ELAINE FOSTER, PH.D., ABPP - PRESCRIBING PSYCHOLOGIST
2488 Calle de Guadalupe #594, Mesilla, NM 88046-0594
(575) 323-0341 • Fax: (575) 521-6132

Pain - Psychological Evaluation Questionnaire

Today's Date: ____________________ Who referred you? _________________________

Name: ____________________DOB: ______________ Age: _____ Social Security#: ______________

Address _________________________________ City___________ State ___ Zip Code__________

Cell Phone: ____________________ Work Phone: ________________ Home telephone: __________

Years of School Completed: _______ Place of Employment: _____________________________

Type of Work: _______________________ E-mail address: ___________________________________

Marital Status: __________ Years Married:_____ Number of Marriages: ____ Height ___ Weight__

Information about Spouse/Partner:

Name___________________________________ DOB __________________Age ______________

Address: __________________________________ City_______________ State_____ Zip Code_____

Cell Phone _______________Work Phone _____________ Home telephone _____________________

Place of Employment: ____

Type of Work: _______________________ E-mail address: _____________________________

Others in the home:

Name	DOB	Age	Relationship
___________________________	__________	______	________________________
___________________________	__________	______	________________________
___________________________	__________	______	________________________
___________________________	__________	______	________________________

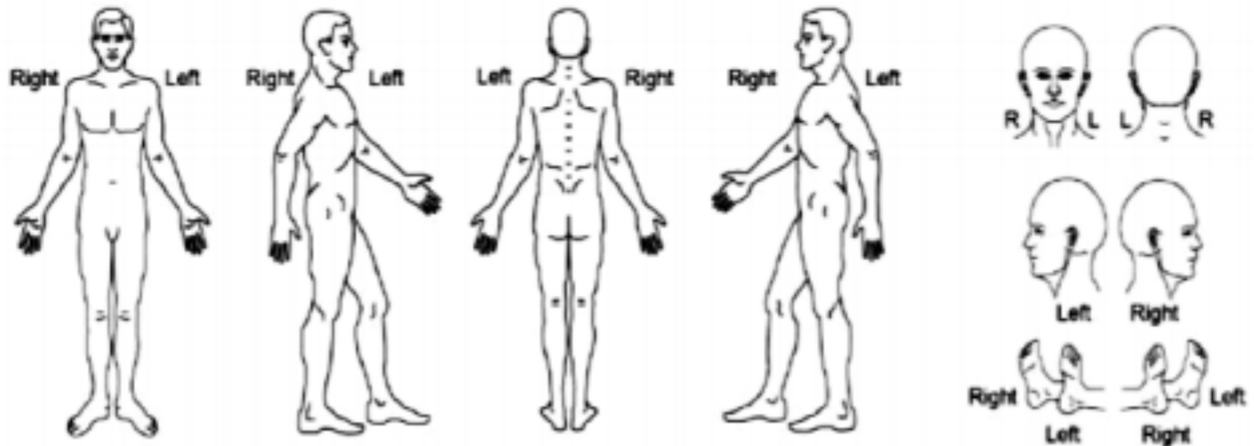
Pain History

Chief Complaint (Reason for your visit today)? ____________________

Does this pain radiate? If so where? ____________________

Please list any additional areas of pain: ____________________

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Pain Description

Check all of the following that describe your pain:

☐ Dull/Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp

☐ Cramping ☐ Numbness ☐ Spasming ☐ Throbbing

☐ Squeezing ☐ Tingling/Pins and Needles ☐ Tightness

When is your pain at its worst?

☐ Mornings ☐Daytime ☐ Evenings ☐ Middle of the night

☐ Always the same

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present

☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now____________ The Best It Gets____________ The Worst It Gets____________

Onset of Symptoms

Approximately when did this pain begin? ____________________

What caused your current pain episode? ____________________

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

Mark the effect each of the following have on your pain level - ☑

	Increases	Decreases	No Change
Bending Backward	☐	☐	☐
Bending Forward	☐	☐	☐
Changes in Weather	☐	☐	☐
Climbing Stairs	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Driving	☐	☐	☐
Lifting Objects	☐	☐	☐
Looking upward	☐	☐	☐
Looking downward	☐	☐	☐
Rising from seated position	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐

What other factors worsen or affect your pain which is not mentioned above?

