Pain Management
STRATEGIES
Living Better

Name_____ Today's Date_____

Date of Birth_____ Age_____ SSN_____ Phone#_____

Address_____ City/State_____ ZIP_____

Referred by_____ Patient Occupation_____

Family Physician_____ Physician Phone_____

Give a Brief Description of your pain problem:_____

Precipitating Incident_____

Work related_____ Litigation Pending_____

How long has the pain been present_____ Location of Pain_____

Treatments Used_____

Medication used to treat pain_____

List all current medication_____

List any diagnostic tests already performed (MRI,I-X-Rays EMG, CAT Scan)_____

List any previous surgeries_____

List any Allergies_____

List any other medical conditions_____

Do you smoke_____ Drink_____ Use Drugs_____

Where 0=No pain and 10=the worst pain imaginable, how is your pain at its: Best_____ Worst_____ Average_____

What makes your pain more tolerable:_____

What makes your pain worse:_____

Has pain affected: Job_____ Sleep_____ Relationship_____ Activity_____

List other physicians who have treated you for pain control:_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it

Name_____

Birthdate_____

Signature_____Date_____

THIS FORM WILL BE PLACED IN PATIENT'S CHART AND MAINTAINED FOR 6 YEARS.

List Below names and relationship of people to whom you authorize the Practice to release Personal Health Information.

_____ _____

_____ _____

_____ _____

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EXPECTATION OF CARE DOCUMENT

Pain Management Strategies is dedicated to interdisciplinary, ethical caring of the patient with chronic pain regardless of race, color, religion, gender, age, sexual orientation or national origin. Agreed upon expectations of patient and the office ensure that this office will meet the needs of all of our patients. With this understanding, this office wants all of our patients to know and understand the following:

1. Our office is an interdisciplinary pain treatment center requiring evaluation by other health professionals such as psychologists before treatment will begin.
2. You will not be seen on your first visit without medical records being released to our office by your referring physician.
3. Our office will not prescribe pain medications to you on your first visit. Treatment may not be prescribed to you on your first visit depending upon your initial evaluation.
4. If you are under the care of a psychiatrist or psychologist you must give permission of release of those records to the psychologists of our office.
5. After initial evaluation by the appropriate members of the pain team at our office, you will be notified of our care and treatment plan.
6. Our office may, after this initial evaluation, decide that treatment at our office is not warranted. In this eventuality, you will be referred back to your referring physician.
7. Once your treatment plan has been determined and agreed upon by you and the treatment team, you will be expected to follow it. You have the right to refuse treatment at any time. If you refuse treatment, this may result in your being referred back to your referring physician.
8. All patients receiving medications prescribed by our office must take their medications as prescribed.
9. You will be given a medication contract to sign before any and all analgesic medications will be prescribed. This contract outlines the responsibilities of

the office to you and your responsibilities to the office regarding the prescription of pain medications.

10. Our office believes that chronic pain is never an emergency! Therefore, the office will not approve of your visiting emergency rooms for treatment of your chronic pain. You are encouraged to do so in case of a new emergent pain, side effects of prescribed pain medications or treatment of a medical emergency.
11. Telephone calls for chronic pain complaints during the evenings, nights, weekends, and holidays will not be tolerated. Patients complaining of new pain, side effects of their medications or treatment or true medical emergencies are encouraged to call the physician or nurse practitioner on call.
12. You must agree to receive your pain medications from one pharmacy registered with our office. Our office must be notified in advance of any planned changed in pharmacy.
13. You must agree not to accept pain medications from any physician not associated with this office, unless prescribed by that physician during a hospital stay or for outpatient or inpatient surgery.
14. You are to be responsible for your medications. No excuses for lost medication, stolen medication, dropped medication; etcetera will be accepted by this office. This means that no refills will be made before allotted time of the prescription.
15. No refills of medication will be made after office hours, during weekends or during a holiday period. You must be responsible for your own medications and make an appointment for a refill of your pain medication before that medication will run out.
16. Telephone refills are strongly discouraged. The office will make every effort to ensure that you will not run out of medications. If you know that you are going to run out of your medications, you are responsible for making an appointment for refill of medications.
17. If you are on chronic narcotic medications, you must understand that our office will allow you to go through narcotic withdrawal from your medications should you manage these medications irresponsibly?
18. Your questions will be answered by one of our professional staff members at your scheduled appointments. Unless there is an emergency, please do not call the office to have your clinical questions answered.

