Patient Information

Patient name: ___________________________________ DOB: __________________ Male / Female

Address: ________________________________ Apt: ____ City: ____________ State: _____ Zip: ______

Home Phone: __________________ Cell Phone: ___________________ Work Phone:________________

Social Security #: _______________________________________ Driver's Lic # ______________________

Email: ____Survey/Feedback

Employer: ____________________________________ Business Phone ____________________________

Primary Care Physician: ________________________ Business Phone ____________________________

Emergency Contact:

Name: ____________________ Relationship:_______________ Phone #: ____________________________

We should send reports to:
Physician: ___________________________ Address: ____
Telephone: ( ) ______________________ ____

Lawyer: _____________________________ Address: ____
Telephone: ( ) ______________________ ____

Case Manager: ________________________ Address: ____
Telephone: ( ) ______________________ ____

Please list any family members or other who may be involved in coordinating your care or payment for care. Also, indicate what type of information may be shared with each individual.

Name	Relation to Patient	All	Appointments/ Scheduling	Medical	Billing

Patient Signature: ____ Date: ______________

Patient Financial Policy

This document is designed to provide you with information regarding your responsibility in the billing process.

As the patient you are ultimately financially responsible for the medical services you receive. You are responsible to furnish us with accurate and up to date insurance information. In addition, it is your responsibility to know your insurance benefits, including coverage for office visits and surgery if applicable.

You are responsible for co-pays, co-insurance as well as deductible which are due at the time of service. Checks

returned by the bank for any reason will be assessed an additional bank fee. Any payments received after this point must be paid by cash, money order or credit card.

As part of our continued effort to provide you with the best care and accommodate call appointment requests, we have implemented a cancellation policy. If you fail to cancel your appointment at least **24hrs ahead** or fail to show for your scheduled appointment, you will be charged a "**NO SHOW**" fee. The fee is ***$25*** for established or new patients. If you need to change or reschedule your appointment, please call the office for which you were scheduled.

I hereby authorize **Pain Medicine Associates, Inc** to furnish all information to my insurance carrier concerning this illness and hereby assign **Pain Medicine Associates, Inc** all payment for medical services rendered. I understand I am responsible of notifying **Pain Medicine Associates, Inc** if there are any changes in any information. I understand that **Pain Medicine Associates, Inc** does not accept Liens.

Signature____ Date __________________

Notice of Privacy Practices Acknowledgement

I understand that, under the **Health Insurance Portability and Accountability Act of 1996** ("**HIPAA**"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved on that treatment directly and indirectly.
Obtain payment from third party payers
Conduct normal healthcare operations such as quality assessments and physician certificates

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare options. I also understand you are not required to agree to my requested restrictions, but if you so agree then you are bound to abide by such restrictions.

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signature: ____________________________________ Date: ________________________

Pain Medicine Associates

Narcotic Agreement

Opioids (narcotics) are used for the treatment of moderate to severe pain. Our goal is to relieve distressing pain, with minimal rug side effects, with improved quality of life. It is our job to continually re-evaluate your pain experience and respond to unrelieved pain.

I, ______________________, understand that compliance with the following guidelines is important to the continuation of pain treatment by **Pain Medicine Associates, Inc.**

1. **No** other pain medications are to be taken unless discussed first with a provider at **Pain Medicine Associates, Inc**. _________initials

2. **No** increase in medication will be made without the approval of **Pain Medicine Associates, Inc**. _________initials
3. I will not request opioids or any other medicine from prescribers other than from **Pain Medicine Associates, Inc**. _________initials

