



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.

Jed Shay, MD - Stacy Thompson, APRN - Jill Bass, APRN - Meghan McMackin, APRN - Jenny Rosics, PA  
Rhonda McLaughlin, APRN - Robert A. Campbell, MD

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Rock Springs, WY 82901  
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(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  
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5850 E 2nd Street, Ste 100  
Casper, WY 82609  
(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): \_\_\_\_\_

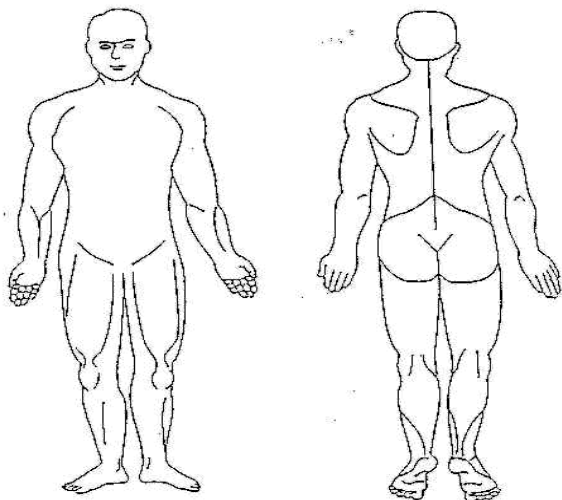
Policy holder's S.S. # \_\_\_\_\_ Policy holder DOB: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Pain Intake page 1/9

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?**

- |                                     |                                 |                                      |                                       |                                      |                                    |
|-------------------------------------|---------------------------------|--------------------------------------|---------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> _Head ache | <input type="checkbox"/> _TMJ   | <input type="checkbox"/> _Face       | <input type="checkbox"/> _Neck        | <input type="checkbox"/> _Upper back | <input type="checkbox"/> _Low back |
| <input type="checkbox"/> _Shoulder  | <input type="checkbox"/> _Elbow | <input type="checkbox"/> _Wrist/Hand | <input type="checkbox"/> _Arm/Forearm |                                      |                                    |
| <input type="checkbox"/> _Hip       |                                 | <input type="checkbox"/> _Knee       | <input type="checkbox"/> _Ankle-Foot  | <input type="checkbox"/> _Thigh/Leg  |                                    |
| <input type="checkbox"/> _Abdomen   |                                 | <input type="checkbox"/> _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 \_laying 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 **LEAST?** \_\_\_\_\_

**Analgesia: Treatment modalities tried, %Pain Relief and any side effects:**

<u>_NO</u> <u>_YES</u> : Chiropractic/PT:	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : TENS Therapy:	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Cervical Traction:	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Lumbar Traction:	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Topical Meds:	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Ibuprofen(Motrin):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Naproxen/Aleve:	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Celecoxib(Celebrex):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Meloxicam (Mobic):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : <b>Other NSAIDs:</b> _____	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Cyclobenzaprin (Flexeril):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Methocarbamol (Robaxin):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Tizanadin (Zanaflex):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Baclofen:	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Corisporidal (Soma):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Clonazepam (Klonopin):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Diazepam (Valium):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Alprazolam (Xanax):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : <b>Other Anxiety meds:</b> _____	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Gabapentin (Neurontin):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Pregabalin (Lyrica):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Duloxetine (Cymbalta):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Tramadol (Ultram):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Hydrocodone/apap (Norco):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Oxycodone/apap (Percocet):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Morphine IR pills:	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Morphine ER pills:	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Oxycodone IR:	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Oxycodone ER (Oxycontin):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Hydromorphone IR(Dilaudid):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : HydromorphoneER (Dilaudid):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Oxymorphone IR (Opana):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Oxymorphone ER (Opana):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Fentanyl Patch:	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Methadone:	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Suboxone/Subutex:	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : <b>Other Narcotics:</b> _____	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Trigger Point Injection:	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Joint Injection:	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Epidural Injection:	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Facet injection:	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Rhizotomy ("Nerve Burning):	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : Spinal Cord Stim/Pump:	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____
<u>_NO</u> <u>_YES</u> : <b>Other Blocks:</b> _____	<u>Current</u> user?: <u>_Yes</u> <u>_No</u> <u>Past</u> User?: <u>_Yes</u> <u>_No</u>	%Pain relief? _____	Side effects? _____

