BLUE RIDGE
PAIN MANAGEMENT ASSOCIATES

We require all new patients to arrive and hand in this COMPLETED packet 30 minutes prior to your scheduled appointment. If, for any reason, you do not have the packet completed front and back and arrive 30 minutes prior to your appointment you will be rescheduled and charged a $25 rescheduling fee.

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To Our New Patients,

We would like to welcome you to our practice. As a new patient, we realize how difficult it can be to become established with a new healthcare provider. Therefore, we will make every effort to make this transition as easy as possible—with some assistance from you.

To make your first visit simple, you will find all of the required forms for new patients enclosed in this packet. It is important that we receive as much medical information about you as possible to facilitate the best medical care.

For your first office visit, you must bring several items:

- Completed information packet
- Insurance card(s)
- Driver's license or state-issued photo identification
- All prescription medications you are currently taking in their original containers

(If you choose, you may complete the information packet online at www.blueridgepm.com. You will need to contact us for an invitation. You will need to start it several days before your appointment to ensure everything is received in time.)

Your referring provider will forward your medical records to us before your first visit. You may bring any diagnostic tests (MRI, X-ray, etc.) or personal information related to your condition as well.

Please note: new patient appointments are for consultations only—there is no guarantee of treatment on this visit.

We also require that new patients **arrive and check in thirty (30) minutes prior to their scheduled appointment time** with the information packet already completed. If you do not arrive thirty (30) minutes prior to your appointment with the completed packet, you will be rescheduled.

Insurance co-pays and/or payment are due at the time of service. For your convenience, we accept Visa, MasterCard, Discover, and American Express. While we do accept cash, we do not accept checks. If you are scheduled for a follow-up appointment after your initial visit you are required to arrive and check in fifteen (15) minutes early prior the your appointment time. If you are not at the appointment fifteen minutes early, you will be rescheduled.

By signing below, you are agreeing to these terms and certify you have read and understand the requirements:

Appointment Date:_____ Appointment Time: _____

Time you are required to arrive: _____ Provider: _____

Patient Signature: _____ Date: _____

Please do not hesitate to call if you have questions: (540) 444-5670.

Sincerely,

Blue Ridge Pain Management Associates, PC

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To Salem Office:

1802 Braeburn Drive, Suite 3C-10

Salem, VA 24153

540-444-5670

From I-81

Take Exit 141 (If going North take a left onto Electric Road. If going South take a right onto Electric Road.) Proceed approximately 5 miles. Turn left onto Braeburn Drive; turn right into hospital entrance. Blue Ridge Pain Management is located in Medical Office Building East, on the 3rd floor of Building C.

To Christiansburg Office:

95 Ponderosa Drive

Christiansburg, VA 24073

From I-81:

Take Exit 118B-C-A for US 11/460
Take Exit 118B, merge onto 460W
Take Exit 4B toward VA-114 W/Radford
Merge onto Peppers Ferry Road
Turn Right onto Arbor Drive
Turn Right onto Ponderosa Drive
We are the last building on the Right. Behind Enterprise Rent-A-Car.

From I-77:
Take Exit 9 for US-460 toward Princeton/Pearisburg VA
Take a left onto US-460 E
Take Exit 4A-4B toward VA-114 W/Radford
Merge onto Peppers Ferry Road
Turn Right onto Arbor Drive
Turn Right onto Ponderosa Drive
We are the last building on the Right. Behind Enterprise Rent-A-Car

To Roanoke Office:

1101 1st Street, SW

Roanoke, VA 24016

From 220:

Take Exit 6 for Elm Ave

(If going North take a left onto Elm Ave: If going South take a right onto Elm Ave) Take a left onto

Jefferson Street; Take a right onto Albemarle Ave; Go 1 block;

Blue Ridge Pain Management is on your left.

Cancellation and Missed Appointment Policy

At Blue Ridge Pain Management, it is our goal to provide quality medical care in a timely manner. “No Shows” and “Late Cancellations” inconvenience those individuals who need access to medical care in a timely manner. Please familiarize yourself with our policies.

Contact Blue Ridge Pain Management promptly if you are unable to show up for an appointment. If it is necessary to cancel or reschedule your appointment, we require you call 24 hours in advance as these appointments are in high demand. Please call 540.444.5670. If you are unable to reach the receptionist, please leave a detailed message with your name, phone number, and the best time to contact you.

