MEDI CENTER
PAIN MANAGEMENT

New Patient Packet

In order to make the most of your experience and to ensure you receive optimal care, **it is MANDATORY that you HAND CARRY the following to your first appointment.**

- ✓ **Current medication list**, also please bring any **opioids** that you are taking to your first appointment
- ✓ **Most recent office notes** pertaining to the treatment of your chronic pain. This includes surgery or procedure notes, pain management notes if you were being treated at a different clinic or clinic notes from other specialists
- ✓ **MRI and X-Ray FILMS**

Please drop off this <u>New Patient Packet 2 days PRIOR</u> to your appointment, if it is not completed by the time of your appointment, you will be asked to reschedule.

If these documents are not with you at your appointment time then the doctor will be limited on how she can care for you.

Thank you for choosing us to help you with your pain management needs

MEDI CENTER
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No Show/Cancellation Policy & Procedures

We understand that there are times when you must miss an appointment due to emergencies or obligations to work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment

Pain Management

- Patients that fail to show up for their scheduled **follow up** appointment, or did not notify MediCenter Specialties Clinic 48 hours prior to their appointment time, will be subject to a "No Show/Cancellation" fee of **$50**

- Patients that fail to show up for their scheduled **office procedure**, or did not notify MediCenter Specialties Clinic 48 hours prior to their appointment time, shall be subject to a "No Show/Cancellation" fee of **$150**

Patient Name D.O.B.

Patient Signature Date

Pain Management New Patient Intake

Please answer the following to the best of your ability and in its entirety so we can optimize your care

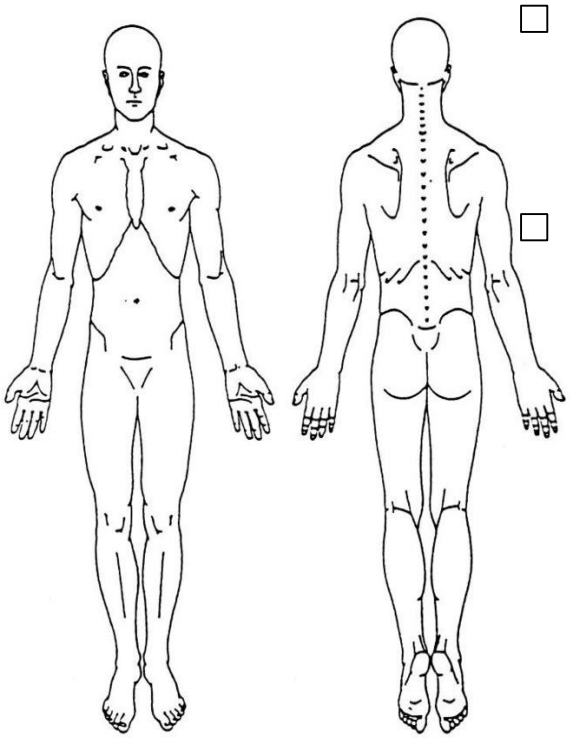
Location of Pain: Please check which area of pain you have and the associated locations.

Shade the diagram in where your pain is and race any patterns or radiation

☐ **Neck Pain**
- ☐ Pain Causes Headaches
  - ☐ Front of Head
  - ☐ Temple, Left
  - ☐ Temple, Right
  - ☐ Back of Head, Left
  - ☐ Back of Head, Right
- ☐ Pain Radiates into Arms
  - ☐ Left
  - ☐ Right
- ☐ Pain Radiates into Hands
  - ☐ Left
  - ☐ Right

☐ **Shoulder Pain**
- ☐ Left
- ☐ Right

☐ Other Pain (Please Explain) _____



☐ **Upper Back**
- ☐ Pain Radiates into Ribs
  - ☐ Left
  - ☐ Right

☐ **Lower Back**
- ☐ Pain Radiates into Hips
  - ☐ Left
  - ☐ Right
- ☐ Pain Radiates into Pelvis
  - ☐ Left
  - ☐ Right
- ☐ Pain Radiates Down the Leg
  - ☐ Left
  - ☐ Right

_____

_____

_____

_____

_____

How long have you had your pain?

Years _____

Months _____

Weeks _____

What was the onset of your pain?