____

Please mark all of the following treatments you have used for pain relief: ☑

	No Change	Worsened Pain	Helped Pain
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
Medications	☐	☐	☐
TENS Unit	☐	☐	☐

Other ____

Interventional Pain Treatment History

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar

☐ Joint Injection – Joint(s) ____

☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar

☐ MILD (Minimally Invasive Lumbar Decompression) - ____________________________

☐ Nerve Blocks – Area/Nerve(s) - ______________________________________

☐ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar

☐ Spinal Cord Stimulator – Trial Only/Permanent Implant ________________________

☐ Trigger Point Injections – Where? ____________________________________

☐ Vertebroplasty/Kyphoplasty – Level(s) _________________________________

☐ Other - ____

Which of these procedures listed above have helped with your pain? ________________

____

Social History: Where were you born and raised? ______________________________

What was your childhood like?

____

Mental Health History

Please check any of the following problems that you have experienced in your life:
___Depression ___Anxiety ____ Hallucinations ___Manic Episodes ___Childhood Physical/Sexual Abuse

___Childhood Neglect ___Spouse Abuse ___Adult Sexual Assault ___Adult Physical Abuse/Assault Other

Traumatic Experiences ____

Have you ever been in **counseling**? Yes ___ No ___
If yes: When_________________________ With whom? ______________________
Did you find the counseling helpful? Yes ___ No ___

Exercise History

Do you exercise regularly (3 or more times per week)? Yes ___ No ___
If no, why not? ___joint pain ___dislike exercise ___other reason: ______________________

Educational History

Years of school completed _____
Did you have learning problems in school? Yes ___ No ___
Were you in Special Education? Yes ___ No ___
Did you like school? Yes ___ No ___

Employment

Are you presently employed? Yes ___ No ___

Type of work ____________________________ Place of

Employment______________________________ If not working, are you are disability? Yes ___ No ___

Review of Systems (check all that apply)

Review of Systems: Please check all that apply.

General:
____Fever
____Night sweats
____Chills
____Fatigue
____Weight change
Up_____ Down____ #_____

Eyes:
____Blurred/double vision
____Loss of vision
____Glasses/contacts
____Dry eyes

Ear, Nose, Throat:
____Hearing loss
____Loss of taste
____Nasal congestion
____Nasal discharge
____Choking
____Hoarseness
____Sore throat
____Dry mouth

Respiratory:
____Cough
____Shortness of breath
With exertion?____ lying flat?____

Cardiovascular:
____Chest pain
____High blood pressure
____Calf pain with walking
____Leg swelling

Gastrointestinal:
____Abdominal pain
____Indigestion
____Nausea
____Vomiting
____Constipation
____Diarrhea
____Bowel incontinence

Genitourinary:
____Urinary frequency/urgency
____Urinary burning
____Bladder incontinence
____Erectile dysfunction
____Sexually active

Gynecological:
____Pregnant
____Abnormal vaginal bleeding
____Excessive menstrual pain
____Postmenopausal
____Vaginal dryness

Musculoskeletal:
____Back pain
____Neck pain
____Joint pain
Which joints____________________
____Joint swelling
____Joint warmth/redness

Neurologic
____Fainting
____Numbness
____Seizures
____Tremors
____Weakness
____Headaches
____Problems with memory or concentration

Psychological
____Anxious/Nervous
____Irritability
____Change in appetite
____Change in sleep pattern
____Feelings of depression

Endocrine
____Diabetes
____Increased thirst
____Thyroid problems
____Excessive sweating
____Heat intolerance
____Cold intolerance

Hematologic
____Anemia
____Easy bruising or bleeding
____Previous transfusions

Skin
____Pressure sores
____Rash

Your Primary Care physician (Name, phone, address): ____

____

Date of last physical exam: ____
Date of latest blood tests: ______________________________ Where? ________________________

