PAIN CARE CENTERS
Treatment Options Close to Home

Dear Patient,

We are happy you are considering seeing us for your pain management needs. We pride ourselves on providing the best, comprehensive pain care available in our communities. Please find and complete the following documents prior to your first appointment. Please come at least 30 minutes early. If you haven't completed the forms prior to your appointment, please come 45 minutes early.

Forms:

- ❏ Information Form Including ALL Insurance Info
- ❏ New Patient Intake Form (Do not complete pages that say "Office Use Only"
- ❏ Consent Forms and Agreements

Items of note or needed in addition to the above-listed forms:

- ❏ Driver's License or Other ID and ALL Insurance Cards
- ❏ List of ALL Medications
- ❏ Medical Records From Other Providers Relative to the Reason for Your Appointment (Imaging, Dr. Notes, etc.)
- ❏ An Email Address: We will establish a "Patient Portal" for you which allows you to access records and communicate with our office.
- ❏ Spouse or Other Family: We encourage you to involve your family in your Pain Management.
- ❏ Urine Drug Testing: Be prepared to provide a sample.
- ❏ Payment of Deductibles and Copays are Always Due at Time of Service.

Please be sure to thoroughly review all documents and forms and complete as accurately and truthfully as possible as this information will provide a basis for your care going forward.

You may bring the forms into our practice ahead of time, fax them or simply bring them with you to your appointment. See the list of our locations below.

Please call 307.212.6270 for any questions or concerns. We look forward to serving you.

Jill Bass, APRN Meghan McMackin, APRN Rhonda McLaughlin, APRN Stacy Thompson, APRN Jed Shay, MD

2620 Commercial Way, #20
Rock Springs, WY 82901
(307) 212-6270 Office
(307) 212-6271 Fax

329 Main Street
Lander, WY 82520
(307) 212-6270 Office
(307) 212-6271 Fax

170 Arrowhead Dr, #2
Evanston, WY 82930
(307) 212-6270 Office
(307) 212-6271 Fax

Name:_____ DOS_____

Patient Demographic/Insurance Information Form | Date:

Name: _____
Last First M.I.
Sex: _____ Date of Birth: _____ S.S.# _____

Address: _____
Street City State Zip Code

Phone Numbers : Home: _____ Work:_____ Cell:_____

Employer: _____ □ Full Time □ Part Time

Who is your primary care physician? _____

Who is your referring physician? _____

Race:
□ American Indian/Eskimo/Aleut □ Afro-American □ White □ Hispanic/Latino □ Asian
□ Native Hawaiian/Pacific Islander □ Other □ Decline to respond

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

Insurance Information

Primary Insurance Company: _____

Insurance Address: _____
Street City State Zip Code

Subscriber (policy holder) _____
Policy Number: _____Group Number: _____
Policy Type: □ Individual □ Group □ Supplemental □ Other:_____
Policy type: Patient relationship to subscriber(policy holder): _____
Policy holder's S.S. # _____ Policy holder DOB:_____

Secondary Insurance Company:_____

Insurance Address: _____
Street City State Zip Code
Subscriber (policy holder) _____
Policy Number: _____Group Number: _____
Policy Type: □ Individual □ Group □ Supplemental □ Other:_____
Policy type: Patient relationship to subscriber(policy holder): _____
Policy holder's S.S. # _____ Policy holder DOB:_____

Jill Bass, APRN Rich Carver, CRNA Meghan McMackin, APRN Rhonda McLaughlin, APRN Stacy Thompson, APRN Jed Shay, MD

2620 Commercial Way, #20
Rock Springs, WY 82901
(307) 212-6270 Office
(307) 212-6271 Fax

8160 WY-789
Lander, WY 82520
(307) 212-6270 Office
(307) 212-6271 Fax

170 Arrowhead Dr, #2
Evanston, WY 82930
(307) 212-6270 Office
(307) 212-6271 Fax

Name:_____ DOS_____

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.

