TANNER
PAIN MANAGEMENT CENTER

Tanner Pain Management Center
204 Allen Memorial Drive, Suite 302-A
Bremen, GA 30110
Phone: 770 812-5720

Dear New Patient:

Your physician has referred you for a consultation to the Tanner Pain Management Center. Please read this letter carefully.

Enclosed is a map to Tanner Pain Management Center. When you enter the building take the elevator to the third floor. We are in Suite 302-A.

You will also find a packet of patient information/history that must be completed in its entirety and brought with you to your consultation. If you need help completing this paperwork, please have someone to help you with it. If it is not completed when you arrive, your appointment will be rescheduled. P<u>lease review all agreements in your packet carefully</u>. Any questions you have will be answered at your appointment.

Please bring photo identification (ex. driver's license), your insurance card(s) and your medications with you to every appointment. Failure to do so will delay your appointment.

Insurance copays, coinsurance, and deductibles are due and payable at each visit. Tanner Pain Management Center is an outpatient department of Tanner Medical Center. Please contact your insurance company prior to your consultation to determine what portion of your visit is your responsibility. Should you need assistance with your medical expenses, please ask about various payment assistance options.

If you are unable to make your appointment, please call at least 24 hours prior to your appointment. Chronic missed appointments will lead to dismissal from the center. **Please note, if you are late for your appointment, you will be asked to reschedule.**

Please be advised if you "Reschedule" your appointment more than twice we will not be able to schedule another appointment. Any "No show" appointments will not be rescheduled. The referring Physician will be notified.

We wish to provide you with the best service and care possible.
THANK YOU FOR YOU COOPERATION.

WELCOME TO TANNER PAIN MANAGEMENT CENTER!

Tanner Medical Group Registration

As a member of Tanner Medical Group, we are committed to providing the best and most comprehensive healthcare possible. We encourage you to ask questions.

PATIENT INFORMATION

Patient's Name: _____ Alias: _____

Date of Birth: _____ Social Security #: _____

Sex: Male Female Race: Caucasian Black Asian Hispanic Other

Patient's Address: _____

City_____State_____Zip_____

Home: _____ Cell: _____ Work: _____

Email: _____ Preferred Communications: Call Text Email

Preferred Language: _____ Interpreter Needed? Yes No

Marital Status: Single Married Divorced Legally Separated Widowed Significant Other

Employer_____ Full PT or NA

Primary Care Doctor: _____ Preferred Pharmacy: _____

Special Needs: _____ Is this Visit Related to an Accident? Yes No

GUARANTOR / RESPONSIBLE PARTY

(If patient is under the age of 18)

Name: _____DOB: _____Phone: _____

Relationship_____ Social Security _____

Employer_____ Full PT or NA

Insurance Subscriber information

Name: _____DOB: _____Phone: _____

Relationship_____ Social Security _____

Employer_____ Full PT or NA

OTHER / EMERGENCY CONTACT INFORMATION

Name: _____ Relationship_____ Phone _____

Name: _____ Relationship_____ Phone _____

Authorized individuals to seek medical attention for Minors

Name: _____ Relationship_____ Phone _____

Name: _____ Relationship_____ Phone _____

Tanner Pain Management Center
204 Allen Memorial Drive, Suite 302-A
Bremen, Ga 30110
770-812-5720
Fax-770-812-5729

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

I, _____, authorize and request

_____ to release to:
(name of physician/practice)

Tanner Pain Management

a complete copy of the medical records of _____

date of birth _____, social security number, _____

from _____ to _____. Reason for disclosure: _____

_____

I am aware that some of the health care information or other information contained in the requested medical records may be confidential or privileged and I hereby specifically waive any privilege or confidentiality existing under federal or state law regarding such information including, but not limited to, protection afforded to:

(1) AIDS confidential information
(2) Medical information concerning alcohol and drug abuse
(3) Medical information
(4) Medical information concerning alcohol and drug dependency
(5) Medical information regarding mental illness
(6) Communications made to a psychiatrist
(7) Communications made to a licensed applied psychologist
(8) Medical information concerning mental retardation

This authorization and consent is subject to revocation at any time, except to the extent that action had already been taken in reliance on it. If not previously revoked, this authorization will terminate in 90 days from the date appearing below.

