Foothills Pain Management Clinic

Dharmesh Mehta, MD
Diplomat, American Board of Pain Medicine
Diplomat, American Board of Anesthesiology

PATIENT NAME_____ D.O.B.____/____/____ AGE_____
(LAST) (FIRST) (INITIAL)

ADDRESS_____ CITY, STATE_____ ZIP_____

PHONE (___)_____CELL (___)_____ S.S.N._____

E:Mail Address: _____, **will be used for a Patient Portal coming SOON**

PLEASE CIRCLE: MALE FEMALE MARRIED SINGLE DIVORCED WIDOWED

D.L.#_____PRIMARY LANGUAGE_____INTERPRETER NEEDED? Y N

HOW WERE YOU REFERRED TO OUR OFFICE?_____

IS YOUR ILLNESS OR INJURY CAUSED FROM WORK? YES NO D.O.I.____/____/____

EMPLOYER_____ PHONE (___)_____

ADDRESS_____ CITY, STATE_____ZIP_____

INSURANCE/BILLING INFORMATION

RESPONSIBLE PARTY_____RELATIONSHIP_____D.O.B.___/___/___

EMPLOYER (IF DIFFERENT)_____ PHONE (___)_____

INSURANCE CO._____ PHONE (___)_____

ADDRESS_____CITY, STATE_____ZIP_____

INSURED I.D.#_____ POLICY/GROUP#_____

CLAIM #_____ ADJUSTER_____

EMERGENCY CONTACT:

NAME_____PHONE (___)_____CELL (___)_____Relation: _____

PATIENT RESPONSIBILITY

Due to stringent rules adopted by the Federal Government (HIPAA-Health Insurance Portability and Accountability Act) with regard to patient confidentiality, the responsibility of delivery of medical testing results and medical records will be the responsibility of the patient. Many facilities will no longer provide a copy of your medical testing or records via fax or mail without an authorization signed by the patient. Our office will make every attempt to obtain your medical records for your convenience. If we are unable to do so, it is the responsibility of the patient to assure that these records are received by Foothills Pain Management Clinic prior to the appointment.

I authorize Foothills Pain Management Clinic to obtain medical records, testing, x-rays or any pertinent information to assist in the evaluation and treatment of my medical condition. This authorization shall remain in effect for 1 (one) year unless revoked by me in writing.

_____ _____
PATIENT SIGNATURE DATE

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CANCELLATION/ NO SHOW/ MISSED APPOINTMENT POLICY

If you do not give the office 24 hours' notice that you will miss your appointment, a charge will be added to your account that must be paid before we can schedule another appointment for you. **Your insurance will NOT pay for this charge.**

$25.00 if you do not provide a 24 hour notice for your office visit.
$50.00 if you do not provide a 24 hour notice for any scheduled procedure/injection.
$50.00 returned check fee.

Reminder calls are a courtesy and cannot always be provided. It is your responsibility to report for your appointment on the scheduled date and time.

Your signature below conveys that you have read and understand our policy regarding missed appointments.

_____
Patient Name Printed

_____ _____
Patient Signature or Legally Authorized individual Signature Date

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Patient Name: _____ DOB: _____

In order to comply with the highest standards for your privacy and the confidentiality of your medical information, we ask you to please complete the following:

	May we contact you at this number? Regarding appointment information? (confirm, cancel, reschedule, etc,)		OK to leave a message	
( )_____ Home Phone	Yes	No	Yes	No
( )_____ Work Phone	Yes	No	Yes	No
( )_____ Cell Phone	Yes	No	Yes	No

Would you like us to TEXT your appointment Reminders? YES NO

_____ E-mail Address	Yes	No	Yes	No

Would you like Access to our Patient Portal so you can access your Medical Information On-Line: _____
Our Patient Portal will be coming July 2014.

Please also list any family members or friends that you would like us to release your Personal Health Information to. If none is listed we will only release your medical treatment plan to you.

