Imperial Pain Specialists

Thank you for your interest in becoming a patient with Imperial Pain Specialists. We have enclosed your application as requested. Please fill out every page and **return in person or through the mail.**

Our process is very thorough. However, this process helps to ensure everything is obtained to provide the best possible care for our patients.

Our new patient application process is outlined as follows:

1. You must turn in your completed application and pay the **$25.00** application fee.
2. We must have: the last 3 notes from your primary care and/or referring physician, the last 3 notes from the most recent pain clinic you were established at (if applicable), and written reports from imaging (MRI/CT) on your area of pain. For example, if you have low back pain, we need an MRI or CT of your lumbar spine within the last 5 years.
3. We can obtain the above mentioned records on your behalf. You can also submit these records to us with your application to help expedite the application process.
4. Once all records are received, your application will go for review.
5. If approved by the Nurse Practitioner and Medical Director, you will be called with an appointment date and time.

Fees:

1. New Patient Visit: **$275**
2. Follow-Up Visit: **$225**

Imperial Pain Specialists does not take any form of insurance. We do not accept cash or money orders. Please be prepared to pay with a credit/debit card or a cashier's check from your bank.

Please be aware of the following:

1. We use an outside lab for drug testing. This lab will take your insurance for your drug screens. You are given a urine drug test at every visit.
2. It is required that you keep an active phone number. You will be called in a minimum of 2 times a year for random medication counts. If you do not present to these appointments, you will be discharged.
3. You must have a primary care physician.
4. Per our medical director's policy, **you may not be prescribed any benzodiazepine medication and be established at our facility.** The FDA Guildelines suggest that concomitant use of benzodiazepines and opioids may result in profound sedation, respiratory depression, coma, and death. Exceptions may be considered. However, it will limit your dosage and the amount of opioid pain medications that you are prescribed.
5. Excessive phone calls hinder our ability to process your application in a timely manner. If you have a question regarding the status of your application, please call and leave a message. We will return your call within 24 hours.

Thank You,
IPS Staff

Imperial Pain Specialists
411 Princeton Rd Ste 101
Johnson City, TN 37601
P: 423-461-0021 F: 423-461-0023

Authorization to Release Medical Information

Patient Name:_________________________________ Dob:__________ Last 4 SS#________

I hereby authorize____ and it's physicians, employees, and agents to release or disclose to the below- named recipient, all of my medical records including especially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted diseases, or HIV/AIDS infection.

Fax Number of Recipient:_________________________________

Please send records to:

Imperial Pain Specialists

411 Princeton Rd Ste 101

Johnson City, TN 37601

Phone: 423-461-0021 **Fax: 423-461-0023**

Purpose of Disclosure: ☐ establish ☐ continue pain management Expires on:__________

This request applies to:

_________Medical Records:_________________________________

_________Radiology:_________________________________

_________Discharge Letter:_________________________________

_________Labs (specify):_________________________________

_________Other:_________________________________

If you do not want certain portions of your medical records released, please initial.

_______Substance Abuse ________Psychological or Psychiatric Treatment ______HIV/AIDS

I understand I have the right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

Signature of Patient:_________________________________

Relationship to Patient:____________________

IMPERIAL PAIN SPECIALISTS

PLEASE COMPLETE THIS APPLICATION IN ITS ENTIRETY AND TO THE BEST OF YOUR ABILITY. DO NOT LEAVE ANY INFORMATION BLANK.

CIRCLE: MALE FEMALE

DATE:________________

LEGAL NAME:____
DATE OF BIRTH:__________________ SSN:____________________

ADDRESS:____
CITY:______________________________ ZIP CODE: ____________

YOU MUST PROVIDE 2 PHONE NUMBERS WHERE YOU CAN BE REACHED.
1. ______________________HOME/CELL MAY WE LEAVE A MESSAGE? Y/N

2. ______________________HOME/CELL MAY WE LEAVE A MESSAGE? Y/N

EMERGENCY CONTACT:________________________ PHONE:____________
WHAT IS THEIR RELATIONSHIP TO YOU?______________________________
MAY WE DISCUSS YOUR PERSONAL HEALTH INFORMATION WITH THIS PERSON? Y/N

WHAT IS YOUR MARITAL STATUS? ______________________________

WHAT TYPE OF WORK DO YOU DO? ______________________________

WHAT PHARMACY DO YOU USE? ______________________________
PHONE NUMBER: ______________________________
ADDRESS:______________________________

PRIMARY CARE PROVIDER: ______________________________
PHONE NUMBER: ______________________________
ADDRESS:______________________________

