Ohio Institute
For Comprehensive
Pain Management Inc.

Mervet K. Saleh, M.D.
Board Certified in Pain Medicine
Board Certified Pain Management
Board Certified Anesthesiology

Dear _____,

You have an appointment scheduled with Dr. Mervet Saleh, M.D. on:

Date: _____ @ _____ AM / PM

Please arrive approximately 15 minutes early if you HAVE completed the health history forms online. If you have not, you MUST arrive 30 minutes early to allow time to complete these forms in the office. Failure to arrive early when forms have not been completed may result in your appointment being rescheduled.

A Portal link was sent to your email for completion of online health history forms and is as follows: https://portal.allmeds.com/memManagement/LoginAccount.aspx?location=R485

User Name:	Your Email
Temporary Password/PIN:	Your four digit year of birth

Please complete the online past health history section AND the "History of Present Illness" Questionnaire (Multifocal Pain). Further instructions for the Portal are attached for your reference.

Please take your time to complete the attached and online forms (if you have access to the internet). It is necessary to have very detailed information concerning your medical condition(s). This will help Dr. Saleh and her staff to give you the best care possible.

Please bring the following items with you to your first visit:

1. Enclosed forms, completed
2. Picture ID
3. Insurance Card(s)
   a. Check with your insurance prior to your appointment to verify your benefits.
4. Co-Pay, if required. *Please note we do not accept checks.

Feel free to call our office at 937-435-6400 with any questions.

Thank You!

1235 East Alex Bell Road Centerville, Ohio 45459 (937) 435-6400 (937) 435-4793

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Welcome!

Thank you for choosing Ohio Institute for Comprehensive Pain Management (OICPM) to manage your chronic pain medical care.

Please take your time to complete the following forms and bring them to the office with you the day of your appointment. Also, please complete the online forms if you have access to the internet (instructions are attached). It is necessary to have very detailed information concerning your medical condition(s). This will help Dr. Saleh and her staff to give you the best care possible.

Listed below are some office policy reminders to make your appointments and treatment a success:

- You must bring your insurance card(s) to each visit. Co-pays are collected at the time of service. **Personal checks are not accepted.** Cash, Mastercard, Visa, and American Express are accepted. If your insurance does not cover the entire claim, any remaining balances are your responsibility.

- Please do not bring children with you for your initial evaluation. Due to the nature of treatment provided and the time needed to evaluate you, we prefer to have one-on-one time to assure you receive the best care.

- All patients must fill out the "Recheck" Form (located at the front window) and provide updated address, phone, and insurance information at **EACH** follow up visit.

- No show/Cancellation Policy – If you do not notify the office of a cancellation within 24 hours of your scheduled appointment or fail to show without notice, you may be subject to a No Show/Cancellation fee. Messages can be left if outside of business hours.

- Patients that are more than **15 minutes late may be rescheduled.**

Thank you for your considerations to the above policies, as these are in place to provide the best care to each patient as possible. OICPM looks forward to treating and taking care of you. Please call if you have any questions prior to your appointment.

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PATIENTS RIGHTS AND RESPONSIBILITIES

CONFIDENTIALITY

It is the policy of **Ohio Institute for Comprehensive Pain Management**, Inc. to treat all patient information confidentially. This includes patient records and conversations. We will investigate any reported violation of this policy. If you have any questions, please ask a front desk representative for information. **Ohio Institute for Comprehensive Pain Management** makes every effort to provide our patients with an environment, which is safe, private and respectful of our patient's needs**.**

ISSUES OF CARE

Ohio Institute for Comprehensive Pain Management is committed to your participation in care decisions. As a client, you have the right to ask questions and receive answers regarding the course of clinical care recommended by any of our health providers, including discontinuing care. We urge you to follow the healthcare directions given to you by our providers. However, if you have any doubts or concerns, or if you question the care prescribed by our providers, please ask.

PATIENT RIGHTS

The patient has the right to receive information from health providers and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their health providers as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their health providers might have, and to receive independent professional opinions.
The patient has the right to make decisions regarding the health care that is recommended by his or her health provider. Accordingly, patients may accept or refuse any recommended medical treatment.
The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs, regardless of race, religion, ethnic or national origin, gender, age, sexual orientation, or disability.
The patient has the right to confidentiality. The health provider should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.
The patient has the right to continuity of health care. The health provider has an obligation to cooperate in the coordination of medically indicated care with other health providers treating the patient. The health provider may discontinue care provided they give the patient reasonable assistance and direction, and sufficient opportunity to make alternative arrangements.

