10321 Kingston Pike
Knoxville, Tennessee 37922

BEARDEN HEALTHCARE
Associates, Inc.

Tel: (865) 584-3565
Fax: (865) 584-2956

Patient Information

Name (First/MI/Last): ________________________

Address: ________________________

City: ________________________

County: __________ State: ______ Zip: __________

Email: ________________________

Date of Birth: _____ / _____ / _____ Chart # __________

SSN: _____ / _____ / _____ TN DL#: __________

Home Ph#: ________________________

Cell Ph#: ________________________

Gender: M F Marital Status: S M D W

Employment Status: ________________________

Patient's Employer: __________ Ph#: __________

Student? Y N School: ________________________

Emergency Contact 1: __________ Relationship: _____

Home Tel#: __________ Cell #: __________

Emergency Contact 2: __________ Relationship: _____

Home Tel#: __________ Cell #: __________

Referring Physician: ________________________

Referring Physician Ph#: ________________________

Insurance Information

How will you be paying for your visit? Self-Pay Insurance Other

____

Insurance Company Name: ________________________

Policy #: __________ Group #: __________

Is your visit related to an on-the-job injury? Y N

Is your visit related to a motor vehicle accident? Y N

Are you currently enrolled in the TennCare Program? Y N

Were you previously enrolled in the TennCare Program? Y N

Dates enrolled: From: __________ To: __________

Name of Insured: ________________________

SSN: _____ / _____ / _____

Date of Birth: _____ / _____ / _____

Address of Insured: ________________________

City: ________________________

County: __________ State: ______ Zip: __________

Home Tel#: __________ Cell #: __________

Your Relationship to insured: Self Spouse Child Parent Other

Insured by (Employer): ________________________

* * * * * * PLEASE READ AND SIGN BELOW * * * * * *

I hereby assign insurance / Medicare benefits otherwise payable to me to be paid to Bearden Healthcare Associates. By signing below, I authorize release of information for insurance purposes. I understand that I am responsible for charges not covered by my insurance. I understand that any legal or collection fees, which can be an additional 35%, incurred by Bearden Healthcare Associates in order to collect balances owed are my responsibility.

________________________ ______________
Signature of patient (or parent if patient is a minor) Date

I hereby request and consent to the treatment deemed necessary by the providers at Bearden Healthcare Associates

________________________ ______________
Signature of patient (or parent if patient is a minor) Date

Welcome to Bearden Healthcare Associates!

Dear New Patient,

Welcome to Bearden Healthcare Associates! We are excited about your pending appointment. You must be prepared with the following required information to be eligible to be seen for your new patient evaluation:

- Valid Tennessee Driver's License or valid Tennessee Identification or government issued photo ID
- All Insurance Cards
- All pharmacy printouts for the last 12 months
- Arrive ON TIME with all New Patient Registration paperwork completed. We realize the paperwork is lengthy and may seem repetitive. This is done on purpose to make sure we have your complete history.
- Approved method of payment (check, debit or credit card). Your name MUST be on the check, debit or credit card. Otherwise, the check owner or cardholder must be in attendance with valid identification. We accept VISA, MasterCard, Discover and American Express.
- Due to state law, self-pay patients without insurance must pay by check, debit or credit card. Pre-payment fees, if applicable, are 100% non-refundable.

We reserve the right to reschedule or cancel any appointment if these requirements are not met.

Our patient schedule is heavy every day and our lobby is busy. Therefore, we must limit visitors. You will be allowed only one individual with you in our lobby if you require accompaniment.

If someone is providing transportation for your visit, please make arrangements for a drop-off and return for pick-up. Due to limited parking, our office respectfully requests that you make alternate arrangements instead of parking for those who transport you. There are multiple establishments nearby for refreshment, entertainment and conveniences, providing comfort for them during your visit. **Expect your first appointment to take as long as four hours**.

