Oswestry Disability Index 2.1a

Patient Label (Office Use Only)

First Name

Last Name

Date of Birth (mm/dd/yyyy)

Today's Date (mm/dd/yyyy)

Office Use Only

Could you please complete this questionnaire? It is designed to give us information as to how your back (or leg) trouble affects your ability to manage in everyday life. Please answer ***every section.*** Fill in the ***one bubble only*** in each section that most closely describes you ***today.***

Section 1 - Pain intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2 - Personal care (washing, dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it is very painful.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, wash with difficulty and stay in bed.

Section 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

Section 4 - Walking

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than one mile.
- Pain prevents me walking more than a quarter of a mile.
- Pain prevents me walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- I can sit in any chair as long as I like.
- I can sit in my favourite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting for more than half an hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6 - Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than half an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 - Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain I have less than 6 hours of sleep.
- Because of pain I have less than 4 hours of sleep.
- Because of pain I have less than 2 hours of sleep.
- Pain prevents me from sleeping at all.

Section 8 - Sex life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

Section 9 - Social life

- My social life is normal and causes me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport,etc.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

Section 10 - Travelling

- I can travel anywhere without pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys over two hours.
- Pain restricts me to journeys of less than one hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from travelling except to receive treatment.

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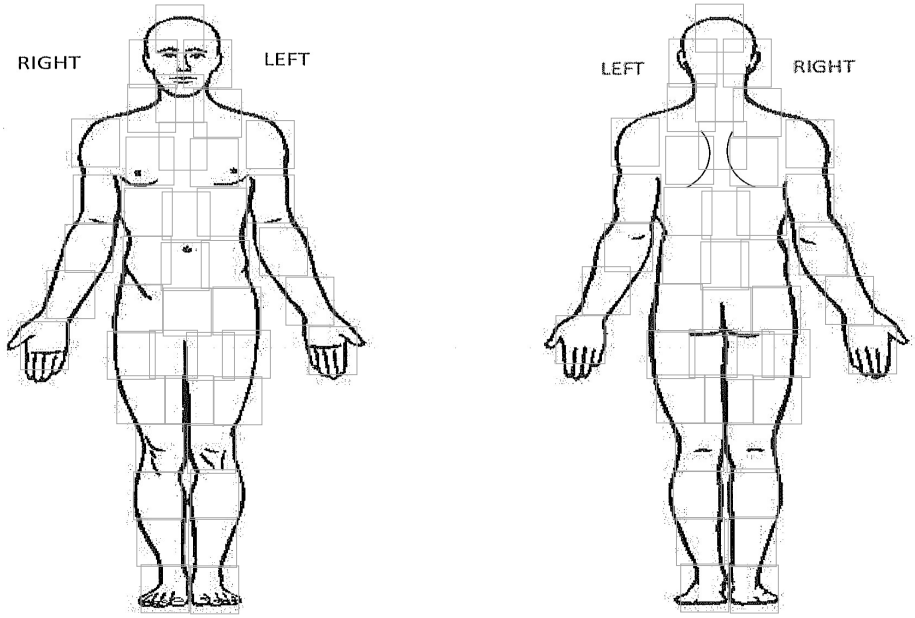
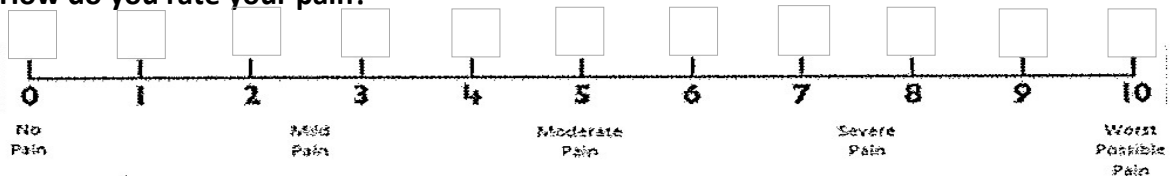
References:
Fairbank JC, Pynsent PB. "The Oswestry Disability Index" Spine 2000; 25(22): 2940-2952
Fairbank JC, Couper J, Davies JB. "The Oswestry Low Back Pain Questionnaire" Physiotherapy 1980: 66: 271-273

Patient Name:_____ Date: _____ DOB: _____

Please check the parts of the body where you have pain



How do you rate your pain?