☐ Trauma _____

☐ Unknown onset: Sudden

☐ Unknown onset: Gradual

Is this a work related injury? ☐ YES ☐ NO

Is Worker's Compensation involved? ☐ YES ☐ NO

If so, date of injury? MM/DD/YYYY _____

Please describe your pain at its….

Best	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Worst	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Average	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Type of Pain

☐ Aching	☐ Burning	☐ Dull	☐ Constant	☐ Episodic
☐ Shooting	☐ Tingling	☐ Tight	☐ Radiating	☐ Intermittent
☐ Cramping	☐ Hot	☐ Heavy	☐ Annoying	☐ Throbbing
☐ Numb	☐ Cold	☐ Intense	☐ Severe	☐ Deep
☐ Stinging	☐ Sore	☐ Knife-like	☐ Sharp	☐ Other _____

Does your pain wake you up at night? ☐ YES ☐ NO

When is your pain worse? ☐ Morning ☐ Afternoon ☐ Night

Assisted devices ☐ None ☐ Cane ☐ Walker ☐ Corset ☐ Brace ☐ Wheelchair

Please note any providers you have seen for your pain:

☐ Orthopedic Surgeon	☐ Rheumatologist
☐ Neurologist	☐ Physical Therapist
☐ Primary Care	☐ Other _____
☐ Emergency Room	_____

Have you ever been discharged from a clinic? ☐ YES ☐ NO

If yes, please explain what happened & name of clinic:

Have you done Physical Therapy to treat this problem? ☐ YES ☐ NO

1. Did it help with your pain? ☐ YES ☐ NO
2. When did you go? _____
3. For how long? _____

Aggravating Factors

☐ Sneezing	☐ Lifting	☐ Other:
☐ Coughing	☐ Sitting	_____
☐ Bowl Movements	☐ Standing	_____
☐ Bending	☐ Walking	_____
☐ Twisting	☐ Lying Down	_____

Relieving Factors

☐ Heat	☐ Standing Up	☐ Other
☐ Ice	☐ Rest	_____
☐ Physical Therapy	☐ Pain Meds	_____
☐ Laying Down	☐ Bending forward	_____
		_____

Please list ALL of your current medications.

Name	Strength	Frequency	Usage

If you have more medications, please list on a separate piece of paper

Please list ALL opioids, pain patches, neuropathic medications etc. that you have taken in the past that did not work

Name	Strength	Why Stopped (side effects, cost, etc.)

Please indicate any diagnostic tests you have had. Approximate date and location

	Body Part	Date MM/YYYY	Facility
X-RAY			
EMG			
Myelogram			
MRI			
Other			

Allergies

☐	Shrimp	☐	Adhesives	☐	Seasonal Allergies	☐		☐	
☐	Shellfish	☐	Lodine	☐		☐		☐	
☐	Latex	☐	Penicillin	☐		☐		☐	

Social History

1.	Do you use tobacco products?	☐ YES	☐ NO	Frequency & Product	
2.	Do you consume alcohol?	☐ YES	☐ NO	Frequency	
3.	History of illegal drug abuse?	☐ YES	☐ NO	Frequency & Product	
4.	Current illegal drug abuse?	☐ YES	☐ NO	Frequency & Product	
5.	Daily caffeinated beverage	☐ 0-1	☐ 2-3	☐ 3-4	☐ 5+
6.	Exercise during the week	☐ 1-2	☐ 3-4	☐ 5+	☐ Never
7.	Do you use a seatbelt?	☐ Always	☐ Sometimes	☐ Never	
8.	What is your occupation?				

Past Medical History

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anesthetic Complication
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Problems
- ☐ Birth Defects
- ☐ Bleeding Disease
- ☐ Blood Clots
- ☐ Blood Transfusion(s)
- ☐ Bowel Disease
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Colon / Rectal Cancer
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Growth / Development Disorder
- ☐ Heart Attack
- ☐ Heart Pain / Angina
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Kidney / Bladder Disease
- ☐ Liver Cancer
- ☐ Lung / Respiratory Disease
- ☐ Lung Cancer
- ☐ Mental Illness
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Prostate Cancer
- ☐ Reflex / GERD
- ☐ Seizures / Convulsion
- ☐ Severe Allergy / Hives
- ☐ Sexually Transmitted Disease
- ☐ Skin Cancer
- ☐ Stroke / CVA of the Brain
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Ulcer

