MD Pain
Comprehensive Pain Management

New Patient Paperwork

Phone: 303-750-8100/Fax: 303-369-1891

Referral Information

Referring Physician: _____ Phone: _____Fax: _____
Primary Care Physician: _____ Phone: _____Fax: _____
Other provider(s) you would like MD Pain to notify of today's office visit:
Provider: _____Phone: _____Fax: _____
Provider: _____Phone: _____Fax: _____

Patient Information

Patient Name: _____ Appointment Date: _____
Driver's License Number/State:_____ Social Security Number (last 4 #s): _____
Date of Birth: _____ Age: _____ Gender: ❑ Male ❑ Female
Home Address: _____ City/State/Zip: _____
Mailing Address different than Home Address: ❑ Yes ❑ No If yes, provide mailing address:
Mailing Address: _____ City/State/Zip: _____
Preferred Phone Number: _____ ❑ Home ❑ Mobile ❑ Work
Secondary Phone Number: _____ ❑ Home ❑ Mobile ❑ Work
Other Phone Number: _____ ❑ Home ❑ Mobile ❑ Work
Emergency Contact Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Race: ❑ Native American ❑ Alaska Native ❑ Asian/Pacific Islander ❑ African American/Black
❑ Caucasian/White ❑ Other
Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic ❑ Other/Undetermined
Preferred Language: ❑ English ❑ Spanish ❑ Other: _____

Primary Insurance Plan

Insurance Company: _____ Telephone: _____
Policy/ID Number: _____ Group Number: _____
Subscriber Name: _____ Subscriber Date of Birth: _____
Relationship to Subscriber: _____

Secondary Insurance Plan

Insurance Company: _____ Telephone: _____
Policy/ID Number: _____ Group Number: _____
Subscriber Name: _____ Subscriber Date of Birth: _____
Relationship to Subscriber: _____

Workers' Compensation/Personal Injury Claim Information (fill out only if applicable)

Is this visit related to a **Workers' Compensation Claim**? ❑ Yes ❑ No
Insurance Company/Work Comp Carrier: _____ Date of Injury: _____
Claim ID: _____ Adjuster's Name: _____
Adjuster's Telephone: _____ Adjuster's Fax: _____
Claim Submission Address: _____
Is this visit related to an **auto or other accident and filed under a personal injury claim**? ❑ Yes ❑ No
Personal Injury Attorney's Name: _____ Phone: _____
Personal Injury Attorney's Practice Name: _____

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____
Street Address: _____City/State/Zip: _____

CLINICAL INFORMATION

Today's Date: _____

❑ **Your Name:** _____**Height**: _____ **Weight** : _____ **Age:**

❑ **Gender** (circle) MALE FEMALE TRANSGENDER

Hand Dominance

❑ Right hand-dominant ❑ Left hand-dominant ❑ Ambidextrous (able to use both hands equally)

Please indicate your WORST PAIN or CHIEF COMPLAINT (Please mark only one)

❑ Headache	❑ Groin	❑ Anal/Rectal	❑ Left Shoulder
❑ Facial	❑ Neck	❑ Vaginal/Scrotal (circle)	❑ Right Shoulder
❑ Chest Wall	❑ Mid Back	❑ Left Upper Extremity	❑ Left Hip
❑ Breast	❑ Low Back	❑ Right Upper Extremity	❑ Right Hip
❑ Abdominal	❑ Buttock	❑ Left Lower Extremity	❑ Left Knee
❑ Pelvic	❑ Tailbone	❑ Right Lower Extremity	❑ Right Knee

Other pain location? _____

Please indicate ALL ADDITIONAL areas of pain (Please mark all that apply)

❑ Headache	❑ Groin	❑ Anal/Rectal	❑ Left Shoulder
❑ Facial	❑ Neck	❑ Vaginal/Scrotal (circle)	❑ Right Shoulder
❑ Chest Wall	❑ Mid Back	❑ Left Upper Extremity	❑ Left Hip
❑ Breast	❑ Low Back	❑ Right Upper Extremity	❑ Right Hip
❑ Abdominal	❑ Buttock	❑ Left Lower Extremity	❑ Left Knee
❑ Pelvic	❑ Tailbone	❑ Right Lower Extremity	❑ Right Knee

Other pain location? _____

History of COMMON PAINFUL CONDITIONS OR ILLNESSES (Please mark all that apply)

Please indicate if you have had any of the following common PAIN problems: (Mark ALL that apply)

❑ Headache	❑ Neuropathy	❑ Chronic back pain	❑ Chronic abdominal/pelvic pain
❑ Fibromyalgia	❑ Scoliosis	❑ Chronic neck pain	❑ Vertebral compression fracture
❑ Osteoarthritis	❑ Stroke	❑ RSD/CRPS	❑ Cancer-related pain
❑ Rheumatoid Arthritis	❑ Hepatitis	❑ Sickle cell anemia	❑ Autoimmune disease
❑ Chronic Sciatica	❑ Crohn's disease	❑ Interstitial cystitis	❑ Post-herpetic neuralgia
❑ Kidney disease	❑ Ulcerative colitis	❑ Multiple sclerosis	❑ Other: _____

