



# Center for Spine & Pain Medicine

## Narcotic Administration Agreement

This is an agreement between you and Center for Spine & Pain Medicine. When controlled substances are being prescribed to control pain, improve the quality of life and function, and minimize disability, the following are the treating Physician's expectations:

### PLEASE READ AND INITIAL EACH ONE

1. \_\_\_\_ The patient will provide a complete history including past pain treatment, any alcohol or drug addiction/dependency history, medical/psychiatric/legal history.
2. \_\_\_\_ Follow your doctors recommendations, **DO NOT** take more or less of any prescribed medications without discussing this with the physician and receiving permission to do so. By doing so it may lead to discontinuation of medication and/or termination from practice.
3. \_\_\_\_ **DO NOT** share or take medications from any other persons including family members; **DO NOT** sell any of your medications. By doing so it may lead to discontinuation of medication and/or termination from practice.
4. \_\_\_\_ Patient will agree to store their medications in a safe guarded place to keep others from stealing and/or abusing them.
5. \_\_\_\_ CSPM will be the only source of pain medication. Written/Verbal authorization will be given when and if another care provider is going to assume medication prescribing responsibilities. **(This includes Post Surgical Prescriptions)**
6. \_\_\_\_ Regularly scheduled appointments will be kept on a frequency determined by the physician. The patient will be seen at least once every 4-8 weeks. Cancellations or missed appointments may lead to discontinuation of the medication and/or termination from practice.
7. \_\_\_\_ I will submit to a urine and/or saliva sample on request at ANY time without prior notification to detect the use of non-prescribed medications, illicit drugs and to confirm the use of prescribed medications. I will submit to random pill counts without notification as per Physicians request.
8. \_\_\_\_ Any evidence of drug seeking behavior such as; the use of illegal drugs, use of alcohol, frequent request for dose increases, or early refills can lead to discontinuation of the medication and/or termination from practice.
9. \_\_\_\_ No prescriptions for controlled substances will be provided on the weekends, holidays or outside of regular business hours.
10. \_\_\_\_ The patient will utilize the pain medication for their medically intended purpose only. CSPM provider may prescribe you pain medication with off label indication.
11. \_\_\_\_ The patient authorizes CSPM to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of medicine. The patient authorizes to provide a copy of this agreement to the pharmacy. The patient waives any right of privacy or confidentiality with respect to these authorizations.
12. \_\_\_\_ If your physician determines that you are not a good candidate to continue with the medication, the physician may discontinue treating you at his/her own discretion and you may be referred to a detoxification program/addiction specialist.

Patient Printed Name: \_\_\_\_\_

13. \_\_\_\_ The patient agrees to immediately inform CSPM if they become pregnant or intend on becoming pregnant.
14. \_\_\_\_ In case of adverse reaction or inefficiency, the patient will not destroy his/her medication on their own. The patient would need to bring medication back to CSPM for pill count before any other medications will be prescribed.
15. \_\_\_\_ Do not operate a motor vehicle if you feel mentally impaired while using controlled medications. The patient is responsible for exhibiting good judgment in daily affairs, including the use of your controlled medications. Alcohol use should be abstained from while using controlled medication.
16. \_\_\_\_ The patient understands that the controlled substance can be discontinued immediately if the patient does not fulfill the terms of this agreement.

Use of narcotic/opiate pain medicines have certain risks including but not limited to: sleepiness, drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing and slowing of reflexes or reaction time.

Chronic use of narcotic medicines in males may be associated with low testosterone levels. This may affect mood, stamina, sexual desire, and physical performance. Females who become pregnant need to contact this office immediately. Appropriate contraception will be used while on the narcotic medication.

The patient understands that the use of narcotic medication has potential complications including: the development of tolerance (reduced effect over time), dependency (potential for withdrawal symptoms upon abrupt discontinuation), and the possibility of "addiction" (loss of control, compulsive use and continued use despite adverse social, physical or psychological consequences).