Late Cancellation /Reschedule

Fee $25.00

No Show

Failure to be present at the time of a scheduled appointment will be recorded in your medical record as “no-show.” After 3 No- Show appointments, you may be discharged from our practice.

Fee $38.00

Late Cancellation/ Reschedule/No Show for Discograms & Rhizotomy Procedures

Fee $75.00

Please note, you will be required to pay this fee before we can reschedule your appointment.

Patient Registration Form

Patient Information

Last Name: _____ First: _____ MI: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Cell: _____ Work: _____
SSN: _____ Date of Birth: _____

Sex (circle one) Male Female Title (circle one) MR / MRS / MS
Marital Status (circle one) Married / Single / Divorced / Separated / Widowed
Employer: _____
Address: _____ City: _____ State: _____ Zip: _____
Emergency Contact: _____ Telephone: _____

Responsible Party

Guarantor's Name: _____ Telephone: _____
Address: _____ City: _____ State: _____ Zip: _____
Guarantor's SSN: _____ Guarantor's Date of Birth: _____
Guarantor's Employer: _____
Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance Company

Insurance Company: _____ Policy Holder: _____
ID Number: _____ Group Number: _____

Secondary Insurance Company

Insurance Company: _____ Policy Holder: _____
ID Number: _____ Group Number: _____

I hereby authorize Blue Ridge Pain Management, P.C. to release medical information to any physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Blue Ridge Pain Management Associates, P.C. of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photo-copy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Patient Signature: _____ Date: _____

Prescription Monitoring Program Consent

The treating provider you will be seeing today will not prescribe any prescriptions until he/she has accessed the information contained in the Virginia Prescription Monitoring Program (PMP) files for prescriptions on Schedule II-V drugs that may have been previously dispensed to you as a patient.

Patient Name: _____

Date of Birth: _____

Street Address: _____

City: _____ State: _____

Zip Code: _____

This authorizes all providers of Blue Ridge Pain Management Associates, P.C. to request and receive from the Virginia Department of Health Professions any and all records held by the Department relating to Schedule II-V controlled substances dispensed to the patient named above.

I understand that this authorization permits the Department of Health Professions to disclose confidential health care records to the prescriber named above. A copy of this authorization shall be included in my original records. There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure as permitted or required by law.

I understand that, if not previously revoked, this consent will expire one year after the date of my signature unless otherwise specified.

Patient Signature: _____ Date: _____

Note: This authorization form is in addition to and separate from any other disclosure forms that you may have signed.

Prescription Refill Policy

All prescription refill requests and medical questions will be processed after 3:00pm each business day. We are not available after 4:00pm Monday—Thursday or after 12:00pm on Fridays. We are also not available for these questions nights, weekends, or holidays. We require **72 hours notice** on all prescription refill requests. Allow 3 (three) business days for you refill request to be completed. We are not a walk-in clinic. Patients will only be seen at scheduled appointment times.

I have read and understand the above statement: _____ (initial here)

When calling for a prescription refill, please press the appropriate extension for the nurse line or tell the receptionist that you are calling for a prescription refill. Be prepared to leave a detailed voicemail, which must contain the following:

- Your full name & date of birth
- Telephone number AND the best time to reach you
- Pharmacy name and telephone number
- Prescription name and dosage (i.e., the milligrams and when you are prescribed to take it, such as three times a day)

When calling to leave a general message for the nursing staff or Physician, please press the appropriate extension or tell the receptionist that you are calling to leave a message for the clinical staff. Be prepared to leave a voicemail with the following information:

- Your full name & date of birth
- Telephone number & the best time to reach you
- A detailed but short message

If you are calling due to an emergency, please do not leave a message—call 911 or report to your nearest Emergency Room.

We appreciate your cooperation with this procedure.

Patient Signature: _____ Date: _____

I acknowledge that I have read and understand the above prescription refill policy for Blue Ridge Pain Management Associates, P.C.

