

PATIENT NAME (Print): _____ DATE: _____

TO OUR PATIENTS

Thank you for choosing Coastal Pain Care. Please complete this entire packet prior to your appointment time. This information is vital to our plan of care for you. You may return the forms at any time, or bring to your appointment. If you need our staff to assist you in completing the forms, please arrive 45 minutes prior to your appointment time, and promptly notify our staff for assistance.

****Please be sure to use black ink****

If the packet is not completed by the time of your appointment, we will be forced to

Reschedule your appointment

Bring the following with you to your appointment:

1. *Photo identification*
2. *Insurance cards*
3. *All medications (or complete medication list)*

Notices:

- All patients are subject to a random urine drug screen in the office at any time. This is **NOT OPTIONAL**.
- This practice utilizes the services of specially trained **NURSE PRACTITIONERS**. Most of your follow up appointments will be with one of them.

Thank you for choosing Coastal Pain Care,

Craig A Charleston, MD
Daniel L. Harris, MD
Connie Brown, RN MSN, FNP-BC
Janet Warner, RN MSN, FNP-BC
Carol Cash, RN, MSN, ACNP-BC
Mary Ann Butler, RN, MSN, FNP-BC

PATIENT NAME (Print) _____ DATE: _____

ASSIGNMENT OF INSURANCE BENEFITS AND STATEMENT OF SERVICE

I hereby authorize and assign payment made directly to COASTAL PAIN CARE for the covered insurance benefits, including major medical benefits, whether payable to me by Blue Cross/Blue Shield, Medicare, Worker’s Compensation, and /or commercial insurance companies. I understand that my health insurance provider may not cover part or all of the medical services rendered, and I fully understand that I am financially responsible for and agree to pay all charges not paid by my health insurance coverage, including deductibles, co-insurance and payments for insurance companies sent directly to me.

The assignment shall apply to all medical services now rendered and to be rendered in the future until the organization and assignments is revoked.

I have listed below the names of all my health insurance providers including tie-in coverage and I represent that such health care coverage is in full force and in effect at this time.

Prior authorization of certification for medical information may be required to process the claims for payment of the medical services rendered and it is expressly understood that the right of such information to be privileged is hereby waived.

I agree to promptly notify your office of any change of address.

A copy of this agreement shall be as valid as the original

Patient Signature: _____ SS # _____ Date: _____

Signature of subscriber: _____ SS# _____ Date: _____

Patient Employer: _____ Subscriber Employer: _____

Primary Insurance: _____ Policy # _____

Secondary Insurance: _____ Policy # _____

Medicare # (if applicable) _____

This assignment covers the physician’s charges for service. Surgical Center or Hospital
Charges are billed separately.

PATEINT NAME (Print): _____ DATE: _____

CANCELLATION AND NO SHOW POLICY

As our goal is to meet the needs of our patients we will make every effort to schedule your appointments as efficiently as possible. In return, it is your responsibility to make every effort to keep your appointment and to arrive promptly at the time you are instructed. However, we realize that unanticipated events can occur and may prevent you from keeping your appointment. In fairness and consideration to the other patients that are trying to be seen as soon as possible, we hereby request that you notify our office immediately when you realize you will not be keeping your appointment.

In any event, your appointment will need to be cancelled with **AT LEAST 24 HOURS NOTICE** or else you may be charged a late cancellation fee. Cancelling the day of your procedure may result in a late cancellation fee. This fee is not covered by your medical insurance policy. Notification of at least 24 hours is necessary so that we may schedule other patients desiring earlier appointments to treat their pain.

In the event that you do not show or notify us of a cancellation 24 hours in advance, future appointments will be made on a work in basis. **IF YOU FAIL TO NO SHOW ON 3 OCCASIONS YOU WILL BE DISCHARGED FROM THE PRACTICE FOR NON -COMPLIANCE AND AN APPROPRIATE NOTE WILL BE SENT TO YOUR REFERRING PHYSICIAN.**

In the event that you present 15 minutes or more than the time you were instructed to arrive, you will be considered late and will be worked into the schedule. We will make every effort to see on-time patients as close to their scheduled appointment times, and therefore late patients will have to wait until an appropriate time slot is available. This could result in a significant delay. Therefore it is in your best interest to show up on time.

I hereby acknowledge that I have read and understand the above cancellation and no show policy and that i agree to abide by these guidelines.

