Lanier Interventional Pain Center

John L. Givogre, M.D.

Board Certified in Pain Medicine and Anesthesiology

2335 Limestone Overlook
Gainesville, GA 30501

Phone 770.297.0356
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PATIENT REGISTRATION

Name: ____ Date: ________________
Last First MI

Address: ____
Street City State Zip

Phone: ____
Home Cell Work

DOB: ____________________ Social Security _____________________________ Marital Status ____________

Employer: _______________________________________ Address: ____________________________________

Emergency Contact: ____ Phone: ___________________________

Primary Insurance:____ Phone: ___________________________

Mailing Address: ____

Insured Party: _______________________________ DOB: _________ Relationship: ______________________

Policy # ___________________ Group # ___________________ Effective Date: _________________________

- PLEASE GIVE INSURANCE CARDS TO FRONT DESK PERSONNEL FOR COPYING PURPOSES –

Secondary Insurance: ____ Phone: ____________________

Mailing Address: ____

Insured Party: ______________________________ DOB: __________ Relationship: ______________________

Policy #_____________________ Group #: ____________________ Effective Date: ______________________

I hereby authorize payment directly to the physician for any professional services rendered to my dependent or myself. I understand that I am financially responsible for any charges not paid by my insurance company, unless my insurance plan is one that contracts directly with the physician and they determine that I am not responsible. Regulations pertaining to medical assignment of benefits apply. In the event it becomes necessary to collect the amount due on my account by legal litigation, the handling fees, service charges, or court cost will be paid by the guarantor. In order to prevent the application of the above, fees should be paid timely upon completion of rendered services.

Signature: ____ Date: ____________________________

Lanier Interventional Pain Center

Authorization for Use and/or Disclosure of Protected Health Information

Patient Name: ____

Date of Birth: ____________________________ Social Security ____

Section A: Use or Disclosure of Health Information

By signing this form, I authorize the exchange, use, and/or disclosure of my individually identifiable health information maintained by ____

Fax: _________________________ Phone: ________________________ Contact: ________________________

Mail/Send records to ____

Section B: Scope and Use of Disclosure

I understand that this authorization may include, if applicable:

- Information pertaining to the identification of, diagnosis, prognosis, or treatment for alcohol or drug abuse.
- Information concerning the testing for HIV (Human Immune Virus) and/or treatment for AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.
- Privileged communications between me and a psychiatrist, psychologist, licensed clinical social worker, licensed marriage and family counselor, or licensed professional counselor or between them concerning my communications with any of them.

Information that may be used or disclosed based on this authorization is as follows:

- Specific health information about me as directed in the preceding section, also including the following: Last two office notes, lab reports, hospital/ER reports, medical records, x-ray reports, drug screens, procedure notes, operative notes, MRI results, bone/dexa scan results.
- All health information and medical records created by the above Doctor/Facility.
- All health information about me as directed above excluding the following: ________________________ ____

Section C: Purpose The purpose for this disclosure is (check only one):

□ Specifically, the following: ____

□ The consumer does not elect to disclose the purpose. Note: This box may not be checked if the information to be disclosed pertains to alcohol or drug abuse.

Section D: Expiration This content will expire without revocation twelve months from the date of signing or in the event written notification is received.

Patient/Consumer Signature: ____ Date: ______________

Lanier Interventional Pain Center

Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Health Care Information

1. I understand that as part of my health care, Lanier Interventional Pain Center originates records and maintains health information about me describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this health care information may be used or disclosed by LIPC for treatment, payment, and health care operations. For example, my health information serves as
   - a basis for planning my care and treatment
   - a means of communication among many health professionals who contribute to my care
   - a source of information for applying my diagnosis and surgical information to my bill
   - a means by which a third party payor can verify that services billed were actually provided
   - a tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.

2. I acknowledge that if I desire I can be provided with Lanier Interventional Pain Center's notice of privacy practices that provides a more complete description of information uses and disclosures. I understand that LIPC reserves the right to change its notice of privacy practices and prior to implementation will mail a copy of any revised notice to the address I have provided.

3. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and that LIPC is not required to agree to the restrictions requested but if it does, it is bound by such restrictions.

4. I understand that I may revoke this consent in writing, except to the extent that LIPC has already taken action in reliance thereon.

5. By signing this form, I consent to Lanier Interventional Pain Center's use and disclosure of my health information for treatment, payment, and health care operations. I give consent to LIPC to obtain copies of my medical records for treatment and health care operations.

□ I request the following restrictions to the use or disclosure of my health information:

□ Restrictions accepted □ Restrictions denied

____ Date: _________________________
Signature/Title

____ Date: _________________________
Signature of Patient or Legal Representative

____ Date: _________________________
Witness

Lanier Interventional Pain Center

Biopsychosocial Trauma Inventory
Pain and Disability Questionnaire Pre-Screening

Patient's Name: ______________________________________ ID: ___________ Date: ____________________

1. Are you now or have you in the past been treated for (A) depression, (B) anxiety, (C) other emotional problems (specify) ____ (D) drug or alcohol problems. *Please circle the appropriate letter.

2. Do you currently have suicidal plans Yes______ No ______

Since becoming ill or injured. *Circle either T for true or F for false.

1. I feel depressed most of the time. T F
2. Pain prevents me from sleeping well. T F
3. I suffer with pain much of the time. T F
4. I often have pressure or pains in my chest. T F
5. I become angry and frustrated much more easily. T F
6. I have trouble remembering things. T F
7. My family and friends have begun to lose patience with me. T F
8. I am seldom happy any more. T F
9. I have frequent headaches. T F
10. Minor things worry or aggravate me more than before. T F
11. I feel nervous much of the time. T F
12. I find I often need medicine to help with the pain. T F
13. I feat that I may be re-injured. T F
14. My overall level of stress has increased. T F
15. I have lost much of my interest in work and social activities. T F
16. I regret not having been more concerned about my health in the past. T F
17. I feel my family and friends do not care for me. T F
18. At times I have found myself thinking "I would be better off dead". T F
19. I often worry about becoming addicted to drugs. T F
20. I worry about supporting myself or my family. T F
21. I have lost hope of recovering. T F
22. I have worried about being harmed by my doctor or treatment. T F
23. I find it difficult to concentrate. T F
24. I have stomach problems and nausea. T F
25. I wonder if I will be able to fully comply with my doctor's orders. T F
26. I find I break into sweats easily. T F
27. I have thoughts of ending my life. T F
28. I have urges to beat, injure, or harm someone. T F
29. I have panic attacks. T F
30. I have difficulty making decisions. T F
31. I feel confused much of the time. T F
32. I have urges to break or smash things. T F
33. I am easily annoyed or irritated. T F
34. I often feel tired or weak all over. T F
35. I sleep a great deal during the day. T F
36. My appetite has changed significantly. T F
37. I sometimes have delusions / hallucinations. T F
38. I feel useless or helpless. T F
39. I sometimes worry that I will not be given enough pain medication. T F
40. I find it difficult to think about much else other than my condition. T F
41. There are times when I want to talk to someone about my condition. T F
42. I am often bothered my muscle spasms or cramps. T F
43. I have numbness in parts of my body. T F
44. I frequently have bad dreams about my condition. T F
45. I have periods when I have blacked out or felt faint for no apparent reason. T F
46. I feel these questions are important to my treatment. T F

___________________ Raw score

Lanier Interventional Pain Center

Informed Consent for Female Patients

The diagnosis and treatment of pain often involves using various medications and x-ray procedures. Be advised that many medicines used in the treatment of pain have not been adequately studied for their effects on pregnant women and/or a developing fetus. Therefore, you are responsible for taking any medications or undergoing diagnostic procedures, as well as the use of adequate measures to prevent pregnancy during such time.