**ONLY ONE PHARMACY WILL BE USED TO FILL PRESCRIPTIONS FOR  
CONTROLLED SUBSTANCES**

**(It is your responsibility to notify our office if you choose to use/change to another pharmacy)**

**Name of Pharmacy:** \_\_\_\_\_

**Pharmacy location:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

This document will be kept as part of the medical record and updated yearly. By signing this you acknowledge that you have read, understand and agree to the above expectations. Failure to follow these guidelines can lead to discontinuation of medication and/or treatment.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Printed Name:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Center for Spine & Pain Medicine

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## Release of Medication Authorization

Due to new regulations in patient confidentiality, it is necessary for you to provide a list of people that you have authorized to pick up your prescriptions, in the event that you are unable to do so. Please list up to 3 people that are over the age of 18. They must present a picture ID upon picking up your prescriptions. We will not release your prescriptions to anyone who we do not have written authorization.

In addition, when you call for your prescriptions to be picked up, if you are not planning to pick your prescriptions up personally, please indicate the name of the designee that will be picking up your prescription. When leaving a message on the refill line, please include the medication information and the name of the person who will be picking up the prescription. If you do not leave the name of the person picking up the prescription, we will assume that you are picking up your prescription and we will not release the prescription to anyone but you.

We appreciate your cooperation in this matter as we strive to provide more excellent care to you as our patient.

Sincerely,

Center for Spine & Pain Medicine

**Listed below are the people authorized to pick up medication and prescriptions on my behalf.**

**\*\*THEY MUST BE AT LEAST 18 YEARS OF AGE AND HAVE A PICTURE ID\*\***

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

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PATIENT'S SIGNATURE

DATE

# Center for Spine & Pain Medicine

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## FINANCIAL POLICY

The objective of this office is to provide you with the highest quality health care in the most cost effective manner. However, the ability of Center for Spine & Pain Medicine, to achieve this depends greatly on your understanding of our financial policy.

IF YOU HAVE MEDICAL INSURANCE, WE WILL FILE YOUR CLAIMS ON YOUR BEHALF. This is done as a courtesy to our patients. We are glad to help you receive the maximum allowable benefits from your insurance. Even though we will file the insurance claim for you, we also need your active participation in the insurance claims process. Your insurance contract is between you and your insurance company. If your insurance pays only part of your bill or rejects your claim, you are financially responsible for the balance and the balance is due upon receipt of your statement. We also check your eligibility as a courtesy. If your eligibility status changes and we are made aware of the change after you have already been seen, you will be responsible for either providing an alternate insurance or payment of the balance in full. You are responsible to pay your copay/deductibles/coinsurance at the time of service. It is your responsibility to make sure that the insurance information that we have on file is correct. In the event that you get a new insurance card in the mail from your insurance company please bring it with you to your next appointment.

### *Authorization for Request of Medical Records*

I hereby authorize Center for Spine & Pain Medicine physicians to release information from my records verbally, via fax or mail to insurance companies, utilization review companies, lawyers and other physicians. This may include diagnosis and test results, which may include drug, alcohol, psychological conditions and Acquired Immunodeficiency Syndrome.

### *Authorization to Release Information to Center for Spine & Pain Medicine*

I hereby authorize my physicians to release information from my records verbally, via fax or mail to Center for Spine & Pain Medicine. This may include diagnosis and test results, which may include drug, alcohol, psychological conditions and Acquired Immunodeficiency Syndrome.

### *Photography Authorization*

I hereby authorize Center for Spine & Pain Medicine to take photographs necessary to document my physical condition & identity. The photograph can/will be used for documentation & identity verification only.

### *Medicare Patients*

As a participating provider of Medicare Part B (Physician Services), Center for Spine & Pain Medicine will only bill you your Medicare co-insurance, deductible or any services rendered that are not covered by Medicare. All other services will be billed directly to Medicare. PAYMENT FOR SERVICES NOT COVERED BY MEDICARE ARE TO BE PAID THE DAY SERVICE IS PERFORMED. For covered services, you will be responsible for paying your 20% co-insurance amount at the time of service if you do not have secondary insurance. If you have Medicare Part A only the services you receive from our practice will not be covered by Medicare and payment is due at the time of service.