1. Uses and Disclosures of Protected Health Information

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 any 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 home 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 a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician'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 physician. We may also call you by name in the waiting room when your physician 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 us 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, and Organ Donation: Research: Criminal Activity: Military Activity and 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.

Your Rights

Following is a statement of your rights with respect to your protected 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 records; psychotherapy note; 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 physician is not required to agree to a restriction that you may request. If physician 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 complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

HIPAA Privacy Rule of Patient Authorization Agreement Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my health care, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement
Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- That this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;

Name:_____ DOS_____

- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested
- ;I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Consent to Treat

I hereby give my permission for **Pain Care Center** to give me medical treatment.
I allow the Practice to file for insurance benefits to pay for the care I receive.
I understand that:

- the Practice will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.
The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.
It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.
Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.
I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

By signing this consent form:

1) You acknowledge the **receipt of TWO HIPPA notices.**
2) You are giving your healthcare provider **permission to collect and share your** pharmacy and your health insurer **information about your prescriptions** that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.
3) You give **consent to obtain your medication history.**
4) You give you **consent to treat.**

Signature:_____

Jill Bass, APRN Rich Carver, CRNA Meghan McMackin, APRN Rhonda McLaughlin, APRN Stacy Thompson, APRN Jed Shay, MD

2620 Commercial Way, #20
Rock Springs, WY 82901
(307) 212-6270 Office
(307) 212-6271 Fax

8160 WY-789
Lander, WY 82520
(307) 212-6270 Office
(307) 212-6271 Fax

170 Arrowhead Dr, #2
Evanston, WY 82930
(307) 212-6270 Office
(307) 212-6271 Fax

Name:_____ DOS_____

Procedure Consent

Name:_____

Procedure: _____

Diagnosis:_____

Allergies:_____

I hereby permit Richard Carver CRNA / Jed Shay MD and Associates to perform the procedure. My diagnosis has been explained to me and I understand it. The procedure has been explained to me and I have been told the reasons why I may benefit from the procedure. The risks of the procedure have also been explained to me. In addition, I have been told that the procedure may not have the result that I expect. I have also been told about other possible treatments for my condition and what might happen if no treatment is received. I understand that in addition to the risks described to me about this procedure there are risks that may occur with any surgical or medical procedure. I am aware that the practice of medicine and surgery is not an exact science, and that I have not been given any guarantees about the results of this procedure. I have had enough time to discuss my condition and treatment with my healthcare providers and all of my questions have been answered to my satisfaction. I believe I have enough information to make an informed decision and I agree to have the procedure. If something unexpected happens and I need additional or different treatment(s) from the treatment I expect, I agree to accept any treatment which is necessary. The risks and benefits, side effects, alternatives, intended goals and likelihood of success of the procedure (including potential problems with recuperation) include but are not limited to:
Risks and Side Effects: Vasovagal reaction, no pain relief, skin irritation, medication reaction, facial flushing, infection, weakness, fall, restlessness, insomnia, fluid retention, head ache, X ray or Ultrasound exposure , worsening of the pain, and respiratory difficulty.
Benefits: identification of painful source and/or pain relief.
Alternatives: do nothing, medication, physical therapy.

Anesthesia: Most injections can be completed without first numbing the skin as that by itself is more painful than the actual injection procedure. However I understand that the following options are available and have chosen:

__Intravenous or MAC Anesthesia: I understand that the procedure may be painful or put me at additional risks requiring resuscitation. Anesthesia services are available for pain control, monitoring of the physiological status, and resuscitation. Anesthesia services have their own risks and benefits in addition to the risks and benefits of the procedure. Risks: unconscious state, reduced breathing, injury to the veins, respiratory difficulty, and need for intubation . Benefits: Reduced anxiety and pain, amnesia. Technique: Injection of anesthetics/ analgesics into the veins. The risks, benefits and alternatives have been explained to me and all of my questions have been answered to my satisfaction.