BLUE RIDGE PAIN MANAGEMENT ASSOCIATES

Monty Baylor, MD — Marc Swanson, MD — Anthony Dragovich, MD — Andrew Crichlow, MD
Laura Davis, PA-C — Dana Adams, PA-C — Kaitlin Daniels, PA-C — Jordan Young, PA-C
1802 Braeburn Drive, Suite 3C10
Salem, VA 24153
540-444-5670 (o) 540-444-5669 (f)

PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

This is an agreement between me and my Physician with Blue Ridge Pain Management Associates, P.C. I understand that the side effects which these drugs can cause include but are not limited to:

Constipation, decreased and/or increased appetite, weight gain and/or loss
Drowsiness, nausea and/or vomiting
Physical dependence (This may result in withdrawal symptoms if the medication is stopped suddenly. This may be very unpleasant and include severe diarrhea, stomach cramps, severe anxiety, and a runny nose which may continue for days).
Addiction to the medication
Withdrawal symptoms in an infant if the infant is born to a mother who is taking these medications

Controlled substance medications (i.e. narcotics, tranquilizers and barbiturates) are very useful but have a high potential for misuse and are, therefore, closely controlled by the local, state and federal governments. The medications are in-tended to relieve pain, thus improving function and/or the ability to work. If my Physician prescribes controlled sub-stance medication to help manage my pain, I agree to the following conditions:

I am solely responsible for the controlled substance and medications prescribed to me.
If my prescription is lost, stolen, or misplaced, or if I use more than prescribed, I understand that my prescription will **not** be replaced.
Refills of controlled substance medications will only be made during regular office hours, Monday through Friday, in person, once a month, during a scheduled office visit. Further, refills of controlled substance medications will **not** be made as an emergency. I will call **72 hours** in advance if I need assistance with a refill.

In order for my Physician to prescribe these medications safely:

I agree to tell my pain specialist if I have ever had problems with or treatment for drug and/or alcohol dependence, or if I have ever been involved in the illegal possession, sale or trafficking of drugs such as pain, sleeping or nerve medications.
Only **one Physician** will provide me my prescriptions for controlled substance medications. Only **one pharmacy** will fill my prescriptions.
I will take my medications as prescribed. Neither my primary care physician or other medical professional is able to prescribe me extra prescriptions if my medication is lost, stolen or misused.
I agree to **keep all scheduled appointments** with this office.
I am aware that I should only tell very close family and/or friends that I am taking controlled substance medication and that I should keep my medications in a secure place to prevent theft.
I agree to bring all my medications in the **original** container, with medication in it, to every office visit.

My Physician may also:

Deem it necessary to undergo a Substance Abuse Evaluation at any time while receiving controlled substance medications. I understand that if I do not attend any appointments scheduled by my provider, my medications may be discontinued and not refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), my medication will no longer be refilled.
I agree to comply with random urine drug screens, blood and/or breath testing, as well as random medication counts to document the proper use of my medications as well as confirming compliance.

I have fully read and understand the above sections of this agreement. (initial): _____ (date): _____

(Continued on back)

Driving an automobile:
Current status of research indicates that opioids (pain medication) appear to impair driving related skills in opioid-dependent patients. However, if I decide to drive, it is my own personal decision. I will use a common-sense approach and use the following guidelines in that regard:

After beginning opioid treatment or after a dose increase, I will not drive for 4-5 days.

I will not drive if I ever feel sedated.

I will report sedation, unsteadiness, and/or cognitive decline immediately to the Physician so that a reduction in dosage can be initiated.

I will avoid taking any over the counter antihistamines such as, but not limited to, Benadryl and some other cold and allergy medications.

Under no circumstances will I utilize alcohol or other illicit drugs and drive.

I will not make changes in my medication without consulting my Physician.

I understand that driving a motor vehicle may not be allowed while taking a controlled substance medication and that it is my responsibility to comply with the laws of the state while taking the prescribed medications.

I understand that if I violate any of the above conditions, my prescription for controlled substance medications may be terminated immediately. If the violation involves obtaining controlled substance medications from an-other provider or individual, or the concomitant use of illegal drugs, I may also be reported to all my Physicians, medical facilities and appropriate authorities.

I understand that the main treatment goal is to reduce pain and improve my ability to function and/or work. In consideration of this goal and the fact that I am being given a potent medication to help me reach this goal, I agree to help myself by following better health habits: exercise, weight control, and the avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my Physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.

I understand that the long-term advantages or disadvantages of chronic opioid use have yet to be scientifically determined and my treatment may change at any time. I understand, accept, and agree that there may be un-known risks associated with the long-term use of controlled substances and that my Physician will advise me of any advances in the field and will make treatment changes as needed.

I have been fully informed by the Physicians and/or staff regarding psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve the desired effect and that there is a risk of becoming physically dependent on the medication. This will occur if I am on medication for several weeks. Therefore, when I need to stop taking the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms.

