The Joint and Spine Pain Center

Medical Director
Benjamin Johnson, MD

980 Professional Park Dr. Ste. C
Clarksville, TN 37040
Phone: 931-919-3813
Fax: 931-919-4279
www.paincenterclarksville.com

Julia Doss, FNP-C
Brian Wills, PA-C
Brandi Holt, FNP-C

Date: _____

(USE BLACK INK ONLY)

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (Middle) _____
Birth/Maiden Name: _____ Male ___ Female ___ SS# _____ Single__Married__Divorced__Widowed__
Birth Date: ___/___/___ Race: Caucasian__African American__Hispanic__Asian__Other_____ Language _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____ Preferred Appointment Reminder: Home ___ Cell ___ Work ___
Preferred Pharmacy: _____ Pharmacy City and Phone: _____
Patient's Employer: _____ Occupation: _____

RESPONSIBLE PARTY (BILL TO) INFORMATION

** COMPLETE THIS SECTION ONLY IF SOMEONE OTHER THAN THE PATIENT IS FINANCIALLY RESPONSIBLE **

Bill To: (Last) _____ (First) _____ (Middle) _____ Male __ Female__
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
SS#: _____ Relationship to Patient: _____ Birth Date: ___/___/___ Age: ____
Name of Employer: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

REFERRAL INFORMATION

Who referred you to our office? _____ Who is your Primary Care Physician? _____
Primary Care Physician City and Phone #: _____

INSURANCE INFORMATION

Primary Insurance Co: _____ Group # _____ Policy # _____
Policy Holder: _____ SS#: _____ Birth Date: ___/___/___ Relationship to Patient: _____
Secondary Insurance Co: _____ Group # _____ Policy # _____
Policy Holder: _____ SS#: _____ Birth Date: ___/___/___ Relationship to Patient: _____

Worker's Compensation Company: _____ Claim #: _____
Contact Information: _____ Phone#: _____

Our office will file insurance for all reimbursable services to both primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts for the date of service you are seen. I agree to pay all costs of collections including legal fees, collection fees, and contingent fees to collection agencies of not less than 35% such contingency fees to be added and collected by the collection agency immediately upon default and referral of my account to said agency. I authorize the release of any medical information necessary to process my claim (s). I authorize payment (s) of medical and surgical benefits to The Joint and Spine Pain Center.

Signature: _____ **Date:** _____
Signature of Patient or Responsible Party

MEDICAL HISTORY

Patient Name_____
Height_____ Weight_____

Check all the surgeries you have had:

___Appendectomy ___Gallbladder ___Hysterectomy ___Spine Surgery
___C-Section ___Heart ___Joint Surgery ___Tonsillectomy
___Other_____

Have you had your flu shot? ___*Yes* ___*No If yes, when?*_____ *Where?*_____

FAMILY HISTORY

Check all health problems your immediate family have had and list that relative:
__High Blood Pressure _____ __Cancer_____ __Heart Attack_____

SOCIAL HISTORY

Do you smoke: Yes_____No_____ If yes, how many packs a day:_____
Are you a former smoker: Yes_____ No_____ If yes, how long ago:_____
Do you drink alcohol: Yes_____ No_____ If yes, how many drinks per day:_____
Have you been treated for alcohol, illegal drug use, or prescription drug abuse: Yes_____ No_____
When:_____
Are you currently in pain management: Yes_____ No_____
If yes, who is your treating pain management physician:_____

MEDICATIONS

List all medications, dosage, and frequency you are currently taking:

Name	Dosage	How Often	Name	Dosage	How Often

ALLERGIES

Are you allergic to: Latex_____ Tape_____Betadine_____
List all medication and/or food you are allergic to and your reaction:
_____

REVIEW OF SYSTEMS-Check all that apply

Dizziness	___	Kidney Problems	___	High Blood Pressure	___
Seizures	___	Kidney Stones	___	Diabetes	___
Stroke	___	Joint Pain	___	Cancer	___
Chest Pain	___	Joint Stiffness	___	Hepatitis	___
Heart Failure	___	Joint Swelling	___	HIV	___
Irregular Heartbeat	___	Difficulty Walking	___	Emphysema	___
Shortness of Breath	___	Taking Blood Thinners	___	Heart Burn/Reflux	___
Heart Attack	___	Blood Clot in Legs	___	Blood in Stool	___
Sleep Apnea	___	Night Sweats	___	Stomach Pain	___
CPAP Machine	___	Loss of Appetite	___		
Asthma	___	Fatigue	___		