# Center for Spine & Pain Medicine

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## URINE DRUG SCREEN TESTING POLICY

Dear Patient,

As you are probably aware, some of the medications we prescribe are "controlled substances" (ex. Oxycodone, Morphine, Hydrocodone, etc.). While regulatory agencies, such as The DEA, The Board of Medical Licensure, and the police require us to monitor our patients who take these medications, most importantly we do it to promote your safety. Therefore, to help provide you with safe and responsible healthcare we will randomly require you to participate in urine drug testing three to four times a year.

Please keep in mind that this may not be the only time you could be required to have a Urine Drug Screen. We consider urine drug testing to be a normal monitoring procedure for anyone taking controlled substances. We monitor controlled substances just like your primary care physician monitors your cholesterol, blood sugar levels and blood pressure.

The billing policy for Urine Drug Screens is as follows:

- ***Patients whose insurance excludes*** Urine Drug Screens will be charged cash price per test. This fee is expected to be paid at the time of service.
- ***Patients with insurance*** will be billed the amount put to their deductible by their insurance. As a courtesy we will adjust off any amount that is put to your co-insurance. ***\*\*\*The only time you will be responsible to pay for a Urine Drug Screen is when it is applied to your deductible.\*\*\****

We appreciate your cooperation. We are all in this together. If you have any questions, please contact our office.

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Patient Signature

Date

# HIPAA Privacy Authorization Form

\*\*Authorization for Use or Disclosure of Protected Health Information  
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.  
Parts 160 and 164)\*\*

## \*\*1. Authorization\*\*

I authorize \_\_\_\_\_ (healthcare provider) to use and disclose the protected health information described below to the following people.

Name	Relationship	Phone#
_____	_____	_____
Name	Relationship	Phone#
_____	_____	_____
Name	Relationship	Phone#
_____	_____	_____

## \*\*2. Effective Period\*\*

This authorization for release of information covers the period of healthcare from:

a.  \_\_\_\_\_ to \_\_\_\_\_ Specific Date Range.

**\*\*OR\*\***

b.  all past, present, and future periods.

## \*\*3. Extent of Authorization\*\*

a.  I authorize the release of my **COMPLETE** health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

**\*\*OR\*\***

b.  I authorize the release of my complete health record with the exception of the following information:

- Mental health records
- Communicable diseases (including HIV and AIDS)
- Alcohol/drug abuse treatment
- Other (please specify): \_\_\_\_\_

**4.** This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

**5.** This authorization shall be in force and effect until \_\_\_\_\_ (date or event), at which time this authorization expires.



**6.** I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the Insurer has a legal right to contest a claim.

**7.** I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

**8.** I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

**9.**  I have received a copy of CSPM Privacy Practices.

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**Signature of patient or personal representative**

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**Printed name of patient or personal representative**

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**DATE**

## 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.

Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. Example: results of laboratory tests and diagnostic procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. Example: your health plan may request and receive information on dates of service, services provided, and the medical condition being treated.

Your health information may be used as necessary to support the day to day activities and management of Center for Spine & Pain Medicine Ambulatory Surgery Center. Example: information on the services you received may be used to support budgeting and financial reporting or activities to evaluate and promote quality.

Your health information may be disclosed to law enforce agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Your health information may be disclosed to public health agencies as required by law. Example: we are required to report certain communicable diseases to the states Public Health Department. Disclosure of your health information or use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your revocation will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional use of information: your health information will be used by our staff to call or send your appointment reminders.

You have certain rights under Federal Privacy Standards. These include:

1. The right to request restrictions on the use and disclosure of your protected health information
2. The right to receive confidential communications concerning your medical condition and treatment
3. The right to inspect and copy your protected health information
4. The right to amend or submit corrections to your protected health information
5. The right to receive an accounting of how and to whom your protected health information has been disclosed
6. The right to receive a printed copy of this notice

### Grievance Policy

Center for Spine & Pain Medicine Ambulatory Surgery Center is required by law to maintain the privacy of your protected health information and to provide you with this notice of Privacy Practices.

We are required to abide by the privacy policies and practices that are outlined in this notice.

To file a complaint with the State agency that licenses this facility, call 1-800-878-6442.

