Advanced Pain Institute

"The path to easing pain and enhancing lives starts here"

Please complete the following questionnaire:

The purpose of this questionnaire is to obtain a thorough understanding of your medical status. Please accurately answer these routine questions before your appointment time. This will result in more time allotted to your actual visit with the physician. We will not be able to see you in a timely manner without a completed questionnaire.

Patient Name/DOB_____ Date:_____

Primary care physician/referring::_____

SOCIAL HISTORY:

What is your occupation? _____

If you are disabled and/or retired, what was your occupation? _____

Highest grade level completed: _____

Are you a current smoker? ___ No ___Yes If yes, how many packs per day? _____

Are you a former smoker? ___ No ___Yes

Do you drink alcohol? ___ None ___ Occasional ___ Moderate ___ Heavy

Have you ever abused any of the following?

___ Alcohol ___No ___ Yes

___ Prescription drugs ___ No ___ Yes If yes, what kind? _____

Have you ever used illegal drugs? ___ No ___ Yes If yes, what kind? _____

Sexually Active? ___ No ___Yes

Married, single, divorced, widowed? _____

Military experience? _____

Physical activity? ____ vigorous _____moderate _____ sedentary

MEDICATIONS AND DOSAGE:

MEDICATION	*STRENGTH*	*# OF PILLS PER DAY*

MEDICATION ALLERGIES:

_____ _____ _____

_____ _____ _____

Reason for today's visit/ Where is your pain? _____

What is your age? _____ Height? _____ Weight? _____

PAST MEDICAL HISTORY:

_____ High blood pressure/hypertension
_____ Diabetes
_____ High cholesterol
_____ Heart disease
_____ Seizure/Epilepsy
_____ Thyroid disease
_____ Headaches/Migraines
_____ Cancer
_____ Stroke
_____ Peptic Ulcer Disease (PUD)
_____ Hepatitis C
_____ HIV/AIDS
_____ Irregular heart beat
_____ Parkinson's Disease
_____ Arthritis
_____ Kidney disease
_____ Asthma
_____ COPD
_____ Multiple Sclerosis
_____ Alzheimer's/Dementia
_____ Degenerative Disc Disease
_____ GERD

FAMILY HISTORY: *(PLEASE INDICATE M- MOTHER, F-FATHER, S- SISTER, OR B-BROTHER)*

_____ High Blood Pressure
_____ Diabetes
_____ High Cholesterol
_____ Heart Disease
_____ Seizure/Epilepsy
_____ Migraine/Headaches
_____ Cancer
_____ Stroke
_____ Muscular Dystrophy
_____ Parkinson's Disease
_____ Multiple Sclerosis
_____ Alzheimer's Dementia
_____ Other_____

List all major surgeries: _____

ADVANCED PAIN INSTITUTE, L.L.C.
and
ADVANCED PAIN INSTITUTE TREATMENT CENTER, L.L.C.

DESIGNATION OF PERSONAL REPRESENTATIVE

You have a right as required by the Health Insurance Portability and Accountability Act of 1996 to nominate one or more persons to act on your behalf with respect to the protection of your health information. By signing this authorization you are informing us of your designation of the named person as your personal representative. This designation may be revoked at any time by signing and dating the revocation of your copy of the form and returning it to this office.

I, _____ hereby designate _____ to act as my personal representative with respect to decisions involving the use and/or disclosure of my health information.

Last Four (4) Digits of Representative's SS No: _____
Representative's Date of Birth _____
Representative's Driver's License No. or other Picture ID No. _____

It is my understanding that this person is to be afforded all of the privileges that would be afforded to me with respect to my health information unless specifically restricted below:

Restrictions: _____

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to ADVANCED PAIN INSTITUTE, L.L.C./ADVANCED PAIN INSTITUTE TREATMENT CENTER, L.L.C., 42131 Veterans Avenue, Suite 100, Hammond, Louisiana 70403. I further understand that such revocation does not apply to the extent that persons who have been authorized by my Personal Representative to use or disclose my health information have already acted in reliance on said designation.

_____ _____
Signature Date

_____ _____
Last four (4) digits of SS# Date of Birth

REVOCATION

I hereby revoke this designation of a personal representative.

_____ _____
Signature Date