INTERVENTIONAL Spine ASSOCIATES

Robert M. Sutherland, M.D.

In this packet you will find several forms that will need to be filled out **prior to arriving at our office.**

You must bring ALL of the medications that you are currently taking in the bottle that they came in to all appointments. Failure to bring your medication with you will result in your appointment possibly being rescheduled.

Appointment cancelations must be received within 48 hrs of your appointment. There is a $30.00 charge for appointments that you fail to give an adequate notice.

Limit the number of family members or friends to no more than 1, our office and exam space it extremely limited. There is extra waiting space for waiting in the main lobby downstairs.

While we are family friendly and appreciate children, remember this is a pain management clinic. If you must bring young children please keep them quiet and seated. If you do not, we will ask you to leave.

If you "No-Show" your initial appointment our office will not reschedule your appointment. Please make sure to communicate with our office if you cannot make the appointment for any reason.

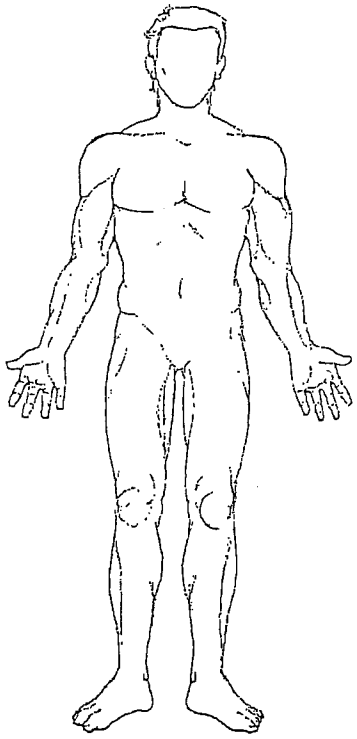
Thank you,
Interventional Spine Associates Management

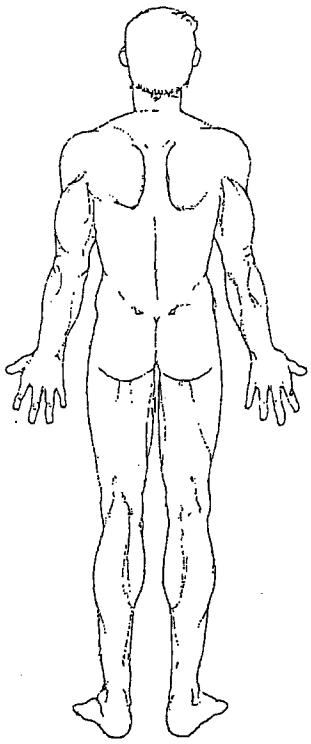
700 Olympic Plaza Suite 404 Tyler, TX 75701
Phone: 903-593-1738 • 866-622-7284
Fax: 903-593-7650 • 903-596-7852

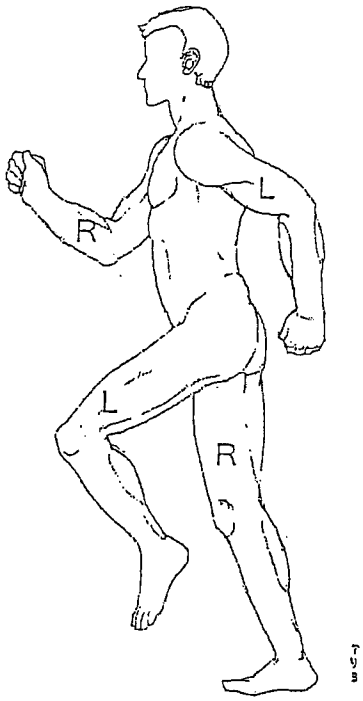
Patient Name _____

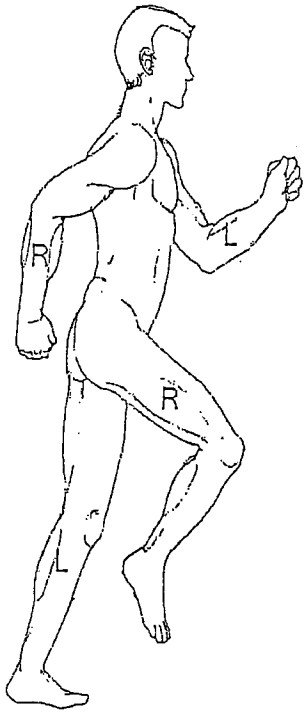
DOB_____ Date_____

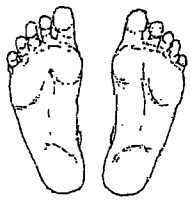
PLEASE SHADE IN YOUR AREA OF PAIN
THAT BROUGHT YOU TO OUR OFFICE











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Patient Name_____Date_____

PLEASE FILL OUT ALL INFORMATION

What is the word that best describes your pain?