__Local Anesthesia: I understand this to be administration of local anesthetic like Lidocaine to skin. The reactions may include local irritation and allergic reaction.

__None: However, if the procedure becomes painful, I agree to be given local anesthesia.

_____

Signature

Jill Bass, APRN Rich Carver, CRNA Meghan McMackin, APRN Rhonda McLaughlin, APRN Stacy Thompson, APRN Jed Shay, MD

2620 Commercial Way, #20
Rock Springs, WY 82901
(307) 212-6270 Office
(307) 212-6271 Fax

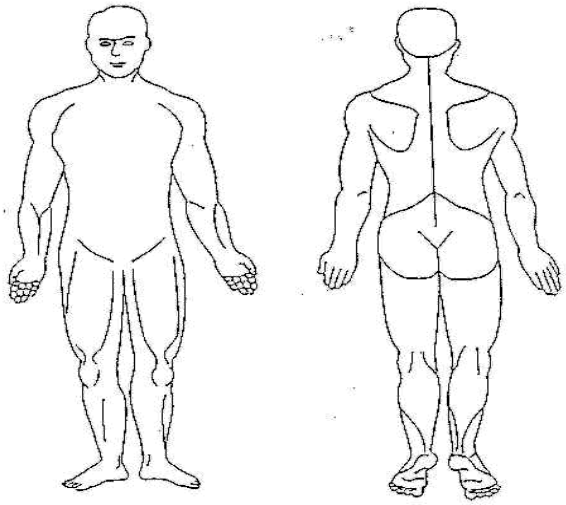
8160 WY-789
Lander, WY 82520
(307) 212-6270 Office
(307) 212-6271 Fax

170 Arrowhead Dr, #2
Evanston, WY 82930
(307) 212-6270 Office
(307) 212-6271 Fax

Name:_____ Date:_____ Pain Intake page 1/7

If this is a **work related injury:** Body parts injured:_____ Date of Injury:_____
WHO referred you for pain management?_____

Place an "X" where you hurt and / or tell us WHY are you here?_____.



Which body part is the **MOST** painful?

_Head ache _TMJ _Face _Neck _Upper back _Low back
_Shoulder _Elbow _Wrist/Hand *_Arm/Forearm*
_Hip *_Knee* *_Ankle-Foot* *_Thig/Leg*
_Abdomen *_Chest wall*

WHEN did the pain start (write date)?_____
WHAT is the cause of your pain? _Surgery _Injury _Arthritis _Fibromyalgia _Migraine _Other:___
Pain QUALITY: _aching _burning _electrical _dull _pins and needle _sharp _throbbing
Pain INTENSITY
Now: 0-----1-------2-----3----4----5----6----7----8----9----10
Average: 0-----1-------2-----3----4----5----6----7----8----9----10
Pain RADIATION: Does your pain travel/radiate from one area to another?
_no: My Pain is localized and does not radiate
_yes: _neck to Right arm _neck to Left arm
_yes: _low back to Right leg _low back to Left leg

Pain TIMING: _night _during the day
Pain FREQUENCY: _once per week _few times a week _daily
Pain DURATION: _min(s) _hrs. _all day _all night

Pain AGGRAVATED BY: (Mark as many as applies) _standing _sitting _ lying on back _laying on stomach _walking _ lifting _bending backward _bending forward _coughing _light _sound _other:
Of these, choose **ONE** single activity that makes the pain the **WORST?**: _____

Pain IMPROVED BY: (Mark as many as applies) _standing _sitting _laying on back _laying on stomach _walking _ bending backward _bending forward _no activity _ taking medication _Other
Of these, choose **ONE** single activity that makes the pain the the **LEAST**?_____

_Yes _No: I take antidepressants. % Effectiveness____
_Yes _No: I do home exercise/PT/Chiro. % Effectiveness____
_Yes _No: I use a TENS device. % Effectiveness____
_Yes _No: I use a TRACTION device. % Effectiveness____
_Yes _No: I take NON-NARCOTICS % Effectiveness____
_Yes _No: I take NARCOTICS: % Effectiveness____
_Yes _No: I get injections/blocks. % Effectiveness____

