CONSERVATIVE CARE SPECIALISTS MEDICAL GROUP, INC.

PATIENT INFORMATION

Name (Last, First, Middle, Suffix)			Employer ☐ Retired ☐ Self Employed
Address			Employer Address
City	State	Zip Code	City / State / Zip Code
Cell Phone ( )	Home Phone ( )		Work Phone ( )
E-Mail Address			Work E-Mail Address
Drivers License Number	Issuing State		Occupation
Social Security Number	Birth Place		Name of Person to be Notified in case of Emergency
Sex / Birth Date / Age	Marital Status		Relationship to Patient: Contact ☐Cell ☐ Home ☐ Work

PRIMARY INSURANCE INFORMATION / SECONDARY INSURANCE INFORMATION

Primary		Secondary	
Name of Insurance Company ☐ Medicare ☐ Medicare HMO		Name of Insurance Company ☐ Medicare ☐ Medicare HMO	
Subscriber Name: Relation to Patient ☐Self ☐ Spouse ☐ Dependant ☐ Other		Subscriber Name Relation to Patient ☐Self ☐ Spouse ☐ Dependant ☐ Other	
Subscriber Social Security Number	Subscriber Birth Date	Subscriber Social Security Number	Subscriber Birth Date
Policy Number		Policy Number	
Group Number		Group Number	
Contact Number–Subscriber/Member ( )	Contact Number-Provider ( )	Contact Number–Subscriber/Member ( )	Contact Number-Provider ( )

REFERRAL INFORMATION

Referral Name ☐ Physician ☐ Patient ☐ Other		Primary Treating Physician	
Phone ( )	Fax ( )	Phone ( )	Fax ( )
Date of Onset/Injury	Reason For Consult		

ATTORNEY INFORMATION / WORK COMP INSURANCE INFORMATION

Attorney			Work Comp		
Name of Attorney			Name of Adjuster		
Name of Firm			Name of Insurance Company		
Address			Address		
City	State	Zip Code	City	State	Zip Code
Phone ( )	Fax ( )	Direct Phone ( )	Phone ( )	Fax ( )	Direct Phone ( )
WCAB #			Claim #		

I, the undersigned, certify that I (or my dependant) have Insurance coverage with the insurance company(ies) listed above and assign directly to Conservative Care Specialists Medical Group Inc., hereinafter referred to as CCSMG, insurance benefits, If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by said insurance company(ies). I hereby authorize CCSMG and its physicians and employees to release all information necessary to secure payments of benefits. I authorize the use of my signature on all insurance submissions. Please note: All 30 days past due accounts are subject to charges of 1.50% per month.

Signature ______________________________ **Date** ____________________

CONSERVATIVE CARE SPECIALISTS MEDICAL GROUP, INC.

FINANCIAL POLICY

We hope that you understand that our credit and collection policies are a necessary part of assuring the financial resources required to maintain healthcare service for our patients and community.

Charges for medical services are due and payable at the time services are rendered. This includes co-payments and verified deductibles. In the event other arrangements are made with the billing representatives, a statement will be sent to you with the payment due upon the receipt of the payment.

Unpaid balances over 60 days old will accrue interest charges of one (1) percent per month.

If you have health insurance, it should be understood that this is an agreement between you and your insurance company to pay certain amounts for medical care. Your doctor's bill is an agreement between you and your doctor. You are responsible for the payment of your bill regardless of the status of your insurance claim. This also applies to Personal Injury Claims.

If unusual circumstances should make it impossible for you to meet our credit terms, we invite you to call or personally discuss the matter with our billing office. This will avoid misunderstandings and enable you to keep your account in good standing. All costs incurred with enforced collection will result in additional legal or court costs to you and may impair your credit rating.

Charges for medical care rendered by this office will be billed through this office and should not be confused with charges for care received in the hospital or other facility.

Should you have any questions, please feel free to contact our billing office, Pinnacle Lien at 951-256-8350.

