Patient Name: _____ D.O.B._____ Date: _____

☐ New Patient

☐ Periodic Review

INTAKE ASSESSMENT FORM

This questionnaire must be completed prior to your appointment with The HEAG Pain Management Center. Your careful answers will help us to understand your pain problem, and design the best treatment program for you. It is understandable that you might be concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential and no outsider is permitted to see your case record without your written permission.

NAME: _____

DOB: _____ **SEX:** ☐ Female ☐ Male ☐ Other

Current Address: _____

City: _____ State: _____ Zip:_____

Telephone: Home: _____ Work: _____ Mobile: _____

REFERRING MD: _____

Address: _____

Phone #: _____ Fax #: _____

FAMILY MD: _____

Address: _____

Phone #: _____ Fax #: _____

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

Chief Complaint

What is bothering you?

_____

_____

_____

_____

_____

_____

_____

Are there any symptoms associated with your pain (check all that apply)?

- ☐ Numbness
- ☐ Weakness
- ☐ Urinary Incontinence
- ☐ Incontinence of bowel
- ☐ Tenderness of affected area
- ☐ Pain with only a light touch
- ☐ Cool, pale skin
- ☐ Swelling
- ☐ Redness
- ☐ Tingling
- ☐ Sleeplessness

Other (describe): _____

_____

_____

_____

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

History of Present Illness – Locations(s) of Your Pain

Describe the location(s) of your pain:

_____

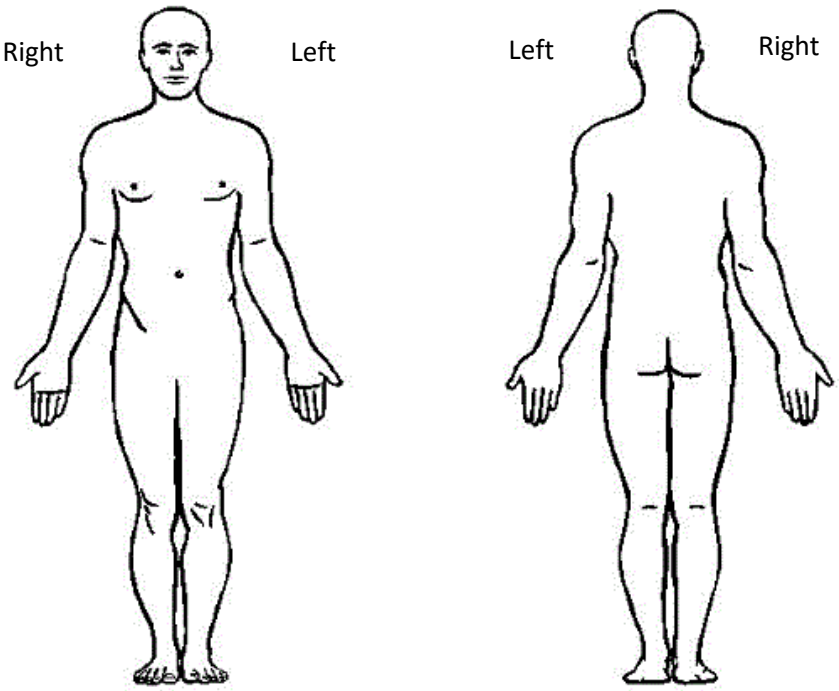
_____

_____

_____

_____

On the diagram, SHADE in the areas where you feel pain.



Please list areas in order of greatest to least pain.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

History of Present Illness – Quality of Pain

Describe the characteristics of your pain (check the box in each column that best describes your average pain the past month).

Intensity	**Reaction**	**Sensation**
☐ Excruciating	☐ Agonizing	☐ Piercing
☐ Intolerable	☐ Intolerable	☐ Stabbing
☐ Very intense	☐ Unbearable	☐ Shooting
☐ Extremely strong	☐ Awful	☐ Burning
☐ Severe	☐ Miserable	☐ Grinding
☐ Very strong	☐ Distressing	☐ Throbbing
☐ Intense	☐ Unpleasant	☐ Cramping
☐ Strong	☐ Uncomfortable	☐ Aching
☐ Uncomfortable	☐ Tolerable	☐ Stinging
☐ Moderate	☐ Bearable	☐ Squeezing
☐ Mild	☐ None	☐ Numbing
☐ Weak		☐ Itching
☐ Very weak		☐ Tingling
☐ Just noticeable		☐ None
☐ Extremely weak		
☐ None		

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

History of Present Illness – Severity of Pain

1) Rate your pain by circling the number to best describe your pain at its WORST in the past month.

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it could be.

2) Rate your pain by circling the number to best describe your pain at its LEAST in the past month.

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it could be.

3) Rate your pain by circling the number to best describe your pain on the AVERAGE.

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it could be.

4) Rate your pain by circling the number to best describe pain you have RIGHT NOW.

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it could be.

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

History of Present Illness – Duration of Pain

How long have you had the pain problem you are currently experiencing (in months and years)?