I have read this agreement and the same has been explained to me by Dr. _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Consent for the Use and Disclosure of Health Care Information

I, _____, understand that as part of my health care, Blue Ridge Pain Management Associates originates and maintains paper and/or electronic medical records describing my health history, symptoms, examination results, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health care professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Blue Ridge Pain Management Associates reserves the right to change their notice and practices prior to implementation in accordance with Section 164.520 of the Code of Federal Regulations. Should Blue Ridge Pain Management Associates change their notice, they will send a copy of any revised notice to the address that I have provided.

The following person(s) have the right to the use or disclosure of my health information:

_____

_____

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax and/or electronically. **I fully understand and accept the terms of this consent.**

Name: _____ **Date:** _____

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Blue Ridge Pain Management's Notice of Privacy Policies, detailing how my health information may be used and disclosed as permitted by federal and state law. **I understand the contents of this notice.**

However, **I request the following restrictions concerning the use of my personal medical information. If you do not have any restrictions, please write "none".**

_____

_____

_____

I permit Blue Ridge Pain Management Associates to leave telephone messages and/or contact me by mail at the telephone number and address that I have provided. I permit Blue Ridge Pain Management Associates to use my full legal name when checking in or out of the clinic. If I have any objections to the above, other arrangements may be made.

Name: _____ **Date:** _____

If not signed by the patient, please indicate relationship to patient:

Relationship: _____ Witness: _____

Office Use Only:

If patient or patient's representatives refuses to sign acknowledgement of receipt of notice, please document date and time notice was presented to the patient and sign below.

Presented (date and time): _____

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out**:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (i.e. my insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Blue Ridge Pain Management Associates
1802 Braeburn Drive, Suite 3C10
Salem, VA 24153

Date: _____

Patient Name: _____

OPIOID RISK TOOL

		Mark each box that applies	Office Use Only: Score If Female	Office Use Only: Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
	TOTAL		_____	_____

Total Score Risk Category
Low Risk 0 – 3
Moderate Risk 4 – 7
High Risk ≥ 8

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool.
Pain Medicine. 2005;6(6):432-442. Used with permission.

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BLUE RIDGE
PAIN MANAGEMENT ASSOCIATES

New Patient Information

Date of Initial Evaluation: _____

Name _____ Date of Birth _____ Age _____

Pharmacy Name and Telephone Number _____

Primary Care Physician Name and Telephone Number: _____

Referring Physician's Name and Telephone Number: _____

Chief Complaint: What is bothering you?

_____

_____

_____

How long have you had the pain you feel currently? _____

What caused your current pain to start? _____

_____

How often do you have this pain?

A. Constantly (80-100% of time)

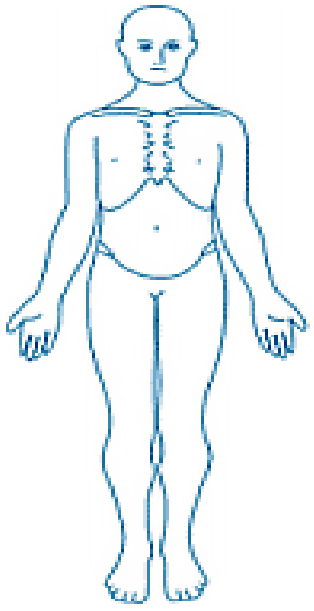
B. Nearly Constantly (50-80% of time)

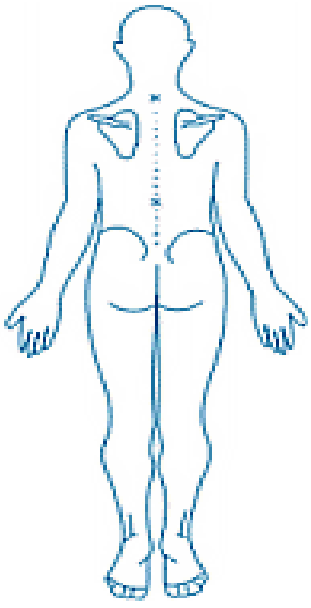
C. Intermittently (25-80% of time)

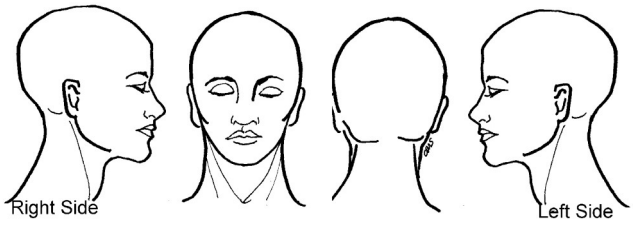
D. Occasionally (less than 25% of time)

History of Present Illness:

Please shade in the areas where you have pain on the diagrams below:







Sleep

Does pain usually awaken you from sleep during the night?

