ENID PAIN AND SPINE
427 East Cherokee Ave
Enid,OK 73703

Chad Owens DO
Barbara Owens NP

Teresa Etter NP

Date: _____

Name:_____Sex: M / F Date of Birth: _____

Referring Physician:_____Primary Care Physician:_____

Allergies:_____Your Occupation:_____Retired / Unemployed / Student

1.) Where is your pain located?

_____

2.) Have you ever been involved in any Motor Vehicle Accident(s) or Slip and Fall(s)? If so, when?

_____

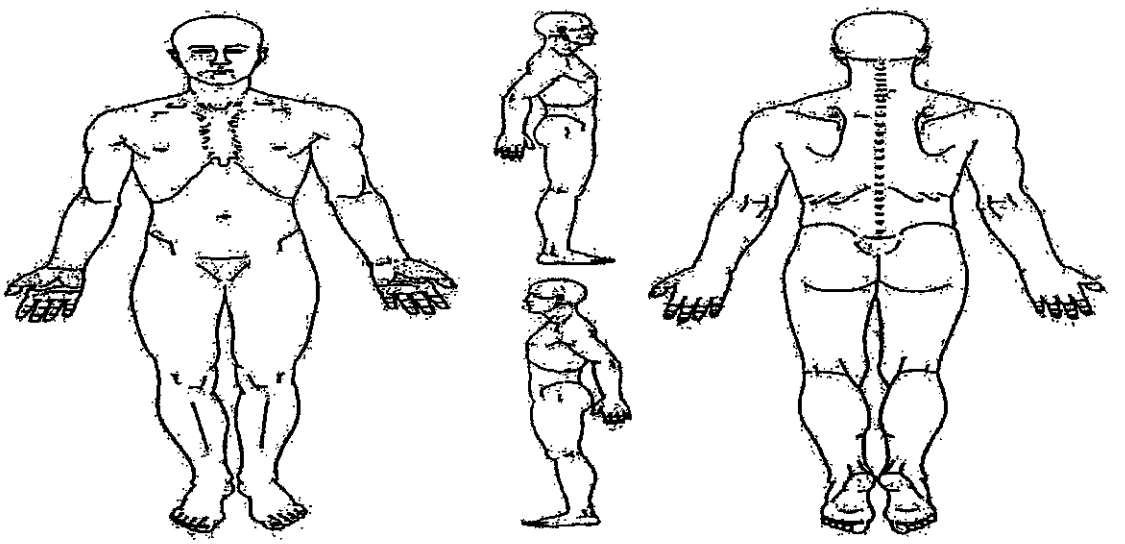
3.) When and how did your pain begin?

_____

4.) Does your pain radiate anywhere? If yes, where?

_____

5.) Please mark the area(s) in the diagrams below where you are having pain:



Is the pain (circle one) Constant / Several Times a day / Intermittent / Occasionally / Less than daily

6.) On a scale from 0-10, with 0 being no pain and 10 being the worst pain imaginable, what number describes your most recent pain: At its best:_____At its worst:_____Right at this moment:_____

7.) When is your pain worse (circle one)? Morning / Afternoon / Evening / No Usual Pattern / All the time

8.) How has the pain intensity changed since it began? Better / Worse / No Change

9.) Circle all the items that describe your pain: Aching / Burning / Cramping / Dull / Electric Shock / Sharp / Shooting / Stabbing / Throbbing / Other _____

10.) Circle what makes your pain worse: Standing / Sitting / Walking / Movement / Lying Down / Using Bathroom / Bending Forward / Arching Backward / Coughing / Other_____

11.) Circle what makes your pain better: Standing / Sitting / Walking / Movement / Lying Down / Using Bathroom / Bending Forward / Arching Backward / Coughing / Other_____

12.) Please list what diagnostic tests you have had done:

Test	Area(s) Tested	Date(s)
X-Ray		
CT Scan		
MRI		
Bone Scan	N/A	
EMG	N/A	
Myelogram		
Other		

13.) Do you have any of the following symptoms associated with your pain?
___Numbness/Tingling If yes, where? _____
___Weakness If yes, where? _____
___Bowel/Bladder Incontinence When did it start? _____

14.) Have you seen any other physicians for this pain? Y / N

What is/are the name(s) of the physician(s) you have seen regarding this pain?