Name:_____ Date:_____ Pain Intake page 2/7

Treatment you have had or are currently on for your PAIN, if it was helpful, and any side effects:

_NO _YES: Chiropractic/PT: % Pain relief ___. Side effects?_____
_NO _YES: TENS Therapy: % Pain relief ___. Side effects?_____
_NO _YES: Cervical Traction : % Pain relief ___. Side effects?_____
_NO _YES: Lumbar Traction : % Pain relief ___. Side effects?_____

_NO _YES: Topical Meds: % Pain relief ___. Side effects?_____ (Other NSAIDS?)
_NO _YES: Ibuprofen(Motrin): % Pain relief ___. Side effects?_____
_NO _YES: Naproxen (Naprosyn,Aleve): % Pain relief ___. Side effects?_____
_NO _YES: Celecoxib(Celebrex): % Pain relief ___. Side effects?_____
_NO _YES: Meloxicam (Mobic): % Pain relief ___. Side effects?_____

_NO _YES: Cyclobenzaprin (Flexeril): % Pain relief ___. Side effects?_____
_NO _YES: Methocarbamol (Robaxin): % Pain relief ___. Side effects?_____
_NO _YES: Tizanadin (Zanaflex): % Pain relief ___. Side effects?_____
_NO _YES: Baclofen: Did it help? % Pain relief ___. Side effects?_____
_NO _YES: Corispordal (Soma): % Pain relief ___. Side effects?_____

_NO _YES: Clonazepam (Klonopin) : % Pain relief ___. Side effects?_____ (Other BZD?)
_NO _YES: Diazepam (Valium): % Pain relief ___. Side effects?_____
_NO _YES: Alprazolam (Xanax): % Pain relief ___. Side effects?_____

_NO _YES: Gabapentin (Neurontin): % Pain relief ___. Side effects?_____
_NO _YES: Pregabalin (Lyrica): % Pain relief ___. Side effects?_____
_NO _YES: Duloxetine (Cymbalta): % Pain relief ___. Side effects?_____

_NO _YES: Tramadol (Ultram): % Pain relief ___. Side effects?_____ (Other opioids?)
_NO _YES: Hydrocodone/apap (Norco): % Pain relief ___. Side effects?_____
_NO _YES: Oxycodone/apap (Percocet): % Pain relief ___. Side effects?_____

_NO _YES: Morphine IR pills: % Pain relief ___. Side effects?_____
_NO _YES: Morphine ER pills: % Pain relief ___. Side effects?_____
_NO _YES: Oxycodone IR: % Pain relief ___. Side effects?_____
_NO _YES: Oxycodone ER (Oxycontin): % Pain relief ___. Side effects?_____
_NO _YES: Hydromorphone IR(Diludid): % Pain relief ___. Side effects?_____
_NO _YES: HydromorphoneER (Diludid): % Pain relief ___. Side effects?_____
_NO _YES: Oxymorphone IR (Opana): % Pain relief ___. Side effects?_____
_NO _YES: Oxymorphone ER (Opana): % Pain relief ___. Side effects?_____
_NO _YES: Fentanyl Patch: % Pain relief ___. Side effects?_____
_NO _YES: Methadone: % Pain relief ___. Side effects?_____
_NO _YES: Suboxone/Subutex % Pain relief ___. Side effects?_____

_NO _YES: Trigger Point Injection: % Pain relief ___. Side effects?_____ (other IPM)
_NO _YES: Joint Injection: % Pain relief ___. Side effects?_____
_NO _YES: Epidural Injection: % Pain relief ___. Side effects?_____
_NO _YES: Facet injection: % Pain relief ___. Side effects?_____
_NO _YES: Rhizotomy (“Nerve Burning):% Pain relief ___. Side effects?_____
_NO _YES: Spinal Cord Stim/Pump: % Pain relief ___. Side effects?_____

Name:_____ Date:_____ Pain Intake page 3/7

Medication List: _NONE, I do not take any.