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Pain Intake page 3/9

**Activity: Does pain medication or current treatment help you with the following activities?**

- \_Yes \_No: My sitting tolerance is improved because of my pain treatment.  
\_Yes \_No: My standing tolerance is improved because of my pain treatment.  
\_Yes \_No: My walking ability has improved because of my pain treatment.  
\_Yes \_No: My lifting ability is improved because of my pain treatment.  
\_Yes \_No: My overhead work ability is improved because of my pain treatment.  
\_Yes \_No: My ability to perform Activities of Daily Living is improved because of my pain treatment.  
\_Yes \_No: I am able to continue to work because of my pain treatment.  
\_Yes \_No: I am able to exercise because of my pain treatment.  
\_Yes \_No: I am able to enjoy my hobbies because of my pain treatment.  
\_Yes \_No: I am able to sleep better because of my pain treatment

**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

**Tobacco:** \_Never Smoker \_Former Smoker \_Current Smoker \_Chews \_Has smoked for: \_\_\_\_\_ years  
**Treatment history:** \_N/A \_Gums/Lozogens/Smokeless \_Wellbutrin \_Chantix

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

**Legal and Living Condition:** \_DUI \_Domestic Violence \_Doctor Shopping \_Probation \_No family/social support

**ROS (Symptoms): Have you had any of these in the last 30 days? NONE**

- |  |   |  |   |   |
|--|---|--|---|---|
| <input type="checkbox"/> _Anxiety          | <input type="checkbox"/> _Constipation        | <input type="checkbox"/> _Difficulty Breathing | <input type="checkbox"/> _Sweating a lot        | <input type="checkbox"/> _Frequent Falls  |
| <input type="checkbox"/> _Depression       | <input type="checkbox"/> _Diarrhea            | <input type="checkbox"/> _Persistent cough     | <input type="checkbox"/> _General Achiness      | <input type="checkbox"/> _Slurred Speech  |
| <input type="checkbox"/> _Insomnia         | <input type="checkbox"/> _Tarry Stool         | <input type="checkbox"/> _Sleep Apnea          | <input type="checkbox"/> _Goose flesh skin      | <input type="checkbox"/> _Sedation        |
| <input type="checkbox"/> _Suicidal Thought | <input type="checkbox"/> _Nausea/Vomit        |  | <input type="checkbox"/> _Cold/Heat intolerance | <input type="checkbox"/> _Tremors         |
|  | <input type="checkbox"/> _Heartburn           |  | <input type="checkbox"/> _Craving               |   |
|  |   |  | <input type="checkbox"/> _Runny Nose/Teary Eyes |   |
| <input type="checkbox"/> _Hearing Loss     | <input type="checkbox"/> _Easy bruising       | <input type="checkbox"/> _Hair loss            | <input type="checkbox"/> _Wt Loss               | <input type="checkbox"/> _Leg Swelling    |
| <input type="checkbox"/> _Yellow Eyes      | <input type="checkbox"/> _On Blood thinner    | <input type="checkbox"/> _Yellow skin          | <input type="checkbox"/> _Fatigue               | <input type="checkbox"/> _Fast Heart Rate |
| <input type="checkbox"/> _Vision changes   | <input type="checkbox"/> _Enlarged Lymph Node | <input type="checkbox"/> _Nail changes         |   |   |
| <input type="checkbox"/> _Dry Mouth        |   |  |   |   |

