

## MEDICAL HISTORY

In order for us to provide you with the highest level of care, please take a moment to complete this form as thoroughly as possible. **Please, fill out all items.**

**Referring Physician:**

**Primary Care Physician:**

Why are you coming to see the doctor? When did this problem start? How did it begin?

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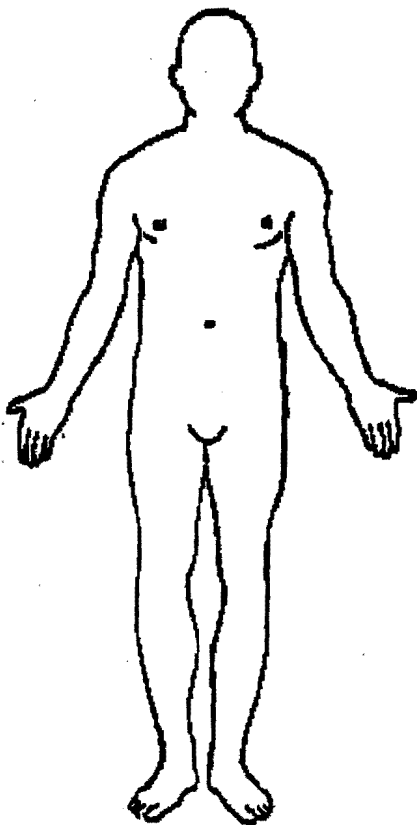


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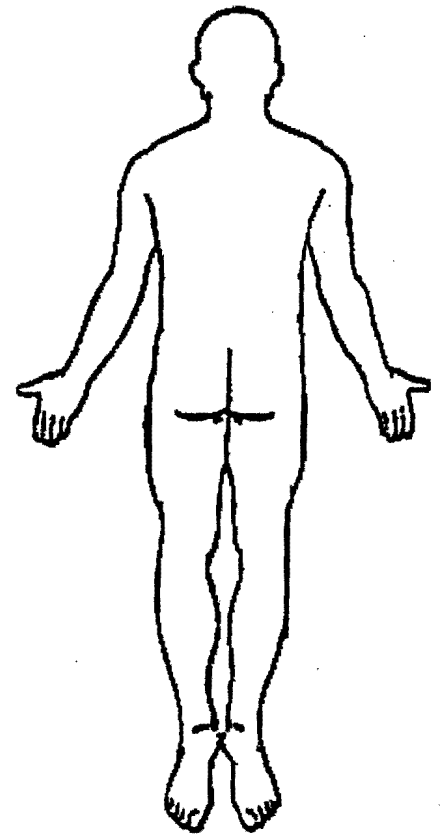


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Please draw the location of your pain using the appropriate colors to indicate the type or types of pain you are having. Mark the single worst area of pain with an **X**.



**Black - Aching**  
**Blue - Stabbing**  
**Red - Burning**  
**Green - Numbness**



Mark a **single X** on the diagram below to indicate the level of your pain as it is **now**.

No Pain



Worst Pain  
Possible



If you have been previously diagnosed with a medical condition, please circle it below:

High Blood Pressure	Bleeding/Clotting Disorders	Neuropathy
Heart Disease	HIV	Rheumatoid Arthritis
High Cholesterol	Hepatitis	Osteoporosis
Diabetes	Tuberculosis	Lupus
Thyroid Deficiency	Chicken Pox	Fibromyalgia
Thyroid Excess	Kidney Stones	Arthritis
Asthma or COPD	Urinary Infection	Spinal Stenosis
Sleep Apnea	Renal Failure	Scoliosis
Nasal Allergies	Epilepsy	Spina Bifida
Stomach Ulcer	Stroke	Sciatica
Gastric Reflux	Anxiety	Herniated Disc-Neck
Cancer	Depression	Herniated Disc-Back

Do you have any other medical problems?  Yes  No

Explain:

Have you had any of the following problems within the last year? If so, please circle it:

**General Health Problems:** fever, chills, poor sleep, unintentional weight loss, sexual dysfunction

**Eye Problems:** blurry vision, double vision, loss of vision

**Ear Problems:** dizziness, ringing, hearing loss

**Mouth and Throat Problems:** snoring, ulcers, painful swallowing, swallowing difficulty, sore throat

**Head or Neck Problems:** swollen glands, neck pain, headache

**Allergy Problems:** food intolerance, frequent sneezing, hives, nasal drip, reaction to insect bite

**Blood or Lymph Problems:** excessive bleeding, easy bruising, swollen lymph nodes

**Gland or Hormone Problems:** cold intolerance, heat intolerance, increased appetite, increased fatigue, unintentional weight gain

**Stomach Problems:** abdominal pain, diarrhea, heartburn, nausea, vomiting

**Urinary Problems:** burning, frequent urination, infections

**Heart or Circulation Problems:** chest pain, irregular heartbeat, leg cramps, ankle swelling, blue lips, fainting

**Lung or Respiratory Problems:** frequent non-productive cough, wheezing, productive cough, shortness of breath

**Bones, Joints and Muscles:** painful joints, swollen joints, stiffness, back pain

**Brain or Neurological Problems:** loss of consciousness, altered mental, numbness, seizures, weakness, loss of bowel control, loss of bladder control

Has anyone in your family suffered from these conditions?  Yes  No

Disease	Relation	Disease	Relation
Heart Disease		Spinal Problems	
Hypertension		Osteoporosis	
Diabetes		Stroke	
Cancer		Neuropathy	
Chronic Pain		Depression	
Asthma		Reaction to anesthesia	
Bleeding Problems			

Have you had any surgeries unrelated to your current problem?  Yes  No

Type of Surgery	Date

What is or was your occupation?  Retired  Disabled

Marital Status? Highest educational level?

Tobacco use?  Yes  No What type and how often?

Alcohol use?  Yes  No How many drinks per day?

Recreational drug use?  Yes  No What type and how often?

Are you involved in litigation because of your current problem?  Yes  No

\_\_\_\_\_  
 Signature of Patient  
 (Or of Caregiver Completing Form)

Account # \_\_\_\_\_

# Parish Pain Specialists, LLC

## PATIENT INFORMATION

Patient: \_\_\_\_\_  
Last First Middle

Title: Mr./Mrs./Other: \_\_\_\_\_ Suffix: Jr/Sr/Other: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Ph.: \_\_\_\_\_ Work Ph.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M or F

Social Security # \_\_\_\_\_

Marital Status: Married Single Widowed Divorced (circle one)

Employment Status: Fulltime Self Employed Part-time  
(circle one) Not Employed Unknown Retired Military Active

Employer: \_\_\_\_\_

Referred By: \_\_\_\_\_

Student: Full or Part time (circle one)

Date of Injury \_\_\_\_\_

Is Injury Work Related: \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

IF OTHER THAN PATIENT, SEND STATEMENT/BILL TO:

Responsible Party: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Phone: \_\_\_\_\_

## PRIMARY INSURANCE

## SECONDARY/SUPPLEMENTAL

Insurance Company \_\_\_\_\_

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

Patient's Relationship to Insured: Self Child Spouse Other

Patient's Relationship to Insured: Self Child Spouse Other

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

\*\* Co-Payments are due at the time of service.\*\*

\*\* Medicare Patients Only: Deductibles due at the time of service.\*\*

\*\* Medicare Patients with no secondary insurance: 20% balance will be your responsibility.\*\*

PLEASE GIVE THIS FORM, YOUR DRIVER'S LICENSE, AND INSURANCE CARD TO THE RECEPTIONIST

By signing this, I hereby acknowledge *Parish Pain Specialists, LLC* has the right to the use and disclosure of protected health information for treatment, payment and health care operations, and that I have received the *Notice of Privacy Practices for Protected Health Information*. I understand I have the right to restrict how protected health information is used or disclosed, and that *Parish Pain Specialists, LLC* is not required to agree to any restriction, but if agreement is reached, *Parish Pain Specialists, LLC* is bound by the agreement.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Charges not covered by Medicare or Managed Care will be the patient's responsibility, please ask if you have any questions. I verify this information is true and accurate as of the below indicated date. I recognize that current, valid insurance information is necessary for reimbursement. I hereby authorize the attached insurance companies to pay directly to *Parish Pain Specialists, LLC* benefits due on my behalf, if any, as provided in the above-unexpired policy. I will pay all charges for all services not permitted or not covered by insurance or subject to deductibles or co-payments and acknowledge and agree in advance to all amounts due from me.