If you are currently pregnant or if you become pregnant while enrolled in a pain treatment program at Lanier Interventional Pain Center, you **must** take immediate steps to inform the physicians so that appropriate treatment adjustments can be made. Additionally, some x-rays and scans are not considered safe for women who are pregnant. Therefore, if any possibility exists that you are pregnant, you must inform us of this prior to diagnostic testing.

By signing below, I understand the above warnings and agree to inform my physician of any possible pregnancy. I fully understand that some medications used to treat pain are not proven safe for women who are pregnant or to a developing baby. I also understand that I must inform my physician if there is a possibility that I am pregnant (or if I am currently pregnant) prior to undergoing any tests or procedures.

____ _________________________

Patient's Signature Date

Lanier Interventional Pain Center

History and Physical Examination

Name ____ Age _________ Date _____________________
BP__________ P _______ R _________ T __________ Wt _______
Intake completed by ____________________________ ____ M.D.
Chief Complaint and Primary Reason for New Patient Visit: ____
____
____

Serious Childhood Illnesses (Answer YES or NO)
______ Chicken Pox ______ Mumps ______ Measles ______ Diphtheria
______ Whooping Cough ______ Scarlet/Rheumatic Fever ______ Mononucleosis ______ Other

Past Surgical History (Operations)
1. ____ Date_________ Facility _____________________
2. ____ Date_________ Facility______________________
3. ____ Date_________ Facility _____________________
4. ____ Date_________ Facility______________________
5. ____ Date_________ Facility______________________
6. ____ Date_________ Facility______________________
7. ____ Date_________ Facility______________________
8. ____ Date_________ Facility______________________

Have you had transfusions? Yes___ No_____ When?_______

Serious Accidents Requiring Medical Care:
1. ____ Date_____________ Place _____________________
2. ____ Date_____________ Place _____________________
3. ____ Date_____________ Place_____________________
4. ____ Date_____________ Place_____________________

Past Medical History (Medical Illnesses as an Adult)
1. ____ Date_____________
2. ____ Date_____________
3. ____ Date_____________
4. ____ Date_____________
5. ____ Date_____________
6. ____ Date_____________
7. ____ Date_____________
8. ____ Date_____________

Do you have any chronic infectious diseases Yes_____ No ______
____

History and Physical Examination #2

Patient Name____

Any emotional or mental illness? Yes____ No ____ ____

List all medications or supplements that you are taking. (Include vitamins and aspirin.)

Name or Type of Medicine	Dose	How often you take

1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____
9.____
10.____
11.____
12.____
13.____
14.____
15.____

Allergies to Medications: Please list and describe adverse effects.

1.____
2.____
3.____
4.____
5.____

Allergies to Food or Other Substances: Please list and describe adverse effects.

1.____
2.____
3.____
4.____
5.____

Family History:

	Health Status				
	Good	Poor	Deceased	Age	Cause of Death
Father	☐	☐	☐	_____	______________________________
Mother	☐	☐	☐	_____	______________________________
Brothers	☐	☐	☐	_____	______________________________
	☐	☐	☐	_____	______________________________
	☐	☐	☐	_____	______________________________
	☐	☐	☐	_____	______________________________
	☐	☐	☐	_____	______________________________

History and Physical Examination #3

Patient Name____

	Health Status				
	Good	Poor	Deceased	Age	Cause of Death
Sisters	☐	☐	☐	_____	____
	☐	☐	☐	_____	____
	☐	☐	☐	_____	____
	☐	☐	☐	_____	____
	☐	☐	☐	_____	____

Do any blood relatives have the following?