Intensity: o Variable o Weak o Moderate o Strong

Mood: o Miserable o Uncomfortable o Distressing

Type of pain: o Non-descript oSharp o Shooting o Stabbing
o Burning o Dull o Aching

Does your pain interrupt your sleep? o Yes o No

How do you rate your pain on a scale from 0-10?
At its best:_____ 0-No pain at all
At its worst:_____10-Agonizing pain

How did your pain start?
o Trauma o Car accident o Travel o Twisting
o Lifting o Bending o No single known cause
o Other (Please specify):_____

Associated signs/symptoms:
o Numbness o Weakness o Pins/Needles
o Loss of bladder control o Loss of bowel control

When is your pain worse?:
o Morning o Evening o Present throughout the day

Improving factors:
o Nothing o Standing o Sitting o Walking
o Rest o Lying down o Exercise o Medications
oOther:_____

Aggravating factors:
o Nothing o Weather o Standing o Walking
o Lifting o Laying down o Sitting o Travel
o Coughing/Sneezing o Bending/Stooping
o Other (Please specify):_____

Previous therapy:
o TENS Unit/Trial o Medications o Chiropractic o Traction
o Injections o Physical Therapy o Surgery for your pain

Previous studies:
o MRI/XRay o Diskogram oCT Scan oEMG/NCV

Patient Name_____

DOB_____ Date_____

MEDICAL HISTORY

Asthma	o Yes	o No
COPD	o Yes	o No
Seizures	o Yes	o No
Stroke	o Yes	o No
CVA	o Yes	o No
TIA	o Yes	o No
Headaches	o Yes	o No
Renal Failure	o Yes	o No
High blood pressure	o Yes	o No
Congestive heart failure	o Yes	o No
Heart attack	o Yes	o No
Blood clots in the legs	o Yes	o No
Diabetes	o Yes	o No
Thyroid disorder	o Yes	o No
Cancer	o Yes	o No
Cirrhosis	o Yes	o No
Pancreatitis	o Yes	o No
Ulcers	o Yes	o No
Hepatitis	o Yes	o No
Arthritis	o Yes	o No
Fibromyalgia	o Yes	o No
Gout	o Yes	o No
Anxiety disorder	o Yes	o No
Depression	o Yes	o No
Panic attacks	o Yes	o No
Bipolar	o Yes	o No
Schizophrenia	o Yes	o No

If you answered yes to any of the 5 questions listed above, are you under a psychiatrist/psychologist's care? o Yes o No

Have you been in a motor vehicle accident? o Yes o No

o If yes, date of accident: _____

Have you been in a work related accident? o Yes o No

o If yes, date of accident: _____

PATIENT RESPONSIBILITY FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

PLEASE INITIAL ON ALL LINES AND SIGN LAST PAGE

Controlled substance medications (i.e. narcotics, tranquilizers, benzodiazepines, and barbiturates) are very useful but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function and/or ability to work. My physician has informed me of his expectations that are necessary for compliance.

Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following conditions (requirements):

Please initial each line below:

_____ 1. I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, misplaced, stolen, or if I "run out early", I understand that the medication will not be replaced.

_____ 2. My physician may require random laboratory tests for drug levels.

_____ a. I agree to comply with random urine, blood, or saliva tests to document the proper use of my medications as well as confirm my compliance.

_____ b. I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the state while taking the prescribed medications.

_____ 3. My physician may limit the number and frequency of refills. Requirement for refills of controlled substance medications:

_____ a. Will be made only during regular office hours, Monday through Thursday between the hours of 8:00 a.m. and 4:45 p.m. No refills will be made over the phone. Refill requests must be called into our main office at 903-593-1738, at least five to seven (5 to 7) days in advance; if this amount of notice is not given, there is NO guarantee of immediate refills.

_____ b. Will not be made if I "run out early", "lose a prescription", or "spill or misplace my medication." I am responsible for taking the medication in the dose prescribed. A police report is required for any stolen prescriptions.

_____ c. Will not be made as an "emergency" such as on Friday afternoon or after hours because I suddenly realize I will "run out tomorrow". I am responsible for keeping track of the amount of medication remaining.

