Dear Patient:

Enclosed you will find all the New Patient Paperwork for your upcoming appointment with Alliance Pain Management. Your time is very valuable to us and to ensure that we stay on schedule, it is imperative that you have all the enclosed paperwork **completed upon your arrival at the office**. Please bring a current list of your medications along with the name of the provider that has prescribed them to you. If the paperwork is not completed when you arrive, you may be asked to come back later. Thank you in advance for your cooperation.

Sincerely,

Beth Smith

Practice Manager

Alliance Pain Management

Patient Registration Form

Date: _____ Patient's Name: _____ Preferred Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____ Email: _____
Home Phone: _____ Mobile: _____ Work: _____
Social Security Number: _____ DOB: ____ / ____ / ____ Sex: ___ Marital Status: _____

Race: ☐ American Indian / Alaskan ☐ Asian ☐ Black / African American ☐ Native / Hawaiian / Other Pacific Islander ☐ White ☐ Other ☐ I prefer not to provide this information

Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic or Latino ☐ I prefer not to provide this information
Preferred Language: _____
How did you hear about us? _____

EMERGENCY CONTACT INFORMATION:
Name: _____ Relationship: _____
Address: _____
Home Phone: _____ Mobile: _____ Work: _____

INSURANCE INFORMATION:
Primary Carrier Name: _____
Group #: _____
Address: _____
Policy Holder's Name: _____ ID #: _____
Relationship: _____
Social Security Number: _____ DOB: ____ / ____ / ____
Employer Name: _____ Employer Phone Number: _____

Secondary Carrier Name: _____ Group #: _____
Address: _____
Policy Holder's Name: _____ Relationship: _____
Social Security Number: _____ DOB: ____ / ____ / ____
Employer Name: _____ Employer Phone Number: _____

I hereby authorize and consent to Alliance Pain Management's providers and other practice professional staff providing outpatient medical treatment, supplies, services, equipment, and other items related to my healthcare to me as determined to be necessary in their professional judgement. I have been informed of the nature and purpose of the treatment, and potential common side effects thereof, as well as alternative treatment modalities, the approximate estimated duration of my healthcare, and that I am able to withdraw my consent for treatment either orally or in writing whether prior to or during the anticipated treatment period.

_____ _____
Signature of Patient or Guardian Date

Patient No Show, Late Arrival, and Cancellation Policy

Alliance Pain Management, PLLC understands there are situations that arise preventing you from coming to your scheduled appointment. You need to make every effort to cancel within 24 hours. By adhering to this policy, this allows another patient who is waiting for an appointment to be scheduled in that appointment window. If you do not cancel your appointment within 24 hours or no show/show up late for your scheduled appointment or procedure:

- If you show up more than **15 minutes** late for your regular scheduled appointment, you may not be seen and will be rescheduled to the next available appointment. If you are a new patient and you do not have your new patient paperwork completed when you arrive, you maybe asked to come back at a later time that same day.
- Medications will not be prescribed until the date of your next available appointment.
- Habitual no shows and late arrivals are grounds for dismissal from the clinic.
- We require **48-hour** notice to cancel or reschedule procedure appointments. Failure to do so will result in a no-show fee of **$100.00** being applied to your next visit.
- Failure to cancel your appointment or procedure will result in a no-show fee being applied:

New Patient $50.00 fee **Return Visit $35.00 fee**.

You must have an appointment. We are unable to accommodate walk-in visits.
APM recommends you confirm your appointment and arrive 10-15 minutes early.

To cancel or reschedule your appointment, please call the center directly and speak with the front office staff at 865-724-0867.

APM understands that unavoidable and unforeseen circumstances may cause you to not be able to cancel within 24 hours. You should call immediately and advise APM of the reason for emergency.

If you have any questions about this Policy, please speak with your provider.

_____ _____

Patient Signature Date

Alliance Pain Management
Patient HIPAA 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 1196 (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 (my insurance company).
- The day-to-day healthcare operations of our 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 the 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 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 revoked this consent is not affected.

We may need to communicate test results, prescription information or respond to a message you left for your physician's office. **We may communicate with you through mail and/or telephone, including leaving messages on your answering machine/voice mail.**

I authorize contact from Alliance Pain Management to contact me by:

☐ phone numbers listed below
☐ leave a message on my voicemail or to verify my appointments with the person or people listed below.
☐ by mail via USPS

Alliance Pain Management is authorized to discuss my medical information with the following individuals in accordance with HIPAA guidelines:

Name / Phone Number	Relationship	Phone Number
1.		
2.		