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you currently have an ADVANCED HEALTH CARE DIRECTIVE FORM? YES NO

Are you interested in obtaining an Advanced Health Care Directive? YES NO

Do you have a Surrogate Decision Maker? YES NO

Who is your Surrogate Decision Maker? _____Phone: (____) _____

_____ Patient Name

_____ Patient Signature

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PAYMENT IS DUE WHEN SERVICES ARE RENDERED. We will bill most insurance companies for your as a courtesy, provided we have all the necessary information. It is your responsibility to verify with your insurance carrier as to whether you are covered for the medical services provided to, e.g. physician consults/follow-up, epidurals, facet blocks, pump refills or spinal cord stimulator. Any Deductible, co-payments, co-insurance or balances not paid by your insurance company are your financial responsibility and are DUE in full prior to services being rendered. This applies the all insurance including Medicare. **Patient Initials: _____**

CO-PAYMENT; DEDUCTIBLES AND CO-INSURANCE RESPONSIBILITY ARE DUE WHEN SERVICES ARE RENDERED. Insured patients are responsible for all charges not paid by the insurance company within 45 days after the date of service. Payment arrangements will only be made on an individual basis and **AT OUR DESCRESTION.** We do not guarantee a payment arrangement will be made, we reserve the right to withdraw the extension of credit at any time. **Patient Initials: _____**

CANCELLATION POLICY. Patients who fail to cancel an appointment within 24 hours of the appointment time will be charged a $25.00 No Show/Late Cancellation fee. $50.00 for all scheduled procedures. This fee Must be paid before you can get back on the schedule.
Patient Initials: _____

RETURNED CHECKS POLICY. There will be a $50.00 fee for all returned checks and Foothills Pain Management Clinic will require another form of payment for all future payments made during your course of treatment**.** **Patient Initials: _____**

MEDICARE-AUTHORIZATION & BENEFIT ASSIGNMENT

I request that payment of authorized Medicare benefits be made to Foothills Pain Management Clinic for any services furnished to me by this physician/supplier. I Authorize Foothills Pain Management Clinic to release any Personal Health Information to the Health Care Financing Administration and its agents to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorize release of Personal Health Information necessary to pay the claim. In Medicare assigned cases, the physician/supplier agrees to accept the charge determination of the Medicare carrier as partial payment of Medicare allowed rate, the balance of the bill will then be billed directly to the patient. **The patient is responsible for any remaining balance not paid by Medicare, deductible, coinsurance and non-covered services.** Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. **Patient Initials: _____**

INSURANCE AUTHORIZATION & BENEFIT ASSIGNMENT

I HEREBY AUTHORIZE Foothills Pain Management Clinic to furnish Personal Health Information to insurance carriers concerning my illness and treatment and I hereby assign to Foothills Pain Management Clinic all payment for medical services rendered to my dependents or myself. I understand I am responsible for patient deductibles, coinsurance and any amount not covered by my insurance. Laboratory, radiology and other ancillary services provided in connection with Foothills Pain Management Clinic will be billed separately. Copayments must be made at the time of service. There is a charge of $50.00 for any returned checks. I understand and agree to give at least 24 hour notice if I am unable to keep an appointment. Failure to do so will result in a "No Show" charge of $25.00 for a follow-up appointment and $50.00 for any scheduled procedure.
Patient Initials: _____

CONSENT TO TREATMENT

The undersigned consents to treatment made by Foothills Pain Management Clinic including but not limited to emergency treatment or services, laboratory procedures, x-ray examination, medical or surgical treatment and/or procedures rendered to the patient under the general and specific instructions of the patient's physician**.** **Patient Initials: _____**

RELAEASE OF MEDICAL RECORDS

I authorize the release of any medical or past medication records to Foothills Pain Management Clinic, Dr. Dharmesh Mehta that will assist in my treatment. ie: Medical Reports; Lab Results; Diagnostic Testing; Previous Medication History prescribed and dispensed. **Patient Initials: _____**

I have read this form in completions and fully understand my responsibility as a patient of Foothills Pain Management and agree to abide by the Office Policy of Foothills Pain Management Clinic during the course of my treatment.

_____ _____/_____/_____
Patient Name Patient Date of Birth

_____ _____/_____/_____
Patient Signature Date

Foothills Pain Management Clinic

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PATIENT/DOCTOR TREATMENT AND MEDICATION AGREEMENT
Informed Consent for OpioId Treatment for Non-Cancer/Cancer Pain

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician/healthcare provider comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

I have agreed to use opioids (morphine-like drugs) as part of my treatment for chronic pain. I understand that these drugs can be very useful, but have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. Because my physician/healthcare provider is prescribing such medication to help manage my pain, I agree to the following conditions:

1. **I am responsible for my pain medications.** I agree to take the medication only as prescribed.
   a. I understand that increasing my dose without the close supervision of my physician could lead to drug overdose causing severe sedation and respiratory depression and death.
   b. I understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal. **Withdrawal symptoms** can include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh", abdominal cramps and diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks.