ONSET and FREQUENCY of pain

How did the current pain episode begin? ❑ Gradually ❑ Abruptly

When did your pain first begin? Exact Date _____ or approximately _____ ❑ Months ❑ Years ago

What caused your pain? ❑ Surgery ❑ A Fall ❑ Accident at work ❑ Car Accident ❑ Sports Injury
❑ Normal Aging ❑ Unknown ❑ Other: _____

Since the pain started, how has it changed? ❑ Decreased ❑ Increased ❑ Unchanged

The frequency of my pain currently is: ❑ constant and never changing ❑ fluctuating but always present
❑ fluctuating but usually present ❑ fluctuating but rarely present

Pain SEVERITY, LOCATION, DESCRIPTION & OTHER FACTORS that affect your pain

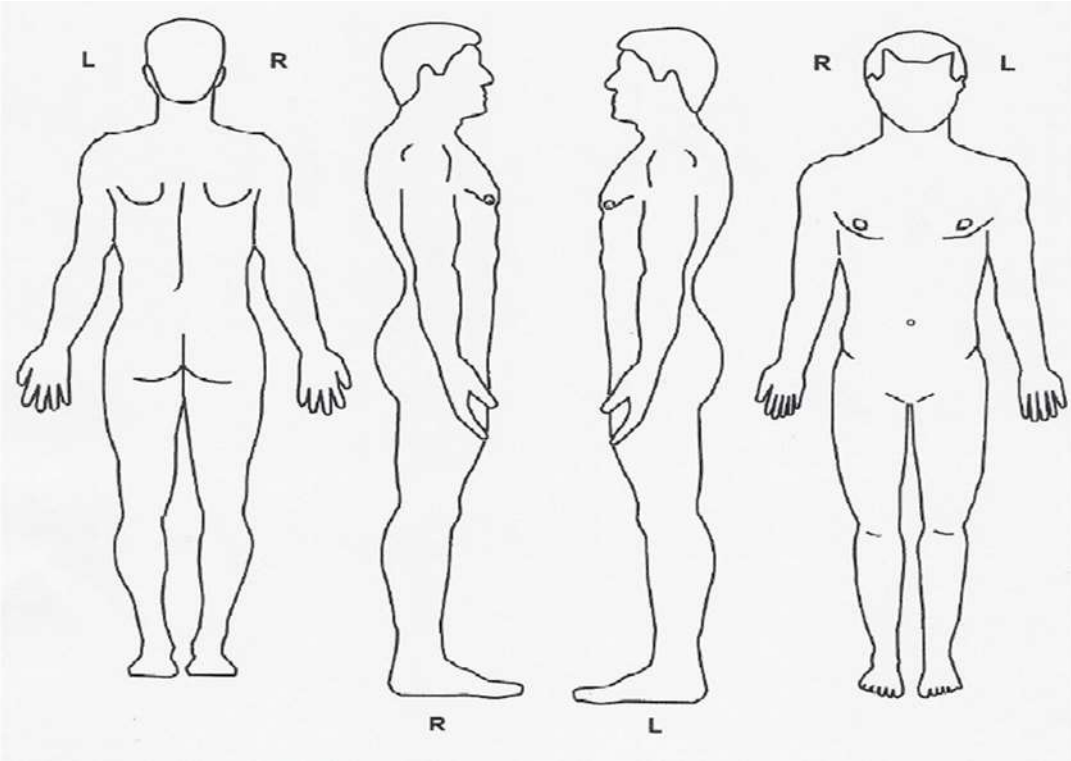
Please rate your pain severity: (0 = No pain, 10 = Unbearable pain)

Now: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Worst: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Least: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
Average: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Please describe your pain. Use the pictures below to mark the areas on your body where you feel the described sensations.



Use the following letters to describe your pain.

Ache = A
Burning = B
Cramping = C
Dull = D
Numbness = N
Pins/Needles = P
Stabbing = S
Throbbing = T
Muscle Spasm = M

Draw arrows where the pain radiates

Please indicate if the following **INCREASE** or **DECREASE** your pain:		
	Increase	Decrease
Heat		
Cold		
Weather Changes		
Sitting		
Standing		
Walking		
Exercise		
Bending forward		
Leaning back		
Twisting at waist		
Looking up		
Leaning back		
Turning head		
Lying down		
Lying on side (R/L)		
Massage		
Physical therapy		
Bowel movement		
Sneezing/Coughing		
Stress		

When is your pain worse?
❑ Morning
❑ During the day
❑ Evening
❑ In the middle of the night
❑ Other _____

Do you have any other symptoms associated with your pain?
❑ Sweating
❑ Skin color changes
❑ Swelling
❑ Hair/nail growth changes
❑ Skin temperature changes
❑ Bowel or bladder changes
❑ Dizziness
❑ Headaches
❑ Blurred vision
❑ Other _____