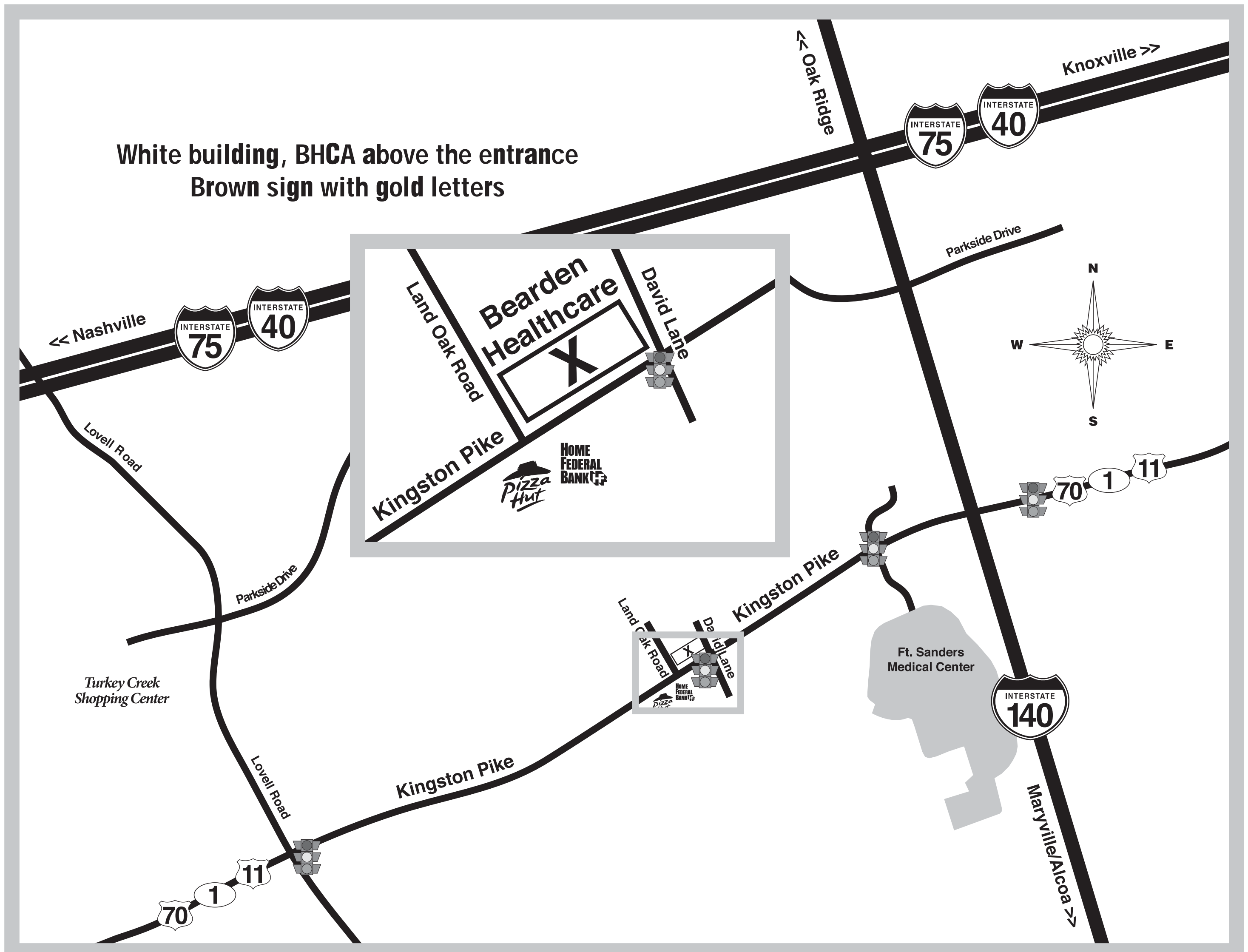
Additionally, we are a no-smoking facility. Kindly extinguish all smoking materials prior to exiting your vehicle. No smoking and no loitering are allowed outside our building. As well, we do not allow outside food or drinks inside the office. Please finish any beverages, meals or snacks prior to entering our lobby.

We are a FRAGRANCE-FREE office. We appreciate your cooperation in accommodating our clients and our employees who are chemically sensitive to products with fragrances. Please help us by **NOT** wearing any of the following items to your appointment: *Perfume, Cologne, After-Shave, Body Spray, Scented Hand Lotion, Fragranced Hair Products and/or similar products.* Thank you.

Thank you in advance for your cooperation. A pleasant, friendly and productive visit will result when you are informed and prepared.

Please turn this page over for a map and directions to the clinic.

Map & Directions to Bearden Healthcare Associates



Directions from East of Knoxville

- Take I-40 West
- Exit 376B, I-140E/Pellissippi Parkway (to Maryville)
- Stay in right lane. Exit 1B for Kingston Pike / US 11S / 70W
- Turn right on to Kingston Pike
- Travel .4 mile to David Lane. Turn right then immediate left into parking lot.

Directions from West of Knoxville

- Take I-40 East
- Exit 374 Lovell Road
- Turn right on to Lovell Road
- Travel .8 mile to Kingston Pike. Turn left on to Kingston Pike.
- Travel .7 mile to David Lane. Turn left then immediate left into parking lot.

Directions from North of Knoxville

- Take I-75 South or I-640 West
- Merge right on to I-40 West
- Exit 376B, I-140E/Pellissippi Parkway (to Maryville)
- Stay in right lane. Exit 1B for Kingston Pike / US 11S / 70W
- Turn right on to Kingston Pike
- Travel .4 mile to David Lane. Turn right then immediate left into parking lot.

Directions from South of Knoxville

- Take I-I40 West/Pellissippi Parkway (to Oak Ridge)
- Exit 1 for Kingston Pike / US 11S / 70W
- Turn left on to Kingston Pike
- Travel .5 mile to David Lane. Turn right then immediate left into parking lot.

Bearden Healthcare Associates, Inc.
10321 Kingston Pike, Knoxville, TN 37922 • 865-584-3565

First Visit Expectations

Dear New Patient,

Welcome to Bearden Healthcare Associates. Please read this letter and you will have a better understanding of what to expect during today's evaluation.

