THE PAIN SPECIALIST
DR. ANA MARIA PLATON, MD
STOCKBRIDGE, GA 30281

PATIENT REGISTRATION FORM

PH: 770-507-6995
FX: 770-507-8252

PATIENTS NAME: _____ DATE OF BIRTH: ___/_____/_____AGE: _____

STREET ADDRESS: _____ CITY/STATE/ZIP: _____

HOME #: _____ CELL #: _____ ALTERNATE: _____

SOCIAL SECURITY NUMBER: _____/_____/_____ MARITAL STATUS: _____

EMPLOYER: _____ PHONE #: _____

PRIMARY OR REFERRING PHYSICIAN: _____ PHONE#: _____

REASON FOR TODAY'S VISIT: _____

PRIMARY INSURANCE CARRIER: _____ PHONE #: _____

PRIMARY POLICY #: _____ GROUP #: _____

POLICY HOLDER: _____DOB: _____ SSN: _____/_____/_____

SECONDARY INSURANCE CARRIER: _____ PHONE#: _____

SECONDARY POLICY #: _____ GROUP #: _____

POLICY HOLDER: _____ DOB: _____ SSN: _____/_____/_____

EMERGENCY CONTACT INFORMATION

NAME: _____

RELATIONSHIP TO PATIENT: _____

PHONE #: _____

CANCELLATION POLICY

We care about our patients. When we schedule you for a procedure, we take 45 minutes to 1-hour appointment slots. We prepare for the procedure, which also involves time. Other patients are also waiting for appointments and we must be considerate of their time. Our policy is structured that one must cancel **24 hours in advance**; otherwise a cancellation fee will apply. The fee for a procedure not cancelled within 24 hours is $100.00. A $50.00 fee will be applied to your account for all follow up visits not cancelled within 24 hours as well. We apologize for any inconvenience as we wish to be kind to all our patients.

Sincerely,
Dr.Platon and Staff

PATIENT SIGNATURE: _____ DATE: _____

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REVIEW OF SYSTEMS

(IF NONE APPLY, PLEASE CHECK THE "NONE" BOX)

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HEAD - NONE ⬭
- ☐ Headache
- ☐ Sinus
- ☐ Entire head
- ☐ Back of neck
- ☐ Back of head
- ☐ Forehead
- ☐ Temples
- ☐ Migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light- headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision

NECK - NONE ⬭
- ☐ Pain in neck
- ☐ Pain with movement
- ☐ Forward
- ☐ Backwards
- ☐ Turn to the left
- ☐ Turn to the right
- ☐ Bend to left
- ☐ Bend to right
- ☐ Pain goes down arm with neck movement
- ☐ Neck feels "out of place"
- ☐ Muscle spasm in neck
- ☐ Popping sound in neck
- ☐ Previous diagnosis of arthritis in neck
- ☐ Difficulty swallowing.

SHOULDERS - NONE ⬭
- ☐ Tension spasm in shoulder
- ☐ Pain in shoulder R L
- ☐ Cant raise arm R L
- ☐ Above shoulder
- ☐ Over head
- ☐ Grinding/popping in shoulders R L

ARMS & HANDS - NONE ⬭
- ☐ Pain in upper arm R L
- ☐ Pain in elbow R L
- ☐ Pain in forearm R L
- ☐ Pain in hand R L
- ☐ Pain in fingers R L
- ☐ Tingling sensation in hand/fingers R L
- ☐ Loss of feeling in arm R L
- ☐ Loss of feeling in hand/fingers R L
- ☐ Hands "go to sleep" R L
- ☐ Hands frequently feel cold R L
- ☐ Hands frequently feel hot R L
- ☐ Swollen joints in fingers R L
- ☐ Sore joints in fingers R L
- ☐ Loss of grip strength R L

UPPER & MID BACK- NONE ⬭
- ☐ Tightness/spasm in upper back
- ☐ Tightness/spasm in mid- back
- ☐ Pain between shoulder blades
- ☐ Pain worsens with deep breath
- ☐ Pain front to back (around ribcage)
- ☐ Pain in kidney area (sides of mid-back)

CHEST/CARDIOVASCULAR- NONE ⬭
- ☐ Chest pain
- ☐ Pain around ribs
- ☐ Pain in chest and left arm
- ☐ Irregular heart beat
- ☐ High blood pressure

