Advanced Pain Management Center
Cedar Hills Surgery Center

10305 SW Park Way
Tel: 503-295-0730 ~ Fax: 503-295-0731

Thank you for your interest in establishing care with Advanced Pain Management Center and/or Cedar Hills Surgery Center. For your convenience we have attached a new patient packet for you to complete. Once we receive your completed packet we can move forward with scheduling your appointment. You may fax it to the above fax number or email it to info@apmconline.org.

Sincerely,

Our New Patient Coordinators

NOTICE OF RIGHTS AND RESPONSIBILITIES

I have read, understand and agree to the rights and responsibilities listed below.

Date_____

Print name patient/representative name_____

Patient/representative signature_____

Advanced Pain Management Center and Cedar Hills Surgery Center recognize and respects patient rights. We support patient understanding of these rights as a means of encouraging patients to become more informed and involved in their care. We shall provide care, treatment and services in a manner that respects and fosters the patient's dignity, autonomy, positive self-regard, civil rights, and involvement in his or her own care. We will also take into account the patient's personal values, beliefs, and preferences. We shall provide notification of the following rights to the patients and/or patient representatives in advance of any scheduled procedure and at a frequency of at least every six months:

You have the right to:

1. Be treated with respect, consideration and dignity at all times.
2. To be protected from discrimination
3. Have considerate and respectful care provided in a safe environment, free from all forms of abuse (including physical, mental/emotional and/or sexual abuse), neglect, harassment and/or exploitation.
4. Exercise these rights without regard to gender, ethnicity, cultural, natural origin, physical disability, economic, educational or religious background, or the source of payment for care.
5. Be provided appropriate and full consideration of privacy concerning his/her medical care program, including confidential case discussions, consultations, examinations and treatment.
6. Have disclosures and records treated confidentially and be given the opportunity to approve or refuse their release, except when the release is required by law. His/her written permission will be obtained before medical records can be made available to anyone not directly concerned with the case.
7. Have access to protective and advocacy services or have these services accessed on the patient's behalf.
8. Have access to their medical information (typically within 5 days) upon written request to inspect the records, except in certain circumstances specified by law.
9. Formulate advance directives regarding his or her healthcare, and to have our staff and practitioners who provide care comply with these directives (to the extent provided by policy, state laws and regulations).
10. To receive a copy of our policy on advance directives prior to your appointment both verbally and in writing.
11. Designate visitors of their choosing, if the patient has decision-making capacity, whether or not the visitor is related by blood or marriage.
12. Have knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will also provide care.
13. Receive information in a manner that he/she understands. Written information provided will be appropriate to the age, understanding and, as appropriate, the patient's language. As appropriate communications specific to the vision, speech, hearing cognitive and language impaired patient will be appropriate to the impairment.

14. Receive information from his/her physician about his/her illness, proposed treatment or procedure in order to give informed consent or refuse treatment, the course of treatment, outcomes of care (including unanticipated outcomes), and his/her prospects for recovery in terms that he/she can understand. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
15. Participate in the development and implementation of his/her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
16. Have an appropriate assessment and management of pain.
17. Have reasonable continuity of care and responses to any reasonable requests he/she may make for service.
18. Be informed of continuing health care requirements post discharge from our center.
19. Be informed of his/her rights as a patient when discontinuing the provision of care and the right to appoint a representative to receive this information if desired.
20. Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on the patient's behalf.
21. Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
22. To leave our center against the advice of the physician.
23. Know the reasons for his/her transfer from the center.
24. Have the right to change their physician if other qualified physicians are available.
25. To be advised of our procedures for expressing suggestions, complaints and grievances, Including those required by state and federal regulations. To exercise these rights without being subjected to discrimination or reprisal.
26. If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf.
27. To refuse to participate in experimental research.
28. To examine and receive an explanation of the bill regardless of the payment source.
29. To know which rules and policies apply to his/her conduct while a patient.
30. To have all patient's rights apply to the person who may have legal responsibility to make Decisions regarding medical care on behalf of the patient.
31. To be notified of appropriate information regarding the absence of malpractice insurance coverage.
32. The right to marketing or advertising regarding the competence and capabilities of the Center that is not misleading.
33. Know of any physician financial interests or ownership in the surgery center (CHSC).

