# NEW PATIENT INFORMATION
# JEFFERSON PAIN & REHAB CENTER

| PATIENT'S NAME (PLEASE PRINT) GOES BY | SS #. | MARTIAL STATUS S M W D SEP | SEX M F | BIRTH DATE | AGE | RELIGION |
|---|---|---|---|---|---|---|
| | | | | | | |

| STREET ADDRESS PERMANENT TEMPORARY | CITY AND STATE | ZIP CODE | HOME PHONE # |
|---|---|---|---|
| | | | |

| PATIENT'S OR PARENTS EMPLOYER | OCCUPATION (INDICATE IF STUDENT) | HOW LONG EMPLOYED | Bus. Phone # ext# |
|---|---|---|---|
| | | | |

| EMPLOYER'S STREET ADDRESS | CITY AND STATE | ZIP CODE |
|---|---|---|
| | | |

| DRUG ALLERGIES, IF ANY | EMERGENCY CONTACT/PHONE NUMBER |
|---|---|
| | |

| INSUREDS NAME | SS # | NUMBER OF CHILDREN AND AGES |
|---|---|---|
| | | |

| INSURED ADDRESS | OCCUPATION (INDICATE IF STUDENT) | HOW LONG EMPLOYED | BUS PHONE # |
|---|---|---|---|
| | | | |

| EMPLOYER'S STREEET ADDRESS | CITY AND STATE | ZIP CODE |
|---|---|---|
| | | |

| SPOUSE'S STREET ADDRESS, IF DIVORCED OR SEPARATED | CITY AND STATE | ZIP CODE | HOME PHONE # |
|---|---|---|---|
| | | | |

| PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE | STREET ADDRESS, CITY, STATE | ZIP CODE | HOME PHONE # |
|---|---|---|---|
| | | | |

| BLUE SHIELD (GIVE NAME OF POLICYHOLDER) [ ] | EFFECTIVE DATE | CERTIFICATE # | GROUP # | COVERAGE CODE |
|---|---|---|---|---|
| | | | | |

| OTHER (WRITE NAME OF INSURANCE COMPANY) ☐ | ADDRESS | POLICY # |
|---|---|---|
| | | |

| OTHER (WRITE NAME OF INSURANCE COMPANY) [ ] | ADDRESS | POLICY # |
|---|---|---|
| | | |

| MEDICARE (PLEASE GIVE NUMBER) [ ] | RAILROAD RETIREMENT (PLEASE GIVE NUMBER) |
|---|---|
| | |

| MEDICAID [ ] | EFFECTIVE DATE | PROGRAM # | COUNTY # | CASE # | ACCOUNT # |
|---|---|---|---|---|---|
| | | | | | |

| INDUSTRIAL [ ] | WERE YOU INJURED ON THE JOB? [ ] YES [ ] NO | DATE OF INJURY | INDUSTRIAL CLAIM # |
|---|---|---|---|
| | | | |

| ACCIDENT ☐ | WAS AN AUTOMOBILE INVOLVED? ☐ YES ☐ NO | DATE OF ACCIDENT |
|---|---|---|
| | | |

| WERE X-RAYS TAKEN OF THIS INJURY OR PROBLEM? [ ] YES [ ] NO | IF YES, WEHRE WERE X-RAYS TAKEN? (HOSPITAL, ETC) | DATE X-RAY TAKEN |
|---|---|---|
| | | |

| ATTORNEYS NAME, ADDRESS AND PHONE # |
|---|
| |

| REFERRED BY | STREET ADDRESS, CITY, STATE | ZIP CODE | PHONE # |
|---|---|---|---|
| | | | |

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR BILLING DEPARTMENT.

## INSURANCE AUTHORIZATION AND ASSIGNMENT

**Name of Policyholder**____ **HIC Number** ____

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to **Jefferson Pain & Rehab Center** for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/Other Insurance Company assigned cases, the physician or supplier agree to accept the charge determination of the Medicare/Other Insurance company as the full charge, and the patient is responsible only for deductible, coinsurance, and noncovered services. Coninsurance and the deductible are based upon the charge determination of the Meicare/Other Insurance company.

Signature ____ Date ____

# PATIENT HISTORY

PLEASE BE SURE TO COMPLETE EVERY BLANK ON THIS FORM.

