Interventional Pain Medical Group
Dr. John F. Petraglia, MD, QME

NAME: _____ DOB: _____

ADDRESS: _____

E-MAIL ADDRESS: _____

CITY: _____ SS# _____

STATE: _____ ZIP CODE: _____

PHONE: _____ ALT. PHONE: _____

EMPLOYER: _____

EMERGENCY CONTACT

NAME: _____

HOME PHONE: _____

WORK PHONE: _____

RELATION TO PATIENT: _____

NEAREST RELATIVE

NAME: _____

HOME PHONE: _____

WORK PHONE: _____

RELATION TO PATIENT: _____

PRIMARY INSURANCE

INS. CO.: _____

ADDRESS: _____

CITY, STATE & ZIP _____

PHONE: _____ CONTACT: _____

ACCT.#/CLAIM#: _____

SECONDARY INSURANCE

INS. CO.: _____ ADDRESS: _____

CITY, STATE, & ZIP: _____

PHONE: _____ CONTACT: _____

ACCT. #/CLAIM # _____

Initial Pain Management Questionnaire

Date: _____ Office Location: _____

Please read these questions carefully and answer them to the best of your ability.

Name: _____ Age _____ Height _____ Weight _____

Soc. Sec# _____ Date of Birth _____ ( ) Right Handed ( ) Left Handed

Address _____ Phone (___) _____

Interpreter needed? ( ) Yes ( ) No If yes language _____ Interpreter Name _____

Insurance : Workers Compensation / Private PPO-POS / Medicare / HMO / Personal Injury _____

Employer: _____ Job Title _____ Duties _____

Attorney Name : _____

Referring Physicians: _____ Phone _____

Primary Physician _____ Phone _____

Chief Complaints *Why have you come to see the Pain Doctor*

1. _____
2. _____
3. _____

Date of Injury(s): _____

If there was no specific incident, but injury occurred over a period of time, please estimate date you first noticed symptoms

History of Injury/ Injuries: *In your own words, please describe the injury/s or accident/s (if more than one, begin with first and describe what you were doing, how you were injured, what parts of your body were affected, your symptoms*

_____

_____

_____

_____

Pain level at time of injury: 0 1 2 3 4 5 6 7 8 9 10

Please rate your pain by circling number. 0 = no pain, to 10 = worst pain imaginable

Did you continue working? ( ) Yes ( ) No If no when did you stop? _____

Was injury reported to employer? ( ) Yes ( ) No if yes, when? _____

Did any of these symptoms exist prior to your injury/illness? ( ) No ( ) Yes, please explain: _____

Previous Workers Comp Claim ? ( ) Yes ( ) No _____

Describe First medical treatment received (when, where, by who, eg. medical /chiropractic?)

_____

Were X-rays taken: ( ) Yes ( ) No Were you hospitalized? ( ) Yes ( ) No _____

Treatments	Yes	No	Did This Help?	Yes	No
Physical Therapy					
TENS					
Chiropractor					
Acupuncture					
Acupressure					
Traction					
Biofeedback/Hypnosis					
Psychiatrist					
Psychologist					
Pain Clinic / Pain Center					
Nerve Block / Pain Blocks					

Have you been seen by a **Pain Management Doctor**? ( ) No ( ) Yes Who _____ _____

Have you received any of the following treatments? Please circle: Epidural blocks, Facet joint injections, Nerve blocks, Spinal blocks, Disc Injections, Trigger point injections, Other injections _____

Have you had Surgery for this problem? _____

Special Studies: X-Ray, MRI, CT Scan, EMG, NCV, Myelogram, Discogram, Bone Scan, Arthrogram

_____

Current Complaints :

With the treatment provided to date, do you feel your condition is ( ) Improved ( ) Worsened ( ) Unchanged
Do you still have pain as a result of the work injury or injuries? ( ) Yes ( ) No If yes describe where?