Other Disease / Cancer or Significant Medical Illness

- ☐ _____
- ☐ _____
- ☐ _____

Family History

- ☐ Family History Unknown
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anesthetic Problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disease
- ☐ Breast Cancer
- ☐ Colon / Rectal Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ _____
- ☐ _____
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney / Bladder Disease
- ☐ Lung / Respiratory Disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Seizures / Convulsions
- ☐ Severe Allergy / Hives
- ☐ Stroke / CVA of the Brain
- ☐ Thyroid
- ☐ _____
- ☐ _____

Surgical History

Cataract Surgery	☐ Left	☐Right	☐Both	Carpal Tunnel Surgery	☐Left	☐Right	☐Both
Deviated Nose Septum	☐ Left	☐Right	☐Both	Rotator Cuff Repair	☐Left	☐Right	☐Both
Sinus Surgery	☐ Positive History			Shoulder Surgery	☐Left	☐Right	☐Both
Mastoidectomy	☐ Left	☐Right	☐Both	Hip Fracture & Surgery	☐Left	☐Right	☐Both
Tonsillectomy	☐ Left	☐Right	☐Both	Hip Replacement	☐Left	☐Right	☐Both
Carotid Artery Surgery	☐ Left	☐Right	☐Both	Knee Surgery	☐Left	☐Right	☐Both
Thyroid Removal	☐ Left	☐Right	☐Both	Neck Surgery	☐ Positive History		
Breast Biopsy	☐ Left	☐Right	☐Both	Low Back Surgery	☐ Positive History		
Breast Lump Removal	☐ Left	☐Right	☐Both	Spinal Fusion	☐ Positive History		
Lung Surgery	☐ Left	☐Right	☐Both	Spinal Decompression	☐ Positive History		
Heart Bypass Surgery	☐ Left	☐Right	☐Both	Ulcer Surgery	☐ Positive History		
Heart Valve Replacement	☐ Left	☐Right	☐Both				
Appendectomy	☐ Positive History			If you have had spinal surgery, please indicate date & facility:			
Gallbladder Surgery	☐ Positive History						
Kidney Removal	☐ Left	☐Right	☐Both				
Inguinal Hernia Surgery	☐ Positive History						
Colon Polyp Removal	☐ Positive History						
Colon Removal	☐ Positive History						
Anal Fissure Repair	☐ Positive History						
Leg Circulation Surgery	☐ Left	☐Right	☐Both				
Foot Surgery	☐ Left	☐Right	☐Both				

Have you had any pain management procedures? ☐ YES ☐ NO

What procedures?

☐ Major joint injection ☐ Facet Joint Injection

☐ Epidural ☐ Discectomy

☐ Rhizotomy ☐ _____

Please indicate date & facility: _____

_____

_____

Did you get any relief from injections/procedures? ☐ YES ☐ NO If so, how long? _____

Please circle the symptoms that are present at this time

General
Fevers
Weight Gain
Weight Loss
Chills Fatigue
Sweats
Loss of Appetite
Anorexia
Malaise
Headaches

Eyes
Vision Loss
Light Sensitivity
Double Vision
Blurring
Eye Pain
Diplopia
Irritation
Discharge
Photophobia

Ears, Nose, & Throat
Ringing in Ears
Decreased Hearing
Congestion
Hoarseness
Earache
Difficulty Swallowing
Ear Discharge
Nose Bleeds
Sore Throat
Runny Nose

Cardiovascular
Difficulty Breathing Lying Down
Leg Cramps during Exertion
Ankle Swelling
Palpitations
Fainting Spells
Chest Pain

Respiratory
Shortness of Breath at Rest
Sputum Production
Shortness of Breath with Exertion
Cough
Chest Pain
Snoring
Coughing Up Blood
Wheezing
Waking Up Gasping for Breath

Gastroifgntestinal
Bloody or Black Stools
Abdominal pain
Nausea
Constipation
Vomiting
Diarrhea
Change in Bowel Habits

Genitourinary
Frequent Urination at Night
Difficulty Starting Urination
Blood in Urine
Pain with Urination
Loss of Bladder Control
Urinary Urgency/Frequency
Discharge
Genital Sores
Decreased Libido

Musculoskeletal
Muscle Weakness
Bone pain in Last 3 Months
Joint pain in Last 3 Months
Muscle Cramps
Joint Pain
Back Pain
Joint Swelling
Joint Stiffness
Stiffness

