Welcome to Rogue Valley Pain, Physical & Regenerative Medicine. We are delighted to have you as a new member of our healthcare family. Our dedicated team of healthcare professionals are committed to providing you with exceptional medical care and ensuring your well-being. As a patient-centered practice, we prioritize your comfort, health, and satisfaction. Thank you for entrusting us with your healthcare journey. We look forward to serving you and building a lasting partnership focused on your optimal health and function.

APPOINTMENTS

Please fill out the attached forms. Bring them to your scheduled appointment along with any medical records, imaging on discs, CDs, Usb's and imaging reports pertinent to your condition. Please arrive at least 30 minutes early for your initial visit, as to have the opportunity to collect and organize your records. Do not hesitate to call our office with any questions.

FINANCIAL POLICY

We participate with most major insurance companies. Co-payments and/or co-insurance payments are due at the time of service. As a convenience to our patients, we accept cash, checks and/or VISA/MasterCard/ Discover and American Express.

Where we are located

Rogue Valley Pain, Physical & Regenerative Medicine
845 Alder Creek Drive, Medford, Oregon, 97504

Phone (541) 200-0929
Fax (541) 207-0111

PATIENT INFORMATION

Today's Date: _____

Patient Name: _____ Date of Birth: _____
Last First M.I

Soc Sec#: _____-_____-_____ Drivers Lic#: _____ Marital Status: _____

Language: English: _____ Other: _____ Race: _____ Ethnic Group: _____

Physical Address: _____ City: _____

State: _____ Zip Code: _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Ok to Leave a Detailed Message? Yes____or No_____ Ok to send a Text Message? Yes_____or No_____

Email Address: _____

Employer: _____ Employer Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referring Provider: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Pharmacy Name: _____ City: _____ Phone: _____

Visit Related to: Work Comp: ☐ Yes ☐ No or Motor Vehicle Accident: ☐ Yes ☐ No

ROGUE VALLEY PAIN
Physical & Regenerative Medicine

RELEASE OF INFORMATION

I, _____, hereby authorize
Patient Name

Rogue Valley Pain, Physical & Regenerative Medicine to release information about my:

- □ Medical Information
- □ Billing Information
- □ Appointment Information
- □ Other: _____

Referring Provider: _____
Name

Primary Care Provider: If requested by: _____
Name

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Patient Signature: _____ Date: _____

Representative Signature	Relationship	Date

ROGUE VALLEY PAIN
Physical & Regenerative Medicine

PAIN QUESTIONNAIRE

Name: _____ DOB: _____ Appointment Date: _____

1. Indicate the area of pain that you would most like to address today (e.g. “neck”, or “low back”)

   _____

   _____

   _____

2. Which side does this primarily affect? (circle one)

   left right both sides equally left more than right right more than left

3. Does this pain radiate anywhere? (circle one) No Yes

   If yes, then where does it radiate to?

4. How long has this pain been present? _____

5. there any known event that caused this pain? (circle one) No Yes

   If you answered “yes”, please describe here: _____

   _____

6. Do you hurt all the time? (circle one) No Yes

7. Is there any one time of day that you reliably hurt more than others? (circle one) No Yes

   If you answered “yes”, please indicate when: _____

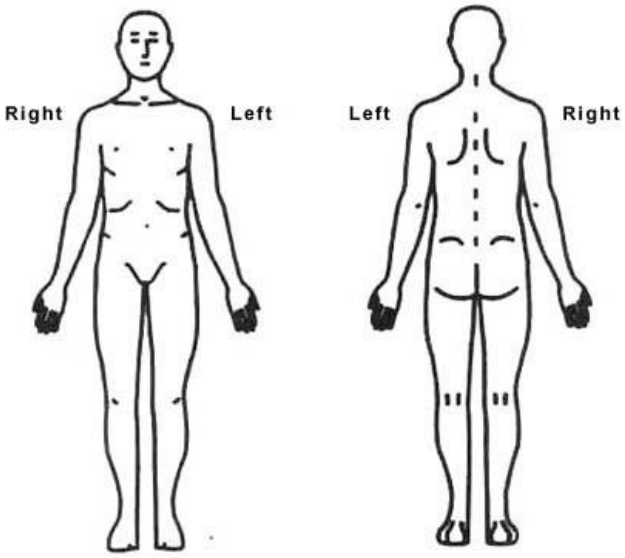
8. Your pain occurs: ☐ Worse after activity ☐ Worse at the end of the day ☐ Worse during cold seasons ☐ Worse during the day ☐ Worse during the night ☐ Worse in the morning