A drug screen will be obtained before you see a provider. The State of Tennessee **requires** drug testing. We test for many medications and illegal drugs. It is of the utmost importance you tell the lab nurse all medications and drugs you have used within the last month. Regardless of how you obtained the substance ***we need to know everything you have used***. Failure to be completely honest will affect our ability to care for you. Failure to remember or thinking it would not show up will not be acceptable excuses once the test is done. Honesty is the only policy!

After the screening part of the urine drug test is performed on site, the specimen is sent to an outside lab for advanced testing. The State of Tennessee **requires** this advanced testing. The outside laboratory will file your insurance or bill self pay (cash) patients directly. The fee charged by the outside labs is usually $99.00 for a simple urine drug confirmation and is subject to change without notice if additional tests are required. Please contact the outside laboratory if you have questions regarding billing. Use your receipt information from the urine drug screen to call the lab. **The laboratory is usually very understanding of patient's financial concerns or hardship.**

After the urine drug screen is complete you will be seen by a medical provider for your initial evaluation. The provider will be reviewing previous medical records and your registration forms. Bearden Healthcare utilizes medical doctors as well as nurse practitioners and physician assistants for these visits. Rest assured, all providers are capable of performing this initial evaluation. You will be asked many questions during this visit. It is extremely important you answer honestly. Medication usage, illegal drug use and prior drug and alcohol related issues will all be discussed. Our providers are caring professionals and will do their best to assist patients in need but honesty is expected. This evaluation will include an examination. Once the provider determines your initial diagnosis, a plan is made. The plan may include diagnostic tests such as x-rays, nerve studies, MRI's or others. The provider may also order a physical therapy or chiropractic evaluation to be performed prior to your second appointment. These tests and evaluations are MANDATORY. Information obtained is incorporated into your plan of care. Additionally, referral to other specialists may be needed. Medical records from previous providers will be requested by our staff. An intial treatment plan will be explained.

At the conclusion of your visit, you will have a **new patient orientation** with a staff member to go over office policies and review your plan of care. Please discuss any remaining concerns you have at this time.

After orientation and any diagnostic testing is performed, you will proceed to the front desk to be rescheduled. BHA requires co-pays and cash balances to be paid at the time of service. If payment arrangements are needed a billing department representative can speak with you prior to being seen on your appointment date.

Should you have questions prior to your first appointment, please call 865-584-3565 xt 222 and leave a detailed message. Should you like to learn more about Tennessee's Chronic Pain Management Guidelines, please go to the state's website.

Please be patient Your **initial visit could take 4 hours** as we attempt to gain as much information as possible

Remember not to wear fragrances.

We appreciate your trust and look forward to being part of your healthcare team.

Bearden Healthcare Associates

OCCUPATION

What is your occupation? ______________________ How Long Have you been doing this type of work? __________

☐ Homemaker ☐ Retired ☐ Working F/T ☐ Working P/T ☐ Unemployed ☐ On Leave From Job ☐ Unable to Work
☐ Military ☐ Retired Military

Are you disabled? Y N Reason for disability: ______________ When did this disability occur? ______________
Was the disability work related? Y N Are you SSI disabled? Y N Was the disability related to military service? Y N
If working, is your job physically demanding? Y N Describe: ______________________________

EDUCATION

☐ Some High School ☐ High School or GED ☐ Some College ☐ Bachelor's Degree ☐ Graduate Degree ☐ Technical or Trade School
☐ Current Student Where: ______________________ Major: ______________________

SOCIAL

What is your maritial status? ☐ Married ☐ Divorced ☐ Married, but separated ☐ Single ☐ Widowed

Please list any children or family members that live with you and their relationship to you:

____

Please list any social or recreational activities you regularly participate in, including hobbies:

____

Do you have a caregiver? Y N Name: ______________________ Relationship to you: ______________
Why do you need them? ____

ALLERGIES

Do you have any known allergies? Y N Please describe below.

Food Allergies (nuts, shellfish, etc.): ______________________________
Type of Reaction: ______________________________

Skin Allergies (including latex): ______________________________
Type of Reaction: ______________________________

Medication Allergies: ______________________________
Type of Reaction: ______________________________

Other Allergies: ______________________________
Type of Reaction: ______________________________

WOMEN'S HEALTH

Are you currently pregnant? Y N Are you currently trying to become pregnant? Y N

Are you capable of becoming pregnant? Y N If no, why not? ______________________________

Birth control method used: ______________________ How many children do you have? __________

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Date of last menstral cycle: ____________________ Date of last Pap Smear: ____________________

Have you reached menopause? Y N Have you had a hysterectomy? Y N

Are you having hormone replacement therapy? Y N Where? ____________________

Have you lost desire to engage in sexual intercourse? Y N If yes, please check all the boxes you feel have contributed.