PATIENT RESPONSIBILITIES

Good communication is essential to a successful health provider-patient relationship. To the extent possible, patients have a responsibility to be truthful and to express their concerns clearly to their health providers.
Patients have a responsibility to provide a complete medical history, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness and other matters relating to present health.
Patients have a responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described.
Once patients and health providers agree upon the goals of therapy, patients have a responsibility to cooperate with the treatment plan. Compliance with health provider instructions is often essential to public and individual safety. Patients also have a responsibility to disclose whether previously agreed-upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.
Patients should also have an active interest in the effects of their conduct on others and refrain from behavior that unreasonably places the health of others at risk.

If you have a complaint about our services, facilities or staff, we want to hear from you. Notify any staff member in person or by phone that you wish to file a complaint. Complaints can be taken either verbally or written. We will do everything we can to see that your experience with us is pleasant and professional in every way.

By signing this form, you agree to and understand the above listed rights and responsibilities.

_____ _____
Patient Name Date

_____ _____
Patient Signature Date of Birth

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FINANCIAL RESPONSIBILITY

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**

IN ORDER TO CONTROL YOUR COST OF BILLING, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID PRIOR TO EACH VISIT.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

PATIENT'S AUTHORIZATION

In order to submit a claim for payment for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

MEDICARE & MEDICAID

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or any related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare or Medicaid for payment to me.

I request that payment under the medical insurance program be made to me or Ohio Institute for Comprehensive Pain Management, Inc. (Dr. Mervet K. Saleh) on any bills for services furnished by Dr. Saleh.

ALL OTHER INSURANCE

I hereby authorize Dr. Saleh to submit a claim to my insurance carrier or it intermediaries for all covered services rendered by the physician and authorize and direct my insurance carrier to issue payment check(s) directly to me or to the physician rendering the covered services.

I authorize Dr. Saleh to furnish complete information to my insurance carriers or its intermediaries regarding services rendered.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original**. I understand that I am financially responsible for all charges whether or not paid by said insurance.** I hereby authorize said assignee to release all information necessary to secure the payment.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR FULL PAYMENT OF MY BILL OR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER IN A TIMELY FASHION.

PATIENT/RESPONSIBLE PARTY SIGNATURE DATE

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Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have certain Patient Rights regarding my protected health information.

I understand that Ohio Institute for Comprehensive Pain Management may use or disclose my protected health information for treatment, payment, or health care operations – which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Ohio Institute for Comprehensive Pain Management has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Ohio Institute for Comprehensive Pain Management will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Ohio Institute for Comprehensive Pain Management to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Ohio Institute for Comprehensive Pain Management has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our 'Notice' at any time by contacting: Ohio Institute for Comprehensive Pain Management 1235 East Alex Bell Road, Centerville, Ohio 45459 Phone: 937-435-6400 Fax: 937-435-4793.

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Pain Management Informed Consent and Patient Contract

Informed Consent

Mervet K. Saleh, MD; Sarah Ballard, PA-C, and Megan Heffner, PA-C will be my providers throughout my treatment at The Ohio Institute for Comprehensive Pain Management (OICPM).

This informed consent confirms I have discussed the following with Dr. Saleh:

My diagnosis;

The nature and purpose of the proposed treatment and/or procedures;

The risks and benefits of the proposed treatment or procedure;

Alternative treatment options available to me regardless of their costs or the extent to which the treatment options are covered by health insurance;

The risks and benefits of these alternative treatments or procedures; and

The risks and benefits of not receiving or undergoing a proposed treatment or procedure.

Patient Contract

The OICPM providers and I have a common treatment goal- to improve my ability to function and/or work. In consideration of that goal, I recognize that I may be treated with potent medications, some of which are narcotics or tranquilizers. These medications are controlled substances and therefore honored by legal, state, and federal agencies. These medications are highly effective when taken as directed under medical supervision, but they also have the potential for misuse and abuse. This agreement is to help both me and my doctor comply with the law regarding controlled pharmaceuticals. **I therefore agree to the following:**

PLEASE READ AND INITIAL EACH OF THE FOLLWING STATEMENTS

_____ I am aware that the use of such medicine has certain risks associated with it including but not limited to; sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction, and the possibility that the medicine will not provide complete pain relief. I am aware of the possible risks and benefits of other types of treatment that do not involve the use of opioids.