_____ d. I will keep my medication follow up appointments or I understand that my medications will not be refilled.

_____ e. I nor anyone on my behalf will call more than once per day regarding prescription refills. Doing so will result in dismissal from the practice.

_____ 4. Only one physician will prescribe controlled substance pain medications.

_____ a. I have designated Robert M. Sutherland, MD as my provider to prescribe controlled substance pain medications.

_____ b. If any other physician or dentist believes I need controlled medications, such as pain medicine, it is my responsibility as the patient to notify Robert M. Sutherland, MD or Interventional Spine Associates staff of the prescription being prescribed.

_____ 5. Only one pharmacy will be used for prescriptions, unless otherwise arranged with the provider.

_____ a. I have designated_____pharmacy in_____ Texas as my local pharmacy.

_____ b. If at any time in the future I decide to change pharmacies, I will notify Robert M. Sutherland MD's office prior to changing.

_____6. Referral to a specialist. I understand that Robert M. Sutherland, MD may decide that it is necessary for me to see one or more specialists while I am taking pain medication. I understand that if I do not attend such appointments, my medication may be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), my medication will no longer be refilled.

I understand that drug therapy may be discontinued for the following reasons:

Initial Each	
	I understand that if I violate any of the above conditions, my prescription for controlled substance medications may be terminated immediately.
	I understand that if the violation involves obtaining controlled substances from another individual or physician, or is the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to all my physicians, medical facilities, and appropriate authorities.
	I understand that I must comply with the treatment plan as prescribed by my provider.
	I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.
	I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined and my treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances and that my provider will advise me of any advances in this field and will make treatment changes as needed.
	I have been fully informed by Robert M. Sutherland, MD or Interventional Spine Associates staff regarding psychological dependence (addiction) of controlled substance medication, necessitating a dose increase to achieve the desired effect. I know that there may be a risk of becoming physically dependent on this medication.
	I understand that it may be necessary to stop taking the medication. If so, I know that I must slowly decrease the dose while under medical supervision or I may have withdrawal symptoms.

I,_____, have read this contract and the same has been explained to me by Robert M. Sutherland, MD and/or Interventional Spine Associates staff. In addition, I fully understand the consequences of violating this agreement.

Patient Signature_____Date_____

Witness signature_____Date_____

Provider Signature_____Date_____

Robert M. Sutherland, M.D.

PLEASE FILL OUT ALL INFORMATION

NAME: FIRST_____MIDDLE_____LAST_____

ADDRESS: _____CITY_____STATE_____ZIP_____

DATE OF BIRTH (M/D/Y) _____SOCIAL SECURITY_____SEX: MALE/FEMALE (CIRCLE)

DRIVES LICENSE #_____OCCUPATION_____

HOME PHONE_____CELL_____WORK_____

EMAIL ADDRESS_____

EMPLOYER ADDRESS_____

NAME OF SPOUSE_____DATE OF BIRTH_____

DESCRIPTION OF PROBLEM

_____

_____

HAVE YOU HAD SIMILAR PROBLEMS BEFORE? YES / NO (CIRCLE) WHEN/HOW LONG? _____

IS THIS A RESULT OF A MOTOR VEHICLE ACCIDENT? YES / NO (CIRCLE)

IS THIS A RESULT OF ACCIDENT? YES / NO (CIRCLE)

DATE OF INJURY_____

PARTY REPONSIBLE FOR THE BILL (ONLY APPLICABLE IF OTHER THAN THE PATIENT)

LAST NAME_____FIRST NAME_____

MAILING ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____WORK PHONE_____

RELATIONSHIP TO PATIENT_____

PLEASE BRING INSURANCE CARDS TO APPOINTMENT

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY_____

POLICY #_____GROUP #_____

ADDRESS_____

POLICY HOLDER_____RELATIONSHIP TO PATIENT_____

MEDICARE #_____MEDICAID #_____

OTHER INSURANCE_____GROUP #_____

NAME OF INSURED_____GROUP #_____

NAME OF INSURANCE COMPANY_____

ADDRESS_____

HOW DID YOU HEAR ABOUT US?

- FRIEND/FAMILY
- NEWSPAPER
- WEBSITE
- OTHER

Robert M. Sutherland M.D.

ASSIGNMENT OF BENEFITS

I hereby authorize assignment and payment directly to Interventional Spine Associates, P.A. major medical benefits due me.

I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR WHICH ARE NOT COVERED BY INSURANCE. IF I HAVE MEDICARE, I AGREE TO PAY ANY DEDUCTIBLES AND CO-INSURANCE.