Health Care Facilities  
Attn: Complaints Unit  
227 French Landing Ste. 501  
Nashville, TN 37243  
(800) 287-0010

Website for Office of Medicare Beneficiary Ombudsman:

[www.cms.hhs.gov/center/ombudsman.asp](http://www.cms.hhs.gov/center/ombudsman.asp)

To File a Complaint with The Joint Commission

Call 1-800-994-6610

[complaint@jointcommission.org](mailto:complaint@jointcommission.org)

Office of Quality Monitoring  
One Renaissance Boulevard  
Oakbrook Terrace, IL 60181

[http://www.jointcommission.org/report\\_a\\_complaint.aspx](http://www.jointcommission.org/report_a_complaint.aspx)

# PAIN MANAGEMENT INITIAL EVALUATION

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Sex:  Male  Female

Location of your pain \_\_\_\_\_

Date your pain first started \_\_\_\_\_

What caused your pain \_\_\_\_\_

How intense is your pain?



0

1

2

3

4

5

6

7

8

9

10

NO Pain

Moderate  
Pain

Worst  
Possible  
Pain

## Describe your pain (circle the most descriptive words)

Constant / Intermittent (Sometimes): Stabbing - Shooting - Sharp - Dull - Aching

Tingling - Numbness - Throbbing - Burning

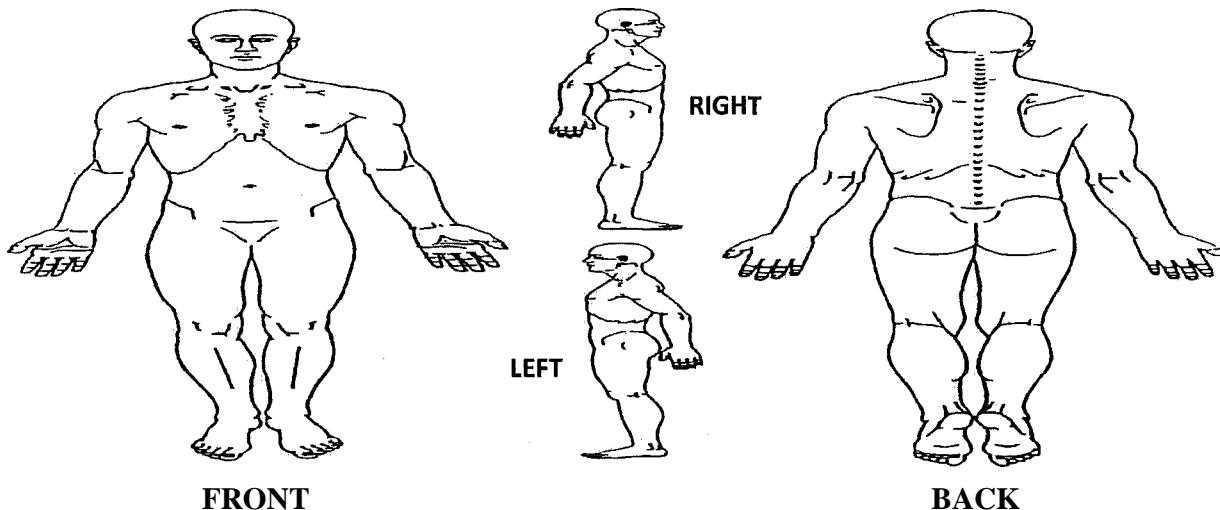
## My pain is made WORSE by (circle the most descriptive words):

Laying - Sitting - Standing - Walking - Exercise - Bending - Lifting - Cold Weather

## My pain is made BETTER by (circle the most descriptive words):

Sitting - Standing - Walking - Repositioning - Lying - Exercise - Medications - Heat - Ice

Using the drawing below, please shade all the areas of pain as specifically as possible.



**Has your pain affected any of the following? If yes, please describe how it has affected you.**

- |  |   |
|--|---|
| <input type="radio"/> Daily Activities _____ | <input type="radio"/> Weight _____      |
| <input type="radio"/> Sleep _____            | <input type="radio"/> Mood Nerves _____ |
| <input type="radio"/> Relationships _____    | <input type="radio"/> Work (Job) _____  |

**Which diagnostic tests have you had for your pain? Please list where and when you had these tests performed.**

- |  |                                       |
|--|---------------------------------------|
| <input type="radio"/> X-Rays _____     | <input type="radio"/> CT Scan _____   |
| <input type="radio"/> UltraSound _____ | <input type="radio"/> Bone Scan _____ |
| <input type="radio"/> MRI _____        | <input type="radio"/> EMG/NCS _____   |