_____ Days _____ Weeks _____ Months _____ Years

What caused your current pain to start? _____

_____

How often do you have your pain?

a. Constantly (80-100% of time)

b. Nearly constantly (50-80% of time)

c. Intermittently (25-50% of time)

d. Occasionally (less than 25% of time)

History of Present Illness – Timing of Pain / Alleviating and Aggravating Factors

What kinds of things make your pain feel better?_____

_____

_____

What kinds of things make your pain feel worse? _____

_____

_____

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

History of Present Illness – Previous Therapy/Adjuvant Therapy

For each treatment listed below that you have tried, choose ONE number indicating the result:

1) No relief or pain worsened
2) Some relief – Temporary
3) Some relief – Permanent
4) Complete relief – Temporary

_____ Acupuncture	_____ Heat/Cold Treatment	_____ Psychotherapy
_____ Biofeedback	_____ Hospital Bed Rest	_____ Surgery
_____ Chiropractor	_____ Hypnosis	_____ TENS (Elec Stim)
_____ Epidural Steroid Inj.	_____ Nerve Block	_____ Traction
_____ Exercise	_____ Physical Therapy	_____ Ultrasound
_____ Brace	_____ Collars	_____ Corset

_____ Other (specify): _____

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

History of Present Illness – Previous Therapy/Adjuvant Therapy (cont'd)

Check all of the medication(s) you have tried for your current pain problem. Using the scale below, indicate the amount of relief obtained.

1) No relief or pain worsened
2) Some relief – Temporary
3) Some relief – Permanent
4) Complete relief – Temporary

_____NSAID

☐ Aspirin	☐ Acetaminophen (Tylenol)	☐ Ibuprofen (Advil)	☐ Aleve	☐ Motrin
☐ Nuprin	☐ Relafen	☐ Tolectin	☐ Anaprox	☐ Naprosyn
☐ Lodine	☐ Daypro	☐ Cataflam	☐ Indocin	☐ Feldene

_____Oral Narcotics

☐ Codeine	☐ Darvocet	☐ Dilaudid	☐ Percocet	☐ Percodan
☐ Talwin	☐ Tylenol #3	☐ Lortab	☐ Lorcet	☐ Lorcet plus
☐ Methadone	☐ Tylox	☐ Vicodin	☐ Vicodin ES	☐ Talacen
☐ Norco	☐ OxyContin	☐ Kadian	☐ MS Contin	

☐ Other_____

_____Antidepressants

☐ Desyrel	☐ Elavil	☐ Nardil	☐ Tofranil

☐ Other_____

_____Barbiturates

☐ Fiorinal	☐ Nembutal	☐ Seconal

_____Sleeping Medications

☐ Chloral Hydrate	☐ Dalmane	☐ Other_____

_____Injectable Narcotics

☐ Demerol	☐ Morphine

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

History of Present Illness – Previous Therapy/Adjuvant Therapy (cont'd)

Check all of the medication(s) you have tried for your current pain problem. Using the scale below, indicate the amount of relief obtained:

1) No relief or pain worsened 2) Some relief – Temporary
3) Some relief – Permanent 4) Complete relief – Temporary

_____Tranquilizers

☐ Haldol ☐ Librium ☐ Serax ☐ Thorazine ☐ Valium
☐ Xanax ☐ Other_____

_____Muscle Relaxants

☐ Flexeril ☐ Baclofen ☐ Zanaflex ☐ Robaxin ☐ Parafon Forte
☐ Skelaxin ☐ Soma ☐ Norflex ☐ Other_____

_____Non-Steroidal Anti-Inflammatory Drugs

☐ Clinoril ☐ Dolobid ☐ Feldene ☐ Indocin ☐ Naprosyn
☐ Voltaren ☐ Other_____

____Non-NSAID

☐ Ultram ☐ Neurontin ☐ Elavil ☐ Paxil ☐ Prozac
☐ Zoloft ☐ Effexor ☐ Trazodone

____Steroid Injections

☐ Medrol ☐ Imitrex ☐ Midrin ☐ Cafergot ☐ Inderal
☐ Tegretol

____COX-II

☐ Vioxx ☐ Celebrex ☐ Bextra ☐ Colchicine ☐ Maxalt

____ Patch

☐ Duragesic ☐ Lidoderm

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

History of Present Illness – Interventional Therapies

Name of Pain Clinic: _____

____ Pumps ____ Stimulators ____ Steroid Injections ____ Intramuscular/Spine

____ Spinal Facet Blocks ____ Rhizotomy ____ Spine Surgery

Affect

Would you say that your pain has affected your mood?	____Yes ____No
Have you ever had any thoughts of wanting to die?	____Yes ____No
Do you feel tense and worry all the time?	____Yes ____No
Have you had any panic attacks?	____Yes ____No
Do you ever feel irritable or angry due to your pain?	____Yes ____No
Do you ever act in angry or aggressive ways?	____Yes ____No
Do you presently have any thoughts of harming or hurting anyone?	____Yes ____No
Do you any history of mental health treatment?	____Yes ____No
Have you ever been hospitalized for psychiatric reasons?	____Yes ____No
Do you feel rested during the day?	____Yes ____No
Have there been changes in your sleeping pattern during the past two weeks?	____Yes ___No

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

History of Present Illness – Activity

Circle the number that best describes how pain has interfered with your:

a. Normal Daily Activities:

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

b. Mood:

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

c. Walking Ability:

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

d. Normal Work (includes both work outside the home and housework):

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

e. Sleep:

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

f. Family Relationship;

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

g. Relationship with your spouse/partner:

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

h. Social activities with other people:

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

i. Enjoyment of life:

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

History of Present Illness – Pain Disability Index

Pain disability index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.
For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. **A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.**

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Recreation: This category includes hobbies, sports, and other similar leisure time activities.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Social Activity: This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Self-Care: this category includes activities that involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed, etc.)