☐ Spinal pain ☐ Fatigue ☐ Vaginal dryness ☐ Vaginal pain ☐ Hip pain ☐ Other: ____________________

OSTEOPOROSIS RISK ASSESSMENT

Have you been tested for osteoporosis? Y N When? ____________________ Where? ____________________

Do you know the results? Y N Results: ____________________

What is your current age? __________ Are you 65 years of age or older? Y N

How much do you weigh? __________ Are you on estogen therapy? Y N

MEN'S HEALTH

Urinary Symptoms

1.	Do you need to urinate every 1-2 hours or more?			Y	N
2.	Do you have the urge to go even with an empty bladder?			Y	N
3.	Have you lost control of urination?			Y	N
4.	Do you have burning with urination?			Y	N
5.	Pain with urination?			Y	N
6.	A weak urinary stream?			Y	N
7.	Do you have to wait a while before your stream starts?			Y	N
8.	Do you empty your bladder completely?			Y	N
9.	How many times at night do you wake up? (cirlce one)	0-1	2-3	4-5	6+
10.	Do you take any medications for your urination?			Y	N
11.	Have you ever had any kidney stones?			Y	N
12.	Have you ever seen blodd in your urine?			Y	N
13.	Have you ever had a urinary tract infection?			Y	N
14.	Do you have pain in your pelvis?			Y	N

Sexual Health

1. Use the folloowing scale for the next 8 questions: 1=terrible 2=poor 3=average 4=good 5=excellent

a.	How would you rate your sex drive?			__________		
b.	How would you rate your energy level?			__________		
c.	How would you rate your strength / endurance?			__________		
d.	How would you rate your enjoyment of life?			__________		
e.	How would you rate your happiness of life?			__________		
f.	How would you rate your work performance over the past 4 weeks?			__________		
g.	How would you rate your sports ability over the past 4 weeks?			__________		
h.	How strong are your erections?			__________		
i.	How often do you fall sleep after dinner? (cirlce one)	1-2x week	3-4x week	5-6x week	every night	
j.	How much height have you lost in your adulthood? (cirlce one)	2″ or more	1.5″-1.9″	1″-1.4″	0.5″-0.9″	None

2.	Do you have a history of low testosterone?	Y	N
3.	Do you have a history of an undescended testicle?	Y	N
4.	Do you have a history of a testicular mass?	Y	N
5.	Do you have a history of a varicocele?	Y	N
6.	Do you get morning erections regularly?	Y	N

Date: ______________ Patient Name: ____________________ No. __________

7. Do you use or have you used any medications for erections? Y N
8. Do you have premature ejaculation? Y N
9. Do you have any penile plaques or deformities Y N
10. Do you have painful erections? Y N
11. Do you have diminished penile sensation? Y N
12. Have you experienced penile trauma? Y N

VACCINATIONS

List all vaccinations you have received in the last 10 years: ☐ Tetanus ☐ Pneumonia ☐ Influenza ☐ Hepatitis ☐ HPV ☐ Other: __________

ALCOHOL CONSUMPTION

☐ I never drink alcohol I drink: ☐ Beer ☐ Wine ☐ Alcohol

How often? ______________________________ Amount? ______________________________

Are you a former alcohol user? Y N Describe your past use: ______________________________
When did you quit? __________ Why did you quit? ______________________________
Do you consider yourself to be an alcoholic? Y N

TOBACCO USE

☐ I never use tobacco I use: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew/Snuff/Snus ☐ Passive Smoker / Around Smoke ☐ E-Cigarettes

How often? ☐ Daily ☐ Regularly ☐ Occasionally Amount? ______________________________

Are you a former tobacco user? Y N
Describe your past use: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew/Snuff/Snus ☐ Passive Smoker / Around Smoke ☐ E-Cigarettes
When did you quit? __________ Why did you quit? ______________________________

DIET

Describe your usual diet: ☐ Well-Balanced ☐ Good ☐ Fair ☐ Poor
Any unusual dietary issues? Y N Describe: ______________________________
Do you take vitamins or supplements? Describe: ______________________________
Do you mostly drink: ☐ Water ☐ Tea ☐ Coffee ☐ Soda ☐ Juice ☐ Sports Drinks ☐ Energy Drinks

EXERCISE

How often do you exercise? ☐ Never ☐ Rarely ☐ 1-2 times per week ☐ 3-4 times per week ☐ More than 5 times per week
What type of exercise do you do? ______________________________

BATHROOM HABITS / BOWEL FUNCTION HEALTH

Are you taking an opioid? Y N If yes, are you taking methadone? Y N How long have you been taking an opioid? ______________

Number of bowel movements per week: Before opioid use: __________ After starting opioid use: __________

Have you had trouble passing stool? Before opioid use: Y N After starting opioid use: Y N

Have you had abdominal discomfort? Before opioid use: Y N After starting opioid use: Y N

Have you had straining? Before opioid use: Y N After starting opioid use: Y N

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Have you had hard or lumpy stools? Before opioid use: Y N After starting opioid use: Y N

Have you had gas? Before opioid use: Y N After starting opioid use: Y N

Have you had bloating? Before opioid use: Y N After starting opioid use: Y N

Do you take fiber? Y N If yes, how often / how long? ______________________________

Do you take laxatives? Y N If yes, how often / how long? ______________________________

