Twin Cities Pain Clinic

Hello, and thank you for choosing Twin Cities Pain Clinic!

During your first visit with us, you will be seen by a nurse practitioner or physician assistant who is certified in the field of pain management and has extensive experience treating patients with pain conditions.

Here is the date, time and clinic location of your upcoming appointment:

_____	_____	_____
Date	**Time**	**Location** *(address & directions enclosed)*

Please complete this packet of paperwork PRIOR to checking in for your appointment. If you are unable to complete it, we ask that you arrive 30 minutes early or we may have to reschedule your appointment.

Please bring the following to your first appointment:

- ☐ Driver's license or other photo identification
- ☐ Insurance card(s)
- ☐ Copay, which is due at time of service
- ☐ A list of medications you're currently taking as well as the original bottles so we can see the dosage, the prescriber, and the pharmacy
- ☐ Any relevant medical records and/or imaging reports

***Please note, you will not be prescribed medications at your first visit, so plan accordingly.**

Please respect our other patients' time by giving at least 24 hours' notice to cancel or reschedule an appointment. If you miss an appointment or cancel more than two appointments less than 24 hours in advance, we reserve the right to discontinue your care at our clinic.

If you have questions about your forms or appointment, please call us at **952-204-3547** between 8:00 am and 4:15 pm. The address and directions to the clinic are enclosed.

We look forward to meeting you!

Twin Cities Pain Clinic

Patient Intake Form

Twin Cities Pain Clinic

Date:_____/_____/_____

Name:_____ **Maiden/Other:**_____

Date of birth:_____/_____/_____ **Age:**_____ **Sex:** Male ☐ or Female ☐

Address:_____ **APT#:**_____ **City:**_____

State: _____ **ZIP:**_____ **Day Phone:**_____ **Cell Phone:**_____

Email:_____ **Social Security Number:**_____-_____-_____

Language:_____ **Race:**_____ **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Emergency Contact:_____ **Phone:** _____

Pharmacy Name:_____ **Pharmacy Phone:**_____

Primary Care Physician:_____ **Primary Care Clinic:** _____

Primary insurance:

Insurance company: _____ Policy #: _____ Group #: _____

Secondary insurance:

Insurance company: _____ Policy #: _____ Group #: _____

How did you hear about our clinic?

☐ Referring Physician/Clinic ☐ Internet ☐ Family/Friend ☐ Other:_____

Name of Physician or Referral source:_____

What problem(s) are you seeking treatment for today?_____

_____

How long have you had your current problem? _____

How did the pain begin? ☐ Suddenly ☐ Gradually ☐ After Injury ☐ Other:_____

How often do you have the pain? ☐ Constant ☐ Intermittent ☐ Infrequent

Was this problem a result of an accident or injury? ☐ Yes ☐ No **If yes,** give date:_____

Is this condition covered under Worker's Compensation? ☐ Yes ☐ No

If yes, what is the name of your Worker's Compensation Carrier?_____

Are you having troubles with health insurance claims, related to this problem? ☐ Yes ☐ No

What number best describes your pain on average in the past week:

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

On the scale below, how has your pain interfered with your enjoyment of life during the past week:

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

On the scale below, how has your pain interfered with your general activity during the past week:

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

What makes your pain worse?
(Check all that apply)

☐ Bending ☐ Sitting ☐ Changing positions
☐ Lifting ☐ Standing ☐ Housework
☐ Lying down ☐ Twisting ☐ Movement
☐ Running ☐ Walking ☐ Stairs
☐ Other:_____

What makes your pain better?
(Check all that apply)

☐ Chiropractic ☐ Massage ☐ Sitting
☐ Heat ☐ Medications ☐ Standing
☐ Ice ☐ Physical therapy ☐ Stretching
☐ Lying down ☐ Rest ☐ Walking
☐ Other: _____

In the space below, describe how the pain began (details about the injury or pain onset):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have you had physical therapy for your area of current pain? ☐ Yes ☐ No

If yes, where did you complete your therapy? _____

Please list the approximate dates of treatment: _____

Was physical therapy helpful? ☐ Yes ☐ No

Have you tried injections for your area of current pain? ☐ Yes ☐ No

If yes, where did you have those injections? _____

What type? ☐ Epidural ☐ Radiofrequency ☐ Nerve block ☐ Unknown/Other: _____

Were these injections helpful? ☐ Yes ☐ No

What types of diagnostic testing have you had for this pain?

