



**Tanner Pain Management Center  
204 Allen Memorial Drive, Suite 302-A  
Bremen, GA 30110  
Phone: 770 812-5720**

Dear New Patient:

Your physician has referred you for a consultation to the Tanner Pain Management Center. Please read this letter carefully.

Enclosed is a map to Tanner Pain Management Center. When you enter the building take the elevator to the third floor. We are in Suite 302-A.

**You will also find a packet of patient information/history that must be completed in its entirety and brought with you to your consultation. If you need help completing this paperwork, please have someone to help you with it. If it is not completed when you arrive, your appointment will be rescheduled. Please review all agreements in your packet carefully.** Any questions you have will be answered at your appointment.

**Please bring photo identification (ex. driver's license), your insurance card(s) and your medications with you to every appointment.** Failure to do so will delay your appointment.

**Insurance copays, coinsurance, and deductibles are due and payable at each visit.** Tanner Pain Management Center is an outpatient department of Tanner Medical Center. Please contact your insurance company prior to your consultation to determine what portion of your visit is your responsibility. Should you need assistance with your medical expenses, please ask about various payment assistance options.

If you are unable to make your appointment, please call at least 24 hours prior to your appointment. Chronic missed appointments will lead to dismissal from the center. **Please note, if you are late for your appointment, you will be asked to reschedule.**

**Please be advised if you "Reschedule" your appointment more than twice we will not be able to schedule another appointment. Any "No show" appointments will not be rescheduled. The referring Physician will be notified.**

We wish to provide you with the best service and care possible.  
THANK YOU FOR YOUR COOPERATION.

WELCOME TO TANNER PAIN MANAGEMENT CENTER!

# Tanner Medical Group Registration

As a member of Tanner Medical Group, we are committed to providing the best and most comprehensive healthcare possible. We encourage you to ask questions.

## PATIENT INFORMATION

Patient's Name: \_\_\_\_\_ Alias: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Sex: Male Female Race: Caucasian Black Asian Hispanic Other

Patient's Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_ Preferred Communications: Call Text Email

Preferred Language: \_\_\_\_\_ Interpreter Needed? Yes No

Marital Status: Single Married Divorced Legally Separated Widowed Significant Other

Employer \_\_\_\_\_ Full PT or NA

Primary Care Doctor: \_\_\_\_\_ Preferred Pharmacy: \_\_\_\_\_

Special Needs: \_\_\_\_\_ Is this Visit Related to an Accident? Yes No

## GUARANTOR / RESPONSIBLE PARTY

(If patient is under the age of 18)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship \_\_\_\_\_ Social Security \_\_\_\_\_

Employer \_\_\_\_\_ Full PT or NA

## Insurance Subscriber information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship \_\_\_\_\_ Social Security \_\_\_\_\_

Employer \_\_\_\_\_ Full PT or NA

## OTHER / EMERGENCY CONTACT INFORMATION

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

### Authorized individuals to seek medical attention for Minors

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Tanner Pain Management Center  
204 Allen Memorial Drive, Suite 302-A  
Bremen, Ga 30110  
770-812-5720  
Fax-770-812-5729

**AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_, authorize and request  
\_\_\_\_\_ to release to:  
(name of physician/practice)

**Tanner Pain Management**

a complete copy of the medical records of \_\_\_\_\_  
date of birth \_\_\_\_\_, social security number, \_\_\_\_\_  
from \_\_\_\_\_ to \_\_\_\_\_. Reason for disclosure: \_\_\_\_\_

I am aware that some of the health care information or other information contained in the requested medical records may be confidential or privileged and I hereby specifically waive any privilege or confidentiality existing under federal or state law regarding such information including, but not limited to, protection afforded to:

- (1) AIDS confidential information
- (2) Medical information concerning alcohol and drug abuse
- (3) Medical information
- (4) Medical information concerning alcohol and drug dependency
- (5) Medical information regarding mental illness
- (6) Communications made to a psychiatrist
- (7) Communications made to a licensed applied psychologist
- (8) Medical information concerning mental retardation

This authorization and consent is subject to revocation at any time, except to the extent that action had already been taken in reliance on it. If not previously revoked, this authorization will terminate in 90 days from the date appearing below.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
(signature of authorized person)

Witness: \_\_\_\_\_ Title: \_\_\_\_\_

**NOTE TO RECIPIENT**

The information that has been disclosed to you is or may be protected by State and Federal law. You are prohibited from making any further disclosure of this information unless further authorization is obtained or disclosure is otherwise permitted by law. A general authorization for release of information may not be sufficient.

