

# SOUTHERN PAIN & ANESTHESIA CONSULTANTS

## PATIENT DATA

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

### RELATIVE OR FRIEND NOT RESIDING WITH YOU

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

### WHO WILL BE RESPONSIBLE FOR PAYMENT?

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

IS THIS WORK RELATED? YES \_\_\_\_\_ NO \_\_\_\_\_

**Southern Pain and Anesthesia Consultants, LLC**

**PAIN ASSESSMENT TOOL**

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Sex: Male / Female

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Referring Physician \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Other Treating Physicians (i.e. Cardiologist) \_\_\_\_\_

Pain Problem / Reason for medical visit? \_\_\_\_\_

Other Medical Conditions (Past Medical History)

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

List all previous Surgeries (year and surgeon if known)

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

**Social History**

Occupation \_\_\_\_\_

Currently Working? (circle one) YES NO If NO, last date of work \_\_\_\_\_

Disabled? When \_\_\_\_\_ Why \_\_\_\_\_

Do you Smoke? YES NO # of packs per day? \_\_\_\_\_ # years a smoker? \_\_\_\_\_

Single / Married (#of years \_\_\_\_\_) / Divorced / Widow / # of Children \_\_\_\_\_

What is your highest level of education? \_\_\_\_\_

Do you use . . . marijuana / cocaine / heroin ?

**Family History of.... (Circle all that apply)**

Diabetes Cancer High Blood Pressure High Cholesterol Other \_\_\_\_\_

**Write a current list of all medications (dose and strength) including over-the-counter medications and the doctor who prescribes them.**

