



## **PATIENT DEMOGRAPHICS**

Patient Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle  
Initial \_\_\_\_\_

Patient Email Address  
\_\_\_\_\_

Address  
\_\_\_\_\_

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

Home Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

Patient DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Patient Sex:  Male  Female

Race:  American Indian  Asian  Black or African American

White  Native Hawaiian or other Pacific Islander

Patient Refusal

Preferred Language: \_\_\_\_\_

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino

Patient Refusal

Social Security Number \_\_\_\_\_-\_\_\_\_-\_\_\_\_

Marital Status  Married  Divorced  Single  Widowed

Other

Primary Care Physician \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_-\_\_\_\_  
\_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_-\_\_\_\_  
\_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_-\_\_\_\_  
\_\_\_\_\_

Name of Employer  
\_\_\_\_\_



Occupation

Is this visit related to an on the job injury?  No  Yes

If Yes, Date of Injury:

Is this visit related to an automobile accident?  No  Yes

If Yes, Date of Accident:

Insurance Company **(if auto or work comp)**

Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Policy #

Are you currently working with an Attorney at this time?  No  Yes

If Yes:  Personal Injury  Workman's Compensation Claim #

Attorney Name

Address

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

Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**RESPONSIBLE PARTY'S BILLING INFORMATION  
(IF MINOR OR SIGNED OVER POWER OF ATTORNEY)**

Last Name \_\_\_\_\_ First Name

Address



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

Home Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_ Responsible Party's DOB  
\_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Patient  
\_\_\_\_\_

### **PRIMARY INSURANCE INFORMATION**

Insurance Company \_\_\_\_\_ Subscriber# \_\_\_\_\_

Employer Sponsoring Plan  
\_\_\_\_\_

Insured DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured Name  
\_\_\_\_\_

### **SECONDARY INSURANCE INFORMATION**

Insurance Company \_\_\_\_\_ Subscriber # \_\_\_\_\_

Employer Sponsoring Plan  
\_\_\_\_\_

Insured DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured Name  
\_\_\_\_\_



## Financial Arrangements and Insurance

We are committed to providing you with the best possible care. If you have health insurance, we will help you receive your maximum allowable benefits. To achieve this we need your assistance, and understanding of our payment policy. Please always bring your current insurance card with you to all appointments. We will collect your co-payment at the time of service, if you cannot pay your co-pay at the time of service, your appointment will need to be rescheduled.

We participate with Medicare. We accept Medicare assignment and will bill Medicare for you. If you have supplemental insurance please bring that information with you to your appointment. You may be responsible for a portion of your charges such as Medicare deductible and co-insurance.

If you belong to an insurance which requires a referral from your Primary care physician, please bring the referral with you to your appointment. We must have a current referral before you can be seen. If you do not bring a current referral with you to your appointment, your appointment will have to be rescheduled.

If you are being treated for a work-related injury, injuries occurring from an automobile accident, or a third-party liability (for example, injured on the property of another person), we must have approval from your adjuster prior to seeing you. We will also need the following information; name of your insurance carrier, their address, and phone number, your adjusters name, your claim number, and the date of your injury/accident.

If your claim is denied by workmen's compensation, auto insurance, or third-party liability, you will be responsible for the entire bill for services. If the automobile insurance fails to pay for 100 percent of the billed charges, you will be held responsible for any amount the insurance does not cover. Returned checks and balances older than 30 days are subject to additional collection fees you will be assessed a \$20.00 fee on any returned check. In addition to collection and legal fees (13-21-109 C.R.S.). Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice.

If payments are not paid as agreed and your account is placed for collection, you agree to pay all reasonable costs of collection, including but not limited to; attorney fees, court costs, and interest at 18% per annum from the date of service.



We will gladly discuss your proposed treatment, and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R" which is defined as "usual, customary, and reasonable" fees, for this region. Thus our fees are considered usual, customary, and reasonable by most companies.

This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as health care providers our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or are uncertain regarding your insurance coverage, PLEASE don't hesitate to ask us. We are here to help you

I have read and understand the above financial policy and agree to abide by the policy as stated.

