Pain Center

Tennessee Valley Pain Consultants

Our qualified professionals work together as a team to bring you the highest quality treatment. Our goal is to help improve your quality of life with new therapies and advanced treatments that are convenient and less invasive.

_____ _____

Patient's Name

Appointment Day, Date, and Time

□ 3rd Floor Suite_____

□ 4th Floor Suite _____

PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT

You are scheduled to see:

□ **Ronald Collins, MD**	□ **Morris Scherlis, MD**	□ **Roddie Gantt, MD**
□ Moira Hizer, PA	□ Greg Gore, CRNP	□ Jeff McCain, CRNP
□ Morena Dayrit, CRNP	□ Michelle Thornton, CRNP	□ Kristen Bentley, CRNP
□ Suzanne Crocker, CRNP	□ Amy Harbin, CRNP	□ Robbie Sheppard, CRNP
□ Erin Percy, CRNP	□ Hannah Brown, CRNP	□ Ashley Tomlin, CRNP
□ **Thomas Kraus, DO**	□ **Michael Cosgrove, MD**	□ **Clayton Newell, MD**
□ Barb Dulaney, CRNP	□ Betsy Briglia, PA	□ Jennifer Camp, CRNP
□ Lori Lowe, CRNP	□ Katie Otto, CRNP	□ Kinsie Lassauw, CRNP
□ Meredith Belew, CRNP	□ Brook Mansoorov, CRNP	□ Jordan Wasserburger, CRNP
□ Jordan Wasserburger, CRNP	□ Lindsie Hogue, CRNP	
	□ Kirsten Morris, CRNP	

*If you need to **reschedule or cancel** your appointment, our phone line hours are 7:00 a.m. to 4:45 p.m. Please contact us at **(256) 265-7246, option 1** (please listen for the prompt to choose the callback option). Appointments not canceled 24 hours in advance may be subject to no show charges. If you are more than 15 minutes late for your appointment, we may need to reschedule.*

Please complete the information sheets included in this packet. All questions must be answered completely. Please bring the following to your appointment:

1. **New Patient Paperwork**
2. **Valid State Issued ID/Driver's License**
3. **Insurance Cards**
4. **Medical Records** **(MRI, Scans, Doctors Notes) Fax# 256-265-7017**

Failure to provide or bring these records to your new patient evaluation may delay our ability to treat your pain problem.

ALL CO-PAYS ARE DUE AT TIME OF YOUR APPOINTMENT. THESE FEES ARE NON-REFUNDABLE.
TVPC DOES NOT ACCEPT PERSONAL CHECKS FOR CO-PAYS.

Your new patient appointment is for evaluation only and does NOT guarantee any specific treatment options, including narcotic medications. Typically, narcotic pain medication will NOT be prescribed at a patient's first visit.

Pain Center

Tennessee Valley Pain Consultants

201 Governors Drive SW, Huntsville, AL 35801

Dear Patient,

Thank you for choosing Tennessee Valley Pain Consultants and Huntsville Hospital for your care. To help us best care for you, please complete the attached paperwork prior to your visit. This packet is an important part of your initial evaluation and assists in determining course of treatment. Please find helpful information for our office below.

APPOINTMENTS

The clinic office doors are open Monday-Friday, 6:30 am to 5:00 pm. The phone lines are open from 7:00 – 4:45. To schedule or cancel an appointment, please call **(256) 265-7246.**

We will see all patients on an appointment basis and ask that you call in advance so that we may reserve time for you. Appointments not canceled 24 hours in advance may be subject to no show charges. If you are more than 15 minutes late for your scheduled appointment, we may need to reschedule.

In the event you are scheduled for a procedure, you must have an adult driver present at check in. The total procedure time typically takes between 2-4 hours. Please be sure that your driver is aware of this.

EMERGENCY CARE

Call 9-1-1 for any life-threatening emergency and notify our center.

TELEPHONE CALLS

We encourage you to call with questions you may have concerning your healthcare. Please do not duplicate your calls, as it will slow the call back system. Phone consultations are subject to a charge. Phone lines are open Monday-Friday, 7:00 am – 4:45 pm.

PRESCRIPTIONS AND RENEWALS

To refill a prescription, please call **(256) 265-7455.**

All prescriptions and authorizations for renewals should be requested during regular office hours. **PLEASE ALLOW 48 BUSINESS HOURS** for your prescription to be refilled. No prescriptions will be refilled on weekends.

NOTE: Prescription refills are not considered an emergency.

INSURANCE

Health insurance is intended to cover some but not all of the cost of your treatment. Most plans include co-payments, deductibles and other expenses, which must be paid by the patient. If your insurance changes at any time, please notify our office.

ABOUT YOUR BILL

As services are provided, you will be billed by the following entities: Huntsville Hospital and Tennessee Valley Pain Consultants. Please see the breakdown of billing below.

