

**WELCOME TO: Back Pain Institute of St. Louis**

To insure proper case information, please provide us with the following information.  
If you need assistance in completing these forms, please step to the front desk.

Today's date \_\_\_\_\_

Name \_\_\_\_\_ Nick-name preferred \_\_\_\_\_

Date of Birth \_\_\_\_\_  Male  Female Soc.Sec # \_\_\_\_\_

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

City, State, Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer's Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Name of person or source how you were referred: \_\_\_\_\_

If different from above, who is your family physician? \_\_\_\_\_ Phone # \_\_\_\_\_

May we contact your PCP regarding your treatment?  Yes  No

**IF WE HAVE COPIES OF YOUR INSURANCE CARDS YOU MAY SKIP THIS SECTION**

FINANCIAL :	PRIMARY INSURANCE	SECONDARY PAYER OR RESPONSIBLE PARTY
CARRIER NAME		
ADDRESS		
CITY,ST.ZIP		
POLICY #		
INSURED NAME		
RELATION		
SOC. SEC. #		
BIRTH-DATE		
GROUP #		
EMPLOYER NAME		

I the undersigned hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

WHAT PROBLEM BRINGS YOU TO SEE US TODAY?

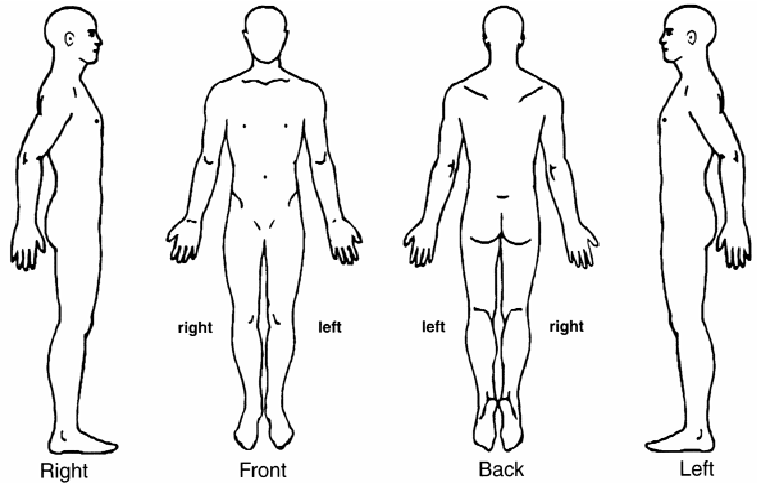
WHEN DID THIS PROBLEM START?

Did it come on:  Suddenly  Built up over several days  Gradually worse over a long time.  
 If you were injured was it:  At Work  At Home  Due to Auto Accident  Other Injury

ON THE FIGURES AT THE RIGHT, PLEASE MARK YOUR AREA(S) OF PAIN OR DISCOMFORT.

+++ Burning                      /// Stabbing  
 .... Pins & needles                      xxx No feeling

**Circle** the areas (if more than one) of pain and tell us on a scale of 1 to 10, with 1 being light pain to 10 being very severe, how severe is your pain in each area most of the time and how frequent.



AREA 1 pain is (1-10) \_\_\_ Constant or Intermittent

AREA 2 pain is (1-10) \_\_\_ Constant or Intermittent

Please help us understand your pain: **Circle the words** for each area that best describes your pain and activity during your day.

**Area 1** is: Worse in AM At Night After exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

**Area 2** is: Worse in AM At Night After exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

**Area 3** is: Worse in AM At Night After exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

I have difficulty with: Walking Sitting Standing Driving a car Sleeping My daily routine Bladder Control Depression

I currently am : Ambulatory without assistance Need to use: Support Brace \_\_\_\_\_ Walker Cane Crutches Wheelchair

Please help us better understand **your personal circumstances** and assist us in providing you customized treatment and care.