Specialty	Physician Name	Approximate Date Seen
Neurosurgeon:		
Orthopedics:		
Pain:		
Psychiatrist/Psychologist:		
Other:		

15.) Please circle all procedures or modalities you have tried to manage or treat your pain with:

	Did It Help?		Did It Help?
Acupuncture		Massage	
Biofeedback		Meditation	
Chiropractor		Nerve Blocks	
Epidural		Physical Therapy	
Trac Block		Psychotherapy	
Ice/Heat		Surgery	
Medications		TENS	

16.) Are you seeking workers compensation as result of your pain? Yes / No

17.) Are you seeking social security benefits/disability as a result of your pain? Yes / No

II. Medical Illnesses (Circle all that apply)

Thyroid

Lung(Asthma, Emphysema, COPD)

[redacted]

Psychiatric(Depression, Anxiety, Suicidal)

Stomach(Ulcer, GERD/Reflux)

[redacted]

High Cholesterol

Neurologic(Stroke, Seizure, Neuropathy, MS, Migraine)

[redacted]

Cancer (Type?)

Other (Please List)

III. Prior Surgeries:

Type	Date	Type	Date
[redacted]			

IV. Medications:

Medication Allergies: _____

Current *Non-Pain* Medications

[redacted]

Previous Pain Medications

Do you take any of the following?: Aspirin / Plavix / Aggrenox / Effient / Coumadin / Brilinta / Pletal / Ticlid / Eliquis / Jantoven / Pradaxa / Xarelto / Other Blood Thinners

V. Social History (circle all that apply)

Tobacco: Never / Former / Current Type: Snuff / Cigarettes / Cigar / Pipe Use: Light / Moderate / Heavy

Alcohol: Never / Former / Current Usage: Special Occasion Only / Socially / Moderately / Daily

Illegal Drugs: Never / Former / Current Type: Marijuana / Cocaine / Heroin / Ecstasy / Other

Have you ever been treated for alcohol or drug addiction? Yes / No. If Yes, date: _____

VI. Family History

	Relative		Relative
Cancer		Hypertension	
Diabetes		Stroke	
Heart Disease		Alcohol/Drug Abuse	

VII. Review of Systems:

General	Weight Gain/Loss, Fever	GI	Heartburn, Nausea, Constipation, Abdominal Pain
Skin	Rashes, Itching	GU	Blood in urine, Incontinence
Head/Eyes	Vision Changes	M.S.	Neck Pain, Back Pain, Joint Pain, Difficulty Walking
ENT	Ear Ringing, Sinusitis, Sore Throat, Snoring	Neuro	Seizures, Dizziness, Headache, Loss of consciousness
RES	Chronic Cough, Shortness of Breath, Sleep Apnea	PS	Depression, Anxiety, Sleep Problems, Memory Loss
CV	Chest Pain, Palpitations, Ankle Swelling	END	Fatigue, Excessive Thirst, Heat/Cold Intolerance
HEM	Anemia, Easy Bruising/Bleeding	Vasc	Bruising, Excessive/Easy Bleeding, Itching, Hives

Patient Signature:_____ **Date:** _____

If this form was completed by someone other than the patient, please complete:

Name:_____

Relationship to Patient: _____

Sign:_____

Date: _____

Date: _____

Intracept Patient Intake Form

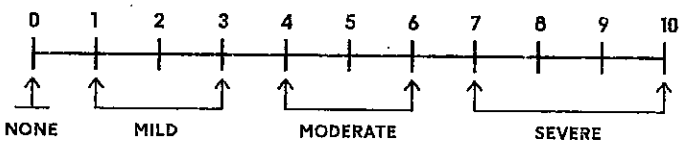
Patient Name: _____ Date of Birth: _____

Occupation: _____

Duration of low back pain: (circle one)

> 6 months > 1 year > 2 year > 3 year > 5 year > 7 year > 10 year

0-10 NUMERIC PAIN RATING SCALE



Average Pain: _____ Back Pain (%) _____

Worst Pain: _____ Leg Pain (%) _____

Best Pain: _____

Please mark an "X" where you are having pain.

Do you have pain when you change positions (i.e. sitting to standing position)? Yes or No

Does your pain negatively affect your activities of daily living (ADLs):

☐ Sleep ☐ Work ☐ Other: _____

☐ Household Chores ☐ Leisure Activities _____

What medications have you taken for your low back pain: _____

_____

Which treatments have you tried to relieve your low back pain:

☐ Physical Therapy ☐ Home Exercise Program ☐ Chiropractic Care

☐ Massage Therapy ☐ Acupuncture ☐ Other:

☐ Injections

Facet Injections # _____

Facet Ablations # _____

Epidural Injections # _____

SI Joint Injections # _____

Pertinent surgical/medical history: _____

_____

Ht: _____ **Wt:** _____

intracept

Modified Oswestry Low Back Pain Disability Questionnaire

Name:_____ Date: _____

Please Read:
This questionnaire has been designed to give your doctor/therapist information as to how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the one box that best describes your condition today.