4. I consent to random drug testing. _________initials
5. I will keep my schedule appointments and/or cancel my appointment a minimum of 24-hours to my scheduled appointment. _________initials
6. I understand that the reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program. _________initials
7. I realize that all the medications have potential side effects and I will have the recommended laboratory studies required to keep the regimen as safe as possible. _________initials
8. I realize that it is my responsibility to keep myself and other from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used any medication for at least four days. _________initials
9. I will not use any illegal controlled substance, including marijuana, cocaine, etc. _________initials
10. I will not share, sell, or trade my medication for money, goods, or services. _________initials
11. I understand and acknowledge that I will not consume any alcohol beverages while on narcotic medications. _________initials
12. I understand that any need for medication adjustments or changes, will require scheduling an appointment in the office. _________initials
13. I will not attempt to get my pain medication from any other health care provider without telling them that I am taking pain medication prescribed by the Doctor. I understand it is against the law to do so, if my primary care provider is willing to prescribe my medication, the Doctor will have to approve the arrangement to make sure there is no duplication. _________initials
14. I will safeguard my medication from loss or theft and agree that the consequences of my failure to do is that I will be without my prescribed medication for a period of time. _________initials

15. I agree to use _______________ Pharmacy, located at ______________, telephone number

    __________, for all my pain medication. If I change pharmacies for any reason, I agree to notify the Doctor at the time I receive a prescription, and advise my new pharmacy of any prior pharmacy's address and telephone number. _________initials

16. I agree to waive any applicable privilege or right of privacy of confidentiality with respect to the prescribing of my pain medication. I authorize the Doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the California Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication, I authorize the Doctor to provide a copy of this agreement to the pharmacy. _________initials
17. I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in me being without medication for a period of time. _________initials
18. I understand that my pain treatment may be stopped if any of the following occur: _________initials
    a. If the practitioner feels that opioids are not effective for my pain or my functional activity is not improved.
    b. I give, sell, or misuse the drug.
    c. I develop rapid tolerance or loss of effect from this treatment.
    d. I develop side effects that are significant in the view of the practitioners.
    e. I obtain opioids from sources other than Pain Medicine Associates, Inc.
19. If we choose to discontinue your opioids, we will generally lower the dose slowly over several days. _________initials
20. I understand medications will be refilled in a timely manner as long as the pharmacy or patient calls us at least **72 hours BEFORE** you run out of your medication. Weekends and after hour refills will not be filled on a routine basis under any circumstances. _________initials
21. I understand that if I have any questions or concerns regarding my pain treatment that I will call **Pain Medicine Associates, Inc.**, Monday through Friday, from 9:00am – 4:30pm. _________initials

Doctor and Patient agree that this Agreement is essential to the Doctor's ability to treat the patient's pain effectively and that failure of the patient to abide by the terms of this Agreement may results in the withdrawal of all prescribed medication by the Doctor and the termination of the Doctor/Patient relationship.

This agreement was signed on ____.

Patient Signature: ____ Date: ____________________

Physician's Signature: ____ Date: ____________________

Counseling Patients on Overdose Risk and Response

Empirical evidence has shown that lay persons can be trained to recognize the signs of an opiate overdose and to safely administer naloxone, an opiate antagonist, programs that have trained lay persons in naloxone administration have reported more than 10,000 overdose reversals.

It is important to educate patients and family/caregivers about the danger signs of the respiratory depression, everyone in the household should know to summon medical help immediately if a person demonstrates any of the following signs while on opioids:

Snoring heavily and cannot be awakened
Periods of ataxic (irregular) or other sleep-disordered breathing
Having trouble breathing
Exhibiting extreme drowsiness and slow breathing
Having slow, shallow breathing with little chest movement or no breathing
Having an increased or decreased heartbeat
Feeling faint, very dizzy, confused or has heart palpitations
Blue skin/lips
Non-responsive to painful stimulation

Please note: All patients must sign this form even if no opioid medication is needed or desired currently. This is for your understanding only. Furthermore, in case of emergency or surgery this allows us to be your primary pain medication prescriber.

________________________ ______________________________ __________

Patient Name Signature Date

COMPREHENSIVE
PAIN MEDICINE ASSOCIATES, INC.
QUESTIONNAIRE

Today's Date:_____/______/______

Your Name:____

Personal History

Primary Care Physician: ______________________________ Phone number: ______________________

Is your condition job related? YES [ ] NO [ ] Last day on the job: ___/___/___
Currently Employed? YES [ ] NO [ ] Current Job: _______________ Part Time [ ] Full Time [ ]

Are you Workman's Compensation? YES [ ] NO [ ] Are you in litigation (lawsuit) ? YES [ ] NO [ ]

Last grade you finished in school? ____

List types of jobs in the past: ____

What diseases run in your family? List family member & relation

_______________________ _______________________ _______________________ ____________

_______________________ _______________________ _______________________ ____________

Ages and Health of Children: _______________________ _______________________ ____________

____________________ ____________________ ____________________ _________________

Is there anyone disabled among your family or friends? ____

How many people in your household? ___________ Who are they?