FILING COMPLAINTS: If you have a complaint against an ambulatory surgery center, call the Oregon Health Authority, Department of Health Care Licensure and Certification at 971-673-0540, or write to: Oregon Health Authority, Health Care Licensure and Certification, 800 NE Oregon Street, Suite 305, Portland Oregon 97232., or email to: **mailbox.hclc@state.or.us**

If you have a complaint against a health care professional, call the Oregon Medical Board at 971-673-2700, or write to: Oregon Medical Board, 1500 SW 1st Ave., Suite 620, Portland, OR 97201-5847, or email to **omb.info@state.or.us**

In addition to filing complaints with the Agency for Health Care Administration set forth in this Notice of Patient Rights and Responsibilities document, you can visit the Centers for Medicare and Medicaid's Office of the Medicare Ombudsman's: **http://www.medicare.gov/Ombudsman/activities.asp**

You may also contact the Administrator, Karen Wood, in writing at 10305 SW Park Way #101, Portland OR 97225 or by telephone at 503-595-9001.

PHYSICIAN OWNERSHIP DISCLOSURE: Cedar Hills Surgery Center is 100% owned by Vladimir Fiks MD.

Please be advised that you have the right to obtain the health care items and services for which you have been referred at any location or from any ambulatory surgery center, hospital, provider or supplier of your choice, including Cedar Hills Surgery Center.

PATIENT RESPONSIBILITIES

Your responsibilities as a patient are:

To read and understand all permits and/or consents you sign. If you do not understand, it is your responsibility to ask the nurse or Physician for clarification.

To provide complete and accurate information to the best of your ability about your health, any medications, including over-the counter products and dietary supplements and any allergies or sensitivities. To answer all medical questions truthfully and to the best of your knowledge.

To read carefully and follow any pre-operative written or oral instructions you have been given and to notify our staff if you have not followed the pre-operative instructions.

To provide a responsible person to transport you home after surgery if you have received medications and/or anesthesia.

To provide for someone to be responsible for your care for the first 24 hours after your procedure.

To follow carefully any written or verbal post-op instructions from your Physician(s) or nurse. This includes keeping any scheduled postoperative appointments with your Physician.

To contact your Physician regarding any post-operative question, problem, or complication.

To assure all financial obligations for services are fulfilled as promptly as possible and to assume ultimate responsibility for payment regardless of insurance coverage.

To notify us immediately if your insurance has changed or termed.

To notify either Administrator or the Director of Nursing if you feel any rights have been violated, or if you have a complaint, or a suggestion for improvement. This can be accomplished by completing and returning your patient questionnaire or by direct contact.

To refrain from using profanity when interacting with others while on the premises.

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AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION FROM OUTSIDE INDIVIDUALS

Authorization: I authorize
_____ to use
and disclose a copy of the health information described below regarding:

Name of patient_____
consisting of **Treatment** (includes activities performed by a physician or other healthcare provider directly delivering care to you, coordinating or managing care provided to you with third parties, and consultations with and between physicians and other healthcare providers including care conferences); **Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities including review of healthcare services for medical necessity, justification of charges, precertification and preauthorization of services); **Healthcare operations** (includes the necessary administrative and business functions of your healthcare provider); **Other** (e.g. family/friend, new healthcare provider – include address and phone number below).

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Portland OR 97225

If the information to be disclosed contains any of the types of records or information listed below, additional laws
relating to the use and disclosure of the information may apply. I understand and agree that this information will
be disclosed if I place my initials in the applicable space next to the type of information.

_____ Last 12 months of medical records _____Drug/alcohol diagnosis, treatment or referral information.

_____ Any imaging studies done within the last 18 months _____ Interventional pain management procedures

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive healthcare service. The only circumstance when refusal to sign means you will not receive healthcare services is if the healthcare services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described above. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization please, send a written statement to our office at the above address.