In the past 3 months have you developed any new symptoms?
❑ Balance problems
❑ Difficulty walking
❑ Bladder incontinence
❑ Bowel Incontinence
❑ Weakness; Where? _____
❑ Numbness; Where? _____
❑ Fine motor control problems (buttoning shirt, using a pencil, etc.)
❑ Falls/Near Falls; Date _____

Medications		
Other:		

❑ Use of assistive devices: ❑ Cane ❑ Walker ❑ Other_____
❑ Other symptoms (please explain) _____

How does your pain affect your functional abilities? (0 = Does not affect, 10 = Significant affect)

- Activities of daily living, such as hygiene & household chores: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
- Ability to function and interact well with family and friends: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
- Work in my usual occupation: (❑ if not working) ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
- Ability to sleep well: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Previous Pain Management Providers

Have you previously been under the care of a PAIN MANAGEMENT SPECIALIST? ❑ Yes ❑ No
If 'Yes', please list up to the two most recent physicians you have seen:

Name	Address/City/State/Zip Code
1.	
Why are you no longer under the care of this physician?	
2.	
Why are you no longer under the care of this physician?	

Current PAIN medications

Please list ALL CURRENT PAIN MEDICATIONS. Include all prescription and over-the-counter medications.

Medication Name	Dose (mg)	Frequency	Prescribing Provider	No Relief	Mild Relief	Moderate Relief	Excellent Relief

❑ I am currently not taking any pain medications.
If you are currently taking pain medications, will the prescribing provider continue to prescribe these medications? ❑ Yes ❑ No

Current PAIN medication EFFECTIVENESS and SIDE EFFECTS

Overall, do your pain medications provide PAIN RELIEF? ❑ Yes ❑ No ❑ N/A
If 'Yes', how much? ❑10% ❑20% ❑30% ❑40% ❑50% ❑60% ❑70% ❑80% ❑90% ❑100%

Overall, do your pain medications IMPROVE YOUR FUNCTION? ❑ Yes ❑ No ❑ N/A
If 'Yes', how much? ❑10% ❑20% ❑30% ❑40% ❑50% ❑60% ❑70% ❑80% ❑90% ❑100%

Overall, do your pain medications IMPROVE YOUR QUALITY OF LIFE? ❑ Yes ❑ No ❑ N/A

If 'Yes', how much? ❑10% ❑20% ❑30% ❑40% ❑50% ❑60% ❑70% ❑80% ❑90% ❑100%

Please indicate any SIDE EFFECTS caused by your current pain medication (Mark ALL that apply)

❑ Nausea	❑ Rash	❑ Confusion	❑ Acid Reflux	❑ Memory loss
❑ Vomiting	❑ Itching	❑ Dizziness	❑ Constipation	❑ Other: _____
❑ Diarrhea	❑ Sedation	❑ Upset Stomach	❑ Urinary retention	❑ **No Side Effects**

PAIN and RELATED medication history

Please mark all medications you have <u>TRIED IN THE PAST</u> FOR PAIN or PAIN-RELATED ISSUES (sleep problems, etc.) and their <u>EFFECTTIVENESS</u>. (Mark only those that apply)

OPIOIDS ❑ I have never taken opioid medications

If you have ever been prescribed opioids, what was your age when you first starting taking them? _____

Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects
Fentanyl (Duragesic patch, Actiq, Fentora, Subsys)				Propoxyphene (Darvocet, Darvon)				Tramadol (Ultram, Ultram ER, Tramadol ER, Ryzolt)			
Morphine (Avinza, Embeda, MS Contin, Kadian, Morphabond, MSER)				Oxymorphone (Opana, Opana ER)				Codeine (Tylenol #3, #4)			
Methadone (Dolophine)				Hydromorphone (Dilaudid, Exalgo)				Meperidine (Demerol)			
Oxycodone (Roxicodone, Percocet, Endocet, OxyContin)				Hydrocodone (Vicodin, Norco, Lortab, Hysingla, Zohydro)				Other:			
Buprenorphine (Butrans, Belbuca, Buprenex, Suboxone, Subutex)				Tapentadol (Nucynta, Nucynta ER)							

ANTI-INFLAMMATORIES ❑ I have never taken anti-inflammatories

Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects
Etodolac (Lodine)				Oxaprozin (Daypro)				Piroxicam (Feldene)			
Ibuprofen (Advil, Motrin)				Meloxicam (Mobic)				Indomethacin (Indocin)			
Naproxen (Aleve, Naprosyn)				Diclofenac (Arthrotec, Voltaren, Zipsor, Flector patch)				Ketorolac (Toradol)			
Celecoxib (Celebrex)				Nabumetone (Relafen)				Other:			

ASPIRIN and ACETAMINOPHEN ❑ I have never taken Aspirin or acetaminophen

Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects				
Aspirin				Acetaminophen (Tylenol)							

MUSCLE RELAXANTS ❑ I have never taken muscle relaxants

Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects
Baclofen (Lioresal)				Chloroxazone (Parafon-Forte, Lorzone)				Tizanidine (Zanaflex)			
Cyclobenzaprine (Flexeril, Amrix)				Orphenadrine (Norflex)				Diazepam (Valium)			
Methacarbamol (Robaxin)				Metaxalone (Skelaxin)				Other:			
Carisoprodol (Soma)											