This request supersedes any prior request for communication of information I may have made.

Print Patient Name/ Responsible Party: _____ Date: _____

Signature of Patient/Responsible Party: _____ Date: _____

Authorization for Disclosure of Protected Health Information

Patient Name: _____ DOB: ____ / ____ / ____
Social Security Number: _____ Phone Number: _____
Maiden/Previous Names/Nicknames: _____

Instructions: Fill out form in its entirety. If any section is incomplete, this form may be invalid, and the request may not be processed.

Request information from:	**Request information to:**
Provider/Facility Name:	Provider/Facility Name: Alliance Pain Management
Address:	Address: 1111 E Lamar Alexander Parkway
City/State/Zip:	City/State/Zip: Maryville, TN 37804
Phone Number:	Phone Number: 865-724-0867
Fax Number:	Fax Number: 865-233-0592

Purpose of Release:
☐ Continuing Care ☐ Personal ☐ Transfer of Care ☐ Disability Determination ☐ Legal ☐ Work Comp
☐ Insurance ☐ Other: _____

Information to be Released: Service Dates: From: _____ To: _____
☐ Entire Medical Record ☐ Lab Reports ☐ Operative/Procedure Notes ☐ Radiology Reports
☐ Records pertaining to HIV or Hepatitis ☐ Psychiatric Records
☐ Office Visit Notes ☐ Billing Statements ☐ Other (Please Specify): _____
_____

This authorization will expire one year from the date of signing unless I indicate an event or earlier date here: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to Refuse to Sign This Authorization: I understand that I have the right to refuse to sign this Authorization and APM will not condition treatment or payment upon my signing of this Authorization.

Right to Revoke Authorization: I understand that I have the right to revoke this Authorization, except to the extent that APM has already disclosed my medical information in reliance of this Authorization. I understand that my revocation is effective only if it is in writing. To revoke my Authorization, I understand that I must send a written request for revocation to APM.

Re-disclosure of Information by Recipient: I understand that if my medical information is disclosed pursuant to this Authorization, it may be subject to re-disclosure by the person(s)/organization(s) receiving my medical information and no longer protected by applicable privacy laws.

Right to Receive a Copy of This Authorization and My Medical Information. I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of the form. I understand that I also have the right to inspect and receive a copy of the health information I have authorized to be disclosed by this Authorization.

By signing this form, I am authorizing APM to disclose my medical information as described in this Authorization.

Signature: _____ Date: _____

Printed Name of Person Signing (if not patient): _____

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased Legal Authority: ☐ Parent of Minor ☐ Legal Guardian ☐ Activated Power of Attorney ☐ Next of Kin

Financial Responsibility

Patient Name: _____ **DOB:** _____

Thank you for choosing Alliance Pain Management for your pain management needs. It is important that you understand the financial policies of this practice. It is just as important that you understand the terms of your medical coverage. Our staff is very knowledgeable of most insurance plans, but it is important that you understand the details of your personal plan. You will find your insurance company's phone number on the back of your insurance card, and we encourage you to contact them with any questions you have pertaining to your coverage.

Patients with Medical Insurance:

- If you have an insurance plan that requires a referral, you must contact your PCP to obtain a referral PRIOR to receiving care from a specialty provider. Many insurers will not cover specialty services that are rendered without a referral and will leave you responsible for the costs. As a result, if we do not have a referral on file, we will not be able to render services to you.
- We participate with most major insurance plans and our billing office will submit claims for services rendered. It is the patient's responsibility to provide all necessary information needed to file the claims prior to leaving our office. We will file your primary and secondary insurance claims; however, your insurance company may need you to supply information directly. You may be financially responsible if you do not comply with this request.
- Please bring your insurance cards to each visit to our office.
- Your insurance company **REQUIRES** us to collect co-payments at the time services are rendered. Failure to collect your co-payment is a contractual requirement so please be prepared to pay this on the date services are rendered. If you do not have your co-payment, we are not required to see you.
- Additionally, you may have deductible and/or coinsurance amounts that are your responsibility and required by your insurance carrier. These outstanding balances on your account following insurance processing will be billed to you.
- This practice will not waive or fail to collect any co-payments, co-insurance, deductibles, or any other financial responsibility in accordance with state and federal law as well as contractual agreements with payers. Full or partial financial responsibility may only be waived if a Financial Hardship application is approved.
- If the office is out of network, your insurance carrier may also pay you directly. As a patient, you are responsible for bringing in the payment and the Explanation of Benefits (EOB) from your insurance company.