Skin
Poor Skin Healing
Hair loss
Itching
Rash
Dryness
Suspicious Lesions
Jaundice

Neurologic
Memory Loss
Tingling Sensation
Unsteadiness
Speech Problems
Numbness
Headaches
Seizures
Tremors
Balance Problems
Transient Paralysis
Weakness

Psychiatric
Suicidal Thoughts
Hallucinations
Anxiety
Depression
Memory Loss
Mental Disturbance
Paranoia

Endocrine
Increased Appetite
Excessive Urination
Cold Intolerance
Increased Thirst
Heat Intolerance
Weight Change

Heme/Lymphatic
Tendency towards Bleeding
Abnormal Bruising
Enlarged Lymph Glands

Allergic/Immunologic
Persistent Infections
HIV Exposures
Hives
Hay Fever

MEDI CENTER
PAIN MANAGEMENT

Pain Management Agreement for Controlled Substances

PATIENT NAME_____**DOB**_____**PHARMACY**_____

Please read and initial the following statements and sign the bottom:

I will NOT use illegal substances, street drugs, or use alcohol while taking my prescribed medication. ____*(initial)*

I will NOT take ANY controlled substances from ANY other prescriber other than the MediCenter Pain Management. ____*(initial)*

I will not be involved in sales, illegal possession, diversion, or transportation of controlled substances such as pain killers, sleeping pills, sedation, etc. ____*(initial)*

I agree to random drug screening and/or pill counts that may include blood alcohol levels at the request of the MediCenter Pain Management. I understand that if I am called in to do so, ALL pills must be brought in within the time frame given. Failure to comply will result in immediate discharge from the clinic. ____*(initial)*

I agree to only take my medications as they are prescribed by the MediCenter Pain Management, this includes quantity and dose. ____*(initial)*

I agree to use ONE pharmacy for all my controlled substances (listed above). ____*(initial)*

I will notify my pharmacy of my next refill date so that they can have a ready supply of my medication in stock. I understand that if I do not notify my pharmacy of my next refill date I may have to wait up to one week for my pharmacy to order my medication and that I will not be able to fill my prescription during that time____*(initial)*

I agree to keep all my scheduled appointments with the MediCenter Pain Management and I understand that TWO no-shows or cancellations will result in immediate discharge from the clinic. ____*(initial)*

I understand that, as the patient, it is my responsibility to keep track of my scheduled appointments and refill dates. ____*(initial)*

I agree that the MediCenter Pain Management may/will communicate information regarding this agreement to other health care entities or professionals when deemed necessary, as well as law enforcement entities. ____*(initial)*

I agree to contact the MediCenter Pain Management at 907-335-2490 AT LEAST 48 hours in advance to my scheduled appointment to reschedule if I am unable to make it and understand that I will not receive my medications until I am seen. ____*(initial)*

I agree to contact the MediCenter Pain Management at 907-335-2490 within 24 hours if an unavoidable emergency occurs requiring a prescription for controlled substances (i.e.; ER visit or an inpatient admission). ____*(initial)*

I understand that if my medication is lost, stolen, misplaced or damaged the MediCenter Pain Management WILL NOT replace my medication for any reason. ____*(initial)*

I understand that no allowances will be made for medication pick up, or dates of pick up (i.e. early refill___*(initial)*

I agree that all medication refills, issues or changes will be done at my scheduled appointments. ___*(initial)*

I understand that, as the patient, it is my sole responsibility to check pill count, dose, manufacture brand of all controlled substances before leaving the pharmacy window and that the MediCenter Pain Management is not responsible for any issue in regards to this (*for instance:* shorted on quantity). ___*(initial)*

I give my permission to the MediCenter Pain Management to access the Prescription Drug Monitoring Program. ___*(initial)*

I understand that the MediCenter Pain Management has committed to a 24 hour time frame *(during the regular business week)* to complete a medication prior authorization if my insurance requires one. That 24 hour time frame starts once the authorization request is received at the MediCenter Pain Management. ___*(initial)*

I understand that harassment of staff by me and/or family members/friends will result in immediate dismissal from the MediCenter Pain Management. This includes calling 3+ times in a single day, repeatedly stopping by the office unannounced, etc. ___*(initial)*