Please (CHECK) your answers:

Describe your pain:
- Aching
- Burning
- Deep, Diffuse
- Discomforting
- Dull
- Electrical
- Localized
- Piercing, Sharp
- Shooting
- Stabbing
- Superficial
- Throbbing

Timing of your pain:
- Continuous and Constant
- Continuous, but variable intensities
- Intermittent
- Progressive
- Variable
- Daily

Do you have these symptoms:
- Numbness
- Tingling
- Weakness
- Pain with coughing or having a BM
- Loss of bowel or bladder control

Aggravated by:
- Any activity
- Stairs
- Daily activities
- Driving
- Exercise
- 1st steps in the morning
- Leaning back
- Leaning forward
- Physical activity
- Sitting
- Standing
- Walking

Relieved by:
- Brace
- Heat
- Ice
- Injections
- Leaning back
- Leaning forward
- Lying Down
- Medications
- Procedures
- Sitting
- Standing
- Walking

Have you had physical therapy? _____ How long did you participate?_____ Did it help?_____
Activities of Daily Living : Not affected or Unable to perform (Specify: _____)
Difficulty sleeping? Yes or No (If yes, is it because of pain? Yes or No)
Procedure _____ and _____% relief
Are you on blood thinners? Yes or No **(if yes, list: _____)**
Are you currently working? Yes or No **Is your blood pressure controlled?** Yes or No

REVIEW OF SYSTEMS

Patient Name: _____ **Date:** _____ **DOB:** _____

Are you CURRENTLY experiencing any of the following symptoms

Constitutional:

o No	o Yes	Fever
o No	o Yes	Weight Gain
o No	o Yes	Weight Loss
o No	o Yes	Other:_____

Head, Eyes, Ears, Nose & Throat:

o No	o Yes	Ear Drainage
o No	o Yes	Nasal Drainage
o No	o Yes	Sinus Pressure
o No	o Yes	Sore Throat
o No	o Yes	Other:_____

Respiratory:

o No	o Yes	Chronic Cough
o No	o Yes	Cough
o No	o Yes	Known TB Exposure
o No	o Yes	Shortness of Breath
o No	o Yes	Wheezing
o No	o Yes	Other:_____

Cardiovascular:

o No	o Yes	Chest Pain
o No	o Yes	Swelling
o No	o Yes	Palpitations
o No	o Yes	Other:_____

Gastrointestinal:

o No	o Yes	Constipation
o No	o Yes	Diarrhea
o No	o Yes	Nausea
o No	o Yes	Vomiting
o No	o Yes	Other:_____

Genitourinary:

o No	o Yes	Painful Urination
o No	o Yes	Blood in Urine
o No	o Yes	Urinary Retention
o No	o Yes	Other:_____

Reproductive:

o No	o Yes	Erectile Dysfunction
o No	o Yes	Other:_____

Integumentary:

o No	o Yes	Brittle Hair
o No	o Yes	Brittle Nails
o No	o Yes	Hair Loss
o No	o Yes	Itching
o No	o Yes	Rash
o No	o Yes	Other:_____

Neurological:

o No	o Yes	Dizziness
o No	o Yes	Extremity Numbness
o No	o Yes	Extremity Weakness
o No	o Yes	Trouble Walking
o No	o Yes	Headache
o No	o Yes	Memory Loss
o No	o Yes	Seizures
o No	o Yes	Tremors
o No	o Yes	Other:_____

Psychiatric:

o No	o Yes	Anxiety
o No	o Yes	Depression
o No	o Yes	Insomnia
o No	o Yes	Other:_____

Musculoskeletal:

o No	o Yes	Back Pain
o No	o Yes	Joint Pain
o No	o Yes	Joint Swelling
o No	o Yes	Muscle Weakness
o No	o Yes	Neck Pain
o No	o Yes	Other:_____

Hematologic/Lymphatic:

o No	o Yes	Easy Bleeding
o No	o Yes	Easy Bruising
o No	o Yes	Other:_____

Southern Pain AND Neurological

Paul J. Hubbell, III, MD
Donald E. Richardson, MD

Melanie Mire, PA-C
Brooke Vincent, PA-C

Southern Pain AND Anesthesia Consultants, LLC

OPIOID SAFETY SURVEY

Because there is an addiction risk with opioid medicines, we must understand your history before we set a treatment plan for you. Please circle "Yes" or "No" in the chart below as the case applies to you today or in the past.

