ADVANCED INTERVENTIONAL PAIN & DIAGNOSTICS OF WESTERN ARKANSAS, LLC
(AIPD)
PO Box 10206, Fort Smith, AR 72917-0206 (7303 Rogers Ave, Ste 100)
Phone: 479-452-0882 Fax: 479-314-5698
John R. Swicegood, MD, FIPP Joseph E. Miller, MD, FACS Jared S. Ennis, MD

Date: _____/_____/_____

Last Name: _____, First Name: _____ MI: _____

Birth Date: _____/_____/_____ SS#: _____-_____-_____

Address: _____, City: _____ State: _____ Zip _____

Home Phone: _____ Cell Phone: _____ Other: _____

Employer (Issuer of Insurance Card): _____

Spouse: _____ Spouse Birth Date: _____/_____/_____

Spouse SS#: _____-____-_____ Spouse Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Is this a Workers' Comp Claim Injury? Yes No Date of Injury: _____/____/_____

Employer Name: _____

Workers' Comp Nurse or Rep: _____

Is this visit as a result of a Motor Vehicle Crash? Yes No Date: _____/____/_____

I hereby authorize AIPD to release any information pertaining to my medical services to my insurance company or governmental agency (VA, TriCare, Medicare, Medicaid, etc.) and their intermediaries/carriers as provided within federal and state law, so that payment of insurance benefits can be made directly to AIPD and its providers for rendered services.
I understand all services provided at AIPD are charged to me pending payment by my insurance, and that I am responsible for these fees regardless of insurance coverage.
I understand it is required by law that I notify this clinic of all parties who may be responsible for paying for my treatment.

Co-pays (or payment for non-covered services) are due prior to being seen and evaluated.

INSURANCE AUTHORIZATION AND ASSIGNMENT
I request that payment of authorized Insurance Benefits or Medicare Benefits be made on my behalf to AIPD for services rendered. Regulations pertaining to Medicare assignment of benefits apply.

SIGN: X _____ Date: _____
SIGNATURE OF INSURED OR AUTHORIZED PERSON

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PATIENT QUESTIONNAIRE

Date ____/____/_____ Sex M / F

Last Name _____ First _____ MI _____ DOB: ____/____/_____

Referred by: _____ Primary care Physician: _____

Spine surgeon (if applicable): _____

. Where is your pain: _____ Which side? Left / Right / Both

. What is associated with the pain? Numbness Cramping Weakness Limping Tightness Headaches Inability to walk

. What caused the pain? Accident (motorized vehicle) / Work / Fall / Repetitive Motion / Arthritis Other: _____

. When did the pain start? _____ How long has it been at its present level? _____

. What makes the pain better? Heat/Ice Rest Standing Sitting Lying down Walking Bending Traction Arthritis Meds Pain Meds Muscle Relaxers Stretching Exercise Physical Therapy TENS Injections Nothing

. What makes it worse? Heat/Ice Rest Standing Sitting Lying down Lifting Walking Bending Traction Arthritis Meds Pain Meds Muscle Relaxers Stretching Turning Head Exercise Physical Therapy TENS Nothing

. What is the character of your pain? Aching Agonizing Burning Dull Gnawing Nagging Numbness Pressure Please circle up to 3) Sharp Shocking Shooting Stabbing Tearing Tingling

. How severe is the pain? Mild Mild to Moderate Moderate Moderate-to-Severe Severe (cannot perform any daily activities) Unbearable (cannot get out of bed)

. When is the pain present? Daytime Nighttime Intermittent Some pain always present Constant Day and Night

0. Any incontinence since pain began? Yes / No

1. Prior therapy for this pain? Arthritis meds Pain meds Physical therapy Chiropractor Acupuncture TENS unit

2. Describe your average daily activity level before the pain began:

Housework &/or light duty Walking for exercise Exercise at a health club Heavy manual labor

Repetitive motion activity

3. What kind of work do you do? _____

14. How much work have you missed due to the pain/illness? _____

15. How is your sleep pattern?: Normal Poor Severely Disrupted

16. Are you: Right-handed or Left-handed

Do you have any of these Medical Illnesses: (Circle all you have)

Alzheimer's Asthma Anemia Blood Clots (DVTs) Breast Cancer Colon Cancer Depression Diabetes Heart Attack Heart Blockages Hepatitis High Cholesterol Hypothyroidism Hypertension Lung Cancer Lupus Lymphoma Osteoarthritis Parkinson's Rheumatoid Arthritis Seizures Stroke

Other: _____

Surgery in past? Spine surgery of: neck low back Heart bypass Gallbladder Hernia Colon Hysterectomy Hip replacement Knee replacement Appendectomy Other: _____

Allergies to Medications: _____ Reaction: _____

_____ Reaction: _____

Which Pharmacy do you use/location? _____

Are you on blood thinners (e.g.: Coumadin/Warfarin, Plavix, Ticlid)?: Yes No

Do you have a pacemaker? Yes No

Are you married? Yes / No Do you smoke or use smokeless tobacco? Yes / No
How much per day?_____ How many years? ____

Do you drink alcohol? Yes / No How much per day on average?_____

Family History: Hypertension Heart attacks Stroke Diabetes Spine surgery Blood Clots Alcoholism Drug abuse Parkinson's

DO YOU HAVE TROUBLE FREQUENTLY WITH YOUR:

1. Eyes: _____ 2. Ears: _____ 3. Throat: _____

4. Thyroid gland, pancreas: _____ 5. Lungs: _____

6. Chest pain or arrhythmias: _____ 7. Joints: _____

8. Stomach/intestines: _____ 9. Arms/shoulders: _____

10. Legs/hips/knees/feet: _____ 11. Skin: _____

12. Depression or Anxiety: _____

emales: Is there a chance you could be pregnant? Yes No

emales: In this clinic we use X-ray equipment for our procedures. You must notify us before each and every eatment if there is a chance you could be pregnant.)

ow tall are you? _____ft _____in Weight? _____lbs.

attest that the information I provided in this document is accurate and complete.

igned: _____ Date: _____/_____/_____