We realize you may feel that two of the statements in any one section relate to you, but please just mark the box which most closely describes your current condition

Section 1 – Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad but I manage without having to take pain medication.
- ☐ Pain medication provides me complete relief from pain.
- ☐ Pain medication provides me moderate relief from pain.
- ☐ Pain medication provides me little relief from pain.
- ☐ Pain medication has no effect on the pain

Section 2 – Personal Care (Washing, Dressing, etc.)
- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally but it increases my pain.
- ☐ It is painful to take care of myself and I am slow and careful.
- ☐ I need help but I am able to manage most of my personal care.
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting
- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking
- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than ¼ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting
- ☐ I can it in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 mins.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing
- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but increases my pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for more than 10 mins.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping
- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using pain medication.
- ☐ Even when I take pain medication, I sleep less than 6 hours.
- ☐ Even when I take pain medication, I sleep less than 4 hours.
- ☐ Even when I take pain medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all

Section 8 – Social Life
- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (ex sports, dancing, etc.
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

Section 9 – Traveling
- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere but it increases my pain.
- ☐ Pain restricts travel over 2 hours.
- ☐ Pain restricts travel over 1 hour.
- ☐ Pain restricts my travel to short necessary journeys under ½ hour.
- ☐ Pain prevents all travel except for visits to the doctor/therapist or hospital.

Section 10 – Employment/Homemaking
- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex: Lifting, vacuuming).
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job/homemaking chores.

ENID PAIN & SPINE

427 East Cherokee Avenue
Enid, OK 73701
(580)234-PAIN (7246)
Fax (580)233-2223
www.enidpain.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement *

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature Date

☐ I authorize release of medical information to the following individuals

_____ _____

_____ _____

☐ I authorize the doctor/staff to leave medical information on an answering machine.

This Agreement shall be valid for 1 year from signature unless otherwise specified below: _____

We here at Enid Pain and Spine are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. Information will only be released with the written or verbal authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer Charissa Mefferd at 580-234-7246.

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

ENID PAIN AND SPINE
427 East Cherokee Ave
Enid,OK 73703

Chad Owens DO **Teresa Etter NP**
Barbara Owens NP

Please complete the following information and sign and date.

Patient Name:_____ Patient DOB: _____
Patient SSN:_____ Gender: M / F Marital Status: _____
Patient Home Phone Number:_____ Email:_____
Patient Primary Address: _____
Race: (White / Black / Asian / American Indian / Pacific Islander / Other)
Ethnicity: Hispanic / Non-Hispanic Language: _____
Pharmacy and Address:_____ Phone:_____
Emergency Contact:_____ Relationship: _____
Phone Number: _____ ☐ Allowed to make medical decisions

Insurance Information:

Primary Insurance: _____
Ins. Address: _____
ID#_____ Group#_____ Phone#_____
Primary Insurance Subscriber Name: _____
Primary Insurance Subscriber Relationship: _____
Secondary Insurance: _____
Ins. Address: _____
ID#_____ Group#_____ Phone#_____
Was this injury due to a car accident? Y / N
Auto Insurance Carrier:_____ Date of Accident:_____
Adjuster:_____ Phone #:_____ Claim #:_____
Was this an on the job injury? Y / N
Workers' Comp Carrier:_____ D.O.I.: _____
Employer:_____ Claim #:_____
Adjuster and/or Case Manager:_____ Phone #:_____

Responsible Party:

Name:_____ Relationship to Patient:_____
Address:_____ Phone Number: _____
SS#_____ DOB:_____ Employed By:_____

Signed:_____ **Date:** _____

Patient Name: | Date:

Orientation Agreement

Our goal is to return you to the best level of functioning and to allow you to regain control of your life. You, the patient, will actively participate in your treatment regime. The following are a list of policies and commitments that as a patient you need to agree to in order to effectively treat your pain.

1. I understand that it is the patient's responsibility to provide a complete set of medical records including MRIs, notes, labs, etc. to the clinic, this is so I may receive the best possible care. MRIs, CT scans, X-rays, notes, labs, etc. will be destroyed if left at the clinic.
2. I will be prepared at every visit with a full list of my medications, their dosages and how often I take them. If on narcotics, I will bring in my bottles with the unused portion of the medication at each visit.
3. There is a $40.00 charge for any forms you would like filled out by the clinic, this must be paid when forms are given. Please allow ten (10) business days for their completion.
4. We may choose to not treat relatives of patients. Please let us know if you are related to any of our other patients.
5. Due to the nature of pain medicine and the prevalence of illicit drug use in our society, a baseline drug screen may be completed on my first clinic visit and randomly thereafter. If found positive for illegal drugs or unlisted medications, continuation in the clinic may be dependent upon completion of a drug treatment program.
6. I am expected to be honest about any prior history of drug abuse or prescription medication misuse. I understand that my criminal history may be screened for prior drug charges.
7. In order to prevent insurance errors, I will promptly update any changes in demographic or insurance information. This includes any Motor Vehicle Accidents, workman's compensation or 3rd party liability.

