MOUNTAINSTAR
Lakeview Hospital
Pain Management Center

Pain Clinic Patient Information Sheet

PATIENT INFORMATION:

REFERRING PHYSICIAN ______________________ PRIMARY CARE PHYSICIAN ______________________

LAST NAME ______________________ FIRST NAME ______________________ M.I. ______

ADDRESS ______________________ CITY, STATE, ZIP ______________________

PHONE (_____) ______________________ CELL (_____) ______________________

SOCIAL SECURITY # ______________________ DATE OF BIRTH ______________________

Employer ______________________

Address ______________________ Phone (_____) ______________________

MARITAL STATUS: ☐ M ☐ S ☐ D ☐ W SPOUSE'S NAME ______________________

REASON FOR VISIT ______________________

INJURY ______________________ DATE OF SYMPTOMS ONSET ______________________

EMERGENCY CONTACT INFORMATION:

NAME ______________________ RELATIONSHIP TO PATIENT ______________________

PHONE (_____) ______________________ CELL (_____) ______________________

ADDRESS ______________________ CITY, STATE, ZIP ______________________

INSURANCE INFORMATION:

PRIMARY INSURANCE ______________________ POLICY # ______________________

GROUP # ______________________ EFFECTIVE DATE ______________________ COPAY ______________________

INSURED NAME ______________________ Insurance Phone (_____) ______________________

If spouse – get DOB and SSN

Spouse's Social Security # ______________________ Date of Birth ______________________

SECONDARY INSURANCE ______________________ POLICY # ______________________

GROUP # ______________________ EFFECTIVE DATE ______________________ COPAY ______________________

INSURED NAME ______________________ Insurance Phone (_____) ______________________

If spouse – get DOB and SSN

Spouse's Social Security # ______________________ Date of Birth ______________________

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NAME____ **DATE**________________

Please indicate the location of your pain area(s) on the diagram below:

Front **Back**

RIGHT LEFT LEFT RIGHT

PMGS

PC507 7.09.2010 Loop – Pain Clinic

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PAIN MANAGEMENT CENTER PATIENT HISTORY

Name: ______________________________

Please fill in completely (0) all circles (**yes and no**) as pertaining to your current symptoms.

Constitutional
weight gain O Yes O No
fatigue O Yes O No
fever O Yes O No
loss of appetite O Yes O No

Ophthalmology
drainage from eyes O Yes O No
glasses/contacts O Yes O No
excess tearing O Yes O No
eye pain O Yes O No
vision changes O Yes O No

ENT
ear pain O Yes O No
ear discharge O Yes O No
hearing loss O Yes O No
ringing in ears O Yes O No
ear infection O Yes O No
post-nasal drip O Yes O No
sore throat O Yes O No
bleeding gums O Yes O No

Cardiology
chest pain (angina) O Yes O No
palpitations O Yes O No
heart murmurs O Yes O No
shortness of breath O Yes O No

Respiratory
cough O Yes O No
wheezing O Yes O No
shortness of breath O Yes O No

Gastroenterology
heartburn O Yes O No
peptic ulcers O Yes O No
nausea O Yes O No
vomiting O Yes O No
diarrhea O Yes O No
constipation O Yes O No
laxative use O Yes O No
jaundice O Yes O No
loss of bowel control O Yes O No

Urology
frequent urination O Yes O No
urinary tract infection O Yes O No
painful urination O Yes O No
urinary retention O Yes O No
urinary dribbling O Yes O No
loss of urinary control O Yes O No

Musculoskeletal
joint pain O Yes O No
joint swelling O Yes O No
joint stiffness O Yes O No
muscle cramps O Yes O No
muscle swelling O Yes O No

Neurology
tingling/numbness O Yes O No
fainting O Yes O No
headache O Yes O No
weakness O Yes O No
dizziness O Yes O No

Dermatology
rash O Yes O No
skin itching O Yes O No
skin infection O Yes O No

Endocrinology
hot flashes O Yes O No
hair loss O Yes O No
always hot O Yes O No
always cold O Yes O No
excessive thirst O Yes O No

Hematology/Lymph
easy bruising O Yes O No
easy bleeding O Yes O No
swollen lymph nodes O Yes O No
anemia O Yes O No

Allergy/ Immune system
AIDS O Yes O No
allergies O Yes O No
frequent infections O Yes O No
steroid use O Yes O No
hives O Yes O No

Psychology
anxiety O Yes O No
depression O Yes O No
mood swings O Yes O No
nightmares O Yes O No

Male reproductive
difficulty with erection O Yes O No

Female reproductive
pregnant O Yes O No

Where is your pain located?

