

Please rate your pain for the following. 0 is no pain and 10 is the worst pain you have ever felt.

Worst pain during the last month:	0	1	2	3	4	5	6	7	8	9	10
Least pain during the last month:	0	1	2	3	4	5	6	7	8	9	10
Average pain during the last month:	0	1	2	3	4	5	6	7	8	9	10
Current pain, as of this office visit:	0	1	2	3	4	5	6	7	8	9	10

Please check the words that best describe your pain:

- Aching Sharp Penetrating Throbbing Tender Nagging Shooting
 Burning Numb Stabbing Exhausting Miserable Gnawing Tiring
 Unbearable

Does your pain travel anywhere, for example your leg or arm?

- Yes No If yes, where?

Which statement best describes your pain frequency?

- Always present, always same intensity
 Always present, intensity varies
 Usually present, but have short periods without pain
 Often present, but have pain free periods lasting for one to several hours
 Often present, but am pain free for most of the day
 Occasionally present, have pain once to several times per day, lasting minutes to an hour
 Occasionally present for brief periods, a few seconds to a few minutes
 Rarely present, have pain every few days or weeks

What time of day is your pain the worst?

- Early morning Late morning Afternoon Evening Bedtime
 Night Pain is always the same Pain varies, but is not worse at any particular time.

Do you have any of the following associated with your pain. Check all that apply

- Numbness Tingling Increased sweating Coldness Bowel problems
 Muscle spasms, tightness Skin discoloration Weakness Bladder problems

What makes your pain feel worse? Check all that apply

- Sitting Coughing, sneezing Lying down Standing
 Physical activity Sexual activity Walking Other:

What makes your pain feel better? Check all that apply

- Sitting Standing Walking Lying down Heat
 Relaxation Sexual activity Alcohol Nothing Other:

Medications for pain relief:

Before your pain began, did you consider yourself to be:

- Extremely ill 0 1 2 3 4 5 6 7 8 9 10 Perfect health
 Very tired 0 1 2 3 4 5 6 7 8 9 10 Very energetic

Do you feel you are helpless to change your present pain condition?

- Always helpless 0 1 2 3 4 5 6 7 8 9 10 Never helpless
 Very hopeless 0 1 2 3 4 5 6 7 8 9 10 Never hopeless

Since your pain began, overall has it: Increased, Decreased, Stayed the same
Year

When did you first notice your pain?	
Date of injury or accident if different?	
When did you first see a doctor for this pain?	

Under what circumstances did your pain begin?

- Accident at work At work, not accident Following surgery Accident at home
 Pain just began, no reason Following illness Motor vehicle accident Other:

Describe the accident or circumstances:

If injured in motor vehicle accident, please answer the following.

- Driver Passenger Pedestrian Rider Automobile Truck Motorcycle

Details:

Have you seen other physicians for your pain? If yes, please list

Date	Physician	Specialty	Diagnosis/Treatment

What tests have you had done to diagnose your pain? Check all that apply

- X-ray CT scan MRI scan Bone scan Myelogram EMG/NCS
 Other:

Have you had injections for pain relief? Yes No

If yes, please list what type of injection:

How long did pain relief last? None, Few hours, Few days, Few Weeks, Month or more

Have you had any of the following for pain relief? Check all that apply

- Hypnosis Biofeedback Osteopathic Psychotherapy TENS
 Acupuncture Chiropractic Heat therapy Bed rest Physical therapy

How much does your pain interfere with you daily activities?

	Does not interfere	Completely interferes
General Activity:	0 1 2 3 4 5 6 7 8 9 10	
Mood:	0 1 2 3 4 5 6 7 8 9 10	
Walking Ability:	0 1 2 3 4 5 6 7 8 9 10	
Normal Work Routine:	0 1 2 3 4 5 6 7 8 9 10	
Social Activity:	0 1 2 3 4 5 6 7 8 9 10	
Sleep:	0 1 2 3 4 5 6 7 8 9 10	
Enjoyment of Life:	0 1 2 3 4 5 6 7 8 9 10	
Ability to Concentrate:	0 1 2 3 4 5 6 7 8 9 10	
Appetite:	0 1 2 3 4 5 6 7 8 9 10	

Review of systems:

Has you appetite: Increased, Decreased, No change

Has your weight: Increased, Decreased, No change – How much gained/lost? _____

Please check any of the following conditions that you are currently experiencing:

General System:

Weight loss/gain Fever Loss of appetite Fatigue

Skin:

Rash Itching Pigmentation Dry Skin

Allergic/Immunologic

Cancer Season Allergies Immune Deficiency

Ear/Nose/Throat:

Nose Bleeding Hoarse Voice Gingival Bleeding Sinusitis

Trouble Hearing Thyroid Mass Neck Stiffness, pain or tenderness

Head/Eyes

Headaches Vertigo Lightheadedness Tearing

Head Injury Vision Change Double Vision Eye Pain

Respiratory:

Pain with Breathing Shortness of Breath Wheezing Cough

Coughing up Blood Recurring Infections Tuberculosis Night Sweats

Cardiovascular:

Chest Pain Palpitations Fainting Discomfort Breathing While Laying Flat

Difficulty Breathing on Exertion Edema Severe Shortness of Breath at Night, during sleep Heart Murmurs

High Blood Pressure

Gastrointestinal:

Loss of Appetite Trouble Swallowing Abdominal Pain After Eating Heartburn

Nausea/Vomiting Vomiting Blood Jaundice (yellow skin) Constipation

Diarrhea Abnormal Stools Hemorrhoids

Genitourinary (Females):

Urgency Frequency Painful Urinating Blood in Urine

Excessive Urinating Urinary Retention Recurring Infections Kidney Stones

Vaginal Discharge Vaginal Bleeding

Endocrine:

Excessive Thirst Cold Intolerance Goiter Excessive Urinating

Heat Intolerance Excessive Hunger

Musculoskeletal:

Pain Swelling Limited Range of Motion Joint Pain

Weakness Muscle Atrophy Night Cramps

Neurologic:

Seizures Paralysis Incoordination Tremor

Tingling Loss of Memory Sensory of Motor Disturbances Impaired Coordination

Psychiatric:

Depression Hallucinations Suicidal Thoughts Anxiety

Blood/Lymphatic:

Easy Bruising History of Blood Clots Lymphedema Bleeding History

History of Swollen Glands Blood Transfusions

Past Surgical History:

No previous surgeries or hospitalizations

<input type="checkbox"/> Gallbladder Removal	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Spinal Fusion
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Cesarean Section	<input type="checkbox"/> Microdiscectomy
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Other Spine Surgery
<input type="checkbox"/> Other:		

Past Medical History:

No significant past medical history

<input type="checkbox"/> Diabetes:	
<input type="checkbox"/> High Blood Pressure:	
<input type="checkbox"/> Neurological Disease:	
<input type="checkbox"/> Heart Disease:	
<input type="checkbox"/> Respiratory Disease:	
<input type="checkbox"/> Gastrointestinal Disease:	
<input type="checkbox"/> Liver Disease, Hepatitis:	
<input type="checkbox"/> Cancer:	
<input type="checkbox"/> Kidney Disease:	
<input type="checkbox"/> HIV, Infection Disease:	
<input type="checkbox"/> Other:	

Family History:

No known significant family history of heart disease, cancer or other serious illness

Family Member

Health Status or Cause of Death

<input type="checkbox"/> Father	<input type="checkbox"/> Obesity	<input type="checkbox"/> Cancer	<input type="checkbox"/> HTN	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Mother	<input type="checkbox"/> Obesity	<input type="checkbox"/> Cancer	<input type="checkbox"/> HTN	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Sibling	<input type="checkbox"/> Obesity	<input type="checkbox"/> Cancer	<input type="checkbox"/> HTN	<input type="checkbox"/> Diabetes	

Do you have any family members with chronic pain?

No Yes If yes, who? _____

Do you have any family members taking pain medicines on a regular basis?

No Yes If yes, who? _____

Do you have any family members with psychiatric illness?

No Yes If yes, what type of illness? _____

Social History:

How often and how much?

Alcohol Consumption: <input type="checkbox"/> Yes, <input type="checkbox"/> No	
Tobacco Consumption: <input type="checkbox"/> Yes, <input type="checkbox"/> No	
Recreational Drugs: <input type="checkbox"/> Yes, <input type="checkbox"/> No	

Marital Status: Married, Single, Divorced, Widowed, Separated

Living Situation: Alone, With Spouse, With Relatives, With Friends, With Roommate

Job History:

Current Work Status: Full time Part time Don't Work

Occupation: _____

Specific Duties: _____

Highest Grade in School: _____

Mental Health History:

Have you ever had psychological or psychiatric treatment? If yes, please explain

Yes No Explain: _____

Do you or have you taken antidepressants or antianxiety medication? If yes, please list