Date: _____ Signature: _____
(signature of authorized person)

Witness: _____ Title: _____

NOTE TO RECIPIENT
The information that has been disclosed to you is or may be protected by State and Federal law. You are prohibited from making any further disclosure of this information unless further authorization is obtained or disclosure is otherwise permitted by law. A general authorization for release of information may not be sufficient.

THE INFORMATION WAS RELEASED TO: _____
ON _____ BY _____

TANNER PAIN MANAGEMENT
PATIENT HISTORY

NAME_____DATE OF BIRTH_____
PRIMARY CARE PHYSICIAN_____REFERRING PHYSICIAN_____

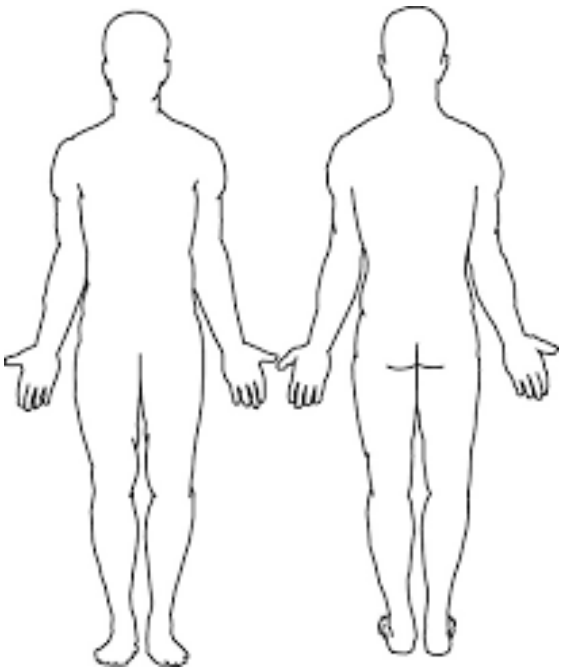
DESCRIPTION OF PAIN (CIRCLE ALL THAT APPLY)

1. I AM HERE FOR EVALUATION OF (NECK, SHOULDER, LOWER BACK, HIP, KNEE, FOOT, OR _____)PAIN.
2. PAIN IS LOCATED IN _____AND SPREADS TO (LEFT, RIGHT, BOTH, ARM, HIP, LEG).
3. WHEN DID THE PAIN BEGIN AND WHAT CAUSED IT?_____.
4. DESCRIPTION OF PAIN IS(ACHE, PINS/NEEDLES, STABBING, BURNING, VIBRATION, NUMBNESS, PRESSURE, COLD, HOT, OTHER_____.
5. WHAT IS YOUR PAIN SCALE NOW?_____

0	1	2	3	4	5	6	7	8	9	10
NONE	**MILD**				**MODERATE**				**SEVERE**	

6. WHAT IS YOUR PAIN SCALE ON YOUR BEST DAY?_____
7. WHAT IS YOUR PAIN SCALE ON YOUR WORST DAY?_____
8. INDICATE ON THE DIAGRAM WHERE YOUR WORST PAIN IS LOCATED.

RIGHT LEFT RIGHT



9. MY PAIN (MILDLY, MODERATELY, SEVERLY, VERY SEVERLY) INTERFERES WITH MY ACTIVITIES OF DAILY LIVING.
10. IS YOUR PAIN ASSOCIATED WITH WEAKNESS?_____WHERE_____
11. IS YOUR PAIN ASSOCIATED WITH NUMBNESS?_____WHERE_____
12. IS YOUR PAIN ASSOCIATED WITH TINGLING?_____WHERE_____
13. DO YOU HAVE ANY SKIN COLOR OR TEMPERATURE CHANGE?_____WHERE?_____
14. I AM HYPERSENSITIVE TO (TOUCH, CLOTHES, COLD, WEATHER CHANGES).
15. DO YOU HAVE INCONTINENCE, CONSTIPATION OR LOSS OF CONTROL OF BLADDER OR BOWELS?_____
16. HOW MANY HOURS OF UNINTERRUPTED SLEEP DO YOU HAVE AT NIGHT?_____DO YOU FEEL RESTED IN THE MORNING?_____DO YOU HAVE NIGHT PAIN?_____

