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555 North New Ballas, Suite #165
Tel: 314-692-7246 Fax: 314-692-8716

Welcome to A & A Pain Institute _____ (patient name)

We are looking forward to seeing you at your appointment on: _____,
at _____.

Please arrive **15** minutes before your appointment. If you cannot make your appointment, please give us more than **24 hours** notice, so that we can offer that time to another patient. Your co-pay is due at the time of your appointment.

Please bring the following items with you:

- This completed pre-treatment questionnaire
- A referral, if required by your insurance
- Pertinent medical records from your referring physician and your Primary care physician. (Please call to provide the name and phone number of your physicians, if you did not do this when you made your appointment.
- Current x-rays and MRI films
- Your current insurance cards

Without the above items we are unable to perform a thorough initial evaluation, which can cause a delay in our treatment program and cause us to reschedule your appointment.

If you are coming on I-270 North (from South County):

Take the Ladue Exit, Turn Right (east)-go about ½ miles. Turn Left (north) at N. New Ballas Road. Go about ½ miles to 555 North New Ballas. Turn left at the traffic light and follow signs to the main lobby in the back of the building.

If you are coming on I-270 South (from North County):

Take the Olive Blvd Exit. Turn Left (east)-go about ¼ miles. Turn Right at N. New Ballas Road. Go about ½ miles to 555 North New Ballas. Turn right at the traffic light and follow signs to the main lobby in back of building.

If you are coming on I-40/64 West (from Illinois):

Exit Ballas Road, turn Right (north). You will go about 2 miles to 555 North New Ballas. Turn left at the traffic light and follow the signs to the main lobby in the back of the building.

If you are coming on I-40/64 East (from West County):

Exit Ballas Road, turn Left (north). You will go about 2 miles to 555 North New Ballas. Turn left at the traffic light and follow the signs to the main lobby in the back of the building.

A & A Pain Institute Pre-Treatment Questionnaire

Please complete this questionnaire as carefully as possible. This is designed to help us better understand your pain problem and how it affects your life. **Please be sure your physician sends us copies of your medical records as this also helps in evaluating your problem.**

Full Name: _____

Chief complaint: _____

Where is your pain? _____

Where is your worst area of pain? _____

Which words best describe your pain?

Aching Burning Stabbing Numbness Pins and needles Brief or momentary Internal External

Continuous Comes and goes

When and how did it start? _____

What makes you feel better? _____

What makes you feel worse? _____

Does your pain prevent you from performing your job, chores, or hobbies? YES / NO Please Describe:

Have you seen a Pain Management Physician in the past? YES / NO

If so, who? _____ Address: _____

Please circle the level of your pain on this scale. 0 is none - 10 is the worst pain you can imagine

Right now 0 1 2 3 4 5 6 7 8 9 10

At its worst 0 1 2 3 4 5 6 7 8 9 10

At its least 0 1 2 3 4 5 6 7 8 9 10

What tests have been performed to diagnose your pain? Date Location of testing

X-rays _____

MRI or CAT scan _____

Myelogram _____

Nerve and muscle testing _____

Other _____

Mark your areas of pain on the diagram using these symbols:

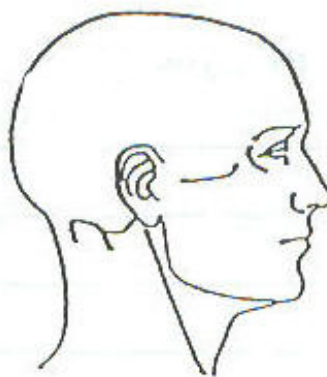
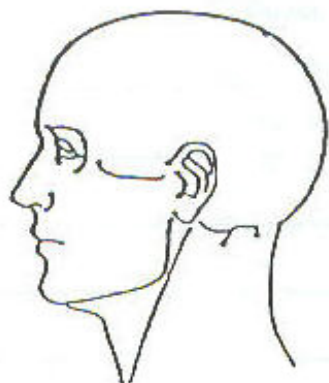
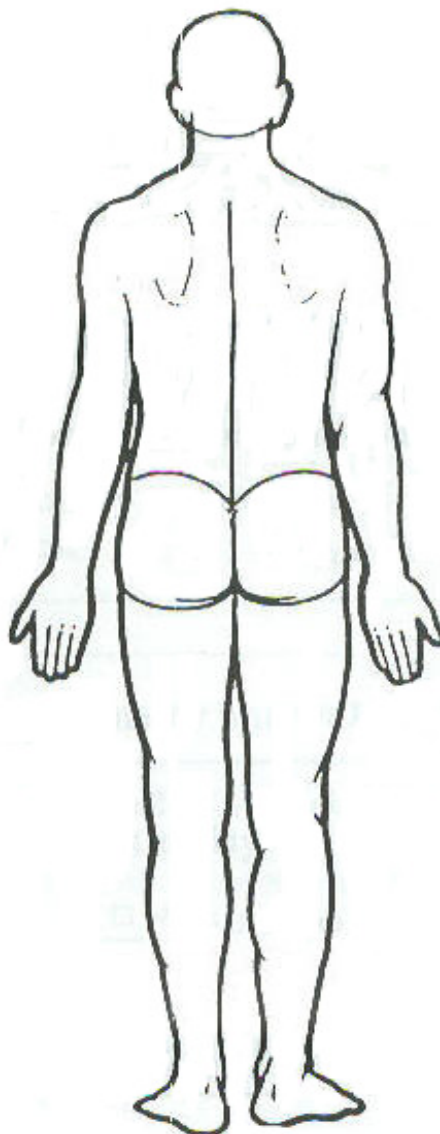
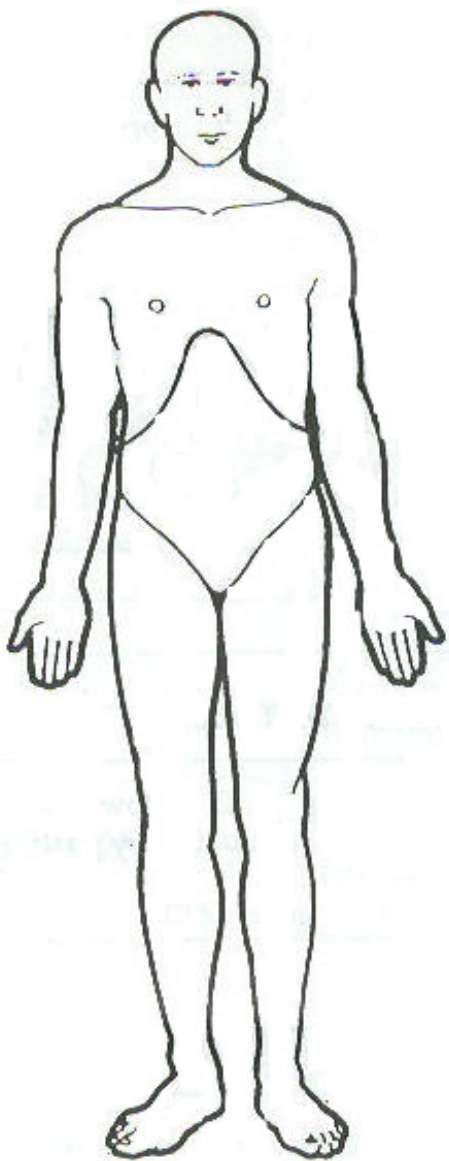
Numbness - - - - -