O neck O shoulder O upper arm O forearm O finger O low back
O headaches O thigh O shin O toes O ankle O groin
O chest O entire arm O axilla O elbow O hand O abdomen
O ribs O buttock O calf O foot O heel O knee
O mid-back O facial

How long have you had your pain?

O 0-6 months O 6-12 months O 1-5 years O 5-10 years O longer than 10 years

In the last 2-3 weeks when does your pain occur?

O intermittent (on/off) O less than 8 hrs/day O 8-16 hrs/day O constant

On a scale of 0 to 10, with 10 being the worst pain, mark where the severity of your pain is.

O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

Associated numbness O Yes O No
Associated Tingling O Yes O No

What was the setting when the problem first occurred?

O alcohol consumption
O birth-related conditions
O school or campus
O prolonged keyboard activity
O running/jogging
O standing
O walking
O underwater diving
O reaching
O bending over
O dancing
O lying down
O sneezing
O animal bite or sting
O emotional stress
O school-related travel
O repetitive grasping
O sports (without obvious trauma)
O straining
O twisting
O stroke (CVA)
O workplace
O driving
O having sex
O none identified
O infectious disease
O home
O toxic substance exposure
O repetitive lifting
O squatting
O throwing
O weight training
O surgery
O medication
O coughing
O head movement
O sitting

Please describe your pain (quality): O aching O boring or drilling O cold O crushing
O gnawing O hot O nagging O penetrating O pins and needles O pressure
O raw O shock-like O shooting O sore O stinging O throbbing
O tightness O burning O stabbing O mild O heaviness O dull
O moderate O sharp O cramping O severe O other
O quality cannot be determined

Please indicate those activities that INCREASE your pain: (check all that apply)
O work O walking O bending O lying flat O standing O sitting O stress
O alcohol consumption O foods or beverages O locale (i.e. home/work/etc.)
O lying on affected side O medications O menstrual cycle
O physical activities O recreational drug use O sleep-related factors
O toxic substance exposure O travel O underwater diving
O weight gain O other

Please indicate those activities that DECREASE your pain: (check all that apply)
O walking O standing O rest O applying heat O applying cold O injections
O sitting down O physical therapy O relaxation exercises O lying flat O bending
O medications O emergency room treatment O elevating the affected area
O position change O non weight bearing O supporting the extremity O avoiding stress
O massage O moving the area continuously O sleeping O nothing O other

Associated signs/symptoms: O bleeding O bone misalignment O cramping O dizziness
O drainage O drop objects O fatigue O fever O joint problems
O language difficulty O mental status change O muscle tightness O muscle weakness
O nausea O numbness O pain O paralysis O poor sleep O swelling O none

Does your pain affect: O your quality of life O sleep

How many ER visits have you had in the last 3 months for pain?
O 1 O 2 O 3 O 4 O 5 O more than five O none

Do you take any of the following anticoagulants? (check all that apply)
O coumadin O heparin O plavix O fragmin O lovenox O enoxaparin O normiflo
O ardeparin O orgaran O danaparoid

Imaging studies in the last 5 years: O CT scan O EMG (electromyogram) O IVP
O MRI scan O Myelogram O X-rays O Other tests O None

Have you tried any of these therapies: O acupressure O acupuncture
O biofeedback O chiropractors O elevation O exercise O heat O ice
O intradiscal therapy O massage O nerve stimulation O occupational therapy O relaxation
O surgery O none

Have you tried any of these pain clinic treatments: O injection therapy O medications
O physical therapy O other pain centers O psychotherapy O relaxation O surgery
O none

Have you tried the following NSAIDS to help relieve your pain: O iburprofen O aleve
O advil O naproxen O celebrex O toradol O indocin

Are you on Workers Comp? O Yes O No

Mark the appropriate information related to Worker's Compensation:
O Work related travel O trauma and/or injury O unable to work at all since the injury
O able to work with restrictions since the injury O temporary limitations after the injury
O no restrictions now O no work restriction since the injury

Litigation Pending: O Yes O No

If you are involved in any lawsuits, who is the lawsuit against? (Check all that apply)
O Worker's Compensation O Auto Accident O Disability Claim O Other

Have you been to any of the following types of doctors?
O Back Surgeon O Neurologist O Rheumatologist O Other pain doctor

