ADVANCED PAIN INSTITUTE & COMPREHENSIVE NEUROLOGICAL SOLUTIONS
TOGETHER, EASING PAIN & ENHANCING LIVES

New Patient Medical Questionnaire

The purpose of this questionnaire is to obtain a thorough understanding of your medical status. Please accurately answer these routine questions before your appointment time. This will result in more time allotted to your actual visit with the physician. We will not be able to see you in a timely manner without a completed questionnaire.

Patient's Full Name: _____ **Date of Birth:** _____

Physical Address: _____

Other Address (if applicable):_____

How did you hear about us? _____ **SS #**:_____

Home Phone: _____ **Other Phone:** _____

Email:_____

Do we have permission to communicate via: **Voicemail**? YES or NO **Email?** YES OR NO

Primary Care Physician/Referring Physician: _____

SOCIAL HISTORY

Employment Status: Disabled Retired Full-time Part- time Unemployed

What is your occupation: _____**If none, previous occupation:** _____

Race: African American/Black Caucasian/White Hispanic/Latino Other

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Other

Relationship: Single Married Divorced Separated Other

Highest Grade Level Completed: _____

Physical Activity: ___**Light** ___**Moderate** ___**Vigorous** ___**Sedentary**

Military Experience: ___**No** ___**Yes** **If yes, explain:** _____

What is your Age? _____ **Weight?** _____**Height?**_____

Patient Initials: _____ Date:_____

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Sexually Active: ___**No** __**Yes**

Current Smoker: ___No ___Yes If yes, how many packs per day? _____

Former Smoker: ___No ___Yes If yes, when did you quit smoking? _____

Do you drink alcohol? ___Yes ___No If yes, how often? _____

Do you have any disabilities? ___Yes ___No If yes, what kind? _____

If yes, what is your preferred method of communication? _____

ALCOHOL/ DRUG ABUSE

Have you ever abused any of the following:

Alcohol ___Yes ___No **Prescription Drugs (including amphetamines, benzodiazepines, barbiturates, codeine, Demerol, or Morphine)? ___Yes ___No**

If yes, what kind? _____

Have you ever used illegal drugs? ___Yes ___No If yes, what kind? _____

ILLEGAL DRUG USE

Do you use or have you ever used any of the following illegal drugs: Circle YES or NO

Marijuana YES or NO **LSD** YES or NO **Cocaine** YES or NO

Heroin YES or NO **PCP** YES or NO **Ecstasy** YES or NO

Inhalants YES or NO **Crack** YES or NO **Crank** YES or NO

Methamphetamines YES or NO

Have you ever been treated by another Pain Management provider?

___Yes ___No If yes, whom and when? _____

ALLERGIES

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Medication Allergies:

_____

Other Allergies: _____

PAST MEDICAL HISTORY

____High blood pressure/Hypertension

____Diabetes

____High Cholesterol

____Heart Disease

____Seizure/Epilepsy

____Thyroid Disease

____Headaches/Migraines

____Cancer What Kind? _____

____Stroke

____ Peptic Ulcer Disease (PUD)

____Degenerative Disc Disease

____Hepatitis C

____HIV/AIDS

____Irregular Heartbeat

____Parkinson's Disease

____Arthritis

____Kidney Disease

____Asthma

____COPD

____Multiple Sclerosis

____Alzheimer's/ Dementia

____GERD

FAMILY HISTORY (Please indicate M-MOTHER, F-FATHER, S-SISTER, OR B-BROTHER)

____High Blood Pressure

____High Cholesterol

____Seizure/ Epilepsy

____Migraine/Headaches

____Muscular Dystrophy

____Multiple Sclerosis

____Other Explain:_____

____Diabetes

____Heart Disease

____Cancer

____Stroke

____Parkinson's Disease

____Alzheimer's Dementia

Patient Initials: _____ Date:_____

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SURGICAL HISTORY

Please list all major surgeries with dates:

_____

_____

_____

MEDICATIONS AND DOSAGE

MEDICATION	DOSE	# TAKEN PER DAY

Where is your pain located? _____

Patient Initials: _____ Date:_____

Advanced Pain Institute

Acknowledgement of Receipt of Notice of Privacy Practices

Advanced Pain Institute reserves the right to modify the privacy practices outlined in the notice.

I acknowledge that I have received a copy of the Notice of Privacy Practices for Advanced Pain Institute.

_____
Print Patient Name

_____ _____
Signature of Patient/Patient Representative Date

_____
Relationship to Patient

Release of Information

Persons whom I give permission to disclose any medical or billing information regarding my care (spouse, family, friends, etc..)

_____
Name of person/ Relationship

_____
Name of person/ Relationship

_____
Name of person/ Relationship

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (Last, First, Middle)		DOB
ADDRESS	SSN	
CITY	STATE	ZIP

PROVIDER AUTHORIZED TO RELEASE THE PHI:	ENTITY RECEIVING THE PHI:
Name Address City Phone: Fax:	ADVANCED PAIN INSTITUTE & COMPREHENSIVE NEUROLOGICAL SOLUTIONS TOGETHER, EASING PAIN & ENHANCING LIVES 42131 Veterans Ave., Ste 100 Hammond, LA 70403 Phone: 985-345-7246 Fax: 985-345-7249

This authorization will expire on the following date or event. If date or event is not indicated, authorization will expire 12 months from date signed.

Date: Event:

Purpose of this Disclosure:

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

Description	Start Date	End Date
☐ All PHI in the record		
☐ Progress Notes		
☐ Laboratory Tests		
☐ X-Ray Tests / Reports		
☐ History and Physical Examination		
☐ Discharge Summary		
☐ Consultation Reports		
☐ Itemized Billing Statement		
☐ Other:		

The following information will be released when included in the above information unless you indicate otherwise:

[ ] AIDS or HIV test results
[ ] Alcohol, drug or substance abuse treatment
[ ] Psychiatric or mental care / treatment
[ ] Other (specify):

I UNDERSTAND THAT:

1. I MAY REFUSE TO SIGN THIS AUTHORIZATION AND IT IS STRICTLY VOLUNTARY.
2. MY TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.
3. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF I DO, IT WILL NOT HAVE ANY AFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION.
4. IF THE REQUESTER OR RECEIVER IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AND MAY BE REDISCLOSED.
5. I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.

Signature of Patient:	Date:
Signature of Patient's Representative (if necessary):	Date:
Personal Representative's Relationship to Patient:	

*** There may be a fee charged to process your request ***

Patient Attestation of Condition or Injury

Is your visit today related to an auto or other accident?
Please circle YES or NO
If yes, please provide the date of your accident, the state your accident occurred in and nature of your injuries.
Date of accident:_____State_____
Injury:_____
Do you have an attorney representing you due to this accident?
Please circle YES or NO
If yes, please provide the attorney's name, address and phone#_____
_____

Is your visit today related to an accidental injury or condition on the job? Please circle YES or NO
If yes, please provide the date of your accident, the state your accident occurred in and the nature of your injuries.
Date of accident:_____State_____
Injury:_____
Do you have a workers comp attorney representing you due to this accident? Please circle YES or NO
If yes, please provide the attorney's name, address and phone#_____
_____

If your condition or injury today is accident or work related and you answer no to the above, our provider will not express an opinion about the cause of your condition or injury now, or at a later date. This is known as addressing causation which is very important to your legal case. Payment will be due in full from you.

Patient Name:_____DOB_____

Signature:_____