Stabbing / / / / / / /

Burning x x x x x

Aching + + + + +

Pins and needles 0 0 0 0 0



Review of Systems

please circle all that apply to you

Constitutional Dry Mouth Drowsiness Weakness Fever Fatigue Loss of appetite Insomnia Weight gain Weight loss	Dermatology Rash Hives Itching Shingles Skin cancer	Endocrinology Fatigue Excessive sweating Excessive thirst Excessive urination Weight loss Sleep disturbance Cold intolerance Heat intolerance Sweats Diabetes Thyroid disease	Neurological Headache Tingling/Numbness Seizures Memory Loss Dizziness Paresthesias Restless legs Syncope Tremors Vertigo Weakness Loss of coordination Head injury Stroke Multiple sclerosis	Ophthalmology Diminished vision Eye irritation Drainage from eyes Blurred vision Burning Double vision Eye pain Light sensitive Glasses Glaucoma	Respiratory Shortness of breath Chest pain Cough Dyspnea Excessive sputum Blood in sputum Wheezing Painful breathing Emphysema Tuberculosis Bronchitis Pneumonia Asthma
Hematology/Lymphatic System Abnormal bruising Abnormal bleeding Varicose veins Enlarged lymph nodes Bruising easily Use of blood thinners Leukemia	Urology Difficulty urinating Blood in urine Urgency Frequency Urinary incontinence Voiding dysfunction Vulvodynia Fecal incontinence Painful intercourse Recurrent UTI Nocturia Impotence Decreased libido Genital sore Painful urination Bladder infection Testicular pain Sexually transmitted disease Sexual dysfunction	Women only Congested breasts Cramps or backache Excessive menstruation Hot flashes Irregular cycles Lumps in breasts Menopause Painful menstruation Vaginal discharge Pain with intercourse	Allergy/Immune Runny nose Scratchy throat Itchy eyes Ear fullness Sinus congestion Stuffy nose AIDS/HIV Allergies other than drugs Hay fever	ENT/Mouth Cold Cough Nosebleeds Hearing loss Sore throat Ringing in ears Ear pain Hoarseness Difficulty swallowing Nasal discharge Nasal congestion Hearing aid Sinus infection Dentures Jaw/tooth pain Mouth sores	Cardiology Dizziness Chest pain Abnormal heart rhythm Leg or ankle swelling Shortness of breath Shortness of breath when lying down Cold extremities High blood pressure Heart attack Pacemaker Blood clot Use of blood thinners
GI Symptoms Abdominal pain Heart burn Hiatal hernia Nausea & Vomiting Constipation Diarrhea Ulcers Liver problems Gallbladder problems Black or blood in stools	Musculoskeletal Leg cramps Joint pain Joint swelling Joint stiffness Back pain Muscle cramps Muscle weakness Arthritis Osteoporosis Poor posture Bursitis Pain shoulder Pain arm Pain hands Pain elbow	Musculoskeletal cont. Pain neck Pain hip Pain legs Pain knees Pain feet Pain tailbone Sciatica Spinal curvature Joint replacement	Psychological Depression High stress level Sleep disturbance Respiratory symptoms worse with stress Suicidal ideation Eating disorder Mental illness Anxiety General malaise Irritability Memory loss Alzheimer's disease Alcoholism	Symptoms Headaches Blurred vision Dizziness Numbness Change in weight Bowel or bladder Problems GI problems Shortness of Breath Sleep disturbances Changes in mood Weakness Dry mouth Drowsiness Heartburn Chest pain	Symptoms cont. Rash Itching Bruising Nausea

MEDICAL HISTORY: Check all that apply

- | | | |
|--|---|--|
| <input type="checkbox"/> glaucoma | <input type="checkbox"/> pneumonia | <input type="checkbox"/> stroke |
| <input type="checkbox"/> hearing loss | <input type="checkbox"/> emphysema | <input type="checkbox"/> headache |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> head injury |
| <input type="checkbox"/> thyroid disease | <input type="checkbox"/> hiatal hernia | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> abnormal heart rhythm | <input type="checkbox"/> ulcers | <input type="checkbox"/> alcoholism |
| <input type="checkbox"/> hypertension | <input type="checkbox"/> liver/gallbladder disease | <input type="checkbox"/> depression |
| <input type="checkbox"/> pacemaker | <input type="checkbox"/> kidney disease | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> blood clot | <input type="checkbox"/> dialysis | <input type="checkbox"/> memory loss |
| <input type="checkbox"/> using blood thinners | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> eating disorder |
| <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> cystitis | <input type="checkbox"/> suicidal thoughts |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> sexually transmitted disease | <input type="checkbox"/> insomnia |
| <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> sexual dysfunction | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> seizures | <input type="checkbox"/> arthritis | <input type="checkbox"/> Other |
| <input type="checkbox"/> tremors | <input type="checkbox"/> spinal curvature | _____ |
| <input type="checkbox"/> restless leg syndrome | <input type="checkbox"/> fibromyalgia | _____ |
| <input type="checkbox"/> hayfever | <input type="checkbox"/> bursitis | _____ |
| <input type="checkbox"/> asthma | <input type="checkbox"/> sciatica | _____ |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> osteoporosis | _____ |
| | <input type="checkbox"/> shingles | _____ |

Surgical History: Please list all surgeries and dates

- Back surgery _____
- Neck surgery _____
- Joint replacement _____
- Cancer surgery _____
- Abdominal surgery _____
- Other _____

Hospitalizations: Please list all hospital stays except surgery and childbirth

Family History: Please indicate if an immediate family member has had:

- Heart disease Hypertension Stroke Diabetes Cancer Psychiatric illness Neurological disease (such as Parkinson's, multiple sclerosis, etc.) Other _____

Social History:

- Smoking (_____ Packs per day x _____ years) Alcohol Recreational drug use
- Problems with alcohol, recreational, or prescribed drugs