Name: _____ Soc. Sec. #_____
Height:_____ Weight:_____ Age:_____
Occupation:_____ Birthdate:_____
Primary Care/Family Physician:_____
Physician's address and telephone number:_____
Emergency Contact:_____
Current Symptoms (why you are here):_____
Place of Injury (home, work, car, etc):_____
Physician that referred you here:_____
Physician's address and telephone number:_____
Previous treatment for present problem? ☐ Yes ☐ No X-rays taken? ☐ Yes ☐ No
If yes, explain: _____

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| **MEDICAL** | **YES** | **NO** | | **YES** | **NO** |
|---|---|---|---|---|---|
| Respiratory Disease | ☐ | ☐ | Thyroid Disease | ☐ | ☐ |
| Neurological Disorder (seizures, epilepsy, etc) | ☐ | ☐ | Cancer | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | Blood transfusion (year_____) | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | HIV Positive | ☐ | ☐ |
| Stroke | ☐ | ☐ | Kidney Disease | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Gastro-intestinal Disease (Ulcers) | ☐ | ☐ |
| Drink (amount_____) | ☐ | ☐ | Smoke (amount_____) | ☐ | ☐ |
| Liver Disease | ☐ | ☐ | Steroids | ☐ | ☐ |
| Hepatitis | ☐ | ☐ | Dizziness/vertigo | ☐ | ☐ |
| Recent Weight Loss/Gain | ☐ | ☐ | Frequent headaches | ☐ | ☐ |
| Low Blood pressure | ☐ | ☐ | Heart pacemaker | ☐ | ☐ |
| Fainting spells | ☐ | ☐ | Ear, nose, throat problems | ☐ | ☐ |
| Eye problems | ☐ | ☐ | Skin disorders | ☐ | ☐ |
| Back injuries/pain | ☐ | ☐ | | | |

Allergies: _____
Other conditions (not listed above): _____

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Medication current taking: _____

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Are you allergic to any medications?:_____
Previous surgeries:_____
Family history (specifically to ANY addictions or psychiatric history): _____

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Social history (Please provide name and contact information of your significant other/friend/family when it is necessary to discuss your treatment/care):

I certify that all information listed above on this sheet is to the best of my knowledge true and correct.