Signature: I have read this authorization and understand it. Unless revoked, this authorization expires one year from the date below. ORS 192.521 specifies when a health care provider can charge for copies of medical records and the maximum amount that can be charged. As such, APMC responds only to written requests for medical records. HIPAA provides that a physician may charge a "reasonable, cost-based fee" - see Financial Policy. **I understand that should the decision be made not to take me on as a patient, records received from the above providers will be shredded as no provider-patient relationship was been established. Should I want a copy of those records I understand I will have to contact that provider directly.**

Print Name:_____ Date:_____
(Patient or personal representative)

Signature_____

PATIENT REGISTRATION FORM

Personal

Name_____Social Security #:_____

Address_____City_____

State_____Zip_____

Date of birth_____Email address_____

[ ] I consent to be contacted by email [ ] I prefer to be contacted by phone

[ ] Preferred phone number_____

Emergency contact name_____Phone_____

Relationship_____

Employer: _____

Employer's phone number: _____

Occupation: _____

Race: ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander

☐ Black ☐ White

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

☐ I refuse to report any information regarding my ethnicity or race

Primary language: ☐ English ☐ Spanish ☐ Russian
☐ Other_____

Primary care provider_____

Telephone_____ Fax_____

How did you hear about us?

☐ Physician ☐ Friend/relative ☐ Internet search

☐ Insurance carrier ☐ Workers comp carrier ☐ Attorney ☐ Patient Pop

☐ Health Grades

Insurance Information

Primary personal insurance_____

ID #_____ Policy holder's name_____

Policy holder's employer_____

Telephone #_____

Secondary personal insurance_____

ID #_____ Policy holder's name_____

Policy holder's employer_____

Telephone #_____

Workers compensation information

☐ I do not have an open workers compensation claim

☐ I do have an open workers compensation claim

Accepted condition(s)_____

W/C Claim #_____W/C Carrier_____

Adjuster's name_____Phone_____

MVA information

☐ I do not have an open MVA claim

☐ I do have an open MVA claim

Accepted condition(s)_____

Claim #_____Carrier_____

Adjuster's name_____Phone_____

Attorney information: If you have an attorney involved in your case please provide that information below.

Name:_____Phone_____

ASSIGNMENT OF BENEFITS

I authorize Advanced Pain Management Center and/or Cedar Hills Surgery Center to furnish my insurance company all information requested concerning my present illness or injury. I assign Advanced Pain Management Center and/or Cedar Hills Surgery Center all benefits for services rendered.

I understand and agree that regardless of my insurance status, I am responsible for the balance on my account for any services rendered by practitioners of Advanced Pain Management Center and/or Cedar Hills Surgery Center.

The assignment will remain in effect until revoked by me in writing. An electronic version of this assignment is to be considered as valid as the original.

Print insured/authorized person's name_____

Signature_____Date_____

FINANCIAL POLICY – If you are being seen under a workers compensation claim you do not need to fill this section out

Patient name (please print)_____Date_____

Payment for services: Per our financial policy, payment is due at the time of service. This includes payment in full for patients who are self- pay and payment in full of all appropriate co-pays for patients with insurance.

We are not contracted with any Medicaid plan.

_____ **(initial) I HAVE active Medicaid (OMAP, DMAP, OHP, Care Oregon etc.)**

_____ **(initial) I do not have an active Medicaid (OMAP, DMAP, OHP, Care Oregon etc.)**

_____ **(initial) Billing your insurance:** As a courtesy, we will bill your insurance for services. If you have a commercial insurance policy that does not reimburse us for services, financial responsibility may default to you.

_____ **(initial) Insurance co-pays, co-insurance and deductibles:** Should your insurance assign you a copay, co-insurance payment or deductible, we cannot waive this for you. We must collect this from you at each visit as appropriate. Physicians may be penalized if they do not hold patients accountable for patient responsibility. As such, if you do not present with appropriate payments, your visit will be rescheduled.

_____ **(initial) Self-pay status:** Payment is due at the time service is rendered. If you present and are not able to pay without making prior arrangements, your visit will be rescheduled.