What is your occupation? _____

Are you still working? Yes No If not, how long have you been out of work? _____

Are you retired? Yes No For how long? _____

Are you disabled? Yes No For how long? _____

Schooling completed: High school/GED _____ years College/Tech school _____ years

Marital Status: Single Married Widowed Separated Divorced Significant other

Children: How many _____ Ages _____

Who lives with you? _____

Is your pain the result of an accident or injury? Yes No Have you settled a lawsuit related to your pain? Yes No

Was this a job related accident? Yes No Have you filed a Workman's Compensation claim? Yes No

Have you filed a lawsuit related to your pain? Yes No Do you currently retain a lawyer regarding your pain? Yes No

List specific ways your life would be different if you had less or no pain: _____

How would your life be different if your pain did not change? _____

List all of your current medications: _____

Do you have any allergies to medications: Yes No If so, what are they? Please Describe Reaction: _____

What methods have been used to treat your pain?	Date	Was it helpful?
<input type="checkbox"/> Surgery _____		
<input type="checkbox"/> Nerve blocks/steroid injections _____		
<input type="checkbox"/> Physical therapy _____		
<input type="checkbox"/> Psychological counseling _____		
<input type="checkbox"/> Relaxation training _____		
<input type="checkbox"/> Biofeedback _____		
<input type="checkbox"/> Chiropractic treatment _____		
<input type="checkbox"/> Acupuncture _____		
<input type="checkbox"/> Other _____		

Do you feel that nothing makes you feel better? Yes No

Please list the other doctors that you see currently or have seen in the past: _____ Phone _____

A & A PAIN INSTITUTE FINANCIAL POLICY

Due to developments with HMOs, Medicare and other insurance agencies, we are doing everything possible to hold down the cost of medical care. The following are our financial policies. Your clear understanding is important to our professional relationship with you. All patients must complete the "Patient Information Form" before seeing the clinical staff.

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 co-payments for participating insurance companies. The A & A Pain Institute accepts cash, personal check, VISA, and MasterCard. There is a \$25.00 service charge for all returned checks.

INSURANCE:

We bill participating insurance companies as a courtesy to you upon receipt of proper documentation and verification of insurance coverage. You are expected to pay your co-payments at the time of service. Once your insurance has paid its portion of your bill, any remaining balance is your responsibility. We cannot become involved in disputes between you and your insurance company regarding covered charges, deductible amounts, co-payments, pre-certifications, pre-authorizations, secondary insurances and what they define as "usual and customary charges." You are responsible for the timely payment of your account.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments can greatly impact our clinic and other patients who could have been seen in the time set aside for you. Cancellations are requested at least 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. This charge is your responsibility and a non-covered benefit by your insurance. Please help us serve you better by keeping scheduled appointments.

I have read and understand the A & A Pain Institute Financial Policy. I understand that I am responsible for the charges incurred. I agree that in the event I fail to pay and it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency for costs of collections and attorney fees associated with resolving my account.

Signature of patient or Authorized Representative:

_____ Date: _____

We would be please to discuss our fees and policies with you, if you need assistance or have questions, please contact the Billing Coordinator between 8:00 a.m. and 4:00 p.m., Monday through Friday.

Notice of Privacy Practices Summary

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please see the front desk to review a full copy of our Notice of Privacy Practices.

Uses and Disclosures of Health Information

We use health information about you as a basis for planning your care and treatment, a means of communication among the many health professionals who contribute to your care, as a legal document describing the care you received, a means by which you or a third-party payer can verify that services billed were actually provided.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization to disclose information you can later revoke to stop future uses.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the new notice in the waiting area. You can also request a copy of our notice at any time.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Your Health Information Rights

Although your health record is the physical property of A & A Pain Institute, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and obtain a copy of your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

For More Information or to Report a Problem

For questions or for additional information, you may contact the practice manager at 314-692-7246.

If you believe your privacy rights have been violated, you can file a complaint with the practice manager, or with the Office for Civil Rights, U.S. Department of Health and Human Services. Please contact the practice manager for the address if necessary.

Written Acknowledgement

I acknowledge that I have reviewed the Notice of Privacy Practice which provides a description of information on uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

Signature of Patient or Legal Representative

Date

A&A Pain Institute
555 N. New Ballas, Ste 165
St. Louis, Mo 63141
Phone: 314-692-7246
Fax: 314-692-8716

Date ____/____/____

Patient's Name _____

Patient's DOB ____/____/____

I authorize the staff of A&A Pain Institute, Inc. to release and/or discuss any and all information regarding my medical care with the following people:

<u>NAME</u>	<u>RELATIONSHIP</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I restrict the release of any/all information regarding my medical care with the following:

_____	_____
_____	_____

Patient Signature _____