**Aberrancy: Check as indicated, if you are not taking any pain meds, go to the next section.**

- \_Yes \_No: I am taking more pain meds and may run out before my appointments.  
\_Yes \_No: I want to take less pain meds, but I just can't..  
\_Yes \_No: I am always worried about when I should be taking my pain meds or if I am running out.  
\_Yes \_No: I have a lot of craving or urge to take pain meds.  
\_Yes \_No: I am falling short on my responsibilities at home, work or school because of pain meds..  
\_Yes \_No: Pain meds make me angry, moody, depressed, unreliable, irresponsible. I have issues with family and friends.  
\_Yes \_No: I miss work, birthdays, gatherings because of the pain meds and their effects.  
\_Yes \_No: The pain meds and their sedative effects are placing me in dangerous physical situations like DUI, frequent falls..  
\_Yes \_No: I know I should not be taking all these pain medication because it is affecting my physical health and emotional wellbeing.  
\_Yes \_No: I have developed TOLERANCE. The same amount that was working before, does not help as much.  
\_Yes \_No: I go through WITHDRAWAL if I miss my dose of pain meds.

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Pain Intake page 4/9

I have had problems with Substance abuse:

\_No problems (0,0):    \_Alcohol (3,3)    \_Illegal drugs (4,4)                      \_Prescription drugs (5,5)

My family has history of Substance Abuse

\_No problems (0,0):                      \_Alcohol (1,3)    \_Illegal drugs(2,3)                      \_Prescription drugs(4,4)

I have a history of \_Mental Disorder:

\_No problems (0,0):                      \_Depression (1,1)                      \_OCD (2,2)                      \_Bipolar (2,2)                      \_Schizophrenia (2,2)

**Females Patients Only:** I experienced Preadolescent Sexual Abuse:

\_No (0,0):                      \_Yes (0,3)

(<<<OFFICE USE>>>: Add 1 for age 16-45: \_\_\_\_\_                      ORT: \_\_\_\_\_)

**Medication List:** NONE, I do not take any.

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

**Allergies:** NONE (NKDA), Yes: \_\_\_\_\_

**Medical Conditions** you have had: NONE

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> _ADD             | <input type="checkbox"/> _Cirrhosis    | <input type="checkbox"/> _Heart Attack     | <input type="checkbox"/> _Migraine         |
| <input type="checkbox"/> _Anxiety         | <input type="checkbox"/> _Depression   | <input type="checkbox"/> _Heart Disease    | <input type="checkbox"/> _Osteoprosis      |
| <input type="checkbox"/> _Arthritis       | <input type="checkbox"/> _Diabetes     | <input type="checkbox"/> _High BP          | <input type="checkbox"/> _PVD              |
| <input type="checkbox"/> _Asthma          | <input type="checkbox"/> _DVT          | <input type="checkbox"/> _High Cholesterol | <input type="checkbox"/> _Sleep Apnea      |
| <input type="checkbox"/> _Bipolar         | <input type="checkbox"/> _Fibromyalgia | <input type="checkbox"/> _Hepatitis        | <input type="checkbox"/> _Seizure Disorder |
| <input type="checkbox"/> _Cancer          | <input type="checkbox"/> _GERD         | <input type="checkbox"/> _HIV              | <input type="checkbox"/> _Stroke           |
| <input type="checkbox"/> _Chronic Fatigue | <input type="checkbox"/> _Glucoma      | <input type="checkbox"/> _IBS              | <input type="checkbox"/> _Hypothyroid      |
| <input type="checkbox"/> _COPD            | <input type="checkbox"/> _GOUT         | <input type="checkbox"/> _Kidney Disease   | <input type="checkbox"/> _Other: _____     |

**Surgical Operations** you have had: NONE

- |                                    |   |  |  |
|------------------------------------|---|--|--|
| <input type="checkbox"/> _Neck     | <input type="checkbox"/> _Wrist (Carpal Tunnel) | <input type="checkbox"/> _Appendectomy         | <input type="checkbox"/> _Gallbladder  |
| <input type="checkbox"/> _Back     | <input type="checkbox"/> _Hip                   | <input type="checkbox"/> _Breast               | <input type="checkbox"/> _Hernia       |
| <input type="checkbox"/> _Shoulder | <input type="checkbox"/> _Knee                  | <input type="checkbox"/> _Heart bypass surgery | <input type="checkbox"/> _Hysterectomy |
| <input type="checkbox"/> _Elbow    | <input type="checkbox"/> _Ankle                 | <input type="checkbox"/> _C Section            | <input type="checkbox"/> _Other: _____ |

