

## **Dear New Patient:**

### **Welcome to the Pain and Headache Center**

A few reminders to make your first visit a little easier:

- Please make sure to bring this completed new patient packet, your ID, and your insurance card to your visit.
  - o If you are a Medicaid patient, you must have your card and \$3 co-pay to be seen for every visit (no exceptions)
- We are trying very hard to stay on schedule. Your appointment time is the time when we hope to actually have you in the exam room, which means that you must arrive early to check in. We do not double-book patients, and so, if you are more than five minutes late, your time with our providers will be dramatically decreased or your appointment will be rescheduled.
- Please bring your records, Xrays (films or disc), and a **list of ALL of your medications** (or the bottles themselves)
  - o Although we have made every effort to get records from your doctor, this is ultimately your responsibility to provide these records; without records, we may not be able to help you.
- If you are requesting pain medications, you will be required to provide a fresh sample of your urine during your visit. Please plan accordingly, because you will not receive a prescription without this urine for screening. If you cannot urinate or if the results of this urine screen are unexpected, we may decline to provide prescriptions at this visit.
- We try to treat our patients as responsible adults, and therefore we will not call to remind you of appointments. **If you no-show for an appointment you will be charged.**

**On behalf of our providers, welcome to the practice!**

Initial: \_\_\_\_\_

**The Pain and Headache Center, LLC**  
**Registration Form (please print)**

**PATIENT INFORMATION**

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Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_  
Is this your legal name? YES NO if not, what is your legal name? \_\_\_\_\_  
Previous name: \_\_\_\_\_ Marital status: Married Divorced Single Widowed Other  
Race: \_\_\_\_\_ Language spoken: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: Male Female  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Hm. Phone: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work#: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Referring Provider: \_\_\_\_\_ PCP (if different): \_\_\_\_\_

**INSURANCE INFORMATION**

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Primary INS: \_\_\_\_\_ Insurance phone #: \_\_\_\_\_  
INS Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_  
Subscriber's name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: Male Female

Secondary INS: \_\_\_\_\_ Insurance phone #: \_\_\_\_\_  
INS Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_  
Subscriber's name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: Male Female

Worker's Comp INS Co.: \_\_\_\_\_ W/C Phone#: \_\_\_\_\_  
W/C Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Claim #: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Site of Injury: \_\_\_\_\_  
Name of Adjuster: \_\_\_\_\_ Adjuster Phone #: \_\_\_\_\_  
Employer at the time of injury: \_\_\_\_\_

**IN CASE OF EMERGENCY**

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Emergency Contact name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Hm. Phone: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work#: \_\_\_\_\_

**CONSENT FOR TREATMENT:** I hereby authorize *The Pain and Headache Center, LLC* providers to provide such medical treatments, examinations, and to perform such procedures deemed as medically necessary.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize *The Pain and Headache Center, LLC* or insurance company to release any information required to process my claim.

Patient/ Guardian printed name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/ Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

## The Pain and Headache Center, LLC

### Financial Policy

Here at The Pain and Headache Center we are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

#### **ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE:**

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. The Pain and Headache Center, LLC accepts cash, personal checks, VISA, and MasterCard. There is a service charge of \$35.00 on returned checks.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments. We realize that financial difficulty is a reality.

#### **INSURANCE:**

We must emphasize that as a medical care provider our relationship is with you, not your insurance company. We file your insurance claim as courtesy to you, and all charges are ultimately your responsibility. Not every service is a covered benefit with your plan. Some insurance companies arbitrarily select certain services they will not cover. **It is important that you read and understand YOUR health insurance policy and its requirements for coverage, including preauthorization of services.** We currently send claims to numerous plans and are not responsible for knowing the requirements of your specific plan. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges and secondary insurance, "usual and customary" charges. If you choose to file an appeal to your insurance, it is your responsibility.

If you need assistance or have questions, please contact The Billing Coordinator between 8:30 a.m. and 5:00 p.m., Monday through Friday at 907-563-1777.

#### **REFUNDS:**

Patient/guarantor credits in amounts less than \$20.00 will be retained on account to be credited toward future balances, unless a written request for refund is received. Amounts \$20.00 and greater will automatically be refunded to the patient/guarantor.

#### **MISSED APPOINTMENTS/LATE CANCELLATIONS:**

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge \$50.00 for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand The Pain and Headache Center, LLC Financial Policy. I agree to assign insurance benefits to The Pain and Headache Center, LLC whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

**BY SIGNATURE BELOW I ACKNOWLEDGE THAT I HAVE READ, I UNDERSTAND AND I APPROVE ALL OF THE ABOVE**

Signature of insured or authorized representative: \_\_\_\_\_ Date: \_\_\_\_\_  
Printed name of insured or authorized representative: \_\_\_\_\_ Date: \_\_\_\_\_

# The Pain and Headache Center, LLC

## Consent for Involvement of Care

In order to comply with specific rules regarding HIPAA, we ask that our patients complete and sign this privacy and security of health information. Unless this form is complete, we are not authorized to speak to anyone but you. I understand this release excludes; insurance companies, attorneys, and other health care providers.