Patient's Signature:_____

Physician's Signature:_____

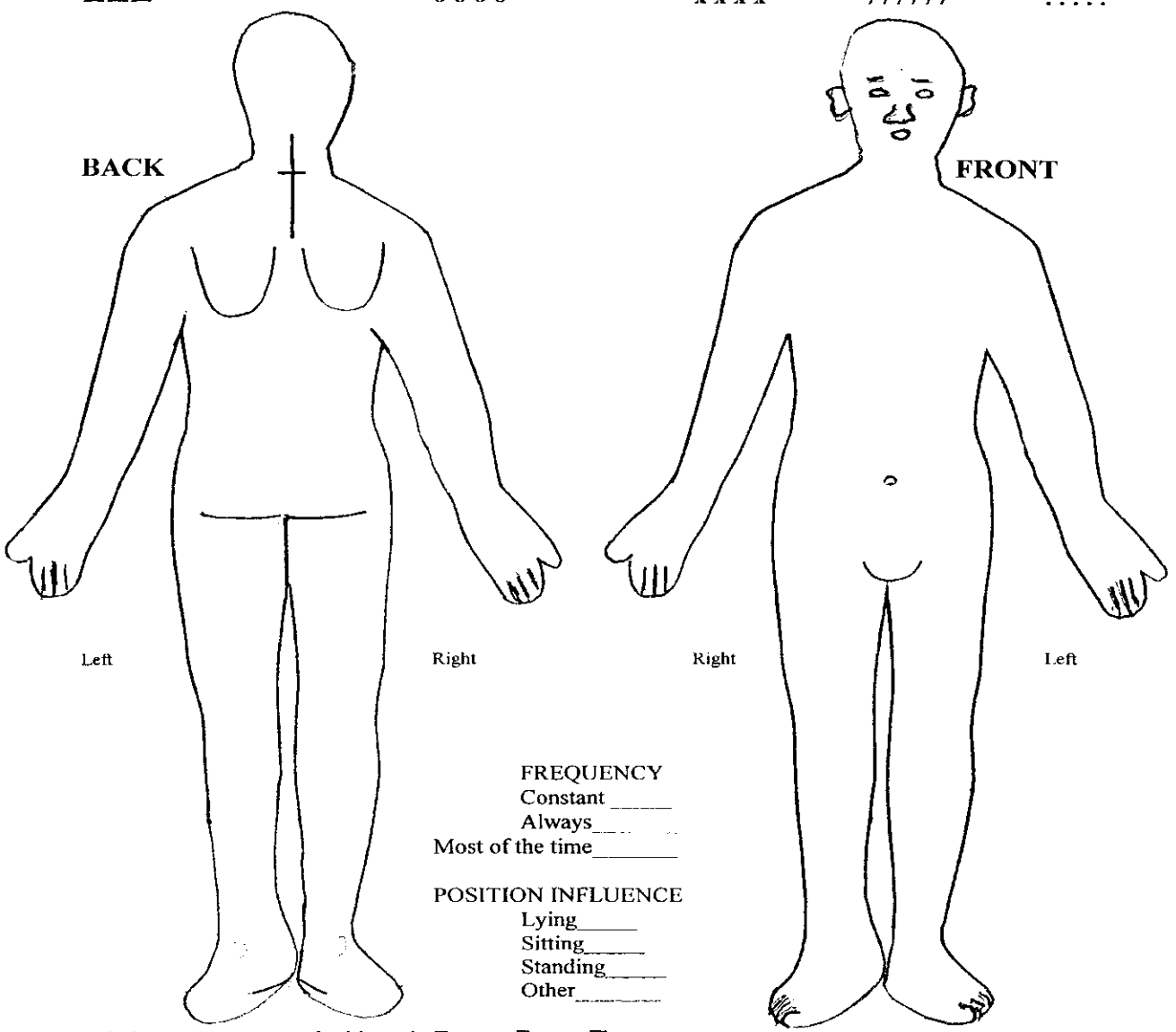
## PAIN STATUS INVENTORIES

Last Name First Name / / Date

PAIN DRAWING

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in your face.

| Aching | Numbness | Pins & needles | Burning | Stabbing | Other |
|---|---|---|---|---|---|
| ▲▲▲ | = = = = = | o o o o | x x x x | / / / / / / | . . . . . |




FREQUENCY
Constant _____
Always_____
Most of the time_____

POSITION INFLUENCE
Lying_____
Sitting_____
Standing_____
Other_____

Pain in arm(s) compared with neck ☐ worse ☐ same ☐ less
Pain in leg(s) compared with back ☐ worse ☐ same ☐ less

Intermittent percent of the time present _____ % (If less than 50% of the time fill in below).

# ORTHO-PHYS MED-CHIRO-NEURO

**ALL PATIENTS MUST COMPLETE THIS FORM ACCIDENT OR NOT**

Date of Exam _____ Examining Doctor _____
Patient's Name _____ Specialty _____
Date of Birth _____ Age _____ Location of Exam _____
Sex: _____Male _____Female History Taken By _____
Race: _____Caucasian _____Black
_____ Hispanic _____ Asian _____Other _____
Are You: _____Right-handed _____Left-handed

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Date of accident/injury/start of disability: _____
Type of Claim: ___Motor vehicle accident ____Worker's Compensation ___Disability ___Other _____
If motor vehicle accident were you: ____Driver ____Passenger ____Pedestrian
Were you wearing a seat belt? ____No ____Yes
Was vehicle hit from: ____Front ____Rear ____Right side ____Left side
Please explain in detail how accident/disability/workers' comp problem/illness occurred _____

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Areas of injury: ____Head ____Neck ____Back Other _____
Any Laceration (cuts)? ____No ____Yes Describe _____
Did you lose consciousness? ____No ____Yes For how long? _____
Did you go to an emergency room (ER)? ____No ____Yes
If yes: name of ER _____
Date: _____Did you go by ambulance? _____No _____Yes
In ER were x-rays taken? ____No _____Yes What other treatment did you receive in ER?
If yes what was x-rayed? _____ ____Medication _____Cane _____Crutches ____Arm sling
Results: _____ ____Neck Collar ____Ace bandage ____Cast ____Other

Have you been hospitalized again for this accident/injury/illness? ____No ____Yes If yes, list all additional hospitalizations (include name of hospital, date and treatment received or physical therapy facilities (Pertaining to injury)

List all doctors seen since accident/injury/illness: ____None

| Name of Doctor | Specialty | Date of First Visit | Date of Last Visit | Frequency of Visits |
|---|---|---|---|---|
| 1) _____ | _____ | _____ | _____ | ____times per week/month |
| 2) _____ | _____ | _____ | _____ | ____times per week/month |
| 3) _____ | _____ | _____ | _____ | ____times per week/month |

