Jane Barnwell, MD

Specializing in Pain Management and Rehabilitation
Office address: 3100 N West St, Ste 200B, Flagstaff AZ 86001
Phone: 928-714-7090 • Fax: Flagstaff: 928-220-8879

Information for New Patients

About Dr. Barnwell

Dr. Jane has been practicing medicine since 1978. She obtained her medical degree from the prestigious Tulane University School of Medicine in New Orleans, Louisiana. Her residency in Physical Medicine and Rehabilitation (PM&R) was completed at Loma Linda University Medical Center at Loma Linda, California. She is board certified in Physical Medicine and Rehabilitation. She is a skilled diagnostician able to find and treat the root cause of a problem even after several other doctors have tried and not succeeded.

Her husband, Nelson Hochberg, runs the business side of the practice and assists Dr. Jane as her medical assistant. He is also a pilot, flight instructor and certified aircraft mechanic.

About the forms and initial visits

Dr. Barnwell is extremely thorough. This is one key to her success in diagnosing complicated problems. Please complete the included forms filling in all the blanks in the intake questionnaire. She will review the information, request any pertinent doctors' records and tests and be better prepared to evaluate your problem during your first visit.

Once we receive the forms, we will schedule two separate one hour appointments with you. The second appointment will be on a later day unless you are traveling a long distance to our office. If you have a complicated problem, the second appointment should be about a week after the first. During the first appointment, Dr. Jane will conduct an extensive evaluation of your problem. At the second appointment, she will discuss her findings and recommendations with you. We split the appointments for two reasons: Many pain and rehab patients cannot tolerate an intensive two hour appointment and this will give Dr. Jane the time necessary for her to review your information and records and obtain any necessary additional information.

Recommended dress for all visits

So that we don't have to have you wear one of those horrible backless gowns, please wear loose fitting clothes that will allow Dr. Jane to see and examine the problem areas. Loose fitting shorts are ideal. Sweatpants are fine if they are loose enough to allow access to the painful areas. Sleeveless tee shirts or tops are best. Short sleeve shirts are okay. If you are uncomfortable wearing these in public, you can bring them with you and change at our office.

Dr Barnwell's opioid policy.

Dr Barnwell only accepts patients who want to control their pain without opioids (narcotics) or who want help in reducing and stopping their current opioids usage. She will accept patients who are currently taking opioids but are committed to decreasing their use of opioids. She has chosen this style of practice because she has learned from 30 years of experience that opioids make it harder to control chronic pain.

Other important information about Dr Barnwell's opioid policy:

Instead of using just medications and procedures to dull the sensation of pain, Dr Barnwell takes the time to do a very thorough history and examination of your problem to find the cause of your pain and then educate you on how to manage the cause. This approach takes more time by Dr Barnwell and more patience and diligence on your part but can result in management of your pain without the side effects, costs and risks of medications and procedures. She may temporarily use medications and procedures but only to the extent that will support you in learning how to manage your pain.

Drug detection tests are performed before providing prescriptions for DEA controlled medications and periodically at the sole discretion of Dr Barnwell. All drug tests will be at your expense for any amount not covered by your insurance. Please be very careful to tell Dr Barnwell ALL the controlled medications that you are taking before the test. If you are not sure if a medication is controlled, ASK.

Opioids will temporarily be prescribed if necessary only if you are following her recommendations and only if you are showing objective improvement in your pain control. If you want to or need to control your pain by the use of opioid medications, we recommend that you find a physician whose practice more closely matches your needs. A list of pain management physicians in Northern Arizona can be found on our website at: www.barnwellmd.com/paindocs. (Being included on this list is not a referral and does not imply that a physician will prescribe opioids for you.)

I understand and voluntarily agree to these policies.

Check one box: (You need to select one to be accepted as a patient.)

☐ I am not using opioids and I wish to learn how to control my pain without opioids.

☐ I am using opioids and I want help to safely decrease and stop using opioids.

