TCPC
TRI-COUNTY PAIN CONSULTANTS, PC

1. Bring your License/ID and Insurance card to each appointment. A *digital picture will also be taken at this initial appointment* for your electronic medical chart.
2. Plan to update or verify your personal information at each appointment.
3. Complete the enclosed Patient Information Forms and bring them to your appointment. This information will be used by the provider during your evaluation. Failure to have the forms completed prior to your arrival may result in your appointment being delayed or rescheduled.
4. Please arrange for a driver to arrive with you for your appointment. Some procedures may require the use of light sedation. Please be aware that you must have a driver present in the waiting room in order to receive sedation.
5. Anticipate being at our office for your initial appointment for approximately two or three (2-3) hours.

FINANCIAL POLICY

Our office participates with a variety of insurance plans including but not limited to:

Medicare	Priority Health	Blue Cross Blue Shield	HAP	Aetna	Cofinity	United Healthcare

If you have questions regarding your insurance, we will try to help. However, questions relating to specific coverage issues must be directed to your insurance company's member services department. Their telephone number should be listed on the back of your insurance card.

Referrals: Many insurance plans require a referral from your primary care physician to be seen by a specialist. We will contact your insurance carrier to arrange for a referral but ask that you follow up with them too. If a referral is required but not secured, your visit may be rescheduled or you may be financially responsible.

All applicable co-payments, deductibles, co-insurance and personal balances, both current and prior, are due at the time of service unless other payment arrangements have been made. In some cases, you may be asked to pay the balance of your account or make payment arrangements prior to making your next appointment.

For your convenience, we accept cash, checks, VISA, MasterCard, Discover, American Express and money orders. You may also pay your bill online through our website (shown below). *Please note that there is a $25.00 service charge for all returned checks*.

We understand that there may be times and circumstances that come up where you are unable to pay your entire bill. In these situations it is very important that you contact our Billing Office (800-319-3118) so a financial representative can assist you in setting up a reasonable payment plan and to keep your account from being sent to a collection agency.

If you fail to meet the financial obligations agreed upon in this financial policy or have other payment arrangements made, your outstanding balance will be sent to a collection agency. You will be required to pay your entire balance and any collection agency fees, up to 25% of your account balance, before being scheduled for any further appointments.

If you have billing related questions, please contact our billing office at (800) 319-3118 and select option 2.

www.tricountypain.com

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TRI-COUNTY PAIN CONSULTANTS, PC

Welcome to Tri-County Pain Consultants. The purpose of this letter is to let you know what to expect from me and our team and to answer some questions that we respond to on a regular basis.

Our practice is not built on a single course of treatment, but on the best use of multiple team members and options. Your treatment with us may involve medications, injections, behavioral health and/or physical therapy. Our goal is to do what works for you; our recommendations are based on a thorough assessment of your current health and your goals for improvement.

Medications may be used to help manage pain, often times they can be a very effective part of a pain management plan. However, we are always looking to find the root cause of the problem so that we aren't masking the symptoms. Pain can be a major hurdle to many daily activities so behavioral therapy including biofeedback and counseling may be a vital component of care. In addition, physical therapy can provide just the right touch to compliment your overall treatment goals.

We use injections for two main reasons. One, is to help diagnose the source of the pain, the second is that it can be therapeutic in reducing pain. Back pain provides an example. Some sources of back pain may be very obvious such as a large disc herniation. In other cases the exact source of back pain may be less certain. I put medications at different spots in the back to help diagnose & treat the source. Not every patient is a good candidate for injections, frequently they can be used to help a person feel better. Injections can initially be used to break the cycle of constant debilitating pain. As a continued treatment, longer lasting injections can be used to encourage activity and reduce the need for medications. Injections coupled with behavioral & physical therapy and/or medication can be a winning combination for helping you to get back to daily activities and to have reduced pain.

Again I welcome you to my practice and I hope this letter answers a few of your questions. I realize that you may have additional questions and I welcome the opportunity to address them when we meet at your first appointment. I appreciate the confidence you have by trusting your care to me and my entire team. We are all eager to meet you and to help you manage your pain.