### Personal Health Information:

I \_\_\_\_\_ herby authorize The Pain and Headache Center, LLC to speak to the person(s) listed below regarding my personal health information.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Billing and payment information:

I \_\_\_\_\_ herby authorize The Pain and Headache Center, LLC to speak to the person(s) listed below regarding my billing and payment information.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Medication Information:

I \_\_\_\_\_ herby authorize The Pain and Headache Center, LLC to release my prescriptions that need to be picked up on my behalf to the person(s) listed below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Appointment Reminders:

I \_\_\_\_\_ herby authorize The Pain and Headache Center, LLC and staff to leave appointment reminders by the following methods:

	Please Circle one		
Home Phone: _____	YES	NO	N/A
Cell Phone: _____	YES	NO	N/A
Work Phone: _____	YES	NO	N/A

I understand and assume responsibility of notifying The Pain and Headache Center, LLC whenever the listed information changes. I understand this release excludes; insurance companies, attorneys, and other health care providers.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**RESEARCH PURPOSES** I also agree to have my telemedicine records and clinical data reviewed for the purposes of evaluation (data collection, analysis, and presentation in verbal or written format at scientific meetings or publications) or other educational purposes. I understand that any presentation will not identify me by name or other identifiable markers. AGREE \_\_\_\_\_ (initials of patient only if AGREEING).

**The Pain and Headache Center, LLC  
HIPAA Privacy Policy**

I (name of patient) \_\_\_\_\_, acknowledge and agree that I have received a copy of the HIPAA Privacy Policy.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

DATE: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

## The Pain and Headache Center New Patient Intake

Please answer the following to the best of your ability and in its entirety so we can optimize your care.

**Location of pain:** Please check which area of pain you have and the associated locations. Shade the diagram in where your pain is and trace any patterns or radiation.