19. Because of increasing demands on our staff for pain management, our physician assistant might see you. Attending physicians, however, will make all final decisions regarding your care plans.
20. Failure to abide by this understanding will be taken by our office to mean that you either no longer want to be treated by our office or that you will not abide by the rules of our office. In either case, failure to abide might be cause for referral back to your referring physician for pain care.

I have read the above document and my questions have been asked and answered.

Signature_____Date_____

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PATIENT MEDICATION AGREEMENT

The purpose of this agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes 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 the 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 about 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 etcetera.

I will not share, sell or trade my medications with anyone.

I will not attempt to obtain any controlled medicines, including Opioid pain medicines, controlled stimulants or anti-anxiety medicines from any other doctor.

I will safeguard my medicine from loss or theft. **Lost or Stolen medicines will not be replaced.**

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 or on weekends.

I agree to use the following pharmacy:

_____

_____

Telephone number (____)_____for refilling prescriptions for all of my pain medicine.

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

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain controlled medicine.

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

I will bring all unused pain medicine to every office visit.

I AGREE TO FOLLOW THESE GUIDELINES THAT HAVE BEEN FULLY EXPLAINED TO ME. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This agreement is entered into this _____day of _____

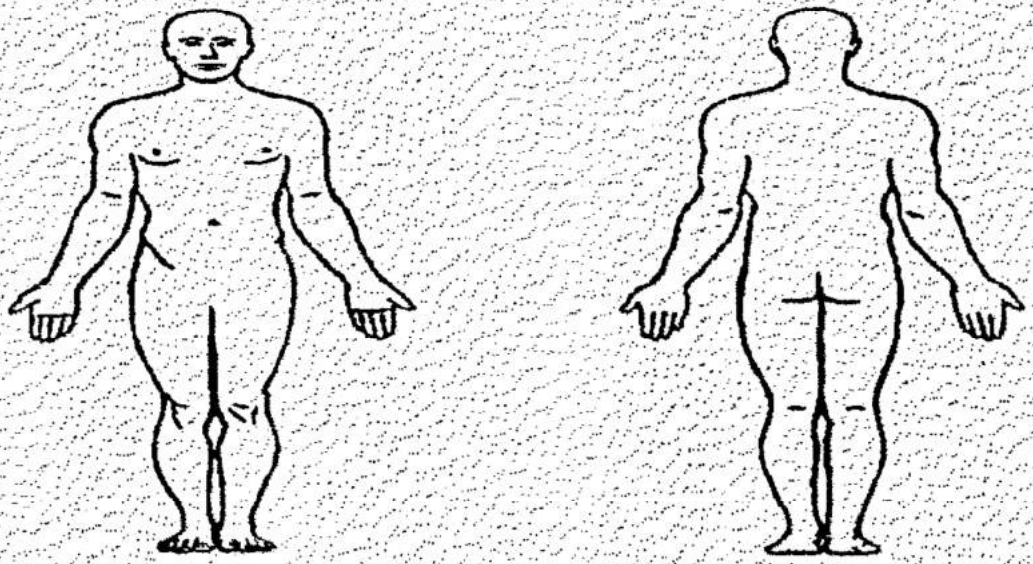
Patient
signature_____

Physician
signature_____

Witnessed
by:_____

INSTRUCTIONS:
PLEASE USE THE APPROPRIATE COLORED PEN AND COLOR IN THE AREA IN WHICH PAIN OR NUMBNESS OCCURS:

RED: MOST SEVERE PAIN
BLUE: LESS SEVERE PAIN
GREEN: NUMBNESS



RIGHT HAND LEFT HAND RIGHT FOOT LEFT FOOT

PATIENT SIGNATURE

DATE

DR. MELANIE ROSENBLATT
ANOTOMICAL DESCRIPTION OF PAIN
REV 2 11/28/12

Pain Management
STRATEGIES

Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

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

No Disability 0___1___2___3___4___5___6___7___8___9___10___. Worst Disability

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

No Disability 0___1___2___3___4___5___6___7___8___9___10___. Worst Disability

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

No Disability 0___1___2___3___4___5___6___7___8___9___10___. Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job.

This includes non-paying jobs as well such as that of a housewife or volunteer.

No Disability 0___1___2___3___4___5___6___7___8___9___10___. Worst Disability

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

No Disability 0___1___2___3___4___5___6___7___8___9___10___. Worst Disability

Self Care: This category includes activities which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed. ect).