_____________________________ _____________________________ ________________________

____

__________________________ _______

Do you smoke? [ ] Yes [ ] No How much? ¼ pk ½ pk 1pk 2pks

Were you a smoker? [ ] Yes [ ] No When Quit? _________________________________

Do you ever drink alcohol? [ ] Yes [ ] No How much? _________ What Kind?

Have you had a drink in the past 24 hours? [ ] Yes [ ] No

Ever had a problem related to alcohol? [ ] Yes [ ]No Date Quit? __________________

Have you had any of the following due to alcohol/drugs ?

AA [ ] Yes [ ] No Injury [ ] Yes [ ] No

DUI [ ] Yes [ ] No Break- Up [ ] Yes [ ] No

Recreational Drugs? Please circle below Currently taking ? Y/N Past? Y/N

Marijuana Cocaine Meth Heroin Methadone Other: _________________

Have you ever had drug abuse treatment? Suboxone Inpatient Outpatient

Do you drink coffee, tea, or cola? [ ] Yes [ ] No Cups per day? __________

PSYCHIATRY

Any anxiety or depression?	Yes	No
Bipolar Disorder?	Yes	No
Schizophrenia?	Yes	No
Borderline P.D?	Yes	No
Any formal inpatient psych hospital relations?	Yes	No
Do you have a psychologist / psychiatrist?	Yes	No

If so, please name: ______________________

What medication/doses are you currently taking:

Name: How many:

______________________ ______________________

______________________ ______________________

______________________ ______________________

How did your pain First start:

[ ] Lifting	[ ] Twisting	[ ] Suddenly	[ ] Gradually
[ ] Fall	[ ] Bending	[ ] While Exercising	[ ] Auto Accident
[ ] Injured at work	[ ] Pulling	[ ] Sports	[ ] Hit from behind
[ ] No Apparent Cause	[ ] Other: ____________________		

C.C. Describe the purpose of your visit and the major problems needing help:

____

____

When did this pain start? Date: ____/____/____

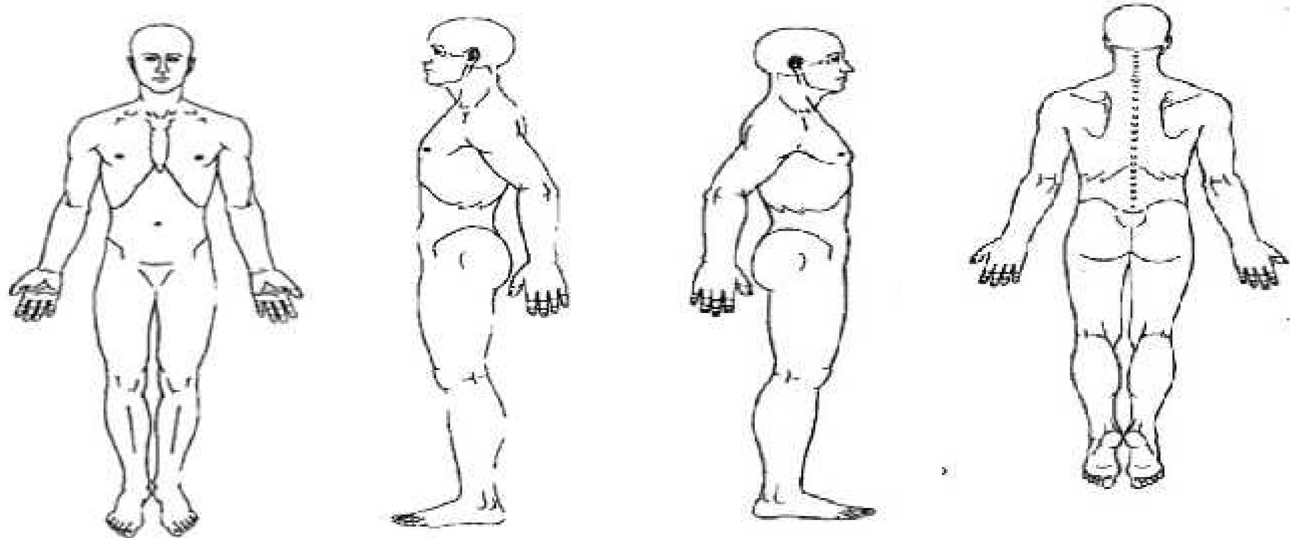
Is your pain intermittent or constant? _______________________________________