ANTIDEPRESSANTS (SSRIs, SNRIs) ❑ I have never taken antidepressants											
Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects
Duloxetine (Cymbalta)				Bupropion (Wellbutrin)				Desvenlafaxine (Pristiq)			
Venlafaxine (Effexor, Effexor XR)				Citalopram (Celexa)				Fluoxetine (Prozac)			
Amitriptyline (Elavil, Endep)				Escitalopram (Lexapro)				Nefazodone (Serzone)			
Nortriptyline (Pamelor, Aventyl)				Sertraline (Zoloft)				Milnacipran (Savella)			
Mirtazapine (Remeron)				Protriptyline (Vivactil)				Trazodone (Desyrel)			
Desipramine (Pertofran, Norpramine)				Doxepin (Sinequan, Silenor)				Other:			
Imipramine (Tofranil)				Paroxetine (Paxil)							
ANTICONVULSANTS ❑ I have never taken anticonvulsants											
Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects
Gabapentin (Neurontin, Gralise)				Carbamazipine (Tegretol)				Oxcarbazepine (Trileptal)			
Pregabalin (Lyrica)				Levetiracetam (Keppra)				Lamotragine (Lamictal)			
Topiramate (Topamax, Trokendi XR, Qudexy XR)				Zonisamide (Zonegran)				Other:			
Tiagabine (Gabatril)				Valproic Acic (Depakote, Depakene)							
OTHER MEDICATIONS FOR PAIN or HEADACHES ❑ I have never taken these medications											
Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects
Sumatriptan (Imitrex)				Nifedipine (Procardia)				Olmesartan (Benicar)			
Rizatriptan (Maxalt)				Nimodipine (Nimotop, Nymalize)				Valsartan (Diovan)			
Zolmitriptan(Zomig)				Metoprolol (Lopressor, Toprol)				Butalbital/acetaminophen/caffeine (Fioricet)			
Fovatriptan (Frova)				Propranolol (Inderal)				Butalbital/aspirin/caffeine (Fiorinal)			
Eletriptan (Relpax)				Nadolol (Corgard)				Acetaminophen/dichloralphenazone/isometheptene (Midrin)			
Almotriptan (Axert)				Atenolol (Tenormin)				Lidoderm patches (Lidocaine patch)			
Naratriptan (Amerge)				Lisinopril (Zestril, Prinivil)				Hydroxyzine (Vistaril)			
Sumatriptan/Naproxen (Treximet)				Rimipril (Altace)				Mexilitine (Mexitil)			
Ergotamine (Ergostat, Cafergot, DHE, Migranal, Migergot)				Enalapril (Vasotec)				Steroids (cortisone, Medrol dose pack, prednisone)			
Methylsergide (Sansert)				Candesartan (Atacand)				OnabotulinumtoxinA (BOTOX) injections			
Diltiazem (Cardiazem)				Irbesartan (Avapro)				Lithium			
Verapamil (Calan, Isoptin, Verelan)				Losartan (Cozaar)				Other:			

SLEEP AIDS ❑ I have never taken sleep aids											
Medication	**Helpful**	**Not Helpful**	**Side Effects**	**Medication**	**Helpful**	**Not Helpful**	**Side Effects**	**Medication**	**Helpful**	**Not Helpful**	**Side Effects**
Zolpidem (Ambien)				**Ramelteon (Rozerem)**				**Trazodone (Desyrel)**			
Eszopiclone (Lunesta)				**Sodium Oxybate (Xyrem)**				**Melatonin**			
Temazepam (Restoril)				**Doxepin (Silenor)**				**Other:**			
Zaleplon (Sonata)				**Suvorexant (Belsomra)**							
SEDATIVES AND ANTI-ANXIETY MEDICATIONS ❑ I have never taken sleep aids											
Medication	**Helpful**	**Not Helpful**	**Side Effects**	**Medication**	**Helpful**	**Not Helpful**	**Side Effects**	**Medication**	**Helpful**	**Not Helpful**	**Side Effects**
Alprazolam (Xanax)				**Clonazepam (Klonopin)**				**Lorazepam (Ativan)**			
Diazepam (Valium)				**Clorazepate (Tranxene)**				**Other:**			

Have you ever tried **Prescription** creams such as EMLA cream, Voltaren gel, etc. for your pain? ❑ Yes ❑ No
Have you ever tried **Compounded** pain creams from a specialty pharmacy? ❑ Yes ❑ No

Previous Treatments

Mark any TREATMENTS FOR YOUR PAIN that you have had PRIOR to this visit: (Mark ALL that apply)

			Improvement/Effect				
Treatment	**Body Part/Area/Level**	**Date(s)**	**Worse**	**None**	**Mild**	**Moderate**	**Excellent**
Chiropractic							
Acupuncture							
Massage Therapy							
Physical Therapy							
Aqua/Pool Therapy							
Weight Loss Program							
Neck/Back Brace							
TENS Unit							
Trigger Point Injection							
Epidural Steroid Injection							
Facet Injection							
Medial Branch Blocks							
Radiofrequency Ablation							
Sacroiliac Joint Injection							
Other Joint Injection							
Peripheral Nerve Block							
Sympathetic Nerve Block							
Spinal Cord Stimulator							
Intrathecal (Pain) Pump							
Ketamine Infusion							
Vertebroplasty							
Kyphoplasty							
Other Treatment:							

❑ I have not had any treatments for my current pain complaint(s).