I have read and understand this Financial Policy

____

Patient Signature **Date**

CONSERVATIVE CARE SPECIALISTS MEDICAL GROUP, INC.

Allergy/History/Medications Form

Name: ________________________________ **Date:** ________________

Allergies:
Please list any food, environmental or medication allergies:

____

____

History:
Have you ever had any of the following:

1. Epidural steroid injection? ☐ Yes ☐ No
2. A surgical operation requiring an anesthetic? ☐ Yes ☐ No
3. Any anesthetic complication or problem? ☐ Yes ☐ No
4. A cold within the last two weeks? ☐ Yes ☐ No
5. Rheumatic Fever? ☐ Yes ☐ No
6. Frequent Headaches? ☐ Yes ☐ No
7. Back pain? ☐ Yes ☐ No
8. Scoliosis? ☐ Yes ☐ No
9. Seizure disorder, epilepsy? ☐ Yes ☐ No
10. Muscle Weakness in arms or legs? ☐ Yes ☐ No
11. Are you pregnant? ☐ Yes ☐ No
12. Do you smoke? ☐ Yes ☐ No
13. Do you faint easily? ☐ Yes ☐ No

Medications
Are you presently taking:

1. Aspirin or medication containing aspirin? ☐ Yes ☐ No
2. Cortisone or other steroids? ☐ Yes ☐ No
3. Insulin or other medication for diabetes? ☐ Yes ☐ No
4. High blood pressure medication? ☐ Yes ☐ No

____
Patient Signature

CONSERVATIVE CARE SPECIALISTS MEDICAL GROUP, INC.

SOAPP® VERSION 1.0 -14Q

Name: ________________________________ **Date:** ________________

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

Question					
1. How often do you have mood swings?	☐**0**	☐**1**	☐**2**	☐**3**	☐**4**
2. How often do you smoke a cigarette within an hour after you wake up?	☐**0**	☐**1**	☐**2**	☐**3**	☐**4**
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	☐**0**	☐**1**	☐**2**	☐**3**	☐**4**
4. How often have any of your close friends had a problem with alcohol or drugs?	☐**0**	☐**1**	☐**2**	☐**3**	☐**4**
5. How often have others suggested that you have a drug or alcohol problem?	☐**0**	☐**1**	☐**2**	☐**3**	☐**4**
6. How often have you attended an AA or NA meeting?	☐**0**	☐**1**	☐**2**	☐**3**	☐**4**
7. How often have you taken a medication other than the way that it was prescribed?	☐**0**	☐**1**	☐**2**	☐**3**	☐**4**
8. How often have you been treated for an alcohol or drug problem?	☐**0**	☐**1**	☐**2**	☐**3**	☐**4**
9. How often have your medications been lost or stolen?	☐**0**	☐**1**	☐**2**	☐**3**	☐**4**
10. How often have others expressed concern over your use of medication?	☐**0**	☐**1**	☐**2**	☐**3**	☐**4**
11. How often have you felt a craving for medication?	☐**0**	☐**1**	☐**2**	☐**3**	☐**4**
12. How often have you been asked to give a urine screen for substance abuse?	☐**0**	☐**1**	☐**2**	☐**3**	☐**4**
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.,) in the past five years?	☐**0**	☐**1**	☐**2**	☐**3**	☐**4**
14. How often in your lifetime, have you had legal problems or been arrested?	☐**0**	☐**1**	☐**2**	☐**3**	☐**4**

Please include any additional information you wish about the above answers. Thank you.

©2008 Inflexxion, Inc. Permission granted solely for use in published format by individual practitioners in clinical practice. No other uses or alterations are authorized or permitted by copyright holder. Permissions questions: PainEDU@inflexxion.com. The SOAPP® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

CONSERVATIVE CARE SPECIALISTS MEDICAL GROUP, INC.