How long does severe pain last? Seconds ___ Minutes ___ Hours ___

How many hours per day do you have pain? ___________________________________

In the past, did you ever have similar pain? ____________ Date ________________________

Where is your pain? Where does it spread to? Please shade where your pain is located



Check all that applies to describing your pain
If category does not describe your pain please leave blank.

[ ] Flickering
[ ] Quivering
[ ] Pulsing
[ ]Throbbing
[ ] Beating
[ ] Pounding

[ ] Jumping
[ ] Flashing
[ ] Shooting

[ ] Pricking
[ ] Boring
[ ] Drilling
[ ] Stabbing
[ ] Lancinating

[ ] Sharp
[ ] Cutting
[ ] Lacerating

[ ] Pinching
[ ] Pressing
[ ] Gnawing
[ ] Cramping
[ ] Crushing

[ ] Tugging
[ ] Pulling
[ ] Wrenching

[ ] Hot
[ ] Burning
[ ] Scalding
[ ] Searing

[ ] Tingling
[ ] Itchy
[ ] Smarting
[ ] Stinging

[ ] Dull
[ ] Sore
[ ] Hurting
[ ] Aching
[ ] Heavy

[ ]Tender
[ ] Taut
[ ] Rasping
[ ] Splitting

[ ] Tiring
[ ] Exhausting

[ ] Sickening
[ ] Suffocating

[ ] Fearful
[ ] Frightful
[ ] Terrifying

[ ] Punishing
[ ] Grueling
[ ] Cruel
[ ] Vicious
[ ] Killing

[ ] Wretched
[ ] Blinding

[ ] Annoying
[ ] Troublesome
[ ] Miserable
[ ] Intense
[ ] Unbearable

[ ] Spreading
[ ] Radiating
[ ] Penetrating
[ ] Piercing

[ ] Tight
[ ] Numb
[ ] Drawing
[ ] Squeezing
[ ] Tearing

[ ] Cool
[ ] Cold
[ ] Freezing

[ ] Nagging
[ ] Nauseating
[ ] Agonizing
[ ] Dreadful
[ ] Torturing

Name: ______________________________________

What Makes Your Pain *Less*?

[ ] Lying down
[ ] Sitting
[ ] Standing
[ ] Walking
[ ] Aspirin
[ ] Heat
[ ] Nothing
[ ] Physical therapy
[ ] Alcohol
[ ] Pain pills
[ ] Injections
[ ] Exercise
[ ] Ice
[ ] Advil-type pills
[ ] Other: ________________________

What Makes Your Pain *Worse*?

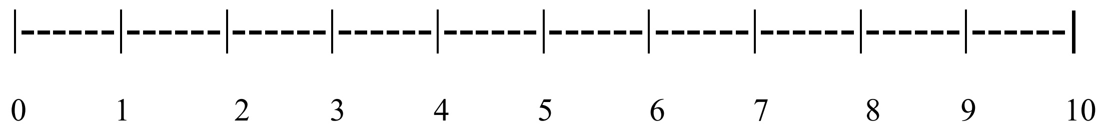
[ ] During exercise
[ ] Sitting
[ ] Walking
[ ] Stress
[ ] Sex
[ ] After exercise
[ ] Standing
[ ] Damp weather
[ ] Bending forward
[ ] Bending backward