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Printed patient name



\_\_\_\_\_  
Patient or representative signature

\_\_\_\_\_  
Date

### **CONSENT TO PAYMENT**

I understand that responsibility for payment of medical services in this office for my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance.** I also assign all benefits to Colorado Pain Consultants, PLLC. I authorize the submission of claims without obtaining my signature on each and every claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize this Colorado Pain Consultants, PLLC and its employees, agents and assignees to contact me via e-mail, text messaging and to my cellular devices.

### **Late for Scheduled Appointments**

We understand that delays can happen, however we must try to keep the other patients and providers on time. If a patient is past their scheduled time it is up to the discretion of the provider if the appointment is to be reschedule.

Initials: \_\_\_\_\_

### **Cancellation/No Show Policy for Office Appointment**



We understand that there are times when you must miss an appointment due to emergencies. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar (\$50) fee; this will not be covered by your insurance company.

Initials: \_\_\_\_\_

### **Cancellation/No Show Policy for Injection Appointment**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a one hundred and fifty dollar (\$150) fee; this will not be covered by your insurance company.

Initials: \_\_\_\_\_

### **CPC POLICY ON MARIJUANA/THC/ALCOHOL/TOBACCO**

Due to government policies and safety reasons, opioids, benzodiazepines, or any controlled substances cannot be prescribed if you are consuming marijuana/THC.

Initials: \_\_\_\_\_



Alcohol is not allowed as it can create adverse effects which can lead to death while taking opioids or any other controlled substances.

Initials: \_\_\_\_\_

Smoking any tobacco products will not be permitted. Recent research shows that nicotine makes people more sensitive to pain. If you are a current smoker, you and your doctor will agree upon a time frame to cease all smoking.

Initials:

\_\_\_\_\_

All patients are required to do a drug screen if their doctors prescribe opioids or any other controlled substances. Your screening may take place during an appointment, or you may be randomly called to our office to supply a sample. It is also possible to be called in for random pill counts. Failure to comply is an automatic dismissal from Colorado Pain Consultants.

Initials: \_\_\_\_\_

Patient's Signature:

\_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_





## **NEW PATIENT INTAKE FORM**

Your completed intake paperwork helps our physicians and other providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk or call (303) 792-2959 if you have any question on how to complete any section on this form.

Name:

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Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### **Patient Information**

Chief Complaint (Reason for your visit today)?

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Does this pain radiate? If so where?

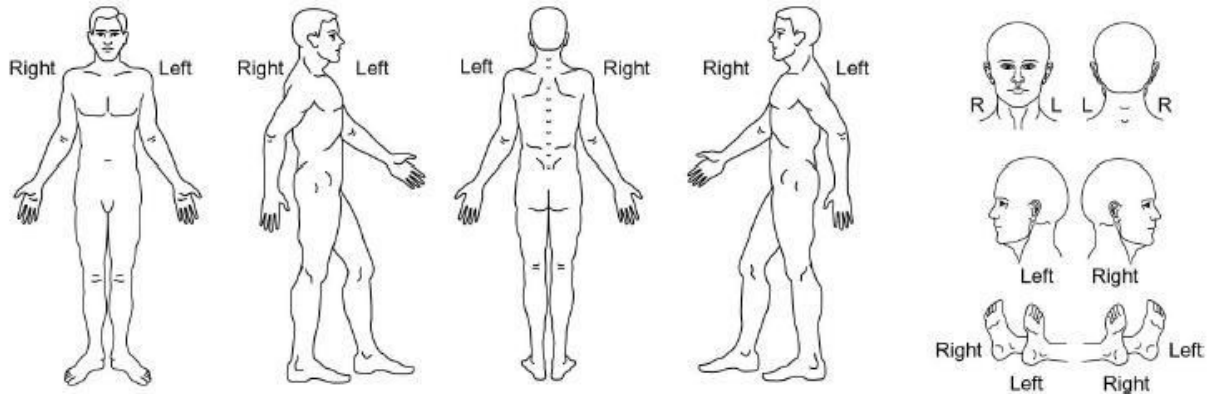
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Please list any additional areas of pain:

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Use this diagram to indicate the area of your pain. Mark the location with an "X"



**PAIN HISTORY**

Approximately when did this pain begin?

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What caused your current pain episode?