_____ Usually _____ Sometimes _____ Never

How many hours do you sleep each night? _____ Hours

Has your ability to sleep changed within the past two weeks? YES NO

How has it changed? _____

For what reason do you think it has changed? _____

Alleviating and Aggravating Factors

	Increases	Decreases	No change
Liquor			
Eating			
Heat			
Cold			
Weather Changes			
Massage			
Exercise			
Rest			
Lying Down			
Sitting			
Standing			
Walking			
Distraction (TV, etc.)			
Urination			
Bowel Movement			
Stress			
Fatigue			
Coughing			
Boredom			
Other _____			

Mood

Has pain affected your mood? _____ Describe your current mood: _____

Have you ever had any thoughts of wanting to die? YES NO

If yes, please describe: _____

Do you now or have you ever had panic attacks? YES NO

Do you feel tense or worry all the time? YES NO

Do you ever feel irritable or angry due to your pain? YES NO

Do you ever act in aggressive or angry ways due to pain? YES NO

Do you ever have thoughts of harming yourself or others? YES NO

If yes, please describe: _____

Do you have a history of mental health treatment (psychiatrist or psychologist)? YES NO

If yes, please describe: _____

Have you ever been hospitalized for psychiatric reasons?

If yes, when? _____ Please describe: _____

Prior Diagnostic Tests

	Date	Location	Attached Results? (if yes, check)
MRI	_____	_____	_____
X-Rays	_____	_____	_____
EMG	_____	_____	_____
CAT Scan	_____	_____	_____
Discogram	_____	_____	_____
Myelogram	_____	_____	_____

Other: _____

Prior Treatment or Procedures

	Have you tried?	Pain Relief ?(Yes/No)	Date Performed?
Epidural Steroid Injections	_____	_____	_____
Nerve Blocks	_____	_____	_____
Physical Therapy	_____	_____	_____
Chiropractor	_____	_____	_____
Acupuncture	_____	_____	_____
Pain Clinic	_____	_____	_____

**If yes, Physician's Name and Location _____

Traction	_____	_____	_____
TENS Unit	_____	_____	_____

Other _____

Past Surgical History

Type of Surgery	Date	Any Complications?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History

Heart	Lungs	Kidney/Liver
_____ Heart Attack	_____ Asthma	_____ Kidney Failure
_____ Blocked Arteries	_____ TB	_____ Kidney Stones
_____ High Blood Pressure	_____ Emphysema	_____ Yellow Jaundice
_____ Heart Murmur	_____ Sleep Apnea	_____ Cirrhosis
_____ Stroke	_____ COPD	_____ Liver Failure
Psychiatric/Nerves	Gastrointestinal	Endocrine/Immune
_____ Anxiety	_____ Bleeding Ulcers	_____ Thyroid Problems
_____ Depression	_____ Hiatal Ulcers	_____ Sugar Diabetes
_____ Panic Attacks	_____ GERD/Reflux	_____ Cancer
_____ Bipolar	_____ Constipation	If yes, type: _____
_____ Seizures	_____ Nausea	_____ HIV or AIDS
_____ Shingles	_____ Diarrhea	
Musculoskeletal	Blood	Past or Present
_____ Arthritis	_____ Anemia	_____ Physical Abuse
_____ Osteoporosis	_____ Frequent Infections	_____ Sexual Abuse
		_____ Emotional Abuse

If other, please explain: _____

Review of Systems

CV	Renal/Liver	HEM/OC
_____ Chest Pain	_____ Burning urination	_____ Easy Bleeding
_____ Palpations	_____ Blood in Urine	_____ Sores that don't heal
_____ Leg Swelling	_____ Yellow Jaundice	_____ New Lumps or Bumps
Respiratory	**Ortho/Rheumatology**	**Constitutional**
_____ Wheezing	_____ Joint Pain	_____ Fatigue
_____ Coughing	_____ Joint Swelling/ Redness	_____ Fever
_____ Sputum	_____ Cool Hands/Feet	_____ Rash
_____ Shortness of Breath	_____ "Popping/ Cracking" Joints	_____ Night Sweats
		_____ Weight Loss/Gain
Neuro	**GI**	**Endocrine**
_____ Numbness	_____ Abdominal Pain	_____ Cold/Heat Intolerance
_____ Weakness	_____ Constipation	_____ Excessive Thirst
_____ Dizziness	_____ Reflux/Burning	_____ Frequent Urination
_____ Headache	_____ Blood in Stool	_____ Hair/Skin Changes
_____ Confusion	_____ Grey or Black Stools	_____ Irregular Menstruation
_____ Tremor	_____ Nausea	_____ Decreased Sexual Desire
_____ Difficulty Speaking	_____ Vomiting	_____ Less Sexual
_____ Difficulty swallowing	_____ Diarrhea	_____ Currently in Menopause

Other Symptoms

_____

_____

_____

Is there anything else you would like to tell me about your pain?