PREVIOUS PAIN CLINIC: ______________________________
PREVIOUS PAIN CLINIC: ______________________________
PREVIOUS PAIN CLINIC: ______________________________

SPECIALISTS: ______________________________
PHONE NUMBER: ______________________________
ADDRESS:______________________________

WHERE CAN WE REQUEST YOUR IMAGING RESULTS FROM? (XRAYS, MRIs, CTs)
LOCATION:______________________________
LOCATION:______________________________

IMPERIAL PAIN SPECIALSITS

PATIENT NAME:________________________ DATE OF BIRTH:________

WHERE IS THE LOCATION OF YOUR PAIN? ________________________

WHEN DID YOUR PAIN BEGIN?________________________

WHAT CAUSED YOUR PAIN?________________________

WHAT MAKES YOUR PAIN WORSE? ________________________

WHAT MAKES YOUR PAIN BETTER?________________________

HOW DO YOU SLEEP? GOOD FAIR POOR
HOW MANY HOURS? ________ HOW OFTEN DO YOU WAKE UP?____________

DO YOU USE A TENS UNIT? Y / N
DO YOU USE A BACK BRACE? Y / N

CIRCLE ANY THERAPIES YOU HAVE DONE IN THE PAST.

BED REST PHYSICAL THERAPY TENS UNIT BACK BRACE TRACTION

EXERCISE HEAT ICE ACUPUNCTURE CHIROPRACTOR PSYCHOTHERAPY

WERE ANY OF THESE HELPFUL IN RELIEVING YOUR PAIN?________________

HOW WELL CAN YOU DO THE FOLLOWING? CIRCLE WHAT APPLIES.

STAND UPRIGHT	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY
WALK NORMALLY	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY
SIT COMFORTABLY	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY
BEND OVER	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY
CONCENTRATING	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY
BATHING/GROOMING	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY
SHOPPING	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY
HOUSEKEEPING/CHORES	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY
DRIVING/CAR RIDES	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY
LIFTING CUP TO MOUTH	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY
OPENING A JAR	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY

IMPERIAL PAIN SPECIALISTS

PATIENT NAME:_______________________________DATE OF BIRTH:__________

HAVE ANY OF THE FOLLOWING BEEN IMPACTED DUE TO CHRONIC PAIN? CIRCLE.

SLEEP MOOD RELATIONSHIPS WEIGHT DAILY ACTIVITIES WORK

HAVE YOU HAD ANY SURGERIES?

SURGERY PERFORMED	DATE	HOSPITAL
1.		
2.		
3.		
4.		

HAVE YOU HAD ANY OF THE FOLLWING INJECTIONS? WHEN? WAS IT HELPFUL?

PROCEDURE	DATE	HELPFUL?
JOINT		
TRIGGER POINT		
NERVE BLOCK		
SPINAL CORD		

HAVE YOU EVER HAD AN INTERNAL NARCOTIC PUMP? ____________________

PLEASE CIRCLE ANY MEDICAL CONDITIONS THAT YOU HAVE OR HAD IN THE PAST.

ASTHMA SLEEP APNEA CPAP USE COPD OXYGEN USE DIABETES

NEUROPATHY HIGH BLOOD PRESSURE HIGH CHOLESTEROL SHINGLES

OSTEOPOROSIS OSTEOARTHRITIS HIV/AIDS STROKE HEART DISEASE DIALYSIS

ANXIETY DEPRESSION BIPOLAR DISORDER PTSD ADD/ADHD SCHIZOPHRENIA

DVT/BLOOD CLOTS HEP A HEP B HEP C CANCER:____________________

OTHER:____

SUICIDE ATTEMPTS:______

ARE YOU TREATED BY MENTAL HEALTH?________ **WHERE?**____________________

IMPERIAL PAIN SPECIALISTS

PATIENT NAME:______________________________ DATE OF BIRTH:________

DO ANY OF THE FOLLOWING APPLY TO YOUR FAMILY MEDICAL HISTORY? CIRCLE.