Huntsville Hospital:

You will be billed for supplies, X-rays (C-Arm), Medications, Psychological Services, Facility Charges or Physical Therapy. If lab work or any additional X-Rays are performed, there will be a separate charge.

Tennessee Valley Pain Consultants:

You will receive a bill from this group in association with clinic visits, follow-up visits, procedures, counseling sessions and anesthesia services.

We look forward to caring for you at your upcoming appointment!

The following information is a copy of information you will sign electronically in the clinic. This information is for your personal records and do not require a signature on paper.

Patient Copy

MEDICARE INSURANCE ASSIGNMENT STATEMENT TO PERMIT PAYMENT OF MEDICAL INSURANCE BENEIFT TO PHYSICIAN

MEDICARE - I certify that the information given by me in applying for payment under the Social Security Act is correct. I request that payment of authorized Medicare benefits be made either to me or on behalf for any services furnished me by or at the Center for Pain Management including physician(s) services. I authorize any holder of medical or other information about me to be released to the Health Care Financing Administration and its agents and any information needed to determine these benefits or benefits for related services.

MEDICAID INSURANCE ASSIGNMENT PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

MEDICAID - I authorize any holder of medical or other information about me to release any information needed for this or any related Medicaid claim to the Medicaid fiscal intermediary, the Medical Services Administration, and/or to any party who may be liable for my Medicaid expenses.

AUTHORIZATION TO RELEASE MEDICAL AND FINANCIAL INFORMATION

I hereby authorize the Center for Pain Management and my physician(s) to release to my insurers, Workman's Compensation Carrier, Social Security Administration, Medicare, Medicaid, other government agencies or any agent of above payer full information including copies of records (including information relating to psychiatric illness, alcohol or drug abuse, HIV testing, AIDS, or infectious diseases) relative to the treatment or examination rendered to me during the period of such medical or surgical care.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to the above named clinic and physician(s) for the benefits payable under the terms of my policy for this period of medical or surgical care.