PREVIOUS TREATMENTS/CONDITIONS

17. CIRCLE THE PREVIOUS TREATMENTS/MEDICATIONS YOU HAVE TRIED; INDICATE DATE IF YOU KNOW.
    DOCTOR:NAME_____
    PAIN SPECIALIST:NAME_____
    PHYSICAL THERAPY:_____DID IT HELP?_____
    ACCUPUNCTURE:_____DID IT HELP?_____
    EPIDURAL INJECTION/NERVE BLOCK:_____DID IT HELP?_____
    NERVE STIMULATOR:_____DID IT HELP?_____
    CHIROPRACTOR: _____DID IT HELP_____
    PREVIOUS NECK/BACK/HIP/KNEE SURGERY:TYPE OF SURGERY/DATE_____
    MEDICATION:ALEVE, ANTI-INFLAMMATORY, ASPIRIN, CELEBREX, CYMBALTA, DILAUDID, HYDROCODONE, IBUPROFEN, LYRICA, METHADONE, MOBIC, MORPHINE, MOTRIN, MUSCLE RELAXERS, NAPROSYN, NAPROXEN, NEUROTIN, OXYCODONE, OXYCONTIN, TYLENOL, VOLTAREN
18. WHAT TESTS HAVE YOU HAD? INDICATE DATE AND RESULTS IF YOU KNOW THEM:
    X-RAY_____
    MRI_____
    CAT SCAN_____
    MYELOGRAM_____
    EMG/NCS_____
19. DO YOU HAVE ANY OF THE FOLLOWING:
    AGE GREATER THAN 50
    HISTORY OF COLON CANCER:DATE_____
    NEUROLOGICAL DISORDERS(SEIZURES, MULTIPLE SCLEROSIS, MYOPATHIES, NEUROPATHIES)
    UNINTENTIONAL WEIGHT LOSS
    DIABETES
20. PLEASE LIST ANY MEDICAL CONDITIONS YOU HAVE AND THE TREATMENT YOU HAVE RECEIVED:_____
    _____
    _____
    _____
    _____
21. PLEASE LIST ANY SURGERIES YOU HAVE HAD AND THE YEAR PERFORMED:_____
    _____
    _____
    _____
    _____
22. DO YOU USE ALCOHOL, TOBACCO, ILLEGAL DRUGS, MARIJUANA? IF YES, PLEASE LIST PRODUCTS AND HOW OFTEN THEY ARE USED:_____
    _____
    _____
23. DO YOU HAVE DEPRESSION OR A HISTORY OF DEPRESSION?_____ARE YOU PRESENTLY BEING TREATED FOR DEPRESSION?_____
24. IN THE PAST YEAR HAVE YOU EXPERIENCED ANY PYSICAL, EMOTIONAL, VERBAL, OR SEXUAL ABUSE?_____
25. MARITAL STATUS:_____DO YOU LIVE ALONE?_____
26. DO YOU HAVE CHILDREN LIVING AT HOME?_____WHAT ARE THEIR AGES?_____
27. ARE YOU PRESENTLY INVOLVED IN A LAWSUIT? IF YES, EXPLAIN_____
28. ARE YOU PRESENTLY ON DISABILITY?_____ ARE YOU SEEKING DISABILITY?_____
29. PLEASE LIST ANY MEDICATION ALLERGIES:_____

30. LIST **ALL** THE MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING PRESCRIPTION DRUGS, HERBS, SUPPLEMENTS AND OVER THE COUNTER. PHARMACY:_____
PHARMACY TELEPHONE:_____

MEDICATION	DOSAGE	DIRECTIONS

PATIENT SIGNATURE_____DATE_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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Driving Directions

From Carrollton:
Take US-27 North approximately 8 miles. Turn RIGHT onto Business U.S. 27 (Alabama Avenue). Go 2 miles. Turn left onto Allen Memorial Drive. Hospital will be on your RIGHT.

From Tallapoosa:
Take Hwy. S-78 East to US-27 South. Turn RIGHT onto US-27 South. Turn LEFT onto Business US-27 (Alabama Avenue). Go 2 miles. Turn left onto Allen Memorial Drive. Hospital will be on your RIGHT.

From Buchanan:
Take US-27 South approximately 5.8 miles. Turn LEFT onto Business US-27 (Alabama Avenue). Go 2 miles. Turn left onto Allen Memorial Drive. Hospital will be on your RIGHT.

From Atlanta:
Take I-20 West to US-27 Exit 11. Turn RIGHT onto US-27 North. Turn RIGHT onto Business US-27 (Alabama Avenue). Go 2 miles. Turn left onto Allen Memorial Drive. Hospital will be on your RIGHT.

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