LOWER BACK - NONE ⬭
- ☐ Low back pain/ache

Low back pain while:
- ☐ Working
- ☐ Stooping
- ☐ Standing
- ☐ Sitting
- ☐ Bending forward
- ☐ Bending backward
- ☐ Bending to side
- ☐ Twisting to side
- ☐ Coughing
- ☐ Walking
- ☐ Other: _____
- ☐ Pain goes down legs
- ☐ Previous diagnosis of low back arthritis

HIPS, LEGS & FEET - NONE ⬭
- ☐ Pain in buttocks R L
- ☐ Pain in the hip/upper leg joint
- ☐ Pain in groin area
- ☐ Pain down leg
- ☐ Knee pain

Knee pain worse while:
- ☐ Bending
- ☐ Straightening knees
- ☐ Walking
- ☐ Lying down

- ☐ Knees grinding or popping
- ☐ Legs cramp
- ☐ Pain in ankle
- ☐ Swelling in ankle
- ☐ Swelling in foot
- ☐ Tingling sensation in leg
- ☐ Numbness of leg
- ☐ Numbness of foot
- ☐ Numbness in toes
- ☐ Foot feels cold

ABDOMEN/GASTROINTESTINAL - NONE ⬭
- ☐ Abdominal pain
- ☐ Upset stomach
- ☐ Lump in abdomen
- ☐ Foods you can't eat _____
- ☐ Nausea
- ☐ Gas/bloating
- ☐ Frequent vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger

WOMAN ONLY - NONE ⬭
- ☐ Are you, or do you think your pregnant? Y N
- ☐ Menopause
- ☐ Date of last menstrual period
- ☐ Hysterectomy? Date _____
- ☐ Menstrual pain? Where? _____
- ☐ Hot flashes
- ☐ Birth control? Type: _____
- ☐ Tumors

ALLERGIES (PLEASE LIST) - NONE ⬭
- ☐ Foods: _____
- ☐ Environmental: _____
- ☐ Medications: _____
- ☐ Herbs: _____
- ☐ Chemicals: _____
- ☐ Other: _____

GENERAL - NONE ⬭
- ☐ Chills
- ☐ Depression
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Irritable
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

SKIN - NONE ⬭
- ☐ Bruise easily
- ☐ Itching
- ☐ Change
- ☐ Rash
- ☐ Scars
- ☐ Sores that wont heal

LIFESTYLE - NONE ⬭
- ☐ Normal sleep: _____ hrs a night
- ☐ Loss of sleep: _____ hrs a night
- ☐ Loss of weight in last year? _____ LBS
- ☐ Gain weight in last year? _____ LBS
- ☐ Coffee? _____ cups a day
- ☐ Cigarettes? _____ pack(s) a day

DISEASE - NONE ⬭
- ☐ Cancer? Type _____
- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hypertension (high blood pressure)
- ☐ High cholesterol
- ☐ Hypoglycemia
- ☐ Stroke
- ☐ Epilepsy
- ☐ Liver disease
- ☐ HIV +
- ☐ AIDS
- ☐ Chicken pox
- ☐ Measles

Have any family members experienced similar conditions for anything checked on this page? Y N
(Describe) _____
_____

I hereby certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member responsible for any errors or omissions that I may have made in the completion of this form.