**Family History:** NONE

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> _Arthritis    | <input type="checkbox"/> _Dementia      | <input type="checkbox"/> _High BP          | <input type="checkbox"/> _Osteoporosis |
| <input type="checkbox"/> _Asthma       | <input type="checkbox"/> _Depression    | <input type="checkbox"/> _High Cholesterol | <input type="checkbox"/> _Stroke       |
| <input type="checkbox"/> _Cancer       | <input type="checkbox"/> _Diabetes      | <input type="checkbox"/> _Kidney Disease   | <input type="checkbox"/> _Obesity      |
| <input type="checkbox"/> _Chronic Pain | <input type="checkbox"/> _Heart Disease | <input type="checkbox"/> _Liver diseases   |  |

**Signature:** \_\_\_\_\_

**Pain and Disability Questionnaire: PDQ**

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

*Work normally* (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) *Unable to work at all*

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

*Take care of myself completely* (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) *Need help with all my personal care*

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

*Travel anywhere I like* (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) *Only travel to see doctors*

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

*No problems* (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) *Can not sit/stand at all*

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

*No problems* (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) *Can not do at all*

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

*No problems* (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) *Can not do at all*

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

*No problems* (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) *Can not walk/run at all*

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

*No decline* (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) *Lost all income*

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

*No medication needed* (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) *On pain medication throughout the day*

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

*Never see doctors* (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) *See doctors weekly*

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* (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) *Never see them*

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

*No interference* (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) *Total interference*

13. Do you **need the help of your family and friends to complete everyday tasks**

*Never need help* (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) *Need help all the time*

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

*No depression/tension* (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) *Severe depression/tension*

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

*No problems* (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) *Severe problems*

**TOTAL:** \_\_\_\_\_ (0-70: Mild, 71-100: Moderate, 101-130: Severe, >130: Extreme)

**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.



Name: \_\_\_\_\_ Date: \_\_\_\_\_ Pain Intake page 7/9

## AUDIT

1. How often do you have a drink containing alcohol?

**(0) Never (Skip to Questions 9-10)**

(1) Monthly or less    (2) 2 to 4 times a month    (3) 2 to 3 times a week    (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2    (1) 3 or 4    (2) 5 or 6    (3) 7, 8, or 9    (4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never    (1) Less than monthly    (2) Monthly    (3) Weekly    (4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never    (1) Less than monthly    (2) Monthly    (3) Weekly    (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never    (1) Less than monthly    (2) Monthly    (3) Weekly    (4) Daily or almost daily

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never    (1) Less than monthly    (2) Monthly    (3) Weekly    (4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?

(0) Never    (1) Less than monthly    (2) Monthly    (3) Weekly    (4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never    (1) Less than monthly    (2) Monthly    (3) Weekly    (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

(0) No    (2) Yes, but not in the last year    (4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?

(0) No    (2) Yes, but not in the last year    (4) Yes, during the last year

SCORE: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Pain Intake page 8/9

BP: \_\_\_\_\_/\_\_\_\_\_ P: \_\_\_\_\_ RR: \_\_\_\_\_ WT: \_\_\_\_\_ Ht: \_\_\_\_\_ ORT \_\_\_\_\_ PHQ9 \_\_\_\_\_ PDQ \_\_\_\_\_ QD \_\_\_\_\_ LL \_\_\_\_\_

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 points

**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 surgery  
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 surgery  
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 surgery  
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 consistent with surgery  
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 consistent with surgery  
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 consistent with surgery  
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 consistent with surgery  
ROM: \_Full \_Mild limited ROM \_Moderate limited ROM \_Severe limited ROM  
PALPATION: \_Nontender \_Tenderness \_Crepitation \_Heat

**Knee Leftt:** INSPECTION: \_No atrophy \_No deformity \_Surgical scar consistent with surgery  
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 consistent with surgery  
ROM: \_Full \_Mild limited ROM \_Moderate limited ROM \_Severe limited ROM  
PALPATION: \_non tender

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

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Pain Intake page 9/9

Ankle 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

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.