FINANCIAL POLICY

It is our desire that payment of our account is as easy and convenient as possible. We will assist you in any way we can to facilitate the settling of your account. In order for us to be able to keep billing fees at a minimum, it is absolutely necessary for you to provide us with accurate and up to date insurance information at each of your visits.

If your insurance status changes form one visit to the next, it is your responsibility to notify us, so that your insurance can be filed correctly.

When you are first referred to our facility, appropriate insurance information will be obtained so that we can verify your coverage and obtain approval when necessary. At your initial visit you will be provided with a patient information sheet. This form must be filled out completely with the correct insurance information. A copy of your insurance card and driver's license is required. As your insurance company will tell you, approval from your insurance company for any service that COASTAL PAIN CARE may render, does not guarantee payment. **The patient is fully and ultimately responsible for the entire payment of services.**

BILLING

You will receive a bill for services provided at each of your visits. Please note that physician's services are different from facility charges. The bill that you receive from COASTAL PAIN CARE is for physician services only. When you have a procedure, you will receive a separate bill from the facility (i.e. Hospital). This is customary and is to cover the costs to the facility for supplies, equipment, medications, personnel the use of the procedure room and observation following the procedure. **As a courtesy we will file the claims for physician services to your insurance company.**

PAYMENTS

In accordance with the agreement you have with your insurance company, and deductible or co-pay is required at the time services are rendered. **Required co-pays and deductibles are expected at each visit and failure to keep your account current in this regard may prohibit future services until your account is made current.** Payments may be made by cash, check, money order, or accepted credit cards. For any questions or assistance with your account, please call our office at (409)892-4600.

I have read the above financial policy and understand my responsibilities.

Patient/Responsible Party Signature _____ Date: _____

PATIENT NAME (Print) _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBED HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. **PLEASE REVIEW CAREFULLY**

The Health Insurance Portability and Accountability Acts of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable information used by us in any form, whether electronically, on paper, or oral are kept confidential. This act gives you, the patient, significant new rights to understand and control your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose health information.

We may use and disclose your medical records only for the each of the following purposes: Treatment, payment and health care operations. Treatment means providing coordination, or managing health care or related services by one or more health care providers an example would be teeth cleaning services.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relaying your information.

You have the following RIGHTS with respect to your protected health information, which you can exercise by presenting a written request to the privacy officer.

- To request restrictions on certain uses and disclosures of protected health information, including those related disclosures to family members, other relatives, close personal friends, or another person identified by you. We are, however, not required to agree to a requested restriction. If we do not agree to a restriction, we must abide by it unless you agree in writing to remove it.
- To request to receive confidential communications of protected health information from us by alternative means or at an alternative location.
- To inspect and copy your protected health information.
- To amend your protected health information
- To receive an accounting of disclosures of protected health information.
- To obtain (and we have the obligation) to provide you a paper copy of this notice from us at your first service delivery date.
- To provide (and we are obligated to receive) a written acknowledgement that you have received a copy of our notice of privacy Practices.

We are required by law to maintain the privacy of your protected health information, and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of privacy Practices and to make the new notice provision effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from the office.

You have recourse if you feel that your privacy protection has been; violated. You have the right to file a formal, written complaint with us, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provision of this notice or the policies and procedures in our office. We will not retaliate against you for filling a complaint.

COASTAL PAIN CARE

PATIENT NAME (Print): _____ DATE: _____

PATIENT MEDICATION AGREEMENT

The purpose of this agreement is to allow us to prescribe for you to treat your chronic pain. Because these drugs have potential for abuse, strict accountability is necessary. You are entitled to dignified, sensitive care for a serious medical condition. Complete pain relief is not likely, but our goal for you is to have reduced pain and a better quality of life. Treatment with medication has both risks and side effects. Please review the following and sign the form indicating your understanding.

RISKS

- There is a risk of physical dependence and in some cases, addiction to the medication.
- There are some serious risks in mixing mind altering drugs or substances (including alcohol, marijuana, narcotics, sedatives and sleeping pills) with controlled substances.
- Taking other drugs or substances while in therapy could result in excessive drowsiness and over sedation and could lead to serious injury or death.
- If you take controlled substances while pregnant, your child may be born with a physical dependency on those substances or otherwise be physically harmed.

SIDE EFFECTS

- It is impossible to predict which opioid side effects you may experience. Having side effects on one opioid does not necessarily mean you will have side effects on another opioid.
- Drowsiness is a common side effect of opioids. Other common usually temporary, side effects include upset stomach, itching and sweating. Psychological depression and lowered hormone levels may also occur. Sleep apnea if present may be worsened by opioids. Constipation commonly occurs and often does not improve with time.

