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 it in person or through the mail.

Our process is very thorough. However, this process helps to ensure that 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 your application in and pay the $50.00 application fee. (Non-refundable) Call office to pay
2. We must have the last 3 office visits from your primary care provider and/or referring physician, the last 2 notes from your most recent pain clinic, if applicable, and written reports from radiology (MRI/CT) on your areas of pain. These images must be within the last 2 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- 325.00**
2. **Follow up Visit- 275.00**
3. **Application Fee- 50.00 (Non-Refundable)** will need to call office to pay

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

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 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 per year for random urine screenings and medication counts. If you are not present to these appointments, you will be discharged. No exceptions.
3. You must keep a primary care physician and see them at minimum 1 time each year.
4. **Per our policy, you may not be prescribed any benzodiazepine medication and be established at this facility. The FDA guidelines 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 medication that you are prescribed.**
5. Excessive phone calls hinder our ability to process your application in a timely manner. If you have questions regarding your application, please allow up to **2 weeks for processing time.**

Imperial Pain Specialists
411 Princeton Rd Ste 101
Johnson City, TN 37601

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 SPECIALSITS

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

DATE:_____ **CIRCLE: MALE FEMALE**

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:_____

SPECIALSITS: _____
PHONE NUMBER: _____
ADDRESS:_____

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
Musculosketal 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