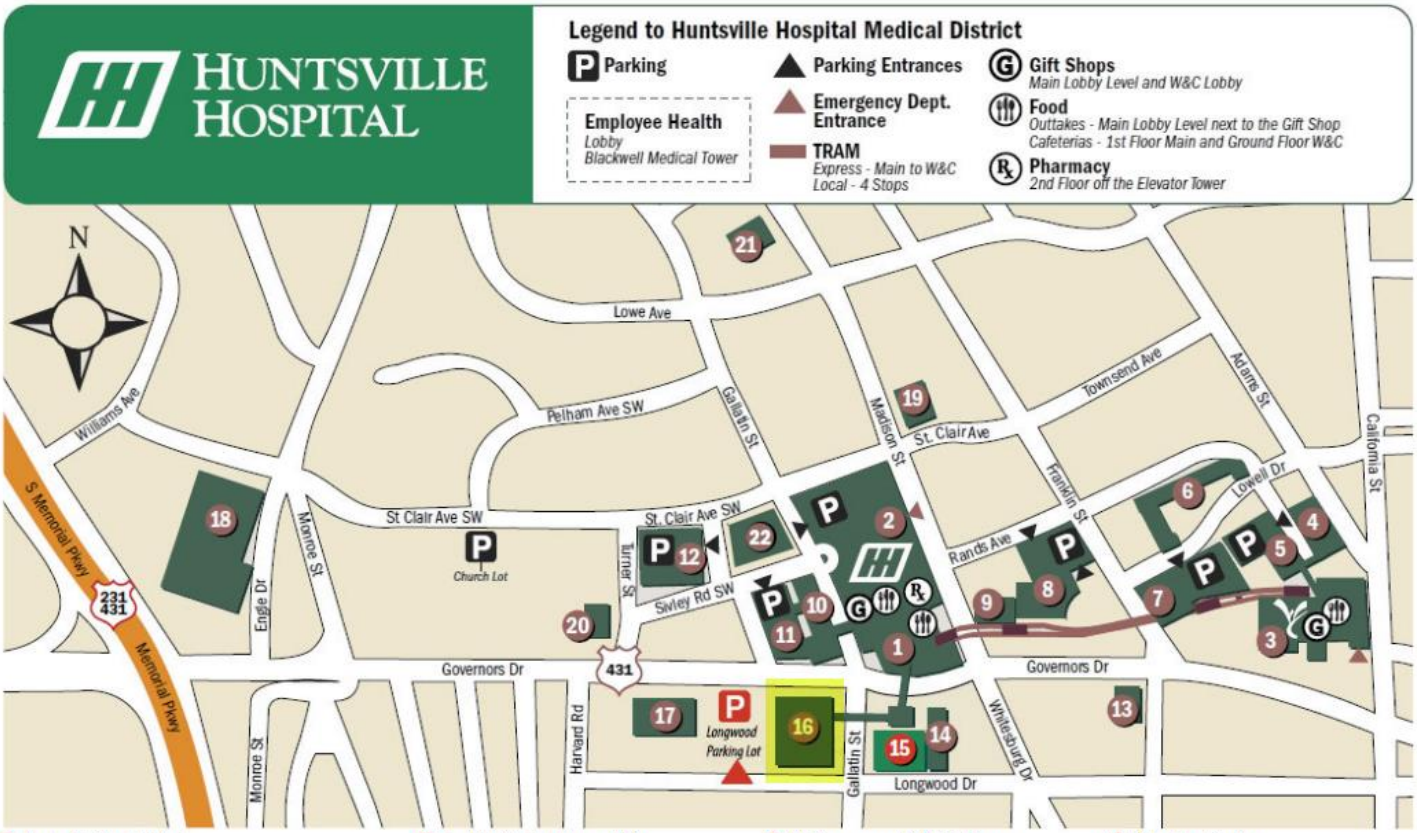
GUARANTEE OF ACCOUNT

For and in consideration of services rendered and to be rendered by the Center for Pain Management, I/we hereby agree to pay and guarantee payment of all charges incurred for the above account and all separate accounts. IN THE CASE OF FAILURE TO MAKE PAYMENT, I agree to pay all costs of collection, including court costs and a reasonable attorney's fee.

Pain Center

Tennessee Valley Pain Consultants

Huntsville Hospital/Medical District



1 Huntsville Hospital Main
2 Emergency Department – Main
3 Huntsville Hospital for Women & Children / Peds ER
4 Women's Pavilion / Breast Center / St. Jude Clinic
5 420 Lowell Office Building
6 401 Lowell
7 Franklin Medical Tower / TOC
8 Heart Center, Inc.
9 Plaza Resource Center
10 Blackwell Medical Tower
11 Blackwell Medical Tower Parking Garage
12 Employee Parking Garage
13 420 Governors / Pediatric Therapy
14 North Alabama Specialty Hospital (NASH)
15 Dowdle Center (Corporate University)
16 Governor's Medical Tower (GMT)
17 UAB – Huntsville Campus
18 Medical Mall
19 Outpatient Services
20 Community Free Clinic
21 Huntsville Hospital Child Care Center
22 Orthopedic & Spine Tower

For questions, please call Security: 265-5666.

Huntsville Hospital Pain Center and Tennessee Valley Pain Consultants (TVPC) are located in the Governor's Medical Tower (GMT) as indicated by the number 16 on the map above. The clinic offices are on the 3rd and 4th floor. Please refer to your appointment information on page 1 for the location of your appointment.

Pain Center

Tennessee Valley Pain Consultants

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Tennessee Valley Pain Consultants

201 Governors Drive Suite 400

Huntsville, AL 35801

Patient Name: _____ Patient Date of Birth: _____

Address: _____ Phone Number: (___) _____

_____

□ Release all records for all dates of service

□ Release records for all dates of service from _____ to present

I authorize the use or disclosure of the above named individual's health information as described below:

1. Tennessee Valley Pain Consultants is authorized to make the disclosure.
2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

☐ Facesheet	☐ Physician Orders	☐ Laboratory Results	Records Release Format
☐ Discharge Summary	☐ Outpatient Record	☐ Imaging Results	☐ e-delivery (Healthport Connect)
☐ History and Physical	☐ Emergency Dept. Record	☐ Bill / Claim Form	☐ CD
☐ Operative Note	☐ EKG Report	☐ Itemized Statement	☐ Paper
☐ Pathology Report	☐ EBC Application	☐ Other_____	
☐ Consultation Report	☐ Autopsy Report		
☐ Progress Notes			

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. This information may be disclosed to, and used by, the following individual or organization:

   Name: TENNESSEE VALLEY PAIN CONSULTANTS

   Address: 201 GOVERNORS DRIVE SUITE 400 HUNTSVILLE ALABAMA 35801

5. For the purpose of _____
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
7. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:

   _____

   If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.
8. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
9. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.
10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

OR

I understand that if I refuse to sign this form, under specific conditions the organization can refuse:
Treatment Enrollment in the Health Plan Eligibility for Benefits

☐ _____

ase indicate relationship to the patier

al Representative: _____ _____ _____

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Please note:
Evaluation and Treatment at HH Pain Center & Tennessee Valley Pain Consultants does not guarantee any specific treatment options including narcotic medications.

Financial Policies

In order to enhance communication and promote understanding regarding this office's financial policies, please read through the following information. After reading, please provide your signature indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment.