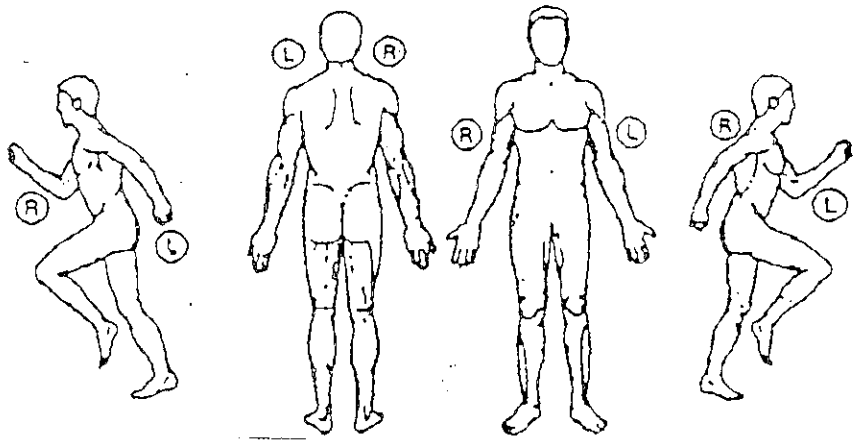
Pain Scale: *Please rate your pain by circling number. **0** = no pain, to **10**=worst pain imaginable*

Morning	0	1	2	3	4	5	6	7	8	9	10
Evening	0	1	2	3	4	5	6	7	8	9	10
Night	0	1	2	3	4	5	6	7	8	9	10

Pain Description: *Please circle the words which best **describe your pain**?*

Aching	Shooting	Dull	Constant	Burning
Tingling	Tight	Radiating	Cramping	Hotness
Heavy	Annoying	Numbing	Coldness	Intense
Severe	Stinging	Soreness	Brief	Unbearable
Stabbing	Sharp	Transient	Excruciating	

Drawing: *Please shade / draw in the areas where you have pain: This is very important !*



Does your present pain travel to other parts of the body? ( ) Yes ( ) No If yes, where? _____
Is there any stiffness / numbness / tingling / weakness / swelling? ( ) Yes ( ) No If yes, draw above where?

What makes the pain **Worse**? (circle appropriate activity) ? Describe activities which aggravate your pain?

Sitting	Bending	Lifting	Driving	Rising from a chair
Walking	Running	Sports	Stress	Sexual Intercourse
Standing	Eating	Lying Down	Other: _____	

What makes your pain **Better**?
Lying down (Face lying, Back lying, Side-lying)

Stretching	Activity	Ice	Heat	Massage
Sitting	Exercise	Sleep	Other: _____	

Any falling?( ) No ( ) Yes How often? _____ Any locking in joints? ( ) No, If yes, where? _____
Any giving way of joints? ( ) No ( ) Yes, where? _____

Are there any <u>new</u> Bowel or Bladder Incontinence problems? ( ) Yes ( ) No Any old Incontinence?

Does the pain affect your sleep? ( ) Yes ( ) No How many hours do you sleep at night? _____
Do you feel /are you depressed? ( ) Yes ( ) No _____
Are you overeating ( ) Yes ( ) No Gaining weight ( ) Yes ( ) No
Are you receiving Physical Therapy? ( ) Yes ( ) No If yes, how often? _____
Is the Physical Therapy helping? Explain: _____

Activities – list 5 of your regular activities that you have trouble doing because of this condition
Has injury in question hindered or stopped you from doing any of these things? ( ) Yes ( ) No Explain

Medications: Do you take any medications? Please List

Name	Dose	How Often?	Name	Dose	How Often?