____Chiropractic _____Heat _____Ultrasound _____ Other _____

Were additional tests (x-rays, scans, EMG, etc) taken? ____No _____Yes

1) X-rays of _____
2) CAT scan of _____
3) MRI scan of _____
4) EMG/NCV _____

Are you still receiving therapy? _____No _____Yes
If yes: ____Physical therapy _____times per week
____Chiro _____times per week
Due to the accident/illness what are your current symptoms? _____None
_____Nausea ____Vomiting ____Dizziness ____Fainting ____Nervousness
Do you have pain? ____No ____Yes
If yes, where? ____Head ____Neck ____Back ____Chest ____Abdomen
____R shoulder ____L shoulder ____R arm ____L arm ____R hand ____L hand
____R leg _____L leg _____R knee ____L Knee ____R foot ____L foot
Do you have numbness? ____No ____Yes
If yes, where? _____
Do you have difficulty with? ____Walking ____Bending ____Sleeping
____Blurred vision _____Double vision ____Lifting
Do you have difficulty moving? ____R arm ____L arm ____R leg ____L leg
(Other complaints) _____

_____

_____

_____

At present, are you? ____Much Better ____Somewhat Better ____Same ____Worse

**PAST HISTORY**

Do you have any other serious illnesses? ____No ____Yes
If yes, describe: _____
Do you take medication now? _____No _____Yes
If yes, what medications? _____
Have you ever had surgery? ____No _____Yes
If yes type of surgery: _____Date_____
_____ _____
_____ _____
_____ _____
Did you ever have a similar condition or prior accident? _____No _____Yes
If yes, describe: (Include date) _____

_____

_____

_____

**EMPLOYMENT HISTORY (Must Be Filled Out)**

When accident/illness occurred, did you have a job? _____No ____Yes
If yes, what type of work? _____ ____Full time ____Part time ____Hrs/wk
Job duties: Lifting/carrying _____lbs Sitting _____hrs/wk Standing _____hrs/kw Walking _____hrs/wk
Did you miss time from work due to accident/illness? _____No _____Yes If yes, how much time?
_____Days/months; Date returned _____
Are you actively working now? _____No _____Yes
If yes: ____Same job (same duties) ____Same job (limited duties)
____New job (what type) _____Hours/wk

## CURRENT STATUS

Name: First/Middle/Last _____ Date _____

The purpose of this section is to understand your present problems.

What is your single greatest concern? _____

_____

Since the injury have you: ☐ improved ☐ remained the same ☐ gotten worse ☐ changed

What is the location of your greatest pain?

☐ low back ☐ upper back ☐ neck ☐ shoulder
☐ arm ☐ wrist/hand ☐ knee ☐ other

Describe more specifically where your pain is located: _____

_____

What does the pain feel like? _____

Does it radiate (travel) to any other area? ☐ no ☐ yes
Where? _____

Please indicate the effects of the following activities on your pain.

| | **Worsens** | | No | **Relieves** | | Don't |
|---|---|---|---|---|---|---|
| | Significantly | Somewhat | Effect | Somewhat | Significantly | Know |
| Forceful use | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Movement | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lifting | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Weather (cold/damp) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Exercise | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cough/sneeze | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sitting | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Standing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Walking | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Rest | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Ice | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heat | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

What other activities, if any, increase your pain? _____

_____

What other factors, if any, reduce your pain? _____

_____

How much of the time do you have the pain?

☐ constant ☐ nearly constant (50-80%)
☐ intermittent (25-50%) ☐ occasional (< 25%)

**CURRENT STATUS, CONT.**

Please rate your pain on a scale of 0 (no pain) to 10 (excruciating):

What number is your pain now? _____

What has it averaged in the past month? _____

What was the low in the past month? _____

What was the high in the past month? _____

What was it when you were first injured? _____

Please indicate if you have any of the following problems at this time.

| **Problems** | **No** | **Yes** | **Don't Know** | **Location/Comments** |
|---|---|---|---|---|
| Numbness | ☐ | ☐ | ☐ | _____ |
| Tingling | ☐ | ☐ | ☐ | _____ |
| Weakness | ☐ | ☐ | ☐ | _____ |
| Morning stiffness | ☐ | ☐ | ☐ | _____ |
| Headache | ☐ | ☐ | ☐ | _____ |
| Anxiety | ☐ | ☐ | ☐ | _____ |
| Discouragement | ☐ | ☐ | ☐ | _____ |
| Depression | ☐ | ☐ | ☐ | _____ |
| Sleep disturbance | ☐ | ☐ | ☐ | _____ |

Are you having any other problems? ☐ no ☐ yes

Please describe these problems: _____

## FUNCTIONAL STATUS

Name: First/Middle/Last _____ Date _____

The purpose of this section is to understand your physical capabilities at this time.