THE INFORMATION WAS RELEASED TO: \_\_\_\_\_  
ON \_\_\_\_\_ BY \_\_\_\_\_

# TANNER PAIN MANAGEMENT PATIENT HISTORY

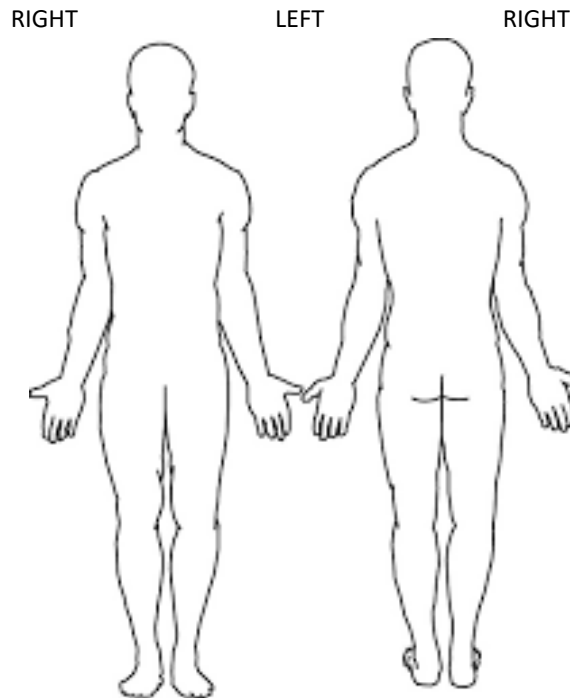
NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
 PRIMARY CARE PHYSICIAN \_\_\_\_\_ REFERRING PHYSICIAN \_\_\_\_\_

### DESCRIPTION OF PAIN (CIRCLE ALL THAT APPLY)

1. I AM HERE FOR EVALUATION OF (NECK, SHOULDER, LOWER BACK, HIP, KNEE, FOOT, OR \_\_\_\_\_)PAIN.
2. PAIN IS LOCATED IN \_\_\_\_\_ AND SPREADS TO (LEFT, RIGHT, BOTH, ARM, HIP, LEG).
3. WHEN DID THE PAIN BEGIN AND WHAT CAUSED IT? \_\_\_\_\_.
4. DESCRIPTION OF PAIN IS (ACHE, PINS/NEEDLES, STABBING, BURNING, VIBRATION, NUMBNESS, PRESSURE, COLD, HOT, OTHER \_\_\_\_\_).
5. WHAT IS YOUR PAIN SCALE NOW? \_\_\_\_\_

0      1      2      3      4      5      6      7      8      9      10  
**NONE            MILD                                    MODERATE                                    SEVERE**

6. WHAT IS YOUR PAIN SCALE ON YOUR BEST DAY? \_\_\_\_\_
7. WHAT IS YOUR PAIN SCALE ON YOUR WORST DAY? \_\_\_\_\_
8. INDICATE ON THE DIAGRAM WHERE YOUR WORST PAIN IS LOCATED.



9. MY PAIN (MILDLY, MODERATELY, SEVERLY, VERY SEVERLY) INTERFERES WITH MY ACTIVITIES OF DAILY LIVING.
10. IS YOUR PAIN ASSOCIATED WITH WEAKNESS? \_\_\_\_\_ WHERE \_\_\_\_\_
11. IS YOUR PAIN ASSOCIATED WITH NUMBNESS? \_\_\_\_\_ WHERE \_\_\_\_\_
12. IS YOUR PAIN ASSOCIATED WITH TINGLING? \_\_\_\_\_ WHERE \_\_\_\_\_
13. DO YOU HAVE ANY SKIN COLOR OR TEMPERATURE CHANGE? \_\_\_\_\_ WHERE? \_\_\_\_\_
14. I AM HYPERSENSITIVE TO (TOUCH, CLOTHES, COLD, WEATHER CHANGES).
15. DO YOU HAVE INCONTINENCE, CONSTIPATION OR LOSS OF CONTROL OF BLADDER OR BOWELS? \_\_\_\_\_
16. HOW MANY HOURS OF UNINTERRUPTED SLEEP DO YOU HAVE AT NIGHT? \_\_\_\_\_ DO YOU FEEL RESTED IN THE MORNING? \_\_\_\_\_ DO YOU HAVE NIGHT PAIN? \_\_\_\_\_