☐ MRI ☐ X-ray ☐ CT Scan ☐ EMG ☐ None/Other:_____

Where did this take place? _____

When was this done?_____

Have you tried medications for your pain? ☐ Yes ☐ No

If yes, please check below:

☐ Gabapentin Dose:_____ When taken:_____

☐ Lyrica Dose:_____ When taken:_____

☐ Topamax Dose:_____ When taken:_____

☐ Cymbalta Dose:_____ When taken:_____

☐ Amitriptyline Dose:_____ When taken:_____

☐ Nortriptyline Dose:_____ When taken:_____

☐ Muscle relaxants:

☐ Cyclobenzaprine ☐ Metaxalone ☐ Methocarbamol ☐ Tizanidine ☐ Orphenadrine

☐ Anti-inflammatory medications:

☐ Ibuprofen ☐ Naproxen ☐ Prednisone

☐ Opioid medications:

☐ Tramadol ☐ Codeine ☐ Hydrocodone ☐ Oxycodone ☐ Morphine

☐ Fentanyl ☐ Hydromorphone

List any other medications you have tried for your pain: _____

What types of treatment are you interested in?_____

Check any of the following problems you have experienced in the past 2 weeks:

☐ Fever	☐ Cough	☐ Diarrhea	☐ None of the above
☐ Weight gain	☐ Shortness of breath	☐ Difficulty urinating	
☐ Weight loss	☐ Chest pain	☐ Loss of bladder control	
☐ Hearing loss	☐ Leg swelling	☐ Depression	
☐ Vision loss	☐ Constipation	☐ Trouble sleeping	

Past medical history (check all that apply):

☐ Heart attack	☐ Immune disorder	☐ Liver disease: _____
☐ Stroke	☐ Asthma	☐ Frequent infections: _____
☐ Hepatitis	☐ Thyroid problems	☐ Circulatory disease: _____
☐ Seizure disorder	☐ Osteoporosis	☐ Respiratory problems: _____
☐ Arthritis	☐ Stomach ulcers	☐ Kidney disease: _____
☐ High cholesterol	☐ Anemia	☐ Bleeding disorder: _____
☐ High blood pressure	☐ Diabetes	☐ Skin problems: _____
☐ Depression	☐ Anxiety disorder	☐ Other: _____

Surgical history:

Surgery/Date:	Surgery/Date:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Is there a history of back pain or chronic pain in your family? ☐ Yes ☐ No

If yes, please describe: _____

Some of the medications we may prescribe could be addictive or abused. Please answer the following questions honestly so we may pursue the best course of action if pain medication is necessary.

Do you smoke? ☐ Yes ☐ No

If yes, how many packs to you normally smoke? _____ per ☐ Day ☐ Week ☐ Month

Do you drink alcohol? ☐ Yes ☐ No

If yes, How alcoholic drinks do you normally consume? _____ per ☐ Day ☐ Week ☐ Month

Do you use recreational or street drugs, including marijuana? ☐ Yes ☐ No ☐ Formerly

Do you have a history of drug abuse? ☐ Yes ☐ No

If yes, did you undergo treatment? ☐ Yes ☐ No

If yes, please describe the treatment, including what the treatment was for and the year(s):

_____

_____

Do you have a history of alcohol abuse? ☐ Yes ☐ No

If yes, did you undergo treatment? ☐ Yes ☐ No

If yes, please describe the treatment, including what the treatment was for and the year(s):

_____

_____

Have you ever had any traffic violations related to drugs or alcohol (DWI, DUI, etc.)? ☐ Yes ☐ No

If yes, please describe: _____

The following questions are to help us understand your situation better so we can help you deal with any social or work stresses that this medical problem may be causing you.

Marital status:

☐ Single, never married ☐ Single, divorced ☐ Single, widowed
☐ Married ☐ Separated ☐ Significant other

Total number of children: _____

Number of girls:_____Their ages: _____

Number of boys:_____Their ages: _____

Last level of school you completed: _____

Are you currently working? ☐ Yes ☐ No **If yes,** answer the next 3 questions:

1. What is your current type of work? _____
2. Are you currently working: ☐ Full time ☐ Part time
3. Are you working: ☐ Without restrictions ☐ With restrictions written by a physician

Are you receiving any financial compensation now for lost income due to disability? ☐ Yes ☐ No

Are you involved in any litigation regarding your pain condition? ☐ Yes ☐ No

LIST ALL ALLERGIES YOU HAVE, including medications, food, latex or other substances. Describe what kind of reaction you had to each (for example, rash, shortness of breath, etc.)