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How did your current pain episode begin?  Gradually  Suddenly

Since your pain began, how has it changed?  Improved  Worsened  
 Stayed the same

Was this caused by an accident? If so, please list if this is auto/work related and describe nature of accident:

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**Pain Description**

**Check all of the following that describe your pain:**

- Dull/Aching
- Hot/Burning
- Shooting
- Stabbing/Sharp
- Cramping
- Numbness
- Spasming
- Throbbing
- Squeezing
- Tightness
- Tingling/Pins and Needles

**Where is your pain worst?**



Morning  Daytime  Evening  Middle of the Night  Always the same

**How often does the pain occur?**

Constant  Intermittent (comes and goes)  Changes in severity but always present

**If pain is “0” is no pain and “10” is the worst pain you can imagine, how would you rate your pain?** Right now \_\_\_\_\_ The Best it gets \_\_\_\_\_ The Worst it Gets \_\_\_\_\_

**Mark the effect each of the following have on your pain level (please check all boxes that best describes your pain):**

	<u>Increase</u>	<u>Decrease</u>	<u>No change</u>
Bending Backward	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Bending Forward	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Changes in Weather	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Climbing Stairs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Coughing/Sneezing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Driving	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Lifting objects	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Looking upward	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Looking downward	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Going from sitting to standing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Sitting	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Standing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Walking	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>



What is the most comfortable position you can get into?

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What other factors worsen or affect your pain which is not mentioned above?

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### **ASSOCIATED SYMPTOMS**

	<b><u>No</u></b>	<b><u>Yes</u></b>	<b><u>Comments</u></b>
Numbness/Tingling	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
_____			
Weakness in the arm/leg	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
_____			
Balance Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Bladder Incontinence	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
_____			
Bowel Incontinence	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
_____			
Joint Swelling/ Stiffness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Fever/ Chills	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
_____			

**Please mark all of the following treatments you have used for pain relief: Please check the box that most reflects your treatment**

**1 -No change    2 -Worsened Pain    3 -Helped Pain**

**4 -Not Done**

Spine Surgery	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
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Physical Therapy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Chiropractic Care	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Massage Therapy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Psychological Therapy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Brace Support	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Acupuncture	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Hot Packs/Heat	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Ice Packs/Cold	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Medications	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
TENS Unit	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Other _____				

-





X-Ray of the: \_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_/\_\_\_\_/\_\_\_\_

CT Scan of the: \_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_/\_\_\_\_/\_\_\_\_

EMG/NCV study of the: \_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_/\_\_\_\_/\_\_\_\_

Other Diagnostic Testing: \_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_/\_\_\_\_/\_\_\_\_

I have not had ANY diagnostic test for my current pain complaint

**Mark the following physicians or specialist you have consulted for your current pain problem(s):**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Neurosurgeon       | <input type="checkbox"/> Psychiatrist/Psychologist |
| <input type="checkbox"/> Chiropractor  | <input type="checkbox"/> Orthopedic Surgeon | <input type="checkbox"/> Rheumatologist            |
| <input type="checkbox"/> Internist     | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Neurologist               |
| <input type="checkbox"/> Other         |   |  |

Have you ever been abused physically, emotionally or sexually?  Yes  No

If Yes, please explain?

\_\_\_\_\_

Have you ever been treated for a psychological disorder (depression, anxiety, bipolar disorder, etc.)?  Yes  No

If Yes, please explain?

\_\_\_\_\_

Have you ever been addicted to alcohol or drugs?  Yes  No

If Yes, what type and for how long?

\_\_\_\_\_

Have any of your family members been addicted to alcohol or drugs?  Yes  
 No



If Yes, who and what type?

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Please check if you suffer from the following:

- Poor Sleep
- Decreased Concentration
- Changes in appetite
- Decreased Sex Drive
- Decreased Interests
- Suicidal Thoughts
- Guilt (about being in pain)
- No Hope for the Future
- Decreased Energy





## **MEDICAL HISTORY**

Please list the names of other Pain Physicians you have seen in the past?