DISCONTINUING OR CHANGING MEDICATION

- Opioid medications may need to be discontinued under these circumstances: not enough pain relief, persistent side effects, not achieving goals of opioid treatment (such as improvement in function), problematic dose escalation. Or inability to comply with the treatment agreement.
- Physical dependence will develop with regular use and a withdrawal syndrome will develop if you stop your medication abruptly.
- Symptoms of withdrawal include pain, nausea, diarrhea, anxiety, sweating and tremor seizures. A slow taper may avoid these symptoms.

I UNDERSTAND AND AGREE

- To only take my prescriptions as directed.
- That there are risks and the potential for negative side effects while taking controlled substances.
- To not use alcohol, sedating medicines, or other prescribed narcotics during the course of my treatment here.
- To not use any illegal drugs or substances
- To inform my pain provider if I choose to stop any of my medications.
- To receive opioid prescription only from Coastal Pain Care and not to ask for opioid medications from other providers
- To have my prescriptions filled at only one pharmacy.
- To keep all scheduled appointments.
- To provide urine samples for urine drug testing when requested.
- To request refills only during office hours and not to request prescriptions to be filled early.
- That if my prescription or medication has been stolen, I must submit a copy of the police report.
- To comply with all aspects of treatment including behavioral medicine (psychology/psychiatry) and physical therapy if recommended.
- To immediately inform my provider if I become pregnant.

I AGREE WITH THE ABOVE GUIDELINES AND RESTRICTIONS. FAILURE TO ABIDE BY THIS AGREEMENT MAY RESULT IN MY BEING DISCHARGED FROM COASTAL PAIN CARE.

PATIENT SIGNATURE: _____ DATE: _____

Coastal Pain Care PA

Craig A Charleston, M.D. Daniel L Harris, M.D.
Connie Brown, RN, FNP-BC Janet Warner, RN, FNP-BC
Carol Cash RN, ACNP-BC Mary Ann Butler, RN, FNP-BC
755 N 11th Street Ste. P2280 Beaumont, Texas 77702
(Phone) 409-892-4600 (Fax) 409-892-4605

Medical Records Release

Patient Name: _____ D.O.B. _____

SS# ___/___/___ Daytime phone Number (___) _____

This is a request that my medical records be forwarded to Coastal Pain Care and that my medical health information may be shared with other healthcare providers or pharmacies to insure continuity of care.

(Please leave blank)

Records From:

Address:

Phone: _____ Fax: _____

Patient signature

Date

Coastal Pain Care PA

Craig A Charleston, M.D. Daniel L Harris, M.D.
Connie Brown, RN, FNP-BC Janet Warner, RN, FNP-BC
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755 N 11th Street Ste. P2280 Beaumont, Texas 77702
(Phone) 409-892-4600 (Fax) 409-892-4605

PATIENT RELEASE OF INFORMATION

In addition to speaking to your provider, your primary care provider, your insurance companies, and any outpatient facility we refer you to, this will allow our office to release your information to those you list below.

I _____, give Coastal Pain Care, P.A. and its representatives permission to speak with, _____,

_____ regarding my personal information. This is effective for one year from signature date.

OR

___ I elect not to give out my information.

Patient signature: _____

Date: _____

Office representative: _____

Date: _____

INITIAL VISIT PATIENT HISTORY / PAIN MANAGEMENT Page 1 of 8

PATIENT NAME (PRINT): _____ DATE: _____

PHYSICIAN (Please circle): Daniel Harris, MD Craig Charleston, MD

PATIENT AGE: _____

What physician / provider referred you to our office? _____

Who is your family doctor / primary care provider? _____

Have you ever seen a PAIN MANAGEMENT SPECIALIST BEFORE? **YES NO** If yes, who? _____

CURRENT MEDICATIONS (Provide name of drug, dose, how taken, and who prescribes). Supplemental Med Sheet Available

NAME OF MEDICATION	DOSE (MILLIGRAMS)	HOW MANY PER DAY?	WHO PRESCRIBES IT?