Do you exercise regularly? Y N If yes, how often / how much? ______________________________

Do you drink water regularly? Y N If yes, how often / how much? ______________________________

ABDOMEN

Do you have: ☐ Abdominal Pain ☐ Constipation ☐ Bowel obstruction or disease of any kind) ☐ Frequent diarrhea ☐ Kidney / Bladder stones
☐ Prostatic problems ☐ Bowel surgery ☐ Gastric surgery ☐ Crohn's Disease ☐ Abdominal aorta distenstion or repair
☐ unexplained belly bloating

Have you had an abdomen xray taken in the last 6 months? Y N If yes, where? ______________________________

For Office Use Only - Please see the American College of Radiology Practice Parameter Guidelines for Abdiminal Radiology. Revised 2016 Res. 2. Additional references available in protocol manual. CPT Code 74000 / other.

LUNG HEALTH

Do you smoke? Y N Did you smoke in the past? Y N Are you around smokers? Y N
Are you exposed to air pollution, fumes, chemicals or dust? Y N Were you in the past? Y N
Are you short of breath (dyspnea) at times? Y N _____ at rest _____ during activity
Are you concerned about your breathing? Y N Does it limit your activity? Y N
Do you have a chronic cough? Y N Does your cough produce mucus? Y N
Do you get lung (respiratory) infections? Y N Do you ever wheeze? Y N
Do you get tired when you exert yourself or in general? Y N
Do you have family members with lung problems or Chronic Obstructive Pulmonary Disease, including chronic brochitis or emphysema? Y N
Have you been diagnosed with Chronic Obstructive Pulmonary Disease, including chronic brochitis or emphysema? Y N

HEART HEALTH

Do you smoke? Y N Did you smoke in the past? Y N Are you around smokers? Y N
Have you had a heart attack? Y N Do you have high blood pressure? Y N Do you have diabetes? Y N
Do you eat foods that are high in fat, cholesterol or sodium? Y N (Please be honest about your diet)
Are you overweight? Y N Do you get regular exercise for your heart? Y N
Do you get tired or weak when you exert yourself or in general? Y N
Do you get short of breath (dyspnea) at times? Y N While laying down? Y N
Have you had weight gain with swelling in the feet, legs, ankles or stomach? Y N
Do you get chest pain? Y N Does your heartbeat feel irregular? Y N
Do you, or a family member, have a heart valve abnormality? Y N
Do you, or a family member, have coronary artery disease? Y N
Have you been diagnosed with congestive heart failure? Y N

Date: ______________ Patient Name: ______________________________ No. ______________

MISCELLANEOUS

Do you have an implant in your chest such as a pacemaker? Y N
Have you had an injury to your ribs, sternum (breast bone) or middle back? Y N
Do you ever get dizzy, feel faint or pass out (syncope)? Y N
Are you over the age of 50? Y N
Do you get unexplained fevers? Y N

Have you had a chest xray taken in the last 6 months? Y N If yes, where? ______

For Office Use Only - Please see the American College of Radiology Practice Parameter for Chest Radiology. amended 2014 (Resolution 39) CPT Code 71010, 71020 / other.

Have you had an EKG / ECG done in the last 6 months? Y N If yes, where? ______

For Office Use Only - Please see the American College of Cardiology and the American Heart Association Guidelines for Ambulatory ECG (EKG) CPT Code 93000 / other.

Have you had a Pulmonary Function test (spirometry) taken in the last 6 months? Y N If yes, where? ______

For Office Use Only - Please see the American College of Physicians, American College of Chest Physicians, American Thoracic Society and European Respiratory Society Clinical Practice Update; Annuls of Internal Medicine Vol 155, No. 3 CPT Code 94375 / 94060 / other.

RECREATION OR STREET DRUG USE

☐ I have NEVER used any recreational or street drugs ☐ I FORMERLY used recreational and/or street drugs ☐ I have used IV drugs recreationally

List ALL recreational and/or street drugs you have taken in the past: ______
______
Describe your past use: ______
When did you quit? ______ Why did you quit? ______

Are you CURRENTLY using any recreational and/or street drugs? Y N List: ______
Do you agree to discontinue using illegal or non prescribed drugs? Y N

ALCOHOL OR DRUG TREATMENT

Have you or a family member ever felt you had a problem with alcohol or drugs? Y N Have you ever considered stopping or cutting down? Y N
Do you get annoyed when others critisize your use of alcohol or drugs? Y N Do you ever feel guilty for your use of alcohol or drugs? Y N
How often do you use alcohol or drugs first thing in the morning to steady your nerves or relieve a hangover? ______

Have you ever received a DUI? Y N Date(s): ______ Have you ever been arrested for public intoxication? Y N Date(s): ______

Have you ever been treated at a methadone, buprenorphine or suboxone clinic? Y N

Where: ______ When: ______

Why: ______

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Have you ever received treatment for alcoholism or drug addiction at a detox facility or alcohol and drug addiction treatment facility? Y N
Date(s) / Facility: ______

Has a member of your family ever received treatment for alcoholism or drug addiction at a detox facility or alcohol and drug addiction treatment facility? Y N
Date(s) / Facility: ______