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Mark the following conditions/diseases that you have been treated for in the past:

### **General Medical**

Cancer- Type \_\_\_\_\_

Diabetes- Type \_\_\_\_\_

### **Cardiovascular/Hematologic**

Anemia

Heart Attack

Coronary Artery Disease

High Blood Pressure

Peripheral Vascular Disease

Stroke/TIA

Heart Valve Disorder

### **Gastrointestinal**

GERD (Acid Reflux) Syndrome

Gastrointestinal Bleeding

Stomach Ulcers

Arthritis

Constipation

### **Urological**

Chronic Kidney Disease

### **Head/Ears/Eyes/Nose/Throat**

Headaches

Migraines

Head Injury

Hyper/Hypo Thyroid

Glaucoma

### **Respiratory**

Asthma

Bronchitis/Pneumonia

Emphysema/COPD

### **Musculoskeletal/Rheumatologic**

Bursitis

Carpal Tunnel

Fibromyalgia

Osteoarthritis

Osteoporosis

Rheumatoid

Chronic Joint Pain

### **Other Diagnosed Conditions**

Kidney Stones

Urinary Incontinence



Dialysis

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**Neuropsychological**

Multiple Sclerosis  
Disorder

Depression

Bipolar

Peripheral Neuropathy

Anxiety

Schizophrenia

Seizures

Obsessive Compulsive Disorder (OCD)

**Past Surgical History**

Please list all surgical procedures you have had done in the past including date:

- 1) \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
- 2) \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
- 3) \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
- 4) \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
- 5) \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I have never had any surgical procedures performed.

**Current Medication**

Are you currently taking any blood thinners or anti-coagulants?  Yes  No

If Yes, which ones:

- Aspirin  Plavix  Coumadin  Lovenox  Dabigatam  Aggrenox
- Xaralto  Other:

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**Please list all medications you are currently taking including vitamins. Attach additional sheet if required:**

	<b><u>Medication Name</u></b>	<b><u>Dose</u></b>	<b><u>Frequency</u></b>
1)	_____	_____	
	_____		
2)	_____	_____	
	_____		



3) \_\_\_\_\_  
\_\_\_\_\_

4) \_\_\_\_\_  
\_\_\_\_\_

5) \_\_\_\_\_  
\_\_\_\_\_

6) \_\_\_\_\_  
\_\_\_\_\_

7) \_\_\_\_\_  
\_\_\_\_\_

8) \_\_\_\_\_  
\_\_\_\_\_

9) \_\_\_\_\_  
\_\_\_\_\_

10) \_\_\_\_\_  
\_\_\_\_\_

**Please list all past pain medications that you have been on at any point for your current pain complaints?**

	<u>Medication Name</u>	<u>Dose</u>	<u>Frequency</u>
1)	_____	_____	
	_____		
2)	_____	_____	
	_____		
3)	_____	_____	
	_____		
4)	_____	_____	
	_____		



5) \_\_\_\_\_  
\_\_\_\_\_

**Allergies**

Do you have any drug/medication allergies?  Yes  No

If so, please list all medications you are allergic to:

<u>Medication Name</u>	<u>Allergic Reaction</u>
1) _____ _____	
2) _____ _____	
3) _____ _____	
4) _____ _____	
5) _____ _____	





## **SOCIAL HISTORY**

Occupation:

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### **Working Status:**

- Full Time  Part-time  Restricted Duty  Disabled  Retired  
 Homemaker  Unemployed

### **Marital Status:**

- Married  Divorced  Single  Widowed  Other

**Are you currently under workman's compensation?**  Yes  No

**Is there an ongoing lawsuit related to your visit today?**  Yes  No

### **Alcohol Use:**

- Social Use  History of Alcoholism  Current

Alcoholism

- Daily use of alcohol  Never

### **Tobacco Use:**

- Current User  Former User  Never used

Packs per day  How many years? \_\_\_\_\_  Date you quit

\_\_\_\_/\_\_\_\_/\_\_\_\_

### **Illegal Drug Use:**

- Denies any illegal drug use  Currently uses Illegal drugs

Formerly used illegal drugs (Not currently using)