Diagnostic Tests and Imaging

List any TESTS or STUDIES you have had to evaluate your current pain complaint(s): (Mark ALL that apply)

Test	Body Part/Area	Date(s)	Facility
X-ray			
CT Scan			
MRI			
EMG/NCV Study			
Discogram			
Other:			

❑ I have not had any diagnostic test performed for my current pain complaints.

Past Medical History

Please check the following medical conditions you have or have had in the past: (❑ I have *never* had any medical problems.)

Head/Eyes/Ears/Nose/Throat
- ❑ **Headaches**
- ❑ **Migraines**
- ❑ **Head Injury**
- ❑ **Glaucoma**
- ❑ **Cataracts**
- ❑ **Blindness**
- ❑ **Deafness**
- ❑ **Hyperthyroidism**
- ❑ **Hypothyroidism**

Respiratory
- ❑ **Asthma**
- ❑ **Chronic Bronchitis**
- ❑ **COPD**
- ❑ **Emphysema**
- ❑ **Lung Cancer**
- ❑ **Pneumonia**
- ❑ **Tuberculosis**

Cardiovascular
- ❑ **Heart Attack**
- ❑ **High Blood Pressure**
- ❑ **Murmur**
- ❑ **Mitral Valve Prolapse**
- ❑ **Coronary Artery Disease**
- ❑ **Pacemaker**
- ❑ **Defibrillator**
- ❑ **Peripheral Vascular Disease**
- ❑ **Deep Vein Thrombosis**

Hematologic
- ❑ **Anemia**
- ❑ **HIV/AIDS**
- ❑ **Bleeding Disorder**
- ❑ **High Cholesterol**
- ❑ **Protein C/S Deficiency**
- ❑ **Systemic Lupus Erythematosus**
- ❑ **Protein C/S Deficiency**
- ❑ **Lymphoma**
- ❑ **Leukemia**

Gastrointestinal
- ❑ **Gastritis**
- ❑ **Gastric Ulcers**
- ❑ **GERD (Acid Reflux)**
- ❑ **Bowel Incontinence**
- ❑ **Diarrhea**
- ❑ **Constipation**
- ❑ **Hepatitis A**
- ❑ **Hepatitis B**
- ❑ **Hepatitis C**
- ❑ **Liver Cancer**
- ❑ **Liver Failure**
- ❑ **Pancreatitis**
- ❑ **Diabetes Type I**
- ❑ **Diabetes Type II**

Musculoskeletal
- ❑ **Amputation**
- ❑ **Phantom Limb Pain**
- ❑ **Bursitis**
- ❑ **Carpal Tunnel Syndrome**
- ❑ **Chronic Low Back Pain**
- ❑ **Chronic Neck Pain**
- ❑ **Chronic Knee Pain**
- ❑ **Chronic Hip Pain**
- ❑ **Chronic Shoulder Pain**
- ❑ **Rheumatoid Arthritis**
- ❑ **Osteoarthritis**
- ❑ **Osteopenia**
- ❑ **Osteoporosis**
- ❑ **Vertebral Body Fracture**

Genitourinary/Kidney
- ❑ **Kidney Disease**
- ❑ **Kidney Cancer**
- ❑ **Acute Renal Failure**
- ❑ **Chronic Renal Failure**
- ❑ **Kidney Stones**
- ❑ **Urinary Incontinence**

Neurologic
- ❑ **Multiple Sclerosis**
- ❑ **Alzheimer's Disease**
- ❑ **Parkinson's Disease**
- ❑ **Restless Leg Syndrome**
- ❑ **Epilepsy/Seizures**
- ❑ **Trigeminal Neuralgia**
- ❑ **Other Neuralgia's**
- ❑ **Peripheral Neuropathy**

Psychologic
- ❑ **Anxiety**
- ❑ **Depression**
- ❑ **Schizophrenia**
- ❑ **Bipolar Disorder**
- ❑ **Prescription Drug Abuse**
- ❑ **Illegal Drug Use**
- ❑ **Alcohol Abuse**

Please list any other medical conditions you have had that are not listed above:

_____

_____

Past Surgical History

Please indicate any surgical procedures you have had in the past, including the dates, type and pertinent details. (❑ I have *never* had any surgical procedures.)