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

**Drug Allergies**

\_\_\_\_\_

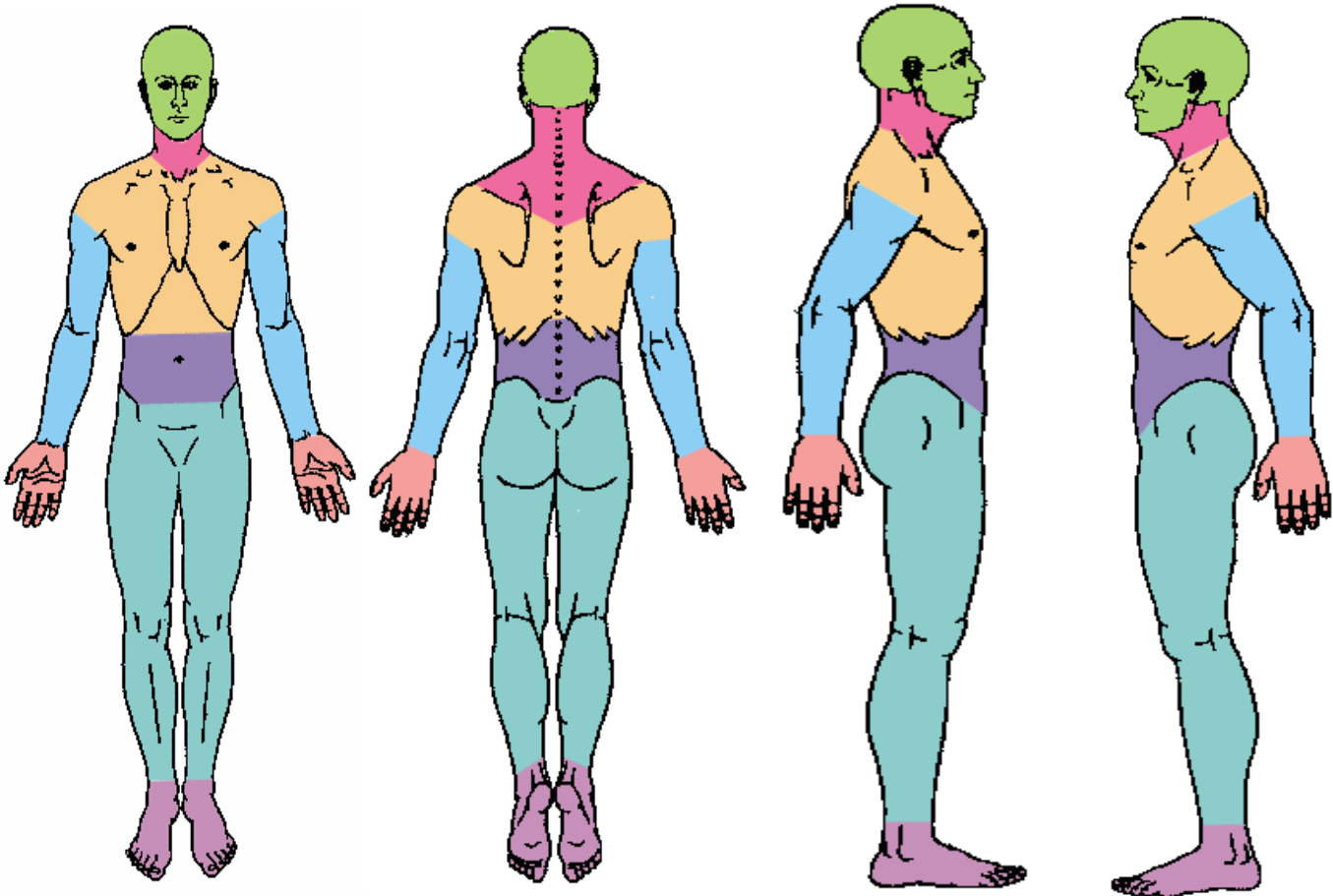
## LOCATION

Where is your pain located?

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**Mark the exact location (s) of your pain on the following diagram**



**How long have you experienced this pain?**

\_\_\_\_\_ Less than 6 months    \_\_\_\_\_ 6 months to 1 year  
\_\_\_\_\_ 1-2 years                    \_\_\_\_\_ Greater than 2 years

Other? \_\_\_\_\_

**Date that the pain first occurred?** \_\_\_\_\_

**Did any of the following cause your pain? (Check all that apply)**

_____ Automobile Accident	_____ Work or Industrial Accident
_____ Surgery	_____ Medical Illness
_____ Accident at home	_____ Fall
_____ Lifting	_____ Pushing
_____ Being struck by an object	
_____ Other – explain: _____	

**If your pain is related to an accident, please indicate the . . .**

Date of Injury \_\_\_\_\_

Place of Injury \_\_\_\_\_

**Are you currently involved in litigation? (Is a lawyer involved because of the injury?)**

(circle one)      YES      NO

If yes, please indicate . . .

Name of Attorney \_\_\_\_\_

Address of Attorney \_\_\_\_\_

\_\_\_\_\_

Telephone of Attorney \_\_\_\_\_

Fax# of Attorney \_\_\_\_\_

**Does your pain prevent you from working?      YES      NO**

**Are you currently off of work because of your pain problem?**

YES      NO

If Yes, how long have you been off of work? \_\_\_\_\_

**Are you applying for or receiving any of the following benefits?**

Workman's Compensation \_\_\_\_\_

Medicaid \_\_\_\_\_

Medicare \_\_\_\_\_

**CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL**



**0**

Very happy, no hurt



**2**

Hurts just a little bit



**4**

Hurts a little more



**6**

Hurts even more



**8**

Hurts a whole lot



**10**

Hurts as much as you can imagine

**Use the above scale to answer these questions:**

At present how would you rate your pain? \_\_\_\_\_

The worst it gets is \_\_\_\_\_

The best it gets is \_\_\_\_\_

**How often do you experience your pain? (Please circle.)**

<25% of the time    50% of the time    75% of the time    Constantly

**How do you describe your pain? (Circle all that apply.)**

Burning    Stabbing    Throbbing    Sharp    Dull  
Shooting    Shock-like    Aching    Squeezing    Other \_\_\_\_\_

**What activities cause or INCREASE the pain? (Circle all that apply)**

Laying      Standing      Bending      Sitting      Walking      Lifting  
Physical Activities \_\_\_\_\_  
Job Activities \_\_\_\_\_  
Other \_\_\_\_\_

**Do any of the following help to RELIEVE your pain? (Circle all that apply)**

Laying      Standing      Bending      Sitting      Walking  
Heat      Cold      Imagery      Relaxation      Medication  
Alcoholic drinks      Nothing relieves the pain  
Other \_\_\_\_\_

**Have you tried any of the following to improve your pain problem?**

\_\_\_\_\_ Exercise Program      \_\_\_\_\_ TENS  
\_\_\_\_\_ Biofeedback      \_\_\_\_\_ Spinal Cord Stimulation  
\_\_\_\_\_ Physical Therapy      \_\_\_\_\_ Relaxation Training  
\_\_\_\_\_ Acupuncture/Acupressure      \_\_\_\_\_ Chiropractic Treatment  
\_\_\_\_\_ Psychological evaluation  
\_\_\_\_\_ Nerve Blocks / Injections / Trigger points / Botox / Facet Injections  
Describe \_\_\_\_\_