- **No Show Fee**: If an appointment is missed without 24 hour notice, a $50.00 fee may be assessed to the patient's account.
- **Forms & Paperwork**: Completed form requests will be subject to a fee. This includes but is not limited to the following forms: Disability Claims/forms, FMLA, Attending Physician forms, Commercial Driver's License forms, FAA forms, etc. We reserve the right to deny any request for form completion.
- **All fees are due at the time of service. These fees are non-refundable.**

Patient Name: _____

Signature: _____ **Date:**_____

Guarantor Name: _____

Guarantor Signature: _____ **Date:**_____

Pain Center

Tennessee Valley
Pain Consultants

HH Pain Center

Tennessee Valley Pain Consultants

HH Pain Center
201 Governors Drive, 4th Floor
Huntsville, AL 35801

DATE_____

PATIENT INFORMATION				
NAME (first, middle, last)	**DATE OF BIRTH**	**AGE**	**SOCIAL SECURITY #**	**GENDER**
MAILING ADDRESS	**APT#**	**CITY, STATE, ZIP**		
EMAIL ADDRESS	**PRIMARY PHONE** **□ HOME** _____ **□ CELL** _____		**OKAY TO LEAVE MESSAGE** **□ YES** **□ NO**	
MARITAL STATUS **□ SINGLE** **□ MARRIED** **□ DIVORCED** **□ WIDOW**				
EMERGENCY CONTACT AND RELATIONSHIP TO YOU			**EMERGENCY CONTACT NUMBER**	
EMPLOYER	**OCCUPATION**		**WORK PHONE**	
WORK ADDRESS			**PERMISSION TO CONTACT AT WORK IF NEEDED** **□ YES** **□ NO**	

GUARANTOR/RESPONSIBLE PARTY (PERSON RESPONSIBLE FOR PAYMENT)		
IS THE INSURANCE IN YOUR NAME □ YES □ NO **IF NO ENTER NAME OF PERSON THAT CARRIES INSURANCE WITH DATE OF BIRTH (DOB) AND SOCIAL SECURITY NUMBER:**	**NAME:**_____ **DOB:**_____ **SOCIAL SECURITY NUMBER:** _____	
INSURANCE	**POLICY NUMBER**	**GROUP NUMBER**
SECONDARY INSURANCE	**POLICY NUMBER**	**GROUP NUMBER**
NAME OF PERSON THAT CARRIES THE SECONDARY INSURANCE	**DATE OF BIRTH OF PERSON THAT CARRIES SECONDARY INSURANCE**	**SOCIAL SECURITY NUMBER OF PERSON THAT CARRIES SECONDARY INSURANCE**

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. IF SOMETHING DOES NOT APPLY, WRITE N/A.

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PATIENT SUMMARY

WHAT IS THE REASON FOR YOUR VISIT TODAY:

WHAT IS YOUR PREFERRED METHOD OF COMMUNICATION?

□ PHONE

□ EMAIL

EMAIL ADDRESS:

CURRENT WEIGHT:

HEIGHT: FT. IN.

HISTORY AND PAIN ASSSESSMENT

LOCATION OF PAIN:

ON A SCALE OF 0-10, WHAT IS YOUR PAIN LEVEL TODAY?

DESCRIBE YOUR PAIN: (CHECK ALL THAT APPLY)

□ ACHING	□ HEAVINESS	□ STINGING
□ BURNING	□ NUMBNESS	□ STABBING
□ CAN'T DESCRIBE	□ PRESSURE	□ TENDERNESS
□ CRAMPING	□ PINS/NEEDLES	□ TINGLING
□ DULL	□ SHARP	□ THROBBING
□ ELECTRIC	□ SHOOTING	□ TWISTING

□ OTHER DESCRIPIVE WORDS NOT LISTED:

HOW AND WHEN DID YOUR PAIN START?

IS THE PAIN ALWAYS THE SAME? □ YES □ NO

IS THIS VISIT WORKERS COMP RELATED? □ YES □ NO

IF YES, DESCRIBE THE ACCIDENT:

ON A SCALE OF 0 – 10, WITH 0 BEING NO PAIN AND 10 BEING THE WORST PAIN IMAGINABLE, WHAT IS YOUR PAIN LEVEL:

ON A GOOD DAY: ON A BAD DAY:

WHAT IS THE TIMING/FREQUENCY OF YOUR PAIN?

RARELY PRESENT

OCCASIONAL

INTERMITTENT

CONSTANT

DO YOU HAVE ANY OF THE FOLLOWING ASSOCIATED WITH YOUR PAIN?