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Life-Support Activity: This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

Review of Systems

Check all that apply:

Neurologic			
☐ Headache	☐ Facial pain	☐ Vision loss	☐ Tingling
☐ Numbness			
Psychiatric			
☐ Depression	☐ Anxiety	☐ Insomnia	☐ Nervousness
Cardiovascular			
☐ Chest pain	☐ Wheezing	☐ Skipped beats	☐ Swelling
Renal/Liver			
☐ Frequent urination	☐ Burning urination	☐ Foul odor of urine	☐ Blood in urine
☐ Yellow jaundice			
Endocrine			
☐ Hair/skin changes	☐ Cold or heat intolerance	☐ Frequent urinating	☐ Excessive thirst
ENT			
☐ Hearing	☐ Smelling	☐ Swallowing	☐ Hoarseness
Respiratory			
☐ Wheezing	☐ Coughing	☐ Sputum	
Hematology/Oncology			
☐ Easy bleeding	☐ Bruising	☐ Do you ever feel or look pale?	
☐ Lumps or bumps that are new?		☐ Any sores that will not heal?	
GI			
☐ Belly pain	☐ Constipation	☐ Reflux/burning	☐ Blood in stool
☐ Grey or black stools	☐ Vomiting	☐ Nausea	
Orthopedics/Rheumatology			
☐ Pain in joints	☐ Swelling or red joints	☐ Cool hands and/or feet	☐ Cracking or popping joints
Constitutional			
☐ Fatigue	☐ Weight loss/gain	☐ Night sweats	☐ Fevers
OB/GYN			
☐ Pregnant	☐ Breast-feeding		

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

Past Medical History

Allergies

Do you have any allergies? (please list) _____

_____

_____

_____

_____

Current Medications

What medications are you currently taking? (please list)

Medication	Strength or Dosage	How Often do Take this Medication	Why do you take this Medication	Who Prescribed This Medication

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

Past Medical History (cont'd)

Past Surgical History

Please List

Date	Type of Operation	Complications (describe)

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

Past Medical History (cont'd)

Metal

Do you have any metal in your body? ☐ Yes ☐ No

Blood Thinner

Do you take Coumadin or any other blood thinner? ☐ Yes ☐ No

Prior Illness or Accidents

In what situation did your present pain originally begin? (choose one)

☐ Accident or injury at home ☐ Accident or injury (other) ☐ Following surgery

☐ Accident or injury at work ☐ Related to illness ☐ No apparent reason

Explain: _____

_____

Have you had any of the following problems?

Heart:	☐ Stroke	☐ Heart Attack	☐ High Blood Pressure
	☐ Blocked Arteries (head, neck, arm, etc.)		
Lungs:	☐ Emphysema	☐ TB	☐ Asthma
	☐ Pneumonia	☐ Obstructive Sleep Apnea	
Nerves:	☐ Anxiety	☐ Depression	☐ Numbness
	☐ Weakness	☐ Dizziness	☐ Seizures
Stomach/Bowels:	☐ Bleeding Ulcers	☐ Hiatal Hernia/Reflux	☐ Constipation
	☐ Meds Cause trouble		
Kidneys/Liver:	☐ Kidney Failure	☐ Cirrhosis	☐ Yellow Jaundice
Glands:	☐ Low or High Thyroid	☐ Diabetes Mellitus	☐ Cancer
Joints:	☐ Rheumatiod Arthritis	☐ Muscle Disease	☐ Osteoarthritis
Blood:	☐ Low or high blood counts	☐ Clotting	☐ Easy or Free Bleeding

Other: _____

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

Family Medical History

Has a member of your family ever had any of the following conditions?

			Family Member (mother, father, etc.)
Anemia	☐ Yes	☐ No	
Anxiety	☐ Yes	☐ No	
Arthritis	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	
Benign Prostatic Hyperplasia	☐ Yes	☐ No	
Back Problems	☐ Yes	☐ No	
Breast Cancer	☐ Yes	☐ No	
Coronary Artery Disease	☐ Yes	☐ No	
Congestive Heart Failure	☐ Yes	☐ No	
Chronic Obstructive Pulmonary Disease	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	
Cholesterol – High	☐ Yes	☐ No	
Dementia	☐ Yes	☐ No	
Depression	☐ Yes	☐ No	
Dermatitis	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Epilepsy	☐ Yes	☐ No	
Gastroesophageal Reflux Disease	☐ Yes	☐ No	
Glaucoma	☐ Yes	☐ No	
Gout	☐ Yes	☐ No	
HIV	☐ Yes	☐ No	
Headache	☐ Yes	☐ No	
Hepatitis	☐ Yes	☐ No	
Hypertension	☐ Yes	☐ No	
Myocardial Infarction	☐ Yes	☐ No	
Migraine	☐ Yes	☐ No	
Pneumonia	☐ Yes	☐ No	
Renal Stone	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No	
Tuberculosis	☐ Yes	☐ No	
Thyroid Disease	☐ Yes	☐ No	
Ulcer	☐ Yes	☐ No	

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

Social History

Current occupation or last job: _____

Present employment status:

☐ Full time ☐ Part time ☐ Student ☐ Unemployed
☐ Retired ☐ Leave of Absence ☐ Homemaker

What type of work do/did you do? _____

How long have/did you work there? _____

If you are working full time or part time, when did you return to work? Date:_____