9. Describe your pain: ☐ Aching ☐ burning ☐cramp-like ☐ dull ☐ tingling ☐ sharp ☐ shooting ☐ stabbing ☐ other

ROGUE VALLEY PAIN
Physical & Regenerative Medicine

PAIN QUESTIONNAIRE

10. On the diagram below, shade in the painful area that you indicated on the previous page.



11. ASSOCIATED SYMPTOMS (select all that apply)

NUMBNESS

- ☐ Left shoulder numbness
- ☐ Left upper arm numbness
- ☐ Left forearm numbness
- ☐ Left hand numbness
- ☐ Left finger numbness
- ☐ Left thigh numbness
- ☐ Left lower leg (below the knee) numbness
- ☐ Left foot numbness
- ☐ Right shoulder numbness
- ☐ Right upper arm numbness
- ☐ Right forearm numbness
- ☐ Right hand numbness
- ☐ Right finger numbness
- ☐ Right thigh numbness
- ☐ Right lower leg (below the knee) numbness
- ☐ Right foot numbness

WEAKNESS

- ☐ Left arm weakness
- ☐ Left leg weakness
- ☐ Right arm weakness
- ☐ Right leg weakness

OTHER

- ☐ Bladder incontinence
- ☐ Balance difficulties
- ☐ Bowel incontinence
- ☐ Groin numbness

12. What activities make your pain worse? (i.e. prolonged sitting, lying down, bending, lifting, twisting, walking, etc.):

_____

13. What makes your pain feel better? (i.e. rest, changing positions, exercise, pain medication, heat, ice, sitting, lying down):_____

_____

ROGUE VALLEY PAIN
Physical & Regenerative Medicine

PAIN QUESTIONNAIRE

14. What therapies have you used to treat these symptoms?

TREATMENTS	NO RELIEF	MODERATE RELIEF	EXCELLENT RELEIF
Activity modification	☐	☐	☐
Acupuncture	☐	☐	☐
Bracing	☐	☐	☐
Chiropractic	☐	☐	☐
Heat	☐	☐	☐
Ice	☐	☐	☐
Physical therapy	☐	☐	☐
When did you last attend PT for this problem?	Month(s):	Year:	Number of sessions?

MEDICATIONS **Check mark all medications that apply below**

Opioids

☐ Tramadol
☐ Codeine
☐ Nucynta
☐ Dilaudid
☐ Oxycodone
☐ Methadone
☐ Morphine
☐ Buprenorphine
☐ Hydrocodone
☐ Oxymorphone

NSAIDS/Tylenol

☐ Tylenol
☐ Aspirin
☐ Naproxen
☐ Voltaren Gel
☐ Indocin
☐ Celebrex
☐ Ibuprofen
☐ Relafen
☐ Daypro
☐ Feldene

Muscle Relaxants

☐ Soma
☐ Flexeril
☐ Baclofen
☐ Zanaflex
☐ Robaxin
☐ Skelaxin
☐ Valium

Antidepressants

☐ Elavil (amitriptyline)
☐ Pamelor (nortriptyline)
☐ Cymbalta (duloxetine)
☐ Effexor (venlafaxine)
☐ Paxil
☐ Prozac
☐ Savella
☐ Zoloft

Other

☐ Neurontin (gabapentin)
☐ Tegretol
☐ Imitrex
☐ Xanax
☐ Ativan
☐ Lyrica (pregabalin)
☐ Topamax
☐ Mexilitine
☐ Klonopin