To our patients regarding Cancellations, Reschedules, and No-Shows

As a courtesy, our office may call to remind you of your appointment. Showing up as scheduled for these visits is your **MOST** important job. The following are our policies regarding cancellations and no-shows.

- **We require 48 business hours notice in the event of a cancellation.**
- **There is a $50.00 charge for a cancellation or a no-show to an office visit without proper notice.**
  - (This charge may or may not be covered by insurance, but will have to be paid by you personally.)
- **There is a $150 charge for a cancellation or a no-show to a procedure without proper notice.**
  - (This charge may or may not be covered by insurance, but will have to be paid by you personally.)
- **Three missed or cancelled appointments may result in discharge from the practice.**

We, the staff at Enid Pain and Spine, have been and continue to be committed to the highest of ethical standards in the conduct of our healthcare and business operations. We demand of ourselves full compliance with all Federal, State, and local laws. We are committed to preventing, detecting, and disciplining any unethical behavior. We thrive and prosper on our quality healthcare treatment and outstanding reputation for professional conduct. We create systems and controls to keep ourselves dedicated to these standards. We are partners in defining the leading edge of vigilance in protecting the right of all those with whom we deal with. We are looking forward to working with you!

I have read and understand the above information. I will, to the best of my ability, adhere to these policies and commitments.

Patient signature Date

Patient Name: _____ Date: _____

Financial Policy

Thank you for choosing Enid Pain & Spine as your pain care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our information and insurance form before seeing the doctor.

If you do not have insurance, payment in full is due **BEFORE** services are rendered, unless prior arrangements have been made. If you do have insurance, co-pays, deductibles, and co-insurance fees are due before services are rendered, unless prior arrangements have been made.

WE ACCEPT CASH, CHECKS, MONEY ORDERS, DEBIT AND MAJOR CREDIT CARDS. A $28 service charge plus any Bank fees will be charged for any returned checks. This fee must be paid in full. A finance charge of 12% will be applied to any balance that remains unpaid after 60 days.

REGARDING INSURANCE: Our office files your insurance as a courtesy to you. The balance of your account is your responsibility regardless of insurance. We will not bill your insurance company unless you give us your most current and correct insurance information. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account within 45 days of service, the balance will be automatically transferred to patient's responsibility. Please be aware that some, and perhaps all, of the services provided may be a non-covered service(s) and not considered reasonable and necessary under the policy provisions of the managed care, Medicare program and/or Medicare replacement. Regarding insurance plans where we are a participating provider, all co-pay and deductibles are due prior to treatment. In the event that your insurance coverage changes it is your responsibility to notify us of this change. If we are not a contracted provider with your insurance then your financial responsibility will be what the insurance does not pay. Our office files your insurance as a courtesy; however, you must notify us if you would like us to **NOT** bill your insurance. If you choose this route, then billed charges must be paid in full prior to services rendered.

USUAL AND CUSTOMARY RATE: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS: Adult patients are responsible for full payment before services are rendered unless you are a member of a managed care organization or other insurance plans that we participate in. These members are responsible for co-pays, deductibles, and co-insurance before services are rendered. Your provider handbook will provide the name of the physicians contracted with you organization.

MINOR PATIENTS: Minors must be accompanied by an adult parent or guardian. The parents and/or guardian of the minor are responsible for payment of services rendered.

CANCELLED, RESCHEDULED, AND NO SHOW APPOINTMENTS: Unless cancelled at least **48** business hours in advance, our policy is to charge for missed office visits at the rate of **$50.00** per visit and missed procedures at **$150** per procedure. Please help us serve you better by keeping scheduled appointments.

MAILED PRESCRIPTIONS: If requesting a prescription be mailed, a $10.00 charge will be billed to your account.

REQUESTED DOCUMENTS: When requesting printed medical records, a fee of $1.00 for the first page and 50¢ for each additional page must be paid before receiving the requested documents. There is a $40.00 charge for any forms you would like filled out by the clinic. Please allow ten (10) business days for their completion.

Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agreed to this Financial Policy.

X_____ DATE: _____

Signature of Patient or Responsible Party