Medication	Dosage	Per day	Medication	Dosage	Per day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Allergies: _NONE (NKDA), Yes:_____

Tobacco: _Never Smoker _Former Smoker _Current Smoker _Chews. _Has smoked for: ____years
Treatment history: _N/A _Gums/Lozegens/Smokeless _Wellbutrin _Chantix

Alcohol : _Never Drinker _Former Drinker _Current Drinker _Drinks per week:_____ (CAGE:)
Treatment History: _N/A _Naltroxone _Acamprosate _Antabuse

Employment: _Unemployed _ Retired _ _Homemaker _Disability benefits **_Working as_____**
Education Level: _High School _2yr. College _4 yr. college _Masters _Doctorate/Ph.D
Marital Status: _Single _Divorced _Separated _Widowed _Married
Legal Issues: _NONE _DUI _Domestic Violence _Doctor Shopping _Probation Other:_____

Medical Conditions you have had: **__NONE**

_ADD	_Cirrhosis	_Heart Attack	_Migraine
_Anxiety	_Depression	_Heart Disease	_Osteoprosis
_Arthritis	_Diabetes	_High BP	_PVD
_Asthma	_DVT	_High Cholesterol	_Sleep Apnea
_Bipolar	_Fibromyalgia	_Hepatitis	_Seizure Disorder
_Cancer	_GERD	_HIV	_Stroke
_Chronic Fatigue	_Glucoma	_IBS	_Hypothyroid
_COPD	_GOUT	_Kidney Disease	_Other:_____

Surgical Operations you have had: **__NONE**

_Neck	_Wrist (Carpal Tunnel)	_Appendectomy	_Gallbladder
_Back	_Hip	_Breast	_Hernia
_Shoulder	_Knee	_Heart bypass surgery	_Hysterectomy
_Elbow	_Ankle	_C Section	_Other:_____

Family History: __NONE

_Arthritis	_Dementia	_High BP	_Osteoporosis
_Asthma	_Depression	_High Cholesterol	_Stroke
_Cancer	_Diabetes	_Kidney Disease	_Obesity
_Chronic Pain	_Heart Disease	_Liver diseases	

ROS: Have you had any of these in the last 30 days? _NONE

_ Anxiety	_Constipation	_ Difficulty Breathing	_Sweating a lot	_Frequent Falls
_ Depression	_Diarrhea	_ Persistent cough	_General Achiness	_Slurred Speech
_ Insomnia	_Tarry Stool	_ Sleep Apnea	_Goose flesh skin	_Sedation
_Suicidal Thought	_Nausea/Vomit		_Cold/Heat intolerance	_Tremors
	_Heartburn		_Craving	
			_Runny Nose/Teary Eyes	

_Hearing Loss	_Easy bruising	_Hair loss	_Wt Loss	_Leg Swelling
_Yellow Eyes	_On Blood thinner	_Yellow skin	_Fatigue	_Fast Heart Rate
_Vision changes	_Enlarged Lymph Node	_Nail changes		
_Dry Mouth				

Signature: _____

Pain and Health Questionnaire 9: PHQ9

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

1. Little interest or pleasure in doing things:
   _Not at all (0) _Several days (1) _More than half the days (2) _Nearly everyday (3)

2. Feeling down, depressed, or hopeless:
   _Not at all (0) _Several days (1) _More than half the days (2) _Nearly everyday (3)

3. Trouble falling or staying asleep, or sleeping too much
   _Not at all (0) _Several days (1) _More than half the days (2) _Nearly everyday (3)

4. Feeling tired or having little energy:
   _Not at all (0) _Several days (1) _More than half the days (2) _Nearly everyday (3)