\_\_\_\_ **Neck Pain**

\_\_\_\_ Pain causes headaches

\_\_\_\_ Front of head

\_\_\_\_ Temple, left

\_\_\_\_ Temple, right

\_\_\_\_ Back of head, left

\_\_\_\_ Back of head, right

\_\_\_\_ Pain radiates into arms

\_\_\_\_ Left

\_\_\_\_ Right

\_\_\_\_ Pain radiates into hands

\_\_\_\_ Left

\_\_\_\_ Right

\_\_\_\_ **Shoulder Pain**

\_\_\_\_ Left

\_\_\_\_ Right

\_\_\_\_ **Upper Back**

\_\_\_\_ Pain radiates into ribs

\_\_\_\_ Left

\_\_\_\_ Right

\_\_\_\_ **Lower Back**

\_\_\_\_ Pain radiates into hips

\_\_\_\_ Left

\_\_\_\_ Right

\_\_\_\_ Pain radiates into pelvis

\_\_\_\_ Left

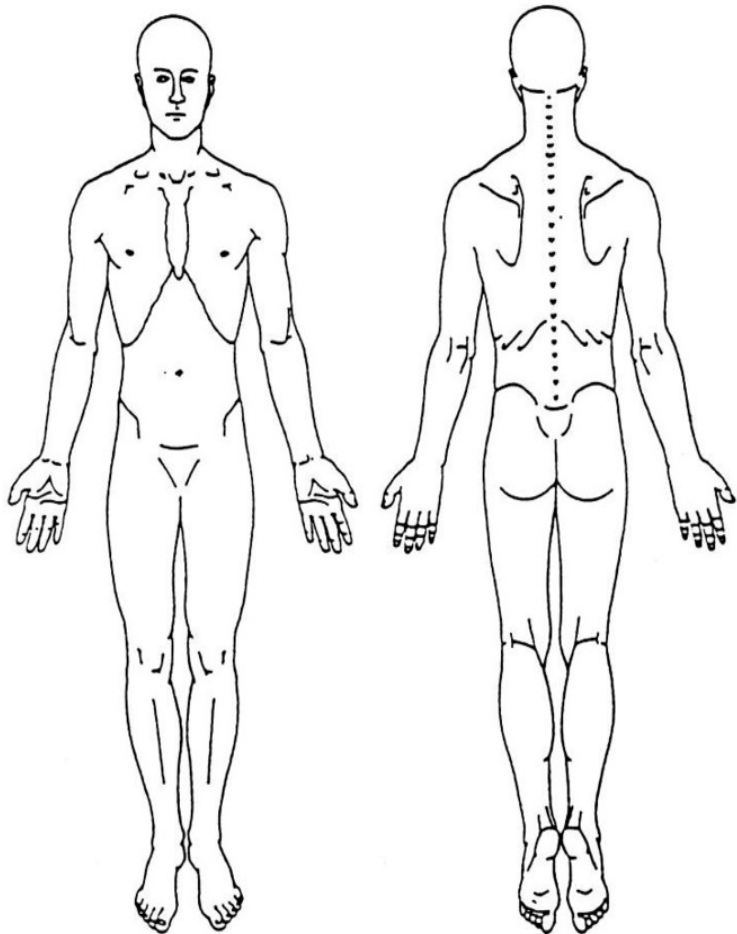
\_\_\_\_ Right

\_\_\_\_ Pain radiates down the leg

\_\_\_\_ Left

\_\_\_\_ Right

\_\_\_\_ **Other (Please explain)** \_\_\_\_\_



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**How long have you had your pain?**

Years \_\_\_\_\_  
Months \_\_\_\_\_  
Weeks \_\_\_\_\_

**What was the onset of your pain?**

Trauma (please explain): \_\_\_\_\_

Unknown onset, sudden

Unknown onset, gradual

**Is this a work related injury?** Yes No

**Is worker's compensation involved?** Yes No

If so, date of injury? \_\_\_\_\_

**Please describe your pain at its....**

Best 1...2...3...4...5...6...7...8...9...10

Worst 1...2...3...4...5...6...7...8...9...10

Average 1...2...3...4...5...6...7...8...9...10

**Type of pain (please circle)**

Aching	Burning	Dull	Constant	Episodic
Shooting	Tingling	Tight	Radiating	Intermittent
Cramping	Hot	Heavy	Annoying	Throbbing
Numb	Cold	Intense	Severe	Deep
Stinging	Sore	Knife-like	Sharp	_____

**Does your pain wake you up at night?** Yes No

**When is your pain worse?** Morning Afternoon Night

**Assisted devices:**

None	Cane	Walker
Corset	Brace	Wheelchair

**Please mark if you have seen any of the following providers for your pain:**

Orthopedic surgeon	Rheumatologist
Neurologist	Physical Therapist
Primary Care	_____
Emergency Room	_____

**Have you been ever been discharged from a clinic?** Yes No

If yes, please explain what happened and name of clinic:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you done physical therapy?** Yes No

- Did it help with your pain? Yes No
- When did you go? \_\_\_\_\_
- For how long? \_\_\_\_\_

**Aggravating Factors (please circle):**

Sneezing	Lifting	_____
Coughing	Sitting	_____
Bowel Movements	Standing	_____
Bending	Walking	_____
Twisting	Lying down	_____

**Relieving Factors (please circle):**

Heat	Standing Up	_____
Ice	Rest	_____
Physical Therapy	Pain Meds	_____
Laying Down	Bending forward	_____

**Please list ALL of your current medications. List name, dosage, frequency and what they are used for:**

Name	Strength	Frequency	Usage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Please list ALL of the narcotics, pain patches, neuropathic medications etc. that you have taken in the past that DID NOT WORK:**

Name	Strength	Why Stopped (side effects cost etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Please indicate any diagnostic tests you have had. Approximate the date and location of where they were performed:**

	Had? Yes/No	Body Part	Date	Facility
XRAY	_____	_____	_____	_____
EMG	_____	_____	_____	_____
Myelogram	_____	_____	_____	_____
MRI	_____	_____	_____	_____
Other	_____	_____	_____	_____

**Allergies (please circle):**

Shrimp	Adhesives	Seasonal Allergies	_____
Shellfish	Iodine	_____	_____
Latex	Penicillin	_____	_____



**Social History**

- |   |     |        |           |     |       |
|---|-----|--------|-----------|-----|-------|
| 1. Do you use tobacco products?                         | Yes | No     |           |     |       |
| Please describe frequency and product consumed: _____   |     |        |           |     |       |
| 2. Do you consume alcoholic beverages?                  | Yes | No     |           |     |       |
| Please describe frequency: _____                        |     |        |           |     |       |
| 3. Do you have a history of illegal drug abuse?         | Yes | No     |           |     |       |
| 4. Is there any current illegal drug abuse?             | Yes | No     |           |     |       |
| 5. How many caffeinated beverages do you consume daily? |     | 0-1    | 2-3       | 3-4 | 5+    |
| 6. How many times do you exercise during the week?      |     | 1-2    | 3-4       | 5-6 | Never |
| 7. How often do you use your seatbelt?                  |     | Always | Sometimes |     | Never |
| 8. What is your occupation? _____                       |     |        |           |     |       |

