Medical Center Pain Clinic

Timothy Luke Cramer, MD • David P. Ellis, MD

PATIENT REGISTRATION AND INFORMATION (04-07-2020)

*** USE BLACK INK ONLY ***

Name: Social Security Number:

Address: City State Zip Code

Home Phone: Cell Phone: Work Phone:

Sex: Date of Birth: Marital Status:

Male Female

Employer: Occupation:

Primary Care Physician Address

Referring Physician: Previous Pain Management Physician(s) & why did you leave?

Pharmacy: Phone Number:

Race: White ☐ Black or African American ☐ Hispanic ☐ American Indian ☐ Asian ☐

Native Hawaiian or Other Pacific Islander ☐ Other Race ☐ Unreported/Refused to Report ☐

SPOUSE INFORMATION

Name of Spouse: Social Security Number: Date of Birth:

Spouse's Employer: Phone Number:

INSURANCE INFORMATION

Primary Insurance:

Policyholder Name (If other than patient) Date of Birth: Social Security Number:

Secondary Insurance:

Policyholder Name (If other than patient) Date of Birth: Social Security Number:

Are you being seen for a work related injury? Yes [ ] No [ ] Are you being seen for a motor vehicle accident? Yes [ ] No [ ]

If yes, please provide information. _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have the above insurance coverage and assign directly to Medical Center Pain Clinic, Timothy Luke Cramer, MD / David P. Ellis, MD - all insurance benefits payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Medical Center Pain Clinic to release any information necessary to secure payment of benefits on all insurance submissions.

X _____

Patient Signature Date

Medical Center Pain Clinic

Timothy Luke Cramer, MD • David P. Ellis, MD

Patient Privacy and Confidential Information Form (06-10-2019)

Your privacy is important to our office. Please complete the following information to assist us with your appointment call reminders as well as contact information regarding your healthcare.

I ask that you call me at: _____ or _____

or email me at _____ regarding my pending appointment, a missed appointment, balances due, lab results, or any other healthcare related function.

You have my permission to leave a message with the following individual(s) regarding my pending appointment, a missed appointment, balances due, lab results, or any other healthcare related function. I understand that this is NOT a release of medical records.

Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number

"By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me."

For security and to protect against medical identity fraud as well as healthcare operation purposes, a patient photo will be taken.

I have read and acknowledge the above information and understand that this release may be revoked at any time by written request. This authorization will be valid until revoked in writing.

Patient/ Guardian/ Parent Signature	Date

Medical Center Pain Clinic

Timothy Luke Cramer, MD • David P. Ellis, MD

Financial and Appointment Policies (06-10-19)

Thank you for choosing Medical Center Pain Clinic – Timothy Luke Cramer, MD - David P. Ellis, MD – for your health care needs. We are committed to your treatment being successful. Please understand that payment of your bill as well as keeping your regularly scheduled appointments are considered a part of your treatment.

Patient Account
All patients are required to have insurance coverage for services provided in our office. Failure to do so will result in release from our practice.

Full payment of office copays is due at time of service. You are responsible for deductibles and coinsurance as directed by your insurance policy. We accept cash, checks, Visa/Mastercard. For your convenience, we will file insurance claims with all insurance carriers. We cannot bill your insurance company unless you provide us with all insurance information, so please bring your insurance card(s) to each of your appointments. You are responsible to notify us of any changes in insurance coverage each visit. Once the card is presented, we will gladly file a claim and refund any money due you.

I understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collections including court fees, collection agency and attorney fees, in addition to my outstanding account balance. Any legal activity would cause a breech in the physician/patient relationship resulting in discharge from the practice.

Laboratory Services
To assist with clinical decision making, patients will be required to provide random urine drug screens. Preliminary urine drug screens are performed in-office. At the discretion of the physician or provider, preliminary urine drug screens may be sent to a reference lab for confirmatory testing. Patients may incur a separate invoice from the reference lab.

Out of Network or Non-Covered Services
Patient is responsible for balance in full not covered by your carrier and is required to pay when billed.