PATIENT PAIN HISTORY

Name: _________________________________ Date of Birth: ________________

Occupation __________________________________ ☐ N/A. Reason___________________________________

____

PAIN HISTORY

Where is your pain located? If in more than one place, please list in order of severity, the worst pain first.

____

____

____

How long have you had this problem?

____

How did the pain start (accident, etc)?

____

____

____

VISUAL ANALOG PAIN SCALE (VASPI)

On a scale from 0-10, please rate the intensity of your pain. Ten represents the pain at its worst; zero represents the absence of pain. Please draw a line on the scale that represents your level of pain.

When pain is at its worst: ________ out of 10
When you have the least pain: ________ out of 10
At the present time: ________ out of 10

What words would you use to describe your pain?
☐ Dull ☐ Aching ☐ Throbbing ☐ Burning ☐ Radiating ☐ Sharp/Stabbing ☐ Pulsating
☐ Other: ____

When does your pain occur?
☐ Always there ☐ Intermittent – # times per day:__________ # times per week:_________________

Intensity of pain: ☐ Steady ☐ Increases and decreases

My pain is better ☐ Upon arising ☐ mid-day ☐ end of day ☐ late at night
My pain is worse: ☐ Upon arising ☐ mid-day ☐ end of day ☐ late at night

How well do you sleep? ☐ Well ☐ Poorly ☐ Only with pills

What seems to make your pain worse?
☐ Movement ☐ Daily Activity ☐ Sitting ☐ Walking ☐ Standing ☐ Bending ☐ Lying Down
☐ Sustained Position ☐ Sexual Activity ☐ Other:-____

What seems to make the pain better?
☐ Rest ☐ Movement ☐ Exercise ☐ Inactivity ☐ Lying Down ☐ Medication Only
☐ Certain Positions: ____

PAIN HISTORY CONTINUED

What medications are you taking currently? What effect do they have?

MEDICATION	HOW HELPFUL	WHAT SIDE EFFECTS
______________	______________________________	__________________________________
______________	______________________________	__________________________________
______________	______________________________	__________________________________
______________	______________________________	__________________________________
______________	______________________________	__________________________________
______________	______________________________	__________________________________
______________	______________________________	__________________________________
______________	______________________________	__________________________________

What other medications, vitamins and/or supplements are you taking?

____

____

____

What other pain treatments have you received?

☐ Physical Therapy ☐ Chiropractic ☐ Chronic Pain Management Programs
☐ Epidural/Blocks ☐ Biofeedback ☐ Acupuncture ☐ Trigger Point Injections
☐ TENS Unit ☐ Surgery ☐ Other: ____

List all Surgeries ☐ N/A

____

____

____

MEDICAL HISTORY

Height: ____________ Weight: ____________

Have you had any of the following?

Cancer	☐ Yes	☐ No
Type/Location of Cancer: ____		
Arthritis	☐ Yes	☐ No
Other bone/joint:	☐ Yes	☐ No
Other vascular problems:	☐ Yes	☐ No
HIV+	☐ Yes	☐ No
AIDS:	☐ Yes	☐ No
Heart Problems:	☐ Yes	☐ No
Heart Attack:	☐ Yes	☐ No
Heart Failure:	☐ Yes	☐ No
Lung Problems:	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Liver Problems	☐ Yes	☐ No

PAIN HISTORY CONTINUED

Condition	Yes	No
Hepatitis	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Stomach Problems	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Gastrointestinal Problems	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Bladder	☐ Yes	☐ No
Infection	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No
Stones	☐ Yes	☐ No
Infection	☐ Yes	☐ No
Bleeding Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No

FAMILY HISTORY

Please list any history or disease

____

____

SOCIAL HISTORY

Marital Status; ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Living arrangements ☐ Live alone ☐ With Spouse ☐ With Family ☐ With roommate

Exercise: ☐ No exercise ☐ Minimal Exercise ☐ Moderate Exercise

Pain has had a significant impact on my: ☐ Social life ☐ Sex life ☐ General lifestyle

____

EMPLOYMENT IMPACT

☐ N/A

What type of work do you do?