LIST ALL DRUG ALLERGIES OR INDICATE "NONE" _____

History of present illness

Location - Where is your WORSE pain on MOST days (For example: neck, low back)? _____

Quality – What it feels like. (Please circle all that apply)

- Aching Burning Dull Pins & Needles Sharp Shooting*
Stabbing Shock-like

Severity: (Circle your pain level ON MOST DAYS). *1 = very little* *10 = worst pain imaginable.*

1 2 3 4 5 6 7 8 9 10

Functional Impairment MOST DAYS (Please circle ONE):

- Mild (Aware of it but it doesn't interfere with daily activities)
 Moderate (When present, it interferes only with some daily activities)
 Severe (When present, it interferes with most but not all daily activities)
 Very Severe (When present, patient is unable to carry out any daily activities)

Effect of pain on sleeping (Please Circle one): Interferes Does not interfere

Timing: How long have you suffered with the current pain problem? _____

Referred or radiating pain, numbness, tingling (Does it move anywhere else? If yes, please describe) _____

Was there any known injury or trauma which caused this pain? YES NO

Where did the injury occur? HOME WORK OTHER _____

If at work, was it reported as a workman's comp injury? YES NO

Are you involved in any legal action regarding the injury? YES NO

PATIENT NAME (PRINT): _____ DATE: _____

Aggravating Factors (What makes it worse? - please circle all that apply):

- | | | | |
|--------------------|------------------------|--------------------|------------------------|
| Lying Down | Lying on affected side | Physical activity | Stress |
| Climbing stairs | Coughing | Head movements | Prolonged keyboard use |
| Low back movements | Overhead activities | grasping / lifting | running |
| sneezing | squatting | walking | sitting |
| | | | Other _____ |

Relieving factors (What makes it better? - please circle all that apply):

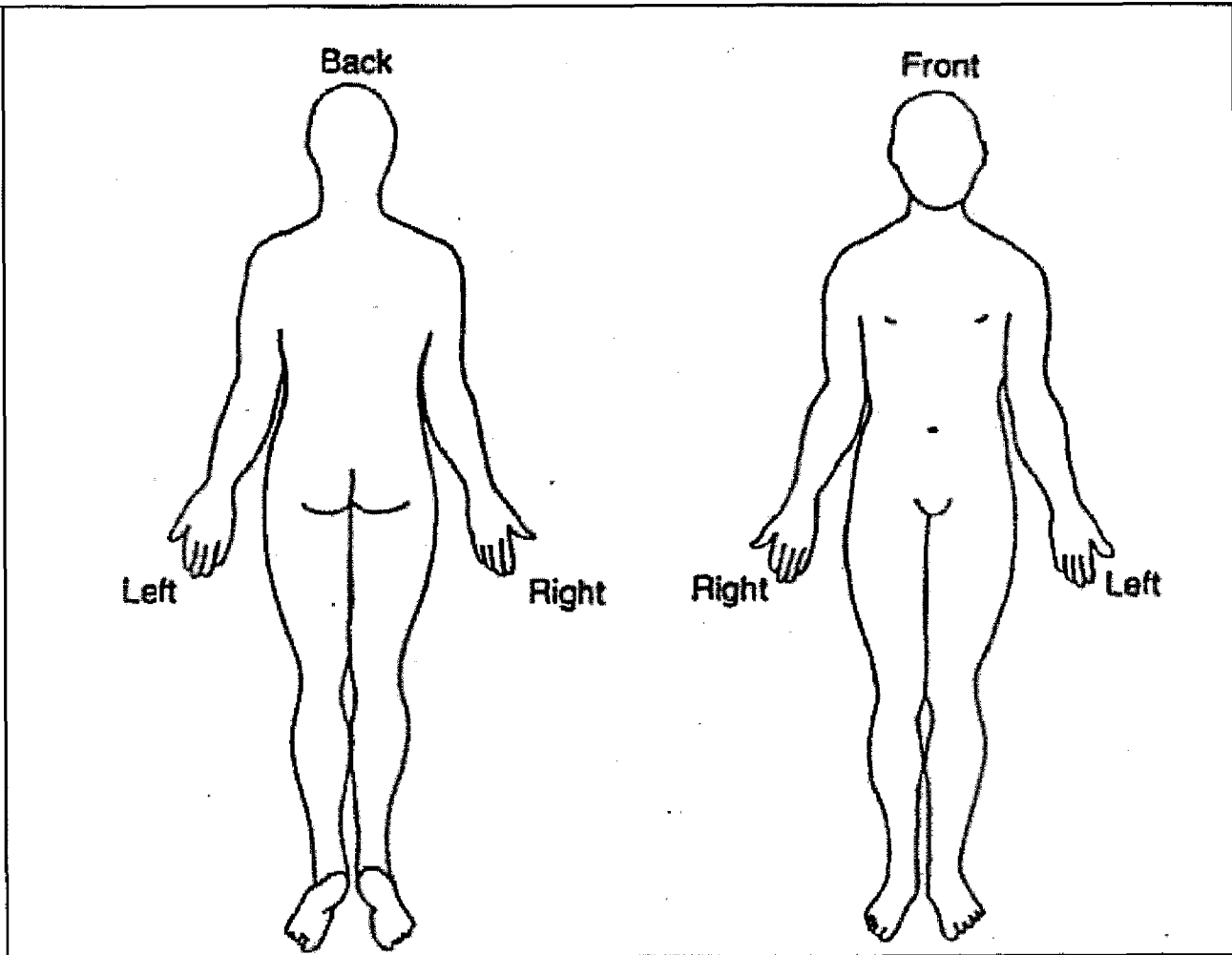
- | | | | |
|---------------|--------------------------|-------------------|------------|
| Applying cold | Applying Heat | Changing position | Lying down |
| Sitting down | Walking or moving around | Other: _____ | |