Assessment:

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 \_TPI
\_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

Objectives:

\_Pain reduction to improve quality of life and function
\_Discussed Anx/Dep/Pain \_Tobacco \_Alcohol \_Discussed Family Participation \_AntidepressantRX: \_Start \_Continue \_Wt.
Reduction
\_PT: \_Rec Home Exercise \_Evaluate and treat
\_LSO: \_Rec \_Given \_Continue \_Needs PA \_Not Covered \_Has tried, not helpful
\_C traction \_Rec \_Given \_Continue \_Needs PA \_Not Covered \_Has tried, not helpful
\_TENS \_Rec \_Given \_Continue \_Needs PA \_Not Covered \_Has tried, not helpful
\_Knee Brace \_Rec \_Given \_Continue \_Needs PA \_Not Covered \_Has tried, not helpful
\_Referred for PM&R evaluation.

\_Topical: \_NSAIDS \_Compound somatic \_Compound Neuropathic \_Education
\_NSAIDS: \_Start \_Continue \_Stop \_Education/ Side effects: GI, Cardiac, Renal, Anti-coagulant
\_MSK Relaxants: \_Baclofen \_Cyclobenzaprine \_Tizanidine \_Start \_Continue \_Stop \_Education: Sedation, Anticholinergic, CV effect
\_Adjunct: \_Gabapentin \_Pregabalin \_Duloxetine \_Start \_Continue \_Stop \_Education / side effects
\_Opioids: \_Taper \_Continue \_Start \_Stop \_Rotation (Suboxone) \_Education/Side effects \_Drug-drug Interaction \_Med Agmt
\_Opioids: \_Naloxone: \_Recommended \_Evzio/SC/Nasal discussed \_Education to patient \_Education to family/caregiver
\_Opioids: \_Constipation RX: \_LOC \_Movantik

Interventional Pain Mgmt:

\_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)

Plan for Aberrant Behavior:

\_Medication agreement discussed \_Frequent visits \_UDS/UDT \_Pill Count \_PDMP \_Pain to OUD Reclassification

List of Medications prescribed, HW, and any other plans:

\_Blood work \_SPECT \_MRI \_PT \_EKG \_EMG/NCV \_Obtain Records::\_\_\_\_\_
\_FU Date:\_\_\_\_\_

Provider:\_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Medication Agreement

The purpose of this agreement is to give you information about the medications you will be taking for your condition and to assure that you and your provider comply with all state and federal regulations concerning the prescribing of controlled substances. The provider's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the Provider(provider)/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat your pain related conditions.

1. You should use only use **Pain Care Centers** to prescribe and monitor all opioid medications and adjunctive analgesics. The providers may allow you to receive certain medication by other providers when notified.
2. You should use one pharmacy to obtain all opioid prescriptions and adjunctive analgesics prescribed by your Provider. An exception to this is allowed when your regular pharmacy does not carry the medication or the medication can be obtained cheaper at another pharmacy.
3. You should inform your Provider of all medications you are taking, including herbal remedies, since opioid medications can interact with over-the-counter medications and ALL other prescribed medications.
4. You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment.
5. Prescriptions for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours or as authorized by your provider.
6. You agree to bring in controlled medication being taken when asked to do so and be prepared to submit to urine drug testing.
7. You are responsible for keeping your medication in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss or theft. Stolen medications should be reported to the police and a case number obtained. You need this to get a replacement medication. However, we may choose to not to replace the medications or to taper and discontinue the medications.
8. You may not give or sell your medications to any other person under any circumstances. If you do, you may endanger that person's life and it could be a violation of the law.
9. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other providers (includes emergency room providers), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.
10. You agree to report any concern or complaint about your treatment when you come in for a visit. You agree to report, fully and truthfully, your pain level and functional activity along with any side effects of the medications at each office visit on the forms provided to you.
11. You should not use any illicit substances, such as cocaine, marijuana, etc. while taking these medications. If you do, it may result in a change to your treatment plan, including discontinuation of your opioid medications when applicable or complete termination from the practice.
12. The use of alcohol and opioid medications is contraindicated. The mixture can be lethal.
13. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, impaired breathing, impaired cognitive (mental status) and/or motor ability, and immunosuppression.
14. Physical dependence and/or tolerance can occur with the use of opioid medications. Physical dependence means that if the opioid medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one's mood. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone. Addiction is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life. Tolerance means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time.
15. If you have a history of alcohol or drug misuse/addiction, you must notify us of such history since the treatment with opioids for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is a must.
16. At any time during or after your treatment at this office, you agree to allow us to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions *if we feel it is necessary for your safety or the safety of public*. You agree to a family conference or a conference with a close friend or significant other *if we feel it is necessary for your treatment, safety or the safety of public*.