	Problem	Relation
☐	Migraine	____________________________________
☐	Epilepsy	____________________________________
☐	Stroke	____________________________________
☐	Glaucoma	____________________________________
☐	Hearing Loss	____________________________________
☐	Rheumatic Fever	____________________________________
☐	Heart Murmur	____________________________________
☐	Heart Disease	____________________________________
☐	High Blood Pressure	____________________________________
☐	Tuberculosis	____________________________________
☐	Emphysema	____________________________________
☐	Lung Disease	____________________________________
☐	Asthma	____________________________________
☐	Stomach Ulcers	____________________________________
☐	Gallstones	____________________________________
☐	Kidney Stones	____________________________________
☐	Nephritis	____________________________________
☐	Arthritis	____________________________________
☐	Diabetes	____________________________________
☐	Cancer	____________________________________
☐	Thyroid Disease	____________________________________
☐	Overweight	____________________________________
☐	Infectious Disease	____________________________________
☐	Allergies	____________________________________
☐	Anemia	____________________________________
☐	Gout	____________________________________
☐	Bleeding Tendency	____________________________________
☐	Mental Illness	____________________________________
☐	Other: ____	

History and Physical Examination #4

Patient Name____

Social History:

Position | Nature or Description of Work | # of Years

Present Occupation: ____

Previous Occupations: 1. ____
2. ____

Any Exposure to Toxic or Dangerous Materials?

Yes No Substance When Name of Type Physical Symptoms Others Affected?

☐ ☐ Insulation____
☐ ☐ Fumes____
☐ ☐ Metals____
☐ ☐ Chemicals____
☐ ☐ Plastics____
☐ ☐ Solvents____
☐ ☐ Dyes____
☐ ☐ Animals____
Other: ____

Foreign Travel (past 10 years):

1. ____ Year____________
2. ____ Year ____________
3. ____ Year____________
4. ____ Year____________

HIV Risk Factors? ____

Pets: Cats________ Dogs________ Other ____

Social History:

Single_________ Divorced________ When?________ How many times?________ Widowed________ When?______
Married_________ How many times?_________ Children: Boys_____ Girls______

Social Habits:

Yes No Started Stopped Amount

☐ ☐ Cigarettes__________________________________Packs per day _______
☐ ☐ Coffee_____________________________________Cups per day________
☐ ☐ Alcohol____________________________________Liquor/day____ beer/day____ wine/day____
☐ ☐ Other Drugs_____________________________________

Meals: Regular? Yes____ No ____ Meals per day: ___________ Snacks per day:______________

Emotional Stress – At work____
Family____
Other____

History and Physical Examination #5

Patient's Name_______________________________________

Exercise: None_____

Regular Exercise – Type? ___________________________________ # times/week____________

Irregular Exercise – Type? ___________________________________ # times/week____________

Sleep: Regular? Yes____ No ____ Hours per night_______ Do you snore? Yes_____ No _____

Other relevant information that may have a bearing on your lifestyle and health, in your own words:

____

____

____

____

Review of Systems:

Yes	No	Problem	Date Began
□	□	Convulsions, Seizures	__________
□	□	Frequent headaches	__________
□	□	Dizzy, balance problems	__________
□	□	Fainting	__________
□	□	Wear glasses, contacts	__________
□	□	Vision worse	__________
□	□	Eye pain	__________
□	□	Frequent earaches	__________
□	□	Decreased hearing	__________
□	□	Sinus pains	__________
□	□	Often stuffy nose, sneezing	__________
□	□	Difficulty/sore swallowing	__________
□	□	High blood pressure	__________
□	□	Chest pain at rest	__________
□	□	Chest pain exercising	__________
□	□	Heart "races"	__________
□	□	Heart "skips beats"	__________
□	□	Heart murmur	__________
□	□	Short of breath:	__________
□	□	…at night	__________
□	□	…at rest	__________
□	□	…exercising	__________
□	□	Swelling feet/ankles	__________
□	□	Frequent cough	__________
□	□	Cough up blood	__________
□	□	Bronchitis	__________
□	□	Pneumonia	__________
□	□	Pleurisy	__________
□	□	Asthma or wheezing	__________
□	□	Emphysema	__________