I agree to keep my contact information up to date with the MediCenter Pain Management (i.e.; phone number, address.) ___*(initial)*

I agree that this Controlled Substance Agreement is part of my permanent medical record. ___*(initial)*

Females: I certify that I am not currently pregnant and will take the necessary precautions to prevent pregnancy during the course of my treatment at the MediCenter Pain Management while under the "Controlled Substance Agreement." ___*(initial)*

I have read the terms and conditions of the above Controlled Substance Agreement. I understand to the best of my knowledge this agreement. I consent to the use of controlled substances under the terms outlined in this agreement. By signing below I understand the possible adverse effects and dependencies associated with the controlled substances and that appropriate education regarding same has been provided and all questions I may have had been answered to my satisfaction.

Patient Name D.O.B.

Patient Signature Date

Provider's Signature Date

MEDI CENTER
PAIN MANAGEMENT

Availability of Opioid Pain Medication at Local Pharmacies

Due to the potential for misuse and abuse, opioid pain medications are regulated by the Drug Enforcement Agency (DEA). The DEA has put several security measures in place for pharmacies that carry opioids and other controlled substances. Due to the strict regulation of these medications, many retail pharmacies have elected to limit the amount of opioid pain medications that they keep in stock. Hydromorphone (Dilaudid, Exalgo) and Oxymorphone (Opana) are especially difficult for pharmacies to store due to the necessary security measures that accompany stocking these medications. Many retail pharmacies do not stock either of these medications and require additional time to fill them while they order the appropriate numbers.

If the Provider prescribes you a new opioid prescription today you may have to wait, up to 72 hours or more, to fill that prescription while your pharmacy orders the necessary numbers. You **will not** be authorized to take that prescription to a pharmacy different that the one noted on your pain contract. It is also **your responsibility** to inform your pharmacy that you will be getting monthly refills of your medication so that they can adjust their stock to meet your needs. Any absence of stock that your pharmacy experiences due to the lack of the necessary communication on your part **will not** result in authorization to fill your prescription at another pharmacy. You **will be required to wait** the amount of time it takes for your pharmacy to special order your medication.

If you are concerned that you may experience withdrawal symptoms while you wait for your pharmacy to receive and fill your prescription there are medications your Provider can prescribe to help manage the withdrawal. Please discuss this with your Provider's office immediately after finding out that you may not be able to fill your prescription.

We understand that some of these stipulations can be difficult and inconvenient to you, the patient. We here at the MediCenter have your best interest in mind when we implement these security measures. They are to protect you from any suspicion that you are misusing or abusing your medications. They also protect your Provider from the penalties that the DEA can impose on medical practices that do not comply with their regulatory guidelines.

By signing the above I agree that I have read and understand the information contained here

Patient Name D.O.B.

Patient Signature Date

MEDI CENTER PAIN MANAGEMENT

Effectiveness of Generic Medication versus Brand Name Medication.

A generic drug is identical, or bioequivalent, to its brand name counterpart. The Federal Drug Administration (FDA) requires that a generic medication must meet certain standards in order to become approved for consumer use. A generic medication must:

- Contain the same active ingredient as the brand name drug (inactive ingredients may differ)
- Be identical in strength, dosage form, and route of administration
- Have the same use indications (blood pressure, pain, cholesterol lowering, etc)
- Be bioequivalent
- Meet the same batch requirements for identity, strength, purity, and quality
- Be manufactured under the same standards of FDA's good manufacturing practice regulations required for brand name products

Despite these rigid standards some generic medication may not be as effective as their brand name counterparts. This can be especially true of opioid pain medications, thyroid medications, and warfarin. There can also be significant difference in efficacy between generic medications. Depending on the patient's metabolism and other factors, hydrocodone manufactured by Watson Pharmaceuticals may not be as effective as hydrocodone manufactured by Zydus Pharmaceuticals, and vice versa.

The majority of patients will not have a problem switching between generic manufacturers. If you have noticed that you get significant changes in your pain management based on a specific manufacturer's generic drug, it is **your responsibility** to make sure that your pharmacy is aware of that. Contacting your pharmacy at least a week before your next scheduled refill date will ensure that they will have enough of the appropriate medication in stock so that you do not have to suffer through a gap in therapy.

By signing the above I agree that I have read and understand the information contained here

Patient Name D.O.B.

Patient Signature Date