The Joint and Spine Pain Center

Patient Questionnaire

Where is your pain?_____
Was the pain initiated by an injury? What cause the pain to start?_____
How long has the pain been there?_____
Is it constant?_____
Rate the pain on a scale of 0-10 with 0=no pain and 10=the worst imaginable pain._____
What kind of activity worsens the pain?_____
What positions worsens your pain?_____
What do you do that helps the pain the most?_____
Have you had surgery for this?_____
Did it help?_____
Does you pain ever radiate into other areas (i.e. hands, arms, legs, feet, etc.)?_____

Are there areas of numbness or tingling?_____
Do you have loss of strength?_____

Does anyone take care of you?_____
What things can you not do for yourself?_____

Was the pain work related?_____
What is your work status now?_____
How long have you been unemployed?_____

Have you ever been a patient with a different pain clinic?_____
Have you ever had pain clinic injections in the past?_____
How well did they work?_____

Have you ever had PT/Chiropractor/Massage Therapy?_____
With which group?_____
What kind of treatments did you receive?_____

Have you received psychological support for your pain?_____
With which psycologist?_____
Has it helped?_____
Have you had Biofeedback or Acupuncture?_____
Have they helped?_____

What medications have you tried in the past?_____
What medications and what dose worked the best?_____
What side effects have you had with pain medications?_____

Has pain effected your sleep?_____
Has pain effected your level of energy?_____
Has the pain made you feel depressed?_____
Has the pain made you feel anxious?_____
Has the pain effected your appetite?_____

Do you use alcohol to ease the pain?_____
How much alcohol do you consume?_____
How often do you smoke marijuana?_____
Do you use any other non-prescription medication? (Heroin, Cocaine, etc.)_____
Have you ever been involved in any illegal activity concerning drugs?_____
Have you ever abused medication including alcohol?_____
Do you suffer from post-traumatic stress disorder?_____

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Pain Questionnaire

Primary Painful Body Part:

1. Was there an accident or injury that caused your pain? _____
2. Which area of your body is the primary cause of your pain? _____
3. Is your pain on the right side, left side, or both sides of your body? _____
4. When did your pain first start? _____
5. Did your pain happen suddenly or over time? _____
6. On a scale of 1 – 10, with 10 being the worse, what would you rate your pain? _____
7. How often do you have the pain in that area? _____
8. How long does your pain last once it starts? _____

Circle the words that describe your pain:

Burning Dull Tender Shooting Sharp Nagging Throbbing Pulsing Agonizing Tingling Aching Stabbing Dreadful

Radiating Numbness Pins/Needles

Secondary Painful Body Part:

1. Was there an accident or injury that caused your pain? _____
2. Which area of your body is the primary cause of your pain? _____
3. Is your pain on the right side, left side, or both sides of your body? _____
4. When did your pain first start? _____
5. Did your pain happen suddenly or over time? _____
6. On a scale of 1 – 10, with 10 being the worse, what would you rate your pain? _____
7. How often do you have the pain in that area? _____
8. How long does your pain last once it starts? _____

Circle the words that describe your pain:

Burning Dull Tender Shooting Sharp Nagging Throbbing Pulsing Agonizing Tingling Aching Stabbing Dreadful

Radiating Numbness Pins/Needles

Migraines:

1. Do you have a history of migraines? _____
2. If so, do the migraines trigger nausea or vomiting? _____
3. Is there light or sound sensitivity? _____
4. Are there triggers such as smells or foods? _____
5. Are your migraines straight across the forehead of on one side (which side)? _____
6. Please list all tried and current medications for your migraines: _____

_____

_____

PATIENT HEALTH QUESTIONNAIRE

Only the patient should enter information onto this questionnaire.

Name:_____ Date:_____

Over the last 2 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
	0	1	2	3
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things such as reading the newspaper or watching television				
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				
9. Thoughts that you would be better off dead or of hurting yourself in any way				

Total Score:_____

Interpretation

__Minimal Depression
__Mild Depression
__Moderate Depression
__Moderately Severe Depression
__Severe Depression

Interpretation of Total Score for Depression Severity

1-4 Minimal Depression
5-9 Mild Depression
10-14 Moderate Depression
15-19 Moderately Severe Depression
20-27 Severe Depression

I confirm this information is accurate.