**Have you tried any of the following to help manage your pain? Did it help? Y-Yes N-No**

- |                                    |     |                                    |     |  |     |
|------------------------------------|-----|------------------------------------|-----|--|-----|
| <input type="radio"/> Bed Rest     | Y/N | <input type="radio"/> TENS Unit    | Y/N | <input type="radio"/> Exercise Program | Y/N |
| <input type="radio"/> Traction     | Y/N | <input type="radio"/> Biofeedback  | Y/N | <input type="radio"/> Physical Therapy | Y/N |
| <input type="radio"/> Heat Therapy | Y/N | <input type="radio"/> Acupuncture  | Y/N | <input type="radio"/> Psychotherapy    | Y/N |
| <input type="radio"/> Ultrasound   | Y/N | <input type="radio"/> Chiropractor | Y/N | <input type="radio"/> Work Hardening   | Y/N |

**Pain Management Procedures**

**Have you tried any of the following pain management procedures in the past? If you have please list when and where you had these procedures performed.**

**Did it help? Y- Yes N- No**

- |  |     |
|--|-----|
| <input type="radio"/> Joint Injections _____           | Y/N |
| <input type="radio"/> Trigger Point Injections _____   | Y/N |
| <input type="radio"/> Nerve Block Injections _____     | Y/N |
| <input type="radio"/> Spinal/Epidural Injections _____ | Y/N |
| <input type="radio"/> Spinal Cord Stimulator _____     | Y/N |
| <input type="radio"/> Internal Narcotic Pump _____     | Y/N |

**Medication History**

**Please ONLY check the medications you have tried in the past to help manage your pain and if they helped.**

- |                                   |     |                                  |     |                                 |     |                                 |     |
|-----------------------------------|-----|----------------------------------|-----|---------------------------------|-----|---------------------------------|-----|
| <input type="radio"/> Ibuprofen   | Y/N | <input type="radio"/> Flexeril   | Y/N | <input type="radio"/> Lyrica    | Y/N | <input type="radio"/> Sonata    | Y/N |
| <input type="radio"/> Naproxen    | Y/N | <input type="radio"/> Robaxin    | Y/N | <input type="radio"/> Risperdal | Y/N | <input type="radio"/> Ambien    | Y/N |
| <input type="radio"/> Relafen     | Y/N | <input type="radio"/> Soma       | Y/N | <input type="radio"/> Pristiq   | Y/N | <input type="radio"/> Lunesta   | Y/N |
| <input type="radio"/> Arthrotec   | Y/N | <input type="radio"/> Zanaflex   | Y/N | <input type="radio"/> Savella   | Y/N | <input type="radio"/> Klonopin  | Y/N |
| <input type="radio"/> Celebrex    | Y/N | <input type="radio"/> Valium     | Y/N | <input type="radio"/> Midrin    | Y/N | <input type="radio"/> Restoril  | Y/N |
| <input type="radio"/> Mobic       | Y/N | <input type="radio"/> Roxicodone | Y/N | <input type="radio"/> Fioricet  | Y/N | <input type="radio"/> Ativan    | Y/N |
| <input type="radio"/> Tramadol    | Y/N | <input type="radio"/> Dilaudid   | Y/N | <input type="radio"/> Amerge    | Y/N | <input type="radio"/> Xanax     | Y/N |
| <input type="radio"/> Tylenol     | Y/N | <input type="radio"/> Percocet   | Y/N | <input type="radio"/> Imitrex   | Y/N | <input type="radio"/> Topamax   | Y/N |
| <input type="radio"/> Hydrocodone | Y/N | <input type="radio"/> Oxycontin  | Y/N | <input type="radio"/> Maxalt    | Y/N | <input type="radio"/> Neurontin | Y/N |
| <input type="radio"/> Demerol     | Y/N | <input type="radio"/> MS Contin  | Y/N | <input type="radio"/> Zomig     | Y/N | <input type="radio"/> Cymbalta  | Y/N |
| <input type="radio"/> Stadol      | Y/N | <input type="radio"/> Kadian     | Y/N | <input type="radio"/> Trazodone | Y/N | <input type="radio"/> Butrans   | Y/N |
| <input type="radio"/> Baclofen    | Y/N | <input type="radio"/> Duragesic  | Y/N | <input type="radio"/> Elavil    | Y/N | <input type="radio"/> Exalgo    | Y/N |
| <input type="radio"/> Skelaxin    | Y/N | <input type="radio"/> Methadone  | Y/N | <input type="radio"/> Remeron   | Y/N |                                 |     |