Are you taking **Coumadin**? ( ) Yes ( ) No Other Blood thinner? _____

ALLERGIES to medications? _____

Medical History : *Please circle if you have had any of the following diseases / illnesses as an adult*

Heart attack	Diabetes	Heart Disease	Epilepsy/Seizures
Anemia	Pneumonia	Kidney Disease	Hepatitis/ Jaundice
Hernia	Chicken Pox/Measles	Fracture	High Blood Pressure
Cancer	Birth Defect	Tuberculosis	Gallbladder Disease
Stroke	Skin Disease	Rheumatic Fever	Bleeding Disorder/ Blood Clot
Ulcer	Current Infections	Thyroid Disease	Asthma
Sexually Transmitted Diseases		Mental Disorder	Arthritis

Other _____

Have you ever been hospitalized for a major illness? _____

Surgeries: Have you had any surgeries? ( ) Yes ( ) No If yes, list: _____

_____

Patient Profile:

Marital Status ( ) Married ( ) Single ( ) Separated ( ) Divorced ( ) Widowed

Number of children _____ Ages _____ Do they live with you ( ) Yes ( ) No

Did you serve in the US Military ? ( ) Yes ( ) No If yes, what branch _____

Do you smoke cigarettes? ( ) Yes ( ) No If yes how many / packs day: _____

Do you drink alcoholic beverages? ( ) Yes ( ) No If yes how often? _____

Do you use any drugs (street, illegal?) ( ) Yes ( ) No Comment _____

Do you have any history of drug or alcohol habit/dependency/ abuse? ( ) Yes ( ) No Comments _____

Do you have any hobbies, special skills, or interests? ( ) Yes ( ) No If yes, describe _____

Do you participate in a fitness program or any sports activities? ( ) Yes ( ) No If yes, describe _____

Systems Review : *Circle if you have problems with any of the following areas at this time.*

Head: Headaches Seizures / Eyes Redness Blurry Vision Double vision Eye Pain / Nose Bleeding Drainage Allergies

Ears: Ringing/Buzzing, Loss of Hearing, Pain / Throat: Hoarseness, Drainage

Kidney/Bladder/Genitalia Incontinence, Frequency/Urgency, Blood in urine/ Abdomen Cramping Pain Ulcer Nausea

Lungs/Breathing Pain with deep breath Persistent Cough Blood Wheezing/ Shortness of Breath Infections

Heart/Circulation Murmur Chest Pain Heart failure

Bones/Joints: Muscle Weakness Joint Stiffness Pain Swelling Grinding/ Popping

Emotional/ Psychological Depression Anxiety Stress at Work Thoughts of Suicide Thoughts/Acts of Violence Loss of Appetite

Do you currently have an **infection** of any kind ? please notify staff ! (Y) (N) Where? _____

Do you relate any of the above problems to the injury or injuries in question at this time? ( ) Yes ( ) No

Disclosure

The information given in this history questionnaire was provided by myself ( ) through an interpreter ( ) and is true. I understand and authorize the release of my medical records to my employer/ workers compensation carrier and all other parties involved as is necessary to process this claim.

Signature of Patient _____ Date _____

Regional Pain Treatment Center

Thank you very much for taking the time to fill out this form!

It will help Your Doctor help you!

Interventional Pain Medical Center
NuLooks Med Spa
Dr. John F. Petraglia, MD

Newport Beach, CA 92660

HIPPA "PRIVACY ACT" PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help in[illegible] that personal information is protected for privacy. The Privacy Rule was also created in order [illegible] provide a standard for certain health care providers to obtain their patients' consent for uses an[illegible] disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medic[illegible] information and will do all we can to secure and protect that privacy. We strive to always tak[illegible] reasonable precautions to protect your privacy. When it is appropriate and necessary, we provi[illegible] the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order [illegible] provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but it must be writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

_____
Print Name

_____
Signature

_____
Date

Interventional Pain Medical Group
NuLooks Med Spa
Dr. John F. Petraglia, MD, QME

6210 N. First St.
Fresno, CA 93710
559.431.6211
Fax 559.431.6202

14350 Whittier Blvd., Ste. 210
Whittier, CA 90605
562.698.9992
Fax 562.698.0013

PRIVACY NOTICE

We have always worked hard to maintain the highest of standards of confidentiality and to respect the privacy of our patient relationships. In that regard, we are providing the Privacy Notice to all of our patients who are or will be under our care, in accordance with the Health Insurance and Portability Act of 2003. This notice supplements any privacy policy or statements that our referring doctors, insurance companies, or we may provide in connection with specific procedures or services.