Patient's Initials_____Date:_____

ASSOCIATED SYMPTOMS:

Do you have associated areas of numbness or tingling: Yes___ No___
(If yes, where?)_____

Do you have associated areas of muscle weakness? Yes___ No___
(If yes, where?)_____

Do you have associated skin changes (temperature/sweating/swelling)? Yes___ No___
(If yes, where?)_____

Is there pain? (circle one) Continuous Intermittent(describe)_____

PAST PAIN TREATMENTS (Indicate which treatments you have tried in the past)

Treatments	Check if tried (x)	When? (Year)	Helpful? (Yes/No)
Biofeedback			
Traction			
Braces			
Nerve Blocks			
Physical Therapy			
Hypnosis			
Acupuncture			
Aquatherapy			
Chiropractor			
Ice/Heat			
Narcotics			
Massage			
Religious Counseling			
Psychological Counseling			
TENS			
Surgery			
Relaxation Training			
Other:_____			

Other conditions no listed above:_____

Which treatment from the above list helped you the most?_____

Cancer?
If yes, what type?_____ Date Last Treated:_____

HEALTH BEHAVIORS:

Caffeine? ___Yes ___No	Quit when?	Type	Amt
Smoking? ___Yes ___No	Quit when?	How Long?	PPD
Alcohol? ___Yes ___No	Quit when?	Type	Freq
Drugs? ___Yes ___No	Quit when?	Type	Freq
Pain Meds? ___Yes ___No	Quit when?	Type	Freq

TRAUMA/PSYCHOLOGICAL HISTORY:

MVA ___Yes ___No	Description:
Emotional Abuse ___Yes ___No	Description:
Physical Abuse ___Yes ___No	Description:
Sexual Abuse ___Yes ___No	Description:
Psychological Treatment History ___Yes ___No	Description:

Constitutional	Cardiovascular	Gastrointestinal	Neurologic	Integumentary
__ Fatigue __ Fever __ Chills __ Night Sweats __ Unintentional Weight Gain __ Unintentional Weight Loss	__ Chest Pain __ Shortness of breath __ Shortness of breath while lying down __ Dizziness __ Leg pain with walking __ Waking up short of breath __ Heart fluttering/palpitations __ Irregular heartbeat __ Racing heartbeat __ Swelling of feet __ Varicose veins	__ Abdominal pain __ Acid reflux __ Heartburn __ Decreased appetite __ Difficulty swallowing __ Painful swallowing __ Nausea __ Vomiting __ Vomiting blood __ Bloating __ Constipation __ Diarrhea __ Blood in stool __ Clay-colored stool __ Dark/tar colored stools __Hemorrhoids	__ Poor coordination __ Poor Concentration __ Dizziness __ Fainting __ Headaches __ Memory Loss __ Seizures __ Tremors __ Vertigo __ Weakness	__Abnormal mole __Breast mass/lump __ Skin lesions __ Change in skin color __ Jaundice/Yellow skin __Dry Skin __ Itching __ Rashes

EYES	RESPIRATORY	GENITOURINARY	ENDOCRINE	HEMATOLOGIC
__ Blurred vision __ Eye Drainage __ Eye Pain __ Eye Pain with Sunlight __ Wear Contacts __ Wear Glasses	__ Shortness of breath __ Wheezing __ Chest pain with deep breath __ Chronic cough __ Coughing up blood __ Exposure to tuberculosis __ Sleep Apnea	__ Difficulty urinating __ Change in urine stream __ Incontinence __ Urinating blood __ Excessive urination __ Frequent urination at night __ Frequent infection __Impotence	__ Enlarging hands or feet __ Hair loss __ Heat/Cold intolerance __ Excessive hair growth __History of fractures __ Excessive thirst __ Excessive hunger __Excessive sweating __ Infertility __Thyroid problems __ History of diabetes	__ Easy bruising or bleeding __ Anemia __ History of blood clots __ History of blood transfusion __ Swollen lymph nodes __ Allergic/Immunologic __ Allergic rhinitis __ Asthma __ Seasonal Allergies __ Frequent upper respiratory infections __ Frequent chest colds/Infections __ Food allergies

EAR/NOSE/THROAT	MUSCULOSKELETAL	Psychiatric
__ Ear Pain __ Hearing Problems __ Ringing in ear __ Nose Bleeds __ Nasal Congestion __ Frequent Nasal Drainage __ Bleeding Gums __ Tooth pain __ Wear Dentures __ Hoarse voice __ Sores in mouth __ Sore throat __ Sore tongue	__ Joint Pain __ Joint Stiffness __ Muscle Pain __ Limb Pain __ Back Pain	__ Anxiety __ Depression __ Crying Spells __ Sadness __ Feeling Stressed __ Poor Concentration __ Suicidal Thoughts __Loss of interest in pleasurable activities __ Sleep disturbance

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SOAPP-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	NEVER 0	SELDOM 1	SOMETIMES 2	OFTEN 3	VERY OFTEN 4
1. How often do you have mood swings?					
2. How often have you felt a need for a higher dose of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in the home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					

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MEDICAL CONSENT FORM

This form authorizes the stated person (s) to inquire or receive the information listed.