PATIENT NAME: _____ DOB: _____

DATE: _____ (M / F)

Circle YES or NO for each question		
Do YOU have a history of substance abuse of any of the following?		
Alcohol	YES	NO
Illegal Drugs	YES	NO
Prescription Drugs	YES	NO
Do you have a FAMILY history of substance abuse of any of the following?		
Alcohol	YES	NO
Illegal Drugs	YES	NO
Prescription Drugs	YES	NO
Are you between 16-45 years old?	YES	NO
Were you sexually abused as a child?	YES	NO
Have you ever been diagnosed with any of the following mental health conditions?		
ADD, OCD, bipolar, schizophrenia	YES	NO
Depression	YES	NO

Southern Pain and Neurological

Were you exposed to anyone with a positive COVID 19 test? Yes ☐ No ☐

Have you been tested for COVID 19? Yes ☐ No ☐

When were you tested? _____

Did you test positive? Yes ☐ No ☐

If positive, have you had a negative test recorded? Yes ☐ No ☐

Do you have any symptoms today? Yes ☐ No ☐

Have you previously had any symptoms? Yes ☐ No ☐

Symptoms: Cough ☐ Shortness of breath or difficulty breathing ☐

Chills ☐ Muscle Pain ☐ Headaches ☐

Sore Throat ☐ NEW loss of taste or smell ☐

Fever: When _____ Temp _____

Any other symptoms, please list:

Today's Temp: _____ Date: _____

Patient Name: _____ DOB: _____

Patient Signature:_____

7/28/2020

SOUTHERN PAIN & NEUROLOGICAL

REGISTRATION FORM
(Please Print)

Today's date:	Race:	Ethnicity:
Referring Physician :	PCP:	

PATIENT INFORMATION

Last Name:	Firs Name:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social security number:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street Address:	City:	State:	Zip Code:

Cell Phone Number: ( )	Home Number: ( )	Email Address:

Occupation:	Employer:	Employer phone no.: ( )

LIST PERSON WE MAY SPEAK WITH REGARDING YOUR HEALTH

Named Person:	Relationship to patient:	Birth date: / /	Phone number: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Please indicate primary insurance ❑ Commercial ❑ Medicare ❑ Workmans Comp ❑ Attorney

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Named Person:	Relationship to patient:	Date of Birth: / /	Phone number: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature ***Date***

SOUTHERN PAIN & NEUROLOGICAL

Metairie / Marrero Fax: (504) 889-1868 Covington Fax: (985) 643-3603

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

□3348 W. Esplanade Ave S, Suite A Metairie, LA 70002 504-887-7207	□1200 Pinnacle Pkwy, Suite 7 Covington, LA 70433 985-643-4144	□1849 Barataria Blvd, Suite B Marrero, LA 70072 504-887-7207

Patient Name:_____ DOB:_____

I hereby authorize Southern Pain & Neurological to (check one) ☐ obtain from the following

☐ release to the following

Name:_____ Phone:_____

Address:_____

THE INFORMATION INDICATED BELOW WITH REGARD TO SERVICES PROVIDED TO ME FOR THE FOLLOWING PURPOSE:

__X__ FOR TREATMENT WITH DOCTOR
__X__ FOR PROCESSING OF MY INSURANCE
__X__ FOR APPLICATION FOR INSURANCE
__X__ OTHER, SPECIFY: treatment at the hospital by any affiliates

REPORTS TO BE FURNISHED:

__x__ Diagnosis (Also drug or alcohol abuse)
__x__ Consultations
__x__ Physicians Progress notes
__x__ Physician's orders
__x__ H & P Exam reports
__x__ Lab & x-ray reports
__x__ Discharge Summary
__x__ Treatment Plan
__x__ Verbal Reports
__x__ Other : complete financial and billing records for each individual treating physician, as well for the facility and any affiliates.