_____

_____

_____

Family History

What health problems or diseases do/did your parents and/or other family members have?

_____

_____

_____

_____

List any family members with a history of drug or alcohol abuse

_____

_____

Allergies

_____

_____

***If you do not have any allergies, write "none"

Current Medications

Even though you must bring your medication to the appointment you must still list them below.
*******************If you do not list your medications you will not be seen.**********************

Medication	Dosage (i.e. milligrams)	How often you take this medication	Prescriber

***If you need more space, please use the blank back page of this packet.

Prior Medications used to treat this pain or taken to treat the effects of this pain (includes narcotics, antidepressants, sleep medications, muscle tranquilizers, over the counter medications and anti-inflammatory medications)

Medication	Dosage (i.e. milligrams)	Did it help?	Why did you stop taking it?

Habits

Caffeine (coffee, tea, cola, energy drinks, etc.) _____ If yes, how many a day? _____

Nicotine (cigarettes, pipe, cigar, chew, etc.) _____ If yes, how many a day? _____

Alcohol _____ None

_____ Rarely (less than one drink per month)

_____ Occasionally (less than one drink per week)

_____ Regularly (drink 2-3 times per week)

_____ Almost Daily

Have you, a family member or friend ever felt you should "cut down" on your drinking? YES NO

Has anyone ever annoyed you by criticizing your drinking? YES NO

Have you ever felt guilty about your drinking? YES NO

Have you ever had a drink first thing in the morning as an "eye opener"? YES NO

Have you ever had withdrawal symptoms (shaking/sweating) when you stopped drinking? YES NO

Have you ever abused prescription medications? YES NO

If yes, please explain: _____

Have you ever used marijuana, other street drugs or "shot up"? YES NO

Has a Physician ever told you he/she was concerned that you were becoming addicted to a prescription medication? YES NO

If yes, please explain: _____

Have you ever committed a crime or served time in jail? YES NO

If yes, please explain: _____

Social History

Marital Status (circle one): Single Married Separated Divorced Widowed Remarried

Number of Children and ages: _____

Present Living Situation (check all that apply):

_____ Alone _____With Spouse ____With Children ____With Parents ____ With Friend _____Other

Education (Check the Highest Grade/Degree Completed)

_____ Less than 8th grade _____ Completed 8th grade _____ Some High School

_____ High School/GED _____ Some College _____ College Graduate

_____ Advanced Degree

Employment History

Current or Last Job _____ Employer _____

Present Employment Status

_____ Full Time _____ Part Time _____ Unemployed

_____ Leave of Absence _____ Retired _____ Student _____ Homemaker

When was your last day of work? _____

Are you still working? YES NO

Are you disabled? YES NO

Are you receiving disability payments? YES NO

For how long? _____

Do you have a Worker's Compensation or Social Security Disability Application Pending? YES NO

Are you now, or do you anticipate, a lawsuit because of your pain or injury? YES NO

Verbal Pain Scale

Rate the intensity of your pain overall by checking the level of your pain overall

_____ No Pain

_____ Mild Pain

_____ Very Uncomfortable

_____ Distressing

_____ Horrible

_____ Excruciating

Wisconsin Pain Disability Index

We would like to know how much of your pain is preventing you from doing what you normally do, or from doing it as you normally would. Please indicate the overall impact of pain in your life, **not** just when the is at its worst.

For each category, please CIRCLE the number that describes the level of disability you typically experience.

A score of "0" means NO disability at all.

A score of "10" means the activity is totally disrupted or prevented by pain.

1. Family/Home Responsibilities (include chores, duties in the house, errands or favors for family members, etc.)

   0 1 2 3 4 5 6 7 8 9 10

2. Recreation (includes hobbies, sports and similar leisure activities)

   0 1 2 3 4 5 6 7 8 9 10

3. Social Activity (includes participation with friends and other non-family members, including dining out and other social functions).