_____ **(initial) ANESTHESIA FEES:** Your anesthesia will be provided by Onsite Anesthesia and you will be billed separately through that company. Questions regarding your anesthesia bill should be directed to (503) 372-2794.

_____ **(initial) NEUROPHYSIOLOGICAL MONITORING FEES:** If your physician believes that this type of monitoring is in your best interest during your procedure, services will be provided by a certified technologist from Willamette Neuromonitoring. You will be billed separately for these services through AHI who limits patient responsibility to $250. Questions regarding your monitoring fees should be directed to at 503-893-4455.

_____ **(initial) RETURNED CHECK CHARGE**
You will be charged a $35 returned check fee when you write a check that does not clear your bank. We do not redeposit returned checks regardless of the reason. If a check from you is returned for any reason, you will be required to pay for all future services with cash, money order or credit card. In addition, we will not accept a check for 12 months.

_____ **(initial) No show fees**

Should it be necessary for you to cancel your appointment, we require 24 hour notice to help us facilitate continuity of care in our clinic. No show fees cannot be billed to your insurance. If your condition is covered under a workers' compensation claim, this does not apply. Failure to call to cancel an appointment will result in the following fees:

1. $50 for follow up appointments
2. $150 for procedure appointments

_____ **(initial) Check acceptance policy: CHECK ACCEPTANCE POLICY**

The Front Desk is not authorized to accept checks:

1. Over the amount of $300 however payments mailed to our office can be paid with a check even if the amount is over $300.
2. Checks written by a third party (i.e., friend, relative, etc.)
3. Checks that are not imprinted with the name, address of the account holder.

_____ **(initial)** We can hold a payment for 72 hours and not beyond this time frame.

_____ **(initial)** My initials on this page indicate that I have read, understand and agree to the financial policy.

HEALTH HISTORY

Pharmacy name_____

Pharmacy Phone_____

Medication Allergies

Medication	Reaction

Non-medication Allergies (other) Please mark all boxes that apply

☐ Seafood ☐ Iodine ☐ Latex ☐ Tape ☐ Contrast agents

Current Medications – pain medications, blood thinners (ibuprofen, Motrin, aspirin), diabetic medications, diuretics, heart medications, blood pressure medications

Name	Strength	How Taken Daily, twice a day	Prescriber

PAST HEALTH HISTORY

If you have ever been diagnosed with one of the problems listed below, please check the box.

☐ Never diagnosed with a significant problem

Cancer ☐ Negative

Type: _____

Ears ☐ Negative
☐ Hearing loss ☐ Meniere's disease

Nose and sinuses ☐ Negative
☐ Recurrent sinusitis ☐ Chronic sinusitis ☐ Nose bleeds

Mouth/throat ☐ Negative
☐ Sleep apnea ☐ TMJ disease

Heart/blood vessels ☐ Negative
☐ Aneurysm ☐ Angina ☐ Atrial fibrillation ☐ Atrial flutter
☐ Blocked carotid artery ☐ Cardiomyopathy ☐ CVA (stroke)
☐ Congenital heart disease ☐ Congestive heart failure ☐ Coronary artery disease (CAD)
☐ Deep vein thrombosis (DVT) ☐ Heart attack ☐ Heart disease ☐ Heart block
☐ Heart valve defect ☐ High blood pressure ☐ Irregular heart beat requires TX
☐ Mitral valve prolapse ☐ Pericarditis ☐ Peripheral vascular disease
☐ Pulmonary hypertension ☐ Raynaud's disease ☐ Rheumatic fever
☐ Thrombophlebitis ☐ Transient ischemic attack (TIA)

Lungs/respiratory ☐ Negative
☐ ARDS (adult respiratory distress syndrome) ☐ Asthma ☐ Bronchiectasis
☐ Chronic interstitial fibrosis ☐ COPD/emphysema ☐ Cystic fibrosis ☐ GERD
☐ Phrenic nerve paralysis ☐ Pneumothorax ☐ Pulmonary embolus ☐ Sarcoidosis
☐ Silicosis ☐ Tuberculosis