1. This authorization shall expire 30 months from the date shown below, unless revoked sooner.
2. I may refuse to sign this authorization and it is strictly voluntary.
3. I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to the covered entity and Requestor. I understand that the revocation will not apply to information that has already been released to the authorization.
4. I have the right to receive a copy of this form after I sign it.
5. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
6. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

Signature of Patient: _____ Date: ___/___/____

_____ Date: ___/___/____

Signature of Parent, Guardian or Legal Representative

_____

Nature of Relationship

NOTICE OF PRIVACY PRACTICES
(MEDICAL)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical exam.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 15, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new Notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Southern Pain & Anesthesia Consultants, LLC
Paul J. Hubbell, III, M.D.
2701 Lake Villa Dr. Ste. A
Metairie, La 70002

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202)619-0257
(877)696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Southern Pain & Anesthesia Consultants, LLC
Paul J. Hubbell, III, M.D.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address listed above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____

Initials: _____

Reason: _____

SOUTHERN PAIN and NEUROLOGICAL

CONTROLLED SUBSTANCE AGREEMENT

I understand that in order to receive any controlled substances from Southern Pain and Neurological I must comply with the following terms and conditions:

If any of the physicians associated with Southern Pain and Neurological prescribe a controlled substance, included but not limited to tramadol, Lyrica or any other pain medications, I can no longer accept prescriptions of controlled substances for pain from any other physician. I am responsible for my medications and early refills will not be issued because of theft, loss or misuse of my medications. I will not take medication that was not prescribed to me and I will not sell or trade my medications. I will follow all directions given to me, by the physician or the pharmacy, as it pertains to the safe use of the medications I am given. I will take my medications as prescribed and if I feel that a change needs to be made I will contact the office for instructions. I understand that random blood or urine drug tests may be performed, without prior notification, to ensure compliance with medications and to screen for any illegal drug use. Evidence of medication misuse, illegal drug use or refusal to submit for the blood or urine drug testing will result in discontinuation of medications and a psychological evaluation by a pain psychologist. If requested, I will bring my medications to the office for a pill count. I will be courteous and respectful to the office staff.

I understand that if I fail to comply with this agreement it may result in termination of my relationship with Southern Pain and Neurological.

I agree to the above terms and conditions and I will receive a copy of this agreement for my records once it is signed.

_____

Patient Date

_____

Witness Date

I decline the above agreement and understand that I will not be able to receive any controlled substances from Southern Pain and Neurological until this agreement is accepted and signed, but I can still receive treatment by way of interventional procedures.

_____

Patient Date

_____

Witness Date

OFFICE USE ONLY

Copy Given to Patient Initials: _____ Date: _____

SOUTHERN PAIN and NEUROLOGICAL

MEDICATION/PHARMACY AGREEMENT

This agreement applies to prescriptions for ANY medications

Primary Pharmacy: Name: _____

Address: _____

Phone #: _____

Secondary Pharmacy: Name: _____

Address: _____

Phone #: _____

If you choose to change your pharmacy please notify the office as soon as possible.

PRESCRIPTION REFILL PHONE # 1-800-419-0462

Prescriptions will only be refilled Monday – Thursday from 8am – 4pm. Prescriptions will not be refilled after hours, or on Friday, Saturday, Sunday and holidays. Calls for refills will be taken Monday – Friday from 8am – 4pm. **Please call one week (7 days) in advance for your refill.** Failure to call one week (7 days) in advance for your refill may result in a delay in receiving your prescription. If your prescription has to be written and picked up from the office please bring a picture ID with you. **You may send someone to pick up your prescription but <u>they must have a signed note from you</u>, with their name, giving them permission to pick up your prescription and they will need to show their ID.**

_____

Patient Date

_____

Witness Date

Office Use Only

Copy Given to Patient Initials: _____ Date: _____

1/8/2016