Patient Balances:

- Any patient balances that remain delinquent after 90 days, with no response to requests or payment, may be referred to a collection agency. You will be responsible for all costs associated with the collection agency up to and including all legal costs.
- Our office accepts the following payment methods: Money Order, Cashier's Check, Cash, and Credit Card. **Self-pay payment methods**: Cashier's check and credit card are the only accepted payment methods per state regulations.
- **Returned checks will be charged a $40 fee.**

Please read the Financial Policy carefully before signing.

I, the undersigned, understand the financial policies of APM and agree to abide by the plan I have signed. I also understand and agree to the following:

- I authorize my insurance benefits to be paid directly to the physician/provider and/or Alliance Pain Management.
- To pay the amount owed to APM for professional treatment and services rendered.
- I understand that I am financially responsible for all charges whether insurance covers them.

If genuine financial difficulties exist, please call our office. We are happy to work with you in resolving your balance and may be able to set up payment arrangements.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Print Patient Name /Responsible Party Relationship to Patient

Information Regarding Advance Directives

Federal law requires that we give you information about your right to make advance health care decisions. Right now, you may be able to make your own health care decisions. You may not always be able to make such decisions, however. By giving advance directions, you can tell your health care provider and family about the medical care you would like to receive and whether you want another person to be able to accept or refuse treatment for you.

You can name a person to make medical treatment decisions for you by appointing someone to have a "Durable Power of Attorney for Health Care" for you. This person is allowed to make health care decisions for you, including life support decisions, but only after your health care provider certifies that you are no longer able to make your own health care decisions.

You can also leave advance direction about life support by executing a "Living Will". A Living Will tells your health care provider and family about the types of life support that you want to be provided or withheld in case you are ever kept alive by artificial means and are no longer able to make decisions for yourself.

If you already have a Living Will or Durable Power of Attorney for Health Care, please tell your health care provider. We need to put a copy of the document in your medical chart to be sure that your wishes are honored. If you want more information on how to name a Durable Power of Attorney for Health Care or how to make a Living Will, please feel free to ask your health provider, hospital, social worker, or attorney.

It is our policy to honor our patient's health care decisions to the full extent required or allowed by law. You are NOT required to give advanced health care decisions to receive care at this facility.

Do you have an advance directive? ☐ Yes ☐ No

_____ _____

Patient Signature Date

Informed Consent

Patient Name: _____ DOB: ____ / ____ / ____

Opioid is the medical name for a substance used to treat moderate to severe pain. Like all medications, opioids have potential to help people and / or cause harm. The purpose of this consent is to outline the overall benefits and potential harms so that together with your practitioner you can determine whether an opioid is suitable for you at this time. Not everyone will benefit from an opioid. In those who do, pain relief is generally modest. A 30% or greater reduction in pain is a meaningful effect. The possible side effects are the same for all the opioids, but different people react to each opioid individually. What might work well for you with few side effects may not work for the next person. Most side effects are worse when the medication is first started and can be effectively managed. Some side effects are more problematic with higher doses and longer-term use.

Using Controlled Medications to Treat Pain:

- Opioids are used to treat moderate-to-severe pain of any type.
- Opioids are best understood as potentially effective tools that can help reduce pain, improve function, and improve quality of life.
- Using these medications requires both the provider and patient work together in a responsible way to ensure the best outcome, lowest side effects, and least complications.

How Do Opioids work?

- Opioid medications work at the injury site, the spinal cord, and the brain.
- They dampen pain, but do not treat the underlying injury.
- They may help to prevent acute pain from becoming persistent chronic pain.
- These medications may work differently on different people because of many factors.
- Side effects and complications will also individually vary.

What to Expect When You Take Controlled Medications for Pain and Related Conditions:

- Pain relief.
- Reduction of anxiety and stress caused by pain.
- Side effects.