If you are current not working when was you last day of work? Date:_____

Would you return to work if you had less pain?	☐ Yes	☐ No
Have you tried to return to work?	☐ Yes	☐ No
Is your present or previous job remaining open for you?	☐ Yes	☐ No
Are you receiving disability payments now?	☐ Yes	☐ No
Do you have an application for compensation or disability payments pending?	☐ Yes	☐ No
Are you in a lawsuit because of your pain or injury?	☐ Yes	☐ No

Marital Status (choose one):

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried

Years Married: _____ Times Married: _____ Times Divorced: _____

Children? ☐ Yes ☐ No Current ages: _____

Residing with you? ☐ Yes ☐ No If no, where: _____

Present living situation (If living with more than one individual, check primary head of household):

☐ Alone ☐ With spouse ☐ With children
☐ With parents ☐ With friend ☐ With other family members

Do you have family nearby? ☐ Yes ☐ No Describe: _____

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

Social History (cont'd)

Have you ever been arrested or convicted? ☐ Yes ☐ No

☐ DWI ☐ Drug-related ☐ Domestic Violence ☐ Other

Have you ever been abused? ☐ Yes ☐ No

☐ Physically ☐ Sexually (including rape or attempted rape) ☐ Verbally ☐ Emotionally

Have you ever attended:

AA: ☐ Current ☐ Past

NA: ☐ Current ☐ Past

If you are not currently attending meetings, what factors led you to stop? _____

_____

Have you ever been in counseling or therapy? ☐ Yes ☐ No

Please describe: _____

Substance intake per day:

Caffeine (coffee, tea, cola, etc.) _____

Nicotine: ☐ Cigarettes ☐ Cigars ☐ Tobacco chewing

Packs per day: _____ # of Years: _____

Alcohol: ☐ Yes ☐ No Drinks per day: _____ # of Years: _____

Education (check highest grade/degree completed):

☐ Less than 8th grade ☐ Completed 8th grade ☐ Some high school

☐ High school graduate ☐ Some college ☐ College graduate

☐ Advanced degree

_____

Patient Signature

THE HEAG
PAIN MANAGEMENT CENTER, P.A.

Patient Name: _____ D.O.B._____ Date: _____

SOAPP

The following questions are given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There is 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 others expressed concern over your use of medication?	○	○	○	○	○
12	How often have others expressed concerned over your use of medication?	○	○	○	○	○
13	How often have any of you 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?	○	○	○	○	○

Patient Name: _____ D.O.B._____ Date: _____

		Never	Seldom	Sometimes	Often	Very Often
		0	1	2	3	4
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?	○	○	○	○	○

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

Personal Health Questionnaire Depression Scale (PHQ-8)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? *(circle **one** number on each line)*

How often during the past 2 weeks were you bothered by:	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3

Scoring

If two consecutive numbers are circled, score the higher (more distress) number. If the numbers are not consecutive, do not score the item. Score is the sum of the 8 items. If more than 1 item missing, set the value of the scale to missing. A score of 10 or greater is considered major depression, 20 or more is severe major depression.

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

Generalized Anxiety Disorder 7-item (GAD-7) Scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	+
Total Score *(add your column scores)* =				

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

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

Sleep Apnea Risk Assessment Questionnaire

Snore Do you snore loudly to be heard through closed doors or your bed partner elbows you for snoring at night?	Yes	No
Tired Do you often feel tired, fatigued, or sleepy during the daytime?	Yes	No
Observed Has anyone observed you stop breathing or choke/gasp during your sleep?	Yes	No
Pressure Do you have or are you being treated for high blood pressure?	Yes	No
BMI Is your body mass index (BMI) greater than 35 kg/m^2?	Yes	No
Age Are you older than 50 years?	Yes	No
Neck Size For males, is shirt collar size 17 inches or larger? For females, is shirt collar size 16 inches or larger?	Yes	No
Gender Are you male?	Yes	No

If you have answered yes to three or more questions, you have a high risk of obstructive sleep apnea.

Patient Signature: _____ Date: _____

Patient Name: _____ D.O.B._____ Date: _____

Balance Self Test – Are You At Risk For Falls?

1. Have you fallen in the past year?	Yes	No
2. Do you lose your balance when you are standing?	Yes	No
3. Do you lose your balance when you initially get up after sitting?	Yes	No
4. Do you get dizzy, faint or have seizures?	Yes	No
5. Does it take you more than one try to get up out of a chair or bed?	Yes	No
6. Do you trip over your own feet or objects on the floor?	Yes	No
7. Do you take corners too sharp, bump into corners or door frames?	Yes	No
8. Do you use a walker, cane or need assistance to get around?	Yes	No
9. Do you lose your balance, feel unsteady or stagger when walking?	Yes	No
10. Have you had a recent loss or decrease in vision or hearing?	Yes	No
11. Do you have numbness or loss of sensation in your feet or legs?	Yes	No
12. Have you experienced a stroke, accident, or any other health problems that may have affected your balance?	Yes	No

If you have answered yes to one or more questions, you may have a balance problem. If you are concerned about falling, you should speak with your physician.

Patient Signature: _____ Date: _____

Patient Name: _____ D.O.B._____ Date: _____

Dizziness Questionnaire

I. Which of these best describes your dizziness? Check only one.

- ☐ A sensation of movement of yourself or the room: spinning, tilting, or wave-like movement
- ☐ Lightheadedness or feeling that you are going to faint
- ☐ Loss of balance
- ☐ Disassociation or disorientation with the world

II. When you are "dizzy" do you experience any of the following sensations? You may circle as many yes responses as necessary.