2. **I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician at the Pain Center. Please Initial** _____

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

4. I understand that the opioid medication is strictly for my own use. The opioid should **never** be given or sold to others because it may endanger that person's health and is **against the law.**

5. I should inform my physician of all medications I am taking, including herbal remedies. Medications like Valium or Ativan; sedatives such as Soma, Xanax, Fiorinal; antihistamines like Benadryl; herbal remedies, alcohol, and cough syrup containing alcohol, codeine, or hydrocodone can interact with opioids and produce serious side effects.

6. During the time that my dose is being adjusted, I will be expected to return to the clinic as instructed by my clinic physician. After I have been placed on a stable dose, I may receive opioids from my primary care physician and will return to the pain clinic for a medical evaluation at least once every six months.

7. I understand that opioid prescriptions **will not be mailed or called into the Pharmacy, they are given at my scheduled appointment ONLY**. If I am unable to obtain my prescriptions monthly, I will be responsible for finding a local physician who can take over the writing of my prescriptions with consultations from my pain physician. **Please Initial:** _____

8. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which include emergency rooms), uncontrolled dose escalations or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.

9. I will communicate fully with my physician to the best of my ability at the initial and all follow-up visits my pain level and functional activity along with any side effects of the medications. This information allows my physician to adjust my treatment plan accordingly.

10. You should not use any illicit substances, such as cocaine, marijuana, etc. while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship.

11. The use of alcohol together with opioid medications is contraindicated.

12. I am responsible for my opioid prescriptions. I understand that:

a. Refill prescriptions can be written for a maximum of one month supply and will be filled at the **same pharmacy.**

Pharmacy:_____Phone Number:_____ City: _____

b. **It is my responsibility to schedule appointments for the next opioid refill before I leave the clinic or within 3 days of the last clinic visit. Refills will not be approved over the phone, you MUST keep your appointment.**
c. I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. ***If my medication is los, or stolen, I will report this to my local police department and obtain a stolen item report.*** I will then report the stolen medication to my physician. I understand I will not be given another prescription without a police report. If my medications are lost, misplaced or stolen my physician may choose not to replace the medications or to taper and discontinue the medications.
d. Refills will not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow".
e. Refills can only be filled by a pharmacy in the state of California, even if I am a resident of another state.
f. *Prescriptions for pain medicine or any other prescriptions will be done only during an office visit during regular office hours. **NO** refills of any medications will be done during the evening or on weekends.*
g. **You must bring back all opioid medications and adjunctive medications prescribed by your physician in the original containers/bottles at every visit.**
h. Prescriptions will not be written in advance due to vacations, meetings, or other commitments.
i. If an appointment for a prescription refill is *missed*, another appointment will be made as soon as possible. *Immediate or emergency* appointments will not be granted.
j. No "walk-in" appointments for opioid refills will be granted.

13. While physical dependence is to be expected after long-term use of opioids, **signs of addiction, abuse, or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the opioids.**

a. **Physical dependence** is common to many drugs such as blood pressure medications, anti-seizure medications, and opioids. It results in biochemical changes such as abruptly stopping these drugs will cause a withdrawal response. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

b. **Addiction** is primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life. If the patient exhibits such behavior, the drug will be tapered and such a patient is not a candidate for opioid trial. He/she will be referred to an addiction medicine specialist.

c. **Tolerance** means a state of adaption in which exposure to the drug induces changes that result in a lessoning of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a *realistic* decrease of the patient's pain.

14. If it appears to the physician/healthcare provider that there is no improvement in my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the physician.

15. If I have a history of alcohol or drug misuse/addiction, I must notify the physician of such history since the treatment with opioids for pain **may** increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery **is a necessity.**

16. I will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, and sometimes two to three days extra **if** the prescription ends on a weekend or holiday. This extra medication is **not** to be used without explicit permission of the prescribing physician unless an emergency requires your appointment to be deferred one or two days.