**Past Medical History (please circle):**

- |                                |  |
|--------------------------------|--|
| Alcoholism                     | High Blood Pressure                                  |
| Anemia                         | High Cholesterol                                     |
| Anesthetic Complication        | HIV  |
| Anxiety                        | Kidney/Bladder Disease                               |
| Arthritis                      | Liver Cancer   |
| Asthma                         | Liver Disease  |
| Autoimmune Problems            | Lung/Respiratory Disease                             |
| Birth Defects                  | Lung Cancer  |
| Bleeding Disease               | Mental Illness                                       |
| Blood Clots                    | Migraines  |
| Blood Transfusion(s)           | Osteoporosis   |
| Bowel Disease                  | Prostate Cancer                                      |
| Breast Cancer                  | Reflux/ GERD   |
| Cervical Cancer                | Seizures Convulsions                                 |
| Colon/Rectal Cancer            | Severe Allergy/ Hives                                |
| Depression                     | STD  |
| Diabetes I                     | Skin Cancer  |
| Diabetes II                    | Stroke/ CVA of the Brain                             |
| Growth/ Developmental Disorder | Suicide Attempt                                      |
| Heart Attack                   | Thyroid Problems                                     |
| Heart Disease                  | Ulcers   |
| Heart Pain                     | Other Disease/ Cancer or Significant Medical Illness |
| Hepatitis A                    | _____  |
| Hepatitis B                    | _____  |
| Hepatitis C                    | _____  |

**Family History (please circle):**

- |                        |                           |
|------------------------|---------------------------|
| Family history unknown | Heart Disease             |
| Alcoholism             | High Blood Pressure       |
| Anemia                 | High Cholesterol          |
| Anesthetic Problems    | Kidney/ Bladder Disease   |
| Arthritis              | Lung/ Respiratory Disease |
| Asthma                 | Migraines                 |
| Bleeding Disease       | Osteoporosis              |
| Breast Cancer          | Seizures/ Convulsions     |
| Colon/ Rectal Cancer   | Severe Allergy/ Hives     |
| Depression             | Stroke/ CVA of the Brain  |
| Diabetes               | Thyroid Problems          |
| Other: _____           | _____                     |

**Surgical History (please circle):**

Cataract Surgery	L	R	Both	Mastectomy	L	R	Both
Deviated Nose Septum	L	R	Both	Breast Reconstruction	L	R	Both
Sinus Surgery				Breast Reduction	L	R	Both
Mastoidectomy	L	R	Both	Hysterectomy			
Tonsillectomy	L	R	Both	Ovary Removal	L	R	Both
Carotid Artery Surgery	L	R	Both	Tubal Ligation			
Thyroid Removal	L	R	Both	C-Section			
Breast Biopsy	L	R	Both	Carpal Tunnel Surgery	L	R	Both
Breast Lump Removal	L	R	Both	Rotator Cuff Repair	L	R	Both
Lung Surgery	L	R	Both	Shoulder Surgery	L	R	Both
Heart Bypass Surgery	L	R	Both	Hip Fracture & Surgery	L	R	Both
Heart Valve Replacement				Hip Replacement	L	R	Both
Appendectomy				Knee Replacement	L	R	Both
Gallbladder Surgery				Knee Surgery	L	R	Both
Kidney Removal	L	R	Both	Neck Surgery			
Inguinal Hernia Surgery				Low Back Surgery			
Colon Polyp Removal				Spinal Fusion			
Colon Removal				Spinal Decompression			
Anal Fissure Repair				Ulcer Surgery			
Leg Circulation Surgery	L	R	Both	_____			
Foot Surgery	L	R	Both	_____			

**If you have had spinal surgery, please indicate date and facility:** \_\_\_\_\_

**Have you had any pain management procedures?**      Yes                      No

What procedure (Please circle):

Major joint injection

Epidural

Rhizotomy

Facet joint injection

Disectomy

Other: \_\_\_\_\_

1. Please indicate date and facility:

\_\_\_\_\_

\_\_\_\_\_

2. Did you get any relief from these injections/procedures?      Yes                      No

3. If so, for how long? \_\_\_\_\_

**Have you ever had difficulty getting numb at the dentist office?**                      Yes                      No

## Review of Systems

Please circle the symptoms that are present at this time

### General

Fever  
Weight gain  
Weight loss  
Chills  
Fatigue  
Sweats  
Loss of appetite  
Anorexia  
Malaise  
Headaches

### Eyes

Vision loss  
Light sensitivity  
Double vision  
Blurring  
Eye pain  
Diplopia  
Irritation  
Discharge  
Photophobia

### Ears, Nose and Throat

ringing in ears  
Decreased hearing  
Congestion  
Hoarseness  
Earache  
Difficulty swallowing  
Ear discharge  
Nose bleeds  
Sore Throat  
Runny Nose