____

____

____

How many hours per week do you work? ______________________

How much time from work, if any, have you missed in the past month due to pain?

____

____

____

____

LITIGATION

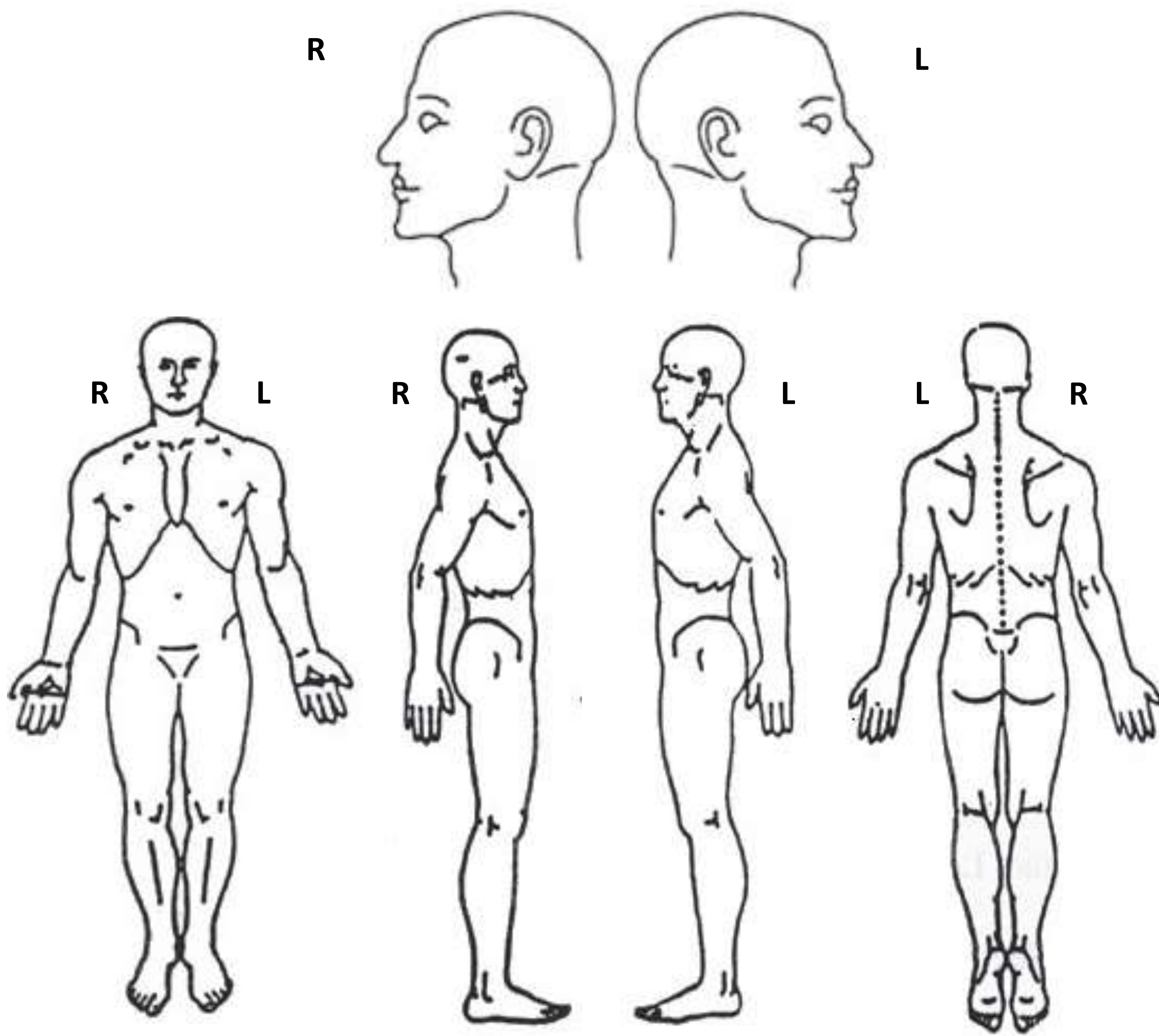
If your pain is due to an accident, is litigation (legal suit) or an insurance settlement pending? If yes, please describe the current status of litigation or settlement.