X:_____

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INITIAL PAIN ASSESSMENT

PH: 770-507-6995
FX: 770-507-8252

PATIENT NAME: _____ TODAY'S DATE: _____

HEIGHT: _____ WEIGHT: _____ DOB: _____ AGE: _____

EMPLOYMENT STATUS: (PLEASE CIRCLE ONE) WORKING UNEMPLOYED DISABLED RETIRED

IF YOU ARE NOT WORKING LIST REASON WHY: _____

HOW LONG HAVE YOU BEEN OUT OF WORK? : _____

TYPE OF INJURY: _____ DATE PAIN BEGAN: _____

HAVE YOU HAD YOUR PAIN FOR GREATER THAN 6 MONTHS? Y N

CHIEF COMPLAINT/PRESENT ILLNESS: _____

_____

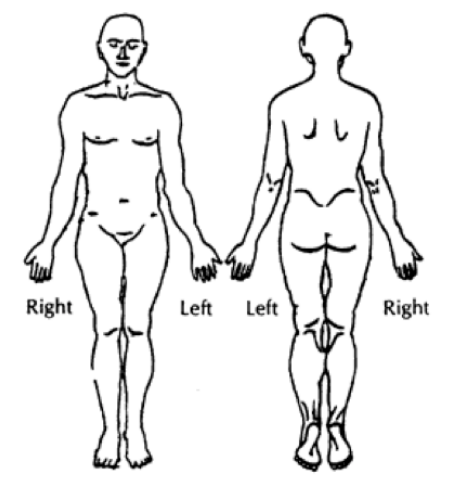
PAIN ASSESSMENT GRID

Mild Discomforting Distressing

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|__

0 1 2 3 4 5 6 7 8 9 10

NO PAIN WORST PAIN



PLEASE SHADE AREAS WHERE YOU ARE HAVING PAIN ON THE FIGURES

PAIN DESCRIPTION
1. Throbbing
2. Shooting
3. Stabbing
4. Sharp
5. Cramping
6. Pulling
7. Burning
8. Numbness
9. Tingling
10. Stinging
11. Dull
12. Aching
13. Tender
14. Squeezing
15. Nagging
16. Other

PAIN FREQUENCY
1. Constant- never pain free
2. Periodic- comes and goes
3. Brief- pain less than 15 minutes at a time.

Please complete the chart below following the example given, and using the descriptions to the left.

LOCATION OF PAIN	PAIN SCORE	DESCRIBE PAIN	FREQUENCY
EX: Front of R leg to top of foot	**6**	**9**	**1**
1.			
2.			
3.			

BEST YOUR PAIN GETS _____/ 10 WORST YOUR PAIN GETS _____/ 10

DOES YOUR PAIN RADIATE DOWN YOUR ARMS? _____ R OR L

DOES YOUR PAIN RADIATE DOWN YOUR LEGS? _____ R OR L

WHAT RELIEVES YOUR PAIN? _____

WHAT MAKES IT WORSE? _____

EFFECTS OF PAIN TO YOUR EVERYDAY LIFE: (DECREASED FUNCTION OR DECREASED QUALITY OF LIFE)

ACCOMPANYING SYMPTOMS (I.E. NAUSEA): _____

SLEEP AFFECTED? _____ APPETITE AFFECTED? _____ CONCENTRATION AFFECTED? _____

PHYSICAL ACTIVITY AFFECTED? _____ HOW IS IT LIMITED? _____

RELATIONSHIP WITH OTHERS AFFECTED? _____

EMOTIONS ASSOCIATED WITH YOUR PAIN (I.E. ANGER, SUICIDAL, CRYING) : _____

_____

PREVIOUS TREATMENTS

HAVE YOU EVER BEEN TREATED AT A PAIN CLINIC? _____ WHERE? _____

HAVE YOU HAD ANY TEST PERFORMED? ☐ MRI ☐ CT SCAN ☐ X-RAYS

IF YES, WHERE? _____ DATE/WHEN? _____

HAVE YOU HAD INJECTIONS TO TREAT THIS PROBLEM? _____

IF YES, WHEN? _____ WHAT TYPE? _____

DID THE INJECTIONS HELP? _____ WERE THE INJECTIONS FOR YOUR CURRENT PROBLEM? _____

HAVE YOU TRIED A TENS UNIT OF OTHER DEVICES FOR PAIN TREATMENT? _____

DO YOU HAVE ANY DEVICES IMPLANTED FOR PAIN CONTROL? _____ WHAT TYPE? _____

WHEN WAS IT IMPLANTED? _____ WHO PLACED THIS DEVICE FOR YOU? _____

HAVE YOU HAD PHYSICAL THERAPY TO TREAT THIS PROBLEM? _____ WHEN? _____

DO YOU PERFORM HOME EXERCISES? _____ WHAT TYPE? _____

ALLERGIES: (PLEASE LIST **ALL** ALLERGIES AND SENSITIVITIES) **LATEX ALLERGY? Y / N**

_____

_____

MEDICATIONS (INCLUDE **ALL** PRESCRIBED MEDS AND OVER THE COUNTER MEDS): _____

_____

HAVE YOU TRIED ANTI-INFLAMMATORIES? _____

DO YOU TAKE BLOOD THINNERS OR ASPRIN PRODUCTS? _____

WHAT MEDICATIONS HAVE YOU TRIED IN THE PAST FOR THIS PAIN? _____

_____

DID THEY WORK? _____ IF YES, WHICH ONES? _____

MEDICAL HISTORY/ SOCIAL HISTORY

DO YOU HAVE, OR HAD IN THE PAST, ANY OF THE FOLLOWING?