17. I agree and understand that my physician reserves the right to perform random or unannounced urine drug testing. If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor may change my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the doctor/patient relationship. The presence of a non-prescribed drug (s) or illicit drug (s) in the urine can be grounds for termination of the doctor/patient relationship. Urine drug testing is not forensic testing, but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

18. I agree to allow my physician/healthcare provider to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions *if the physician feels it is necessary.*

19. I agree to a family conference with a close friend or significant other *if the physician feels it is necessary.*

20. I understand that non-compliance with the above conditions may result in a re-evaluation of my treatment plan and discontinuation of opioid therapy. I may be gradually taken off these medications, or even discharged from the clinic.

I _____ have read the above information or it has been read to me and all of my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy & acknowledge receipt of this document.

Patient's Signature_____ Date_____

Witness's Signature_____ Date_____

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Acknowledgement of Receipt of Notice of Privacy Practices (NPP)

In compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Foothills Pain Management Clinic, PC is required to provide the patient the Notice of Privacy Practices. The notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

En conformidad con el acto de la Portabilidad y de la Responsabilidad del seguro medico de 1996 (HIPPA), Foothills Pain Management Clinic, PC es requerido que laproporcione al paciente el Aviso de la salud sobre usted puede ser utilizada y ser divulgada, y com ousted puede tener el acceso a esta informacion. Por favor lea esta information cuidadosmente.

I hereby acknowledge that I have received a copy of Foothills Pain Management Clinic's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. In addition, a Notice of Privacy Practices is posted in the patient waiting area.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

_____ _____
Signature Date

_____
Print Name

If not signed by patient, please indicate relationship:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this receipt of Notice of Privacy Practices form but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____

Foothills Pain Management Clinic

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Patient Name/Nombre: _____**Patient DOB**/Fecha de Nac: ____/____/____ **Gender**/Género: Male Female

Weight/Peso: _____**Height**/Altura: _____**Ethnicity**/Raza: _____**Language Preference**/Preferencia de idioma: _____

Describe why you are being seen by Dr. Mehta/ Explicar por qué están siendo vistos por el Dr. Mehta:

_____

Who do you live with at home?/ ¿Con quién vives en casa con? ( ) live alone/solo _____
Living Arrangement/Arreglo de vivienda: House/Casa Apartment/apartamento Care Facility/Instalacion de Atencion Other/Otro: _____
Are you/ ¿Está: Married/Casado Single/Soltero Divorced/Divorciado Widowed/Viudo
Number of Children/ Número de niños: _____ **Highest level of Education**/Nivel mas alto de education: _____

Alcohol Use/Alcohol: Daily/Diario Weekly/Semanal Socially/Socialmente NEVER/Nunca
Number of Years Drinking Alcohol/Numero de anos que bebe:_____

Tobacco Use/Tabaco: Daily/Diario Weekly/Semanal Socially/Socialmente NEVER/Nunca
Number of Years Smoking/Numero de Anos de fumar: _____/Pack/day(Paquete/dia) _____
If you are a CURRENT Smoker, Have your Tried to QUIT in the past 3 Years? YES NO
Why were you unsuccessful in Stopping? _____

Illegal Drug Use/Ilicito de dogas: Daily/Diario Weekly/Semanal Socially/Socialmente NEVER/Nunca
Number of Years using Illegal Drugs/Numero de usar drogas ilegales: _____

List doctors you have previously seen/ Los médicos que ya ha visto Lista . INCLUDING REFERRING DOCTOR/Referirse a medico:

Name of Doctor/Nombre el Medico	Specialty/ Especialidad	Phone Number/Numero de Telefono	City/Ciudad

When did the pain start?/¿Cuándo fue la fecha de inicio?_____( ) Unknown
What made the pain start?/Lo que hizo que comenzo el dolor?_____ ( ) Unknown
What makes the pain **worse**?/ ¿Qué hace que el dolor empeore?_____( ) Unknown
What makes the pain **better**?/ ¿Qué hace que el dolor se alivie?_____ ( ) Unknown
What is your pain Level on a scale 1-10? Please Mark your pain level on the Pain Intesnity Scale Below: _____