Have you ever attended AA, NA or Alanon meetings? Y N Do you currently attend AA, NA or Alanon meetings? Y N Meetings per week: ______

MENTAL ILLNESS

Are you currently under care for a mental illness? Y N Clinic: ______ Provider: ______

Reason: ______

Have you ever received treatment for a mental illness? Y N Date(s) / Facility: ______
Diagnosis (ADD, ADHA, OCD, Depression, Biplor, Anxiety, PTSD, Personality Disorder, Schizophrenia, Other): ______

Have you been institutionalized? Y N Date(s) / Facility: ______
Diagnosis (ADD, ADHA, OCD, Depression, Biplor, Anxiety, PTSD, Personality Disorder, Schizophrenia, Other): ______

Have you ever considered seriously harming yourself or someone else? Y N Have you ever seriously harmed yourself or someone else? Y N
Have you ever considered suicide? Y N Have you ever planned to commit suicide? Y N Have you ever attempted to commit suicide? Y N

CAGE-AID Questionnaire

1. In the last three months, have you felt you should cut down or stop drinking or using drugs?
   Yes No
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?
   Yes No
3. In the last three months, have you felt guilty or bad about how much you drink or use drugs?
   Yes No
4 In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?
   Yes No

MEMORY ISSUES

Do you have difficulty remembering things? Y N Do you have difficulty concentrating on daily activities? Y N

How often do you feel "foggy" or not clear-headed? ______ Is it more difficult in the morning or evening? ______

Are there situations that bring on this feeling? Y N What situations? (i.e. waking up, after meals or exertion) ______

Have you even been treated for a concussion? Y N Date(s) / Facility: ______

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SLEEP ISSUES

How many hours of sleep do you average at night? _____ Are you excessively tired during the day? Y N
Is your sleep peaceful and restful? Y N Is your sleep disturbed and you have trouble sleeping through the night? Y N
Have you been told that you snore? Y N Have you been told that you either stop breathing or gasp for breath when sleeping? Y N

Do you have a history of hypertension (high blood pressure)? Y N Is your neck size greater than 17″ (men) or 16″ (women)? Y N
Do you experience restless leg syndrome? Y N Is is more difficult to go to sleep initially or to stay asleep? ______________________________

How likely are you to fall asleep in the following situations on a normal day (as opposed to just feeling tired)?
This refers to your usual way of life in recent times. Even if you have not done these activities recently, try to determine how these situations would MOST LIKELY effect you.

Use the scale for the most appropriate rating for each situation.
0 = No chance of falling asleep 1 = Slight chance of falling asleep 2 = Moderate chance of falling asleep 3 = High chance of falling asleep

Situation	**Chance of Falling Asleep**			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (theatre or in a meeting)	0	1	2	3
As a passenger in a car riding for an hour with no breaks	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking with someone	0	1	2	3
Sitting quietly after lunch, without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

BALANCE SELF TEST

To help determine if you may be headed for a fall, or have a balance disorder, take the Balance Self Test below. If you answer "yes" to one or more of the questions, you could be at risk. The best way to determine if you have a problem is to share with your provider any fears or concerns you have regarding falling, dizziness or vertigo, so that he or she may help determine the cause of your symptoms.

	Please read each question and check the box that most describes your answer.	Yes or Often	Sometimes	No or Never
1	Do you ever lose your balance or feel dizzy or unsteady?	☐	☐	☐
2	Have you continued to experience dizziness after an injury or accident?	☐	☐	☐
3	Do you feel unsteady when you are walking or climbing stairs?	☐	☐	☐
4	Do you feel dizzy while sitting down or rising from a seated or lying position?	☐	☐	☐
5	Does walking down the isle of a supermarket or stopping next to moving traffic make you dizzy?	☐	☐	☐
6	Does moving your head quickly make you dizzy or cause you to feel nauseous?	☐	☐	☐
7	Are you dizzy or unsteady when you first get up in the morning?	☐	☐	☐
8	Do you ever fall or feel like you are about to fall for no apparent reason?	☐	☐	☐
9	Do you use a walker, cane or any other form of assistance for your mobility?	☐	☐	☐
10	Have you had a recent loss of, or decrease in, your vision or hearing?	☐	☐	☐
11	Do you fear falling?	☐	☐	☐
12	Have you experienced dizziness, vertigo or serious imbalance in the past six months?	☐	☐	☐
13	Has your balance problem caused problems in your social life?	☐	☐	☐
14	Have you fallen more than once in the past year, without an obvious cause?	☐	☐	☐
15	Does dizziness or imbalance interfere with your job or your household responsibilities?	☐	☐	☐

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Have YOU or any of your family members had any of these medical conditions? Please indicate the family member that has had the condition.
P = Patient (Self) F = Father M = Mother G = Grandparent S = Sibling C = One of your children