Workers' Compensation
Only authorized referrals will be accepted. If notification is not received prior to your appointment, you will be responsible for charges at the time of service. Patients must provide the following information prior to the scheduled appointment: attorney's name and phone number; employer's name, contact person and phone number; workers' comp carrier name, adjustor's name and phone number; the date of injury and claim number.

Personal Injuries
Payment is expected at time of service. We will file private insurance provided you have subrogated with your insurance company. You are responsible for all copays at the time of service. Deductible and/or coinsurance is your responsibility and are required to be paid when billed.

Appointment Policies
In order to allow appropriate time and avoid inconveniencing other patients, we have the following standard policies:

- If you cannot keep your scheduled appointment, please give us (24) hours' notice so that we may offer your appointment time to another patient. All No Show appointments will be charged $25 and must be paid before being seen. We cannot file the No Show charge to your insurance.
- If you are more than (10) minutes late for your appointment, we may reschedule you for another day.
- If you are late for your appointment on (3) occasions, you may be dismissed from our practice.
- If you fail to show for an appointment, it may be (30) days before your next scheduled appointment.
- If you fail to show for an appointment on (2) occasions without having given us (24) hours' notice, you may be dismissed from our practice.

After carefully reading and understanding the above terms, I request treatment by Medical Center Pain Clinic – Timothy Luke Cramer, MD – David P. Ellis, MD - and agree to follow the terms of the Financial and Appointment Policies.

_____ _____

Patient/ Guardian/ Parent Signature Date

Medical Center Pain Clinic

Timothy Luke Cramer, MD • David P. Ellis, MD

Opioid (Narcotic) Agreement (03-01-2020)

1. I understand that I have a chronic pain problem which currently requires the prescription of opioid (narcotic) pain medication designed to help improve my ability to function. I understand the long term risks of the dependency and tolerance outweigh the benefits unless function is improved along with the pain being reduced.
2. In the event that I develop a psychological dependency or addiction to the medication or in the opinion of my physician, I display any drug seeking behavior or other evidence of potential addiction, the medication will be tapered in a manner that will avoid withdrawal side effects and then be discontinued. If I am unable to control the intake of my pain medication, I agree to undergo inpatient treatment (detox).
3. I will obtain my prescriptions for opioids (narcotics) and other controlled medications only from Medical Center Pain Clinic - Timothy Luke Cramer, MD – David P. Ellis, MD.
4. **I understand I am required to have a working phone, voicemail set-up and will return calls within (24) hours. I may be released from the practice or my appointment rescheduled, if I fail to return calls.**
5. To the extent possible, I will have prescriptions filled at only one pharmacy.
6. I will take the medication **only as prescribed** and will promptly notify the office if I cannot.
7. I agree to random urine drug tests and medication count to confirm compliance with the planned treatment. Failure to comply may result in release from the practice.
8. I understand that the eventual goal is to taper to the lowest level of opioid (narcotic) medication needed to increase my level of functioning and, if possible, discontinue the medication.
9. I will meet monthly with the providers of Medical Center Pain Clinic to assess my progress.
10. I will not share my medications with others.
11. I understand that it is important to keep my medication locked and away where no one can access them except for me. I understand it is my responsibility to take care of my medications and that lost, misplaced or stolen medications will not be replaced.
12. I understand that refills of medications will be given only during scheduled appointments.
13. If you are unable to tolerate any medication, you must return the unused portion of the medication to our office before you are given a different prescription.
14. Proper and safe disposal of medications is very important. You can contact your local pharmacy or police department for information or for "take back" locations.
15. If requested by a Provider of Medical Center Pain Clinic, I agree to have another individual keep control of the medication and dispense it to me accordingly.
16. Lack of compliance with other therapies prescribed, i.e. other medication therapies, home exercise, physical therapy, imaging request, psychological therapy will lead to tapering and discontinuation of medications or release as a patient.
17. I understand this medication should be stopped slowly with tapering. I should not stop it on my own or without medical advice. I have been made aware of withdrawal side effects which may include excessive tearing, runny nose, dilated pupils, "goose pimples" flesh, sweating, yawning, diarrhea, muscle aches, headaches and/or insomnia.
18. If you fail to appear for an appointment, your medication will not be refilled. If you fail to appear for more than (2) scheduled appointments, you may be dismissed from our practice. You must provide (24) hours' notice to cancel an appointment. If you fail to provide this notice, your appointment will be considered as a failure to appear.
19. I understand that possible reasons for dismissal from our practice may include: rude or disruptive behavior, repeated attempts to obtain extra controlled substances before they are legally available, receiving narcotic prescriptions from multiple physicians or verbal abuse of any kind.
20. Failure to follow terms of this agreement will result in dismissal from our practice.