What Should Not Be Expected from Treatment with Controlled Medications:

- Cure of the underlying injury.
- Total elimination of pain, anxiety, and stress.
- Loss of ability to feel other physical pain.

Opioid Side effects:

There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing).

_____ It is my responsibility to notify my physician/health care provider for any side effects that continue or are severe (i.e., sedation, confusion). I am also responsible for notifying my pain provider immediately if I need to visit another provider or need to visit an emergency room due to pain, or if I become pregnant.

Opioid medications may cause a physical dependency marked by abstinence syndrome when they are stopped abruptly. If these medications are stopped or rapidly decreased, the patient may experience

chills, goose bumps, profuse sweating, increased pain, irritability, anxiety, agitation, and diarrhea. The medicines will not cause these symptoms if taken as prescribed and any decision to stop these medications should be done under the supervision of your physician in a slow downward taper.

Tolerance:
This means that over time the body becomes "use to" the medication and it feels less effective. The dose of the opioid may have to be adjusted to a dose that produces benefit and a realistic decrease of your pain yet does not have intolerable side effects. Sometimes this is not possible, and the opioid will have to be stopped and/or alternate therapy explored.

_____ I am aware that drowsiness or clouded thinking may make it dangerous for me to drive or operate heavy machinery. Alcohol or other medications that also cause drowsiness may worsen this effect.

_____ I agree not to drive or operate heavy machinery or sign legal documents while my practitioner is starting me on these new medications, significantly increasing my dose, or if I feel in any way impaired from this therapy at other times.

_____ I understand the use of alcohol and opioids together is potentially dangerous. I have been advised not do this.

Misuse of medications:
Addiction: This is a psychological condition of use of a substance despite self- harm. Between six and ten percent of the population of the United States have problems with substance abuse and addiction. Controlled medications are likely to activate addictive behavior in this group of people. It is a disease that occurs in some individuals. Like becoming overweight does not necessarily mean you will become diabetic, taking opioids does not necessarily cause addiction, however, if you have risk factors for addiction (such as a strong family history of drug or alcohol abuse) or have had problems with drugs or alcohol in the past you must notify your practitioner since using opioids will put you at greater risk. The extent of this risk is not certain.

_____ I have notified my practitioner of any personal or family history of drug or alcohol abuse.

Diversion:
It is illegal to share your controlled medications with other people. It is illegal to provide false information to a prescriber to obtain controlled medication. It is illegal to doctor shop or visit multiple doctors in attempt to obtain controlled medications. Federal and state laws exist to address diversion problems. It is critical that you safeguard your controlled medications and use them only as prescribed by your provider.

Driving:
Studies of patients with chronic pain demonstrate improved driving skills when taking certain controlled medications, I however may have problems driving and need to realistically assess their own skills, as well as listen to others who drive with them to determine if they should be driving while taking these medications. You should consult the State Department of Transportation if you have questions about driving and taking your medication.

Common Sense Rules for Using Controlled Medications:

- Follow your provider's recommendations.
- Do not take more pills than prescribed without discussing this first with your provider and receiving permission to do so.

Informed Consent

- Do not share medications with family or friends.
- Do not take medications from family or friends.
- Any medication you are prescribed may need to be tapered to stop. Please discuss with your provider before abruptly stopping any medications.
- Do not sell medications.
- Do not take medications in any manner other than prescribed. For example, do not chew, snort, or inject your medications.
- Keep all medications out of reach of children and pets.
- Do not leave your prescriptions or controlled medications lying around unprotected for others to steal and abuse them.
- Do not operate a motor vehicle if you feel mentally impaired using controlled medications. You are responsible for exhibiting good judgment in your daily affairs, including your use of controlled medications and operating motor vehicles or heavy equipment or tools.

Continued Use of Controlled Medication is based on your provider's judgment and a determination of whether the benefits to you of using controlled medications outweigh the risks of using them. Your provider may discontinue treating you at his or her discretion.

Your provider may require a consultation with an addiction specialist. Your provider may require more frequent visits.

We believe in treating your pain and we recognize the value of controlled medications in this process. When used properly, controlled medications can help restore comfort, function, and quality of life. However, as stated above, controlled medications may also have serious side effects and are highly controlled because of their potential for misuse and abuse. It is important to work with your provider and communicate openly and honestly with them about your pain. By doing so, medications can be used safely and successfully.

