ACELLERATED INTERVENTIONAL ORTHOPEDICS

Address:
3414 NW Cache, Suite F
Lawton, OK, 73505

Phone: 580-771-2011
Fax: 877-292-3457

Initial Visit Forms (MEDICAL HISTORY) Date _____

PATIENT NAME (Last, Middle, First):

BIRTH DATE: SEX: HEIGHT: WEIGHT:

____/____/_____ *Male / Female*

_____

REFERRING DOCTOR: _____

PRIMARY CARE DOCTOR: _____

PRIMARY INSURANCE: _____

INSURANCE / MEMBER ID: _____

GROUP NUMBER: _____

ADDRESS: _____

CITY: _____

ZIP CODE: _____

SOCIAL SECURITY #: _____

MOBILE PHONE: _____ (OTHER): _____

OK TO TEXT APPOINTMENT REMINDERS? *YES NO (CIRCLE)*

PRIMARY INSURED NAME: _____

(If different from patient)

RELATIONSHIP: SPOUSE OTHER _____

PRIMARY INSURED SOCIAL SECURITY #: _____

_____

PAIN QUESTIONNAIRE

WHERE IS YOUR PRIMARY AREA OF PAIN

HEAD KNEE BACK MIDDLE

NECK HIPS BUTT LOW

SHOULDER

DOES THE PAIN RADIATE OR GO ANYWHERE? *YES / NO*

DOWN THE ARM(S) *RIGHT / LEFT / BOTH*

DOWN THE LEG(S) *RIGHT / LEFT / BOTH*

WHEN DID YOUR PAIN START? WHAT YEAR?

STARTED: *GRADUALLY? SUDDENLY?*

TIMING: *CONSTANT? COME & GOES?*

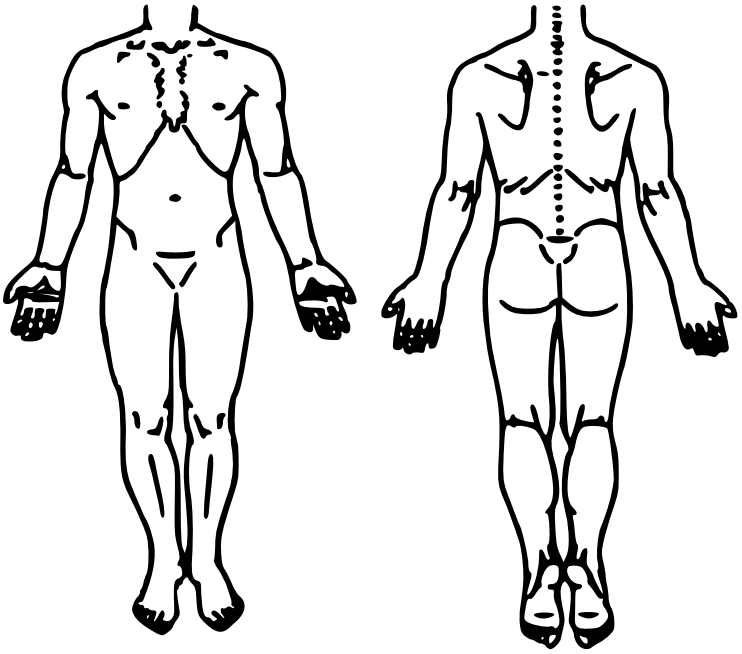
HOW LONG – HAD PAIN? *WEEKS? MONTHS? YEARS?*

WHAT CAUSED YOUR PAIN INITIALLY?

CAR ACCIDENT:

OTHER: _____

WHERE IS YOUR PRIMARY AREA OF PAIN? (DRAW ON DIAGRAM)



PAIN RATING:

BEST	0	1	2	3	4	5	6	7	8	9	10
AVERAGE	0	1	2	3	4	5	6	7	8	9	10
WORST	0	1	2	3	4	5	6	7	8	9	10

DESCRIBE THE PAIN:

DULL ACHEY CRAMPING THROBBING OTHER?

SHARP STABBING BURNING TINGLING NUMBING

WHAT MAKES PAIN WORSE?