□ WEAKNESS	□ ANXIETY
□ FATIGUE	□ DEPRESSION
□ IRRITABLITY	□ OTHER

AGGRAVATING FACTORS – CHECK ALL THAT APPLY

□ HEAT	□ LYING DOWN	□ STANDING	□ LIFTING
□ COLD	□ QUIET	□ WALKING	□ TWISTING
□ ACTIVITY	□ SITTING	□ MEDICATION	□ OTHER
□ REST	□ BENDING	□ MASSAGE	

ALLEVIATING FACTORS – CHECK ALL THAT APPLY

□ HEAT	□ LYING DOWN	□ STANDING	□ PROCEDURE
□ COLD	□ QUIET	□ WALKING	□ OTHER:
□ ACTIVITY	□ SITTING	□ MEDICATION	
□ REST	□ BENDING	□ MASSAGE	

MEDICATIONS TRIED IN THE PAST FOR PAIN, AND EFFECTIVE WERE THEY (INCLUDING NARCOTICS

AND NON-NARCOTICS)

PREVIOUS PAIN MANAGEMENT TREATMENTS				
INTERVENTION	**DATE**	**LOCATION**		
NERVE BLOCK/INJECTIONS				
EPIDURAL				
PHYSICAL THERAPY				
SURGERY				
PAIN PUMP □ YES □ NO	**TYPE**	**SPINAL CORD STIMULATOR □ YES □ NO**	**TYPE**	

OTHER THERAPIES	
□ TENS UNIT	**□ BIOFEEDBACK**
□ ACCUPUNCTURE	**□ HYPNOSIS**

IMAGING HISTORY (X-RAY, CT SCAN, MRI)		
WHAT IMAGES HAVE YOU HAD IN THE PAST	**DATE OF IMAGES**	**LOCATION WHERE IMAGES WERE DONE**
X-RAY		
MRI		
CT SCAN		
MYELOGRAM		
EMG		
OTHER		

GENERAL INFORMATION

ARE YOU ABLE TO PERFORM ACTIVITIES OF DAILY LIVING WITHOUT ASSISTANCE? □ YES □ NO	**ARE YOU ABLE TO WALK WITHOUT ASSISTANCE OR MEDICAL DEVICE?** □ YES □ NO	**DO YOU HAVE ANY OF THE FOLLOWING LIMITATIONS IN YOUR MOBILITY?**
	IF NO, DO YOU USE ANY OF THE FOLLOWING?	□ NO LIMITATIONS
FAMILY DOCTOR:	□ CANE	□ AMPUTATIONS
	□ WALKER	□ PROSTHESIS
	□ CRUTCHES	□ PARAPLEGIC
REFERRING DOCTOR:	□ WHEELCHAIR	□ QUADRIPLEGIC
	□ BRACES	□ RIGHT □ LEFT HEMIPLEGIC
	□ OTHER	□ PERIPHERAL NEUROPATHY
SENSORY DEFICITS □ NONE □ TOUCH DEFICIT □ BLIND LEFT EYE □ SPEECH DEFICIT □ BLIND RIGHT EYE □ HARD OF HEARING LEFT EAR □ UNCORRECTED VISUAL DEFICIT □ HARD OF HEARING RIGHT EAR □ NON-VERBAL □ OTHER	**SENSORY AIDS** □ GLASSES □ HEARING AID L EAR □ HEARING AID R EAR □ HEARING AID BOTH EARS □ COMMUNICATION BOARD □ OTHER	**DENTAL PROBLEMS** □ NO DENTAL PROBLEMS □ POOR DENTATION □ GUM DISEASE □ MOUTH SORES □ IMPROPER FITTING DENTURES □ OTHER

REVIEW OF SYSTEMS (PLEASE INDICATE ALL THAT APPLY)