### Cardiovascular

Difficulty breathing lying down  
Leg cramps during exertion  
Ankle swelling  
Palpitations  
Fainting spells  
Chest pain

### Respiratory

Shortness of breath at rest  
Sputum Production  
Shortness of breath with exertion  
Cough

### Respiratory Cont.

Chest pain  
Snoring  
Coughing up blood  
Wheezing  
Waking up gasping for breath

### Gastrointestinal

Bloody or black stools  
Abdominal pain  
Nausea  
Constipation  
Vomiting  
Diarrhea  
Change in bowel habits

### Genitourinary

Frequent urination at night  
Difficulty starting urination  
Blood in urine  
Loss of bladder control  
Urinary urgency/frequency  
Vaginal discharge  
Incontinence  
Abnormal menstrual period  
Pelvic pain

### Musculoskeletal

Muscle weakness  
Bone pain in last 3 months  
Joint pain in last 3 months  
Muscle cramps  
Joint pain  
Back pain  
Joint swelling  
Joint stiffness  
Stiffness

### Skin

Poor skin healing  
Hair loss  
Itching  
Rash  
Dryness  
Suspicious lesions  
Jaundice

### Neurological

Memory loss  
Tingling sensation  
Tremors  
Balance problems  
Transient paralysis  
Weakness  
Unsteadiness  
Speech problems  
Numbness  
Headaches  
Seizures

### Psychiatric

Suicidal thoughts  
Hallucinations  
Anxiety  
Depression  
Memory loss  
Mental disturbance  
Paranoia

### Endocrine

Increased appetite  
Excessive urination  
Cold intolerance  
Increased thirst  
Heat intolerance  
Weight change

### Heme/Lymphatic

Tendency towards bleeding  
Abnormal bruising  
Enlarged lymph glands


### Allergic/Immunologic

Persistent infections  
HIV exposures  
Hives  
Hay fever

### Pain and Headache Center Screening Questionnaire

Patient name \_\_\_\_\_ Date \_\_\_\_\_

Nicotine Addiction	Heavy Smoking Index
How soon after waking do you smoke your first cigarette?	<input type="checkbox"/> Within 5 minutes <input type="checkbox"/> 6-30 minutes <input type="checkbox"/> 31-60 minutes <input type="checkbox"/> Longer than 60 minutes
How many cigarettes do you smoke per day?	<input type="checkbox"/> 10 or less <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-30 <input type="checkbox"/> 31 or more
Alcohol dependence	CAGE-Questionnaire
Have you ever felt you needed to cut down drinking?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have people annoyed you by criticizing your drinking?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you ever felt guilty about drinking?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you ever felt you needed a drink first thing in the morning (eye-opener) to steady your nerves or get rid of a hangover?	<input type="checkbox"/> yes <input type="checkbox"/> no
Psychiatric History	
Is there any history of psychiatric illness or addiction (such as alcohol or drugs) in your family (parents or siblings)?	<input type="checkbox"/> yes <input type="checkbox"/> no
Before the age of 14, have you experienced psychological strain and/or suffered from a cerebral lesion or disease that had negative influence on your development (resulting in difficulties at school, changes in behaviour or stuttering)?	<input type="checkbox"/> yes <input type="checkbox"/> no

Are you or have you ever been suffering from a Depressive Disorder or Anxiety Disorders?	<input type="checkbox"/> yes <input type="checkbox"/> no
Evidence of former or current Abuse of or Addiction to illicit drugs?	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>Expected Effect of Pain Medication</b>	
Do you think that a drug can make you happier, more content or more self-secure?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you think that a drug can help you unwind and/or reduce stress?	<input type="checkbox"/> yes <input type="checkbox"/> no
<b>Origin of Pain</b>	
<p>In your opinion, is your pain mainly due to organ damage or could psychologic factors or psychosocial stress lead to your pain?</p> <p>Please assign your estimation with a horizontal line on the line between the two poles:</p>	<p>My pain is caused by physical reasons only</p> <p>100%</p>  <p>100%</p> <p>My pain is caused by psychologic reasons only</p>

# The Pain and Headache Center, LLC

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## SLEEP APNEA RISK ASSESSMENT

Sleep apnea has been shown to increase the risk for heart disease, heart attack and stroke. It is also associated with numerous conditions that are known to increase the risk for cardiac disease, such as diabetes mellitus and hypertension. To find out if you may be at risk for sleep apnea, fill out the survey below.