Stomach/Digestive ☐ Negative
☐ Achalasia ☐ Barrett's esophagus ☐ Cirrhosis ☐ Crohn's disease
☐ Diverticulitis/diverticulosis ☐ Diverticulum (Meckel's)
☐ Duodenal ulcer ☐ GERD ☐ H. pylori ☐ Hepatitis B ☐ Hepatitis A
☐ Hepatitis C ☐ Irritable bowel syndrome ☐ Pancreatitis
☐ Portal hypertension ☐ Pyloric stenosis ☐ Ulcerative colitis

Genitourinary Is it possible you may be pregnant? ☐ Yes ☐ No

Kidneys/urinary tract ☐ Negative
☐ Glomerulonephritis ☐ Incontinence (type undetermined) ☐ Renal failure
☐ Renal insufficiency

Bones, joints, and muscles ☐ Negative
☐ Ankylosing spondylitis ☐ Arthritis (osteo)
☐ Arthritis (rheumatoid) ☐ Congenital dislocated hip ☐ Degenerative bone disease
☐ Disc disorder in back ☐ Disc disorder in neck ☐ Fibromyalgia ☐ Gout
☐ Muscular dystrophy ☐ Myasthenia gravis ☐ Osteopenia ☐ Osteoporosis
☐ Recurring bursitis ☐ Spinal stenosis

Skin ☐ Negative
☐ Dermatitis unspecified ☐ Eczema ☐ Exfolative dermatitis ☐ MRSA
☐ Extensive/severe burn ☐ Fungal infection ☐ Herpes simplex dermatitis

☐ Lyme disease ☐ Lupus (involving the skin only) ☐ Neurofibromatosis
☐ Porphyria ☐ Psoriasis ☐ Scleroderma ☐ Shingles

Brain and nervous system ☐ Negative
☐ Alzheimer's disease ☐ Amyotrophic lateral sclerosis
☐ Aneurysm of blood vessel in the brain ☐ AV malformation ☐ Carpal tunnel syndrome
☐ Complex regional pain syndrome ☐ Dementia ☐ Encephalopathy
☐ Entrapped nerve ☐ Epilepsy ☐ Guillain-Barre syndrome
☐ Hydrocephalus ☐ Mononeuropathy ☐ Multiple sclerosis
☐ Neuralgia ☐ Neuritis ☐ Paralysis
☐ Parkinson's disease ☐ Polyneuropathy ☐ Progressive neurologic disorder
☐ Restless leg syndrome ☐ Radiculitis ☐ Ruptured cervical disc
☐ Ruptured lumbar disc ☐ Sleep disorder ☐ Spinal cord infarction
☐ Stroke ☐ Subarachnoid hemorrhage
☐ Transient ischemic attack (TIA) ☐ Tumor of the brain, unspecified
☐ Tumor of the spinal cord, unspecified ☐ Tumor of the brain, benign
☐ Vertebral basilar occlusion

Mental and emotional health ☐ Negative
☐ Alcohol or drug treatment ☐ Alcoholism ☐ Bipolar disorder
☐ Depression ☐ Drug dependency ☐ General psychiatric illness
☐ IV drug abuse ☐ Posttraumatic stress syndrome
☐ Schizophrenia

Endocrine, hormones, and metabolic problems ☐ Negative
☐ Diabetes, type uncertain ☐ Diabetes, Type I ☐ Diabetes, Type II
☐ Glycogen storage syndrome ☐ Graves' disease ☐ Hyperthyroidism, high
☐ Thyroid dysfunction

Blood and lymph node problems ☐ Negative
☐ Anemia, type not stated elsewhere ☐ Clotting disorder ☐ Hemophilia
☐ Sickle cell disease ☐ Von Willebrand's disease

Immune/Autoimmune and infectious problems ☐ Negative
☐ Anaphylaxis ☐ AIDS ☐ Autoimmune disorder ☐ HIV positive
☐ Lupus, systemic ☐ MRSA

Surgeries and hospitalizations

Mouth ☐ Negative
☐ Jaw surgery

Neck ☐ Negative
☐ Neck surgery, type unspecified _____

Heart and blood vessels ☐ Negative
☐ Angioplasty of heart arteries ☐ Bypass of heart arteries (coronary artery)
☐ Carotid endarterectomy ☐ Heart implantable defibrillator ☐ Heart pacemaker
☐ Heart transplant ☐ Repair aortic aneurysm, abdominal