___ Abdominal Pain
___ Abnormal Discharges
___ Abnormal Sweating
___ Acid Reflux
___ Acne
___ Adrenal Gland Problems
___ Alcoholism
___ Alzheimer Disease
___ Anemia
___ Anxiety Attacks
___ Apathy
___ Arthritis
___ Asthma
___ Atypical Moles
___ Back Pain
___ Bipolar Disorder
___ Black-outs, Fainting
___ Bladder Control Difficulty
___ Bleeding Disorder
___ Bloating
___ Blood Clots
___ Bloody / Black Stools
___ Bloody Urine
___ Blurred Or Double Vision
___ Bowel Control Difficulty
___ Bronchitis
___ Bruises Easily
___ Burning Or Dry Eyes
___ Burning Or Painful Urination
___ Bursitis
___ Cancer
___ Carpal Tunnel Syndrome
___ Chest Pain
___ Chicken Pox
___ Chills
___ Choking
___ Chronic Cough
___ Chronic Pain
___ Clearing Throat Frequently
___ Cold Or Heat Intolerance
___ Cold Sores
___ Concussion / Head Injury
___ Congestive Heart Failure
___ Constant Thirst
___ Constipation
___ Convulsions
___ COPD
___ Dental Problems
___ Depression
___ Diabetes
___ Diarrhea
___ Dislipidemia
___ Diverticulosis
___ Dizziness

___ Drug Abuse
___ Dry Mouth
___ Dry Skin
___ Dysuria
___ Ear Discharge / Drainage
___ Ear Infections
___ Ear Pain / Aches
___ Easily Fatigued
___ Easily Fractures Bones
___ Eating Disorder
___ Eczema
___ Emphysema
___ Epilepsy
___ Excessive Mucous
___ Eye Discharge
___ Eye Redness
___ Falls
___ Fatigue
___ Fevers
___ Flank Pain
___ Focal Weakness
___ Frequent Falls
___ Frequent Illness
___ Frequent Infections
___ Frequent Urinating At Night
___ Gagging
___ Gastrointestinal Bleeding
___ Genital Itch or Discharge
___ GERD
___ Hair Loss
___ Hallucinations
___ Hay Fever
___ Headaches
___ Hearing Difficulty
___ Heart Attacks
___ Heart Disease
___ Heart Palpitations
___ Heartburn
___ Hepatitis
___ Hernia
___ High Blood Pressure
___ High Cholesterol
___ HIV / AIDS
___ Hives
___ Hot Flashes
___ Hyperactivity
___ Hypothyroidism
___ Impotence
___ Incontinence
___ Indigestion
___ Insomnia
___ Intense Fear
___ Itching (Skin)
___ Itchy Ears

___ Jaundice
___ Joint Pain
___ Joint Stiffness
___ Kidney Disease
___ Kidney Stones
___ Learning Disability
___ Light Sensitivity
___ Light-headedness
___ Liver Disease
___ Loss Of Appetite
___ Loss Of Consciousness
___ Loss Of Sex Drive
___ Lupus
___ Measles
___ Melanoma
___ Memory Loss
___ Meningitis
___ Menstrual Problems
___ Mental Illness
___ Methadone Treatment
___ Migraines
___ Mood Swings
___ Mumps
___ Muscle Aches
___ Muscle Cramps
___ Muscle Spasms
___ Nail Changes
___ Nausea, Vomiting
___ Neck Pain
___ Nervous Breakdown
___ Night Sweats
___ Nose Bleeds
___ Numbness Of Extremities
___ Obsessive-Compulsive Disorder
___ Osteoarthritis
___ Osteoporosis
___ Overall Weakness
___ Overweight
___ Pain In Extremities
___ Pancreatitis
___ Panic Attacks
___ Paralysis
___ Peripheral Neuropathy
___ Persistent Congestion
___ Persistent Runny Nose
___ Persistent Hoarseness
___ Polio
___ Poor Coordination
___ Pneumonia
___ Poor Concentration
___ Poor Mental Clarity
___ Psoriasis
___ PTSD
___ Racing Or Irregular Heartbeat

___ Rashes
___ Restless Leg Syndrome
___ Restlessness
___ Rheumatoid Arthritis
___ Ringing In The Ears
___ Schizophrenia
___ Sciatica
___ Seizures
___ Shingles
___ Shortness Of Breath
___ Sinus Problems
___ Skin Sores
___ Sleep Apnea
___ Sleep Difficulty
___ Slurred Speech
___ Sneezing
___ Speech Difficulties
___ Spinal Disc Degeneration
___ STDs
___ Stomach Ulcers
___ Stress
___ Strokes
___ Stuttering
___ Swallowing Difficulty
___ Swelling Of Ankles
___ Swollen Glands
___ Swollen Joints
___ Taste Or Smell Difficulty
___ Thyroid Problems
___ Tingling
___ Trembling Or Shaking
___ Tuberculosis
___ Uncoordinated
___ Unexplained Weight Change
___ Unsteadiness When Standing
___ Unsteadiness When Walking
___ Urinary Tract Infections
___ Vertebral Compression Fracture
___ Water Retention
___ Weakness Of Extremities
___ Wheezing

Other: ________________________
____
____
____
____

Date: __________________________ Patient Name: ____ No. ____________________

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Do you have a primary care provider? Y N Provider's Name / Clinic Name: ____________________

Telephone #: ____________ Address: ____________________ Fax #: ____________

Date of last visit: ____________ Did this provider refer you here? Y N

Did another provider refer you here? Y N Name: ____________________

If no, how did you hear about this clinic: ☐ Internet search ☐ Yellow pages ☐ Referrred by another patient

☐ Other: ____________________

If you do not have a primary care provider and would like one, please ask. We may be able to see you for primary care or recommend a provider.