Do you snore?	Yes (2) No (0)	
Can your snoring be heard through a door or wall?	Yes (2) No (0)	
Has anyone ever told you that you stop breathing at night?	Yes (2) No (0)	
<b>What is your collar size?</b>		
Male: Less than 17 inches (0) More than 17 inches (2)		
Female: Less than 16 inches (0) More than 16 inches (2)		
<b>Do you occasionally fall asleep during the day when:</b>		
You are not busy or are inactive?	Yes (2) No (0)	
You are driving or stopped at a light?	Yes (2) No (0)	
Are you over weight?	Yes (2) No (0)	
Do you have high blood pressure?	Yes (2) No (0)	
Are you often tired during the day?	Yes (2) No (0)	

Total: \_\_\_\_\_

9 POINTS OR MORE

Severe Risk for Sleep Apnea

6-8 POINTS

Moderate Risk for Sleep Apnea

5 POINTS OR LESS

LOW Risk for Sleep Apnea

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# The Pain and Headache Center, LLC

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## BECK'S DEPRESSION INVENTORY

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1	0	I do not feel sad.
	1	I feel sad.
	2	I am sad all the time and I can't snap out of it.
	3	I am so sad and unhappy that I can't stand it.
2	0	I am not particularly discouraged about the future.
	1	I feel discouraged about the future.
	2	I feel I have nothing to look forward to.
	3	I feel the future is hopeless and that things cannot improve.
3	0	I do not feel like a failure.
	1	I feel I have failed more than the average person.
	2	As I look back on my life, all I can see is a lot of failures.
	3	I feel I am a complete failure as a person.
4	0	I get as much satisfaction out of things as I used to.
	1	I don't enjoy things the way I used to.
	2	I don't get real satisfaction out of anything anymore.
	3	I am dissatisfied or bored with everything.
5	0	I don't feel particularly guilty.
	1	I feel guilty a good part of the time.
	2	I feel quite guilty most of the time.
	3	I feel guilty all of the time.
6	0	I don't feel I am being punished.
	1	I feel I may be punished.
	2	I expect to be punished.
	3	I feel I am being punished.
7	0	I don't feel disappointed in myself.
	1	I am disappointed in myself.
	2	I am disgusted with myself.
	3	I hate myself.
8	0	I don't feel I am any worse than anybody else.
	1	I am critical of myself for my weaknesses or mistakes.
	2	I blame myself all the time for my faults.
	3	I blame myself for everything bad that happens.

9	0	I don't have any thoughts of killing myself.
	1	I have thoughts of killing myself, but I would not carry them out.
	2	I would like to kill myself.
	3	I would kill myself if I had the chance.
10	0	I don't cry any more than usual.
	1	I cry more now than I used to.
	2	I cry all the time now.
	3	I used to be able to cry, but now I can't cry even though I want to
11	0	I am no more irritated by things than I ever was.
	1	I am slightly more irritated now than usual.
	2	I am quite annoyed or irritated a good deal of the time.
	3	I feel irritated all the time.
12	0	I have not lost interest in other people.
	1	I am less interested in other people than I used to be.
	2	I have lost most of my interest in other people.
	3	I have lost all of my interest in other people
13	0	I make decisions about as well as I ever could.
	1	I put off making decisions more than I used to.
	2	I have greater difficulty in making decisions more than I used to.
	3	I can't make decisions at all anymore.
14	0	I don't feel that I look any worse than I used to.
	1	I am worried that I am looking old or unattractive.
	2	I feel there are permanent changes in my appearance that make me look unattractive
	3	I believe that I look ugly.
15	0	I can work about as well as before.
	1	It takes an extra effort to get started at doing something.
	2	I have to push myself very hard to do anything.
	3	I can't do any work at all.

16	0	I can sleep as well as usual.
	1	I don't sleep as well as I used to.
	2	I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
	3	I wake up several hours earlier than I used to and cannot get back to sleep.
17	0	I don't get more tired than usual.
	1	I get tired more easily than I used to.
	2	I get tired from doing almost anything.
	3	I am too tired to do anything.
18	0	My appetite is no worse than usual.
	1	My appetite is not as good as it used to be.
	2	My appetite is much worse now.
	3	I have no appetite at all anymore.
19	0	I haven't lost much weight, if any, lately.
	1	I have lost more than five pounds.

	2	I have lost more than ten pounds.
	3	I have lost more than fifteen pounds.
20	0	I am no more worried about my health than usual.
	1	I am worried about physical problems like aches, pains, upset stomach, or constipation.
	2	I am very worried about physical problems and it's hard to think of much else.
	3	I am so worried about my physical problems that I cannot think of anything else.
21	0	I have not noticed any recent changes in my interest in sex.
	1	I am less interested in sex than I used to be.
	2	I have almost no interest in sex.
	3	I have lost interest in sex completely.

Total: \_\_\_\_\_

### INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. You can evaluate your depression according to the Table below.