Please list the maximum number of hours you can do the follow at one time:

Sitting: _____ Standing: _____ Walking: _____

What is the maximum number of pounds you can lift on an occasional basis? _____ ☐ not sure

What is the maximum number of pounds you can lift on a frequent basis? _____ ☐ not sure

Please indicate if you have any problems performing the following task (L= left, R= right).

| Task | Unable | Major Difficulty | Minor Difficulty | No Difficulty | Unsure |
|---|---|---|---|---|---|
| Lifting gallon of milk (4 lts) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lifting light bag of groceries | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lifting heavy bag of groceries | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lifting heavy weight | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bending | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lifting from floor to waist | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lifting from waist to shoulder | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lifting above shoulder | ☐L☐R | ☐L☐R | ☐L☐R | ☐L☐R | ☐L☐R |
| Reaching above shoulder | ☐L☐R | ☐L☐R | ☐L☐R | ☐L☐R | ☐L☐R |
| Pulling | ☐L☐R | ☐L☐R | ☐L☐R | ☐L☐R | ☐L☐R |
| Pushing | ☐L☐R | ☐L☐R | ☐L☐R | ☐L☐R | ☐L☐R |
| Using hands | ☐L☐R | ☐L☐R | ☐L☐R | ☐L☐R | ☐L☐R |
| Opening doors | ☐L☐R | ☐L☐R | ☐L☐R | ☐L☐R | ☐L☐R |
| Opening jars | ☐L☐R | ☐L☐R | ☐L☐R | ☐L☐R | ☐L☐R |
| Sweeping/vacuuming | ☐ | ☐ | ☐ | ☐ | ☐ |
| Climbing stairs | ☐ | ☐ | ☐ | ☐ | ☐ |
| Climbing ladders | ☐ | ☐ | ☐ | ☐ | ☐ |
| Moving neck | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kneeing | ☐ | ☐ | ☐ | ☐ | ☐ |
| Driving a car | ☐ | ☐ | ☐ | ☐ | ☐ |

What tasks are most difficult for you? _____

**Neck and Arm Pain Disability Questionnaire**

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realized that you may feel that more than one statement may relate to you but, **PLEASE JUST CIRCLE THE ONE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1 Pain Intensity
- A. I have no pain at the moment
- B. The pain is mild at the moment
- C. The pain comes and goes and is moderate
- D. The pain is fairly severe at the moment
- E. The pain is very severe at the moment
- F. The pain is the worse imaginable at the moment

SECTION 2 Personal Care (Washing, Dressing, etc)
- A. I can look after myself without causing extra pain
- B. I can look after myself normally but it causes extra pain
- C. It is painful to look after myself and I am slow and careful
- D. I need some help, but manage most of my personal care
- E. I need help every day in most aspects of self-care
- F. I do not get dressed, I have difficulty and stay in bed

Section 3 – Lifting
- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain
- C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- D. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very light weights.
- F. I cannot lift or carry anything at all.

Section 4—Reading
- A. I can read as much as I want to with no pain in my neck
- B. I can read as much as I want with slight pain in my neck
- C. I can read as much as I want with moderate pain in my neck
- D. I cannot read as much as I want because of moderate pain in my neck
- E. I cannot read as much as I want because of severe pain in my neck
- F. I cannot read at all

Section 5 Headache
- A. I have no headaches at all
- B. I have slight headaches which comes infrequently
- C. I have moderate headaches which comes infrequently
- D. I have moderate headaches which comes frequently
- E. I have severe headaches which comes frequently
- F. I have headaches almost all the time.