No Disability 0___1___,2___,3___,4___,5___,6___,7___,8___,9___,10___. Worst Disability

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

No Disability 0___1___,2___,3___,4___,5___,6___,7___,8___,9___,10___. Worst Disability

Signature_____Name (Printed)_____

Date_____

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Live Life Better

SOAPP ®Version 1.0

Name:_____ Date:_____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you feel that your pain is "out of control"? 0 1 2 3 4
2. How often do you have mood swings? 0 1 2 3 4
3. How often do you do things that you later regret? 0 1 2 3 4
4. How often has your family been supportive and encouraging 0 1 2 3 4
5. How often have others told you that you have a bad temper? 0 1 2 3 4
6. Compared with other people, how often have you been in a car accident? 0 1 2 3 4
7. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4
8. How often have you felt a need for higher doses of medication to treat your pain? 0 1 2 3 4
9. How often do you take more medication than you are supposed to? 0 1 2 3 4

10. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? 0 1 2 3 4

11. How often have any of your close friends had a problem with alcohol or drugs? 0 1 2 3 4

12. How often have others suggested that you have a drug or alcohol problem? 0 1 2 3 4

13. How often have you attended an AA or NA meeting? 0 1 2 3 4

14. How often have you had a problem getting along with the doctors who prescribed your medicine? 0 1 2 3 4

15. How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4

16. How often have you been seen by a psychiatrist or a mental health counselor? 0 1 2 3 4

17. How often have you been treated for an alcohol or drug problem? 0 1 2 3 4

18. How often have your medications been lost or stolen? 0 1 2 3 4

19. How often have others expressed concern over your use of medication? 0 1 2 3 4

20. How often have you felt a craving for medication? 0 1 2 3 4

21. How often has more than one doctor prescribed pain medication for you at the same time? 0 1 2 3 4

22. How often have you been asked to give a urine screen for substance abuse? 0 1 2 3 4

23. How often have you used illegal drugs (for example marijuana, cocaine, ect.) in the past five years? 0 1 2 3 4

24. How often in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

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Pain Management STRATEGIES

MELANIE ROSENBLATT, MD

DATE:	
PATIENT NAME:	
PATIENT ADDRESS:	
PATIENT CITY/STATE/ZIP:	
PATIENT PHONE:	
PATIENT EMAIL ADDRESS:	
PATIENT'S REGULAR PHARMACY:	
PHARMACY PHONE NUMBER:	

DUE TO THE GOVERNMENT CHANGES EFFECTIVE OCTOBER 2011, PLEASE COMPLETE THE FOLLOWING INFORMATION. PLEASE CIRCLE ONE IN EACH OF THE CATEGORIES LISTED BELOW:

RACE:	AMERICAN INDIAN OR ALASKIN
	ASIAN
	BLACK OR AFRICAN AMERICAN
	NATIVE HAWAIIAN OR OTHER
	WHITE
	TWO OR MORE RACES
	DECLINE TO SELF IDENTIFY

ETHNICITY:	HISPANIC OR LATINO
	NON HISPANIC OR LATINO
	DECLINE TO SELF IDENTIFY

LANGUAGE:	ENGLISH
	FRENCH
	GERMAN
	JAPANESE
	MANDARIN
	RUSSIAN
	SPANISH

I AUTHORIZE THE OFFICES OF DR. ROSENBLATT TO REQUEST AND OBTAIN MY MEDICAL AND MEDICATION HISTORY

_____

(PATIENT SIGNATURE)

I AUTHORIZE THE OFFICES OF DR. ROSENBLATT TO REFER ME TO A SPECIALIST IF NECESSARY

_____

(PATIENT SIGNATURE

Date_____

Name_____

My Email Address is_____ and I would like to access the Patient Portal.

____ I do not have Email and therefore cannot access the Patient Portal

____ I do not wish to access the Patient Portal but understand if I choose to in the future I will need to notify the office with my email address.

_____

Signature

_____

Witness

CREDIT CARD PAYMENTS

Please be advised that in order to process your credit card payment we must have your permission to release your medical records to your credit card supplier to validate our claim, should a payment dispute arise.

_____ _____

Signature Date

_____

Print Name

_____

Witness

REQUEST FOR SPECIAL CONFIDENTIALCOMMUNICATIONS PROCEDURES

I hereby request that_____(name of practice)

request that all written communications to be mailed only to the following address:

I hereby request that_____(name of practice)
request that all telephone calls placed to me only be placed to:_____

I hereby request that_____(name of practice)

request that no voice mail messages be left on the above listed or any other telephone listings relating to me.

_____ _____

Patient's Signature Patient's Date of Birth

For Use by Privacy Officer Only

Practice ____ Accepts ____Denies

Signature of Privacy Officer_____

Date_____