Summit Pain Alliance

Date of Visit: _____/_____/_____

INITIAL PAIN ASSESSMENT

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

Primary Care Physician: _____ Referring Physician: _____

Marital Status: Single Married Divorced Widowed # of Children: _____

Currently Working: Yes No Occupation: _____ Last day of work: _____

Height: _____ Weight: _____ Date Pain Began: _____ Average Pain Score (0-10): _____

Location of Pain: Upper Back Lower Back Head Neck Arms Hands Feet Other_____

Pain Radiates To: Left Arm Right Arm Left Leg Right Leg Other_____

Pain Quality: Constant Intermittent Sharp Dull Burning Throbbing Shooting Tingling Other_____

What makes the pain worse?

_____

What makes the pain better?

_____

Numbness: Yes No Where:_____ **Weakness:** Yes No Where:_____

What imaging studies have you had?

MRI Date: _____ Where: _____

CT Scan Date: _____ Where: _____

EMG/NCS Date: _____ Where: _____

History of Treatment (list the dates next to each):

Acupuncture_____ Aquatic Therapy_____ Biofeedback_____ Chiropractic_____

Back Brace_____ Physical Therapy_____ Occupational Therapy_____ Massage Therapy_____

Medical History:

High Blood Pressure	High Cholesterol	Heart Attack	Heart Failure	Cancer
Recent Cough/Cold	Asthma	Bronchitis	Liver Problems	Hepatitis
Kidney Problems	Diabetes	Thyroid Problems	Seizure	Stroke
Prolong Bleeding	Other_____			

Drug and/or Food Allergies: _____

Smoke History: Yes No How many packs per day: ____ How many years: ____ Date when quit: _____

Alcohol History: None Socially Excessive # of drinks per week: ____

Substance Abuse: Yes No What Type: _____ Date when quit: _____

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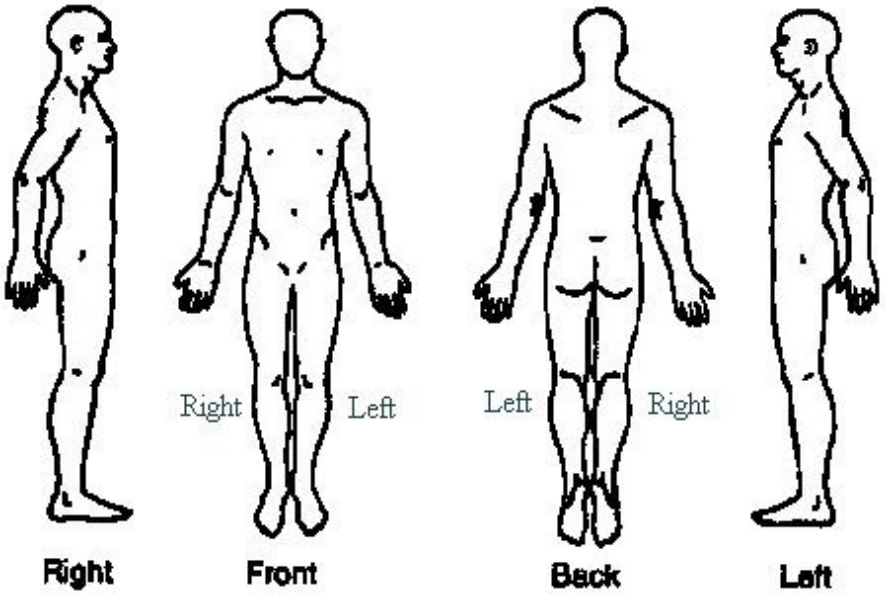
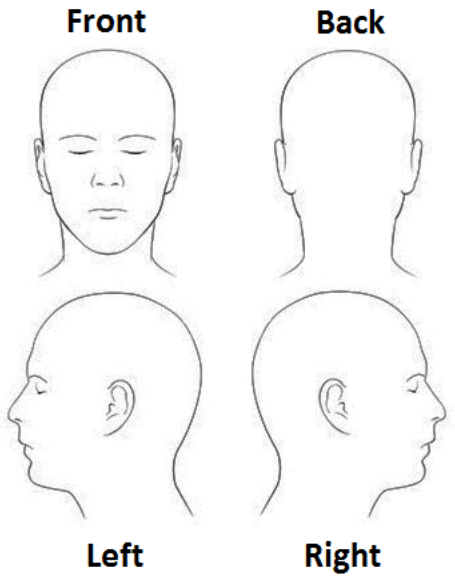
Location of Pain(s): (shade or drawn in where your pain is located on the figures)