**Past Medical History**

**Which of the following do you have or have you had in the past?**

- |  |  |   |  |
|--|--|---|--|
| <input type="radio"/> Stroke               | <input type="radio"/> Reflux             | <input type="radio"/> Osteoporosis              | <input type="radio"/> Seizures                 |
| <input type="radio"/> Ulcers               | <input type="radio"/> Cancer             | <input type="radio"/> Migraines                 | <input type="radio"/> Diverticulitis           |
| <input type="radio"/> Hepatitis            | <input type="radio"/> Asthma             | <input type="radio"/> Diabetes                  | <input type="radio"/> HIV                      |
| <input type="radio"/> Emphysema            | <input type="radio"/> Liver Disease      | <input type="radio"/> Syphilis                  | <input type="radio"/> Gonorrhea                |
| <input type="radio"/> Heart Disease        | <input type="radio"/> Kidney Disease     | <input type="radio"/> Drug/Alcohol Abuse        | <input type="radio"/> Gout                     |
| <input type="radio"/> Bronchitis/Sinusitis | <input type="radio"/> Arthritis          | <input type="radio"/> High Blood Pressure       | <input type="radio"/> Congestive Heart Failure |
| <input type="radio"/> Parkinson's Disease  | <input type="radio"/> Currently Pregnant | <input type="radio"/> Trying to become Pregnant |  |

**Past Surgical History**

**Which, if any, of the following have you had? Please include the approximate date.**

- |  |   |   |
|--|---|---|
| <input type="radio"/> Brain Surgery      | <input type="radio"/> Stomach Surgery           | <input type="radio"/> Blood Vessel Surgery    |
| <input type="radio"/> Facial Surgery     | <input type="radio"/> Gallbladder Surgery       | <input type="radio"/> Spine Surgery Neck      |
| <input type="radio"/> Eye Surgery L or R | <input type="radio"/> Bowel Surgery             | <input type="radio"/> Spine Surgery Back      |
| <input type="radio"/> Oral Surgery       | <input type="radio"/> Appendectomy              | <input type="radio"/> Shoulder Surgery L or R |
| <input type="radio"/> Tonsillectomy      | <input type="radio"/> Hand/Wrist Surgery L or R | <input type="radio"/> Hernia Repair           |
| <input type="radio"/> Thyroid Surgery    | <input type="radio"/> Kidney Surgery L or R     | <input type="radio"/> Hip Surgery L or R      |
| <input type="radio"/> Lung Surgery       | <input type="radio"/> Bladder Surgery           | <input type="radio"/> Knee Surgery L or R     |
| <input type="radio"/> Heart Surgery      | <input type="radio"/> Tubal Ligation            | <input type="radio"/> Foot Surgery Lor R      |
| <input type="radio"/> Hysterectomy       |   |   |

**Please list and indicate current dosage and frequency of ALL medications currently being taken including herbs, vitamins, and supplements.**

Name of Medication	Dosage	Frequency

**List ALL your medication allergies and their reactions:**

Medication	Reaction	Other allergies:
		Are you allergic to latex? Y/N
		Are you allergic to metals? Y/N
		Are you allergic to tape? Y/N
		Are you allergic to any vaccines? Y/N

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**Family History**  
**Grandparents, Parents, Brothers, Sisters**