   0 1 2 3 4 5 6 7 8 9 10

4. Occupation (includes activities that are related to one's job, including non-paying jobs like volunteering).

   0 1 2 3 4 5 6 7 8 9 10

5. Sexual Activity (includes the frequency and quality of one's sex life).

   0 1 2 3 4 5 6 7 8 9 10

6. Self Care (includes activities of personal maintenance, like showering, driving, dressing, etc.).

   0 1 2 3 4 5 6 7 8 9 10

7. Life Support Activities (includes eating, sleeping, and breathing).

   0 1 2 3 4 5 6 7 8 9 10

Verbal Intensity Pain Rating (VIPR)

Describe the characteristics of your pain. Circle the letter in EACH column that best describes your average pain in the last month.

Intensity	Reactions	Sensations	
A. excruciating	A. agony	A. piercing	J. electric
B. very intense	B. intolerable	B. sharp	K. needles
C. severe	C. horrific	C. shooting	L. stinging
D. very strong	D. miserable	D. grinding	M. burning
E. intense	E. awful	E. aching	N. tingling
F. strong	F. distressing	F. throbbing	
G. uncomfortable	G. unpleasant	G. cramping	
H. moderate	H. uncomfortable	H. pressure	
I. mild	I. tolerable	I. numb	

Associated Symptoms

Are there any symptoms associated with your pain?

A. Numbness—where? _____
B. Weakness—where? _____
C. Urinary Incontinence?_____
D. Lose control of bowel movements? _____
E. Swelling—where? _____
F. Tenderness to touch? _____
G. Cool or pale skin? _____
H. Redness? _____
I. Other? _____

Visual Analog Pain Scale (VAPS)

Rate your pain by placing an "X" on the line to describe your WORST pain in the past month.

No Pain _____ Worst Pain Possible

Rate your pain by placing an "X" on the line to describe your LEAST pain in the past month.

No Pain _____ Worst Pain Possible

Rate your pain by placing an "X" on the line to describe your AVERAGE pain in the past month.

No Pain _____ Worst Pain Possible

Rate your pain by placing an "X" on the line to describe your pain RIGHT NOW.

No Pain _____ Worst Pain Possible

Short Form McGill Pain Questionnaire

Check the column to indicate the level of your pain for each word:

	None	Mild	Moderate	Severe
Throbbing	_____	_____	_____	_____
Shooting	_____	_____	_____	_____
Stabbing	_____	_____	_____	_____
Sharp	_____	_____	_____	_____
Cramping	_____	_____	_____	_____
Gnawing	_____	_____	_____	_____
Hot/Burning	_____	_____	_____	_____
Aching	_____	_____	_____	_____
Heavy	_____	_____	_____	_____
Tender	_____	_____	_____	_____
Splitting	_____	_____	_____	_____
Tiring/Exhausting	_____	_____	_____	_____
Sickening	_____	_____	_____	_____
Fearful	_____	_____	_____	_____
Cruel/Punishing	_____	_____	_____	_____

Interference Scale

Check the one that best applies to the patient.

100% _____ The patient is totally bedridden and needs an ambulance for transportation.

99% _____ The patient is bedridden; however, is able to use the bathroom or bedside commode.

80% _____ The patient is not bedridden; however, is confined to a wheelchair.

70% _____ The patient is up in the house; however, is confined to a wheelchair.

60% _____ The patient is able to perform limited household chores and is able to perform self-care activities. This is the first stage of normalcy.

50% _____ The patient is able to make short trips (less than 30 minutes) and is ambulatory in the yard.

40% _____ The patient is able to take longer trips (less than 2 hours). This may include grocery shopping, mall shopping; however, the patient does require rest breaks.

30% _____ The patient is able to participate in Physical Therapy even on a limited basis and is capable of performing minimal activities of daily living (i.e., bathing, dressing, etc.).

20% _____ The patient can participate in normal activities for short periods of time with frequent rest breaks.

10% _____ The patient can participate in normal activities for longer periods of time with rest breaks.

0% _____ The patient is participating in normal activities.