STROKE SEIZURES ULCER MIGRAINE DIVERTICULITIS DIABETES ARTHRITIS

LIVER DISEASE HEARTH DISEASE GOUT HIGH BLOOD PRESSURE

OSTEOPOROSIS KIDNEY DISEASE CANCER ASTHMA HEART FAILURE

DO YOU HAVE ANY ALLERGIES? LIST THEM BELOW

1. ______________________ REACTION:______________
2. ______________________ REACTION:______________
3. ______________________ REACTION:______________

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

__________ __________ __________ __________

__________ __________ __________ __________

DO YOU HAVE ANY METAL IN YOUR BODY? Y / N
IF YES, WHERE? ______________________________

DO YOU SMOKE? Y / N
DO YOU DRINK ALCOHOL? Y / N
HAVE YOU EVER BEEN HOSPITALISED FOR ALCOHOL ABUSE? Y / N
DO YOU CURRENTLY HAVE A PROBLEM WITH ALCOHOL ABUSE? Y / N
HAVE YOU EVER USED ANY ILLICIT/ILLEGAL DRUGS? Y / N
IF YES, WHAT HAVE YOU USED? ______________________________

HAVE YOU EVER HAD A DRUG OVERDOSE, INTENTIONAL OR NOT? Y / N
HAVE YOU EVERY BEEN, OR ARE YOU CURRENTLY, IN A DRUG TREATMENT PROGRAM? Y / N
HAVE YOU EVER TAKEN SUBOXONE/BUPRENORPHINE FOR DRUG ADDICTION? Y/N
DO YOU DEPEND ON CONTROLLED (OPIOID TYPE) MEDICATIONS TO MANAGE YOUR PAIN CONDITION? Y / N
ARE YOU EXPERIENCING PHYSICAL ABUSE? Y/ N
ARE YOU EXPERIENCING EMOTIONAL ABUSE? Y / N
ARE YOU TAKING ANY BENZODIAZEPINE MEDICATIONS? Y / N
IF YES, WHAT ARE YOU TAKING/PRESCRIBED? ______________________________

WHAT PAIN MEDICATIONS HAVE YOU TAKEN IN THE PAST TO CONTROL YOUR PAIN?

__________ __________ __________ __________ __________

IMPERIAL PAIN SPECIALISTS

PATIENT NAME: ______________________ DATE OF BIRTH: __________

General

Fatigue Fever Weight Loss Weight Gain

Gastrointestinal

Blood in Stool Heart Burn Nausea Changes in Bowel Movements
Loss of Appetite Vomiting

Endocrine

Excessive Urination Heat Tolerance Excessive Thirst Cold Intolerance
Gland or Hormone Problems

Skin

Itching Skin Color or Changes Rash

Hematologic

Anemia Bruising Tendencies Slow Healing Past Blood Transfusions
Bleeding Tendencies

HEENT

Headache Double Vision Earache /Drainage Mouth Sores
Swollen neck or glands

Bleeding Gums Blurred Vision Pain in Eyes Hearing Loss
Sinus Problems

Psychiatric

Depression Nervousness Suicidal Thoughts Poor Sleep

Cardiovascular

Chest Pain Swelling of Feet Irregular Heart Beat Swelling of the Hand

Respiratory

Chronic Cough Shortness of Breath Coughing up Blood

Musculoskeletal

Muscle Pain Neck Pain Joint Pain Difficulty Walking Morning Stiffness Muscle Cramps

Back Pain Joint Stiffness Joint Swelling

Neurological

Frequent Headaches Numbness Tremors Trouble with Memory Tingling

IMPERIAL PAIN SPECIALISTS
BECK'S DEPRESSION INVENTORY

Circle the answer that best describes your situation. If it does not apply, circle "0".

A. 0. I do not feel sad
   1. I feel sad
   2. I am sad all the time and can't snap out of it
   3. I am so sad and unhappy that I can't stand myself

B. 0. I am not particularly discouraged about the future
   1. I feel discouraged about the future
   2. I feel I have nothing to look forward to
   3. I feel the future is hopeless and nothing will improve

C. 0. I do not feel like a failure
   1. I feel like I have failed more than the average person
   2. As I look back on my life, I see a lot of failures
   3. I feel I am a complete failure as a person

D. 0. I get as much satisfaction out of things as I used to
   1. I don't enjoy things the way I used to
   2. I don't get real satisfaction out of anything anymore
   3. I am dissatisfied or bored with everyone

E. 0. I don't feel particularly guilty
   1. I feel guilty a good part of the time
   2. I feel quite guilty most of the time
   3. I feel guilty all of the time

F. 0. I don't feel I am being punished
   1. I feel I may be punished
   2. I expect to be punished
   3. I feel I am being punished

G. 0. I don't feel disappointed in myself
   1. I am disappointed in myself
   2. I am disgusted with myself
   3. I hate myself

H. 0. I don't feel I am any worse off than others
   1. I am critical of myself for my weaknesses/mistakes
   2. I blame myself all the time for my faults
   3. I blame myself for everything bad that happens

I. 0. I don't have any thoughts of killing myself
   1. I have thoughts of killing myself, but I wouldn't do it
   2. I would like to kill myself
   3. I would kill myself if I had the chance

J. 0. I don't cry any more than usual
   1. I cry more than I used to
   2. I cry all the time now
   3. I used to be able to cry, now I can't even if I want to