Associated Manifestations: Have you been experiencing any of the following?

- | | | |
|-------------------------|-----|----|
| Loss of bladder control | YES | NO |
| Loss of Bowels | YES | NO |

PAIN DIAGRAM: Using the symbols next to each sensation, mark the areas of your body where you feel the sensation.

ACHING ^ ^ ^ ^
 NUMBNESS = = = =
 PINS AND NEEDLES 0 0 0 0
BURNING X X X X
 STABBING / / / /



PATIENT NAME (PRINT): _____ DATE: _____

PREVIOUS TESTS (For each test you have had, indicate approximate year done, where done, who has a copy of the report):

TEST	YEAR OF TEST	WHERE WAS TEST DONE?	WHO HAS A COPY
CT SCAN (Neck)			
CT SCAN (Lumbar)			
DISCOGRAM (Neck)			
DISCOGRAM (Lumbar)			
EMG or nerve studies			
MRI (Neck)			
MRI (Lumbar)			
Myelogram			
X/rays			

PREVIOUS TREATMENT TRIED FOR THIS CONDITION (please indicate your response to EACH treatment by circling the appropriate answer).

TREATMENT				
Chiropractor	<i>IMPROVED</i>	<i>NO CHANGE</i>	<i>WORSE</i>	<i>N/A (Never tried)</i>
Epidural Steroid Injections	<i>IMPROVED</i>	<i>NO CHANGE</i>	<i>WORSE</i>	<i>N/A (Never tried)</i>
Facet Nerve Blocks / Medial Nerve Blocks	<i>IMPROVED</i>	<i>NO CHANGE</i>	<i>WORSE</i>	<i>N/A (Never tried)</i>
Occipital nerve Blocks	<i>IMPROVED</i>	<i>NO CHANGE</i>	<i>WORSE</i>	<i>N/A (Never tried)</i>
TENS Unit	<i>IMPROVED</i>	<i>NO CHANGE</i>	<i>WORSE</i>	<i>N/A (Never tried)</i>
Spinal Cord Stimulator	<i>IMPROVED</i>	<i>NO CHANGE</i>	<i>WORSE</i>	<i>N/A (Never tried)</i>
Physical Therapy	<i>IMPROVED</i>	<i>NO CHANGE</i>	<i>WORSE</i>	<i>N/A (Never tried)</i>

MEDICATIONS TRIED FOR PAIN MANAGEMENT (For each medication ever tried, circle the appropriate response you had to the medication):

Anti-depressants/ Mood						
	Paxil (paroxetine)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Elavil (amitriptyline)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Celexa (citalopram)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Effexor (venlafaxine)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Cymbalta (duloxetine)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Savella (milnacipran)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Depakote (divalproex)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Lamictal (phenyltriazine)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Lexapro (escitalopram)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>

PATIENT NAME (PRINT): _____ DATE: _____

	Pamelor (nortriptyline)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
		<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
Muscle Relaxers	Amrix (cyclobenzaprine)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Baclofen	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Soma (carisoprodol)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Flexeril (Cyclobenzaprine)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Norflex (Orphenadrine)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Robaxin (methocarbamol)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Skelaxin (metaxalone)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Valium (diazepam)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Zanaflex (tizanidine)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Parafon Forte	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
NSAIDS						
	Aspirin	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Celebrex (celecoxib)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Anaprox (naproxen sodium)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Etodolac	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Mobic (meloxicam)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Ibuprofen (motrin, advil)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Naprosyn (naproxen)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Pennsaid (diclofenac)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Voltaren (diclofenac)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Feldene (piroxicam)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Aleve (naproxen)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
		<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
		<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
Narcotics /Opioids						
	Avinza (morphine)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Demerol (meperidine)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Kadian (morphine)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Oxycontin / Oxycodone	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Oxymorphone (Opana)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Darvocet (propoxyphene)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Nucynta (tapentadol)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Codeine / Tylenol #3	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Hydrocodone (Vicoden, Norco, Lortab, Lorcet)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Embeda (morphine +	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>

