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I authorize the release of any and all medical information, including history, treatment, diagnosis, prognosis, any information related to psychiatric care, drug and alcohol treatment and abuse and HIV/AIDS confidential information.

I, _____, request release of confidential medical information from:

Doctor: _____

Hospital: _____

Address: _____ City, State, Zip Code: _____

Phone: _____ Fax: _____

Date(s) of Service Requested: ___/___/___ to ___/___/___

I request records to be sent to:

Specialists in Pain Management
2339 McCallie Avenue, Ste. 309
Chattanooga, TN 37404

Print Patient Name

Patient DOB

Patient SS #

Signature of Patient/Guardian

Date

Specialists in Pain Management
PAIN EVALUATION QUESTIONNAIRE

We require a copy of all imaging reports and records from physicians who have treated you in the past for your persistent pain. You must sign a Medical Records Release of information so that we can request these records.

Patient Name: _____ Date of Interview: _____ by: _____

DOB: _____ SS # _____

Phone: _____ Additional Phone _____

Mailing Address: _____

Insurance Company Name _____

Policy Number _____ Group Number _____

Phone Number on back of Insurance Card _____

If Dependent: Spouses Name, Date of Birth and Social security Number _____

Patients Primary Care Doctor (Full Name) _____

1. Where do you hurt? _____

2. Under what circumstances did your pain start?

Accident at work Accident at home other accident Work, no accident

Following Surgery Following Illness Pain just began

Other reason (explain) _____

3. Is your pain work related? YES NO (If no, go to question #4.)

If so, where are/were you employed? _____

What is your case manager/adjusters name? _____

Case manager/adjusters phone number? _____

Do you have a claim number? _____

What is the insurance carrier name? _____

What date was you injured? _____

What area of the body was injured? _____

4. Who has treated you for your pain in the past five years?

	Name	Date	Treatment given
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

5. Have you had an MRI, X-ray, CT Scan, or Nerve Conduction Study, etc in the past 5 years?

YES NO

Where and when did you have these studies performed?

Parkridge Memorial COC Erlanger Diagnostic Imaging Chattanooga Imaging

Other: _____

6. Do you have an implantable device, such as a pain pump, or spinal cord stimulator? _____