Yes	No	1. Lightheadedness or swimming sensation in the head.
Yes	No	2. Blacking out or loss of consciousness.
Yes	No	3. Tendency to fall.
Yes	No	4. Objects spinning or turning around you.
Yes	No	5. Sensation that you are turning or spinning inside.
Yes	No	6. Loss of balance when walking.
Yes	No	7. Headache.
Yes	No	8. Pressure in the head.
Yes	No	9. Nausea or vomiting.

III. Please fill in the blanks or circle the appropriate answer.

A. When did the dizziness first occur? _____

B. Is the dizziness CONSTANT or does it come in ATTACKS?

C. If the dizziness comes in attacks, how often do these attacks occur?
_____ times per day / week / month / year.

D. If the dizziness comes in attacks, how long do the attacks last?
_____ seconds / minutes / hours / days.

E. What factors provoke the dizziness or make the dizziness worse?
_____.

Patient Name: _____ D.O.B._____ Date: _____

F. What makes the dizziness better?
_____.

G. Does your hearing change when the dizziness occurs?
Yes No How? _____.

Which ear? Right / Left

H. Are there any other symptoms associated with the dizziness, such as visual changes, numbness or tingling in the arms or legs, weakness in the arms or legs, changes in speech?

Explain: _____.

I. Are you completely free of dizziness between attacks? Yes No

J. Have you ever been diagnosed with a head or neck injury? Yes No

K. Do you have any history of a neurological disease such as migraine, multiple sclerosis or stroke? Yes No
Explain _____.

IV. Do you have any of the following symptoms? Please circle Yes or No and circle the ear involved.

Yes No 1. Difficulty in hearing? Right Left

Yes No 2. Noise in your ears? Right Left

Yes No 3. Does noise change during the dizziness? How? _____.

Yes No 4. Fullness or stuffiness in your ears? Right Left

V. Have you experienced any of the following symptoms?

Yes No 1. Double vision, blurred vision or blindness.

Yes No 2. Numbness of face

Yes No 3. Numbness of arms or legs.

Yes No 4. Weakness in arms or legs

Yes No 5. Clumsiness of arms or legs.

Yes No 6. Confusion or loss of consciousness.

Yes No 7. Difficulty with speech.

Yes No 8. Difficulty with swallowing.

Yes No 9. Pain in the neck or shoulder.

Patient Signature: _____ Date: _____

Patient Name: _____ D.O.B._____ Date: _____

Universal Precaution Compliance Assessment

1) Do you have any prior or pending charges and/or convictions?	☐ Yes	☐ No
2) Ever attempted suicide?	☐ Yes	☐ No
3) Suicidal or planning suicide?	☐ Yes	☐ No
4) Any thoughts of suicide in the past or present?	☐ Yes	☐ No
5) Ever made plans for suicide?	☐ Yes	☐ No
6) Ever overdosed?	☐ Yes	☐ No
7) Ever addicted?	☐ Yes	☐ No
8) Drug treatment, rehab, or detox?	☐ Yes	☐ No
9) Drug conviction, indictment, or investigation?	☐ Yes	☐ No
10) Ever bought, sold, or abused drugs?	☐ Yes	☐ No
11) Any recreational drug use?	☐ Yes	☐ No
12) Ever felt you should cut down substance abuse?	☐ Yes	☐ No
13) Ever felt annoyed by others' criticism of your substance use?	☐ Yes	☐ No
14) Ever felt guilty about your substance use?	☐ Yes	☐ No
15) Ever had a morning eye opener to start your day?	☐ Yes	☐ No
16) Have you ever sued or planning to sue any healthcare provider?	☐ Yes	☐ No
17) Have you ever received medications over the internet?	☐ Yes	☐ No
18) Have you ever abused any illegal substances?	☐ Yes	☐ No
19) Have you ever abused any legal substances?	☐ Yes	☐ No
20) Have you ever been diagnosed with schizophrenia, psychosis, hallucinations, major depression, bipolar, antisocial or borderline personality disorder, hepatitis C, AIDS, or liver disease?	☐ Yes	☐ No
21) Do you have or have you ever had any needle track marks on your skin?	☐ Yes	☐ No
22) Has anyone in your family or household had any type of substance abuse or drug problems?	☐ Yes	☐ No

Explain All Yes Answers

_____

_____

_____

_____

_____

By signing I certify the above information is true.

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	Date/Time of Last Use	Quantity Last Used
Alcohol						
Caffeine (pills or beverages)						
Cocaine						
Crystal Meth-amphetamine						
Heroin						
Inhalants						
LSD or hallucinogens						
Marijuana						
Methadone						
Pain killers						
PCP						
Stimulants (pills)						
Tranquilizers/Sleeping Pills						
Ecstasy						
Other:						

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

Treatment Goals

(Specific, Measureable, Attainable, Reproducible, Titrated)

What do you hope to do with this treatment that you can't do now? (please be specific)

1)_____

_____

2)_____

_____

3)_____

_____

Please select at least 2 items from below.

- ☐ Decrease Pain
- ☐ Improved Function
- ☐ Return to Work
- ☐ Return to School
- ☐ Complete Evaluation with Vocational Rehab
- ☐ Other: _____
- ☐ Other: _____

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

OTHER COMMENTS

I agree that I will be seen and examined by The HEAG Pain Management Center, PA (HPMC), their staff, LPNs, RNs and physicians today and will answer all questions truthfully.