Section 6- Concentration
- A. I can concentrate fully when I want to with no difficulty
- B. I can concentrate fully when I want to with slight difficulty
- C. I have a fair degree of difficulty in concentrating when I want to
- D. I have a lot of difficulty in concentrating when I want to
- E. I have a great deal of difficulty in concentrating when I want to
- F. I cannot concentrate at all

Section 7- Work
- A. I can do as much work as I want to.
- B. I can only do my usual work, but no more
- C. I can do most of my usual work, but no more
- D. I cannot do my usual work
- E. I can hardly do any work at all
- F. I cannot do any work at all

Section 8 Driving
- A. I can drive my car without neck pain
- B. I can drive my car as long as I want with slight pain in my neck
- C. I can drive my car as long as I want with moderate pain in my neck
- D. I cannot drive my car as long as I want because of moderate pain in my neck
- E. I can hardly drive my car at all because of severe pain in my neck
- F. I cannot drive my car at all

Section 9- Sleeping
- A. I have no trouble sleeping
- B. My sleep is slightly disturbed (less than 1 hour sleepless)
- C. My sleep is mildly disturbed (1-2 hours sleepless)
- D. My sleep is moderately disturbed (2-3 hours sleepless)
- E. My sleep is greatly disturbed (3-5 hours sleepless)
- F. My sleep is completely disturbed (5-7 hours sleepless)

Section 10—Recreation
- A. I am able to engage in all recreational activities with no pain in my neck at all.
- B. I am able to engage in all recreational activities with some pain in my neck
- C. I am able to engage in most, but not all recreational activities because of pain in my neck
- D. I am able to engage in a few of my usual recreational activities because of pain in my neck
- E. I can hardly do any recreational activities because of pain in my neck
- F. I cannot do any recreational activities at all.

0-20% - Mild disability
21-40% -Moderate disability
41-60%- Severe disability
61-80% -Crippled
81-100%- Bedridden
Score: _____

Name: _____ Date: _____

**Revised Oswestry Low Back Pain Disability Questionnaire**

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Section 1- Pain Intensity
- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much
- C. The pain comes and goes and is moderate
- D. The pain is moderate and does not vary much
- E. The pain comes and goes and is severe
- F. The pain is severe and does not vary much

Section 2- Personal Care
- A. I would not have to change my way of washing or dressing in order to avoid pain
- B. I do not normally change my way of washing or dressing even through it causes some pain
- C. Washing and dressing increases the pain, but I manage not to change my way of doing it
- D. Washing and dressing increases the pain and I find it necessary to change my way of doing it
- E. Because of the pain, I am unable to do some washing and dressing without help
- F. Because of the pain, I am unable to do any washing or dressing without help

Section 3- Lifting
- A. I can lift heavy weights without extra pain
- B. I can lift heavy weights, but it causes extra pain
- C. Pain prevents me from lifting heavy weights off the floor
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg on a table
- E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- F. I can only lift very lift weights, at the most

Section 4- Walking
- A. Pain does not prevent me from walking any distance
- B. Pain prevents me from walking more than 1 mile
- C. Pain prevents me from walking more than ½ mile
- D. Pain prevents me from walking more than ¼ mile
- E. I can only walk while using a cane or on crutches
- F. I am in bed most of the time and have to crawl to the toilet

Section 5- Sitting
- A. I can sit in any chair as long as I like without pain
- B. I can only sit in my favorite chair as long as I like
- C. Pain prevents me from sitting more than 1 hour
- D. Pain prevents me from sitting more than ½ hour
- E. Pain prevents me from sitting more than 10 minutes
- F. Pain prevents me from sitting at all

Section 6 – Standing
- A. I can stand as long as I want without pain
- B. I have some pain while standing, but it does not increase with time
- C. I cannot stand for longer than 1 hour without increasing pain
- D. I cannot stand for longer than ½ hour without increasing pain
- E. I cannot stand for longer than 10 minutes without increasing pain
- F. I avoid standing, because it increases the pain straight away

Section 7- Sleeping
- A. I get no pain in bed
- B. I get pain in bed, but it does not prevent me from sleeping well
- C. Because of pain, my normal night's sleep is reduced by less than ¼
- D. Because of pain, my normal night's sleep is reduced by less than ½
- E. Because of pain, my normal night's sleep is reduced by less than ¾
- F. Pain prevents me from sleeping at all.