Signature: \_\_\_\_\_

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## 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 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, 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

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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;

Jed Shay, MD - Stacy Thompson, APRN - Jill Bass, APRN - Meghan McMackin, APRN - Jenny Rosics, PA  
Rhonda McLaughlin, APRN - Robert A. Campbell, MD

Name: \_\_\_\_\_

- 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: \_\_\_\_\_

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# PATIENT RELEASE FORM

Dominion Diagnostics is the clinical laboratory that your physician or healthcare provider has chosen to integrate into his or her practice and your treatment at \_\_\_\_\_.  
(PRINT TREATMENT FACILITY NAME)

Dominion’s laboratory offers clinical urine drug testing and monitoring that provides key clinical information to your physician or healthcare provider regarding prescription adherence, illicit drug usage, and drug elimination.

When applicable, Dominion Diagnostics will bill your health insurance provider for the clinical urine drug testing services performed at its laboratory and accept reimbursement as determined by your coverage plan.

### Patient Authorization:

I \_\_\_\_\_, \_\_\_\_\_ authorize Dominion Diagnostics to:  
(PRINT PATIENT NAME) (PRINT PATIENT DATE OF BIRTH)

- (1) Release the laboratory test results to the ordering facility listed above and to my treatment providers.
- (2) Bill my insurance provider for necessary charges associated with laboratory testing performed.
- (3) Receive payment from your health insurance provider for the laboratory testing performed.
- (4) Collect from your treatment provider and utilize any medical information necessary to process the insurance claim.

I further understand that Dominion Diagnostics will bill my insurance provider its Usual and Customary Charge for the testing ordered by my physician or healthcare provider. I understand that I am responsible for any co-pays, deductibles, or other fees that my insurance provider deems my responsibility.

If my insurance provider should reimburse me directly, I agree to endorse the check and send it to Dominion Diagnostics within 30 days. Otherwise, I am responsible for the amount owed.

I understand I may contact Dominion Diagnostics Billing Department at 1-800-511-8427, Option 4 to discuss any questions or concerns regarding payment or to receive information on Dominion’s financial assistance program.

### FINANCIAL STATUS QUALIFICATION STATEMENT

Financial Hardship (Indigent) \_\_\_\_\_ Yes \_\_\_\_\_ No

Patient qualifies as indigent per the following definition: Patient is receiving free or reduced care from the Treatment Facility listed above, has no health insurance, and is unable to pay the Usual and Customary Charge without financial hardship. The Treatment Facility shall maintain, and make available to Dominion Diagnostics if requested, financial records verifying “indigency” status.

\_\_\_\_\_  
Authorized Treatment Facility Signature (REQUIRED)

\_\_\_\_\_  
Date

**SIGN HERE** →

\_\_\_\_\_  
Patient Signature (REQUIRED)

\_\_\_\_\_  
Parent/Legal Guardian Signature  
(REQUIRED FOR CHILDREN UNDER 18 YEARS OLD)

\_\_\_\_\_  
Date

**NOTE: This release is in effect for the patient’s entire length of treatment.**