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 1 2 3 4 5 6 7 8 9 10

Please Make your Pain 0=NO PAIN 5= Moderate Pain 10= Worst Possible Pain

¿Qué tan malo es su dolor en una escala de 1-10 (Uno de ellos es el menor y 10 el peor) _____
Level of Pain/Nivel de dolor: Mild/Leve Moderate/Moderada Severe/Severo
How often Are you in Pain?/¿Con qué frecuencia siente dolor: _____
Out of a 24 hour day How Many Hours does your pain Last? _____
Is the pain: **CONSTANT COMES AND GOES ONLY IN MORNING ONLY IN AFTERNOON ONLY AT NIGHT**

Are you able to?/¿Es usted capaz?( ) Walk/Caminar ( ) Stand/Parada ( ) Daily Activities/Actividades Diarias ( ) Drive/Conducir
( ) Work/Trabajo ( )Sleep/Dormir ( ) Sex/Sexo ( ) Sit/Sentar ( ) Laying Down/Acostado ( ) Movement/Movimiento

Is this Work Related/¿Es esto relacionado de trabajo?: YES/Si NO Last Date Worked/Última fecha de trabajo: ___/___/_____
What type of work do you do?/ ¿Qué tipo de trabajo hace usted?**:** _____
Are you on Disability/¿Está usted en la discapacidad?: YES/Si NO Who put you on Disability?/¿Quién te puso en la discapacidad? _____
Is/Was there a lawsuit regarding this injury?/¿Es/fue alli una demanda por esta lesion?: YES/Si NO
Attorney Name/Nombre del abogado: _____ Phone/Teléfono: (_____) _____-_____

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Use any of the following WORDS to describe your Pain:

Tender/Tierno	Swollen/Hinchado	Weakness/Debilidad
Paralyzed/Paralizado	Dulling/Embotamiento	Throbbing/Palpitante
Spasm/Espasmo	Straining/Esfuerzo	Nauseous/náusea
Burning/Ardor	Numbness/ entumecimiento	Tingling/Hormigueo
Stabbing/ puñalada	Cramp/Calambre	Sore/Adolorido
Sharp/Agudo	Constant Shooting/Tiro Constante	Crushing/Apalstante
Pressure/presión	Muscle Spasms/Espasmos musculares	Freezing/congelación
Unbearable/inaguantable	Stiffness/Rigidez	Excruciating/agudísimo
Ache/Dolor/Tightness/opresión	Crushing/Aplastante	Electric Shock/Descarga eléctrica

Indicate where the pain is and what the pain feels like/Indique donde esta el dolor y lo que se siente el dolor:

	Describe the Pain/Describa el dolor	When did pain start	Pain Level from 1-10
Headaches/dolor de cabeza			
Migraines			
Occipital Neuralgia			
Shoulders/Hombro: RIGHT LEFT			
Arm/Brazo: RIGHT LEFT			
Elbow/Codo: RIGHT LEFT			
Wrist/Muñeca: RIGHT LEFT			
Hand/Mano: RIGHT LEFT			
Neck/Cuello:			
Mid-Back/Media de la Espalda:			
Pelvic/Pelvico:			
Low Back/Parte Baja de la Espalda:			
Buttocks/Asentaderas			
Hip/Cadera: RIGHT LEFT			
Leg/Pie: RIGHT LEFT			
Knee/Rodilla: RIGHT LEFT			
Ankle/Tobillo: RIGHT LEFT			
Foot/Pie: RIGHT LEFT			
Toes/Dedos de los pies: RIGHT LEFT			

Please mark any of the following treatments that you may have had in the past, and tell is who performed them; when and the outcome:

Treatment Done/Trato Hecho	Who/Quién/Where/Donde	When/Cuando	What was the outcome/cuál fue el resultado
Physical Therapy/Terepia Fisica			
Pool Therapy/Piscina Terapeutica			
Biofeedback			
Tens Unit/ Decenas Unidad			
Acupuncture/Acupuntura			
Trigger Point/En Los Puntos Gatillo			
Epidural Steroid/Epidural de esteroides			
Surgery/Cirugia			
Detox/Rehabilitation:			
Hospitalized for Pain/Hospitalizado por dolor			
Other Specialist/Otro Especialista:			
Chiropractic Manipulation			
Psychological Counseling For Pain			
X-Rays/Rayos X:			

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MRI:			
CT Scan:			

Please MARK any medical problems that you have experienced since the onset of your PAIN to current.