15. What procedure(s) have you had to treat the pain?

☐ No procedure
☐ Joint/Bursa injection
☐ Epidural steroid injection
☐ Facet joint injection
☐ Medial branch block trial
☐ Radio Frequency Ablation
☐ Sacroiliac joint injection(s)
☐ Spinal cord stimulator
☐ Trigger point injection(s)
☐ Peripheral nerve injection
☐ Decompression surgery (laminectomy or discectomy
☐ Spinal fusion surgery
☐ Other (Please write in here): _____

ROGUE VALLEY PAIN
Physical & Regenerative Medicine

PAIN QUESTIONNAIRE

Medications (Please list all current medications or check the applicable box below)

☐ I brough a copy of my medication list (Please provide the list to the front desk receptionist)
☐ I am not currently taking any medications

Medication Name	Dosage	# of times dosage taken per day

Allergies (please list all known allergies or check applicable box below):
☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)
☐ I have no known drug allergies

Medication	Please describe allergic reaction, severity & symptoms

ROGUE VALLEY PAIN
Physical & Regenerative Medicine

PAIN QUESTIONNAIRE

Past Medical History

- ☐ Anemia
- ☐ Arthritis
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bipolar disorder
- ☐ Bleeding disorder
- ☐ BPH
- ☐ Breast cancer
- ☐ Bronchitis
- ☐ CHF
- ☐ Clotting disorder
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ GI ulcer
- ☐ Heart attack
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Osteoporosis
- ☐ Cancer _____
- ☐ Prostate cancer
- ☐ Seizures
- ☐ Shingles
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Other: _____

Family History

Please mark if a Blood Family Member has ever had any of these conditions. If so, please indicate their relationship to you.

Disease	Relationship
☐ Cancer	_____
☐ Heart disease	_____
☐ Diabetes	_____
☐ Hypertension	_____
☐ Stroke/TIA	_____
☐ Alcohol abuse	_____
☐ Drug abuse	_____
☐ Depression	_____
☐ Seizures	_____
☐ Depression	_____
☐ Osteoarthritis	_____
☐ Scoliosis	_____

Social History

Marital status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed/Widower

Alcohol use

- ☐ None
- ☐ Drinks per day: _____
- ☐ Occasional

Drug use

- ☐ History of drug abuse _____
- ☐ Current drug abuse _____

Tobacco use

- ☐ Never smoker
- ☐ Former smoker; Quit _____
- ☐ Current smoker; Cigarettes per day _____

ROGUE VALLEY PAIN
Physical & Regenerative Medicine

PAIN QUESTIONNAIRE
Review of Symptoms

Constitutional	Yes	**Respiratory**	Yes	**Musculoskeletal**	Yes
Activity change		Chest tightness		Joint pain	
Appetite change		Choking		Back pain	
Chills		Cough		Gait problem	
Abnormal sweating		Shortness of breath		Joint swelling	
		Stridor		Muscle pain	
HENT		Wheezing		Neck pain	
Congestion				Neck stiffness	
Dental problem		**Cardio**			
Drooling		Chest pain		**Skin**	
Ear discharge		Leg swelling		Color change	
Ear pain		Palpitation		Pallor	
Facial swelling				Rash	
Hearing loss		**GI**		Wound	
Mouth sores		Abdominal distension			
Nosebleeds		Abdominal pain		**Immuno**	
Postnasal drip		Anal bleeding		Environmental allergies	
Runny nose		Blood in stool		Food allergies	
Sinus pain		Constipation		Immunocompromised	
Sinus pressure		Diarrhea			
Sneezing		Nausea		**Neurological**	
Sore throat		Rectal pain		Dizziness	
Ringing ears		Vomiting		Facial asymmetry	
Trouble swallowing				Headaches	
Voice change		**Genitourinary**		Light-headedness	
		Difficulty urinating		Numbness	
Eyes		Pain with urination		Seizures	
Eye discharge		Involuntary urination at night		Speech difficulty	
Eye itching		Flank pain		Syncope	
Eye pain		Increased urinary frequency		Tremors	
Eye redness		Genital sore		Weakness	
Photophobia		Blood in urine			
Visual disturbance		Penile discharge		**Hematologic**	
		Penile pain		Enlarged lymph nodes	
		Penile swelling		Bruise/bleed easily	
		Scrotal swelling			
		Testicular pain		**Psychiatric**	
		Urinary urgency		Agitation	
		Decreased urine output		Behavior problem	
				Confusion	
				Decreased concentration	
				Bad mood	
				Hallucinations	
				Hyperactive	
				Nervous/anxious	
				Self-injury	
				Sleep disturbance	
				Suicidal ideas	