After carefully reading and understanding the above terms, I request treatment by Medical Center Pain Clinic – Timothy Luke Cramer, MD - David P. Ellis, MD (to include narcotic medications if appropriate), and agree to follow the terms of this agreement.

_____ _____

Patient/Guardian/ Parent Signature Date

Medical Center Pain Clinic

Timothy Luke Cramer, MD • David P. Ellis, MD

Chronic Narcotic Analgesic Therapy for Pain Informed Consent (01-11-2018)

It may recommend that a maintenance narcotic analgesic be given in order to manage your pain and increase your activities at home and at work. As you begin this treatment program you should be aware of the following risks associated with the use of this medication:

Side effects of these medications may include drowsiness, dizziness, constipation, nausea, confusion, altered levels of male and female hormones including level of testosterone and/or respiratory depression including respiratory arrest and death.

You should see how this medication affects you before you drive a motor vehicle or do any task requiring concentration. **You should not drive or operate machinery if the medication makes you feel drowsy**. It usually takes 5 to 7 days for a person to get an idea of how he/she is affected. Frequently these effects diminish in a few days. Any time your dose is increased you may experience sedation. If sedation occurs you should not operate vehicles or machinery until sedation resolves. Cognitive impairment or mental clouding may occur during treatment and may or may not decrease over time. If the medication is used with other sedatives or alcohol the resulting heightened impairment is potentially dangerous. **It is strongly advised not to use alcohol while taking this medication**.

Constipation is a common side effect. If this is a problem for you, try adding fiber and fruit to your diet. You may also try 1) Konsul- mix ½ teaspoon with a cup of water twice a day. 2) Fibercon- one four times a day. 3) Senokot- take 1-4 as needed at bedtime.

The use of other medications can increase side effects. It is important that your physician know all the medication you are taking. Medications that make you sleepy (antihistamines in cold medications and alcohol) will make you sleepier while taking this medication. It is advised that you talk with your physician or pharmacist before buying any over-the-counter products.

Risk of psychological dependence on these medications may occur in probably less than 1% of patients being treated with narcotic analgesics. This means there is a continued desire for the mood altering and other psychological effects of the medication and concern for its continued availability. Communication with our office is necessary for you to understand the role of the medications in your pain management program and to avoid development if this type of dependence.

Risk of physical dependence on these types of medications is very high. With higher doses of this type of medication, your body may get used to it. If you stop taking the medications abruptly, your body may react adversely with withdrawal symptoms. To prevent these uncomfortable symptoms you should take your medication regularly and communicate to your physician any side effects. Discontinuing use of the medication should be under the supervision of your physician.

Questions and issues of addiction are frequently on the minds of patients. Psychological and physical dependence are not the same and they are treated differently. Addiction is a term to describe deviant behavior where the primary goal is to obtain narcotic analgesics for use other than pain control, such as recreational use and other forms of illicit use. Patients who are using these types of medications for medical reason and have a clear understanding of why they are using them are at a very low risk for this problem. If any of the dependence characteristics develop, we will discuss the problem with you and the appropriate measures will be taken.

Tolerance to the medications may occur in the course of your treatment. Tolerance is the decreasing effect of a medication at a stable dose. This is different than increasing the dose to manage an increase in pain. This would mean that your body is adapting to the medication and that the medication is losing its ability to treat your pain. This may call for tapering and stopping of the medication to regain sensitivity to the medication.