I Am  Working Full Time  Part Time  Homemaker  Full Time Student  Unemployed  Retired

Now: Occupation: \_\_\_\_\_

On sick leave  On Temp disability  On Full Disability My last day worked was \_\_\_\_\_

Age \_\_\_\_\_ Single Married Separated Divorced Widowed

**Please feel free to discuss with us any situation in your personal relationships that may affect your recovery.**

I Now  Smoke \_\_\_ Packs per day Stopped \_\_\_\_\_  Use Alcohol Type and Amt \_\_\_\_\_

Consume Caffeine: Type/ Amt \_\_\_\_\_  Use recreational drugs \_\_\_\_\_

I am now or have in the past been :  Addicted to drugs alcohol  Treated for alcohol or drug addiction

<b>WOMEN ONLY</b>	Can you become pregnant? YES NO	Date of last period _____	Normal Yes No
	If not, why? _____	Date of last Mammogram _____	Normal Yes No
	<b>Are you now or could you be pregnant ??</b> YES NO	Pap Smear _____	Normal Yes No

Patient		Primary Intake History
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**Pertinent History:** Please advise us of any special circumstances, previous tests, therapy or conditions.

**Are you allergic to any medications?** NO YES (If yes, please list all that you are allergic to below)

**If you previously had any of the following procedures, please list the date and place they were performed.**

PROCEDURE	DATE(S)	PLACE PERFORMED
X-Rays		
C.T. / MRI		
Myelogram		
Ultrasound		
E.M.G.		
Treatment by Another Physician		
For what?		

**PLEASE MARK ANY CONDITION THAT YOU NOW HAVE OR HAVE RECOVERED FROM IN THE RECENT PAST.**

Severe headaches / Chest pain / Angina / Kidney Stones / Digestive problems / Hypertension / Renal disease / Gout / Stroke / Heart murmur / Diabetes / Arthritis / Epilepsy / Arrhythmia / Endocrine disease / HIV / AIDS / Fatigue / Congenital heart disease / Urinary, genital problems / Dizziness / Fainting / Anemia / Rheumatic fever / Scarlet fever / Prostate problems / Ulcers / Gall Stones / Sexual dysfunction / Venereal disease / Hepatitis / Shortness of breath / Menstrual dysfunction / Mental Illness / Asthma / Liver disease / Alcohol or Drug problems.

CURRENT MEDICATIONS PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. (Prescription and over the counter)	HOSPITALIZATION and SURGERY																		
<p><b>Name of medication and Strength</b>                      <b># of doses / day</b></p> <table border="1"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>													<p>PLEASE LIST ALL SURGERY AND ANY PERIODS OF HOSPITALIZATION (give dates)</p> <table border="1"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>						

**FAMILY HISTORY:** Has anyone in your immediate family (mother, father, grandparents, brothers, sisters, children) had

condition	who?	condition	who?
Heart Disease		Epilepsy	
Hypertension		Glaucoma	
Stroke		Bleeding disorders	
Cancer		Kidney disease	
Diabetes		Thyroid disease	

**Do you require special care or have any concerns that might affect your treatment or recovery?** NO YES (If yes please describe)

**Thank you** for assisting us in gathering the information our medical providers need to help determine a personal treatment plan for you. To verify that the information is correct as given to us by you, please affix your signature in the area (x) provided below.

Patient Signature: X

Primary Intake History #6011

## HIPAA— Notice of Privacy Practice

### Back Pain Institute of St Louis, LLC Consent for Purposes of Treatment, Payment and Healthcare Operations

I, \_\_\_\_\_ [Name of Individual] consent to Back Pain Institute of St Louis, LLC's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative

I furthermore hereby authorize Back Pain Institute of St. Louis, LLC to release my medical information to the following person(s)/entities:

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

Back Pain Institute of St. Louis, LLC does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: Angela J. Moses, (314) 770-2225, TDD 711. The above signature states that I have read and understand the preceding paragraph.

_____	_____	_____
PATIENT	ID#	DATE

**MEDICATION CONTRACT**