Medical Problem/Problemas Medicos	X	When/Cuando	Treating Physician/ Tratamiento Medico	Family History/ Historia Familiar	Family Member/ Miembro de la Familia
AIDS/SIDA					
Alcoholism/alcoholism					
Anesthesia Reaction/anesthesia reaccion					
Aneurysm/Aneurisma					
Anxiety/Ansiedad					
Arthritis/Artritis/ Rheumatoid/Reumatoide					
Asthma/Asma					
Bleeding Disorder/Desangramiento					
Bloody Stool/Sangre en las Heces					
Breast Cancer/Cancer de Mama					
Broken Bone/Fractura de Huesos:					
Carpal Tunnel Syndrome					
Cancer/Cancer:					
Cardiovascular Problems/Problemas de Cora					
Cellulites/Celulitis					
Cervical (Neck)Pain:					
Change in: Bladder/Cambio en: Vejiga					
Change in: Bowel/Cambio en: Heces					
Constipation/Estrenimiento					
Crohn's Disease/Enfermedad Corona					
Cyst:Quiste					
Degenerative Joint/Articular Degenerativa					
Depression/Depresion					
Diabetes/Diabetico					
Difficulty Sleeping/Dificil Dormir					
Dizziness/Mareo					
Fatigue/Fatiga					
GERD/ERGE					
Glaucoma					
Feeling Hopeless/Sentimientos de Desespera					
Feeling Worthless/Sentirse sin Valor					
Headaches/Dolores de Cabeza					
Heart Attack/Ataque del Corazon					
Hepatitis A					
Hepatitis B					
Hepatitis C					
High Blood Pressure/Presion Arterial Alta					
Hypoglycemia/La Hipoglucemia					
Hypothyroid/Hipotiroidismo					
Insomnia/ Insomnio					
Irregular Heartbeats/irregular palpitacion del					
Kidney Problems/Problemas Renales					
Leukemia/Leucemia					
Liver Problems/Problemas Hepaticos					
Low Back Pain/Dolor de Espalda					

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Loss of Interest/Perdida de interes:					

Please indicate any medical problems that you have experienced since the onset of your PAIN to current.

Medical Problem/Problemas Medicos	X	When/Cuando	Treating Physician/ Tratamiento Medico	Family History/ Historia Familiar	Family Member/ Miembro de la Familia
Menopause/Menopausia					
Migraine/Migraña					
Multiple Sclerosis/Esclerosis Multiple					
Muscular Dystrophy/Distrofia Muscular					
Night Sweats/Sudores Nocturnos					
Numbness/Entumecimiento					
Obesity/Obesidad					
Panic Attack:					
Preadolescent Sexual Abuse					
Reiter's Syndrome					
Restless Leg Syndrome/Síndrome de las pie					
Schizophrenia/Esquizofrenia					
Sciatica/Ciática					
Seizures/Incautación					
Sleep Apnea/Apnea del sueño					
Stroke/Embolia					
Swelling/Hinchazón					
Substance Abuse:					
Tendonitis/Tendinitis					
Trigeminal Neuralgia					
Tuberculosis					
Tumor:					
Ulcers/úlceras					
Unexplained Crying/llanto inexplicable					
Urinary Incontinence/Incontinencia Urinaria					
Weakness/Debilidad					
Weight Gain/Ganancia de peso					
Weight Loss/la pérdida de peso					
Other/Otro:					

List ALL CURRENT & PAST medications/ Los medicamentos Actuales y Pasados

Name of Medication/Nombre Del Medicinas	Dose/Dosis	Frequency/Frecuencia	Prescribing Doctor/ prescripción médica

ARE YOU TAKING ANY BLOOD THINNING MEDICATION: YES NO : _____

Example: Plavix, Coumadin, Pradaxa etc: What Dr Prescribes it: _____ Why: _____

Allergies/Alergias: ( ) None/Ninguno ( ) Latex/ Látex ( ) IV Dye/Contrast ( ) Penicillin/Penincilina

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Diplomat, American Board of Pain Medicine
Diplomat, American Board of Anesthesiology