- 1-10 These ups and downs are considered normal
- 11-16 Mild mood disturbance
- 17-20 Border line clinical depression
- 21-30 Moderate depression
- 31-40 Severe depression
- 40+ Extreme depression

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# The Pain and Headache Center, LLC

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## Opioid Risk Tool

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	Seldom	Sometimes	Often	Very Often
1. How often do you have mood swings?	0	1	2	3	4
2. How often have you felt a need for higher doses of medication to treat your pain?	0	1	2	3	4
3. How often have you felt impatient with your doctors?	0	1	2	3	4
4. How often have you felt that things are just too overwhelming that you can't handle them?	0	1	2	3	4
5. How often is there tension in the home?	0	1	2	3	4
6. How often have you counted pain pills to see how many are remaining?	0	1	2	3	4
7. How often have you been concerned that people will judge you for taking pain medications?	0	1	2	3	4
8. How often do you feel bored?	0	1	2	3	4
9. How often have you taken more pain medication than you were supposed to?	0	1	2	3	4
10. How often have you worried about being left alone?	0	1	2	3	4
11. How often have you felt a craving for medication?	0	1	2	3	4
12. How often have others expressed concern over your use of medication?	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4

[Type text]

[Type text]

	Never	Seldom	Sometimes	Often	Very Often
14. How often have others told you that you had a bad temper?	0	1	2	3	4
15. How often have you felt consumed by the need to get pain medication?	0	1	2	3	4
16. How often have you run out of pain medication early?	0	1	2	3	4
17. How often have others kept you from getting what you deserve?	0	1	2	3	4
18. How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4
19. How often have you attended an AA or NA meeting?	0	1	2	3	4
20. How often have you been in an argument that was so out of control that someone got hurt?	0	1	2	3	4
21. How often have you been sexually abused?	0	1	2	3	4
22. How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
23. How often have you had to borrow pain medications from your family or friends?	0	1	2	3	4
24. How often have you been treated for an alcohol or drug problem?	0	1	2	3	4

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

[Type text]

[Type text]

**PATIENT: PLEASE RETURN THIS FORM TO THE FRONT DESK TO BE FAXED TO BLUEPRINT HEALTH.**

**1. COMPLETE THE SURVEY** below so that we may determine whether some of the symptoms you are experiencing may be due to Hormone Deficiencies.

**Make sure you have provided accurate contact information below, so one of our nurses can contact you to discuss next steps.**

**Doctor you are seeing today:** \_\_\_\_\_

**2. PATIENT INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Email: \_\_\_\_\_

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

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

Phone (Best to Call): \_\_\_\_\_ Best Time to Call (please circle): MORNING NOON NIGHT

SSN: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Gender:  Female  Male

**3. PATIENT SURVEY**

0 = I do not experience this symptom / 1 = This symptom is a minor problem for me / 2 = This symptom is a moderate issue for me  
3 = This symptom is a real problem / 4 = This symptom is so severe that I can barely function

EVERYONE (please complete)			
<p><b>1. Do you have trouble falling/staying asleep? Are you fatigued throughout day?</b></p> <p style="text-align: center;">0 1 2 3 4 <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>	<p><b>2. Have you experienced unexplained weight gain, especially around the middle, over the past year?</b></p> <p style="text-align: center;">0 1 2 3 4 <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>	<p><b>3. Loss of libido or a change in sexual desire?</b></p> <p style="text-align: center;">0 1 2 3 4 <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>	<p><b>4. Do you feel sad, irritable, depressed, quick to anger or suffer from mood swings?</b></p> <p style="text-align: center;">0 1 2 3 4 <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>
<p><b>5. Do you have difficulty putting on muscle, not noticing improvements with workouts? Notice a decline in normal strength?</b></p> <p style="text-align: center;">0 1 2 3 4 <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>	<p><b>6. Do you have reduced mental clarity, like trouble concentrating, recalling facts, or remembering things?</b></p> <p style="text-align: center;">0 1 2 3 4 <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>	<p><b>7. Do you suffer from acne or have oily skin?</b></p> <p style="text-align: center;">0 1 2 3 4 <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>	<p><b>8. Do you have reduced interest in normal activities? Decreased self-confidence or motivation?</b></p> <p style="text-align: center;">0 1 2 3 4 <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>

**EVERYONE (please check all that apply)**

- Hungry or not, I snack on foods at home or at work, and If there's food around me, I'll probably eat it.
- I rarely take the time to plan my meals, so most are take-out or eaten in restaurants.
- I have difficulty controlling my portion sizes.
- I want to exercise but have little time to devote to being more active because of my hectic schedule.
- Being physically active has never been one of my priorities.
- Negative self-talk makes me my own worst enemy and I feel ashamed of my body.
- Food and drink is my trusted friend and comfort source and I find myself eating and drinking instead of expressing my emotions.
- I'm doubtful that I will ever find someone who can help me lose weight.