**PREVIOUS TREATMENTS/CONDITIONS**

17. CIRCLE THE PREVIOUS TREATMENTS/MEDICATIONS YOU HAVE TRIED; INDICATE DATE IF YOU KNOW.

DOCTOR:NAME \_\_\_\_\_

PAIN SPECIALIST:NAME \_\_\_\_\_

PHYSICAL THERAPY: \_\_\_\_\_ DID IT HELP? \_\_\_\_\_

ACCUPUNCTURE: \_\_\_\_\_ DID IT HELP? \_\_\_\_\_

EPIDURAL INJECTION/NERVE BLOCK: \_\_\_\_\_ DID IT HELP? \_\_\_\_\_

NERVE STIMULATOR: \_\_\_\_\_ DID IT HELP? \_\_\_\_\_

CHIROPRACTOR: \_\_\_\_\_ DID IT HELP \_\_\_\_\_

PREVIOUS NECK/BACK/HIP/KNEE SURGERY:TYPE OF SURGERY/DATE \_\_\_\_\_

MEDICATION:ALEVE, ANTI-INFLAMMATORY, ASPIRIN, CELEBREX, CYMBALTA, DILAUDID, HYDROCODONE, IBUPROFEN, LYRICA, METHADONE, MOBIC, MORPHINE, MOTRIN, MUSCLE RELAXERS, NAPROSYN, NAPROXEN, NEUROTIN, OXYCODONE, OXYCONTIN, TYLENOL, VOLTAREN

18. WHAT TESTS HAVE YOU HAD? INDICATE DATE AND RESULTS IF YOU KNOW THEM:

X-RAY \_\_\_\_\_

MRI \_\_\_\_\_

CAT SCAN \_\_\_\_\_

MYELOGRAM \_\_\_\_\_

EMG/NCS \_\_\_\_\_

19. DO YOU HAVE ANY OF THE FOLLOWING:

AGE GREATER THAN 50

HISTORY OF COLON CANCER:DATE \_\_\_\_\_

NEUROLOGICAL DISORDERS(SEIZURES, MULTIPLE SCLEROSIS, MYOPATHIES, NEUROPATHIES)

UNINTENTIONAL WEIGHT LOSS

DIABETES

20. PLEASE LIST ANY MEDICAL CONDITIONS YOU HAVE AND THE TREATMENT YOU HAVE RECEIVED: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

21. PLEASE LIST ANY SURGERIES YOU HAVE HAD AND THE YEAR PERFORMED: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

22. DO YOU USE ALCOHOL, TOBACCO, ILLEGAL DRUGS, MARIJUANA? IF YES, PLEASE LIST PRODUCTS AND HOW OFTEN THEY ARE USED: \_\_\_\_\_

\_\_\_\_\_

23. DO YOU HAVE DEPRESSION OR A HISTORY OF DEPRESSION? \_\_\_\_\_ ARE YOU PRESENTLY BEING TREATED FOR DEPRESSION? \_\_\_\_\_