**Do you experience any of the following items because of you pain?**

**(Check all that apply)**

\_\_\_\_\_ Numbness or loss of sensation      \_\_\_\_\_ Weakness or Falling  
\_\_\_\_\_ Muscle Spasms or tightness      \_\_\_\_\_ Change of skin color  
\_\_\_\_\_ Swelling      \_\_\_\_\_ Hair loss  
\_\_\_\_\_ Burning pain to light touch      \_\_\_\_\_ Bowel or Bladder problems  
\_\_\_\_\_ Increased temperature or warmth      \_\_\_\_\_ Decreased temperature or coolness  
\_\_\_\_\_ Change in sweat pattern.      \_\_\_\_\_ Nausea  
\_\_\_\_\_ Headaches

**Has your pain affected any of the following? (Please circle)**

Sleep	YES	NO	Energy	YES	NO
Appetite	YES	NO	Relationships	YES	NO
Emotions	YES	NO	Concentration	YES	NO
Hope	YES	NO	Feelings of self-worth	YES	NO
Pleasure in doing things	YES	NO			

**How are you dealing with the pain?**

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

**Do you ever think of hurting yourself? If so, what is your plan?**

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

**When did you first see a medical professional for your current problem? Who have you seen?** \_\_\_\_\_

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**Have you had any of the following tests? (Check all that apply)**

_____ X-rays	When _____	Where _____
_____ EMG/NCV	When _____	Where _____
_____ MRI Scan	When _____	Where _____
_____ Myelogram	When _____	Where _____
_____ Bone scan	When _____	Where _____
_____ CT scan	When _____	Where _____

**Circle all medications that you have taken to try to improve your pain.**

*Anti-inflammatory Medication:* Tylenol (acetaminophen), Aleve (naprosyn), Daypro(oxaprozin), Feldene, Lodine (etodolac), Voltaren, Ansaid, Relafen (nabumetone), Arthrotec, Vioxx, Celebrex, Bextra, Mobic (meloxicam), Advil (ibuprofen), Motrin, Oruvail (ketoprofen), Indocin (indomethacin), Feldene (piroxicam), Clinoril (sulindac), aspirin, Dolobid, Salsalate, diclofenac, Toradol(ketorolac)

*Antidepressant / Anti-anxiety Medication:* Elavil (amitriptyline), Doxepin (sinequan), Pamelor (nortriptyline), Effexor (venlafaxine), Paxil (paroxetine), Prozac (fluoxetine), Zoloft (sertraline), Seroquel, BuSpar (Buspirone), Celexa(citalopram), Lexapro (escitalopram), Wellbutrin (Bupropion), Cymbalta (duloxetine), Remeron (mirtazapine), Trazodone (Desyrel)

*Migraine Medication:* Imitrex, Axert, Relpax, Amerge, Maxalt, Zomig, Cafergot, Midrin, Depakote (valproic acid), Topamax

*Benzodiazepine Medication:* Ativan (lorazepam), Valium (diazepam), Xanax (alprazolam)

*Pain Medication:* Lortab, Lorcet, Vicodin, Norco, Zydone, Percodan, Percocet, Oxycodone, Roxicodone, Hydrocodone, Tramadol, Tylenol#3, Tylox, Darvocet(propoxyphene), Demerol, Morphine, OxyContin, MS Contin, MSIR, Duragesic Patches(Fentanyl), Dilaudid, Kadian,, Avinza, Methadone, Xodol, Tylenol #4, Actiq, Ultracet, Ultram, Opana, Fioricet, Fiorinal, Talacen, Vicoprofen, codeine

*Muscle Relaxers:* Soma (carisoprodol), Robaxin (methocarbamol), Flexeril (cyclobenzaprine), Skelaxin, Zanaflex (tizanidine), Baclofen (lioresal), Dantrium(dantrolene), Parafon Forte (chlorzoxazone), Norflex (orphenadrine), Valium (diazepam), Quinine

*Nerve Pain Medication:* Neurontin (gabapentin), Topamax (topiramate), Gabitril, Zonegran, Lamictal (lamotrigine), Tegretol, Dilantin, Lyrica

*Sleep Aids:* Ambien (zolpidem), Sonata, Lunesta, Rozeram, chloral hydrate, Restoril (temazepam)

Other Medications:

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**Past Medical History**

**Do you have or have you ever been diagnosed with any of the following Medical Conditions? (Circle all that apply)**

- |  |  |                            |
|--|--|----------------------------|
| High Blood Pressure                                | Psychiatric Illness (i.e. Schizophrenia) |                            |
| Angina (Chest Pain/Tightness)                      | Bipolar disorder                         | Thyroid Disease            |
| Heart Attack                                       | Anxiety                                  | Anemia                     |
| Congestive Heart Failure                           | Depression                               | HIV+                       |
| Pacemaker  | Emphysema                                | AIDS                       |
| Valve Disease                                      | Shortness of Breath                      | Glaucoma                   |
| Heart Surgery                                      | Pulmonary Embolism                       | Seizures                   |
| Peripheral Vascular Disease                        | Bronchitis                               | TIA                        |
| Recent weight loss / gain                          | Asthma                                   | CVA / Stroke               |
| Obesity  | COPD                                     | Hearing Loss               |
| Dentures / Loose Teeth                             | Inflammatory Bowel Disease               | Osteoarthritis             |
| Clotting Abnormality                               | Ulcers                                   | Rheumatoid arthritis       |
| Kidney Stones                                      | Gastric Reflux (GERD)                    | Osteoporosis               |
| Kidney Failure / Dialysis                          | Pancreatitis                             | Scoliosis                  |
| Diabetes   | Hepatitis A / B / C                      | Hiatal Hernia              |
| Neuropathy   | IBS (Irritable Bowel Syndrome)           | Crohn's Disease            |
| History Alcohol Abuse                              | Liver Disease                            | Enlarged Prostate          |
| History Substance Abuse (marijuana, cocaine, etc.) |  |                            |
| Bleeding problems                                  |  |                            |
| Cancer-Type / Year Diagnosed? _____                |  | (Radiation / Chemotherapy) |

**Are you taking any blood thinners (Aspirin, Plavix, BC Powder, Etc.)? YES NO**

**Goals for therapy**

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**Comments**

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## **NOTICE OF PRIVACY PRACTICES (MEDICAL)**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical exam.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you.

We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 15, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new Notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Southern Pain & Anesthesia Consultants, LLC  
Paul J. Hubbell, III, M.D.  
2701 Lake Villa Dr. Ste. A  
Metairie, La 70002  
118 Village Street Suite A  
Slidell, LA 70458

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202)619-0257  
(877)696-6775

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

Southern Pain & Anesthesia Consultants, LLC  
Paul J. Hubbell, III, M.D.  
2701 Lake Villa Dr. Ste. A  
Metairie, LA 70002  
(504)887-7207  
118 Village Suite A  
Slidell, LA 70458  
(985)643-4144

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address listed above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

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

Signature: \_\_\_\_\_

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

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**OFFICE USE ONLY**

I attempted to obtain the patient’s signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

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

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

Reason: \_\_\_\_\_

**SOUTHERN PAIN & ANESTHESIA CONSULTANTS, LLC**

**Paul J Hubbell, III, M.D.**

**Edwin G. Hyde, M.D.**

Metairie: 504-887-7207 Slidell : 985-643-4144 Fax: 504-889-1868

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ **HEREBY AUTHORIZE**

\_\_\_\_\_ **ADDRESS** \_\_\_\_\_

\_\_\_\_\_ **PH** \_\_\_\_\_

**FACILITY RELEASING RECORDS**

**To Release to: Southern Pain & Anesthesia Consultants, LLC**

2701 Lake Villa Dr. Suite A  
Metairie, LA 70002

118 Village St. Suite A  
Slidell, LA 70458

THE INFORMATION INDICATED BELOW WITH REGARD TO SERVICES PROVIDED TO ME FOR THE FOLLOWING PURPOSE:

- FOR TREATMENT WITH DOCTOR
- FOR PROCESSING OF MY INSURANCE
- FOR APPLICATION FOR INSURANCE
- OTHER, SPECIFY: treatment at the hospital by any affiliates

**REPORTS TO BE FURNISHED:**

- Diagnosis (Also drug or alcohol abuse)
- Consultations
- Physicians Progress notes
- Physician's orders
- H & P Exam reports
- Lab & x-ray reports
- Discharge Summary
- Treatment Plan
- Verbal Reports
- Other : complete financial and billing records for each individual treating physician, as well for the facility and any affiliates.

- . This authorization shall expire 30 months from the date shown below, unless revoked sooner.
- . I may refuse to sign this authorization and it is strictly voluntary.
- . I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to the covered entity and Requestor. I understand that the revocation will not apply to information that has already been released to the authorization.
- . I have the right to receive a copy of this form after I sign it.
- . My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- . The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

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

**Signature of Parent, Guardian or Legal Representative**

\_\_\_\_\_  
**Nature of Relationship**