Risk to unborn children: If you are a female of childbearing age and become pregnant, there is a risk that any child born will likely be physically dependent at birth. We strongly recommend that you maintain safe and effective birth control while in this program. If you become pregnant, you should immediately contact our office so that the medication can be tapered and stopped. If you are of childbearing age and you are planning a family, you should contact your physician immediately.

Risk of not having this treatment: You should understand that your physician believes that the potential benefit of their treatment outweighs these potential risks and therefore is recommending it to you. However, it is your choice whether or not you accept this treatment plan. If you choose to not follow this treatment, your physician will continue to offer other alternative treatments for your pain. You are free to refuse any treatment.

Evaluation by clinic visits will assess: 1) how effective the treatment is in reducing your pain. 2) Whether or not it improves your function (increases your activity at work or at home). 3) Any adverse effects you have experienced (excessive sedation, constipation and/or worsening depression). 4) Accidental or purposeful medication misuse/abuse. 5) In increased dose from what is recommended by your physician. Each evaluation will be documented in your medical record. If there is no improvement of pain control and function or if you experience bothersome side effects, the medications will be tapered and finally discontinued.

I understand the nature and purpose of this treatment and I affirm that the risks, benefits, possibility of complications, as well as the expected results and medical alternatives, including the expected consequences of refusing the treatment.

_____ _____

Patient/ Guardian/ Parent Signature Date

Medical Center Pain Clinic

Timothy Luke Cramer, MD • David P. Ellis, MD

Acknowledgement of Receipt of Notice of Privacy Practices (01-11-2018)

I acknowledge that I have been provided Medical Center Pain Clinic's (MCPC) Notice of Privacy Practices. I have read and fully understand that MCPC may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and administrative operations related to treatment or payment. I understand that I have the right to request restrictions on how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the office in writing. I also understand that MCPC will consider requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in MCPC's Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing.

_____ _____

Patient/ Guardian/ Parent Signature Date

Medical Center Pain Clinic

New Patient Health Questionnaire (04-07-2020)

Name: _____ Date of Birth: _____

1. **Where is your pain located?** _____

   When did the symptoms start? _____ **Was this due to an injury?** ☐ Yes ☐ No (If "yes", please answer below)

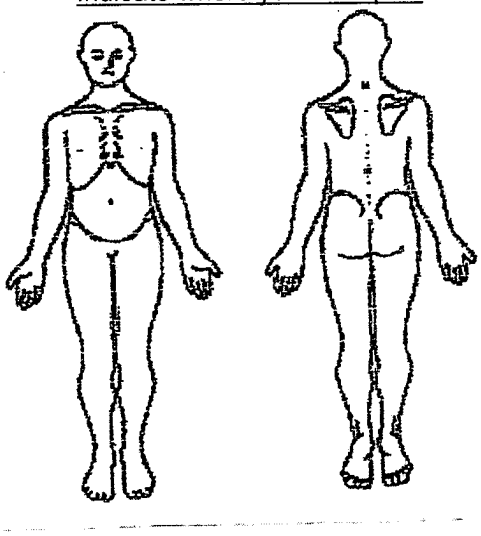
   • Is your injury work related? ☐ Yes ☐ No • Is your injury due to a motor vehicle accident? ☐ Yes ☐ No

2. **What describes the nature of your symptoms?**

   ☐Sharp ☐Shooting ☐Dull ache

   ☐Burning ☐Numb ☐Tingling

Indicate where you have pain



3. **Since they started, are your symptoms**:

   ☐Getting better ☐Not changing ☐Getting worse

4. **Indicate the average intensity of your symptoms**:

   WITH medications
   None 1 2 3 4 5 6 7 8 9 10

   WITHOUT medications
   None 1 2 3 4 5 6 7 8 9 10

5. **In general, how well are you sleeping?**

   ☐I have no pain in bed

   ☐Pain in bed, but not prevented me from sleeping

   ☐Sleep is reduced by 25% because of pain

   ☐Sleep is reduced by 50% because of pain

   ☐Sleep is reduced by 75% because of pain

   ☐Pain prevents me from sleeping

6. **In general, how are you doing with exercise?**

   ☐Not at all ☐Twice per month ☐Once per week ☐Twice per week ☐Three or more times per week

7. **Do any of the following items help to <u>increase</u> your pain? (check all that apply):**

☐ Physical activity	☐ Lying down	☐ Loud noises	☐ Anger
☐ Sitting	☐ Cold weather	☐ Financial worries	☐ Massage
☐ Standing	☐ Damp weather	☐ Stress	
☐ Walking	☐ Warm weather	☐ Other people	

Previous Pain Management Physician _____

Reason you are no longer there? _____

Name: _____ Date of Birth: _____

8. **When you are feeling pain, do any of the following items help to <u>decrease</u> your pain? (check all that apply):**

☐ Lying down	☐ Socializing	☐ Cool compress	☐ TENS unit	☐ Nothing
☐ Sitting	☐ Getting away	☐ Heating pad	☐ Drinking Alcohol	
☐ Standing	☐ Working	☐ Warm bath	☐ Watching TV	
☐ Walking	☐ Activity	☐ Massage	☐ Changing position	

9. **Please answer the following:**

Are you pregnant? ☐ Yes ☐ No ☐ N/A **Are you currently breastfeeding?** ☐ Yes ☐ No ☐ N/A

Do you have any open wounds/spider bites? ☐ Yes ☐ No **Are you currently taking antibiotics?** ☐ Yes ☐ No

Do you have any rashes? ☐ Yes ☐ No

10. **Have you seen any of the following specialists for your pain?** If yes, please list their name:

Anesthesiologist	☐ No ☐ Yes	_____
Pain Management Physician	☐ No ☐ Yes	_____
Neurologist	☐ No ☐ Yes	_____
Surgeon	☐ No ☐ Yes	_____
Primary Care Physician	☐ No ☐ Yes	_____
Psychiatrist/Counselor	☐ No ☐ Yes	_____
Rheumatologist	☐ No ☐ Yes	_____
Other	☐ No ☐ Yes	_____

11. **Previous Treatments: Have you had any of the following treatments for your pain?**

Injections:	☐Yes ☐No	Helpful? ☐Yes ☐No	Who did them?_____
Physical Therapy:	☐Yes ☐No	Helpful? ☐Yes ☐No	What facility?_____
Massage Therapy:	☐Yes ☐No	Helpful? ☐Yes ☐No	What facility?_____
Chiropractor:	☐Yes ☐No	Helpful? ☐Yes ☐No	Who?_____
Accupuncture:	☐Yes ☐No	Helpful? ☐Yes ☐No	Who?_____
TENS unit:	☐Yes ☐No	Helpful? ☐Yes ☐No	

12. **Previous Workup: Have you had any of the following tests for your pain area?**

X-rays:	[] Yes [] No	If yes, date _____	Where performed:_____
CT scan:	[] Yes [] No	If yes, date _____	Where performed:_____
MRI scan:	[] Yes [] No	If yes, date _____	Where performed:_____
Discography:	[] Yes [] No	If yes, date _____	Where performed:_____

Name: _____ Date of Birth: _____

13. **MEDICATIONS**
Pharmacy:_____
NAME ADDRESS PHONE NUMBER

Are you currently taking blood thinners, aspirin or baby aspirin? [] NO [] YES If YES, please list below.

Medication Name	Strength	How often do you take it?