Abdominal Surgery:
- ❑ Gallbladder removal _____
- ❑ Appendix removal _____
- ❑ Hernia repair _____
- ❑ Laparotomy _____
- ❑ Gastric bypass _____
- ❑ Other_____

Cardiovascular Surgery:
- ❑ Coronary artery bypass _____
- ❑ Valve replacement _____
- ❑ Stent placement _____
- ❑ Aneurysm repair _____
- ❑ Peripheral vascular surgery _____
- ❑ Other_____

Orthopedic/Joint Surgery:
- ❑ Foot/Ankle surgery _____
- ❑ Knee scope/repair _____
- ❑ Knee replacement _____
- ❑ Hip scope/repair _____
- ❑ Hip replacement _____
- ❑ Shoulder surgery _____
- ❑ Other _____

Gynecological Surgery:
- ❑ Hysterectomy _____
- ❑ Tubal Ligation _____
- ❑ C-section _____
- ❑ Laparoscopy _____
- ❑ Other_____

Spine & Back Surgery:
- ❑ Cervical (neck) fusion _____
- ❑ Lumbar (lower back) fusion _____
- ❑ Laminectomy _____
- ❑ Discectomy _____
- ❑ Other_____

Common Surgery:
- ❑ Prostatectomy _____
- ❑ Thyroidectomy _____
- ❑ Tonsillectomy _____

Please list any other surgical procedures you have had not listed above:

_____

_____

Current NON-Pain Medications (such as those to treat high blood pressure, high cholesterol, etc.)

Please list ALL NON-PAIN medications. Include prescription, over-the-counter medications and herbal supplements. (Use separate page if necessary)

Medication Name	Dose	Frequency

Medication Name	Dose	Frequency

Blood-thinning Medication

Please indicate which, if any, of the following BLOOD THINNING medications you are taking: (Mark ALL that apply) ❑ I am not CURRENTLY taking any blood thinners.

- ❑ Aspirin (❑81 mg ❑ 325 mg)
- ❑ Pletal (cilostazol)
- ❑ Persantine (dipyridamole)
- ❑ Aggrenox (dipyridamole/aspirin)
- ❑ Arixtra (fondaparinux)
- ❑ Xarelto (rivaroxaban)
- ❑ Eliquis (apixaban)
- ❑ Savaysa (edoxaban)
- ❑ ReoPro (abciximab)
- ❑ Pradaxa (dabigatran)
- ❑ Plavix (clopidogrel)
- ❑ Effient (prasugrel)
- ❑ Anti-inflammatories
- ❑ Heparin
- ❑ Lovenox (enoxaparin)
- ❑ Coumadin (warfarin)
- ❑ Garlic
- ❑ Ginseng
- ❑ Gingko
- ❑ Fish oil

Please list any other blood-thinning medications not listed above: _____

Name and phone number of prescribing physician: _____

Allergies

Do you have any drug allergies? Yes ❑ No ❑ If 'Yes', please list all drugs and the allergic reactions:

Drug/Medication	Allergic Reaction

Pregnancy Status

If you are FEMALE, please tell us your child-bearing/pregnancy status:

❑ Hysterectomy ❑ Child-bearing Age - No contraception
❑ Post-Menopausal ❑ Child-bearing Age - Birth Control Medication
❑ Not able to get pregnant ❑ Child-bearing Age - Other contraception

Anesthesia and Pain Procedure History

Have you ever had any problems or adverse reaction to anesthesia? ❑ Yes ❑ No ❑ Never had anesthesia.
If 'Yes', which type of anesthesia? _____; What was the reaction? _____
Have you ever had an adverse reaction to the iodine contrast used during a pain procedure? ❑ Yes ❑ No
If 'Yes', what was the reaction? _____

Family History

Please mark each box that is pertinent to your family history (biological relatives only)

	Autoimmune Disorder	Cancer	Diabetes	Headache	Heart Disease	Mental Health Problems	Alcohol Abuse	Kidney Disease	Liver Disease	Rheumatoid Arthritis	Illicit Drug Abuse	Stroke
Mother												
Father												
Sibling												

Other family history not listed above: _____
❑ I have no significant family medical history ❑ I am adopted (No medical history available)

Social History

Alcohol Use ❑ Never ❑ Occasional ❑ Daily ❑ History of Alcoholism
Tobacco Use ❑ Never ❑ Occasional ❑ Daily, How many packs per week? _____
Illegal Drug Use ❑ Never ❑ Occasional ❑ Daily ❑ History of Drug use, What Drug? _____

Any problems with prescription medication misuse, abuse, addiction? ❑ Yes, currently ❑ Yes, in past ❑ No
If 'Yes', which prescription medications? _____

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated

Who do you live with? ❑ Alone ❑ Friend/Roommate ❑ Spouse ❑ Spouse & Children ❑ Children
❑ Parents ❑ Assisted living facility ❑ Skilled nursing facility

What is your current work status? ❑ Employed ❑ Unemployed ❑ Retired ❑ Disabled (% disabled _____)
Occupation (if employed): _____

Social History (continued)

If you are unemployed, employed part-time, or have work restrictions, is this due to your current pain condition? ❑ Yes ❑ No

What are your current work restrictions, if any? ('N/A' if not applicable) _____

Are you currently involved in litigation related to this pain? ❑ Yes ❑ No

If 'Yes', attorney's name/phone number _____

Psychiatric History

Do you currently see a psychiatrist, psychologist, or therapist? ❑ Yes ❑ No

If 'Yes', please list his/her name? _____

Have you had any recent thoughts of hurting yourself or others? ❑ Yes ❑ No

Do you suffer from any of the following psychiatric conditions?