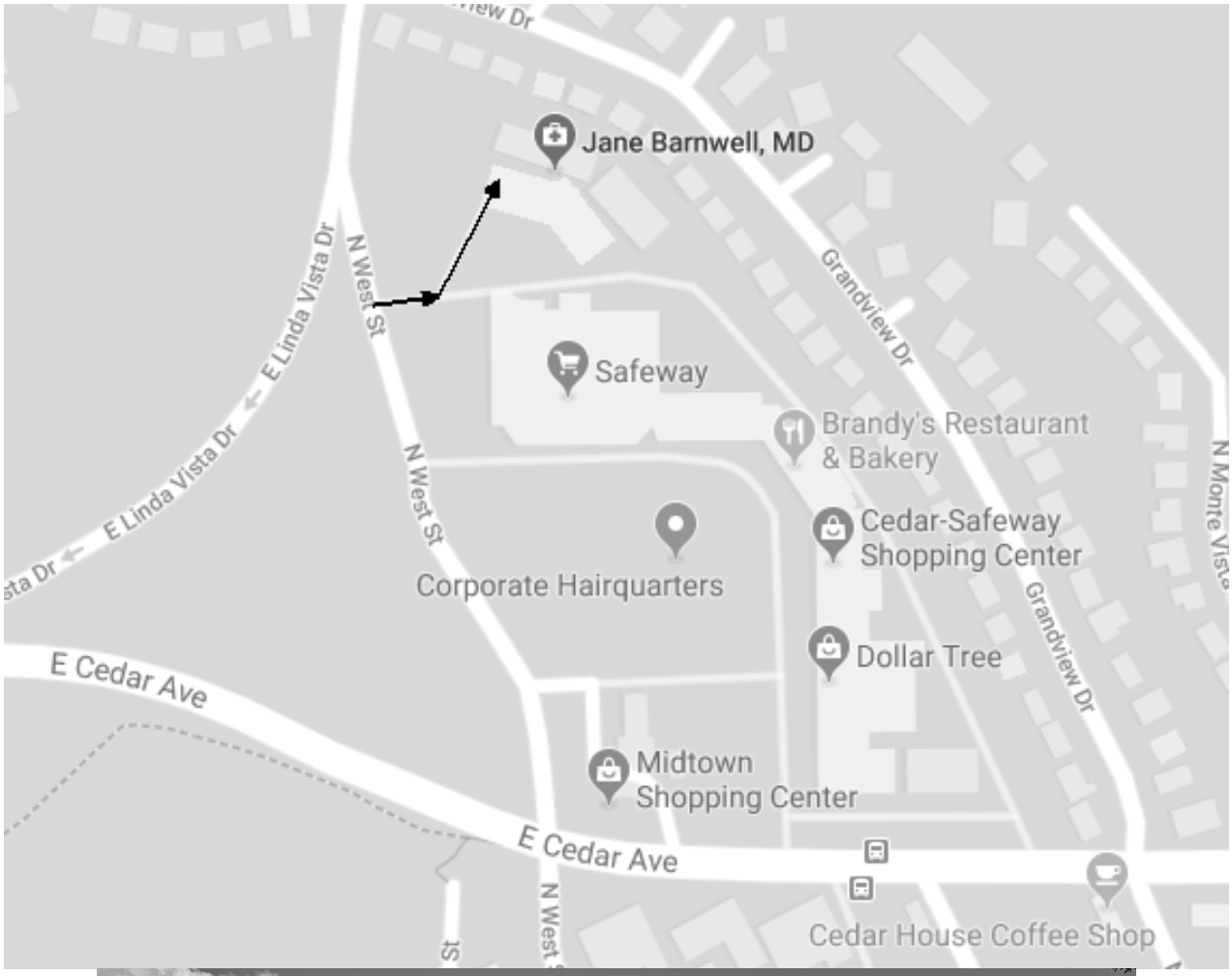
Name (print):_____

Signature: _____ Date: _____

Jane Barnwell, MD

Specializing in Pain Management and Rehabilitation
Office address: 3100 N West St, Ste 200B, Flagstaff AZ 86001
Phone: 928-714-7090 • Fax: Flagstaff: 928-220-8879

Map to Office



KEEP THIS PAGE FOR YOUR REFERENCE

Jane O. Barnwell, M.D.,
Physical Medicine and Rehabilitation
3100 N West St, Ste 200B
Flagstaff Arizona 86001
928-714-7090

Patient Profile

Please fill in all the blanks

Last name	First name	Nickname or preferred name	Mid. Initial
Address		If work related, date of injury:	
City		State	Zip
Phone: Home ❒ I prefer this contact	Work ❒ I prefer this contact	Cell ❒ I prefer this contact	
Email* ❒ I prefer this contact		Create a password for secure email:*	

***Federal laws prohibit us sending health information via normal email as it is not secure. Please create a password we can use to send info to you securely.**

❒female ❒male	❒single ❒partnered ❒divorced ❒married ❒widowed	Date of birth	Social security number
Your occupation:	Spouse's/partner's name:	Should we share your medical information and records with your spouse/partner? ❒yes ❒no	
Referring doctor:	Problem(s) you are seeing Dr for:		
Preferred pharmacy: Name:	City:	Location: (if more than one in city)	
Other doctors/attorneys to send records to (name & address):			
Emergency contact name:	Relationship	Phone #	
Nearest relative not living with you name:	Relationship	Phone #	Address

