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:** _____________________

Mailing Address:____

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

Do you have an Advanced Directive in place (Living will and/or Medical Durable Power of attorney)?

______Yes _______No

Primary Care Physician/Referring Physician: ____

Pharmacy____

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

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?______________

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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

_____Diabetes

_____Heart Disease

_____Cancer

_____Stroke

_____Parkinson's Disease

______Alzheimer's Dementia

____Other Explain:____

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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? ____

Have you had any recent imaging? Yes_____ No ________

If yes, where and when______________________________________

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:____

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's Narne

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

Patient Name:	**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 included, authorization will expire 12 months from date signed.

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/Results**		
□ **History and Physical Examination**		
□ **Discharge Summary**		
□ **Consultation Reports**		
□ **Itemized Billing Statements**		
□ **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 AGFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION.
4. IF THE REQUESTOR OR RECEIVER IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PRETECTED BY FEDERAL PRIVACY REGULATIONS AND MY 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 *****