K. 0. I am no more irritated by things than I ever was
   1. I am slightly more irritated now than usual
   2. I am quite annoyed or irritated most of the time
   3. I feel irritated all the time

L. 0. I have not lost interest in other people
   1. I am less interested in people than I used to be
   2. I have lost most of my interest in other people
   3. I have lost all of my interest in other people

M. 0. I make decisions as well as ever
   1. I put off making decisions more than I used to
   2. I have greater difficulty making decisions more now
   3. I can't make decisions at all anymore

N. 0. I don't' feel that I look any worse than I used to
   1. I am worried I am looking old or unattractive
   2. I feel changes in my appearance make me unattractive
   3. I believe that I am ugly

O. 0. I can work about as well as before
   1. It take extra effort to get started at doing something
   2. I have to push myself very hard to do something
   3. I can't do any work at all

P. 0. I can sleep as well as usual
   1. I sleep somewhat more OR somewhat less than usual
   2. I sleep a lot more OR a lot less than usual
   3. I sleep most of the day OR wake up 1-2 hours early and cannot go back to sleep.

Q. 0. I don't get more tired than usual.
   1. I get tired more easily than I used o
   2. I get tired from doing almost anything
   3. I am too tired to do anything

R. 0. I have not experienced any change in my appetite
   1. My appetite is somewhat less OR greater than normal
   2. My appetite is much less OR much greater than before
   3. I have no appetite at all OR crave food all the time

Patient Name ______________________ Date of Birth ______________

Patient Signature ______________________ Date ______________

OFFICE USE ONLY BELOW THIS LINE. DO NOT COMPLETE.

SCORE:__________ Provider Signature ______________________ Date ______________

IMPERIAL PAIN SPECIALISTS
COMM RISK TOOL

Answer the following questions by circling the answer that best describes your situation ***IN THE LAST 30 DAYS***.

SCALE:
0=NEVER 1=SELDOM 2=SOMETIMES 3=OFTEN 4=VERY OFTEN

Question					
1. How often have you had trouble with thinking clearly or memory problems?	0	1	2	3	4
2. How often do others complain you are not completing necessary tasks?	0	1	2	3	4
3. How often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications.	0	1	2	3	4
4. How often have you taken your medications differently from how they are prescribed?	0	1	2	3	4
5. How often have you seriously though about hurting yourself?	0	1	2	3	4
6. How much of your time was spent thinking about opioid medications?	0	1	2	3	4
7. How often have you been in an argument?	0	1	2	3	4
8. How often have you had trouble controlling your anger?	0	1	2	3	4
9. How often have you needed to take pain medication belonging to someone else?	0	1	2	3	4
10. How often have you been worried about how you're handling your medication?	0	1	2	3	4
11. How often have others been worried about how you're handling your medication?	0	1	2	3	4
12. How often have you had to make an emergency phone call to your clinic or shown up without an appointment?	0	1	2	3	4
13. How often have you gotten angry with others?	0	1	2	3	4
14. How often have you had to take more of your medications than prescribed?	0	1	2	3	4
15. How often have you borrowed pain medications from someone else?	0	1	2	3	4
16. How often have you used your pain medication for symptoms other than pain (to help you sleep, improve your mood, etc.)?	0	1	2	3	4

____________________________ ______________
Patient Name Date of Birth

____________________________ ______________
Patient Signature Date

OFFICE USE ONLY BELOW THIS LINE. DO NOT COMPLETE.

SCORE:__________ ____________________________ ______________
Provider Signature Date

IMPERIAL PAIN SPECIALISTS

OPIOID RISK TOOL (ORT)

Mark the box if it applies to your situation.

Mark the FEMALE column only if you are female.

Mark the MALE column only if you are male.

		FEMALE	MALE
1. Family history of substance abuse	Alcohol Illegal Drugs Prescription Drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
2. Personal history of substance abuse	Alcohol Illegal Drugs Prescription Drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
3. Age	Mark box if you are 16-45 years old	[ ]	[ ]
4. Personal history of pre-adolescent sexual abuse		[ ]	[ ]
5. Do you have any of these psychological disorders/diseases?	ADHD, OCD, Bipolar disorder,or Schizophrenia? Depression?	[ ] [ ]	[ ] [ ]

Patient Name ______________________ Date of Birth ____________

Patient Signature ______________________ Date ____________

OFFICE USE ONLY BELOW THIS LINE. DO NOT COMPLETE.

SCORE: ____________

Provider Signature ______________________ Date ____________

LOW RISK 0-3

MODERATE RISK 4-7

HIGH RISK >7