CONDITION	Y	N	SURGERIES/TREATMENTS	FAMILY HISTORY?
AIDS/HIV				
Arthritis				
Respiratory Problems				
Bleeding Problems			Blood Thinners?	
Cancer				
Diabetes			Type Insulin? Y N	
Epilepsy / Seizures				
Headaches				
Heart Problems (stroke, heart attack)				
High Blood Pressure				
Psychiatric Conditions			Type Therapy? Y N	
Kidney Problems (Stones, UTI)				
Thyroid problems				
Spinal Problems			Location:	
Broken Bones/ Surgical Implants			Location:	
GI problems (Ulcers, Bleeding)				
Do you smoke?			PPD: Years:	
Do you drink? AMT:			Treatment Programs?	
History of addiction?			Treatment Programs?	
Are you Pregnant?			LMP / /	

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AUTHORIZATION FOR THE USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

PH: 770-507-6995
FX: 770-507-8252

As required by the Health Insurance Portability and Accountability Act of 1996, The Pain Specialist Corp, it's agents, subsidiaries or designated representatives may not disclose your health information except as provided in her Notice of Privacy Practices without your authorization.

Your signature on this form indicates that you are giving permission for the users and disclosures described herein. You may revoke this authorization at any time by signing and dating the revocation section of this form and returning it to The Pain Specialist Corp. The revocation section of this form is available upon request.

AUTHORIZATION SECTION

I, _____ (printed name) authorize the following Protected Health Information that pertains to me to be used or disclosed on my behalf by The Pain Specialist Corp. and her agents or designated representatives, for treatment, payment, and health care operations.

1. All information regarding my health coverage or treatment received.
2. All medical records and x-rays.
3. All claims and payment information.
4. All appeals information.
5. All benefits and billing information disclosures of my health information.

I authorize the following persons to receive these disclosures of my health information : Any entity that is involved in my care, including insurance companies and employers.

I request that payment of authorized benefits be made on my behalf to The Pain Specialist Corp or its designated representative.

I hereby authorize The Pain Specialist Corp and its designated representatives to obtain from the Social Security Administration, any information required to establish my entitlement to Medicare/Medicaid benefits.

I understand that I am financially responsible to The Pain Specialist Corp for charges not covered by this assignment.

I understand that information disclosed pursuant to this authorization be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation form. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose by health information have already acted in reliance on this authorization. I have read the contents of this authorization and understand and agree to the use and disclosure of my Protected Health information as specified above. I also understand that this authorization is voluntary, does not effect my ability to obtain treatment, and that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

_____ _____

SIGNATURE DATE

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NARCOTIC AGREEMENT

(AS POSTED ON THE AMERICAN ACADEMY OF PAIN MEDICINE WEBSITE)

PH: 770-507-6995
FX: 770-507-8252

THE PURPOSE OF THIS AGREEMENT IS TO PROTECT YOUR ACCESS TO CONTROLLED SUBSTANCES AND TO PROTECT OUR ABILITY TO PRESCRIBE FOR YOU

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment)

2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

_____ Phone : _____

3. You are expected to inform our office of any new medication or medical conditions, and of any adverse effects you experience from any of the medications that you take.

4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacies or other professionals who provide your health care for purposes of maintaining accountability.

5. You may not share, sell, or otherwise permit others to have access to these medications.

6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.

7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.

8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

9. Original containers or medication should be brought in to each office visit.

10. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

11. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication is stolen and you complete a police report regarding the theft, an exception MAY be made.

12. Early refills will generally not be given.

13. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they may not be filled prior to the appropriate date.

14. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

16. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

17. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

18. The risk and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have reviewed such explanation).

19. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

PHYSICIAN SIGNATURE	PATIENT SIGNATURE
DATE	PATIENT NAME (PRINTED)