By your signature below, you are acknowledging that you have read and reviewed this agreement with your provider and that you have sufficient information to decide to use the controlled medications prescribed.

You should NOT sign this form if you do not believe you have enough information to make an informed decision about your use of controlled medications and how they fit in to your pain management treatment plan.

Patient Name : _____ Date : _____

Patient Signature : _____ Date : _____

Provider Signature : _____ Date: _____

PLEASE READ CAREFULLY

NEW PATIENT INTAKE FORMS

GENERAL INFORMATION

In order for Alliance Pain Management to obtain a complete medical history, it is important for you to fill out this form as completely and accurately as possible. This is vital information. **Please fill out every item**. It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer, and you are welcome to have a copy of the report if you wish.

We also require a copy of all imaging reports and records from physicians who have treated you in the past for your persistent pain. This may require you to come to the office and sign a release of information so that we can request these records.

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Preferred Pharmacy: _____

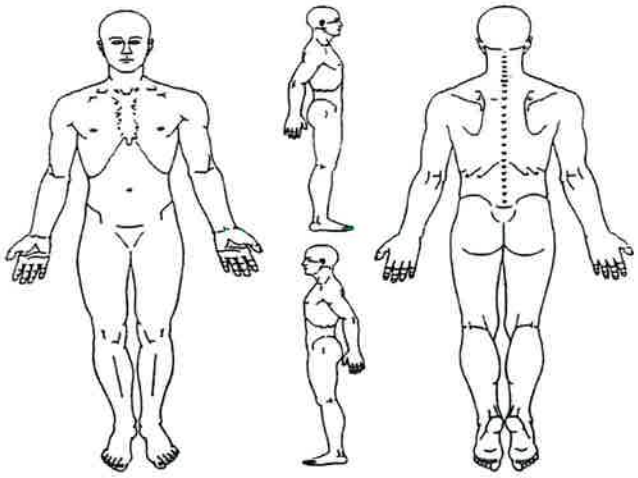
Pharmacy Phone: _____

Primary Care Physician: _____

Referring Physician: _____

New Patient Medical History Intake

Please shade in the areas in which you are seeking treatment by Alliance Pain Management.



Please rate the quality of your pain. Circle all that apply.

Weakness	Burning	Tingling	Numbness
Swelling	Aching	Drilling	Dull
Cold	Cramping	Crushing	Nagging
Gnawing	Hot	Itching	Sharp
Penetrating	Pins & Needles	Pressure	Stabbing
Shock-like	Shooting	Sore	Throbbing
Tightness	Other		

On a scale from 0 (none) to 10 (worst):
What is your level of pain TODAY: 0 1 2 3 4 5 6 7 8 9 10

Things that make your pain better

	Sitting
	Walking
	Exercising/Standing
	Moving around
	Lying Down
	Applying heat
	Applying ice
	Taking medication
	Physical Therapy
	Massage
	Sleep
	Injections
	Using a walker/cane

Things that make your pain worse.

	Looking up		Walking
	Looking down		Coughing
	Turning head from side to side		Touching the affected area
	Loud noises		Move from sitting to standing
	Bright Light		Lying down
	Chewing		Changes in the weather
	Emotional stress		Standing
	Bending forward at the waist		Sitting
	Bending backward at the waist		

Are you allergic to any medications? YES / NO
If yes, please list the Medication Name and Type of Reaction._____

_____

Have you ever had a substance abuse problem? YES / NO
If yes, with which substance(s) and have you had treatment for your substance abuse? _____

_____

Past Medical Problems

List all medical problems that you are being treated for: _____

_____

_____

_____

_____

List any surgeries you have had RELATED TO YOUR PAIN and when you had them.
Use additional paper if necessary.

Surgery	Date	Surgery	Date
1.		4.	
2.		5.	
3.		6.	

Do you have anything implanted in your body? YES / NO If yes, please, explain below.

Family History

Please list current/past major medical conditions for each family member

Family Member	Medical Condition(s)	In Good health (Yes/No)	Living/ Deceased
Father			
Mother			
Sibling			
Sibling			
Sibling			

Check all medications you have taken related to your chief complaint.