- ❑ Depression
- ❑ Anxiety
- ❑ Bipolar Disorder
- ❑ Substance abuse/Addiction
- ❑ Attention Deficit/Hyperactivity Disorder (ADD/ADHD)
- ❑ Obsessive-Compulsive Disorder (OCD)
- ❑ Personality Disorder
- ❑ Schizophrenia

Do you have a personal history of physical, emotional, or sexual abuse or other trauma? ❑ Yes ❑ No

If 'Yes' please discuss with your provider.

Preventative Medicine: Falls Risk Screening: If you are 65 or older, please check all that apply to you.

Have you had any falls in the last year?

- ❑ No falls in the past year
- ❑ One fall with injury in the past year
- ❑ Two or more falls with injury in the past year
- ❑ 1 fall without injury in the past year
- ❑ 2 or more falls without injury in the past year

Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true. I authorize MD Pain and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for MD Pain to retrieve and review my medication history. I understand that this will become part of my medical record. I acknowledge that I have had the opportunity to review the Notice of Privacy Practices of MD Pain, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records. I authorize the MD Pain to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize MD Pain to release any information required in obtaining procedure authorization or the processing of any insurance claims. I understand that MD Pain will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website. In the event that I am asked to provide a urine, saliva and/or blood sample, **I voluntarily seek laboratory services and hereby consent to provide a urine, saliva and/or blood sample as requested**. I have the right to refuse specific tests, but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected 30 days of being notified of any balance due. Please note that in the event that you fail to make payment when due, this account will be referred to a collection agency for collections. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

Signature: _____ **Date:** _____

(Patient, guardian or patient representative)

Printed name of patient or other person signing: _____

Opioid Therapy Statement

Welcome to MD Pain. This document contains the Opioid and Controlled Medications Agreement/Contract, the Informed Consent for the Treatment of Chronic Pain with Opioid Pain Medications, and the Opioid Therapy Statement. If you plan to ask for an opioid or other controlled substance for the treatment of your pain, then please read all three of these documents carefully and sign or initial where indicated. If you have any questions, please do not hesitate to as a provider or staff member.

At MD Pain, it is the goal of our physicians and staff to help give you your life back by reducing your pain and improving your daily functioning. We accomplish these goals with customized, safe, comprehensive and effective treatment plans that reduce risks and maximize benefits.

To protect our patients from the significant risks associated with opioid therapies including addiction, we follow recommendations and applicable guidelines from the Drug Enforcement Agency (DEA), Colorado state regulatory agencies and the Colorado Medical Board regarding the safe and responsible prescribing of these medications. We first try non opioid medications and other treatments before progressing to treating pain with opiates. Furthermore, we only prescribe opioid medications if, after thorough screening, risk stratification from the forms you fill out, and after through history and physical, we determine that a patient's pathology warrants their use, they meet specific criteria, and other treatment options, including alternative non-opioid pain medications, have failed to achieve satisfactory results.

The opioid therapy statement and patient agreement serve to document that both you and your clinician agree on a care plan so that controlled substances are used in a way that is safe and effective in treating your pain.

MD Pain takes a conservative approach to opioid therapy. Depending on a patient's specific situation, these medications may not be prescribed at all, may be prescribed at a lower dose, or changed to a safer, more appropriate alternative opioid. Research results continue to demonstrate conflicting evidence for the long-term use of opioid medications for chronic non-cancer pain. High doses or ever-escalating doses can result in a greater risk of physical dependence, tolerance addiction, and increased pain (opioid induced hyperalgesia). The lowest effective dosage of opioids used in conjunction with non-opioid medications in concert with pain management procedures, physical therapy, mental health therapy and other conservative treatments have been shown to produce the best long-term, effective results.

We track our treatment outcomes to do our best to ensure that our patients are being helped. We are proud of our results and believe that if you suffer from chronic pain we can help you. We provide a multidisciplinary approach to pain management that is safe, minimally invasive and clinically proven to be effective.

Side Effects of opioid Medications

I understand that the medication I will be taking may cause side effects to include, but not limited to: sleepiness or drowsiness, constipation, inability to urinate, nausea, vomiting, dizziness, an allergic reaction, immune suppression, hormone deficiencies, sexual problems, lack of coordination, kidney or liver disease, and bone thinning/weakness. Furthermore, the medication may cause my reflexes and reaction time to slow down. Finally, the medication may cause my breathing to become shallow and slower, leading to decreased

oxygen supply to my body, which may lead to permanent neurological, mental, cognitive and physical deficits and possibly death.

I have read, understand, and acknowledge the MD Pain Opiate Therapy Statement.

Printed Name _____

Signature _____ Date

Opioid and Controlled Substances Provider-Patient Agreement

Consent for Treatment

I, _____, understand and voluntarily agree that: (Please initial each statement after reviewing):

___ Identification of Alternative Treatment Options: I am aware that my MD Pain physician and his/her staff have discussed the possible benefits and risks of other treatments that do not include opioid therapy. These treatments include, but are not limited to, non-opioid medications, injections, physical therapy, mental health therapy and surgery, among others.