[ ] Morning
[ ] Night
[ ] Fatigue
[ ] Cold Weather
[ ] Coughing
[ ] Sneezing
[ ] Touching skin
[ ] Work
[ ] Other: ___________________________

Pain Level: Please mark this line with the intensity of your pain using all the following letters:

L = least it gets　　P = present pain
M = most of the time　　W = worst it gets

No pain　　Suicidal pain



0　1　2　3　4　5　6　7　8　9　10

Pain Treatments Tried?	Did It Help?		
[ ] Surgery	[ ] Yes	[ ] No	please specify:
[ ] Medications	[ ] Yes	[ ] No	please specify:_________________
[ ] Physical Therapy	[ ] Yes	[ ] No	
[ ] Trigger Point Injections	[ ] Yes	[ ] No	
[ ] Acupuncture	[ ] Yes	[ ] No	
[ ] Epidural Injections	[ ] Yes	[ ] No	please specify:_________________
[ ] TENS (electronic nerve stimulation)	[ ] Yes	[ ] No	
[ ] Psychology Counseling	[ ] Yes	[ ] No	
[ ] Biofeedback/Relaxation Techniques	[ ] Yes	[ ] No	
[ ] Group Therapies	[ ] Yes	[ ] No	please specify:_________________
[ ] Pain Management Program	[ ] Yes	[ ] No	please specify:
[ ] Nerve Blocks	[ ] Yes	[ ] No	please specify:_________________

[ ] Other ____

Allergies to Medications	Reactions:
_____________________	Hives Swelling Nausea Drowsy Hallucinations Dry Mouth Other:________
_____________________	Hives Swelling Nausea Drowsy Hallucinations Dry Mouth Other:________
_____________________	Hives Swelling Nausea Drowsy Hallucinations Dry Mouth Other:________
_____________________	Hives Swelling Nausea Drowsy Hallucinations Dry Mouth Other:________

Pain medication that you take <u>NOW</u>: (Please bring in all medication bottles ex. Blood thinner, blood pressure, diabetes)

Name	How many times a day	Date Started
______________________	______________________	______________
______________________	______________________	______________
______________________	______________________	______________
______________________	______________________	______________
______________________	______________________	______________
______________________	______________________	______________
______________________	______________________	______________
______________________	______________________	______________
______________________	______________________	______________
______________________	______________________	______________

<u>Pain Medicines that you tried in the past:</u>

Name(s)	Side Effects/Problems:
______________________	__________________________
______________________	__________________________
______________________	__________________________
______________________	__________________________

<u>FC</u>

What You Can Do Now:

[ ] Drive	[ ] Walk 1 Block	[ ] Exercise
[ ] Housework	[ ] Climb stairs	[ ] Buy Groceries/Shop
[ ] Work at a job	[ ] Life items above head	[ ] Bend Over

<u>PMH</u> General Medical Problems:

a. cancer history	[ ]	i. stomach, ulcer, intestines	[ ]
b. heart disease	[ ]	j. diabetes	[ ]
c. lungs, asthma	[ ]	k. arthritis	[ ]
d. liver, hepatitis	[ ]	l. migraine	[ ]
e. bleeding disorder	[ ]	m. shingles	[ ]
f. epilepsy (seizures)	[ ]	n. other: _______________	[ ]
g. high blood pressure	[ ]	o. other: _______________	[ ]
h. HIV status (+) or (unknown)			

<u>HOSPITALIZATIONS</u> (surgeries, prolonged hosp.)