Allergies

Do you have any allergies to **medications**? ❑ Yes ❑ No
If so, to which ones?:
Allergies to **foods**? ❑ Yes ❑ No If so, to which ones?:

Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical
- ☐ Cancer – Type ________________
- ☐ Diabetes – Type ________________

Cardiovascular/Hematologic
- ☐ Anemia
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stoke/TIA
- ☐ Heart Valve Disorders

Gastrointestinal
- ☐ GERD (Acid Reflux)
- ☐ Gastrointestinal Bleeding
- ☐ Stomach Ulcers
- ☐ Constipation

Urological
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Dialysis

Neuropsychological
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bipolar Disorder

Head/Ears/Eyes/Nose/Throat
- ☐ Headaches
- ☐ Migraines
- ☐ Head Injury
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Glaucoma

Respiratory
- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD

Musculoskeletal/Rheumatologic
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Chronic Joint Pains

Other Diagnosed Conditions
- ☐ ______________________________
- ☐ ______________________________
- ☐ ______________________________
- ☐ ______________________________
- ☐ ______________________________
- ☐ ______________________________

History of Surgeries:

____

____

____

Family History

Mark all appropriate diagnoses as they pertain to your first degree relatives:

☐Arthritis ☐Cancer ☐Diabetes

☐Headaches/Migraines ☐High Blood Pressure ☐Kidney Problems

☐Liver Problems ☐Osteoporosis ☐Rheumatoid arthritis

☐Seizures ☐ Stroke

☐Other Medical Problems: ____

☐ I have no significant family medical history

Pain physician (Name, phone, address):

Medications

Please list all medications (include over-the-counter) and their doses that you are currently taking:

MEDICATION	DOSE	MEDICATION	DOSE
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

All Hospitalizations

Have you ever been hospitalized for a psychiatric reason? ❑ Yes ❑ No Please list all hospitalizations, medical AND psychiatric:

Dates of hospitalization	Place	Reason

Other History:
Illicit Drugs:
Have you ever used any street drugs for recreation, including high school?
_____Yes _____No

Have you ever been addicted to any drug including medicines prescribed by a physician?
_____Yes _____No

Please circle the pieces of equipment you have in your home for your use. Please indicate how often you use this equipment.

I USE THIS EQUIPMENT:	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
Cane					
Crutches					
Walker					
Wheelchair, manual					
Wheelchair, power or scooter					
Walking boot					
Braces or other Orthotics					
Raised toilet seat					
Grab bars					
Shower bench					
Hand held shower					

Even though we will ask to make a copy of your insurance card, we would appreciate if you would fill in the following information:

PRIMARY INSURANCE COMPANY

Name of Insurance Company: _________________ Policy# ______________________________

Group#____________________________________ Authorization or Referral #

Name of Insured Person ________________________DOB ______ Social Security# ________________

Address: ____________________________________Phone Number: ____________________________

Place of Employment for Insured (if different from first page): __________________________________

Address: ____________________________ City: __________ State: ______ Zip Code: ______________

Home telephone: ______________________________ Cell Phone: _______________________________

SECONDARY INSURANCE COMPANY

Name of Insurance Company: _________________ Policy# ______________________________

Group#____________________________________ Authorization or Referral #

Name of Insured Person ________________________DOB ______ Social Security# ________________

Address: ____________________________________Phone Number: ____________________________

Place of Employment for Insured (if different from first page): __________________________________

Address: ____________________________ City: __________ State: ______ Zip Code: ______________

Home telephone: ______________________________ Cell Phone: _______________________________

NOTICE OF PRIVACY PRACTICES

This Notice describes how protected health information (PHI) about you may be used and disclosed at PsyConOps. This includes all our staff and contractors. This Notice describes how you can access your information and your other privacy rights.

We are required by law to 1) make sure your medical information is kept private, 2) give you this Notice about our legal duties & privacy practices about your health information and 3) do what we say in the Notice.