HPMC has agreed to participate with numerous managed care programs. It is extremely difficult for us to keep track of all the individual requirements of the numerous plans. Each one has different policies regarding how often services may be rendered and even more importantly, where those services may be performed. I agree that if I do not supply copies of all insurance cards and applicable referrals on each visit that may be secondary to motor vehicle, personal injury or Worker's Comp coverage, I will be responsible for all charges in full that are not covered by the liability carrier. Providing quality medical care to our patient's is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at **EACH** time of service exactly what those guidelines are. You may need to contact your carrier (customer service number is usually on the back of the card) and ask for this information. We are unable to do this for you. If you do not inform us of any kind of special requirement in your contract and we subsequently order services, i.e. lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. You will be responsible for those charges. With your cooperation and help, you should be able to receive all of the benefits offered to you and we will be able to concentrate on caring for your medical needs.

The initial visit ranges in price from $195. to $600. Follow-up visits range from $90. to $235. Forms are $50. per page and narrative reports are $550. and both must be prepaid. Orthotics and supplies range in price from $30. to $3,695. On most orthotics, there is a handling/adjust/fit charge ranging from $25. to $150. All orthotics over $500. will be pre-certified with the patient's insurance. *No orthotics returns will be accepted.* I understand that I have a choice regarding orthotic suppliers, diagnostic imaging centers, lab testing centers, physical therapy centers, pharmacies, psychologist, psychiatrist, MRI centers, urine drug testing, hospitals, physicians, etc., regarding my care. I agree that only formulary medications will be prescribed to provide cost-effective quality care.

I understand my insurance will be billed as a courtesy to me. If my insurance does not pay within 45 days, I will be responsible for the bill in full. I also understand that I am responsible for any co-payment or amount that is not paid by insurance within 45 days. I understand interest in the amount of 1.5% monthly and 18% annually will be added to my account on any balance over 45 days and I will also be responsible for any interest charges on my account. I will also be responsible for collection fees, attorney fees and all court costs incurred to collect my balance in full. If I am involved in litigation regarding a motor vehicle accident, personal injury, Worker's Compensation injury, I authorize HPMC to intervene in the litigation to collect any monies owed for medical services related to my injury. I authorize release of my PIP log to HPMC.

I hereby authorize HPMC to furnish any information concerning my illness to my insurance carrier(s) and my attorney. I authorize payment for medical services to go directly to the physician. I understand that I am responsible for paying any amount not covered by my insurance. I understand that if my treatment is for a non-work-related injury or if I seek treatment outside of network, I will be responsible for the bill in full. I understand and agree that HPMC does not issue refunds to patients who receive back-dated or spend-down Medicaid cards. HPMC accepts Medicaid insurance cards and submits claims on my behalf for dates of service on and after presentation of the medical card. I authorize release of my past, present and future medical records (including drug, alcohol, behavioral health) from all and any healthcare providers to and from HPMC or any surgical assistant or their employer. I will authorize HPMC to obtain a narcotic profile and authorize release of past, present and future profiles. I understand that if my condition worsens or fails to improve, I am to return to the office or go to the emergency room immediately. I authorize my free copy(s) of medical records to go to the medical provider that sent me here as well as with my bill to the insurance company. I understand that receiving controlled substances from more than one doctor is a felony. I understand that no diagnosis or treatment can be done by phone.

I have read and understand the above statement regarding office policy and procedures and consent for HPMC. I understand that I personally will be responsible for any amount not covered by my insurance (i.e. P3s, physical therapy, MRI, pain procedure, surgery, etc.) I further certify that if I am unable to read or write that the witness below has explained this form to my satisfaction. I also give full consent to be treated by physicians and staff of HPMC and understand that no guarantees have been made regarding outcome. Noncompliance such as missing appointments, rude behavior, not following physician's orders, may result in my being released from this practice. I understand that doctors seek to deliver good care and if I have any questions or problems whatsoever, a separate office visit may be scheduled with the office manager and the doctors. I understand that if I allow other people to accompany me to the office visit, I give consent for them to hear my personal health information. If I have a complaint, I will leave my complaint in writing today with the office manager.

I understand that many times there will be long delays before seeing one of the physicians. I understand I may wait even up to four to eight hours and then have the appointment canceled. I understand that office appointments are for non-emergent problems and agree to hold HPMC and staff harmless for any delays. I understand I may seek treatment elsewhere at any time with other medical practices. I certify that I have not provided false information on the intake form, to referring physicians or seeking care under false pretense. I agree to obtain a second opinion before initiating treatment. I understand that it may be necessary to be referred for outside services as a result of the information obtained from my P3. Should this occur, I will be notified by certified mail of the location and date of my appointment. If I am unable to keep this appointment, it will be my responsibility to reschedule. Failure to reschedule could result in my release as a patient from HPMC.

Subsequent care will be provided at times by a Physician Assistant (PA) or a Nurse Practitioner.