Allergy/Reaction:

_____
_____
_____
_____
_____

Allergy/Reaction:

_____
_____
_____
_____
_____

LIST THE NAMES OF ALL THE MEDICATIONS YOU ARE CURRENTLY TAKING IN THE TABLE BELOW. You may also bring a medication list with you to your appointment.

Medication:	Dose:	When taken:

PRIVACY POLICY

Patient Consent for Use and Disclosure of Protected Health Information

Twin Cities Pain Clinic

I hereby give my consent for TWIN CITIES PAIN CLINIC ("Clinic") to use and disclose protected health information (PHI) for performing any activity for **treatment**: providing, coordinating, and managing quality patient care; **payment**: ensuring that the practice gets paid for services; and **operations of the practice**: internal management activities. This is also referred to as **TPO**.

Clinic's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have reviewed the Notice of Privacy Practices prior to signing this consent.

With this consent:

1. Clinic may call my home or other alternative location and leave a message on the recorder or in person in reference to any items that assist the practice in carrying out TPO, such as insurance items and my clinical care including laboratory results.
2. Clinic may mail to my home or other alternative location any items that assist the practice in carrying out TPO such as patient statements.
3. I authorize the following person(s) to be my personal representative(s), which means the doctor and staff may speak freely to the named representative(s) regarding all my PHI, Medical and Treatment matters and Billing:

Name **Relationship**

_____

_____

I have the right to request that Clinic restrict how it uses or discloses my protected health information to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I was notified of the Privacy Practices and am consenting to Clinic's use and disclosure of my protected health information to carry out treatment, payment, and operations. Clinic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Twin Cities Pain Clinic at 7235 Ohms Lane, Edina, MN 55439.

Federal law permits Twin Cities Pain Clinic to use and disclose medical information about you for research purposes, either with your specific, written authorization or when the study has been reviewed for privacy protection by an Institutional Review Board or Privacy Board before the research begins. In some cases, researchers may be permitted to use information in a limited way to determine whether the study or the potential participants are appropriate. Minnesota law generally requires that we get your consent before we disclose your health information to an outside researcher. We will make a good faith effort to obtain your consent or refusal to participate in any research study, as required by law, prior to releasing any identifiable information about you to outside researchers. (Minn. Stat. § 144.295 subd.1)

_____ _____

Patient Signature Date

_____ _____

Patient Printed Name Date of Birth

TCPC OFFICE USE ONLY	Patient was given Notice of Privacy Practices and refused to sign this consent on: DATE:_____ EMPLOYEE INITIALS:_____

Twin Cities Pain Clinic

Financial Policy

Our practice is committed to providing you the best health care possible. It is your responsibility to understand your insurance plan benefits. This includes co-payments, co-insurance and any deductible amounts for the services you receive. We are happy to assist you with any questions you may have about your account or balance with us.

INSURANCE

As your medical provider, our relationship is with you. Your insurance is a contract between you and your insurance carrier. While insurance can be confusing, it is ultimately your responsibility to know your insurance plan. Not all services may be covered by your insurance plan. As a courtesy to you, we will file your claim in a timely manner. **You must present a valid health insurance card, photo ID and any co-payment or past-due balances at each visit. We accept cash, check, or credit/debit cards. We are also able to accept credit/debit card payments over the phone or online.** If your insurance has changed, you may need to pay the full cost of your visit. In these cases, we will assist you in obtaining reimbursement or credit from your insurer.

FORMS / APPEALS

Insurance covers only your medical care. It does not cover submitting forms that may assist you in collecting disability benefits and maintaining employment. There are fees for these services which reflect the resources diverted to the effort. Your insurance may not cover all treatments or medications. You may pay cash, forego treatment or appeal to your insurer. If you ask us to appeal, we will bill you an hourly rate as this is not medical care.