___ I understand my condition and I voluntarily request that my healthcare provider/ professional and his/her staff treat my condition. I further authorize my provider to administer or write prescriptions of controlled substances/ opioids/ "pain killers" to me for the purpose of treating my chronic pain. I am in agreement with taking these medications and in no way did my provider require me or talk me into taking these medications.

____I understand all controlled substances can be addictive and can lead to death.

____I understand the side effects of opioids listed in the Opioid Therapy Statement and will ask questions if needed.

____ I will participate in all other types of treatment that I am asked to participate in within reason

____ I will be responsible for my medicines and will keep the medicine safe, secure, locked, and out of the reach of children.

____ I will not sell my medicine or share it with others. I understand that if I do, my treatment will be stopped and authorities may be called.

____ If my medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

____ I will not take anyone else's medicine.

____ I will only take my medications as they are prescribed by my MD Pain physician. I will not alter dosage (ie: increase), route, frequency in which I am prescribed without discussing with my MD Pain physician.

____ I will bring the pill bottles with any remaining pills of this medicine to each clinic visit. I will authorize MD Pain staff to count my pills if necessary

____ If I see another doctor, who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.), I must bring this medicine in the original bottle, even if there are no pills left, to my MD Pain appointment.

____ I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team

____ I will not call between appointments, or at night or on the weekends looking for refills and I understand that no early or emergency refills may be made.

____ I understand that prescriptions will be filled only during scheduled office visits with the treatment team. I will make sure I have an appointment for refills, PRIOR to running out of medications.

____ I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

____ I will tell my MD pain physician all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

____ I will not obtain any non-opioid pain medicines or other prescription medicines for treatment of anxiety or pain, from other providers without permission from my MD Pain physician. If taken with opiates, I know these drugs, such as benzodiazepines (Klonopin/ clonazepam, Xanax, and valium/ diazepam) or stimulants (Ritalin, amphetamine), can be addictive, and dangerous to my health, or even causing death.

____ I will not use illegal drugs such as heroin, cocaine, or amphetamines. I understand that if I do, my treatment may be stopped.

____ I will come in for drug testing and counting of my pills within 24 hours of being called (random testing). I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.

____ I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore. I understand that I may lose my right to treatment in this office if I break any part of this agreement.

___ **Provider communication consent**: I authorize my MD Pain physician to talk with my other providers, pharmacists, attorneys, when appropriate for my care. I give them permission to discuss my opioid use as it pertains to my care. I know my MD Pain physician along with MD pain staff will review the CO-PDMP and I will sign a release form to let the doctor speak to all other doctors or providers that I see.

____ I will use only one pharmacy to get all on my medicines: [Pharmacy name/phone#] I will notify the practice in writing if I wish to change pharmacies.

___ **Right to Discontinue Treatment or Medication**

I understand that I may discontinue using my medication at any time and I agree to notify my MD Pain physician and/or his/her staff immediately upon discontinuing the use of my medication. I understand that I will be provided supervision and care, if needed, by my MD Pain physician and/or his/her staff if I choose to discontinue my medication. MD Pain reserves the right to terminate our patient/ provider relationship, if you are in violation of this agreement at any time. In these situations, alternative care by other pain or addiction providers, will be suggested to you.

I know and understand, that opioids and controlled medications may be stopped by the MD Pain providers if any of the following occurs:

- I trade, sell, give away, misuse, or abuse these medications;
- MD Pain finds that I have broken any part of this agreement;
- I do not present immediately for a blood, urine or saliva test, or pill count when requested by MD Pain;
- My blood, urine, or saliva tests show the presence of controlled or non-controlled medications that have not been previously reported to MD Pain, the presence of illegal drugs or alcohol, or fail to show opioid and other controlled medications that I am being prescribed by MD Pain;
- I receive prescriptions for opioid and controlled medications from sources other than MD Pain, unless arranged and discussed previously with my MD Pain physician or provider;
- Any member of the professional staff at MD Pain feels that it is in my best interest, from a safety or accountability standpoint, that opioid and controlled medication treatment be discontinued;
- I demonstrate ANY aggressive, belligerent, or unacceptable behavior toward any physician, provider, patient, or staff member at MD Pain;
- I consistently miss scheduled appointments at MD Pain, including office visits and procedures scheduled at MD Pain or any other facility utilized by MD Pain.
- Illicit Drug use i.e.: cocaine, methamphetamine, heroin
- Misrepresenting or lying about medical history including not disclosing risks to addiction such as family history of abuse, prior abuse of drugs or alcohol, prior military experience.

My signature indicates that I understand and agree to abide by each issue displayed on this page and I understand that if I fail to abide to any issue displayed on this page, I may be discharged from this clinic.

_____

Patient Printed Name

Patient Signature _____ Date_____

I attest, that I, have explained each issue discussed in this document to this patient and she/ he has indicated their understanding of each issue by affixing their initials next to each issue and signing the bottom of each page:

_____ _____

Staff Signature Date