEL BETTER?	WHAT MAKES THE PAIN FEEL WORSE?

ON THE DRAWING TO THE RIGHT, MARK THE AREAS WHERE YOU FEEL THE PAIN AND INDICATE WITH AN **E** IF THE PAIN IS EXTERNAL, **I** IF THE PAIN IS INTERNAL OR **EI** IF THE PAIN IS BOTH EXTERNAL AND INTERNAL NEXT TO THOSE AREAS. INDICATE ANY AREAS OF NUMBNESS WITH A LETTER **X**

HAVE YOU EVER BEEN SEEN AND / OR TREATED BY A PAIN MANAGEMENT SPECIALIST?

YES NO



NAME (LAST, FIRST)		DATE OF BIRTH		TODAYS DATE	
YOUR SOCIAL HISTORY					
WHAT IS YOUR OCCUPATION?		<input type="checkbox"/> PART-TIME <input type="checkbox"/> PERMANENT <input type="checkbox"/> RETIRED <input type="checkbox"/> CURRENTLY WORKER'S COMP			
ARE YOU DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		WHAT IS YOUR MARITAL STATUS? <input type="checkbox"/> SINGLE <input type="checkbox"/> SEPARATED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED			
WHAT IS YOUR HIGHEST LEVEL OF EDUCATION?					
ARE YOUR FAMILY & FRIENDS SUPPORTIVE OF YOUR CHRONIC PAIN SITUATION? <input type="checkbox"/> YES <input type="checkbox"/> NO					
WHO IS YOUR MAIN SUPPORT PERSON?					
PLEASE DESCRIBE THE MEDICAL CARE YOU EXPECT TO RECEIVE DURING YOUR TREATMENT HERE					
PLEASE NOTE ANY ADDITIONAL INFORMATION WE MAY NEED TO KNOW TO PROVIDE MEDICAL CARE					
SURGERY - PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING (CHECK ALL THAT APPLY)					
<input type="checkbox"/>	ADENOIDECTOMY	<input type="checkbox"/>	EXPLORATORY LAPAROTOMY	<input type="checkbox"/>	LUMBAR FUSION
<input type="checkbox"/>	APPENDECTOMY	<input type="checkbox"/>	FOOT SURGERY	<input type="checkbox"/>	LUMBAR LAMINECTOMY
<input type="checkbox"/>	BREAST AUGMENTATION	<input type="checkbox"/>	GASTRIC BYPASS	<input type="checkbox"/>	PACEMAKER IMPLANT
<input type="checkbox"/>	CARPAL TUNNEL SURGERY	<input type="checkbox"/>	HEART SURGERY	<input type="checkbox"/>	PROSTATE SURGERY
<input type="checkbox"/>	CATARACT SURGERY	<input type="checkbox"/>	HERNIA REPAIR	<input type="checkbox"/>	SHOULDER ARTHROSCOPY
<input type="checkbox"/>	CERVICAL FUSION	<input type="checkbox"/>	HIP REPLACEMENT	<input type="checkbox"/>	SPINAL CORD STIMULATION IMPLANT
<input type="checkbox"/>	CESAREAN SECTION	<input type="checkbox"/>	HYSTERECTOMY	<input type="checkbox"/>	TONSILLECTOMY
<input type="checkbox"/>	CHOLECYSTECTOMY (GALL BLADDER)	<input type="checkbox"/>	INTRATHECAL PUMP IMPLANT	<input type="checkbox"/>	TUBAL LIGATION
<input type="checkbox"/>	CYSTECTOMY	<input type="checkbox"/>	KNEE ARTHROSCOPY	<input type="checkbox"/>	WRIST SURGERY
<input type="checkbox"/>	ELBOW SURGERY	<input type="checkbox"/>	KNEE REPLACEMENT	<input type="checkbox"/>	OTHER _____
HAVE YOU BEEN IMMUNIZED AGAINST THE FLU?			HAVE YOU BEEN IMMUNIZED AGAINST PNEUMONIA?		
<input type="checkbox"/>	YES, DATE _____	<input type="checkbox"/>	NO, REFUSED	<input type="checkbox"/>	YES, DATE _____
		<input type="checkbox"/>		<input type="checkbox"/>	NO, REFUSED