_____ I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include but are not limited to using heavy equipment or a motor vehicle, working at unprotected heights, or being responsible for another individual who is unable to care for himself or herself.

_____ I am aware there is a chance of becoming addicted to my pain medicine. I am aware that addiction is defined as the use of a medicine even if it causes harm, having craving for a drug, feeling the need to use a drug, and a decreased quality of life.

_____ I understand that physical dependence is a normal and expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware that physical dependence means that if my pain medicine use is markedly decreased, stopped, or reversed by some of the agents, I will experience a withdrawal syndrome. This means I may have any or all of the following; runny nose, yawning, large pupils, goose bumps, abdominal pain, and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life-threatening.

_____ I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur in me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

For 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.

For Females Only: _____ If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and the OICPM office to inform them. I am aware that should I carry a baby to delivery while taking this medicine the baby will be physically dependent upon opioids. I am aware that use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medications and there is always the possibility that my child will have a birth defect while I am taking opioids.

_____ I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor agrees to treat me based on this agreement.

_____ I understand that if I break this agreement, my doctor will stop prescribing these pain control medicines. In this case, my doctor will taper off medicine over a period of several days as necessary to avoid withdrawal symptoms. Also, a drug dependence treatment program may be recommended.

_____ I will communicate fully with my doctor regarding the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

_____ I will not use any illegal controlled substances including marijuana, cocaine, etc.

_____ I agree that refills of my prescriptions for pain medicines will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings, weekends, or holidays. This requires that I plan ahead and call at least 24 hours ahead of when I need my prescription.

_____ I agree that medications for the control of pain related to my pain condition will be prescribed only by my OICPM physician. I will not use any medications for pain or my pain condition obtained from any other source.

_____ If my referring physician or primary care physician prefers to write prescriptions for all of my medications including those prescribed for pain, I will inform OICPM so that the OICPM physician can consult with and make recommendations to my primary care or referring physician.

_____ I understand that my medications are prescribed for my use *only*. ***I will not share, give, or sell medications to anyone else. This is illegal as well as dangerous for the other person.***

_____ I agree to use my prescription exactly as written, including the prescribed dose, time interval, frequency, and route of administration. If I take more medication than prescribed, it could result in me being out of medication for a period of time.

_____ I will actively participate in additional pain therapies as requested by my physician, which may include physical therapy and interventional procedures. I understand my failure to participate could result in medication adjustments.

_____ I agree to provide OICPM with information regarding any and all medication I am taking for any medical conditions. If another physician prescribes any new or additional medications, I agree to notify OICPM immediately.

_____ I understand that I must be re-evaluated on a regular basis by my OICPM physician. I agree to come in for all evaluations ordered by my OICPM physician. I understand that failure to schedule visits and/or failure to show for the visits may result in an OICPM decision to stop providing any further treatment to me.

_____ I understand that some patients develop a tolerance which is a need to increase the dose of the medication to achieve the same pain relief. I also understand that as a result of other treatment, therapy, or the natural course of my disease process, my pain may improve or increase. Therefore, my medication doses may have to be adjusted (increased or decreased) as deemed appropriate by my OICPM physician. If I feel that my pain condition has worsened, I will contact my OICPM physician because a worsening of my pain may necessitate further work-up. I will not adjust the medication by myself.

_____ I understand that some of the medications prescribed for my pain condition are controlled substances and there is a risk of physical and psychological dependence. If this happens, I will follow my OICPM physician's treatment plan and participate in any treatment program prescribed which may include medical treatment, psychological counseling, or detoxification.

_____ I understand that to stop taking the medications abruptly may be dangerous and lead to withdrawal symptoms. If the medications need to be discontinued, I will do so gradually and only under medical supervision by my OICPM physician or other health care professional that I be referred to by my physician.

_____ I am responsible for my pain center prescriptions and medications. ***Prescriptions or medications will not be replaced if they are lost, misplaced, or stolen for any reason.***

_____ I agree that I will submit to a blood or urine test or pill count if requested by my OICPM physician to determine my compliance with my program of pain control medications.

_____ Generally OICPM will not provide early refills of narcotic medications. In the event of an emergency, I agree to immediately contact OICPM.

_____ Occasionally a medication will not be effective to treat my pain. In such instances, I understand that my OICPM physician may decide to try a different medication. I agree to dispose of any leftover/unused portions of any previous medications.