Section 8- Social Life
- A. My social life is normal and gives me no pain
- B. My social life is normal, but increases the degree of my pain
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, my eg. , dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home
- F. I have hardly any social life because of pain

Section 9 – Traveling
- A. I get no pain while traveling
- B. I get some pain while traveling, but none of my usual forms of travel make it any worse
- C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel
- D. I get extra pain while traveling which compels me to seek alternative forms of travel
- E. Pain restricts all forms of travel
- F. Pain prevents all forms of travel except that done lying down

Section 10- Changing Degree of Pain
- A. My pain is rapidly getting better
- B. My pain fluctuates, but overall is definitely getting better
- C. My pain seems to be getting better, but improvement is slow at present
- D. May pain is neither getting better nor worse
- E. My pain is gradually worsening
- F. My pain is rapidly worsening

Name:_____Date_____Score_____

0-21% -Mild disability 21-40%- Moderate disability 41-60%- Severe disability

61-80% Crippled 81-100% Bedridden

Patient Name :

Date :

# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

| Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

**If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

| PHQ-9 Score | Depression Severity |
|---|---|
| 0-4 | Minimal |
| 5-9 | Mild |
| 10-14 | Moderate |
| 15-19 | Moderately severe |
| 20-27 | Severe |

PHQ-9 = Patient Health Questionnaire 9.

SMART

Patient name: _____

Date of birth: _____

# Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

| | | | | | |
|---|---|---|---|---|---|
| 1. How often do you have a drink containing alcohol? | Never | Monthly or less | 2 - 4 times a month | 2 - 3 times a week | 4 or more times a week |
| 2. How many drinks containing alcohol do you have on a typical day when you are drinking? | 0 - 2 | 3 or 4 | 5 or 6 | 7 - 9 | 10 or more |
| 3. How often do you have six or more drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 4. How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 5. How often during the last year have you failed to do what was normally expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 7. How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 8. How often during the last year have you been unable to remember what happened the night before because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 9. Have you or someone else been injured because of your drinking? | No | | Yes, but not in the last year | | Yes, in the last year |
| 10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down? | No | | Yes, but not in the last year | | Yes, in the last year |
| | 0 | 1 | 2 | 3 | 4 |

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

| | I | II | III | IV |
|---|---|---|---|---|
| M: | 0-4 | 5-14 | 15-19 | 20+ |
| W: | 0-3 | 4-12 | 13-19 | 20+ |

| Score* | Zone | Action |
|---|---|---|
| 0-3: Women<br>0-4: Men | I – Low Risk | Brief education |
| 4-12: Women<br>5-14: Men | II – Risky | Brief intervention |
| 13-19: Women<br>15-19: Men | III – Harmful | Brief intervention/Brief treatment |
| 20+: Men<br>20+: Women | IV – Dependent | Referral to specialized treatment |

JEFFERSON PAIN & REHABILITATION CENTER
Pain Management Patient Care Agreement

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotics analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

I also understand that if I break the agreement, it may result in immediate discharge from the practice.

Jefferson Pain & Rehab Center must have a current and up to date way of contacting you. You must inform JPRC of any address or phone number changes.

1) I understand that I must have an active PCP while being treated by JPRC. If I change PCPs I must notify the JPRC and provide the name, address, and phone number of the current PCP.
2) I agree to obtain prescriptions for pain medication **only** from JPRC. **I will not** attempt to obtain opioid pain medicines from any other doctor while a patient at JPRC. I also agree that refills of my prescriptions will only be made at the time of an office visit or during regular office hours. No refills will be available during evening or on weekends. Controlled medication may be discontinued if they fail to achieve set goals. I agree to participate in a drug detoxification program if prescribed.
3) All controlled substances must be obtained at the same pharmacy.
4) You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
5) The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability. If you were obtaining medications at several pharmacies, or doctors, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
6) You may not share, sell, or otherwise permit others to have access to these medications. You are not allowed to use ANY illegal substances (e.g. marijuana, cocaine, heroin, methamphetamine). You are not to use alcohol on the same day as your narcotic use.
7) These drugs should not be stopped abruptly, as an abstinences syndrome can develop.
8) Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder and possible discharge from the clinic.
9) Unannounced medication inspection and count may be requested and your cooperation is required.
10) Prescription and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
11) Original containers of medications should be brought when medication count is requested.
12) Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
13) Medications will not be replaced for ANY reason.
14) Early refills will not be given.
15) It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance referral for further specialty assessment.
16) Renewals are contingent on keeping scheduled appointments. Patients that miss three (3) consecutive appointments (cancellations or no shows) will be discharged from the clinic.
17) Use of physician's pager (800-314-3085) is LIMITED to post procedure emergencies ONLY. Responses will not be given regarding any medication issues. Abuse of this pager system will warrant discharge from the clinic.
18) All medication issues need to be addressed during regular business hours and Friday until noon only.
19) It should be understood that any medical treatment is initially a trial and that continued prescription is contingent on evidence of benefit.
20) The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation).
21) You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.
22) If you become pregnant, it is your responsibility to inform JPRC because opioid medications are considered category B & C and may carry a potential harm to the fetus.