**WOMEN (please check symptoms)**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Irregular Periods               | <input type="checkbox"/> Bloating, Gas          | <input type="checkbox"/> Vaginal Dryness          | <input type="checkbox"/> Breast Swelling |
| <input type="checkbox"/> Hot Flashes and/or Night Sweats | <input type="checkbox"/> Diarrhea, Constipation | <input type="checkbox"/> Thinning Hair            | <input type="checkbox"/> Headaches       |
| <input type="checkbox"/> PMS-like symptoms               | <input type="checkbox"/> Stiff or Achy Joints   | <input type="checkbox"/> Painful Menstrual Cramps |  |
| <input type="checkbox"/> Irritability                    | <input type="checkbox"/> Weight Gain            | <input type="checkbox"/> Insomnia                 |  |
|  | <input type="checkbox"/> Loss of Libido         | <input type="checkbox"/> Mood swings              |  |

FOR STAFF USE ONLY

Complete requested information, and fax to (844) 965-9871 or email to [info@blueprint2health.com](mailto:info@blueprint2health.com)



## PATIENT INFORMATION

### FEELING TIRED? LOW-LIBIDO? MOOD SWINGS? BLUEPRINT HEALTH IS THE ANSWER!

We provide a comprehensive, individualized, and most importantly, physician guided approach to wellness.

Blueprint Health is the only hormone replacement therapy (HRT) organization that has partnered with leading, local physicians to manage total wellness for men and women with a safe and individually prescribed method. It's time to look and feel your best while reclaiming your vitality and youth.

#### KNOW YOUR LEVELS

Do you feel like you're constantly battling your body to stay focused and on the ball? It's time to take your body back and free your mind with a carefully-balanced approach that will completely transform your day-to-day life. Blueprint Health's unique approach to better health has

won praise and has earned the program an unrivaled reputation in the United States.

Working closely with our clients, we help to establish each individual's personal hormone profile and create a custom program that rewards them with restored vitality and better living.

#### SIGNS THAT YOU MIGHT SUFFER FROM A HORMONE IMBALANCE

Combinations of these symptoms could indicate an underlying hormone imbalance:

- Constant feeling of being low on energy
- Hot flashes
- Inexplicable mood swings
- Decreased libido
- Mildly impaired cognitive function
- Trouble sleeping



## IT ALL STARTS WITH KNOWING YOUR LEVELS

#### ASSESSMENT OF YOUR CHOLESTEROL AND CARDIAC HEALTH

Monitoring the plaque in the arteries, possible damage to arterial walls, and cardiovascular health

- Lipid panel, cholesterol, HDL, LDL, & Triglycerides

#### ASSESSMENT OF YOUR LIVER AND KIDNEY HEALTH

Monitoring the toxins that are filtered by the kidneys and liver. Any decrease in the function of these vital organs can contribute to an increase in your weight, fatigue, and chronic diseases

- BUN, Creatinine, AST, & ALT

#### ASSESSMENT OF YOUR HORMONES

Poorly controlled hormones can lead to the development of advanced signs of aging and age-related diseases leading to over weight/obese, depression, and sexual dysfunction

- Free and total Testosterone, Estradiol, & Progesterone

#### ASSESSMENT OF YOUR METABOLIC FUNCTION AND BLOOD SUGAR

These basic functions can be severely damaged by chronic stress and metabolic problems all leading to a decrease in your energy and muscle tone; and an increase in your weight and fat storage.

- CMP

#### ASSESSMENT OF YOUR THYROID HEALTH

The thyroid has a very important role in the proper function of your metabolism. If the Thyroid is not working properly you are at risk for increase weight and decrease energy.

- T3/T4, TSH

#### ASSESSMENT OF YOUR COMPLETE BLOOD COUNT AND ADVANCED NUTRIENT HEALTH

This panel looks at your blood to ensure your tissues and organs are being given the proper amounts of oxygen and nutrition.

- CBC and platelets

#### ASSESSMENT OF YOUR REPRODUCTIVE PANEL HEALTH

The function levels of your reproductive organs are checked to allow you to achieve the highest function possible.

- Testosterone, Estradiol, Progesterone

#### ASSESSMENT OF YOUR ADRENAL HEALTH

The adrenals play a vital role in metabolic function, inflammation, memory, electrolyte balance, some cancers, and tumors. An examination will allow you to gain an increase in your health status and early detection of any adrenal complications.

- DHEA, Electrolytes

#### ASSESSMENT OF YOUR SKELETAL HEALTH

Proper levels need to be checked to confirm healthy bones are being repaired and maintained, which allow you to have an increase in your quality of life.

- Calcium, Phosphorus, Magnesium, Vitamin D3