PATIENT NAME (PRINT): _____ DATE: _____

	naltrexone)					
	Talwin/Talacor (pentazocine)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Dilaudid (hydromorphone)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Percocet / Percodan (Oxycodone)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	MS Contin (morphine)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Duragesic (fentanyl) patch	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Methadone	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Suboxone (buprenorphine)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Ultram (tramadol)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
		<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
		<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
		<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
Non-narcotics / other						
	Acetaminophen (tylenol)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Fiorinal (butalbitol/aspirin/caffeine)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Fioricet (butalbitol/acetam./caffeine)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Steroids (prednisone, medrol)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
Anti- convulsants						
	Trileptal (oxcarbazepine)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Tegretol (carbamazepine)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Dilantin (phenytoin)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Depakote (divalproex)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Zoncgram (zonisamide)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Keppra (levetiracetam)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Neurontin (Gabapentin)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
	Lyrica (Pregabalin)	<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>
OTHERS		<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>No Effect</i>	<i>Had Side Effects</i>

PATIENT NAME (PRINT): _____ DATE: _____

PAST HEALTH HISTORY

***PLEASE LIST ALL ALLERGIES, OR STATE "NONE":** _____

***PLEASE CIRCLE IF ALLERGIC TO:** **LATEX / IODINE / DYES**

PLEASE CHECK BELOW FOR EACH CONDITION THE PATIENT HAS NOW OR HAS HAD IN THE PAST:

PATIENT'S MEDICAL PROBLEMS:

- Cancer (Location/Type: _____)
- Migraine Headaches
- Tension Headaches
- Cerebrovascular accident (CVA/Stroke)
- Congestive Heart failure
- Coronary Artery Disease (Heart blockage)
- Deep Vein Thrombosis (Blood clot in leg)
- Heart Attack
- Hypertension (high blood pressure)
- Transient Ischemic Attack (TIA, Mini Stroke)
- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic constipation
- Cirrhosis (Liver failure)
- Hepatitis
- Ulcers (Stomach)
- Kidney Disease
- Renal / Kidney Failure
- Amputation
- Ankylosing Spondylitis
- Osteoarthritis
- Rheumatoid Arthritis
- Degenerative Bone Disease
- Fibromyalgia
- Osteoporosis (Thinning of the bones)
- Scoliosis
- Spinal Stenosis
- Shingles
- Alzheimers
- Dementia
- Epilepsy or Seizures
- Meningitis
- Paralysis
- Nervous Breakdown
- Alcohol or drug abuse treatment
- Chronic anxiety
- Bipolar (Manic depression)
- Depression
- Panic Attacks
- CLAUSTROPHOBIA**
- Diabetes
- Thyroid Dysfunction
- Anemia
- Clotting Disorder
- AIDS / HIV
- Lupus
- OTHER MEDICAL CONDITIONS

PATIENT'S SURGERIES (Check):

***PATIENT PROBLEMS WITH ANESTHESIA? YES NO**

Heart Surgeries

- Balloon Angioplasty
- Bypass
- Carotid Endarterectomy (Removal of carotid blockage)
- Heart Pacemaker
- Heart Transplant
- Stent of Coronary Artery
- Other _____

Thoracic / Lung Surgery

- Partial Pneumectomy / Pneumectomy (Lung removal)
- Other _____

Abdominal Surgeries

- Liver surgery
- Intestinal Obstruction repair
- Bariatric / weight loss surgery
- Other _____

Genitourinary Surgeries

- Kidney surgery
- Kidney removal (nephrectomy)
- Kidney Transplant
- Other _____

BONES, JOINTS, MUSCLES Surgeries

- Joint Surgery (please specify location/date: _____)
- Spine Surgery
 - Laminectomy (Specify levels and date: _____)
 - Fusion (Specify Levels / date: _____)
 - Kyphoplasty
 - Vertebroplasty
 - Unspecified spine surgery