GENERAL	RESPIRATORY/LUNG	HEART/VASCULAR	REPRODUCTION
□ WEIGHT CHANGE > 10 LBS	□ STOP BREATHING DURING SLEEP	□ CHEST PAIN/TIGHTNESS	□ BLOOD IN SEMEN/SPERM
□ FEVER	□ SHORTNESS OF BREATH	□ IRREGULAR/RAPID HEART BEAT	□ INABILITY TO HAVE AN ERECTION
□ CHILLS	□ COUGHING UP BLOOD	□ SMOTHERING FEELING AT NIGHT	□ INABILITY TO REACH A CLIMAX
□ FATIGUE	□ WHEEZING	□ ANKLE SWELLING	□ INFERTILITY
□ DIFFICULTY SLEEPING	□ COUGH	□ FAINTING	□ PAINFUL INTERCOURSE
□ RECENT BLOOD TRANSFUSION			□ DECREASED SEXUAL DESIRE
			□ SEXUALLY TRANSMITTED DISEASE
			□ CHILD BEARING AGE
			□ BIRTH CONTROL USAGE
WOMEN	**STOMACH/BOWEL**	**NEUROLOGICAL**	**MUSCULOSKELETAL**
□ BREAST PAIN/LUMPS	□ BLACK/BLOODY STOOL	□ NUMBNESS OR TINGLING	□ GOUT
□ PELVIC PAIN	□ FREQUENT NAUSEA/VOMITING	□ SEVERE FREQUENT HEADACHES	□ BACK PAIN (MAJOR)
□ VAGINAL DISCHARGE	□ FREQUENT HEARTBURN/ACID	□ ABNORMAL COORDINATION	□ NECK PAIN (MAJOR)
□ VAGINAL DRYNESS	□ ABDOMINAL PAIN	□ TROUBLE WITH SPEECH	□ WEAKNESS OF ARM OR LEG
□ FREQUENT SWEATS/HOT FLASHES	□ FREQUENT DIARRHEA	□ FORGETFULLNESS/CONFUSION	□ JOINT SWELLING/STIFFNESS
□ MENSTRUAL PROBLEMS	□ CONSTIPATION	□ DIZZINESS	□ BODY DEFORMITIES
□ MENOPAUSE	□ DIFFICULTY SWALLOWING	□ HEADACHES	□ MUSCLE CRAMPS/SPASMS
□ PREGNANCY PROBLEMS	□ VOMITING BLOOD	□ SEIZURES	□ RESTLESS LEGS
□ BABY WEIGHING 9 LBS OR MORE	□ BOWEL INCONTINENCE		
KIDNEY/BLADDER	**SLEEP**	**NARCOLEPSY**	**SKIN AND HAIR PROBLEMS**
□ URINARY/BLADDER INFECTIONS	□ SNORING	□ VIVID DREAMS	□ CHANGES IN HAIR/HAIR LOSS
□ URINARY INCONTINENCE	□ SLEEP APNEA	□ CATAPLEXY	□ MAJOR SKIN PROBLEMS
□ URINARY HESITANCY	□ POSITIONAL SNORING	□ SLEEP PARALYSIS	□ NON HEALING WOUNDS
□ FREQUENT URINATION	□ DIFFICULTY SLEEPING		□ PERSISTENT RASH
□ URINARY URGENCY			□ CHANGES IN MOLES
□ NIGHT TIME URINATION			
□ PAINFUL/DIFFICULT URINATION			
□ BLOOD IN URINE			
□ DIFFICULTY EMPTYING BLADDER			
HEAD AND NECK	**ENDOCRINE**	**PSYCOLOGICAL/SOCIAL**	**OTHER**
□ VISUAL CHANGES	□ COLD INTOLERANCE	□ FEELING BLUE/DEPRESSION	
□ DIZZINESS	□ HEAT INTOLERANCE	□ HIGH ANXIETY/STRESS	
□ DOUBLE VISION	□ EXCESSIVE THIRST	□ LOSS OF FRIENDS	
□ SINUS PROBLEMS	□ EXCESSIVE HUNGER	□ FEELING LIKE LIFE HAS NO PURPOSE	
□ FREQUENT NOSE BLEEDS	□ EXCESSIVE URINATION	□ FEELING LIKE PEOPLE ARE TALKING ABOUT YOU	
□ EAR PAIN	□ UNUSUAL WEIGHT CHANGE	□ FEELING FEAR	
□ TROUBLE HEARING	□ HYPOTHYROID	□ HEARING VOICES	
□ RINGING IN EARS	□ HYPERTHYROID	□ RELATIONSHIP PROBLEMS	
□ HOARSENESS	□ DIABETES	□ EARLY MORNING WAKENINGS	
□ MOUTH SORES			
□ FREQUENT SWOLLEN GLANDS			
□ SORE THROAT			

FOR WOMEN ONLY:

DATE OF LAST MENSTRUAL PERIOD	ARE YOU PREGNANT □ YES □ NO	ARE YOU LACTATING □ YES □ NO

SOCIAL HISTORY

SMOKING STATUS		
□ CURRENT □ FORMER □ NEVER	CURRENT SMOKER: HOW MANY PACKS PER DAY:_____ YEAR STARTED: _____	FORMER SMOKER: YEARS SMOKED: _____ YEAR STOPPED: _____
SMOKELESS TOBACCO STATUS		
□ CURRENT □ FORMER □ NEVER	CURRENT USER: _____ TYPE: _____ AMOUNT: _____	
ALCOHOL USE STATUS		**HISTORY OF ALCOHOL REHAB:**
□ CURRENT □ FORMER □ NEVER	CURRENT DRINKER: HOW MANY DRINKS PER DAY: ____ TYPE ALCOHOL: _____	□ YES □ NO IF YES, WHEN: _____
SUBSTANCE USE STATUS		**HISTORY OF SUBSTANCE ABUSE REHAB:**
□ CURRENT □ FORMER □ NEVER	TYPE OF SUBSTANCES USED: _____	□ YES □ NO IF YES, WHEN: _____
PERSONAL HISTORY		
MARITAL STATUS: □ SINGLE □ DIVORCED □ MARRIED □ WIDOWED	DO YOU LIVE ALONE: □ YES □ NO	OCCUPATION: _____
ARE YOU DISABLED: □ YES □ NO IF YES, REASON FOR DISABILITY: _____	HIGHEST LEVEL OF SCHOOL COMPLETE: □ GRADE SCHOOL □ SOME COLLEGE □ HIGH SCHOOL □ COLLEGE DEGREE □ GED □ GRADUATE DEGREE	DO YOU EXERCISE: □ YES □ NO IF YES, HOW OFTEN AND WHAT TYPE: _____