REFERRALS

Some insurers require a referral from your primary doctor; refer to your medical policy. Please have your primary care provider send a referral prior to your appointment. Without a referral, insurers may require you to pay for your visit in full.

ASSIGNMENT OF BENEFITS

I authorize all insurance benefits to be paid directly to Twin Cities Pain Clinic, DBA Andrew J. Will, M.D., P.A. I authorize the release of all necessary information to file and complete all insurance claims.

ACCOUNT BALANCES

Payment for services is expected within 30 days of your first statement. Accounts that are 90 days past due will be sent to collections. This may impact your credit and you will be responsible for collection costs including court and attorney fees. Returned checks are subject to a $30.00 service charge.

MISSED AND CANCELLED APPOINTMENTS

Your appointment time is set aside specifically for you. If you are unable to keep an appointment, you are responsible to provide us with a 24-hour notice. Failure to do so will result in a $50.00 cancellation fee. This fee is not covered by insurance. You are responsible for paying this fee before you are allowed to schedule another appointment.

I have read and understand all information on this financial policy. I agree to its terms and assignment of benefits and release of information as described above.

With my signature I am also authorizing medical treatment to be performed by Twin Cities Pain Clinic.

Patient/Guardian Signature: _____

PRINT Patient/Guardian Name: _____

Date: _____

HEALTH ASSESSMENT QUESTIONNAIRE (HAQ-DI)©

Name:_____ Date: _____

Please place an "x" in the box which best describes your abilities OVER THE PAST WEEK:

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
DRESSING & GROOMING				
Are you able to:				
Dress yourself, including shoelaces and buttons?	☐	☐	☐	☐
Shampoo your hair?	☐	☐	☐	☐
ARISING				
Are you able to:				
Stand up from a straight chair?	☐	☐	☐	☐
Get in and out of bed?	☐	☐	☐	☐
EATING				
Are you able to:				
Cut your own meat?	☐	☐	☐	☐
Lift a full cup or glass to your mouth?	☐	☐	☐	☐
Open a new milk carton?	☐	☐	☐	☐
WALKING				
Are you able to:				
Walk outdoors on flat ground?	☐	☐	☐	☐
Climb up five steps?	☐	☐	☐	☐

Please check any AIDS OR DEVICES that you usually use for any of the above activities:

☐ Devices used for Dressing (button hook, zipper pull, etc.)
☐ Built up or special utensils
☐ Crutches
☐ Cane
☐ Wheelchair
☐ Special or built up chair
☐ Walker

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

☐ Dressing and grooming ☐ Arising ☐ Eating ☐ Walking

Please place an "x" in the box which best describes your abilities OVER THE PAST WEEK:

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
HYGIENE				
Are you able to:				
Wash and dry your body?	☐	☐	☐	☐
Take a tub bath?	☐	☐	☐	☐
Get on and off the toilet?	☐	☐	☐	☐
REACH				
Are you able to:				
Reach and get down a 5 pound object (such as a bag of sugar) from above your head?	☐	☐	☐	☐
Bend down to pick up clothing from the floor?	☐	☐	☐	☐
GRIP				
Are you able to:				
Open car doors?	☐	☐	☐	☐
Open previously opened jars?	☐	☐	☐	☐
Turn faucets on and off?	☐	☐	☐	☐
ACTIVITIES				
Are you able to:				
Run errands and shop?	☐	☐	☐	☐
Get in and out of a car?	☐	☐	☐	☐
Do chores such as vacuuming or yard work?	☐	☐	☐	☐

Please check any AIDS OR DEVICES that you usually use for any of the above activities:

☐ Raised toilet seat
☐ Bathtub bar
☐ Long-handled appliances for reach
☐ Bathtub seat
☐ Long-handled appliances in bathroom
☐ Jar opener (for jars previously opened)

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

☐ Hygiene
☐ Reach
☐ Gripping and opening things
☐ Errands and chores

Your ACTIVITIES: To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

COMPLETELY	MOSTLY	MODERATELY	A LITTLE	NOT AT ALL
☐	☐	☐	☐	☐

Your PAIN: How much pain have you had IN THE PAST WEEK?
On a scale of 0 to 100 (where zero represents “no pain” and 100 represents “severe pain”), please record the number below.

Your HEALTH: Please rate how well you are doing on a scale of 0 to 100 (0 represents “very well” and 100 represents “very poor” health), please record the number below.