- |  |  |                                    |
|--|--|------------------------------------|
| <input type="radio"/> Stroke                   | <input type="radio"/> Reflux           | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Seizures                 | <input type="radio"/> Ulcers           | <input type="radio"/> Cancer       |
| <input type="radio"/> Migraines                | <input type="radio"/> Diverticulitis   | <input type="radio"/> Other: _____ |
| <input type="radio"/> Asthma                   | <input type="radio"/> Diabetes         | <input type="radio"/> Other: _____ |
| <input type="radio"/> Emphysema                | <input type="radio"/> Liver Disease    | <input type="radio"/> Other: _____ |
| <input type="radio"/> Heart Disease            | <input type="radio"/> Kidney Disease   | <input type="radio"/> Other: _____ |
| <input type="radio"/> Congestive Heart Failure | <input type="radio"/> Arthritis        | <input type="radio"/> Other: _____ |
| <input type="radio"/> High Blood Pressure      | <input type="radio"/> Gout             | <input type="radio"/> Other: _____ |
| <input type="radio"/> COPD                     | <input type="radio"/> High Cholesterol | <input type="radio"/> Other: _____ |
- 

**Social History**

- Marital Status:**     Single         Married         Divorced         Widowed
- Living Situation:**     Alone         W/Spouse         Family/Friend     Homeless
- Your Habits:**         Alcohol         Tobacco         Caffeine         Illicit Drugs
- If you use tobacco, do you**     Smoke     Dip/Chew    How much?? \_\_\_\_\_
- 

**Work Status**

- Are you currently:     Employed         Unemployed         Disabled         Retired
- Full Time     Part Time
- If you are disabled, is it     Long Term     Short Term
- On what date did you become disabled: \_\_\_\_\_
- Are you being treated for a Work Camp Injury?     Yes     No
- Are you being treated for an automobile accident?     Yes     No
- Are there legal issues to your pain problem?     Yes     No
- Have you retained an attorney?     Yes     No
- Name of your Attorney: \_\_\_\_\_
- Address of your Attorney: \_\_\_\_\_
- Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

In your own words please describe what type of work you do or were doing prior to your injury

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## **Review of Systems**

**Check all that you have**

### **General**

- Good general health lately
- Poor Sleep
- Fatigue

### **Cardiovascular**

- Angina
- Fluid retention
- Cardiac arrhythmia
- Heart murmur

### **Respiratory**

- Asthma
- Chronic cough
- Shortness of breath
- Wheezing

### **Musculoskeletal**

- Neck pain
- Back pain
- Difficulty walking
- Joint pain
- Joint stiffness
- Joint swelling
- Muscle Cramps

### **Neurological**

- Lightheaded or dizzy
- Stroke
- Head Injury
- Paralysis
- Frequent Headaches
- Memory Loss
- Seizures
- Tingling/Numbness
- Tremors

### **Psychiatric**

- Addiction
- Anxiety
- Nervousness
- Depression
- Mental Illness
- High stress level
- Suicidal thoughts

### **Endocrine**

- Diabetes
- Hypothyroid
- Hyperthyroid

### **Gastrointestinal**

- Loss of Appetite
- Peptic ulcers
- Blood in stool
- Hepatitis/Jaundice
- Abdominal pain
- Change in bowel habits
- Constipation
- Diarrhea
- Heartburn
- Nausea
- Vomiting

### **Hematological**

- Abnormal bleeding
  - Anticoagulant therapy/blood thinners
-

## SOAPP QUESTIONNAIRE

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

<u>Patient Name:</u>	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How often have you felt a need for higher doses of medication to treat your pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. How often have you felt impatient with your doctors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. How often have you felt that things are just too overwhelming that you can't handle them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. How often is there tension in the home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. How often have you counted pain pills to see how many are remaining?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. How often have you been concerned that people will judge you for taking pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. How often do you feel bored?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. How often have you taken more pain medication than you were supposed to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. How often have you worried about being left alone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. How often have you felt a craving for medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. How often have others expressed concern over your use of medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. How often have any of your close friends had a problem with alcohol or drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. How often have others told you that you had a bad temper?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. How often have you felt consumed by the need to get pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. How often have you run out of pain medication early?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. How often have others kept you from getting what you deserve?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. How often, in your lifetime, have you had legal problems or been arrested?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. How often have you attended an AA or NA meeting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. How often have you been in an argument that was out of control that someone got hurt?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. How often have you been sexually abused?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. How often have others suggested that you have a drug or alcohol problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. How often have you had to borrow pain medications from your family or friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. How often have you been treated for an alcohol or drug problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