Current Medications:

Name of Medication	Dose	Frequency

Surgery, Nerve Blocks, Trigger Point or Epidural Injections

Surgery / Procedure	Date

Patient Signature: _____ **Date:** _____

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REVIEW OF SYMPTOMS

Fevers	Yes	No	Nausea	Yes	No
Chills	Yes	No	Vomiting	Yes	No
Recent Weight Gain	Yes	No	Diarrhea	Yes	No
Recent Weight Loss	Yes	No	constipation	Yes	No
			Heartburn	Yes	No
Visual Disturbances	Yes	No	Liver Disease / Hepatitis	Yes	No
Hearing Loss	Yes	No	Signs of GI Bleeding	Yes	No
Glaucoma	Yes	No			
Cataracts	Yes	No	Hematuria	Yes	No
			Dysuria	Yes	No
Heat Intolerance	Yes	No	Recent Urinary Tract Infection	Yes	No
Cold Intolerance	Yes	No		Yes	No
Diabetes	Yes	No	Back Pain	Yes	No
Thyroid Dysfunction	Yes	No	Neck Pain	Yes	No
			Arthritis	Yes	No
Asthma	Yes	No	Osteoporosis	Yes	No
Cough	Yes	No			
Wheezed	Yes	No	Dizziness	Yes	No
Emphysema	Yes	No	Headaches	Yes	No
Shortness of Breath	Yes	No	Fainting	Yes	No
History of Tuberculosis	Yes	No	Numbness	Yes	No
			Paralysis	Yes	No
High Blood Pressure	Yes	No	History of Stroke	Yes	No
High Cholesterol	Yes	No	Vertigo	Yes	No
Bleeding Disorders	Yes	No			
Chest Pain	Yes	No	Anxiety	Yes	No
Coronary Artery Disease	Yes	No	Depression	Yes	No
Heart Murmurs	Yes	No	Mood Disorders	Yes	No
Palpitations	Yes	No			
History of Heart Attack	Yes	No	Cancer	Yes	No

If you answered “yes” to any of the questions, please provide a brief description & when it occurred:

_____

_____

_____

_____

Date of Visit: _____/_____/_____

PAIN CENTER PRESCRIPTION AGREEMENT

I, _____ understand that in order to receive any prescription medications for the treatment of pain from the pain center physicians, I must comply with the following rules and expectations of the pain center:

1. **All** medications prescribed by a physician at the pain center will be used only as ordered and for the reason ordered. Stopping a medication suddenly, using a medication for a reason other than that for which it was prescribed, or increasing a medication without medical advice is not acceptable behavior and can also be dangerous. **Any prescription changes must be addressed at the time of your appointment.** Early refills will generally not be given.
2. Triplicate medications will be refilled **ONLY** at the scheduled pain center appointments. I am expected to make and keep all the appointments. Prescriptions will **NOT** be mailed or called to the pharmacy.
3. I will not request or receive pain medications nor controlled substances from any physician who is not from the pain center (or their designee).
4. I will not use illegal drugs or medications - if I am on medical marijuana I must provide a copy for my chart, with the understanding that no opioids will be prescribed from the pain center.
5. I will comply with a random blood, urine or oral swab test when requested. I may be asked to provide a blood, urine or oral swab test during my initial consultation.
6. Out of town refills will not be processed, if leaving town for emergencies, please make arrangements before leaving, and itineraries may be requested.
7. It is my responsibility to protect my prescriptions from loss, selling, theft, or damage. A police report will be required if medications are stolen. Any stolen or lost medications may not be replaced. If a second loss, theft, or damage of medications should occur, you may be dismissed from the practice.
8. I will fill all prescriptions under one pharmacy.
9. I understand that I am not to drive while under the influence of medications (i.e. narcotics/opiates), nor should I operate heavy machinery nor serve in any capacity related to public safety.
10. I am aware that the risks of opiates/benzodiazepines/muscle relaxants may include: addiction, sedation, physical dependence, nausea/vomiting, drowsiness, hypogonadism, tolerance, depression, decrease bone density, slowed reflexes and response time, and constipation.
11. Violation of any points in this agreement may result in dismissal from the practice at the discretion of the physician.

_____ _____

Patient Signature Date