Employer's name	Phone number
Address	
City / State / Zip	

Person responsible for bill (not your insurance company)	Relationship
Address	
City / State / Zip	
Phone: Home	Work / Cell

Primary insurance company name			Insurance phone number
Address, City State Zip			
Policy holder name	Soc Sec No	DOB	Relationship
Policy or Claim number	Group name & number		Copay for specialist

Secondary insurance company name			Insurance phone number
Address, City State Zip			
Policy holder name	Soc Sec No	DOB	Relationship
Policy or Claim number	Group name & number		Copay for specialist

BE SURE TO READ AND SIGN THE POLICY AGREEMENT ON THE NEXT PAGE.

General Policies

We specialize in the management of pain, occupational injuries and rehabilitation. To handle other medical problems you may have, you should have a primary care physician. We are not available after hours or on weekends. If you have an emergency after hours, you should contact your primary care physician, an extended hours clinic or the hospital emergency room.

Payment Policies

1. If you have insurance in which we participate, you will be expected to pay the copay, deductible or percentage you owe as contracted with your insurance company at the time of service.
2. When you pay the total bill at the time of service, we'll give you a 25% discount. Any payments from your insurance company to us will be immediately reimbursed to you.
3. You may set up a payment plan with us of the higher of $50.00 or 10% of your bill each month debited directly from your account. To initiate this payment plan, request a debit authorization form from our office.
4. If you have not made other prior payment arrangements with our office, we will send you a monthly statement. The total amount is due 10 days after we send the statement to you.

Please understand that whether you have insurance or not and whether we participate in your insurance program or not, you are responsible for payment of the fees for medical services provided. Checks or debits returned unpaid will be charged $25.00. Overdue accounts will be charged 2% (24% APR) for each month they are overdue. Amounts three months overdue will be filed with the appropriate court at which time the court filing and notification fees will be added to your bill. Each time that we need to go to court to collect moneys owed us, we will add $50.00 to your bill to cover the internal office collection costs. You are also responsible for other costs to us in collecting the fees you owe our office including but not limited to reasonable attorney and billing service fees and court costs.

When you make an appointment with our office, we reserve that time for you. We require 24 hours notice or by noon Friday for Monday appointments if you have to cancel or reschedule. If you do not give us timely notice or do not show up, you will be charged $50.00 for follow up appointments and $150.00 for initial appointments. If we are able to fill the cancelled appointment, we will not charge you. If you have an emergency and need to cancel with less than the required notice, call us as soon as you can to cancel and we may be able to waive or reduce the charge.

Privacy Policies

We keep records of the health care services we provide you. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your records, obtain a copy of them or get more information about them by contacting our Office Manager or General Manager. You may also add your own statement(s) into your records if you feel something is incorrect. We keep your medical information strictly confidential; however for your convenience and medical care, we have general policies to share your medical information with the following people: We will share your medical information with your spouse or partner, the doctors, attorneys and insurance companies listed on the front of this profile, your pharmacy and with other health care providers currently providing you care. We will leave messages for you to call our office, that prescriptions have been sent to your pharmacy or the date and time of your appointment on your home answering machine, with anyone that answers your home phone or to your personal email address. We will leave messages for you to call our office with anyone that answers your work phone. All other communications to anyone else of your medical information will require your direct approval. This is a short summary of our privacy policies. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. The Notice of Privacy Practices is posted in the reception area at our office and on our website at www.barnwellmd.com/privacy. You may also call our office to have us send you a copy. We will attempt to contact you twice to give you non critical infomation. You agree to these policies unless you direct us otherwise in writing.

Record Release Policies

From time to time, we need to share portions of your records with third party payers to receive payment for your medical services. We also need to share portions of your records with services we contract with and agencies to help us with our billing. You authorize us to release your personal and medical information necessary to process payment of your bill.

If we refer you to another doctor or order tests and x-rays or you choose to see another doctor, the other office will need to see your medical records. We also need to request medical records from other offices. You authorize release of your medical information as necessary for continuation of your medical care.

We use facsimile or mail to transmit patient records. We are extremely careful to ensure that the facsimile or mail goes to the right person and we only send facsimile of patient records to offices that are used to handling confidential patient records. However, it is possible that a mistake can be made. You agree to hold us harmless if such a mistake is made.

I understand and agree to the fee schedule, and policies above.

Signature _____ Date _____

Intake Questionnaire

Please fill in all blocks. The more complete the information, the more likely Dr. Barnwell will be able to help you.