Signature:_____ Date:_____

Relationship to Patient:_____

700 Olympic Plaza, Suite 404 Tyler, TX 75701
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Fax: 903-596-7852

Robert M. Sutherland, M.D.

NOTICE TO PATIENTS

You may be referred to Texas Spine and Joint Hospital in which Interventional Spine Associates, P.A. physicians have a financial interest. Furthermore, as part of your treatment plan, the physicians may use drugs, devices (pedicle screws, manufactured by Allez Spine), or products in which they have a financial interest in the company, which manufactures or supplies such products. If you would like further information, please contact our office administrator.

_____ _____

Patient Name Date of Birth

_____ _____

Patient's Signature (or guardian, if minor) Date

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INTERVENTIONAL Spine ASSOCIATES

Robert M. Sutherland, M.D.

HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for an office procedure may require that your relevant protected health information be disclosed to the health plan to obtain approval for this visit

Healthcare Operations

We may use or disclose, as-needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, National Security, Workers' Compensation, Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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INTERVENTIONAL Spine ASSOCIATES
Robert M. Sutherland, M.D.

HIPAA Notice of Privacy Practices

Your Rights

The following is a statement of your rights with respect to your health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following record; psychotherapy notices; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complain. **We will not retaliate against you for filing a complaint.**

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Robert M. Sutherland, M.D.

FINANCIAL POLICY

Thank you for choosing Interventional Spine Associates, P.A., as your health care provider. We are committed to your treatment being successful. Please understand that payment for services is considered as a *part of your treatment.* The following is a statement of our Financial Policy, which we ask that you read, agree to, and sign prior to any treatment.

- All patients must complete the "Patient Information" form before seeing the doctor.
- The patient share of the cost of our services is due at the time of service.
- The adult accompanying a minor is the responsible party for payment of our services.

INSURANCE: Our physicians are providers for most major insurers including HMO's and PPO's. HMO insurers may require authorization from your primary doctor, prior to seeing a specialist. *You must get that insurance authorization prior to your appointment with us to receive maximum benefits.* We accept assignments for Medicare. Texas Workers' Compensation is gladly accepted when properly verified in advance of the appointment. We do not file on MVA/auto insurance, however in some instances we will accept an attorney "Letter of Protection".

COPAYS: Your co-pays and deductibles are due at the time of service.

USUAL & CUSTOMARY CHARGES: Our practice is committed to providing the best treatment possible for our patients. We charge what we believe to be the usual and customary fees for our area. You are responsible for paying the bill in full, regardless of your insurance company's interpretation of usual and customary rates.

PROCEDUREAL FINANCIAL ARRANGEMENTS: Many of the patients referred to Interventional Spine Associates, P.A. will require interventional pain management. If a procedure is indicated, we will pre-certify your procedure with your insurance carrier. We will also verify your insurance benefits, and get deductible and out-of-pocket status. From this information we can estimate the patient portion of the procedure. The patient portion of the procedure is ***collected prior to the procedure*** (unless prior arrangements are made with our financial counselor). Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand, and agree to the above stated financial policy.

_____ _____

Patient Signature or Responsible Party Date

Robert M. Sutherland, M.D.

Acknowledgement of the Notice of Privacy Practices

This office will not release any information other than those circumstances described above, unless disclosure is required by law, a court, a legal process, or governmental agencies.

Any complaints you may have pertaining to the security of your information should be directed to this office.

I have read the above notice and have had any questions answered by the staff of Interventional Spine Associates. I understand that by signing this form, I consent to the sharing of information state in this notice. My consent is freely given. I understand that I may revoke this consent at this time if the revocation is in writing, but any disclosures given prior are permissible.

_____ _____

Patients Signature (or guardian, if minor) Date

Robert M. Sutherland, M.D.

AUTHORIZATION FOR ACCESS OF CONFIDENTIAL INFORMATION

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY#: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness/psychological, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) and I authorize the release of all such records.

I authorize Interventional Spine Associates to release my protected health information to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

A photocopy of this authorization is as valid as the original. This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:

Patient's Name (printed): _____

Patient's Signature: _____

Date: _____

700 Olympic Plaza Suite 404 Tyler, TX 75701
Phone: 903-593-1738 • 866-622-7284
Fax: 903-593-7650 • 903-596-7852

Robert M. Sutherland, M.D.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness/psychological, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) and I authorize the release of all such records.