***** If you provide a MEDICATION LIST, you must SIGN and Date the form. *****

14. **MEDICAL HISTORY (check all that apply)**

☐ Heart attack	☐ High blood pressure	☐ Pneumonia	☐ Rheumatoid Arthritis	☐ Vascular disease
☐ Heart failure	☐ High cholesterol	☐ Bronchitis	☐ Osteoarthritis	☐ Blood clot in leg
☐ Angina (chest pain)	☐ Diabetes	☐ Asthma	☐ Lupus	☐ Gout
☐ Pacemaker/defibrillator	☐ Glaucoma	☐ Emphysema	☐ Multiple sclerosis	☐ Anemia
☐ Stroke/TIA	☐ Rheumatic fever	☐ COPD	☐ Sickle Cell disease	☐ HIV
☐ Headache	☐ Bipolar disorder	☐ Kidney stones	☐ Osteoporosis	☐ AIDS
☐ Hearing disorder	☐ Schizophrenia	☐ Hepatitis A		
☐ Anxiety	☐ Alcohol abuse	☐ Hepatitis C	☐ Cancer of_____	
☐ Depression	☐ Drug dependence	☐ Stomach Ulcers	☐ Other _____	
☐ PTSD	☐ Kidney failure	☐ Thyroid problems	_____	

15. **ALLERGIES:** ☐LATEX ☐IODINE ☐MEDICATIONS (please list):_____

_____

16. **SURGICAL HISTORY**

Operation	Date	Surgeon	Where was it performed

Name: _____ Date of Birth: _____

17. **HOSPITAL STAYS or EMERGENCY ROOM VISITS**

Date	Reason	Location

18. **FAMILY MEDICAL HISTORY (please indicate any blood relatives with the following illnesses or pain problem)**

Condition	Mother, Father, Brother, Sister, Grandparent, Aunt, Uncle, or Children
Bleeding Disorder	Who: ☐ Alive ☐Deceased
Cancer	Who: ☐ Alive ☐Deceased
Diabetes	Who: ☐ Alive ☐Deceased
Heart Disease	Who: ☐ Alive ☐Deceased
High blood pressure	Who: ☐ Alive ☐Deceased
Stroke	Who: ☐ Alive ☐Deceased
Osteoporosis	Who: ☐ Alive ☐Deceased
Rheumatoid Arthritis	Who: ☐ Alive ☐Deceased
Addiction	Who: ☐ Alive ☐Deceased

19. **SOCIAL HISTORY**

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Who lives with you at home?_____

Use of alcohol: ☐ Never ☐ Rarely ☐ Frequent (drinks per week ___)

☐ Alcohol Dependent ☐ Recovered Alcoholic

Use of tobacco (smoke or chew): ☐ Never ☐ Current, ___ packs a day ☐ Quit date _____

☐ Live with a smoker ☐ Work around smoke/smokers

Abuse of prescription drugs? ☐ Never ☐ Current, drug:_____ ☐ Past, drug:_____

Recreational drug use? ☐ Never ☐ Current, drug:_____ ☐ Past, drug:_____

Have you ever been treated for an accidental overdose? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

Have you ever been physically abused? ☐ Yes ☐ No

Have you ever been sexually abused? ☐ Yes ☐ No

Work: ☐ Working, job _____ ☐ Not Working ☐ Retired ☐ Disabled

☐ Student ☐ Homemaker ☐ Veteran

Name: _____ Date of Birth: _____

20. **Please mark any symptoms experienced in the past month**

General

Recent weight loss	☐ Yes	☐No
Recent weight gain	☐Yes	☐No
Fever	☐Yes	☐No
Headache	☐Yes	☐No
Fatigue	☐Yes	☐No

Eyes

Eye disease or injury	☐Yes	☐No
Blurred vision	☐Yes	☐No
Dry eyes	☐Yes	☐No

Ear/Nose/Mouth/Throat

Hearing loss	☐Yes	☐No
Ringing in ears	☐Yes	☐No
Dry mouth	☐Yes	☐No
Sinus pain	☐Yes	☐No

Endocrine

Thyroid disease	☐Yes	☐No
Diabetes	☐Yes	☐No
Heat intolerance	☐Yes	☐No
Cold intolerance	☐Yes	☐No

Respiratory

Chronic or frequent coughs	☐Yes	☐No
Shortness of breath	☐Yes	☐No
Wheezing	☐Yes	☐No