BENDING LIFTING SITTING FOR A WHILE

WALKING DRIVING STANDING FOR A WHILE

STAIRS OTHER

WHAT MAKES PAIN WORSE?

REST SITTING STRETCHING CHANGING POSITION

WALKING STANDING EXERCISE PHYSICAL THERAPY

HEAT PAD MEDICATION MASSAGE CHIROPRACTIC

COLD/ICE INJECTIONS BRACE

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PATIENT NAME (Last, Middle, First):

CIRCLE ALL THAT APPLY TO THE PATIENT

HEART/CARDIOVASCULAR

HIGH BLOOD PRESSURE *HEART FAILURE*

HEART ATTACK *HEART STENT*

LUNG/PULMONARY

ASTHMA *COPD/EMPHYSEMA*

LIVER/KIDNEY

HEPATITIS *CIRRHOSIS*

LIVER FAILURE *KIDNEY FAILURE*

BRAIN/SPINE/NEUROLOGICAL

STROKE *SEIZURE DISORDER*

NEUROPATHY *TRAUMATIC BRAIN INJURY*

STOMACH/GASTROINTESTINAL

REFLUX (GERD) *ULCERS*

METABOLIC/ENDOCRINE

DIABETES *THYROID DISEASE*

OTHER *CHRONIC STEROIDS*

BLOOD DISORDER/HEMATOLOGY

BLEEDING DISORDER *EASY BRUISING*

DVT (BLOOD CLOT IN LEG OR ARM OR LUNG

ON BLOOD THINNERS *OTHER*

JOINT/MUSCULOSKELETAL

ARTHRITIS *RHEUMATOID ARTHRITIS*

OSTEOARTHRITIS *SCOLIOSIS*

PSYCHOLOGICAL/PHYCHIATRIC

DEPRESSION *PSYCHIATRIC HOSPITAL?*

ANXIETY *BIPOLAR*

MEDICATION ALLERGIES:

DRUG/SUBSTANCE: REACTION (RASH, ITCH ECT)

_____

_____

_____

PHARMACY NAME:

PHONE #: CITY/STATE:

_____

CURRENT MEDICATION LIST:

PAIN/MEDS:

NAME: *MG* *Number of Pills per Day*

_____

_____

_____

_____

OTHER PRESCRIBED MEDS:

NAME: *FOR?*

_____

_____

_____

_____

SOCIAL HISTORY:

EMPLOYMENT:

MARITAL STATUS:

_____

SUBSTANCE USE:

SMOKING:	NEVER	CURRENT	QUIT
(# of Years)			
ALCOHOL	NEVER	SOCIAL	ADDICTED
COCAINE	NEVER	SOCIAL	ADDICTED
AMPHETAMINE	NEVER	SOCIAL	ADDICTED

SURGICAL HISTORY:

BODY PART *YEAR* *HOSPITAL* *SURGEON*

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FOLLOW UP VISIT FORM

Date _____

PATIENT NAME (Last, Middle, First):

_____

BIRTH DATE: / /

REVIEW OF SYSTEMS – To Be Completed by ALL Patients

☐ Check Here If NO CHANGES Since Last Visit (NOT Applicable to New Patients)

(CIRCLE ALL THAT APPLY)