I authorize _____
to release the protected health information specified below to be released to:

Interventional Spine Associates, P.A.
Robert M. Sutherland, M.D.
700 Olympic Plaza Suite 404
Tyler, TX 75701

Information to be released:
□ Complete record
□ Records of care for the following dates: _____ to _____
□ Other (Please specify): _____

Purpose of disclosure:
□ Medical care □ Attorney □ Insurance □ Social Security/Disability
□ Other (Please specify): _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

A photocopy of this authorization is as valid as the original. This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:

Patients Signature: _____
Date: _____

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INTERNAL USE: PID: _____ Health Goal: _____

Wellness Intake Form

Name: _____ Date: _____ Age: _____

Address: _____ City: _____ State: ____ Zip: _____

Email Address: _____ Phone: _____ Date of Birth: ___/___/___

DIETARY INTAKE SUMMARY:

How many servings of fruit do you consume per day? _____

How many servings of vegetables do you consume per day? _____

How many servings of protein do you consume per day? _____

How many servings of bread/crackers/pasta do you consume daily? _____

Do you consume artificial sweeteners? __Yes __ No If yes, what brands? _____

Do you consume fast food? __ Yes __ If yes, what do you typically eat? _____

Do you eat breakfast? __ Yes __ No If no, what time is your first meal of the day? _____

Do you consume alcoholic beverages? __ Yes __ No If yes, how many per week? _____

Do you consume coffee? __ No __ Yes If yes, how many cups per day? _____

Do you consume dietary supplements? __ No __ Yes If yes, please list all of them below. Additionally, please bring them in so we can check for ingredients that are not healthful or may have contraindications with medications.

_____

Please indicate the areas of health that you want to improve:

____ Lose weight ___ More energy ___ Sleep better ___ Improve digestion

____ Improve blood work ___ Prevent problems ___ Anti-aging support ___ Improve general health

If you could improve ONE thing about your health, what is your priority?

_____

IDENTIFYING YOUR HEALTH GOALS:

To help our office understand your wellness goals and give you the type of care that you want, please use this chart to answer the questions below.

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
I have serious concerns about my overall health	I feel worried about my health	I have constant concerns that affect my health	I have health challenges that affect me on a daily basis	I have some minor complaints about my health	I feel okay about my health with no complaints	I feel good most days	I feel well on a daily basis	I feel energetic and healthy	I feel active, energetic and fit	I feel great and am proactive about my health

1. What number best describes how you feel about your health today? _____
2. What health goal do you want to achieve?: _____

NOTE: In our commitment to your health, our office provides our patients with access to a free online resource for education, science and wellness support. We will create your login ID and provide access information. Please indicate which free wellness classes you wish to be informed of:

__ Health Reality Check __ The Meaning of Essential Nutrients __ Creating Optimal Health __ Other _____

__ Customizing Your Health Plan __Healthy Age Management __ Genetics and Health __ Healthy Weight Loss

Opioid Risk Tool (ORT)

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

MARK EACH BOX THAT APPLIES	FEMALE	MALE
FAMILY HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 1	☐ 3
Illegal drugs	☐ 2	☐ 3
Rx drugs	☐ 4	☐ 4
PERSONAL HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 3	☐ 3
Illegal drugs	☐ 4	☐ 4
Rx drugs	☐ 5	☐ 5
AGE BETWEEN 16–45 YEARS	☐ 1	☐ 1
HISTORY OF PREADOLESCENT SEXUAL ABUSE	☐ 3	☐ 0
PSYCHOLOGIC DISEASE		
ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
SCORING TOTALS		

ADMINISTRATION

- On initial visit
- Prior to opioid therapy

SCORING (RISK)

0–3: low

4–7: moderate

≥8: high

INTERVENTIONAL Spine ASSOCIATES

RM-3A Sympathetic and Parasympathetic Autonomic Test
Cardiovascular and Neurological Health

Please check the appropriate answer for each of the following questions:

1. Do you have Diabetes? Yes ☐ No ☐
2. Do you now or have you ever smoked Tobacco/used a nicotine vaping device? Yes ☐ No ☐
3. Do you have high blood pressure, high Cholesterol, or heart disease? Yes ☐ No ☐
4. Do you ever have pain or numbness in your Fingers, toes, hands, feet, arms, or legs? Yes ☐ No ☐
5. Do you ever have pain in your legs when you Walk? Yes ☐ No ☐

If you answered yes to one or more of these questions, Dr. Sutherland recommends this preventive assessment. This is a test of nervous and vascular systems to help determine overall cardiac and sensory health.

_____ _____
Printed Patient Name (or legal guardian) Patient's DOB

_____ _____
Patient or legal guardian signature Today's Date

----------Office Use Only----------
Was test completed? Yes ☐ No ☐

Reason: _____