Yes	No	Problem	Date Began
□	□	Abdominal pain	__________
□	□	Frequent nausea	__________
□	□	Vomiting blood	__________
□	□	Bloody or black stools	__________
□	□	Frequent diarrhea	__________
□	□	Frequent constipation	__________
□	□	Hepatitis or jaundice	__________
□	□	Cirrhosis of liver	__________
□	□	Pancreatitis	__________
□	□	Pain on urination	__________
□	□	Blood in urine	__________
□	□	Rapid gain in weight	__________
□	□	Rapid loss of weight	__________
□	□	Constant loss of feeling somewhere on body	__________ __________
□	□	Nervousness	__________
□	□	Difficulty sleeping	__________
□	□	Poor appetite	__________
□	□	Pain in joints	__________
□	□	Pain in muscles	__________
□	□	Swelling of joints	__________
□	□	Weakness in arms	__________
□	□	Weakness in legs	__________

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Patient's Full Name____ ID #___________________

Referring Physician____ Date__________________

General Pain Questionnaire #1 Please answer the following questions to the best of your ability.

1. Where is your pain located? ____
2. Since your pain first began has it gotten worse, better, or remained the same? ________________________
3. Does your pain travel anywhere? Yes___ No___ If yes, where? ____________________________________
4. Which statement best describes your pain?
   _____Always present, always the same intensity.
   _____Always present, but intensity changes.
   _____Usually present, but have short periods without pain.
   _____Occasionally present – have pain once to several times per day.
   _____Occasionally present for brief periods, a few seconds to minutes.
5. When did you first see a doctor for your pain? ____
6. What doctors have you seen for your pain? ____
7. Have you had any of the following for your pain?
   X-ray____ Myelogram____ EMG____ CT scan____ MRI ____ Bone scan____ Other ____________________
8. Have you had surgery for your pain? Yes___ No___ If yes, please describe___________________________
   ____
9. Have you had nerve blocks (injections) for your pain? Yes___ No___ Were they helpful? Yes____ No ____
   Helpful for a short time____________
10. Have you had any of the following for your pain? Biofeedback_____ TENS _____ Chiropractic ___________
    Heat therapy____ Bed rest____ Traction_____ Relaxation therapy____ Corset____ Ultrasound __________
11. Were any of these therapies helpful? Yes___ No ___ If yes, please list which ones were useful __________
    ____
12. If you have taken medication for your pain, please list the ones that were useful.______________________
    ____
    Please list the ones that were not useful____
    ____
13. Do any of the following make your pain feel worse? Relaxation______ Sitting_____ Standing ___________
    Lying down_____ Walking_____ Physical Activity _____ Sexual Activity______ Other __________________
14. Do any of the following make your pain feel better? Relaxation____ Sitting____ Standing_____ Lying
    Down____ Walking____ Physical Activity_____ Sexual Activity_____ Other___________________________
15. Does pain interrupt your sleep? Yes___ No____ Do you have a difficult time getting comfortable in bed?
    Yes___ No____ Do you have a hard time going to sleep? Yes____ No _____

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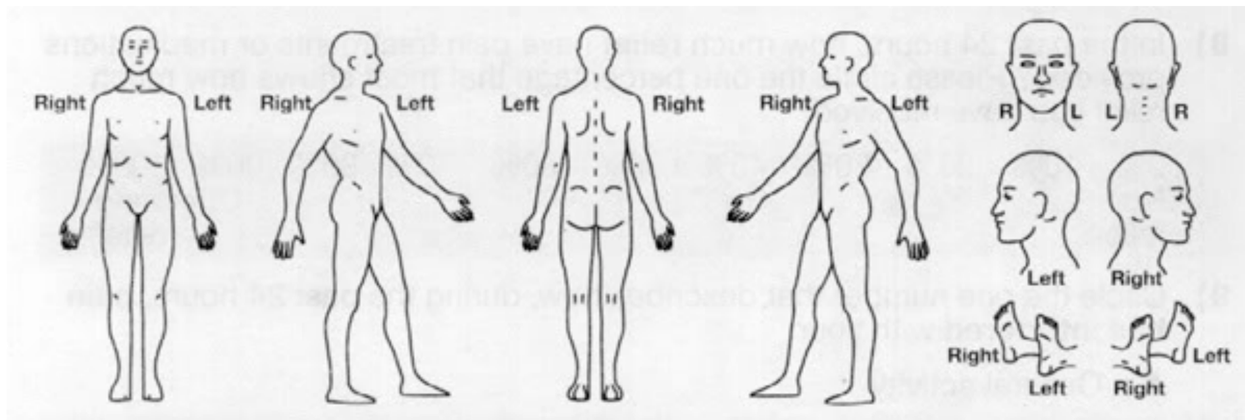
Patient's Full Name ____ ID #________________
Referring Physician ____ Date________________

General Pain Questionnaire #2 Please answer the following questions to the best of your ability.