Marijuana/cTHC

Have you ever abused Narcotic or Prescription medications?  Yes  No



## **REVIEW OF SYSTEMS**

**Mark the following symptoms that you currently suffer from:**

### **Constitutional:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Chills        | <input type="checkbox"/> Fever                   | <input type="checkbox"/> Difficulty sleeping     |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Night Sweats            | <input type="checkbox"/> Fatigue                 |
| <input type="checkbox"/> Insomnia      | <input type="checkbox"/> Low sex drive           | <input type="checkbox"/> Tremors                 |
| <input type="checkbox"/> Weakness      | <input type="checkbox"/> Unexplained weight gain | <input type="checkbox"/> Unexplained weight loss |

### **Eyes:**

- Recent vision changes

### **Ear/Nose/Throat/Neck:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Earaches       | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Nosebleeds      | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Nosebleeds       |

### **Cardiovascular:**

- |                                     |                                       |  |
|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blood Clots  | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Fainting   | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Swelling in feet    |

### **Respiratory:**

- |                                |                                   |  |
|--------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Shortness of Breath |
|--------------------------------|-----------------------------------|--|

### **Gastrointestinal:**

- |                                       |  |   |
|---------------------------------------|--|---|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Acid Reflux     | <input type="checkbox"/> Abdominal Cramps |
| <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Hernia           |

### **Musculoskeletal:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Back Pain      | <input type="checkbox"/> Joint Pain    | <input type="checkbox"/> Joint Stiffness |
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Neck Pain       |

### **Genitourinary/Nephrology:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Flank Pain                            | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Decreased Urine Flow/Frequency/Volume |   |  |



**Neurological:**

- Dizziness                       Headaches                       Tremors  
 Numbness/Tingling

**Psychiatric:**

- Depressed Mood                       Feeling Anxious                       Stress  
Problems  
 Suicidal Thoughts                       Suicidal Planning                       Thoughts of  
Harming Others  
 All other review of systems negative

Reviewer:

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## **PHARMACY INFORMATION**

I agree to use only \_\_\_\_\_ pharmacy for all my medications given to me by Colorado Pain Consultants, PLLC.

My pharmacy is located at \_\_\_\_\_ and their phone number is (\_\_\_\_) \_\_\_\_-\_\_\_\_.

My pharmacy fax number is (\_\_\_\_) \_\_\_\_-\_\_\_\_.

It is my responsibility to notify my pharmacy that I am under a narcotic agreement with Colorado Pain Consultants, PLLC.

If I change my pharmacy for any reason, I agree to notify Colorado Pain Consultants, PLLC. I must put in writing at my next visit the name, address, phone number and fax number of the new pharmacy I have chosen to use.

- I will also advise my new pharmacy of my prior pharmacy's name and address.
- I agree **NOT** to use multiple pharmacies as this is a violation to my narcotics agreement.
- I will bring all prescription bottles to all my appointments and upon request by my provider.

Patient's name:

\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_



Patient's Signature:

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## **PATIENTS RIGHTS**

- Patients are treated with respect, consideration and dignity.
- Patients are provided appropriate privacy. Patients have the right to privacy of any information or treatment concerning his/her own medical care. Patients have the right to be informed of any person other than routine personnel that would be observing or participating in his/her treatment.
- Patients have the right to know the person or persons responsible for coordinating his/her care.
- Patient disclosures and records are treated confidentially, and except when required by law, patients are given the opportunity to approve or refuse their release.
- Patients are provided, to degree known, complete information concerning their diagnosis, treatment and prognosis. When it is medically inadvisable to give such information to a patient the information is provided to a person designated by the patients or to a legally authorized person.
- Patients have the right to receive from his/her physician enough information so that he/she may understand the procedure or treatment being received in order to sign the informed consent.
- Patients have the right to refuse treatment and to be informed of the consequences of his/her actions. Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
- Patients have the right to know if any research will be done during his/her treatment and have the right to refuse.
- Patients have the right to expect quality of care and service from the facility.
- Patient have the right to be informed of mechanism by which he/she will have continuing health care following if discharged from Colorado Pain Consultants, PLLC.



- Patients have the right to know services that are provided by Colorado Pain Consultants, PLLC.
- Patients have the right to know methods for expressing grievances and suggestions to Colorado Pain Consultants, PLLC.
- Patient has the right to information concerning the instruction to which he/she may have to be transferred. The institution to which the patient is being transferred must give approval prior to transfer.

Patient's Signature:

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Date: \_\_\_\_/\_\_\_\_/\_\_\_\_