	Anti-Inflammatories
	Sleeping Aids
	Narcotic Pain Relievers

	Acetaminophen/Tylenol
	Anti-Anxiety Medication
	Antidepressants

	Muscle Relaxants
	Medicated Patches
	Neurontin/Gabapentin

Review of Systems

Check all symptoms below that apply to you.

	General
	Decreased Activity Level
	Fever
	Chills
	Fatigue
	Night Sweats
	Loss of Appetite
	Weight Loss
	Weight Gain

	Vision
	Blurred vision
	Double vision
	Vision loss

	Gastrointestinal
	Nausea
	Vomiting
	Diarrhea
	Constipation
	Loss of bowel control
	Abdominal Pain
	Stomach Ulcers
	Acid Reflux

	Neurological
	Paralysis
	Seizure
	Abnormal feeling in fingers/toes
	Loss of memory
	Confusion
	Headaches
	Impaired coordination

	Psychiatric
	Irritability
	Depression
	Disturbed Sleep
	Suicidal Thoughts
	Anxiety
	Nervousness

	Cardiac
	Chest pain
	Palpitations
	Light headedness/Fainting
	High Blood Pressure
	Swelling

	Joint/ Muscle
	Joint pain
	Joint weakness
	Joint swelling
	Joint stiffness
	Neck pain
	Back pain
	Muscle pain
	Muscle weakness

	Endocrine
	Skin Changes
	Nail Changes
	Diabetes
	Heat intolerance
	Cold intolerance

	Genito Urinary
	Frequent urination
	Urgency
	Trouble starting/stopping
	Burning with Urination
	Incontinence
	Decreased stream
	Sexual Dysfunction
	Hesitancy

	Pulmonary
	Coughing
	Wheezing
	Congestion
	Shortness of breath

	Skin
	Rash
	Itching
	Dryness
	Hives

	Hematologic
	History of anemia
	Abnormal bleeding
	Bruising

Please state how and when your pain began: _____

_____

_____

_____

_____

_____

_____

☐ **My Pain is not due to a specific event**

What treatment have you received related to your pain? Circle all that apply.

Medication | Physical Therapy | Osteopathic Treatment | Chiropractic care | Injections | Surgery | Other

Current or most recent occupation: _____

Marital Status: Single Married Divorced Separated Widowed

Number of Children: _____

Do you eat a well-balanced diet? Never / Rarely / Occasionally / Usually / Regularly

Do you exercise? Never / Rarely / Occasionally / Usually / Regularly

What kind of exercise do you do? _____

Do you drink alcohol? Never / Occasionally / Frequently (3+ times per week) / Daily

Do you drink caffeine? Never / Occasionally / Frequently (3+ times per week) / Daily

Do you smoke? Never / Occasionally / Frequently (3+ times per week) / Daily

If female: **Are you pregnant?** YES / NO **Are you nursing?** YES / NO

Do you drive? YES / NO

What are your goals of care? What activities do you want to...

...maintain and continue doing	...start doing
Showering / Bathing yourself	Showering / Bathing yourself
Getting Dressed	Getting Dressed
Cooking	Cooking
Laundry	Laundry
Pay Bills	Pay Bills
Yard Work	Yard Work
Childcare	Childcare
Vacuuming / Mopping	Vacuuming / Mopping
Doing Dishes	Doing Dishes
Shopping (Grocery & Other)	Shopping (Grocery & Other)

Select one statement in each category that best describes your situation.

	Pain Intensity
	Tolerates without pain killers
	No pain killers, but pain is bad
	Pain killers give complete relief
	Pain killers give moderate relief
	Pain killers give little relief
	Pain killers have no effect/do not use
	Personal Care
	Can look after self without extra pain
	Can look after self with extra pain
	Painful to look after self, must be slow and careful
	Needs some help, but can manage most care
	Needs help every day in most aspects of care
	Needs help in all aspects of personal care
	Lifting
	Lifts heavy weights with no pain
	Lifts heavy weights with pain
	Can lift heavy weights from a table
	Can lift light weights from a table
	Can only lift light weights
	Cannot lift or carry anything
	Walking
	Pain does not prevent walking any distance
	Cannot walk more than 1 mile
	Cannot walk more than ½ mile
	Cannot walk more than ¼ mile
	Can only walk with crutches
	Bedridden and must crawl to the toilet
	Sitting
	Can sit in any chair as long as desired
	Can only sit in favorite chair as long as desired
	Can sit no more than 1 hour
	Can sit no more than ½ hour
	Can sit no more than 10 minutes
	Cannot sit at all due to pain