FAMILY HISTORY

FAMILY HISTORY (INDICATE WHICH FAMILY MEMBER HAS CONDITIONS LISTED) □ UNKNOWN/ADOPTED							
CONDITION	**FATHER**	**MOTHER**	**BROTHER**	**SISTER**	**SON**	**DAUGHTER**	**OTHER**
ARTHRITIS							
ASTHMA							
BLEEDING PROBLEMS							
CANCER (INDICATE TYPE)							
COPD/LUNG DISEASE							
DIABETES							
FIBROMYALGIA							
HEART DISEASE							
HEPATITIS							
HIGH BLOOD PRESSURE							
HIV/AIDS							
KIDNEY DISEASE							
LIVER DISEASE							
MIGRAINES							
PSYCHIATRIC ILLNESS							
SICKLE CELL							
STROKE							
THYROID DISEASE							
TUBERCULOSIS							
ULCER							
OTHER:							

SURGICAL HISTORY					
SURGERY	YEAR	SURGEON			COMPLICATIONS

MEDICATION ALLERGIES □ YES □ NO LIST ANY KNOWN MEDICATION ALLERGY BELOW		
MEDICATION NAME	REACTION	SEVERITY
		□ MILD □ MODERATE □ SEVERE
		□ MILD □ MODERATE □ SEVERE
		□ MILD □ MODERATE □ SEVERE
		□ MILD □ MODERATE □ SEVERE
		□ MILD □ MODERATE □ SEVERE
		□ MILD □ MODERATE □ SEVERE
		□ MILD □ MODERATE □ SEVERE
		□ MILD □ MODERATE □ SEVERE
		□ MILD □ MODERATE □ SEVERE
LATEX ALLERGY □ YES □ NO		□ MILD □ MODERATE □ SEVERE
ENVIROMENTAL/FOOD ALLERGIES □ YES □ NO LIST ANY KNOWN ENVIRONMENTAL/FOOD ALLERGY BELOW		
SUBSTANCE/FOOD	REACTION	SEVERITY
MEDICATION LIST (LIST ALL MEDICATIONS YOU AR		RENTLY TAKING. INCLUDE VITAMINS, HERBALS,

AND OVER THE COUNTER MEDICATIONS)			
MEDICATION NAME	DOSAGE	FREQUENCY	REASON FOR TAKING

CURRENT PHARMACY NAME	PHARMACY ADDRESS	PHARMACY PHONE NUMBER

HH Pain Center

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HEALTH HISTORY		
ARE YOU TAKING BLOOD THINNERS □ YES □ NO	ARE YOU TAKING GLP-1 Medications □ YES □ NO	IF YES, INDICATE MEDICATION BELOW WITH DATE OF LAST DOSAGE TAKEN

MEDICATION NAME	DATE OF LAST DOSE TAKEN	MEDICATION NAME	DATE OF LAST DOSE TAKEN
□ ASPRIN		□ GLP-1 Medications	
□ PLAVIX		□ Semaglutide – including compounded Semaglutide	
□ COUMADIN		Examples: Ozemptic, Rybelsus, Wegovy	
□ XARELTO		□Tirzepatide – including compounded Tirzepatide	
□ OTHER		Examples: Zepbound, Mounjaro	

ARE YOU CURRENTLY ON:	HAVE YOU HAD ANY RECENT:	DO YOU HAVE:
□ STEROIDS	□ SURGERIES	□ PACEMAKER
□ ANTIBIOTICS	□ PROCEDURES	□ METALLIC FRAGMENT
□ CHEMOTHERAPY	□ DENTAL WORK	□ ANEURSYM CLIP OR COIL
		□ FOREIGN BODY

HAVE YOU EVER HAD PROBLEMS WITH SEDATION OR GENERAL ANESTHESIA	□ YES □ NO	IF YES, EXPLAIN:
DO YOU HAVE A FAMILY HISTORY OF PROBLEMS WITH ANESTHESIA	□ YES □ NO	IF YES, EXPLAIN:

MEDICAL HISTORY (INDICATE ALL THAT APPLY)			
□ ASTHMA	□ HIGH BLOOD PRESSURE	□ CANCER (TYPE)	□ LIVER DISEASE
□ COPD/LUNG DISEASE	□ HEART DISEASE	□ ARTHRITIS	□ KIDNEY DISEASE
□ TUBERCULOSIS	□ STROKE	□ DIABETES	□ THYROID DISEASE
□ HIV/AIDS	□ BLEEDING PROBLEMS	□ HEPATITIS	□ ULCERS
□ MIGRAINES	□ SICKLE CELL	□ CHRONIC FATIGUE	□ FIBROMYALGIA
□ PSYCHIATRIC ILLNESS	□ OTHER		

Pain Center

Tennessee Valley Pain Consultants

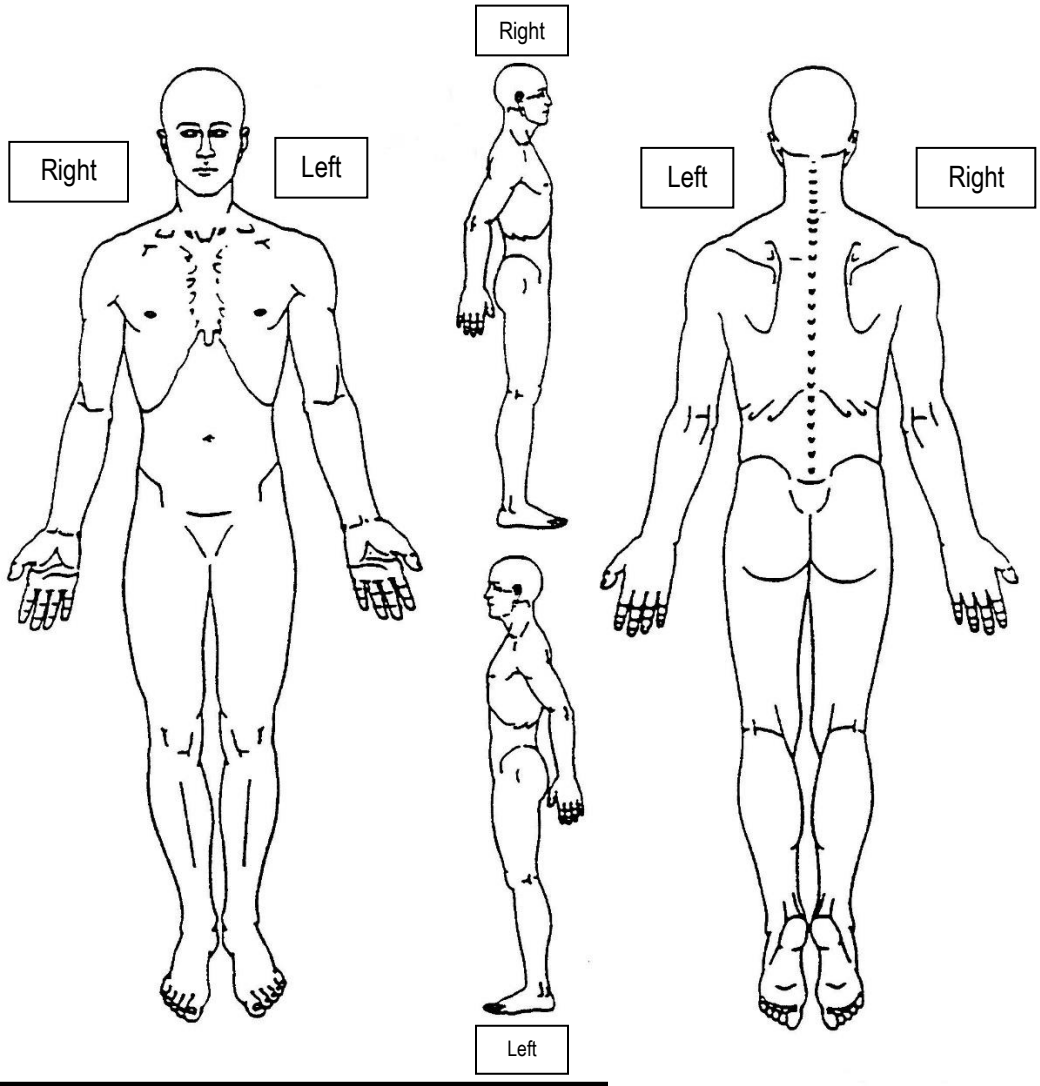
PAIN DIAGRAM

Rate the severity of your pain by circling one box on the following scale:

0(none)	1	2	3	4	5	6	7	8	9	10(worst)

On the diagrams below, mark where you are experiencing pain right now. Use the letters below to indicate the type and location of your sensations:

A – Ache B – Burning N – Numbness P – Pins and Needles S – Stabbing O – Other



For Office Use Only:

MRI Scan result: _____

_____

Previous Block Result Improvement: 25%, 50%, 75%, 100%

Duration of Improvement: 1 month, 2 months, 3 months

Improved function: Yes or No

Patient Label