Sincerely,

Tri-County Pain Consultants

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TRI-COUNTY PAIN CONSULTANTS, PC

History Form

Patient Name: Date of Consultation:

DOB: ❒ Male ❒ Female Social Security No.: _____

REFERRING PHYSICIAN
Full Name: _____
Address: _____
City: _____
State, Zip: _____
Phone No.: _____

FAMILY PHYSICIAN
Full Name: _____
Address: _____
City: _____
State, Zip: _____
Phone No.: _____

CHIEF COMPLAINT: (Explain what brought you into the office today.) _____

_____

_____

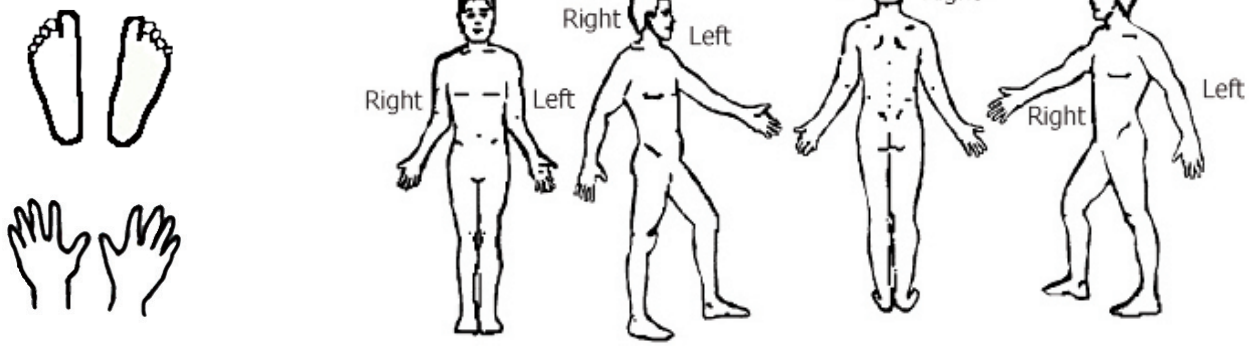
Do you have pain or another symptom_____

A particular condition or diagnosis? _____

Did a physician ask you to come to our office for a particular type of treatment?

_____

HISTORY OF PRESENT ILLNESS:
Please indicate on the drawings below where your pain is located.



Please circle any of the following symptoms that you are experiencing.
Is your problem: constant, intermittent, frequent, occasional, infrequent

Is the pain: sharp, dull, aching, throbbing, burning, tingling, shooting, stabbing, electrical

Is your problem: mild, moderate, severe, excruciating

How would you rate your average pain on a scale of 0 to 10, where 0 is no pain and 10 is unbearable? _____

How long have you been experiencing this problem? _____

Do any of the following make the problem worse: time of day, sitting, standing, bending, lifting, twisting, crawling, stair climbing, coughing, sneezing, heat, cold, eating, weather changes, light touch, stress, other, _____

Do any of the following make the problem better: rest, heat, cold, massage, medication, other _____

Are there any factors or symptoms that occur with your problem, such as, numbness, muscle weakness, bowel or bladder problems, or others? _____

_____

What doctors have you seen for this problem? (Name and Specialty) _____

_____

What tests have you had for this problem and what were the results, if known?

MRI _____
CT Scan _____
X-Rays _____
EMG _____

What treatments have you had for this problem and what were the results?

Surgery _____
Physical Therapy/Occupational Therapy _____
Injections/Nerve Blocks _____
TENS _____
Psychological/Behavioral Pain Management _____
Osteopathic/Chiropractic Manipulation _____
Acupuncture _____

What medication are you currently taking for this problem and how much? _____

_____

What medication have you used in the past for this problem? _____

_____

PAST MEDICAL HISTORY: Do you have any of the following conditions? Please check all that apply.

❒ High Blood Pressure	❒ Diabetes ❒Type 1 ❒Type 2	❒ Scleroderma
❒ High Cholesterol	❒ Hepatitis	❒ Carpal Tunnel Syndrome
❒ Irregular Heart Beat	❒ Pancreatitis	❒ Glaucoma
❒ Congestive Heart Failure	❒ Stomach Ulcers	❒ Strokes
❒ Coronary Artery Disease	❒ GERD	❒ TIAs
❒ Heart Attack/MI	❒ Thyroid Disorder	❒ Seizure Disorder
❒ Peripheral Vascular Disease	❒ Kidney Disease	❒ Headaches
❒ Sleep Apnea	❒ Gynecological Problems	❒ Depression
❒ Asthma	❒ Pregnancy / LMP _____	❒ Anxiety/Panic Disorder
❒ Bronchitis/Emphysema/COPD	❒ Osteoarthritis	❒ Bleeding Disorder
❒ Pneumonia	❒ Rheumatoid Arthritis	❒ HIV/AIDS
❒ Tuberculosis	❒ Lupus	❒ Cancer, type _____

❒ Other, _____

PAST SURGICAL HISTORY: (Please list all surgeries you have had and the approximate dates.) _____

_____

_____

_____

_____

_____

_____

HOSPITALIZATIONS: (If you have been hospitalized, when was it and for what reason.)
_____
_____
_____

Accidents/Injuries: (Please list any significant accidents or injuries and when they occurred.) _____
_____
_____
_____

Medications: (Please list all medications you are currently taking, including aspirin.)