24. IN THE PAST YEAR HAVE YOU EXPERIENCED ANY PYSICAL, EMOTIONAL, VERBAL, OR SEXUAL ABUSE? \_\_\_\_\_

25. MARITAL STATUS: \_\_\_\_\_ DO YOU LIVE ALONE? \_\_\_\_\_

26. DO YOU HAVE CHILDREN LIVING AT HOME? \_\_\_\_\_ WHAT ARE THEIR AGES? \_\_\_\_\_

27. ARE YOU PRESENTLY INVOLVED IN A LAWSUIT? IF YES, EXPLAIN \_\_\_\_\_

28. ARE YOU PRESENTLY ON DISABILITY? \_\_\_\_\_ ARE YOU SEEKING DISABILITY? \_\_\_\_\_

29. PLEASE LIST ANY MEDICATION ALLERGIES: \_\_\_\_\_



## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

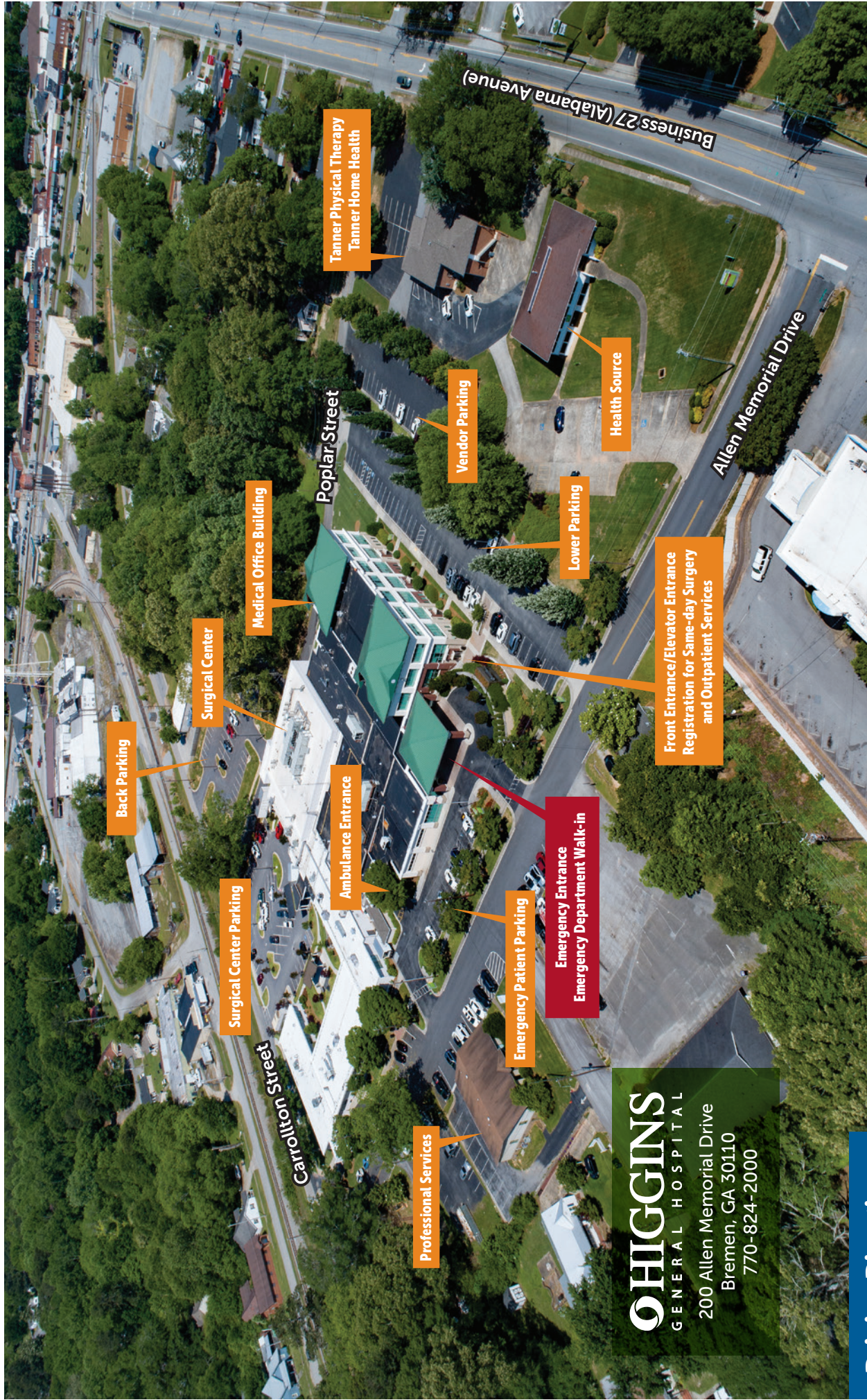
Over the last 2 weeks, how often have you been bothered by any of the following problems?  
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns  +  +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

<b>10.</b> If you checked off <i>any problems</i> , how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____



# HIGGINS

GENERAL HOSPITAL

200 Allen Memorial Drive  
Bremen, GA 30110  
770-824-2000

## Driving Directions

**From Carrollton:**  
Take US-27 North approximately 8 miles. Turn RIGHT onto Business U.S. 27 (Alabama Avenue). Go 2 miles. Turn left onto Allen Memorial Drive. Hospital will be on your RIGHT.

**From Tallapoosa:**  
Take Hwy. S-78 East to US-27 South. Turn RIGHT onto US-27 South. Turn LEFT onto Business US-27 (Alabama Avenue). Go 2 miles. Turn left onto Allen Memorial Drive. Hospital will be on your RIGHT.

**From Buchanan:**  
Take US-27 South approximately 5.8 miles. Turn LEFT onto Business US-27 (Alabama Avenue). Go 2 miles. Turn left onto Allen Memorial Drive. Hospital will be on your RIGHT.

**From Atlanta:**  
Take I-20 West to US-27 Exit 11. Turn RIGHT onto US-27 North. Turn RIGHT onto Business US-27 (Alabama Avenue). Go 2 miles. Turn left onto Allen Memorial Drive. Hospital will be on your RIGHT.