Last name	First name	M.I.	Date

DOB	❒Left ❒Right handed	❒Male ❒Female	Referring provider	Primary care provider

***Federal laws prohibit us sending health information via normal email. Please create a password we can use to send info to you securely.**

Phone number	Email * address	Create a password for secure email:*	Preferred contact method: ❒Phone ❒Secure email

Describe the reason for your visit:
Be as specific as you can.

What date did the problem start? Did it start ❒Gradually ❒Suddenly ❒Not Sure

How did it start? ❒Auto accident ❒Work injury ❒Other accident/injury ❒After infection, illness or operation ❒Not known ❒Other:

Explain the cause of the problem:

On a scale from 0 to 10 indicate the level you are feeling **right now**:

Pain level: 0 = No pain _____ 10 = The worst pain imaginable (uncontrolled screaming)
Fatigue: 0 = Unlimited energy _____ 10 = Completely exhausted (unable to lift your head)
Ability to do daily activities: 0 = Fully functional _____ 10 = Unable to function (unable to arise from your bed)

If you have pain, please answer the following questions:

Where is your worst pain?
(which pain you want to deal with first)

Does it travel or radiate anywhere else? ❒No ❒Yes: Where:

Does the pain intensity change during the day or from day to day? ❒No ❒Yes: Describe when it is the worst:

Is the pain ❒Getting worse ❒Getting Better ❒Staying the same

What makes the pain better? ❒Lying down ❒Sitting ❒Standing ❒Walking ❒Changing position ❒Stretching ❒Hot pack ❒Cold pack ❒Brace ❒Distractions (Movies, TV, chatting, etc) ❒Medications What helps the most?:

What makes the pain worse? ❒Lying down ❒Sitting ❒Standing ❒Walking ❒Changing position ❒Stretching ❒Hot pack ❒Cold pack ❒Brace ❒Work ❒Stress ❒Other:

Are there any other areas of pain?
❒No ❒Yes: Where:

Do you believe you must use opioids to control your pain? ❒Yes ❒No Are you willing to try other pain control methods? ❒Yes ❒No

What do you think will help you get better? ❒Better understanding of the causes ❒Exercise ❒Yoga ❒Meditation ❒Biofeedback ❒Stress management ❒Physical Therapy ❒Medication (pills) ❒Surgery ❒Other:

What **tests** have been done to evaluate your problem? PLEASE LIST ALL (Blood tests, X-rays, MRIs, CTs, EMGs, etc.)

When?	What test?	What was found?	What facility?

Who have you seen for this problem? PLEASE LIST ALL (Physicians, chiropractors, naturopaths, PT, message therapists, acupuncturists, etc.)

When?	Full name	City, State (if not Flag)	What was done?	Helped?

List any surgeries you have had:	When	What	When	What	When	What

Do you have trouble sleeping? ❒no ❒yes: when did it start:

While sleeping, do you ❒snore loudly ❒gasp ❒don't know

Do you feel refreshed after sleep? ❒always ❒usually ❒rarely ❒never

What keeps you from sleeping well? ❒can't stop thinking ❒pain ❒worry ❒restless limbs ❒day/night rhythm out of whack ❒other:

How long can you: Sit in an office chair? _____Minutes Stand? _____Minutes Walk? _____ Minutes or _____miles or _____feet

Alcohol: ❒day ❒year
If 0, write 0 _____# drinks per ❒month

Caffeine # / day: _____Coffee _____Tea _____Soda _____Chocolate

Tobacco # / day: ____cigarettes ____packs ____cigars ____cans of chew _____pipe bowls

Recreational drugs you are using: ❒Marijuana ❒Cocaine ❒PCP ❒ Heroin ❒Amphetamines ❒Ecstasy ❒None

Work, school, **unemployment, disability or retirement**.

Now	Since:	# hours / week	❒school ❒unemp ❒disabled ❒retired	Description:
Before above	Since:	# hours / week	❒school ❒unemp ❒disabled ❒retired	Description:

Medical History: Check ☒ all active or recurring medical problems **that have been diagnosed by a health care provider**:

Head:
❑Headache
❑Migraine
❑Head injury
❑TMJ
❑Facial pain

Eyes:
❑Cataracts
❑Glaucoma

Heart/vascular:
❑High blood pressure
❑Heart attack
❑Congestive heart failure
❑Mitral valve prolapse
❑Blood clots
❑Atrial fibrillation

Lungs/breathing:
❑Asthma
❑Bronchitis
❑COPD
❑Emphysema
❑Sleep apnea
❑Tuberculosis

GI/abdominal:
❑Ulcers
❑GERDS
❑Hiatal hernia
❑Crohn's disease
❑Gallbladder disease
❑Hepatitis ❒A ❒B ❒C

Skin:
❑Eczema
❑Psoriasis

Kidneys/bladder:
❑Kidney stones
❑Kidney disease/failure
❑Bladder infections
❑Prostate hypertrophy

Endocrine:
❑Diabetes type 1
❑Diabetes type 2
❑Hyperthyroidism
❑Hypothyroidism

Rheumatologic:
❑Osteoarthritis
❑Rheumatoid arthritis
❑Gout
❑Osteoporosis/osteopenia
❑Fibromyalgia
❑Chronic fatigue synd.