_____ I authorize OICPM to provide this agreement and my medical records, and to discuss any condition, treatment, and prescribed medications with my pharmacist and other physicians and health care providers. I also agree to sign a release authorizing my other health care providers to provide records to OICPM and to discuss my treatment with OICPM.

_____ I agree that I will use my medication at a rate no greater than the prescribed rate, and that use of my medicine at a greater rate will result in my being without medication for a period of time.

_____ I understand that if I exhibit signs of addiction/misuse of medications or use of illegal substances that I will be referred to an addictionologist for consultation. It is my responsibility to attend this consult, I am aware that if I do not I am at risk for my treatment being terminated.

_____ I agree to use only one pharmacy for filling all of my pain prescriptions. If I change pharmacies for any reason, I agree to immediately notify OICPM. The name and contact information for the pharmacy is:

Name of pharmacy: _____

Address: _____

Phone Number: _____

I authorize my OICPM doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency including the State Board of Pharmacy in the investigation of any possible misuse, sale, or other diversion of my pain medications. I authorize my OICPM doctor to provide a copy of this agreement to any pharmacy. I agree to waive any applicable privilege or rights of privacy or confidentiality with respect to these authorizations.

I understand that if I violate any of the above conditions, my treatment at OICPM may be terminated. Moreover, if the violation involves obtaining controlled substances or any prescription for my pain condition form another individual, or any illegal activity such as altering a prescription, the incident may be reported by OICPM to other physicians caring for me, legal facilities, pharmacies, and other authorities such as the local police department, drug enforcement agency, etc. as appropriate for the situation.
I consent to the use of opioids to help control my pain, and I understand that my treatment with opioids will be carried out in accordance with the conditions stated above. I understand that if I do not follow the conditions of this contract, I can endanger my health as well as my life.

I have read this Informed Consent and Pain Contract and have had it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my informed consent for the treatment of my pain with opioid medications and I agree to comply with the pain contract.

_____ _____

Patient Signature Date

_____

Witness to Above

Ohio Institute for Comprehensive Pain Management Inc.
1235 E. Alex Bell Rd
Centerville, Ohio 45459
Tel. 937-435-6400 Fax 937-435-4793

Mervet K. Saleh M.D.
Board Certified Anesthesia
Board Certified Pain Management

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the below identified person, do hereby authorize the release of my medical information, as indicated, between the following parties:

FROM:_____ TO:_____

_____ _____

_____ _____

I, authorize this release of information to either verify services rendered to process a claim for benefits, to provide continuity of my medical care or as specified herein:_____. I direct that all information obtained in association with this release be held in strict confidence by the recipient and further direct that it is not to be at any time by further disclosed without my specific written authorization. I understand, also, that except to the extent that action has been taken based on my authorization, I may withdraw this authorization at any time by written notification to the parties involved.

It is my desire that only the information in my___ inpatient record, ___clinic record, ___emergency record and/or, ___ambulatory testing (please check the appropriate box) indicated below is to be released as a result of this authorization:

___ Face Sheet	___ HIV Status
___ History & Physical	___ Pathology Reports
___ Discharge Summary	___ Physician Progress Notes
___ Consultation Reports	___ Physicians Orders
___ Radiology Reports	___ Therapy Reports
___ Laboratory Reports	___ Emergency Treatment
___ Operative Reports	___ Other/specify here:

I am also making the following qualification: If the information specified above contains information related to treatment for drug and/or mental conditions, or HIV test results or diagnosis, I am including this type of information to be included with other information to be released in association with this authorization.

_____

(Date) (Patient or Guardian Signature)

To assist you in providing the following additional identifying information:

_____

(Print name when treated) (Address/Street)

_____

(Date of Birth) (City) (State) (Zip Code)

_____

(Social Security #) (Dates of Treatment)

Authorization for Verbal Release of Protected Health Information or Treatment Records

Last Name: First: Middle:

Other Names Used: Date of Birth: SS#:

Address:

Home Phone: Cell Phone: Work Phone:

I, _____, give my permission to: **The Ohio Institute for Comprehensive Pain Management and its staff** to release information regarding appointment dates/times and my protected health information (or, if I am a student, my treatment/education record), including but not limited to; insurance, address, phone number, test results, health care information, and treatment to the following:

Name of Person: _____ Persons Phone #: _____

Relationship to Patient: _____ Persons Address:_____

Exceptions: _____ _____

Should this person also be listed as your Emergency Contact: **Yes** or **No**

I understand that:

I may revoke this Authorization at any time, in writing. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless revoked, the automatic expiration date will be 12 months from the date of the signature.