☐ Repair aortic aneurysm, thoracic

☐ Surgery not listed above_____

Thoracic (lungs) ☐ Negative
☐ Thoracic surgery, type unspecified _____

☐ Lung surgery, type unspecified _____
☐ Pneumonectomy (removal of lung) ☐ Resection of lung tumor

Abdominal and gastrointestinal ☐ Negative
☐ Liver surgery, unspecified ☐ Liver transplant ☐ Pancreas surgery, unspecified
☐ Pancreas resection, partial ☐ Pancreas resection, total
☐ Pancreas resection, radical ☐ Spleen surgery, unspecified
☐ Spleen resection, splenectomy

Small intestine, colon, and rectal ☐ Negative
☐ Colectomy ☐ Colon resection ☐ Colostomy ☐ Gastrectomy, unspecifie
☐ Bariatric (weight loss) surgery ☐ Bariatric surgery, gastric banding

Bones, joints and muscles ☐ Negative
☐ Bone, joint or muscle surgery_____
☐ Bone surgery, amputation ☐ Bone surgery, fracture reductions
☐ Joint surgery, arthroscopic procedures ☐ Joint surgery, open
☐ Spine surgery (disc removal, laminectomy, kyphoplasty, vertebroplasty) / Please list below

_____

Brain, spinal cord and nervous system ☐ Negative
☐ Brain surgery, unspecified ☐ Nerve surgery, unspecified
☐ Spinal cord surgery, unspecified ☐ Carpal tunnel release ☐ Craniotomy, unspecified

Interventional pain management ☐ **Negative**
☐ Celiac plexus block ☐ Epidural steroid injection ☐ Facet injection
☐ Ganglion impar injections ☐ Hypogastric plexus block ☐ Intrathecal pump
☐ Medial branch block ☐ Peripheral stimulator implant ☐ Peripheral stimulator trial
☐ SI joint injection ☐ Spinal cord stimulator implant ☐ Spinal cord stimulator trial
☐ Splanchic block ☐ Sympathetic nerve block
☐ Transforaminal epidural steroid injection ☐ Trigeminal nerve block

SOCIAL HISTORY

☐ Select if patient is retired

Employment status ☐ Currently employed ☐ Disabled and unable to work
☐ Unemployed

Marital status ☐ Single ☐ Divorced ☐ Married ☐ Other

Current use of tobacco products ☐ None
☐ Yes, currently uses tobacco ☐ Current every day smoker

Current use of alcoholic beverages ☐ None
☐ When did you last consume alcohol and how much _____

Recreational drug use ☐ No
☐ Yes If yes, please list which drugs below

_____

Home living situation ☐ Lives with spouse ☐ Lives with spouse and children
☐ Lives with partner ☐ Lives in assisted living residence ☐ Lives in nursing home

REVIEW OF SYSTEMS

This section tells us what you are currently being treated for and/or problems, signs or symptoms that you may currently be experiencing.

☐ No problems now or in the recent past

CONSTITUTIONAL SYMPTOMS (general health) ☐ **Negative**
☐ Dizziness ☐ Feeling bad all over (malaise) ☐ Fever ☐ Fever and chills
☐ Generalized aching ☐ Heals poorly

EYES ☐ **Negative**
☐ Dry eyes ☐ Spots or specks ☐ Wears corrective glasses or contacts

EARS, NOSE, MOUTH AND THROAT ☐ **Negative**
Ears:
☐ Dizziness ☐ Hearing loss ☐ Ringing in ears

Nose and sinuses: ☐ **Negative**
☐ Facial pressure sensation ☐ Nasal congestion ☐ Nasal obstruction
☐ Mouth breathing

Mouth and throat: ☐ **Negative**
☐ Dry mouth ☐ Hoarseness ☐ Popping sound in the jaw when chewing
☐ Snoring ☐ Partials, dentures or loose teeth