Cardiovascular

Shortness of breath with exercise	☐Yes	☐No
Chest pain with exercise	☐Yes	☐No
Palpitations	☐Yes	☐No
Dizziness	☐Yes	☐No
Swelling of feet, ankles, or hands	☐Yes	☐No
Murmurs	☐Yes	☐No

Gastrointestinal

Nausea	☐Yes	☐No
Vomiting	☐Yes	☐No
Frequent diarrhea	☐Yes	☐No
Constipation	☐Yes	☐No
Rectal bleeding or blood in stool	☐Yes	☐No

Genitourinary

Frequent urination	☐Yes	☐No
Incontinence or dribbling	☐Yes	☐No
Difficulty urinating	☐Yes	☐No
Blood in urine	☐Yes	☐No
Female – pain with periods	☐Yes	☐No
Could you be pregnant now	☐Yes	☐No
Are you breast feeding	☐Yes	☐No
Pain with intercourse	☐Yes	☐No

Musculoskeletal

Joint pain	☐Yes	☐No
Joint Stiffness	☐Yes	☐No
Weakness	☐Yes	☐No
Muscle Cramps	☐Yes	☐No

Integumentary

Change in skin color	☐Yes	☐No
Dry skin	☐Yes	☐No
Hives	☐Yes	☐No
Skin Cancer	☐Yes	☐No

Neurological

Fainting	☐Yes	☐No
Light headed or dizzy	☐Yes	☐No
Convulsions or seizures	☐Yes	☐No
Numbness/Tingling	☐Yes	☐No
Memory loss or confusion	☐Yes	☐No

Psychiatric

Anxiety	☐Yes	☐No
Depression	☐Yes	☐No
Insomnia	☐Yes	☐No

Abdominal pain	☐Yes	☐No
Peptic Ulcer	☐Yes	☐No
Hepatitis	☐Yes	☐No
Pancreatitis	☐Yes	☐No

My signature confirms that the answers to the above questions are accurate and answered to the best of my ability. I understand that false information may result in release from this practice.

_____ _____

Patient/ Guardian (if under 18) signature Date

Personal Goals for Chronic Pain (11-15-2016)

Patient:_____ **DOB:** _____ **Date :**_____

<u>This information is required</u>. Per CDC guidelines and most insurance carriers, this is necessary for the treatment of chronic pain.

<u>Let's work together to set personal measureable goals. For example:</u> I can walk to the end of the drive way with a pain level of (8), but I would like to walk one block with decreased pain level to (5) and meet this goal within (12) months.

1. I would like to return to **<u>specific</u>** activities, hobbies, sports, work, etc... _____

_____

2. When doing this specific activity, my pain level is a: (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
3. I would like to **<u>decrease</u>** my pain level to a: (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

   within the next _____ weeks _____ months _____ years

Comments:_____

<u>Increase physical activity</u>

☐ Complete daily stretching (_____ # of reps, _____ times per day, for _____ minutes)

☐ Complete aerobic exercise/endurance exercise

Walking (_____ times per day, for _____ minutes) **<u>or</u>** pedometer (_____steps per day)

Treadmill, bike, rower, elliptical trainer (_____ times per week, for _____ minutes)

Swimming or water aerobics (_____ # of laps, _____ times per week, for _____ minutes)

☐ Strengthening

Elastic bands, hand weights or machines (_____ # of reps, ____ times per day, for ____ minutes)

Comments:_____

For Provider Use Only

_____

_____

_____

_____

Initials _____ **Physician or Provider Signature** _____

Medical Center Pain Clinic, PLLC
1226 N. Shartel Ave, #300, Oklahoma City, OK 73103
Phone (405) 232-8003 FAX (405) 232-8008

Date: _____

Patient: _____ Date of Birth: _____

SOAPP®-R

The following are questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

Patient: _____ Date of Birth: _____

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

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

_____ _____

Patient's Signature Date

For Provider Use Only **SCORE** _____

_____

Provider Signature _____ Date _____