____

____

Do you plan to pursue a legal or insurance settlement in the future? If yes, please describe.

Please indicate the areas of your pain on the diagrams below:



Name: ____________________

CONSERVATIVE CARE SPECIALISTS MEDICAL GROUP, INC.

CONTROLLED SUBSTANCE REFILL PROGRAM PATIENT AGREE FORM

Treatment Agreement for Chronic Opioids

We want to ensure the patients and caregivers have clear communication and safe, effective procedures when patients use opioids.

EFFECTIVENESS: For more patients and pain conditions, opioids are effective pain-relieving medications. However, it is possible opioids will not work well for you and your pain.

SAFETY: Most people can take these drugs safely, but some people do experience side effects. (See below.)

SIDE EFFECTS: Most patients do not have serious side effects or drug interactions. Unfortunately, some do experience side effects and must stop the medication(s). Common side effects include constipation, itching, nausea, vomiting, sedation or lightheadedness. Uncommon reactions include swelling in the legs, water on the lungs, trouble breathing (especially if you have emphysema/COPD or are on other narcotics), mental slowing and loss of coordination, lowering of sex drive, decreased testosterone (male sex hormone) and addiction. Note: Pregnant women using opioids could make their newborn child dependent upon opioids. If you are pregnant, you need to alert your health care provider.

DEPENDENCE: Dependence is not the same as addiction. Many people who take opioids daily will become dependent on them. Dependence is when your body adapts to the medication and then experiences withdrawal if the medication is stopped or lowered too quickly. Withdrawal symptoms include moodiness, aches and pains, sweating, diarrhea, abdominal pain and seizures.

ADDICTION: Addiction is not the same as dependence. While many people become dependent on daily opioids, only a small percentage of these people will become addicted. Addiction is characterized by behaviors such as loss of control of drug use, compulsive use and craving, and continued use despite harm or risk to the person. When people are addicted, they are not taking opioids simply to treat the pain.

GOALS: The goals of chronic pain management are to:

1. Improve your ability to function in your daily life,
2. Lower you pain.

TREATMENT OPTIONS:

1. Medications,
2. Counseling, relaxation training, hypnosis and meditation,
3. Chiropractic care, massage, acupuncture and physical therapy,
4. Surgery and injections.

WHAT YOU NEED TO DO:

1. Realize that opioid therapy is only one part of treatment.
2. Remain active every day and try to increase activity a little bit at a time.
3. Use your medications ONLY as directed by your provider.
4. Work with your provider and follow treatment recommendations in addition to taking prescribed medications.

Conservative Care physicians and staff have explained the risks and benefits of chronic opioid therapy for my pain. I, ______________________, understand that I must comply with the following rules or I will not be given opioids. I will fill the prescription at one and only one pharmacy. I understand that my health care provider may retrieve a CURES report to verify that prescriptions are being used as written and that I am not receiving narcotics from other providers.

CONTROLLED SUBSTANCE REFILL PROGRAM PATIENT AGREE FORM

Additionally, you also agree to abide to the following:

I will not increase the dose or stop the medication unless asked to do so by my provider or my provider's partner.

I will report any worrisome side effect soon after it begins.

I will follow through on appointments that may help me with chronic pain and functioning. These may include physical and occupational therapy, counseling and other mental health practices, neurosurgery, neurology and orthopedics. Consistent failure to keep these appointments and therapies may result in the stopping of the opioid medications.

If prescribed, I will use the medications other than opioids to control pain.

I will accept opioids for chronic pain from my provider only.