Yes No Explain: _____

Do you or have you had substance or alcohol abuse problems? If yes, please explain

Yes No Explain: _____

Atlanta Spine Specialists

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Employment: (please circle)

Full-time Student Part-time Student Employed Not Employed
Self-Employed Retired Active Military

Name of Employer: _____

Address: _____ Suite: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Information:

1. Name: _____ Relationship: _____

Phone: _____ *cell, home or work (please circle)*

2. Name: _____ Relationship: _____

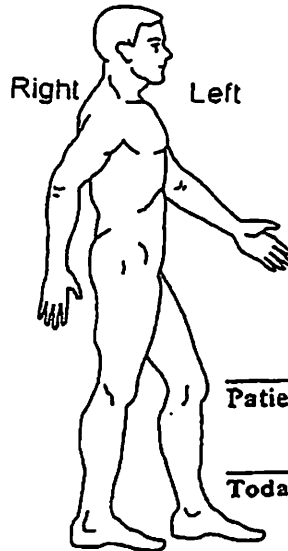
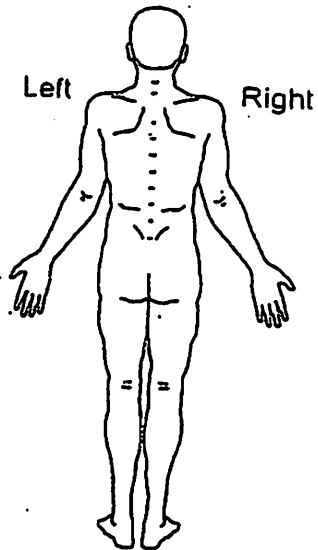
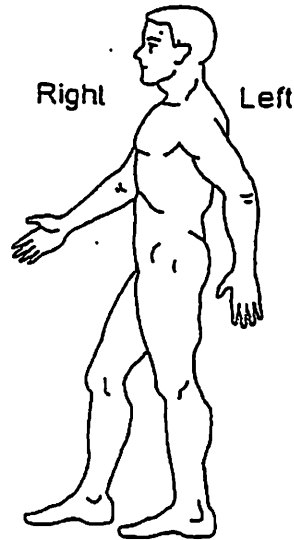
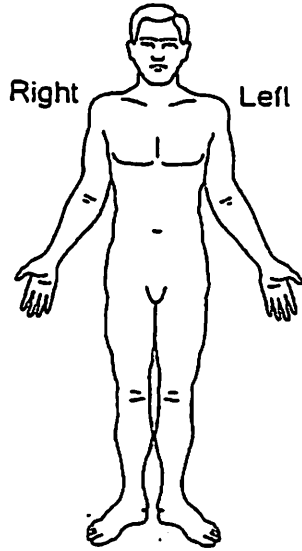
Phone: _____ *cell, home or work (please circle)*

PAIN COLOR CHART

Red: Most Severe Pain

Blue: Less Severe Pain

Green: Numbness



Patient Name (Print Clearly)

Today's Date

For Office Use Only

Procedure:

Atlanta Spine Specialists/Windward Surgery Center

Name: _____ Date: _____

1. Have you traveled outside of Géorgia in the past 3 week? If so where?
 - a. ____Yes, ____No
2. Have you had contact with someone with confirmed diagnosis of COVID-19?
 - a. ____Yes, ____No
3. Have you or anyone in your family experienced a fever **AND** any one of the following symptoms: sore throat, cough, shortness of breath, muscle aches in the last week?
 - a. ____Yes, ____No

Patient Signature: _____

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Appointment Cancellations:

We understand that circumstances occasionally arise changing your plans. Therefore, if you need to cancel or reschedule your appointment, you are requested to notify us as soon as possible, but no later than 48 hours in advance. If you do not cancel within 48 hours or fail to show for your appointment, you will be responsible for a \$50.00 cancellation charge. Cancellation charges are not covered by insurance and are due and payable prior to any further appointments.

If you need to reschedule your appointment, please call the office. If you call after hours, please leave a message.

I have read and understand these guidelines and agree to the terms therein.

Signature of patient

Date

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Please read and initial each of the following statements. By initialing you indicate that you have read, understand and agree to each one.

HIPPA

 Initials:

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers for my health care services.

Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my surgeon's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my surgeon has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Assignment of Benefits

 Initials:

I acknowledge that payment for services and supplies are due in full at the time services are rendered. In consideration for Atlanta Spine Specialists (Provider) not requiring me to pay all charges for care and services rendered during my visit at the time of delivery. I hereby assign to Provider any and all rights to receive insurance benefits otherwise payables to me for products or services provided by the Provider to the extent payable. I understand that my signature requests that payment by my insurance carrier be made directly to the Provider. I authorize Provider to appeal denied insurance authorization and/or benefits on my behalf. I agree to cooperate with the requests of the Provider for assistance in efforts made by the Provider with its efforts to assist me in filling and collecting claims for coverage. If my insurance carrier does not accept assignment of benefits, I understand that all correspondence and payments to Provider may be sent directly to me. I agree that when and if such payments are received, I will hold them in trust for Provider and promptly and immediately transmit them to the Provider for payment of my bill. I acknowledge that this assignment of benefits in no way absolve me from financial responsibility for ensuring that the Provider is promptly paid in full for all charges for care, services and supplies regardless of availability or lack of insurance coverage for such charges. I am responsible for the deductible, co-insurance and non-covered service as well as any other charges not promptly paid by my insurance carrier. I agree that I will be financially responsible for and promptly pay the Provider for any claim or portion of claim thereof, due to Provider for supplies and/or services not covered by my insurance policy as of the date that care, service or supply was rendered. If my insurance company denies coverage or within 60 days of billing by the Provider has failed to pay for all or any billed charge, I will promptly pay the Provider for the full amount of any such charge. If my insurance company changes I will promptly notify the Provider within 30 days of such change. In Medicare assigned cases, Provider agrees to accept the charge determination of the Medicare carrier as the full charge for services and supplies that are covered by Medicare to the extent required by Medicare.

I acknowledge that Provider has supplied me with its Notice of Privacy Acts.

I acknowledge that Provider has the right to collect co-pay/co-insurance amounts.

I acknowledge that I am the patient or the patient's duly authorized representative and that the information given by me to the Provider for payment under insurance plans, Medicare is correct and complete. Any modifications, deletions or changes to this form are void and will not be honored. I understand and acknowledge and agree to the terms set forth above.

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Authorization to Release Claims Information

Initials:

_____ I hereby authorize Atlanta Spine Specialists (Provider), its employees and agents, to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my (or the patient's) medical care and treatment to all appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare), or any private reimbursement which may have a bearing on benefits payable by or on the behalf of any such person. I hereby authorize Provider, its employees and agents to act on my behalf in completing claims.

Precertification

Initials:

_____ I understand that my insurer may require compliance with a utilization review (UR) program to ensure that plan benefits are justified. I understand that if the UR program determines that the admission or treatment is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, healthcare benefits may be withheld. I understand that precertification may be the responsibility of the patient or financially responsible party. I understand that Provider is willing to provide medical services and help in any precertification process.

Permission To Perform Pain Management Care

Initials:

_____ I understand that I am seeking medical care for pain management at Atlanta Spine Specialists. This may include care from multiple disciplines, including diagnostic and/or therapeutic interventions, behavioral medicine (psychology, psychiatry and coping strategies), alternative therapies, physical therapy, and weight management. I understand that Atlanta Spine Specialists may provide interventional pain management treatments, such as injections, to treat my pain condition after diagnosis. I understand that Atlanta Spine Specialists do not provide long-term pain medication to treat my pain condition.

I understand the type of medical care I receive may vary from visit to visit. I understand that it is impossible to predict the results of any pain management medical care. I understand that the doctors giving the medical care feel it may benefit or diagnose my condition; however they cannot guarantee that the medical care will help. I understand that if any problems occur or I believe a complication may have occurred and I cannot immediately speak with the office staff I should seek immediate emergency medical care at the closest hospital emergency room or other emergency medical facility. I understand that I may refuse any type of pain management medical care at any time by telling my physician and the medical staff.

By signing this form, I acknowledge that I have read or had this form read and/or explained to me, that I fully understand its contents, that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily. I understand that this form will be applicable to medical care today and that upon voluntarily returning for medical care this form will continue to be permission for all subsequent pain management medical care performed or directed by Dr. Skaliy. I understand that prior to any medical care I can and I am encouraged to ask questions including but not limited to diagnosis, the risks and nature of a medical care and also practice alternative to a medical care, and the prognosis with and without a type of medical care; and receive satisfactory answers to my questions from the physician and/or medical staff.

I hereby voluntarily request and consent for Dr. Michael Skaliy, as my physician, and such associate(s), assistant(s), or other medical personnel involved performing such Pain Management medical care.

Signature of person giving consent Date

Signature of witness Date

Print name of person giving consent

Print name of witness