Year	Name of Hospital/Address	Problem and Treatment
________	__________________________	__________________________
________	__________________________	__________________________
________	__________________________	__________________________

RESPIRATORY

Do you have any breathing problems?	Yes	No
Do you get repeated chest infections?	Yes	No
Do you have sleep apnea?	Yes	No
Have you coughed up blood?	Yes	No
Have you had pneumonia or pleurisy?	Yes	No
Do you suffer from any respiratory diseases?	Yes	No

CARDIOVASCOLAR

Have you bad heart trouble?	Yes	No
Have you ever had high blood pressure?	Yes	No
Do you have pains in the heart or chest?	Yes	No
Do you easily become short of breath?	Yes	No
Are your ankles often swollen?	Yes	No
Do leg pains ever stop you from walking?	Yes	No
Have you had phlebitis or vein trouble?	Yes	No
Do you have a bleeding problem?	Yes	No

G.I./G.U

Do you have any swallowing problems?	Yes	No
Have you had a weight loss or gain of more than 10 pounds in the past year?	Yes	No
Do you have any trouble with nausea, vomiting or abdominal pain?	Yes	No
Have you ever had a stomach ulcer?	Yes	No
Have you ever vomited blood?	Yes	No
Do you have trouble with constipation?	Yes	No
Do you take laxatives, enemas, stool softeners, or suppositories regularly?	Yes	No
Do you have trouble with diarrhea?	Yes	No
Have you ever had black tarry stools?	Yes	No
Do you have hernia (rupture)?	Yes	No
Do you dribble urine or use a catheter?	Yes	No
Have you passed blood in your urine?	Yes	No
Do you have frequent chills or fever?	Yes	No
Does it burn when you pass your urine?	Yes	No
Have you had a kidney infection?	Yes	No
Have you had kidney/bladder stones?	Yes	No
Do you have problems with erections/intercourse?	Yes	No
Bowel or bladder incontinence?	Yes	No

GYNECOLOGIC (Women Only)

Date of last menstrual period:		
Problems with your menstrual period?	Yes	No
Are you taking birth control pills?	Yes	No
Date of your last "Pap" Smear: _____________		

ENDOCRINE

Have you ever had diabetes?	Yes	No
Have you had thyroid trouble?	Yes	No

IMMUNE

Do you catch infections easily?	Yes	No
Have you ever had an HIV Test?	Yes	No
Have you been exposed to someone who had HIV or AIDS?	Yes	No
Do you have trouble healing?	Yes	No
Do you have any skin problems?	Yes	No

SKELETAL

Do you have any joint stiffness, pain or swelling?	Yes	No
Do you have neck or back pain?	Yes	No
Do you have gout?	Yes	No

NEUROLOGICAL

Do you have seizures or take medications to control seizures?	Yes	No
Do you have fainting spells or dizziness?	Yes	No
Do you have severe headaches?	Yes	No
Weakness or numbness of arms or legs?	Yes	No
Do you have any learning problems?	Yes	No
Have you ever had a stroke?	Yes	No
Did you ever have a head injury?	Yes	No
Are you finding fewer enjoyable things to do?	Yes	No
In the past year have you had thoughts of suicide?	Yes	No
Trouble with memory or concentration?	Yes	No
Is your appetite poor?	Yes	No
Are you less interested in sex?	Yes	No

WELL BEING

Have you been less social lately?	Yes	No
Often preoccupied with your pain?	Yes	No
Are you a nervous or anxious person?	Yes	No
More irritable or temperamental lately?	Yes	No
Have you been feeling sad or depressed?	Yes	No
Do people often make you angry?	Yes	No
Have you ever been treated by a psychiatrist or been in psychotherapy?	Yes	No
Are you finding fewer enjoyable things to do?	Yes	No
In the past year have you had thoughts of suicide?	Yes	No
Trouble with memory or concentration?	Yes	No
Is your appetite poor?	Yes	No
Are you less interested in sex?	Yes	No

SLEEP

Hours per night? ___________________

Do you have trouble falling asleep?	Yes	No
Do you have trouble staying asleep?	Yes	No
Does pain wake you up?	Yes	No

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Name: ____ Date: ______________

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank You!

Please answer the questions below using the following 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 any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0	1	2	3	4
How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
How often have you attended an AA or NA meeting?	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 been treated for an alcohol or drug problem?	0	1	2	3	4
How often have your medications been lost or stolen?	0	1	2	3	4
How often have others expressed concern over your use of medication?	0	1	2	3	4
How often have you felt a craving for medication?	0	1	2	3	4
How often have you been asked to give a urine screen for substance abuse?	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

Please include any additional information you wish about the above answers. Thank you.

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