Unless the purpose of this Authorization is to determine payment of a claim or benefits, the provision of treatment or payment for my care may not be conditioned upon my signing of this Authorization.

For non-students, Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. Student records may contain continuing privacy protections in accordance with 34 CFR Part 99.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR A NONCOMMUNICABLE DISEASE.

The information authorized for verbal release may include protected health information related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order.

The information authorized for verbal release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health information to be released.

_____ _____ _____

Signature of patient, parent, or legally authorized representative* **Relationship to Patient** **Date**

***May be requested to show proof of representative status.**

Authorization for Verbal Release of Protected Health Information or Treatment Records

What this means for you:

The attached authorization allows that someone (spouse, close family member, or caretaker—this person would be your "HIPAA Contact") can contact the office and discuss your; appointment dates/times, treatment plan, laboratory/imaging results, and any other personal information. If you do not list a person on the attached sheet with your signature we cannot provide any information regarding you to anyone regardless of their relationship to you. You can also make exceptions to things you may not want released to your HIPAA contact that limits what we can disclose.

If you would like to authorize someone to be your HIPAA Contact with the ability to contact the office on your behalf please list them on the attached sheet with your signature and date.

However if you decline to have a HIPAA Contact, please check the box below and sign and date the bottom of this form.

☐ I, _____, decline to list anyone as my HIPAA Contact and wish that none of my Protected Health Information be released to anyone other than myself.

_____ _____

Signature of patient, parent, or legally authorized representative* Date

*May be requested to show proof of representative status.

COMM

Name: _____ DOB:_____ Today's Date: _____

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days.** There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can. Check in the appropriate box.

Please answer the questions using the following scale:	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
In the past 30 days, how often have you had trouble thinking clearly or had memory problems?					
In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments.)					
In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, emergency room, friends, street sources)					
In the past 30 days, how often have you taken your medications differently from how they are prescribed?					
In the past 30 days, how often have you seriously thought about hurting yourself?					
In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?					
In the past 30 days, how often have you been in an argument?					
In the past 30 days, how often have you had trouble controlling your anger? (e.g., road rage, screaming, etc.)					
In the past 30 days, how often have you needed to take pain medications belonging to someone else?					
In the past 30 days, how have you been worried about how you're handling your medications?					
In the past 30 days, how often have others been worried about how you're handling your medications?					
In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?					
In the past 30 days, how often have you gotten angry with people?					
In the past 30 days, how often have you had to take more of your medication than prescribed?					
In the past 30 days, how often have you borrowed pain medication from someone else?					
In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve you mood, or relieve stress)?					
In the past 30 days, how often have you had to visit the Emergency Room?					

PainEDU
Improving Pain Treatment Through Education

Please complete the following information to the best of your knowledge:

PAIN MEDICATIONS YOU HAVE TAKEN IN THE PAST OR ARE TAKING CURRENTLY:

Name of Medication	Prescribing Doctor	Pain Relief (0-100%)	Taking Currently (Yes or No)

DO YOU USE DRUGS RECREATIONALLY? Yes or No ****If yes, type: _____**
DO YOU HAVE A HISTORY OF RECREATIONAL DRUG USE? Yes or No ****If yes, type: _____**
DO YOU HAVE A HISTORY OF ALCOHOL ABUSE? Yes or No
DO YOU HAVE A HISTORY OF DRUG DEPENDENCY/ADDICTION? Yes or No ***If yes, what drug: _____**

******PLEASE LIST ANY DRUG/MEDICATION ALLERGIES (include the type of reaction)**

_____

_____

_____

******ARE YOU ALLERGIC TO: (CHECK ALL THAT APPLY)**

☐ **Adhesive tape** ☐ **Latex** ☐ **Iodine** ☐ **Contrast dye**

WORK STATUS

☐ Employed Full time ☐ Employed Part Time ☐ Disabled ☐ Unemployed ☐ Retired
☐ Temp. Disability

If not working, date last worked: _____
Duties (or type) of previous or current job: _____

_____

If currently working, do you have any limitation/restrictions? Yes or No
Please list: _____

PLEASE INDICATE IN DETAIL HOW AND WHEN PAIN STARTED

_____

_____

_____

_____

DATE _____
(If unsure of date or cause, please estimate approximate amount of time experiencing pain.)