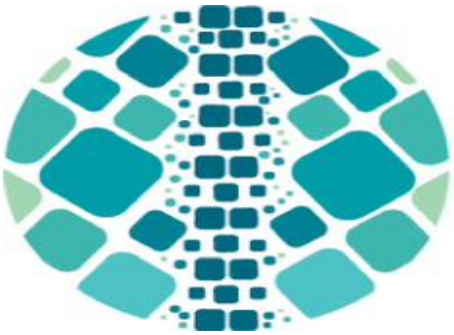

COMPREHENSIVE NEUROLOGICAL SOLUTIONS

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:_____

Physical Address_____

Primary care physician/referring::_____

Pharmacy_____

How did you hear about us ? _____ SS # _____

Home Phone _____ Other Phone _____

Email _____

SOCIAL HISTORY:

What is your occupation? _____

Do you have any disabilities ? _____ If yes, what kind ? _____

If yes, what is your preferred method of communication ? _____

Race: African American/ Black Caucasian/ White Hispanic/Latino Other

Relationship: Single Married Divorced Separated Widow Other

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

Patient Initials: ____

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

Military experience? _____

Physical activity? ____ vigorous _____moderate _____ sedentary

MEDICATIONS AND DOSAGE:

MEDICATION ALLERGIES:

_____ _____ _____

_____ _____ _____

Reason for today's visit?_____

Please briefly explain anything else you feel is relevant to today's visit：

Patient Initials: ____

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:

Any prior imaging or labs? (MRI, CT, or bloodwork) If yes, where and when ?

Patient Initials: ____

Patient Attestation of Condition or Injury

Is your visit today related to an auto or other accident?
Please circle YES or NO
If yes, please provide the date of your accident, the state your accident occurred in and nature of your injuries.
Date of accident:_____State_____
Injury:_____
Do you have an attorney representing you due to this accident?
Please circle YES or NO
If yes, please provide the attorney's name, address and phone#_____
_____

Is your visit today related to an accidental injury or condition on the job? Please circle YES or NO
If yes, please provide the date of your accident, the state your accident occurred in and the nature of your injuries.
Date of accident:_____State_____
Injury:_____
Do you have a workers comp attorney representing you due to this accident? Please circle YES or NO
If yes, please provide the attorney's name, address and phone#_____
_____

If your condition or injury today is accident or work related and you answer no to the above, our provider will not express an opinion about the cause of your condition or injury now, or at a later date. This is known as addressing causation which is very important to your legal case. Payment will be due in full from you.

Patient Name:_____DOB_____

Signature:_____

Advanced Pain Institute

Acknowledgement of Receipt of Notice of Privacy Practices

Advanced Pain Institute reserves the right to modify the privacy practices outlined in the notice.

I acknowledge that I have received a copy of the Notice of Privacy Practices for Advanced Pain Institute.

_____
Print Patient Name

_____ _____
Signature of Patient/Patient Representative Date

_____
Relationship to Patient

Release of Information

Persons whom I give permission to disclose any medical or billing information regarding my care (spouse, family, friends, etc..)

_____
Name of person/ Relationship

_____
Name of person/ Relationship

_____
Name of person/ Relationship

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (Last, First, Middle)	DOB

ADDRESS	SSN

CITY	STATE	ZIP

PROVIDER AUTHORIZED TO RELEASE THE PHI:	ENTITY RECEIVING THE PHI:
Name Address City Phone: Fax:	ADVANCED PAIN INSTITUTE & COMPREHENSIVE NEUROLOGICAL SOLUTIONS TOGETHER, EASING PAIN & ENHANCING LIVES 189 Greenbriar Blvd. Ste C Covington, LA 70433 Phone: 985-246-3058 Fax: 985-273-3017

This authorization will expire on the following date or event. If date or event is not indicated, authorization will expire 12 months from date signed.

Date: Event:

Purpose of this Disclosure:

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

Description	Start Date	End Date
☐ All PHI in the record		
☐ Progress Notes		
☐ Laboratory Tests		
☐ X-Ray Tests / Reports		
☐ History and Physical Examination		
☐ Discharge Summary		
☐ Consultation Reports		
☐ Itemized Billing Statement		
☐ Other:		

The following information will be released when included in the above information unless you indicate otherwise:

[ ] AIDS or HIV test results
[ ] Alcohol, drug or substance abuse treatment
[ ] Psychiatric or mental care / treatment
[ ] Other (specify):

I UNDERSTAND THAT:

1. I MAY REFUSE TO SIGN THIS AUTHORIZATION AND IT IS STRICTLY VOLUNTARY.
2. MY TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.
3. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF I DO, IT WILL NOT HAVE ANY AFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION.
4. IF THE REQUESTER OR RECEIVER IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AND MAY BE REDISCLOSED.
5. I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.

Signature of Patient:	Date:

Signature of Patient's Representative (if necessary):	Date:

Personal Representative's Relationship to Patient:

*** There may be a fee charged to process your request ***