5. Poor appetite or overeating:
   _Not at all (0) _Several days (1) _More than half the days (2) _Nearly everyday (3)

6. Feeling bad about yourself or that you are a failure or have let yourself or your family down
   _Not at all (0) _Several days (1) _More than half the days (2) _Nearly everyday (3)

7. Trouble concentrating on things, such as reading the newspaper or watching television
   _Not at all (0) _Several days (1) _More than half the days (2) _Nearly everyday (3)

8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual
   _Not at all (0) _Several days (1) _More than half the days (2) _Nearly everyday (3)

9. Thoughts that you would be better off dead or of hurting yourself in some way
   _Not at all (0) _Several days (1) _More than half the days (2) _Nearly everyday (3)

Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

___Not difficult at all
___Somewhat difficult
___Very difficult
___Extremely difficult

1-4:MIN. 5-9:MILD. 10-14: MOD. 15-19:MOD. to SEV. 20-27: SEV.

Pain and Disability Questionnaire: PDQ

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?

Work normally — *Unable to work at all*

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

2. Does your **pain interfere with personal care (**such as washing, dressing, etc.)?

Take care of myself completely — *Need help with all my personal care*

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

3. Does your **pain interfere with your traveling**?

Travel anywhere I like — *Only travel to see doctors*

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

4. Does your **pain affect your ability to sit or stand**?

No problems — *Can not sit/stand at all*

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

5. Does your **pain affect your ability to lift overhead, grasp objects, or reach for things**?

No problems — *Can not do at all*

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

6. Does your pain **affect your ability to lift objects off the floor, bend, stoop, or squat**?

No problems — *Can not do at all*

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

7. Does your **pain affect your ability to walk or run**?

No problems — *Can not walk/run at all*

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

8. Has your **income declined** since your pain began?

No decline — *Lost all income*

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

9. Do you have to **take pain medication every day** to control your pain?

No medication needed — *On pain medication throughout the day*

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

10. Does your pain force your to **see doctors much more often** than before your pain began?

Never see doctors — *See doctors weekly*

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?

No problem — *Never see them*

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

12. Does your pain **interfere with recreational activities** and hobbies that are important to you?

No interference — *Total interference*

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

13. Do you **need the help of your family and friends to complete everyday tasks** (including both work outside the home and housework) because of your pain?

Never need help — *Need help all the time*

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

14. Do you now feel more **depressed, tense, or anxious** than before your pain began?

No depression/tension — *Severe depression/tension*

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

15. Are there **emotional problems** caused by your pain that interfere with your family, social and or work activities?

No problems — *Severe problems*

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

TOTAL:_____

OTHER COMMENTS:

_____ With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. Spine 2004; 29 (20): 2290-2302.

0-70: Mild, 71-100: Moderate, 101-130: Severe, >130: Extreme

Name:_____ Date:_____ Pain Intake page 6/7

<<<<< OFFICE USE >>>>>>>>>>OFFICE USE <<<<< OFFICE USE >>>>>>>>> OFFICE USE <<<<< OFFICE USE >>>>>>>>> OFFICE USE >>>>

BP:_____/____ P: ____ RR: _____ WT:_____ Ht: _____ _ORT___ _PHQ9____ _PDQ____
Tab: Demographic:_ Referring Provider checked
Tab: Demographic: _Pharmacy_____
Tab: Summary: _Allergy, _Risk Factor
Tab: Medication: _Authorization to access med report _Import history _Enter medication:

Diagnostics Reviewed:: _ORT _PHQ9 _PDQ _UDS _PDMP _Imaging _EKG/ QTC: _Records

Presentation: General**:** _Well groomed, clean, casually dressed, ambulating on own power. _Cognition: Oriented to time place, person. _Memory is intact. _Attention/Concentration: appear normal. _Behavior: Cooperative, calm, with normal eye contact. Speech: Normal rate, and rhythm. _Mood/Affect: normal mood with congruent affect and appropriately reactive. Thought process: Linear and goal oriented. _Insight/Judgment: good insight and intact judgment. _Fund of knowledge: _average _above average intellect and knowledge.