NO SHOW/MISSED APPOINTMENT POLICY

Rogue Valley Pain, Physical & Regenerative Medicine understands that sometimes you need to cancel or reschedule your appointment and that there are family obligations or emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-48-hour notice). You can cancel appointments by calling the following number: 541-200-0929

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1-2) business days prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24-48 hours' notice: There is a waiting list to see our providers and whenever possible, we like to fill canceled spaces to shorten the waiting period for our patients.

2. If less than a 24-48 hour cancellation is given this will be documented as a "No-Show" appointment.

3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.

4. If you have a "No-Show/Missed" appointment, you may receive a no-show fee of $25.00.

5. Dismissal from the practice may be considered.

I have read and understand Rogue Valley Pain, Physical & Regenerative Medicine's "No Show/Missed Appointment Policy" and understand my responsibility to plan appointments accordingly and notify our clinic appropriately if I have difficulty keeping my scheduled appointments.

Patient Name	Date of Birth	Date

Patient Signature or Parent/Guardian if minor	Relationship to Patient

Staff Signature	Date

Thank you for your understanding and cooperating as we strive to best serve the needs of our patients

FINANCIAL POLICY

Please be assured that everyone in this practice provides medical care in the highest quality possible to all our patients, in an atmosphere of caring, trust and mutual respect.

Your complete understanding of your financial responsibilities is essential; the following is our financial policy that all patients are required to read and sign prior to seeing a healthcare provider. Please let us know if you need any clarification on our payment policies.

Please present to the office, a form of payment to meet your financial obligations to your insurance provider and to your healthcare provider. We accept cash, debit card, check, MasterCard, Visa, Discover and American Express.

You are responsible for all copays, coinsurance, deductibles, and non-covered services. We are obliged to collect your copay at the time of service per your insurance company. Please understand that we cannot waive deductibles, coinsurances or copays that are required by your insurance. The patient portion of payment is due at time of service unless prior arrangements have been made with the business office.

We accept assignment with most major insurance companies and participating provider plans. However, please note:

1. Your insurance policy is a contract between you, your employer and the insurance company. Our relationship is with you, not your insurance carrier.
2. All charges are your responsibility whether your insurance company pays or not (to the extent of insurance contractual obligation).
3. Returned checks will be subject to any bank fees charged to our office, in addition to a service fee, and will be billed to you.
4. Unpaid balances are subject to a collections process.

We understand that temporary financial problems may affect timely payment of your balance. Balances not paid within 90 days will be turned over to an outside collections agency, unless prior payment arrangements have been made with our business office. Patients turned over to a collection agency will also cease to be patients of Rogue Valley Pain, Physical & Regenerative Medicine.

Due to the hardship imposed on the practice and other patients, scheduled appointments that are missed, cancelled and /or rescheduled with less than 24 hours' notice will result in a fee and may also result in discharge from the practice. The fee for missed appointments is determined based on the level of hardship it imposed on the practice. This fee will not be covered by your insurance and must be paid prior to you seeing the healthcare provider.

Prescriptions provided outside of an office visit due to missed, cancelled and/or rescheduled appointments are subject to a fee and payment will be required at the time prescription is provided.

I have read and understand Rogue Valley Pain, Physical & Regenerative Medicine's "Financial Policy" as described above.

Patient Signature/Authorized Signature Date

Printed Name of Patient / Printed Name of Authorized Signer Relationship to patient if not patient

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photocopy or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to Rogue Valley Pain, Physical & Regenerative Medicine the medical and/or procedural benefits I am entitled from my insurance company and/or Medicare. This authorization is in effect for all future claims until I choose to revoke it in writing.

Patient Signature/Authorized Signature Relationship to patient if not patient Date