Oswestry Disability Questionnaire

******Please check only 1 per section.******

Section 1 — Pain Intensity	Office Use Only
_____ I have no pain at this moment.	(0 points)
_____ The pain is very mild at the moment.	(1 point)
_____ The pain is moderate at the moment.	(2 points)
_____ The pain is fairly severe at the moment.	(3 points)
_____ The pain is very severe at the moment.	(4 points)
_____ The pain is worst imaginable at the moment.	(5 points)

Section 2 — Personal Care	Office Use Only
_____ I can look after myself normally.	(0 points)
_____ I can look after myself normally but it causes pain.	(1 point)
_____ It is painful to look after myself and I am slow.	(2 points)
_____ I need some help but can manage most of my personal care.	(3 points)
_____ I need help every day in most aspects of my care.	(4 points)
_____ I do not get dressed without help, wash myself with difficulty and stay in bed.	(5 points)

Section 3 — Lifting	Office Use Only
_____ I can lift heavy weights without extra pain.	(0 points)
_____ I can lift heavy weights but it gives me extra pain.	(1 point)
_____ Pain prevents me from lifting heavy weights off the floor but I can manage if they are placed on a table.	(2 points)
_____ Pain prevents me from lifting heavy weight but I can manage light to medium weights if conveniently placed.	(3 points)
_____ I can lift only very light weights.	(4 points)
_____ I cannot lift or carry anything at all.	(5 points)

Section 4 — Walking	Office Use Only
_____ Pain does not prevent me walking any distance.	(0 points)
_____ Pain prevents me from walking more than 1/2 a mile.	(1 point)
_____ Pain prevents me from walking more than 1/4 a mile.	(2 points)
_____ Pain prevents me from walking more than 500 yards.	(3 points)
_____ I can only walk using a stick, cane or crutches.	(4 points)
_____ I am in bed most of the time.	(5 points)

Section 5 — Sitting	Office Use Only
_____ I can sit in any chair as long as I like.	(0 points)
_____ I can only sit in my favorite chair as long as I like.	(1 point)
_____ Pain prevents me sitting for more than 1 hour..	(2 points)
_____ Pain prevents me from sitting for more than 30 minutes.	(3 points)
_____ Pain prevents me from sitting for more than 10 minutes.	(4 points)
_____ Pain prevents me from sitting at all.	(5 points)

Section 6 — Standing **Office Use Only**

_____ I can stand as long as I like. (0 points)

_____ I can stand as long as I want but it gives me extra pain.. (1 point)

_____ Pain prevents me from standing for more than 1 hour. (2 points)

_____ Pain prevents me from standing for more than 30 minutes.. (3 points)

_____ Pain prevents me from standing for more than 10 minutes. (4 points)

_____ Pain prevents me from standing at all. (5 points)

Section 7 — Sleeping **Office Use Only**

_____ My sleep is never disturbed by pain. (0 points)

_____ My sleep is occasionally disturbed by pain. (1 point)

_____ Because of pain I have less than 6 hours of sleep. (2 points)

_____ Because of pain I have less than 4 hours of sleep. (3 points)

_____ Because of pain I have less than 2 hours of sleep. (4 points)

_____ My pain keeps me from sleeping at all. (5 points)

Section 8 — Sex Life (if applicable) **Office Use Only**

_____ My sex life is normal and causes no extra pain. (0 points)

_____ My sex life is normal but causes some extra pain. (1 point)

_____ My sex life is nearly normal but is very painful. (2 points)

_____ My sex life is severely restricted by pain. (3 points)

_____ My sex life is nearly absent because of the pain. (4 points)

_____ Pain prevents any sex life at all. (5 points)

Section 9 — Social Life **Office Use Only**

_____ My social life is normal and gives me no extra pain. (0 points)

_____ My social life is normal but increases the degree of pain. (1 point)

_____ Pain has no significant effect on my social life apart from limiting my more energetic interests (i.e. sports). (2 points)

_____ Pain has restricted my social life and I do not go out as often. (3 points)

_____ Pain has restricted my social life to my home. (4 points)

_____ I have no social life because of pain. (5 points)

Section 10 — Traveling **Office Use Only**

_____ I can travel anywhere without pain. (0 points)

_____ I can travel anywhere but it gives me extra pain. (1 point)

_____ Pain is bad but I manage journeys over 2 hours. (2 points)

_____ Pain restricts me to journeys of less than 1 hour. (3 points)

_____ Pain restricts me to short necessary journeys of less than 30 minutes. (4 points)

_____ Pain prevents me from traveling except to receive treatments. (5 points)

******Office Use Only******

Total score = SUM (points for all 10 sections)

Disability in percent = (total score) / 50 * 100

If not all questions are answered then

Disability in percent = (total score) / (5 * [number of questions answered]) * 100