CERVICAL and THORACIC Spine:
INSPECTION: _No atrophy _No deformity _Loss of lordosis _Scoliosis/deformity _Guarded movement _Surgical scar c/w history
ROM: _Full _Mild reduction _ Moderate reduction _Severe reduction Causes pain: _Extension _Flexion
PALPATION: _Non tender , _No spasm, Tender Facet : _R _ L, Tender Occiput : _R _L, Paraspinal spasm: _R _L Trigger points: _R _L
PROVOCATION : Spurling's: _Negative OR _R _L

LUMBAR/SACRAL Spine:
INSPECTION: _No atrophy _No deformity _Loss of lordosis _Scoliosis/deformity _Surgical scar consist with medical history
ROM: _Full _Mild reduction _ Moderate reduction _Severe reduction Causes pain: _Extension _Flexion
PALPATION: _Non tender _ No spasm, **Tender Facet : _R _ L, SI Tenderness _R _ L Sciatic notch tenderness _R _L**
Trigger points _R _L. Paraspinal spasm: _R _L Piriformis Spasm : _R _L
PROVOCATION: SLR: _ R _L SI: Comp: _R _L Distraction: _R _L, FABER: _R _L Gaenslen's: _R _ L Thigh Thrust _R _L

MOTOR: _5/5 bilateral upper extremities _5/5 bilateral lower extremities.
SENSATION: _Normal pinwheel sensation bilaterally along the _Cervical _Lumbar/sacral dermatomes.
REFLEXES: _2+ biceps _ 2+ brachioradialis _2+ triceps _2+ patellar _2+ Achilles

Shoulder Right: INSPECTION: _No atrophy _No deformity _Surgical scar consistent with surgery
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _Non tender _No instability **_Tender: _Biceps groove, _ A/C Joint , _SAB, _GHJ _Trigger point**s
Shoulder Left: INSPECTION: _No atrophy _No deformity _Surgical scar consistent with surgery
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _Non tender _No instability **_Tender: _Biceps groove, _ A/C Joint , _SAB, _GHJ _Trigger points**
Elbow Right: INSPECTION: _No atrophy _No deformity _Surgical scar consistent with history
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _non tender Tender _Medial _Lateral
Elbow Left: INSPECTION: _No atrophy _No deformity _Surgical scar consistent with history
ROM: _Full _ Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _non tender _Tender _Medial _Lateral
Wrist Right: INSPECTION: _No atrophy _No deformity _Surgical scar consistent with history
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _non tender **Tinnels +: _R _L**
Wrist Left: INSPECTION: _No atrophy _No deformity _Surgical scar
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _non tender **Tinnels: _R _L**
HIP Right: INSPECTION: _No atrophy _No deformity _Surgical scar
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _non tender **Tender: _ Trochanteric _Anterior hip**
Hip Left: INSPECTION: _No atrophy _No deformity _Surgical scar
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _non tender **Tender: _ Trochanteric _Anterior hip**
Knee Right: INSPECTION: _No atrophy _No deformity _Surgical scar
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _Nontender **_Tenderness** _Crepitation _Heat
Knee Left: INSPECTION: _No atrophy _No deformity _Surgical scar
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _Nontender **_Tenderness** _Crepitation _Heat
Ankle Right: INSPECTION: _No atrophy _No deformity _Surgical scar
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _non tender
Ankle Left: INSPECTION: _No atrophy _No deformity _Surgical scar
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _non tender

Name:_____ Date:_____ Pain Intake page 7/7

HEENT: normocephalic, atraumatic, sclera is anicteric.
LYMPHATICS: no lymphadenopathy.
RESPIRATORY: clear to auscultation, equal breath sounds, no wheezes.
CARDIAC: regular rate & rhythm.
ABDOMEN: soft and non-tender, no rebound or guarding.
SKIN: no hyperalgesia and/or allodynia, no temperature asymmetry or skin color changes, no edema, and/or sweating asymmetry, no skin/nail trophic changes and/or motor dysfunction (weakness, tremor, dystonia) and/or decreased ROM.