Brain, Spinal Cord, Nervous System

- Brain Surgery _____
- Spinal Cord Surgery _____
- Carpal Tunnel Release

PATIENT NAME (PRINT): _____ DATE: _____

PATIENT'S SOCIAL HISTORY:

Please answer / check ALL THAT APPLY regarding you (the patient):

- Are you retired? YES NO
- Most Recent Occupation: _____
- Marital Status: _____
- Do you currently use tobacco products? YES NO
If yes, what type? _____
- Current use of alcohol: _____
_____ (#) per _____ (day, week, month, year)
type consumed (beer, wine, liquor) _____
- _____ History of alcoholism
- _____ History of alcoholism treatment
- _____ # of caffeine products per day.

RECENT USE OF NON-PRESCRIBED DRUGS BY PATIENT
(BOUGHT OFF STREET OR BORROWED) - Honesty please:

- _____ Amphetamines (Speed, Uppers)
- _____ Barbiturates (Sedatives, Sleeping pills)
- _____ Cocaine
- _____ Diazepam (Valium)
- _____ Xanax (Alprazolam)
- _____ Ecstasy
- _____ Heroin
- _____ Hydrocodone (Vicoden, Lortab, Norco)
- _____ Marijuana
- _____ Oxycodone
- _____ Soma

PATIENT EVER HAD DRUG ADDICTION? NO YES

PHYSICAL ACTIVITIES CAUSING DIFFICULTY FOR PATIENT (Check all that apply)

- _____ NONE
- _____ Bathing
- _____ Climbing Stairs
- _____ Controlling Bladder
- _____ Doing Laundry
- _____ Dressing
- _____ Eating
- _____ Getting up / down from chair or bed
- _____ Housekeeping
- _____ Lifting / Carrying

PRESENT EXERCISE LEVEL (PATIENT)

- _____ Little or none
- _____ 20 minutes or more, 1 - 2 days per week
- _____ 20 minutes or more, 3 or more times per week

HOME LIVING SITUATION (PATIENT)

- _____ Lives alone
- _____ Lives with spouse or other responsible adult
- _____ Lives in Assisted Living / Retirement Facility
- _____ Nursing Home

PERSONAL HANDICAPS, DISABILITIES, DEVICES (PATIENT)

- _____ None
- _____ Amputation _____
- _____ Kyphosis
- _____ Legally Blind
- _____ Mentally or emotionally challenged
- _____ Needs 1 person assistance to walk
- _____ Needs 2 or more person assistance to walk
- _____ Neurologic Disorder
- _____ Permanently Disabled
- _____ Paraplegic (Paralyzed legs)
- _____ Quadriplegic (Paralyzed legs and arms)

FAMILY MEDICAL HISTORY

Check ALL THAT APPLY below about IMMEDIATE family members (Parents, siblings, children only):

****PROBLEMS WITH ANESTHESIA (family)? YES NO**

- _____ CANCER IN FAMILY: Type / location? _____
- _____ Migraine Headaches (In Family)
- _____ Heart Disease (In Family)
- _____ Hypertension (In Family)
- _____ Asthma (In Family)
- _____ Chronic Obstructive Pulmonary Disease (Family)
- _____ Cirrhosis of the Liver (In Family)
- _____ Ulcers (In Family)
- _____ Arthritis (In Family)
- _____ Osteoporosis (In Family)
- _____ OTHER BONE / JOINT PROBLEMS (Please describe _____)
- _____ Dementia (In Family)
- _____ Epilepsy (In Family)
- _____ Stroke (In Family)
- _____ Anxiety (In Family)
- _____ Depression (In Family)
- _____ Alcoholism (In Family)
- _____ Substance Abuse (Drug addiction) (In Family)
- _____ Suicide (In Family)
- _____ Nervous Breakdown (In Family)
- _____ Diabetes (In Family)
- _____ Thyroid Disorder (In Family)
- _____ Bleeding / clotting problems (In Family)
- _____ Bruising (In Family)
- _____ Fibromyalgia (In Family)
- _____ Lupus (In Family)

PATIENT NAME (PRINT): _____ DATE: _____

REVIEW OF SYSTEMS

Please check any/all of the following symptoms you have experienced in the PAST 2 WEEKS:

GENERAL / CONSTITUTIONAL:

- Difficulty carrying out usual activities
- Dizziness
- Excess daytime sleepiness
- Generalized aching

EYES / EARS:

- Vision changes
- Yellow discoloration of sclera (white of eyes)
- Ringing in the ears

CARDIOVASCULAR:

- Chest Pain
- Irregular or fast, pounding heart beat
- Leg cramps/pain in legs when walking-
short distance

RESPIRATORY:

- Cough
- Shortness of Breath
- Required use of oxygen

GASTROINTESTINAL:

- Abdominal Pain
- Gastrointestinal bleeding (blood in stool,
vomiting of blood)
- Constipation
- Diarrhea
- Heartburn
- Nausea

MUSCULOSKELETAL:

- Decrease in size of muscles
- Limitation in use of a joint
- Loss of muscle strength
- Back Pain
- Neck Pain
- Joint Pain (Where?) _____

SKIN:

- Yellow color of skin (Jaundice)
- Rash

NEUROLOGICAL:

- Change in vision
- Falling down
- Headaches (Unusual for you)
- Loss of Bladder / Urine Control
- Loss of Bowel Control
- Numbness
- Seizures
- Tingling or "pins and needles" sensation
- Paralysis
- Weakness

PSYCHOLOGICAL:

- Concerned about your alcohol consumption
- Feels need to drink alcohol
- Feels need to take prescription
medications / drugs more than prescribed
- Feels need to take street drugs
- Feels nervous (anxiety)
- Feels sad more than usual
- Homicidal thoughts
- History of suicidal attempt
- Suicidal plans
- Violent thoughts

ENDOCRINE:

- Unwanted or unexpected weight change

HEMATOLOGIC:

- Bruises easily

<p>**CHECK BELOW IF NONE IN EITHER COLUMN</p> <p>_____ NONE OF THE ABOVE</p>
--

SOAPP® Version 1.0

Name: _____ Date: _____

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

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

- | | | | | | |
|---|---|---|---|---|---|
| 1. How often do you feel that your pain is "out of control?" | 0 | 1 | 2 | 3 | 4 |
| 2. How often do you have mood swings? | 0 | 1 | 2 | 3 | 4 |
| 3. How often do you do things that you later regret? | 0 | 1 | 2 | 3 | 4 |
| 4. How often has your family been supportive and encouraging? | 0 | 1 | 2 | 3 | 4 |
| 5. How often have others told you that you have a bad temper? | 0 | 1 | 2 | 3 | 4 |
| 6. Compared with other people, how often have you been in a car accident? | 0 | 1 | 2 | 3 | 4 |
| 7. How often do you smoke a cigarette within an hour after you wake up? | 0 | 1 | 2 | 3 | 4 |
| 8. How often have you felt a need for higher doses of medication to treat your pain? | 0 | 1 | 2 | 3 | 4 |
| 9. How often do you take more medication than you are supposed to? | 0 | 1 | 2 | 3 | 4 |
| 10. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? | 0 | 1 | 2 | 3 | 4 |
| 11. How often have any of your close friends had a problem with alcohol or drugs? | 0 | 1 | 2 | 3 | 4 |

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0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

- | | | | | | |
|---|---|---|---|---|---|
| 12. How often have others suggested that you have a drug or alcohol problem? | 0 | 1 | 2 | 3 | 4 |
| 13. How often have you attended an AA or NA meeting? | 0 | 1 | 2 | 3 | 4 |
| 14. How often have you had a problem getting along with the doctors who prescribed your medicines? | 0 | 1 | 2 | 3 | 4 |
| 15. How often have you taken medication other than the way that it was prescribed? | 0 | 1 | 2 | 3 | 4 |
| 16. How often have you been seen by a psychiatrist or a mental health counselor? | 0 | 1 | 2 | 3 | 4 |
| 17. How often have you been treated for an alcohol or drug problem? | 0 | 1 | 2 | 3 | 4 |
| 18. How often have your medications been lost or stolen? | 0 | 1 | 2 | 3 | 4 |
| 19. How often have others expressed concern over your use of medication? | 0 | 1 | 2 | 3 | 4 |
| 20. How often have you felt a craving for medication? | 0 | 1 | 2 | 3 | 4 |
| 21. How often has more than one doctor prescribed pain medication for you at the same time? | 0 | 1 | 2 | 3 | 4 |
| 22. How often have you been asked to give a urine screen for substance abuse? | 0 | 1 | 2 | 3 | 4 |
| 23. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? | 0 | 1 | 2 | 3 | 4 |
| 24. How often, in your lifetime, have you had legal problems or been arrested? | 0 | 1 | 2 | 3 | 4 |

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

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