	Standing
	Can stand an unlimited amount of time without pain
	Standing gives extra pain
	Cannot stand for more than 1 hour
	Cannot stand for more than ½ hour
	Cannot stand more than 10 minutes
	Cannot stand at all
	Sleeping
	Pain does not prevent sleep
	Can sleep well using tablets
	Can sleep no more than 6 hours even with tablets
	Can sleep no more than 4 hours even with tablets
	Can sleep no more than 2 hours even with tablets
	Cannot sleep at all due to pain
	Sex Life
	Normal and causes no extra pain
	Normal but causes extra pain
	Almost normal but causes severe pain
	Severely restricted by pain
	Nearly absent due to pain
	Pain prevents sexual relations
	Social Life
	Normal and causes no pain
	Normal but causes extra pain
	Limits energetic interests
	Pain limits most excursions
	Pain restricted social life to home
	Pain restricts all social life
	Traveling
	Can travel anywhere without pain
	Can travel anywhere but causes pain
	Can travel more than 2 hours with pain
	Pain restricts travel to less than 1 hour
	Pain restricts travel to less than 30 minutes
	Pain restricts travel except to doctor

Pregnancy Status

Date: _____

Patient Name: _____ DOB: ____ / ____ / ____

☐ Male (Please proceed to the end of the document to sign in the designated area)
☐ Female

1. Are you currently pregnant? ☐Yes ☐ No

2. Do you still experience a regular or irregular menstrual period? ☐Yes ☐ No

   a. If NO,
      - Age of menopause? _____

3. Do you still have reproductive organs? ☐Yes ☐ NO

   a. If NO,

      - NO - I have had a complete hysterectomy (uterus and both ovaries surgically removed)
        Date of complete hysterectomy? _____

      - NO - I have had a partial hysterectomy (one or both ovaries remaining)
        Date of partial hysterectomy? _____

Patient Signature : _____ Date : _____

Provider Signature : _____ Date : _____

Pregnancy Status

Risks of Opioid Use in Pregnancy-(For Female Use Only)

There are significant risks associated with opioid use during pregnancy. Studies have shown treatments with opioid analgesics during pregnancy are linked to the following health risks:

- Known risks to the fetus:
  - Spina Bifida (a type of neural tube defect)
  - Hydrocephaly (buildup of fluid in the brain)
  - Glaucoma (an eye defect)
  - Gastroschisis (a defect of the abdominal wall)
  - Congenital Heart Defects
    - Conoventricular Septal Defect
    - Hypoplastic Left Heart Syndrome
    - Atrial Septal Defect
    - Tetralogy of Fallot
    - Pulmonary Valve Stenosis
  - Incomplete Pulmonary System Development
  - Neonatal Abstinence Syndrome
  - Low Birth Weight
- Known risks to the woman:
  - Miscarriage
  - Preterm Labor and/or Delivery
  - Categorization of High Risk Pregnancy

Please Read and Initial the Statements Below:

_____ I have read and understand the risks associated with the use of opioids during pregnancy as listed above.

_____ I understand that while being prescribed opioid medication, it is my responsibility to ensure that I am taking reasonable measures to prevent pregnancy.

_____ I agree to notify my provider with any changes in my method of birth control.

_____ I will immediately notify my provider should I become pregnant while receiving treatment.

_____ I will notify my provider should I plan to become pregnant.

Patient Signature : _____ Date : _____

Provider Signature : _____ Date : _____

Sleep Apnea Questionnaire

Patient Name: _____ DOB: ___ / ___ / ___ ☐ Male ☐ Female

Age: _____ Height: _____ Weight: _____

STOP		
Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feed TIRED, fatigued, or sleepy during the daytime?	Yes	No
Has anyone ever OBSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood PRESSURE?	Yes	No

BANG		
BMI more than 35kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

- **For Clinical Use Only – DO NOT WRITE BELOW THIS LINE**

TOTAL SCORE		

High risk of OSA: Yes 5-8

Intermediate risk of OSA: Yes 3-4

Low risk of OSA: Yes 0-2