I agree that this document has been read and understood in its entirety. I agree to follow these guidelines. I have been provided with a copy of this agreement.

This agreement is entered into on this _____day of _____.

Patient's Signature:_____ Copy to Patient

Physician's Signature at JPRC: _____ Date: _____

Witness at JPRC: _____

NP13

**PATIENT CONSENT AND AGREEMENT FOR "OFF-LABEL" PAIN TREATMENT**

## Reason for this Consent and Agreement

All prescription drugs in the United States have a label approved by the United States Food and Drug Administration. This label provides an indication and dosage for the drug, but neither physician nor patient is legally bound to follow them. Pain treatment is virtually impossible unless the physician prescribed one or more medications that are for an indication or dosage not listed on the drug label.

## Consent and Agreement

The undersigned acknowledges that pain control cannot be achieved without "off-label" use of one or more drugs. The undersigned furthermore accepts, all risks and complications that may occur from off-label use, since the benefit of pain control cannot otherwise be achieved. The undersigned agrees to waive all liability against the physicians and clinic who provide pain treatment.

## Specific Off-Label Uses

Any and all off-label use of drugs are covered by this consent including, but not limited to the following:

1. Actiq for non-cancer pain.
2. The use of antidepressants, anti-epileptics, muscle relaxants, tranquillizers, and nutriceuticals for pain relief.
3. The administration of sustained release preparations of morphine and oxycodone use more frequently than every 12 hours.
4. Maximal dosage of opioids is to be determined by therapeutic effect rather than any arbitrary, published maximal closing level.
5. Topical use of morphine, methadone, naloxone, carisoprodol, and Ketamine.

I, the undersigned, agree to the above and release the physician and clinic of all liability for off-label use of drugs.

_____ _____

Patient Signature Today's Date

Informed consent for Procedures/prescription medicine

You have been referred by your doctor for interventional treatment of your pain. You have a pain problem which has not been relieved by routine treatments. A procedure, specifically injections and prescription medications are now indicated for further evaluation and treatment of your pain. (Procedures include spinal injection, joint injection, muscular injection, bursa injection, nerve block, tendon injection, etc.)

There is no guarantee that a procedure will cure your pain and in rare cases, it could become worse, even when the procedure is performed in a technically perfect manner. The degree and duration of pain relief varies from person to person, so after your procedure we will re-evaluate your progress then determine if further treatment is necessary.

**Alternatives** to the procedure include medications, physical therapy, acupuncture, surgery, etc.
**Benefits** include increased likelihood of finding the correct diagnosis and/or of decrease or elimination of your pain.
**Risks** include infection, bleeding, allergic reaction, increased pain, bone, joint, or eye damage from steroids, cardiac arrhythmia. Other serious risks include numbness, weakness, paralysis, nerve and tissue damage, pneumothorax (air in lung requiring placement of chest tube) and death.

In addition to procedures, prescription medications can be used as a treatment modality. Categories of prescription drugs include but not limited to narcotics, anti-depressants, sedatives, anxiolytics, anti-seizure, sleep aids, Benzodiazepines, anti-migraine, anti-inflammatories, muscle relaxants.

Certain prescribed medications may not be FDA approved for certain pain syndromes.

Potential common reactions include but not limited to

| | |
|---|---|
| Constipation | Dry mouth |
| Nausea/vomit | Sweating |
| Drowsiness/light-headedness | Anorexia |
| Somnolence | Nervousness |
| Psychomotor impairment | Insomnia |
| Dizziness | Confusion |
| Pruritus | Hypotension |
| Headache | Rash |

Uncommon serious reactions include but not limited to

| | |
|---|---|
| Respiratory depression/arrest | Seizure |
| Coma | Ileus |
| Dependency/abuse | Hallucination |
| Apnea | Hepatotoxicity/renal toxicity |
| Hypotension/syncope | Central nervous depression |
| Cardiovascular collapse | Withdrawal symptoms |

Due to the possible above reactions it is advisable to take the first few doses at night only in a safe and monitored setting. No driving or operating machineries until potential side effects is realized after continued use. If persistent side effects occur which impair your cognitive functions, do not operate heavy machineries, driving, and use with supervision to avoid harm/accidents.

| Patient/Guardian Signature | Date | Witness | Dr. Signature |
|---|---|---|---|