Past Medical History

HTN	O Yes O No	Cancer or Tumor	O Yes O No
Diabetes	O Yes O No	Anemia/Blood disorder	O Yes O No
Arthritis	O Yes O No	Neurological disorders	O Yes O No
Asthma	O Yes O No	Bladder/Kidney disease	O Yes O No
Heart disease	O Yes O No	Liver/gallbladder problems	O Yes O No
Lung disease	O Yes O No	Rheumatic fever	O Yes O No
Stroke	O Yes O No	Thyroid/endocrine problem	O Yes O No
Pancreatitis	O Yes O No	Tension headache	O Yes O No
Bleeding disorder	O Yes O No	Peptic ulcer disease	O Yes O No
Colitis	O Yes O No	Autoimmune disorder	O Yes O No
Anxiety disorder	O Yes O No	Migraine headache	O Yes O No
Seizures	O Yes O No		

Family History
Is your father still alive? O Yes O No
Is your mother still alive? O Yes O No
Do you have children or other dependents at home? O Yes O No

Social History
What is your marital status? O Married O Single O Divorced O Widowed
Are you currently employed? O Yes O No
Are you on disability? O Yes O No
What type of disability do you have?
O Short term O Long term O Social Security O Other

Do you use alcohol to control your pain? O Yes O No

Mark if you use any of the following drugs recreationally:
O Amphetamines O Barbituates O Cocaine O Codeine O Diazepam O Heroin
O Hydrocodone O Marijuana O Oxycodone O Soma

Dependency or addiction to drugs now or in the past? (Check all that apply)
O Amphetamines O Barbituates O Cocaine O Codeine O Diazepam O Heroin
O Hydrocodone O Marijuana O Morphine O Oxycodone O Soma

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ARBITRATION AGREEMENT

ARTICLE 1 Dispute Resolution

By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

ARTICLE 2 Definitions

A. The term "we," "parties" or "us" means you, (the Patient), and the Provider.

B. The term "Claim" means one or more Malpractice Actions defined in the Utah Health Care malpractice Act (Utah Code 78-14-3 (15)). Each party may use any legal process to resolve non-medical malpractice claims.

C. The term "Provider" means the physician, group or clinic and their employees, partners, associates, agents, successors and estates.

D. The term "Patient" or "you" means:

1) you and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents or legal representatives, AND

2) your unborn child or newborn child for care provided during the 12 months immediately following the date you sign this Agreement, or any person who makes a Claim for care given to that unborn or newborn child.

ARTICLE 3 Dispute Resolution Options

A. Methods Available for Dispute Resolution. We agree to resolve any Claim by:

1) working directly with each other to try and find a solution that resolves the Claim, OR

2) using non-binding mediation (each of us will bear on-half of the costs), OR

3) using binding arbitration as described in this Agreement.

You may choose to use any or all of these methods to resolve your Claim.

B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.

C. Arbitration – Final Resolution. If working with the Provider or using non-binding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

ARTICLE 4 How to Arbitrate a Claim

A. Notice. To make a Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the Provider by certified mail, it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.

B. Arbitrators. Within 30 days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.

1) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.

2) Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly-Selected Arbitrator"). If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will chose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Utah court selects an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Select Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah Uniform Arbitration Act.

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C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoint. Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.

D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Utah Uniform Arbitration Act.

E. All Claims May be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Joined Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement.

ARTICLE 5 Liability and Damages May Be Arbitrated Separately

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

ARTICLE 6 Venue / Governing Law

The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this Agreement. We hereby waive the pre-litigation panel review requirements. The arbitrators will apportion fault to all person or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

ARTICLE 7 Term / Rescission / Termination

A. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.

B. Rescission. You may rescind this Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing, except in the case of a Joint Party that provided care prior to the signing of this agreement (see Article 4 (E)).

C. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any Claim that arises while it is in effect, even if you file a claim or request arbitration after the Agreement has been terminated.

ARTICLE 8 Severability

If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

ARTICLE 9 Acknowledgement of Written Explanation of Arbitration

I have received a written explanation of the terms of this Agreement. I have had the right to ask questions and have my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs. I understand that this Agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care. I understand that I can rescind this Agreement within 10 days of signing it.

ARTICLE 10 Receipt of Copy I have received a copy of this document.

Name of Physician, Group or Clinic (printed name) Dr. Vikas Garg

Signature of Physician or Authorized Agent ______________________ Date __________

Name of Patient (printed name) ______________________

Signature of Patient or Patient's Representative ______________________ Date __________

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