THE INFORMATION WE COLLECT ABOUT YOU

The non-public personal information we collect about you (your "information") comes primarily from the personal and insurance information worksheets, discussions, or other forms you submit to us. We may also collect medical information (about your health history and procedures, x-rays and insurance) relating to the services we provide from your other medical offices. We urge our patients to provide us with all pertinent information to enable us to maintain patient responsible party privacy. Having accurate information ensures that we will speak only with the correct parties about the procedures or account.

OUR DISCLOSURE POLICIES

We do not disclose your information to anyone, except as permitted by law. This may include sharing your information with outside doctors, labs, pharmacies, collection and insurance companies that perform support services for your procedures or account. Additionally it may include disclosing your information pursuant to your express consent, to fulfill your instructions or to comply with applicable laws and regulations.

OUR INFORMATION SECURITY POLICIES

We limit access to your information to those of our employees and care providers who are involved in your care or who are administering services. We maintain physical, electronic, and procedural safeguards that are designed to comply with federal standards to guard your information.

All employees are required to sign a confidentiality agreement as a condition of employment and to follow our policies and procedures. After the appointment we will continue to treat the information as described in this Privacy Notice.

24-HOUR CANCELLATION POLICY

Interventional Pain Medical Group & NuLooks Med Spa enforces a 24-hour cancellation policy for all appointments. In order to cancel and/or reschedule your appointment you must notify the office at least 24 hours prior to the scheduled appointment time to avoid being charged **a fee of $75.00**. Please note that Monday appointments require Friday notification. We will always do our best to accommodate your needs.

SIGNATURE
Dr. John F. Petraglia, MD, QME

INTERVENTIONAL PAIN MEDICAL GROUP
JOHN PETRAGLIA, M.D.
1601 Dove St. , Suite 170
Newport Beach, CA 92660
Ph (949)474-7246 / Fx (949)474-7247

MEDICAL MRI & X-RAY RECORDS RELEASE AUTHORIZATION

I _____, hereby authorize and request the release of all medical Records/Diagnostic studies/X-Rays which pertain to my case, from the office of:

_____
Provider's name

RECORDS TO BE FAXED TO: Fax# (949)474-7247

_____
Patient's Signature Date:

_____
Guardian/Parent Date:

GOT PAIN? INTERVENTIONAL PAIN MEDICAL GROUP

Interventional Pain Medical Group
John F. Petraglia, MD, QME
Diplomate, American Board of Anesthesiology
Diplomate, American Academy of Pain Management

1601 Dove St, Ste. 170
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2143 Orangewood Ave., Ste. 100
Orange, CA 92868
714.940.0947
Fax 714.940.9909

Long-term Controlled Substances Therapy Agreement for Chronic Pain

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 to 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.

- 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.)

- 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:

Address: _____ **phone:** _____

Pharmacy Name: _____

INTERVENTIONAL PAIN MEDICAL GROUP

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

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

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

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

- 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.

- Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely 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.

- Original containers of medications should be brought in to each office visit.

- 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.

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

GOT PAIN? INTERVENTIONAL PAIN MEDICAL GROUP

- Early refills will generally not be given.
- 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 not be filled prior to the appropriate date.
- If the responsible legal authorities have questions concerning your treatment, as might occur, for example, you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
- 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.
- Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
- It should be understood that any medical treatment is initially a trial and that confined prescription is contingent of evidence of benefit.
- The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation).
- Your 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)** _____