Neurologic:
❑Stroke
❑TIA
❑Parkinson's disease
❑Epilepsy
❑Neuropathy
❑Shingles
❑Postherpetic neuralgia

Cancer:
❑Skin
❑Lung
❑Breast
❑Prostate
❑Colorectal
❑Other:

Psychiatric:
❑Depression
❑Anxiety
❑PTSD
❑Schizophrenia
❑Dementia
❑Bipolar

Addiction:
❑Alcohol
❑Tobacco
❑Prescribed drugs
❑Recreational drugs

Immune diseases:
❑HIV / AIDS

Other:

Symptom Review: Check ☒ all current or recent symptoms:

Constitutional:
❑Unplanned weight loss
❑Unplanned weight gain
❑Recurrent fever
❑Night sweats

Skin:
❑Dry skin
❑Rashes
❑Itching
❑Changes in hair or nails

Blood/lymph systems:
❑Swollen/tender glands
❑Anemia
❑Easy bruising/bleeding, not on blood thinners

Eyes/ears/nose/mouth:
❑Vision loss
❑Double vision
❑Blurred vision
❑Hard of hearing
❑Earaches
❑Vertigo
❑Ringing in ears
❑Nosebleeds
❑Nasal discharge
❑Sinusitis
❑Dentures
❑Bleeding gums
❑Dry mouth
❑Trouble swallowing

Lungs:
❑Cough
❑Wheezing

Cardiovascular:
❑Swelling of feet
❑Chest pain
❑Cold hands/feet
❑Palpitations
❑Shortness of breath when walking
❑Varicose veins

Bladder:
❑Frequent urination
❑Painful urination
❑Loss of bladder control

Gastrointestinal:
❑Loss of appetite
❑Indigestion or nausea
❑Vomiting
❑Diarrhea
❑Constipation
❑Abdominal bloating/gas
❑Heartburn
❑Abdominal pain

Endocrine:
❑Excessive thirst
❑Heat intolerance
❑Cold intolerance

Musculoskeletal:
❑Muscle cramps
❑Stiff joints
❑Swelling of joints

Sexual:
❑Sexual problems
❑Sexual abuse as a child

Neurologic/Psychiatric:
❑Fainting
❑Dizzy spells
❑Tremors
❑Confusion
❑Concentration problems
❑Memory problems
❑Stress ❒high ❒med ❒low

Family Medical History: Include your siblings (brothers and sisters)

Relation	Age if living	Age at death	Major problems	Cause of death
Father				
Mother				
Sibs:				

What causes your stress?

What exercise do you do **now**?

How long ago did you last exercise? ❒0-3 days ❒4-7 days ❒1-3 weeks ❒4+ weeks

Answer the questions below using this scale: 0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

How often do you have mood swings? ❒0 ❒1 ❒2 ❒3 ❒4

How often do you smoke a cigarette within an hour after you wake up? ❒0 ❒1 ❒2 ❒3 ❒4

How often have you taken medication other than the way that it was prescribed? ❒0 ❒1 ❒2 ❒3 ❒4

How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? ❒0 ❒1 ❒2 ❒3 ❒4

How often, in your lifetime, have you had legal problems or been arrested? ❒0 ❒1 ❒2 ❒3 ❒4

Are you involved in a lawsuit? ❒no ❒yes: Describe:

List any allergies and sensitivities you have

Allergen	What happens

List **all** the medications, vitamins and supplements you are **currently** taking.

Name of product	Dosage milligram / pill	Frequency times / day	Date started	What is it for?

List **all** the medications, vitamins and supplements you **were** taking but **have stopped** taking for pain, fatigue or related problems.

Name of product	Dosage milligram / pill	Frequency times / day	Date started	Date stopped	Why did you stop using it?

Using the diagrams on the right, draw the location of your pain using the symbols below. If the pain refers or travels from one area to another area, draw an arrow from where it starts to where it goes.

X Burning
~~ Numbness
O Aching
• • Pins and needles
✳ Stabbing