Primary Diagnosis: __Chronic Pain __Long Term Opioid Therapy __OIC __ Opioid UD
Comorbid Diagnosis: _Obesity __Tobacco use _Alcohol Use __Depression _Anxiety
Historical Diagnosis: Past Medical/Surgical/Radiological:
_DDD: _C _ L Spondylosis: _C _ LS _Post Laminectomy _S/P (__surgery) _FM _Osteo _ RA _CRPS _Other

Differential Diagnosis includes: (for the Primary Diagnosis):

_LBP _Sciatica	Suspect: _SI dysfunction _GTB _Piriformis Syndrome _Facet disease _Disc disease _TP
_Cervicalgia	Suspect: _Facet Disease _Disc Disease _TP
_Thoracicalgia	Suspect: _Facet Disease _Disc Disease _TP
_Shoulder pain:	Suspect: _AC arthritis _Bicipital Tendinitis _SAB _GHJ arth _TP
_Elbow pain:	Suspect: _Medial _lateral _Epicondylitis
_Wris/hand pain:	Suspect: _CTS
_Hip pain:	Suspect: _Hip arthropathy _GTB
_Knee pain:	Suspect: _Knee arthropathy
_Ankl/ Foot pain	Suspect: _Ankle arthropathy _Plantar Fasciitis

Plan:

_Discussed Anx/dep/pain _AntdepressantRX: _Start _Continue _Wt. Mgmt _Tobacco _Alcohol _BP FU _MET _CBT

_PT to teach home exercise program _PT to Eval/Treat _PT not effective
_TENS _Rec _Provided _Continue _Not helpful _Not covered _PADS Given _Needs PA (MC: Not Covered, MD: Covered, Other: Needs PA)
_LSO _Rec _Provided _Continue _Not helpful _Not covered _Not Candidate _Needs PA (MC: Covered, MD: Covered, Other: Needs PA)
_DDS _Rec _Provided _Continue _Not helpful _Not covered _Not Candidate _Needs PA (WC: Not Covered MD: Covered, Other: Needs PA)

_Topical : _NSAIDS _Compound somatic _Compound Neuropathic _Education

_NSAIDS: _Start _Continue _Stop _Education/ Side effects: GI Cardiac Renal Anti-coagulant

_Baclofen _Cyclobenzaprin _Tizanadine _Start _Continue _Stop _Education: Sedation CV effect Anti cholinergic

_Gabapentin _Pregabalin _Duloxetin _Start _Continue _Stop _Education / side effects

_Opioids: _Start _Partial Agonist _Full Agonist _Continue _ Stop _Rotation _Taper _Education to patient _Education to family/caregiver
_Consider RX for OUD
_Constipation RX: _LOC _Movantik

_The IPM Options discussed: _Not candidate or interested. _Referred for evaluation
_SI _GTB _Piriformis _TPI _AC _GHJ _Bicipital _SAB _GHJ _Elbow _CT/Wrist _Hip _Knee _Ankle _Plantar Fascia _TPI
_CFB _ CESI _LFB _Caudal ESI _TLLESI _TFLESI _Rhizotomy (Needs Diagnostics: Facet: X ray, MRI, ESI: MRI, Rhizotomy: Past hx of)

Prescribed RX , Orders, Other
_Blood work _SPECT _MRI _PT _EKG _Obtain Records::_____

__Informed Consent _Medication Agreement _Family Participation _Medication R&B discussed. _Benefits Opioids Outweigh Risks.

_JBass, APRN _RCarver CRNA _RMcLaughlin APRN _MMcMackin, APRN _SThompson, APRN _ In consult _JShay, M.D.