If you have questions or concerns about privacy of information, you may contact: Privacy Office PsyConOps, P.O. Box 594, Mesilla, NM 80846. Phone Number: 850-502-9237.

Use & Disclosure of Protected Health Information (PHI)
We may use or disclose information about your treatment for the following reasons:

Written Authorization. You may authorize us to disclose your health care information. We will honor your authorization and, if requested, provide a copy of the recorded health care information unless we have denied you access to your health care information under state law. We have a form you can complete that allows us to share PHI with someone or an organization.

Treatment. We use and disclose your PHI to you in order to provide treatment and other services. We may contact you to provide appointment reminders. We may talk to you about alternatives or other benefits and services that may be of interest to you. We may share information between PsyConOps independent-contract mental health providers in order to coordinate care. We may disclose information for supervision or case consultation within PsyConOps.

Payment. We may use and disclose your PHI to obtain payment for services that we provide to you from your insurance plan or payer.

Health Care Operations. We may use and disclose your PHI for our health care operations. This includes our internal administration and planning. This also includes various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our therapists. We may also disclose information within PsyConOps in order to resolve complaints.

Disclosure to Relatives Close Friends and Other Caregivers. We will use or disclose your PHI to a relative, friend, or caregiver only if you are present and we can reasonably infer you do not object to the disclosure. For example, if you bring a friend or relative to a session, we may decide to use or disclose information for treatment purposes.

Public Health Activities. We may disclose PHI for the following public health activities: (1) *to report health information to public health authorities for preventing or controlling disease*, injury or disability;
(2) *to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration*;
(3) *to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition;* and

(4) *to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.*

Abuse or Neglect. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose your PHI to the appropriate government authority. This includes children, persons who have a mental health diagnosis, and the elderly. We may also disclose PHI if we come in contact with someone who has abused or neglected someone as defined by state laws.

Health Oversight Activities. There are organizations that are responsible for overseeing compliance with government rules for delivering healthcare. We may disclose your PHI to them to ensure compliance.

Judicial and Administrative Proceedings. We may disclose your PHI in response to a court or administrative order.

Law Enforcement Officials. We may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. This includes, but is not limited to, identifying or locating missing persons, fugitives, or suspects, or reporting crimes committed on our property.

Decedents. We may disclose your PHI to a coroner or medical examiner as authorized by law. We may also disclose PHI as required for any investigation related to a death as allowed by law.

Health or Safety. We may use or disclose your PHI to prevent or reduce a serious threat to anyone's health or safety. This includes preventing or lessening a serious and imminent threat to the health or safety of a person or the public. The information is disclosed only to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Special Government Functions. We may use and disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State when the law requires it.

Workers Compensation. We may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

As required by law. We may use or disclose PHI when required to do so by any other law not listed here.

Uses and Disclosures of Your Highly Confidential Information.
In addition, federal law imposes special privacy protections for "Highly Confidential Information". This includes alcohol and drug abuse treatment program services, HIV/ AIDS testing, and genetic testing. To disclose this information (unless allowed or required by law), we will obtain your authorization.

Coordination with Health Care Providers.
We believe in "holistic" care: the mind and body relate to one another. So, it is important for us to coordinate your care with your health care providers, especially your PCP. Both federal and state privacy laws encourage this coordination between health care providers. This includes Health Information Exchanges such as CareQuality and the Collective Platform (Premanage and EDIE). We only share basic information such as diagnostic information, plans for care, and medications (if they are prescribed) with these exchanges. If we need to share other information, it will be only the minimum necessary to

coordinate care. You may request to restrict this disclosure if you do not want us to share information with other providers.

Your Rights Regarding Your Protected Health Information.

Complaints. If you want more information or have a concern about privacy, you may contact our Privacy Officer, Mr. Joseph Foster at 850-502-9237. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. The Privacy Officer can provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of your PHI. This is for treatment, payment and health care operations. We are not required to agree to the request. To request a restriction, contact our Privacy Officer for the form. We will send you a written response to a completed form. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information with your health insurer. We will say "yes" unless a law requires us to share that information.