Patient Signature | Date | Pharmacy Name

The HEAG Pain Management Center Staff Witness | Date

Patient Name: _____ D.O.B._____ Date: _____

TREATMENT AGREEMENT – CONDITION TERMS FOR TREATMENT

To receive treatment with or without narcotic pain medication, the patient must meet the following condition/terms:

1. The patient has never been diagnosed with, treated, or arrested for substance abuse or trafficking.
2. The patient has never been involved in the sale, illegal possession, dispersion, or transport of controlled substances (narcotics, sleeping pills, nerve pills, pain pills); or, under investigation or arrested for such activities.
3. **(FEMALE ONLY) - The patient certifies that she is not pregnant.** The patient agrees and understands that it is her responsibility to notify The HEAG Pain Management Center immediately if she is planning a pregnancy, or believes that she may be pregnant; and, agrees not to take any medication without approval of OB-GYN doctor, if pregnant.
4. The patient agrees to supply The HEAG Pain Management Center the name, address, and telephone number of the pharmacy that is filling the prescription of pain medication, and will use only one pharmacy.
5. The patient agrees to have his/her prescriptions prescribed by The HEAG Pain Management Center physicians, filled by only one pharmacy. In the event a pharmacy does not cover prescribed medication, the patient will attend another office visit to complete appropriate paperwork for pharmacy change per our controlled substance agreement. In the event of an emergency requiring another physician's attention, the patient will immediately inform his/her physician at The HEAG Pain Management Center of such prescribing physician and dispensing pharmacy.
6. The patient agrees to allow his physician at The HEAG Pain Management Center to send a copy of the agreement to the patient's pharmacy, referring physician(s), and all other physicians involved in the patient's care. The patient agrees to allow the physician at The HEAG Pain Management Center to discuss his/her care freely with other physicians.
7. The patient agrees to **take the medication only and exactly** as prescribed by the physician at The HEAG Pain Management Center. The patient agrees **not to share the medication with other individuals**. The patient agrees that medications will only be prescribed that are on plan formulary. The patient **will not drink alcohol** with controlled medications.
8. The patient agrees not to take any over the counter medication (i.e. Tussionex Robitussin, Vicks inhaler, etc.), Marinol, hemp oil, and/or Chinese herbs.
9. The patient agrees to random urine testing.
10. The patient understands that each prescription is for a specific number of pills, designed to last a certain amount of time. **NO EARLY REFILL. NO EXCEPTIONS**.
11. The patient understands that NO refills will be given if the prescription does not last until the next scheduled visit.
12. The patient understands that NO allowance will be made for lost or stolen prescription pills, or those destroyed by fire, flood, etc. **If medications prescribed cause adverse reactions, patient is to stop medicine immediately and inform physician and is required to bring unused medication to next office visit. The patient will safeguard medications.**
13. The patient understands that prescriptions will be dispensed only after a scheduled office visit, not over the phone.
14. The patient understands that **NO** prescriptions for pain medication will be given over the telephone. **NO EXCEPTIONS.**
15. The patient agrees that they will not seek pain medication at night, on weekends, holidays, or prior to the next visit.
16. The patient agrees not to obtain pain medication from any other physician, emergency room, or other person.
17. The patient agrees to keep all scheduled appointments at The HEAG Pain Management Center. If the patient is unable to keep an appointment, he/she must give at least 24-hours advance notice. However, **NO PRESCRIPTIONS WILL BE CALLED IN.**
18. The patient agrees to see the physician at The HEAG Pain Management Center if the physician feels it is necessary to change the patient's dosage. If the physician suspects the patient is not following his/her orders when asked to cease use of a controlled substance, the patient permits The HEAG Pain Management Center to pursue remedies which will disable the patient's driving privileges. The patient understands not to drive or operate machinery while taking controlled medications.
19. The patient allows The HEAG Pain Management Center to call other pharmacies for poly-drug prescriptions and/or usage. All patients are required to undergo a mandatory drug screen at facility of choice (i.e. primary care physician, hospital, or walk-in clinic), and agrees not to use Vicks inhalers, poppy seeds, or cough/cold remedies.
20. The patient certifies they are a legitimate patient needing legitimate care.
21. The patient understands that the physicians at The HEAG Pain Management Center may stop treatment, and cancel any prescriptions if any of the following occur: **a) The patient gives, sells, or misuses the pain medication, or fails to keep appointments b) The patient fails to reach goals such as decreased pain levels. c) The patient attempts to obtain pain medication at night, on weekends, on holidays, sooner than next office visit, from any other physician, from an emergency room, or from any other source d) the patient is released for any reason or fails to show improved function.**
22. The patient understands that an accurate diagnosis requires an accurate history, physical exam, and imaging. Therefore, treatment recommendations are not made over the phone, only in person after being seen by a physician.
23. The patient certifies that they have not provided misleading or false information or false medical history to the referring physician or physicians at The HEAG Pain Management Center, and they are not seeking treatment under false pretense. The patient understands that physicians base treatment, at least 50%, on history and if it is found that the patient has provided false statements they may be released. The patient agrees they (or anyone with them) do not carry concealed weapons, tape recorders, cameras, or other devices. The patient certifies they are not appearing to seek care as part of an ongoing investigation or threat of prosecution. The patient agrees to set a goal such as decreased pain, improved function, return to work, or return to school.
24. The patient will adhere to the advice of the physicians regarding operation of motor vehicles or any other machinery. If The HEAG Pain Management Center witnesses, or is able to validate information of the patient's driving under the influence (i.e. drugs or alcohol), the patient authorizes The HEAG Pain Management Center to notify the authorities and not to be held liable for any damages which may occur.
25. The patient agrees their record may be given to Narcotic Detectives, DEA, or other authorities and will hold The HEAG Pain Management Center harmless, and the patient agrees to random drug testing.
26. I authorize The HEAG Pain Management Center to obtain narcotic profile from DEA and release all past, present, and future profiles to anyone with written authorization to receive medical records, and understand that obtaining controlled medications from more than one physician is a felony.
27. I understand that controlled medications such as codeine, Tylenol #3, Methadone, Morphine, MS Contin, Kadian, Avinza, Percocet, Tylox, OxyContin, Roxicet, Darvon, Darvocet, Dilaudid, Lortab, Lorcet, Vicodin, Valium, Xanax, Soma, Ambien, Ativan, Fiorinal, Restoril, Hydrocodone, etc. have risks