CONSTITUTIONAL SYMPTOMS

FEVER *FATIGUE*

WEAKNESS *WEIGHT LOSS*

HEAD, EYES, EARS, NOSE, THROAT

HEADACHE *HEAD INJURY*

DIZZINESS *VISION CHANGES*

OTHER

LUNG/PULMONARY

SHORT OF BREATH *COPD/EMPHYSEMA*

OTHER *SLEEP APNEA*

HEART/CARDIOVASCULAR

HIGH BLOOD PRESSURE *HEART FAILURE*

HEART ATTACK *HEART SILENT*

OTHER *ATRIAL FIBRILLATION*

STOMACH/GASTROINTESTINAL

REFLUX (GERD) *ULCERS*

LIVER DISEASE *HEPATITIS*

OTHER *CONSTIPATION*

JOINT/MUSCULOSKELETAL

ARTHRITIS *RHEUMATOID ARTHRITIS*

OSTEOARTHRITIS *SCOLIOSIS*

MUSCLE PAIN *CONSTIPATION*

WEAKNESS *PARALYSIS*

OTHER

PSYCHOLOGICAL/PHYCHIATRIC

DEPRESSION *PSYCHIATRIC HOSPITAL STAY?*

ANXIETY *PTSD*

OTHER *MOOD WINGS*

SKIN

ITCHING *RASH*

DRYNESS *BRUISHING*

BRAIN/SPINE/NEUROLOGICAL

STROKE *SEIZURE DISORDER*

NEUROPATHY *TRAUMATIC BRAIN INJURY*

UNSTEADY GAIT *NUMBNESS/TINGLING*

TREMORS *NERVE DAMAGE*

OTHER

METABOLIC/ENDOCRINE

DIABETES *THYROID DISEASE*

OTHER *CHRONIC STEROIDS*

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SOAPP-R FORM

The following questions for patients being considered for pain medication.

Please answer each question as honestly as possible there are no right or wrong answers.

NAME _____ BIRTH DATE _____ DATE _____

	0	1	2	3	4
How often do you have mood swings?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have you felt a need for higher doses of medication to treat your pain?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have you felt impatient your doctors?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have you felt that things are just too overwhelming that you can't handle them?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often is there tension in the home?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have you counted pain pills to see how many are remaining?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have you been concerned that people will judge you for taking pain medication?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often do you feel bored?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have you taken more pain medication than you were supposed to?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have you worried about being left alone?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have you felt a craving for medication?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have others expressed concern over your use of medication?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have any of your close friends had a problem with alcohol or drugs?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have others told you that you had a bad temper?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have you felt consumed by the need to get pain medication?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have you run out of pain medication early?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have others kept you from getting what you deserve?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often, in your lifetime, have you had legal problems or been arrested?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have you attended an Alcoholics Anonymous or Narcotics Anonymous meeting?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have you been in an argument that was so out of control that someone got hurt?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have you been sexually abused?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have others suggested that you have a drug or alcohol problem?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have you had to borrow pain medications from your family or friends?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*
How often have you been treated for an alcohol or drug problem?	*Never*	*Seldom*	*Sometimes*	*Often*	*Very Often*

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GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?

(Circle a number to indicate your answer)

		Not at All	Several Days	More than Days 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 is 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
	For office coding: Total score	_____	_____	_____	_____

TOTAL _____

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

		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 asleep, 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're 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 dgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

OFFICE Staff will total				
TOTAL SCORE				

_____ + _____ + _____ _____

10 If you check off any problems, how dif cult have those problems made it for you to do your work, take care of things at home, or get along with other people?
Not dif cult at all Somewhat dif cult Very dif cult Extremely dif cult

POLICY STATEMENT

The mission of AIO (aCELLerated Interventional Orthopedics) is to serve patients in their management of pain through a patient centered approach. Our goal is to ensure your healthcare needs are met while your pain level is diminished and quality of life is improved.

As a part of your treatment plan, patients may be asked to:

1. Please give a 24 hours notice of appointment cancellation. A late-cancellation or no-show fee of $40 will be required before another appointment is made.
2. We utilize a team-approach in caring for our patients. Patients may have appointments with a Nurse Practitioner or Physician assistant for routine follow up appointments. These providers always consult with & work closely with our Physicians.
3. AIO requires each patient has a Primary Care Physicians.
4. Bring your medication ONLY if you are asking for a medication change or if we ask you to bring them.
5. Your medication may be checked for compliance with a random pill count.
6. The patient may be asked to count their medication in front of AIO staff. Medication should remain in the patient's possession AT ALL TIMES.
7. To maintain high levels of care & compliance, AIO providers follow the standard of care guidelines of the following:
    - Oklahoma state department of health
    - Oklahoma Board of Narcotics & Dangerous Drugs
    - Oklahoma Prescription Monitoring Program
    - Oklahoma Anti-drug Diversion Act
    - CDC Guidelines for prescribing opioids for chronic pain

PATIENT SIGNATURE _____ DATE _____