( ) Morphine/Morfina ( ) Codiene/Codeina ( ) **Other**/Otro: _____

Allergic Reaction/ Reacción de Alergias:_____

Brief Pain Inventory

Patient Name: _____ DOB: _____

Brief Description of what YOU hope to get out of today's Visit (In your own words): _____

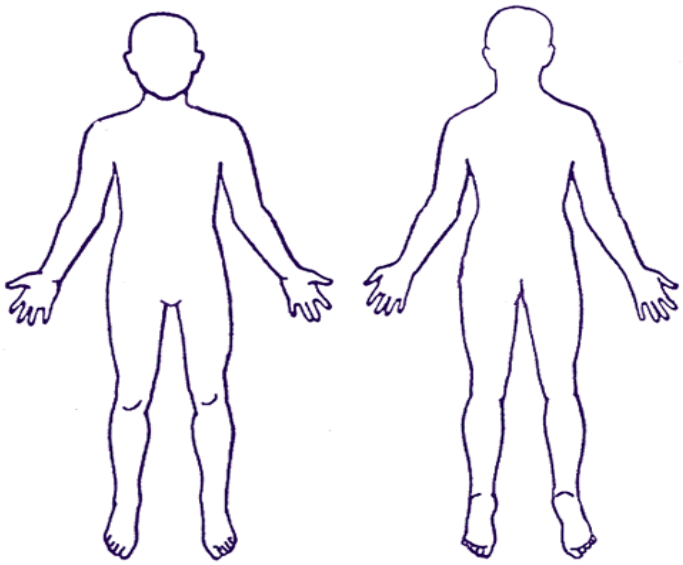
_____

Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches.) Have you had PAIN other than these everyday kinds of pain today?

1. YES 2. NO

On the below Diagram, shade in the areas where you feel pain. Put an X on the area that hurts MOST.

Right Front Left Left Back Right



Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| **Please Make your Pain 0=NO PAIN 5= Moderate Pain 10= Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| **Please Make your Pain 0=NO PAIN 5= Moderate Pain 10= Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

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|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| **Please Make your Pain 0=NO PAIN 5= Moderate Pain 10= Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| **Please Make your Pain 0=NO PAIN 5= Moderate Pain 10= Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

What treatment or medications are you receiving for your pain? _____

_____

In the past 24 hours, how much relief have pain treatments or medication provided? Please circle the one percentage that most shows how much RELIEF you have received.

_____

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Circle the once number that describes how, during the past 24 hours, pain has interfered with your:

A. GENERAL ACTIVITY:

_____

0 1 2 3 4 5 6 7 8 9 10

Does Not Interfere — Completely Interferes

B. MOOD:

_____

0 1 2 3 4 5 6 7 8 9 10

Does Not Interfere — Completely Interferes

C. WALKING ABILITY:

_____

0 1 2 3 4 5 6 7 8 9 10

Does Not Interfere — Completely Interferes

D. NORMAL WORK (includes both outside the home and housework):

_____

0 1 2 3 4 5 6 7 8 9 10

Does Not Interfere — Completely Interferes

E. RELATIONS WITH OTHER PEOPLE:

_____

0 1 2 3 4 5 6 7 8 9 10

Does Not Interfere — Completely Interferes

F. SLEEP:

_____

0 1 2 3 4 5 6 7 8 9 10

Does Not Interfere — Completely Interferes

G. ENJOYMENT OF LIFE:

_____

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0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere — Completely Interferes

REFILL REQUESTS will NOT be Approved without an appointment.

ALL Refills/Prescriptions will ONLY be given during an **OFFICE VISIT**

NO EARLY REFILLS will be **APPROVED**

ORIGINAL PRESCRIPTION BOTTLES MUST be brought to EVERY appointment or a Refill will NOT be Given.

PRIOR AUTHORIZATIONS will **NOT** be done in the **OFFICE** YOU MUST choose a PHARMACY that will process the Authorization. If you choose a pharmacy that will NOT process the Authorization YOU will need to PAY out of your pocket.
The following are pharmacies that have agreed to Process Authorizations:

California Specialty Pharmacy- 562-698-6305- They Deliver
Express Pharmacy- 909-398-1289
Maxson Medical Pharmacy- 626-338-1143

NO EXCEPTIONS

_____ Date: _____/_____/_____
Patient Name

_____ Date: _____/_____/_____
Patient Signature