Cardiovascular ☐ **Negative**
☐ Blacking out or fainting ☐ Bluish discoloration of lips and/or fingernails
☐ Chest pain at rest ☐ Chest pain with exercise ☐ Cold hands or feet
☐ Enlarged veins in legs ☐ Heart murmur ☐ Irregular heart beat

☐ Leg cramps when walking ☐ Lightheadedness or near fainting on standing up
☐ Palpitations ☐ Shortness of breath when lying down
☐ Shortness of breath when sitting or standing
☐ Suddenly waking up short of breath at night
☐ Swelling including ankles or legs

Respiratory ☐ **Negative**

☐ Coughing up blood ☐ Pain or tightness in chest
☐ Shortness of breath or difficulty breathing
☐ Sleep disturbance due to breathing ☐ Snoring (excessive) ☐ Wheezing

Gastrointestinal (upper and lower digestive system) ☐ **Negative**

☐ Abdominal pain ☐ Abdominal swelling ☐ Abdominal tenderness
☐ Black stools ☐ Bleeding (rectal) ☐ Blood in stools
☐ Blood in vomitus ☐ Constipation ☐ Constipation and diarrhea
☐ Diarrhea ☐ Gas (excessive) ☐ Heartburn/indigestion
☐ Nausea ☐ Rectal pain ☐ Difficulty swallowing (general)
☐ Vomiting

Musculoskeletal (bones, joints, and muscles) ☐ **Negative**

☐ Cramping ☐ Decrease in size of muscles ☐ Limitation of joint including back
☐ Loss of muscle strength ☐ Muscle pain ☐ Muscle tenderness
☐ Pain in back ☐ Pain in neck ☐ Painful joints
☐ Pain when using muscles ☐ Redness of skin over joints ☐ Stiffness in joints
☐ Stiffness in neck ☐ Swelling of joints ☐ Weakness

Integumentary (skin, breasts, hair, nails) ☐ **Negative**

☐ Bruises easily ☐ Hair changes ☐ Nail changes
☐ Poor wound healing ☐ Skin lesions (suspicious) ☐ Skin rash

Neurological (brain and nervous system) ☐ **Negative**

☐ Change in alertness ☐ Difficulty remembering ☐ Difficulty speaking
☐ Difficulty thinking ☐ Difficulty walking ☐ Difficulty with balance
☐ Difficulty with coordination ☐ Drooping on one side of the face
☐ Excessive daytime sleepiness ☐ Falling down ☐ Headache
☐ Loss of bladder control ☐ Loss of bowel control ☐ Loss of consciousness
☐ Numbness ☐ Pain, facial, severe
☐ Seizures ( ) with abnormal body movements ( ) without abnormal body movements
☐ Spinning sensation ☐ Tingling / pins and needles sensation ☐ Tremor
☐ Paralysis ☐ Weakness

Endocrine (glands, hormones, blood sugar control) ☐ **Negative**

☐ Lightheadedness or near fainting on standing up

Hematologic/lymphatic (blood and lymph nodes) ☐ **Negative**

☐ Bleeding into a joint ☐ Bleeds excessively after injury or minor surgery
☐ Bruises easily ☐ Uses aspirin

Allergic, infectious, immunologic ☐ **Negative**

☐ Hives ☐ Infections (recurring) ☐ Low blood pressure ☐ Mouth breathing

Patient name (please print) _____

SOAPP-R

	Never	Seldom	Sometimes	Often	Very often
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 your felt impatient with your medical providers					
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 worried about being left alone					
10. How often have you felt a craving for medication					
11. How often have others expressed concern over your use of medication					
12. How often have any of your close friends had a problem with alcohol or drugs					
13. How often have others told you that you had a bad temper					
14. How often have you felt consumed by the need to get pain medication					
15. How often have you run out of pain medication early					
16. How often have others kept you from getting what you deserve					

17. How often in your lifetime have you had legal problems or been arrested					
18. How often have you attended an AA or NA meeting					
19. How often have you been in an argument that was so out of control that someone got hurt					
20. How often have you been sexually abused					
21. How often have others suggested that you have a drug or alcohol problem					
22. 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					