Right to Request Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

Right to Revoke Your Authorization. You may request to revoke an Authorization by contacting the Privacy Officer listed above or obtain the form from our website (www.psyconops.com). If we have already used or disclosed information, we cannot take the information back.

Right to lnspect and Copy Your Health Information. You may request access to your health information with PsyConOps. To access your records, complete a Record request form that is at the PsyConOps site, through Medical Records at P.O. Box 594, Calle de Guadalupe, Mesilla, NM 88046 or by calling 850-502- for the Privacy Officer listed above, or at our website (www.PsyConOps.com). There are limited circumstances where we may deny you access to portions of your record. If you request copies, there may be charges. If you request a summary of your PHI, we will charge you $150 per hour for completing the summary.

Right to Amend Your Records. You may request that we amend PHI at PsyConOps. To amend your records, obtain and complete an Amendment Request Form from Medical Records or Privacy Office listed above or download the request at our website. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

Right to Receive an Accounting of Disclosures. You may request a listing of some types of disclosures of your PHI. This applies to disclosures within the last six years. If you request an accounting more than once during a twelve (12) month period, we will charge you $10.00 for each page.

Right to Receive Paper Copy of this Notice. This is a paper copy of our Notice. You may receive paper copies by contacting the front desk.

Right to Be Notified of a Breach. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information

Effective Date and Changes. This Privacy Notice was first effective on 4 February 2020 and was last amended on that date. We may change the terms of this Privacy Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any

information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in waiting areas at PsyConOps. You also may obtain any new notice by contacting the Privacy Office.

Acknowledgment of Informed Consent, Rights & Responsibilities, Complaints Process, and Privacy Policies

Print Client Name: ___________________ Client Date of Birth: ______________________ If

Parent/Guardian, print name: __________________ Parent Guardian Other _________

Informed Consent Initial I have read and understand the risks & benefits related to treatment and
evaluation at PsyConOps. I consent to receive mental health services by PsyConOps. Any questions I have regarding these have been answered.

Rights & Responsibilities and Complaints/Grievances Initial I have reviewed and understand my rights and responsibilities and the
Complaint/Grievance process for services at PsyConOps. This includes complaints, fees, no-show/cancellation policies, and my rights. I have a copy of these rights and responsibilities. Any questions on these have been answered.

Notice of Privacy Practices Initial I have reviewed PsyConOps' privacy practices. This includes privacy and
exceptions to confidentiality. Any questions I have regarding these practices have been answered. I have a copy of these policies. I understand that PsyConOps will share basic information with my primary care provider unless I ask to "restrict" this disclosure.

Financial Initial If I cancel within 24 hours or do not show for an appointment, I will pay $55 (OHP and General Fund excepted). I am the "financial guarantor", meaning I will be responsible for payment of co-pays, co-insurance, deductibles, and fees for services not covered by a plan or EAP.

Signature of Client or Parent/Guardian: __________________________ Date: _____________________

RELEASE OF INFORMATION:

I authorize the release of any medical, psychological or other info necessary to process **insurance** claims:
Yes ___ No ___

Patient Signature ____ *Date*

I authorize **payment** of medical benefits for services rendered:

____

Yes ___ No ___

Patient Signature ____ ***Date*** ______________________

For each item, below, please indicate **your preference**, provide your **initials on the line to the left**, and then sign below:

❑ Yes ❑ No I grant permission for Dr. Foster to speak with my pain specialist/physician, Dr. Foster ____________________about my psychological and medical status.

Name ___________________________ Signature _____________________ Date _____________

❑ Yes ❑ No I grant permission for Dr. Foster to speak with *(other healthcare provider's name, address, and phone number):* ____ about my psychological/health status.

Name ____________________________ Signature _______________________ Date ________________

HIPAA Acknowledgement

Your signature below indicates that you have read Dr. Foster's HIPAA and privacy policies

and consent to this patient-psychologist agreement.

Name ____________________________ Signature _______________________ Date _______________