1. Under what circumstances did your pain begin? Accident at work _____ Accident at home _________ At work, but not an accident_____ Pain just began, no reason_______ Motor vehicle accident___________ Following surgery______ Following an illness________ Other______________________________________
2. If pain was caused by an accident, please describe what happened____________________________________ ____
3. How often do you take part in social activities? Never____ Infrequently____ Regularly ________
4. Does pain prevent you from taking part in activities? Yes____ No_____ Do you normally enjoy social activities? Yes____ No_____
5. How often do you take part in recreational activities? Never____ Infrequently _____ Regularly _________
6. Does pain prevent you from taking part in these activities? Yes____ No_____
7. Please rate on a scale of 1-10 your ability to cope with your pain (0=totally unable to cope, and 10=coping very well) _______________
8. Do you feel helpless with your pain? Yes, all the time_____ Sometimes____ Infrequently____ Never_____
9. Do you feel your present pain condition is hopeless? Yes____ No____
10. Please rate your relationship with your family and spouse: excellent and supportive_____ good but could use improvement_____ frequently stressful______ poor with very little support________
11. Are you employed now? Yes, full time_____ Yes, full time with restrictions____ Yes, part-time________ Yes, part-time with restrictions_____ On sick leave_____ No, but not because of pain_____ No, unable to work because of pain __________
12. What is your occupation?____
13. What is the highest level of school that you completed? ____
14. Do you find your job satisfying? Yes___ No___. If you job giving you hassles because of your pain problem? Yes____ No_____ If you are off work now due to a job injury, do you think he will ever be able to go back to that job again? Yes___ No_____
15. Do you think your work was too heavy for you? Yes___ No____
16. Have you received financial compensation for your pain? Yes___ No____
17. Do you have a lawyer? Yes___ No ____
18. Have you ever had emotional problems? Yes___ No____
19. Do you live with: spouse___ children____ other relative_____. Do any other relatives have serious health problems? Yes____ No _____

Please indicate on the diagram where your pain occurs by shading the painful areas.



Please rate your pain on a scale of 0-10

0 = no pain and 10=the worst pain in the world.

Your pain at its worst________

Your pain at its least severe ________

Your pain at the present time________

What does your pain feel like?

Some of the words below describe your present pain. Circle ONLY those words that best describe it. Leave out any category that is not suitable. Use only a single word in each appropriate category – the one that applies best.

1
Flickering
Quivering
Pulsing
Throbbing
Beating
Pounding

5
Pinching
Pressing
Gnawing
Cramping
Crushing

9
Dull
Sore
Hurting
Aching
Heavy

13
Fearful
Frightful
Terrifying

17
Spreading
Radiating
Penetrating
Piercing

2
Jumping
Flashing
Shooting

6
Tugging
Pulling
Wrenching

10
Tender
Taut
Rasping
Splitting

14
Punishing
Grueling
Cruel
Vicious
Killing

18
Tight
Numb
Drawing
Squeezing
Tearing

3
Pricking
Boring
Drilling
Stabbing
Lancinating

7
Hot
Burning
Scalding
Searing

11
Tiring
Exhausting

15
Wretched
Blinding

19
Cool
Cold
Freezing

4
Sharp
Cutting
Lacerating

8
Tingling
Itchy
Smarting
Stinging

12
Sickening
Suffocating

16
Annoying
Troublesome
Miserable
Intense
Unbearable

20
Nagging
Nauseating
Agonizing
Dreadful
Torturing