NAME (LAST, FIRST)	DATE OF BIRTH		TODAYS DATE		
SOAPP® - R					
PLEASE ANSWER EACH QUESTION AS HONESTLY AS POSSIBLE. THERE ARE NO RIGHT OR WRONG ANSWERS.	NEVER	SELDOM	SOMETIMES	OFTEN	VERY OFTEN
HOW OFTEN DO YOU HAVE MOOD SWINGS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE YOU FELT A NEED FOR HIGHER DOSES OF MEDICATION TO TREAT YOUR PAIN?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE YOU FELT IMPATIENT WITH YOUR DOCTORS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE YOU FELT THAT THINGS ARE JUST TOO OVERWHELMING THAT YOU CAN'T HANDLE THEM?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN IS THERE TENSION IN THE HOME?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE YOU COUNTED PAIN PILLS TO SEE HOW MANY ARE REMAINING?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE YOU BEEN CONCERNED THAT PEOPLE WILL JUDGE YOU FOR TAKING PAIN MEDICATION?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN DO YOU FEEL BORED?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE YOU TAKEN MORE PAIN MEDICATION THAT YOU WERE SUPPOSED TO?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE YOU WORRIED ABOUT BEING LEFT ALONE/	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE YOU FELT A CRAVING FOR MEDICATION?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE OTHERS EXPRESSED A CONCERN OVER YOUR USE OF MEDICATION?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE ANY OF YOUR CLOSE FRIENDS HAD A PROBLEM WITH ALCOHOL OR DRUGS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE OTHERS TOLD YOU THAT YOU HAD A BAD TEMPER?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE YOU FELT CONSUMED BY THE NEED TO GET PAIN MEDICATION?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE YOU RUN OUT OF PAIN MEDICATION EARLY?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE OTHERS KEPT YOU FROM GETTING WHAT YOU DESERVE?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN, IN YOUR LIFETIME, HAVE YOU HAD LEGAL PROBLEMS OR BEEN ARRESTED?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE YOU ATTENDED AN AA OR NA MEETING?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE YOU BEEN IN AN ARGUMENT THAT WAS SO OUT OF CONTROL THAT SOMEONE GOT HURT?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE YOU BEEN SEXUALLY ABUSED?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE OTHERS SUGGESTED THAT YOU HAVE A DRUG OR ALCOHOL PROBLEM?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE YOU HAD TO BORROW PAIN MEDICATIONS FROM YOU FAMILY OR FRIENDS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOW OFTEN HAVE YOU BEEN TREATED FOR AN ALCOHOL OR DRUG PROBLEM?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OFFICE ONLY: add columns

TOTAL

NAME (LAST, FIRST)	DATE OF BIRTH	TODAYS DATE		
PHQ - 9				
OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS? (CHECK TO INDICATE YOUR ANSWER	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
LITTLE INTEREST OR PLEASURE IN DOING THINGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FEELING DOWN, DEPRESSED, OR HOPELESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TROUBLE FALLING OR STAYING ASLEEP, OR SLEEPING TOO MUCH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FEELING TIRED OR HAVING LITTLE ENERGY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
POOR APPETITE OR OVEREATING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FEELING BAD ABOUT YOURSELF – OR THAT YOU ARE A FAILURE OR HAVE LET YOURSELF OR YOUR FAMILY DOWN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TROUBLE CONCENTRATING ON THINGS, SUCH AS READING THE NEWSPAPER OR WATCHING TELEVISION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MOVING OR SPEAKING SO SLOWLY THAT OTHER PEOPLE COULD HAVE NOTICED. OR THE OPPOSITE – BEING SO FIGETY OR RESTLESS THAT YOU HAVE BEEN MOVING AROUND A LOT MORE THAN USUAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THOUGHTS THAT YOU WOULD BE BETTER OFF DEAD, OR OF HURTING YOURSELF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OFFICE ONLY: add columns _____

TOTAL _____

IF YOU CHECKED OFF ANY PROBLEMS, 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	<input type="checkbox"/>
	SOMEWHAT DIFFICULT	<input type="checkbox"/>
	VERY DIFFICULT	<input type="checkbox"/>
	EXTREMELY DIFFICULT	<input type="checkbox"/>