Signature \_\_\_\_\_

Date \_\_\_\_\_

PARISH PAIN SPECIALISTS  
PAIN DISABILITY INDEX (PDI)

Name \_\_\_\_\_ Date \_\_\_\_\_

**Pain Disability Index:** The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst. For each of the seven categories of life activity listed, please circle the number on the scale which describes the level of disability you typically experience. *A score of "0" means no disability at all and a score of "10" signifies that all of the activity is prevented by your pain.*

PAIN DISABILITY INDEX (PDI)

**Family/Home Responsibilities:** This category refers to activities related to the home or family. It might include chores or duties performed around the house, such as yard work and errands or favors for other family members (driving children to school).

No disability \_\_\_\_\_ Worst disability \_\_\_\_\_  
0 1 2 3 4 5 6 7 8 9 10

**Recreation:** This category includes hobbies, sports and other similar leisure time activities.

No disability \_\_\_\_\_ Worst disability \_\_\_\_\_  
0 1 2 3 4 5 6 7 8 9 10

**Social Activity:** This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out and other social functions.

No disability \_\_\_\_\_ Worst disability \_\_\_\_\_  
0 1 2 3 4 5 6 7 8 9 10

**Occupation:** This category refers to activities that are a part of or directly related to one's job. This includes non-paying jobs as well, such as housewife or volunteer work.

No disability \_\_\_\_\_ Worst disability \_\_\_\_\_  
0 1 2 3 4 5 6 7 8 9 10

**Sexual Behavior:** This category refers to frequency and quality of one's sex life.

No disability \_\_\_\_\_ Worst disability \_\_\_\_\_  
0 1 2 3 4 5 6 7 8 9 10

**Self Care:** This category includes activities which involve personal maintenance and independent daily living (bathing, dressing, driving)

No disability \_\_\_\_\_ Worst disability \_\_\_\_\_  
0 1 2 3 4 5 6 7 8 9 10

**Life Support Activity:** This activity refers to basic life supporting behaviors such as eating, sleeping and breathing.

No disability \_\_\_\_\_ Worst disability \_\_\_\_\_  
0 1 2 3 4 5 6 7 8 9 10

**NOTICE FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR  
TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

**PRIVACY NOTICE**

**Effective Date April 14, 2003**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. **Uses and Disclosures:** Parish Pain Specialists, LLC and East Jefferson Interventional Pain Center, Inc. are permitted by law to disclose the minimum necessary personal health information of each patient to carry out treatment, payment and health care operations of Parish Pain Specialists, LLC and East Jefferson Interventional Pain Center, Inc. (Collectively the "Facility"). For treatment purposes, such disclosures may be made to physicians and other health care providers as necessary to effectuate the appropriate treatment and care of patients. Personal health information may be disclosed to the government or other third party payors for the purpose of obtaining payment for services provided. Facility may also use personal health information to carry out Facility's day to day operations such as scheduling, quality review and appointment reminders. A list of other examples of disclosures can be obtained from the Privacy Officer upon request.
  
2. **Required Authorizations:** Facility will not disclose any patient's personal health information for any purpose aside from payment, treatment and health care operations, without patient's authorized consent to such disclosure. Upon request for such authorization, patient shall have the right to refuse and/or revoke any disclosure of patient's personal health information.
  
3. **Privacy Compliance:** In accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164 (the Privacy Regulations"), Facility has adopted privacy policies regarding usage of patients' personal health information. Facility is committed to compliance with the Privacy Regulations and all other laws and regulations regarding patients' right to privacy.
  
4. **Additional information:** For additional information regarding Facility's privacy policy or for a copy of this notice, please contact our Privacy Officer. Facility reserves the right to change this Notice and to make the revised and changed notice effective for medical information that Facility already has about you, as well as any information Facility receives in the future. We will post a copy of the current notice in Facility. The notice will contain the effective date.

The following signature acknowledges that I have received notification of my privacy rights concerning the use and disclosure of protected health information as defined by the Privacy Regulations.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

The following signature acknowledges that I have chosen not to receive a copy of this Notice.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date