Patient Name: _____ D.O.B._____ Date: _____

associated with their use, such as drug interactions, respiratory, depression, death addiction, drowsiness, allergic reactions, and agree to discuss all risks/side effects with my pharmacist, family members, family physician, other treating physicians before and during treatment.,

28. I understand obtaining controlled medications from more than one physician/dentist/ clinic is a felony.
29. I understand that I should take the least amount of controlled medications to relieve the symptoms and should never exceed the prescribed amount, and should slowly taper off all controlled substances over several weeks whenever possible. I understand that these medications are only to be taken as needed. I understand the risks of taking controlled medications up to and including death. I will take the minimal amount of medication to improve function.
30. I understand that all medications and any refills will be canceled immediately if, in the opinion of the physician/staff, an unsatisfactory psychological/psychiatric test result is received back after the patient takes the test, any allegations, suspicious information or investigation is initiated by anyone regarding potential violations of this contract is brought to The HEAG Pain Management Center.
31. We reserve the right to require the patient to submit to psychological/psychiatric evaluation and/or pain patient profile and release this information as part of any medical records request.
32. The patient understands that physical dependence is a normal response to many types of medications including steroids, antidepressants, and controlled medications, but tolerance to pain relieving effects are rare.
33. The patient understands that impaired control, craving, compulsive use, continued use despite negative consequences, inability to take medications as prescribed, isolation from friends and family, doctor shopping, using illegal drugs, intoxication, apathy, depression, noncompliance, and inability to function represent abnormal behavior patterns and agrees to discontinue medications, and immediately seek psychiatric care, and notify The HEAG Pain Management Center and primary care provider.
34. The patient realizes pain medication may interfere with endocrine function, i.e. interference with libido, sexual function, etc and the patient agrees to see their family physician or endocrinologist if they have any of these problems.
35. If I develop any feelings of hopelessness, suicidal thoughts, or desire to hurt myself or others, I agree to immediately seek immediate psychiatric care, and notify The HEAG Pain Management Center and primary care provider. I will return all medication to the office if this feeling happens.
36. The patient agrees that The HEAG Pain Management Center physicians/staff may cancel medications at any time without cause and without warning for any medical or non medical reason, suspicious incarceration, or even without a specific reason, and understand to see primary care provider, mental health provider immediately when medications are canceled or treatment discontinued.
37. I understand that not taking medications as prescribe or over dosing on medications usually causes death.
38. I have told (or will tell)my family members and caregivers of my use of controlled medications for treatment of pain and discontinue treatment if family is not in agreement, or my family physician is not in agreement, or if I fail to reach goals.
39. I will discuss my diagnosis and treatment with family, family physician, mental health provider, second opinion physician, and if they are not in agreement, will discontinue treatment and notify The HEAG Pain Management Center.
40. I hereby authorize any pharmacy of record to release any and all Information to the physician and/or nursing staff of The HEAG Pain Management Center upon their request.
41. I agree that I have been seen and examined by a HEAG Pain Management Center physician today and have no complaints, regarding any diagnosis, treatment plan, physicians, or staff at The HEAG Pain Management Center, and if I do have problems will hand deliver it in writing to office manager today. I agree to discontinue treatment if I don't reach set goals such as decreased pain, improved function, return to work and return to school.
42. I have read the conditions and terms stated above and have had all of my questions regarding these conditions and terms explained to my satisfaction. I have met the conditions, and I agree to honor all of the terms unconditionally. I also understand that if I violate any term of this agreement, it is cause for the physicians at The HEAG Pain Management Center to refuse prescriptions and/or treatment. I agree that if I am unable to read or write that this have been verbally explained to my satisfaction.
43. The patient will notify The HEAG Pain Management Center if they have been or are currently receiving treatment at a Methadone Clinic
44. The patient will notify The HEAG Pain Management Center if they have been or are currently receiving treatment at a Pain clinic
45. The patient will notify The HEAG Pain Management Center if they have been or are currently receiving treatment from a Psychiatrist.
46. If you are having a serious reaction to medication or a severe pain problem, call 911 or go to the Emergency Room.
47. You agree to a family conference or a conference with a close friend or significant other if the physician feels it is necessary.
48. Medication in its original container should be brought in to **each** office visit.
49. Medications will not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen/lost, you will need to bring a police report regarding the theft/loss.
50. I am aware that certain other medications such as nalbuphine (Nubain™), pentazocine (Talwin™), buprenorphine (Buprenex™) and butorphanol (Stadol™) may reverse the action of the narcotic medicine I am using for pain control. Taking any of these other medications while I am taking my pain medications can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medications and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of these medications listed above.
51. **(Males only)** I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.
52. Subsequent care will be provided at times by a Physician Assistant (PA) or Nurse Practitioner.
53. I agree to release my doctor and his/her staff from any and all liability caused by or due to my misuse of narcotic drug(s).

The above agreement has been explained to me by _____ and I agree to its terms so that Dr. _____ can provide quality pain management using opioid therapy to decrease my pain and increase my function.

_____

Patient Signature Date Pharmacy Name

_____

The HEAG Pain Management Center Staff Witness Date