Name of Patient: _____ Date of Birth: _____

(Patient/Parent/Guardian)

I, _____, give the following individual (s) my permission to inquire and/or receive the indicated information.

Name of Individual	Information to Release (Medical Records, Prescriptions, Appointments, Etc.)
_____	_____
_____	_____
_____	_____

Please check one of the following:

_____ This notice is effective only on the following date (s): _____

_____ This notice is effective indefinitely or until I revoke it myself in writing.

_____

Patient/Parent/Guardian (Print Name)

_____ _____

Patient/Parent/Guardian (Signature) Date

VERBAL CONSENT OBTAINED FROM PATIENT/PARENT/GUARDIAN

Name of Patient/Parent/Guardian: _____

Date: _____

Effective thru: _____ or indefinitely (unless revoked by patient/parent/guardian)

Staff member documenting consent: _____

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CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I, _____, whose signature appears below, authorize The Joint and Spine Pain Center and its affiliated providers to view my external prescription history via the RxHub service.

I understand that prescription history from other multiple unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions from prior years.

My signature certifies that I read and understood the scope of my consent and that I authorize the access.

_____ _____

Patient Signature Date

_____

The Joint and Spine Pain Center Witness Signature

Joint and Spine Pain Center

Urine Lab Testing Procedure Information

Urine Lab Testing

Joint and Spine Pain Center, Clarksville and its providers of care (hereinafter referred to collectively as JSPC) will perform routine URINE DRUG SCREENINGS on all patients who participate in a pain management program which includes regular medication management and drug screening (including alcohol) in addition to referrals for outside injection procedures and other services performed or ordered for the overall treatment of chronic pain. Our drug screening services are charged separately in addition to procedures and office visits, therefore, check with your insurance company regarding your benefits for office visits, procedures, and laboratory services-as benefits for these services may differ, resulting in out of pocket expense (ie: deductible, coinsurance, co-pay) to which the patient will be responsible.

In regard to the urine screening, done via liquid chromatography/dual mass spectrometry, it is extremely unlikely to produce a false positive (much more sensitive and specific than traditional immunoassay tests). Despite being under 100 ng/mL, JSPC accepts ng/mL as cutoff for a likely non-environmental exposure.

I,_____, have read the above information regarding urine drug testing, and consent to having my urine tested for the purpose of managing my treatment and medication.

Privacy Policy Acknowledgement Form

I,_____, have been notified of The Joing and Spine Pain Center's privacy policy which describes my rights concerning my health information. I may view this policy at any time.

Signature of Patient or Patient's Representative	Date
Printed Name and Relationship of Patient's Representative	Date
Signature of The Joint and Spine Pain Center Staff	Date

NAME _____ DOB _____ DATE _____

1. Please rate your pain by circling the number that tells how much pain you have RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10
No pain — Pain as bad as you can imagine

2. Please rate your pain by circling the number that best describes your pain at its WORST over the past month.

0 1 2 3 4 5 6 7 8 9 10
No pain — Pain as bad as you can imagine

3. Please rate your pain by circling the number that best describes your pain at its LEAST over the past month.

0 1 2 3 4 5 6 7 8 9 10
No pain — Pain as bad as you can imagine

4. Please rate your pain by circling the number that best describes your pain on the AVERAGE.

0 1 2 3 4 5 6 7 8 9 10
No pain — Pain as bad as you can imagine

5. On average, how much pain relief have your pain treatments or medications provided? Please circle the percentage that most shows how much RELIEF you have received.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
No relief — Complete relief

6. Circle the number that describes how pain has interfered with your:

a. General Activity

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

b. Mood

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

c. Walking ability

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

d. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

e. Social interactions

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

f. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

g. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

7. Circle the number that best describes how often pain has interfered with your ability to complete each of these activities:

a. Wash dishes

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

b. Yard work/gardening

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

c. Prepare a meal

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

d. Go grocery shopping

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

e. Visit friends/take a trip

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere — Completely interferes

f. Clean the house

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

g. Take a ride in the car

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

Opioid Risk Tool

This tool should be administered to patients upon initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to7 indicates moderate risk for opioid abuse, and score of 8 or higher indicates a high risk for opioid abuse.

The ORT (Opioid Risk Tool) is a brief, self-report screening tool designed for use with adult patients to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of future abusive drug-related behavior. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female patients, but not in non-pain populations.

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
Psychological disease		
ADD, OCD, Bipolar, schizophrenia	2	2
Depresion, Anxiety	1	1
Scoring totals		