I will not share, exchange or sell my opioids, as the law prohibits those actions. I understand that my provider will report serious concerns of drug misuse to any and all authorities for investigation.

I will not use illegal/street drugs (this includes marijuana). I will not use narcotic medications unless provided to me from my provider.

I agree to provide samples for random drug testing when asked. If I fail to provide the sample when asked or if the results are unsatisfactory, I may forfeit the right to continue receiving the medication.

If my provider is concerned that I might have a substance abuse problem, I must agree to an evaluation by a specialist in abuse/addiction. If the evaluation suggests I have a drug abuse problem, my provider may stop my medication in a way that does not cause withdrawal symptoms.
I will not get early refills unless something has dramatically changed and then only if my provider agrees.

I recognize that opioids by themselves, in combination with alcohol or in a combination with other medications can result in unclear thinking and loss of coordination. I agree to contact my provider if these symptoms arise. I should not drive or operate equipment if I have these side effects.

It is my responsibility to keep my medications safe. If opioids are lost, damages or stolen, the medication may or may not be refilled early. Each case will be looked at individually. If the medication is stolen, I must file a police report and submit the number for verification to my provider's office. Again, stolen medications may or may not be refilled. If a refill is given, it will be given only once.

If a new condition develops that causes acute pain, I have the right to expect appropriate treatment for that new condition from the provider treating me for the new condition. I should not be required to increase the use of my chronic pain medication for a serious and new pain.

I understand that if my provider does not feel I am following through adequately with the treatment plan, my provider may lower or stop the opioid altogether.

I understand that my provider may decide to stop the opioid if after increasing it adequately, my pain and function have not responded positively.

CONSERVATIVE CARE SPECIALISTS MEDICAL GROUP, INC.

CONTROLLED SUBSTANCE REFILL PROGRAM PATIENT AGREE FORM

By signing this form, I authorize my provider's office to contact any and all groups and organizations involved with my care and involved with the investigation of medication and drug abuse. I give permission to my provider to discuss my care with past caregivers, all pharmacies and policing agencies. This also gives these caregivers and pharmacies permission to share with my provider information about my past treatments and care.

Patient Signature ____

Date

Doctors' Signature ____

Date

CONSERVATIVE CARE SPECIALISTS MEDICAL GROUP, INC.

MEDI-CAL WAIVER

I am aware that Conservative Care Specialists Medical Group, Inc. is *not* a Medi-Cal participating facility and therefore will not submit claims for payment to them. I further understand that I will be solely responsible for any amounts not covered by my primary carrier.

I understand and acknowledge the above and choose to receive treatment in light of the same.

____
Signature of patient

____
Signature of witness

____
Date

cc: **PINNACLE LIEN**

CONSERVATIVE CARE SPECIALISTS MEDICAL GROUP, INC.

Patient Name ______________________ **Patient DOB** ______________________

Provider ______________________ **Date** ______________________

	Patient Responses (PRESENT TENSE)	Rarely or none of the time (less than 1 day)	Some or a little of the time (1 – 2 days)	Occasionally or a moderate amount of the time (3 – 4 days)	Most or all of the time (5 – 7 days)
1.	I was bothered by things that usually don't bother me.				
2.	I did not feel like eating; my appetite was poor.				
3.	I felt that I could not shake off the blues, even with the help from family or friends.				
4.	I felt that I was just as good as other people.				
5.	I had trouble keeping my mind on what I was doing.				
6.	I felt depressed.				
7.	I felt that everything I did was an effort.				
8.	I felt hopeful about the future.				
9.	I thought my life had been a failure.				
10.	I felt fearful.				
11.	My sleep was restless.				
12.	I was happy.				
13.	I talked less than usual.				
14.	I felt lonely.				
15.	People were unfriendly.				
16.	I enjoyed life.				
17.	I had crying spells.				
18.	I felt sad.				
19.	I felt that people dislike me.				
20.	I could not get going.				