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Allergies: Please list all medication and other allergies. _____
_____

Family History: Please list any illnesses that are present in your family or the cause of their death: _____
_____
_____

SOCIAL HISTORY:

❒ Married ❒ Single ❒ Divorced ❒ Separated ❒ Widow/Widower

Do you live with your spouse or significant other? ❒ Yes ❒ No

How many children and grandchildren do you have? Children _____ Grandchildren _____

If you smoke, how many packs per day and for how many years? _____

How many alcoholic beverages do you drink a day? _____

Do you now or have you ever used illegal drugs? _____

Have you ever been the victim of abuse or violence? _____

What is your highest level of education? _____ Do you have vocational training and in what area? _____

OCCUPATIONAL HISTORY

❒ Working full-time ❒ Working part-time ❒ On medical leave ❒ Disabled ❒ Unemployed ❒ Retired

What is your current occupation? _____

Where do you work and how long have you been there? _____

REVIEW OF SYSTEMS: Please circle of any of the following symptoms that you are experiencing.

General: Weight gain/loss, Fatigue, Fever, Chills, Night Sweats

Skin: Hair changes, Nail changes, Itching, Rashes

Head: Trauma, Headaches

Eyes: Vision loss, Blurriness, Tearing, Glasses, Contact lenses

Ears: Hearing loss, Ringing, Dizziness, Ear ache

Nose/Sinuses: Allergies, Nose bleed

Mouth/Throat/Neck: Bleeding gums, Hoarseness, Sore throat, Difficulty swallowing, Swollen neck, Masses

Breasts: Skin changes, Lumps/masses, Discharge

Respiratory: Shortness of breath, Wheezing, Productive cough, Coughing up blood

Cardiovascular: Palpitations, Heart murmur, Chest pain, Shortness of breath lying down, during sleep, Leg swelling, Leg pain, Leg pain when walking

GI: Loss of appetite, Nausea, Vomiting, Indigestion, Irregular bowel movements, Constipation, Diarrhea, Vomiting blood, Bloody stools, Black/tarry stools, Hemorrhoids, Abdominal pain, Jaundice

Urinary: Frequency, Urgency, Hesitancy, Painful urination, Blood in urine, Incontinence, Stones, Infections

Male: Testicular pain or masses, Hernias, Discharge, STD's, Loss of sex interest/function

Female: Pregnant, Irregular periods, Painful periods, Hot flashes/sweats, STD's, Loss of sex interest/function

Musculoskeletal: Joint stiffness, Joint instability, Reduced range of motion, Swelling/redness of joints

Neurological: Numbness, Tingling, Loss of sensation, Muscle weakness, Paralysis, Tremors, Seizures Fainting/blackouts

Hematologic: Anemia, Easy bruising/bleeding, Bleeding disorder, Transfusions

Endocrine: Heat/cold intolerance, Excessive sweating, Excessive thirst, Excessive Hunger

Psychiatric: Changes in mood, Stress/tension, Anxiety, Depression, Thoughts of suicide, Memory problems

FUNCTIONAL STATUS:

How long can you:
Sit _____
Stand _____
Walk _____
Climb Stairs _____
Drive _____

Does the pain interfere with:
❒ Daily activities
❒ Eating
❒ Dressing
❒ Bathing
❒ Using the toilet
❒ Getting out of Bed/Chair
❒ Recreational activities
❒ Housework
❒ Yard work
❒ Work Duties

PATIENT GOALS

What are your goals for treatment? _____

_____

_____

_____

_____

_____

DEMOGRAPHICS

Spoken Language:

☐ English ☐ Spanish ☐ Vietnamese ☐ Non-English Other_____
☐ Declined

Ethnicity:

Are you Hispanic/Latino?

☐ Yes
☐ No
☐ Declined

Race:

☐ American Indian / Alaskan Native
☐ Asian
☐ Black/African American
☐ White
☐ Native Hawaiian / Other Pacific Islander
☐ Multiracial
☐ Other_____
☐ Declined

Gender Identity Values

- o Identifies as Male
- o Identifies as Female
- o Female-to-Male (FTM/Transgender Male/Trans Man)
- o Male-to-Female (MTF/Transgender Female/Trans Woman)
- o Genderqueer, neither exclusively male nor female
- o Choose not to disclose

Sexual Orientation Values

- o Lesbian, gay, or homosexual
- o Straight or heterosexual
- o Bisexual
- o Don't know
- o Choose not to disclose

_____ _____
Signature: Date:

Thank you for completing this questionnaire. It will help us serve you better.