LIST ALL MEDICAL CARE PROVIDERS THAT YOU HAVE BEEN TO including those you have seen for reasons other than pain.
Be sure to list clinics, doctors and hospitals.

List current and most recent first. If you need more space, please ask the staff for an additional page.

Dr.'s Name / Clinic / Hospital: ____________________

Telephone #: ____________ Address: ____________________

Reason(s) for seeking medical care: ____________________

Treatment received: ____________________

Was any medication prescribed? Y N What medications? ____________________

Dr.'s Name / Clinic / Hospital: ____________________

Telephone #: ____________ Address: ____________________

Reason(s) for seeking medical care: ____________________

Treatment received: ____________________

Was any medication prescribed? Y N What medications? ____________________

Dr.'s Name / Clinic / Hospital: ____________________

Telephone #: ____________ Address: ____________________

Reason(s) for seeking medical care: ____________________

Treatment received: ____________________

Was any medication prescribed? Y N What medications? ____________________

LIST ALL PHARMACIES THAT YOU HAVE BEEN TO IN THE PAST YEAR including those you have received prescriptions for reasons other than pain.

List current and most recent first. If you need more space, please ask the staff for an additional page.

LOCAL PHARMACY

Pharmacy: ____________________

Telephone #: ____________ Fax #: ____________ Address: ____________________

Precription(s) picked up: ____________________

Pharmacy: ____________________

Telephone #: ____________ Fax #: ____________ Address: ____________________

Precription(s) picked up: ____________________

MAIL ORDER PHARMACY

Pharmacy: ____________________

Telephone #: ____________________ Fax #: ____________________

Precription(s) mailed: ____________________

Date: ____________ Patient Name: ____________________ No. ____________

LIST ALL SURGERIES including those that were preformed for reasons other than pain.
Be sure to list clinics, doctors and hospitals that performed the surgeries.

List current and most recent first. If you need more space, please ask the staff for an additional page.

Dr.'s Name / Clinic / Hospital: ______________________________
Telephone #: ______________ Address: ______________________________
Surgery performed: ______________________ Reason(s) for surgery: ______________________

Dr.'s Name / Clinic / Hospital: ______________________________
Telephone #: ______________ Address: ______________________________
Surgery performed: ______________________ Reason(s) for surgery: ______________________

Dr.'s Name / Clinic / Hospital: ______________________________
Telephone #: ______________ Address: ______________________________
Surgery performed: ______________________ Reason(s) for surgery: ______________________

Dr.'s Name / Clinic / Hospital: ______________________________
Telephone #: ______________ Address: ______________________________
Surgery performed: ______________________ Reason(s) for surgery: ______________________

Dr.'s Name / Clinic / Hospital: ______________________________
Telephone #: ______________ Address: ______________________________
Surgery performed: ______________________ Reason(s) for surgery: ______________________

ABSORPTION CONCERNS

Have you had gastric / stomach surgery? Y N Stapling? Y N By Pass? Y N Lap Band? Y N
Small intestine? Y N Large intestine? Y N
Have you been diagnosed with Crohn's Disease? Y N Bowel Obstruction? Y N Ulcerative Colitis? Y N
Do you have Type 2 Diabetes? Y N Have you noticed medication tablets in your stool? Y N

EMERGENCY ROOM CARE

In the previous year, how many times have you been treated in an Emergency Room - for pain or for any other medical reason? __________

☐ I have NOT been treated at an Emergency Room in the past year

Date: __________ What hospital: ______________________ Reason: ______________________
Date: __________ What hospital: ______________________ Reason: ______________________
Date: __________ What hospital: ______________________ Reason: ______________________

HOSPITALIZATION

How many times have you been hospitalized overnight for your pain? ____________ ☐ Never

IMPLANTS / HARDWARE

Please list any implants and hardware:

☐ Spine Stimulator ☐ Pacemaker ☐ Defribillator ☐ Rods / Screws ☐ Prosthetics ☐ Morphine Pump
☐ Other ______________________________

Date: ______________ Patient Name: ______________________________ No. ______________

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ALTERNATIVE HEALTH CARE PROVIDER

In the previous year, how many times have you been treated by an alternative health care provider - for pain or for any other medical reason? ___________

☐ I have NOT been treated by an alternative health care provider in the past year ☐ I am currently being treated

These health care providers would include Chiropractors, homeopathic, naturopathic, accupuncturists, accupressurists, physical therapy, occupational therapy and massage therapy.

Date: ___________ Provider: _______________________________ Reason: _______________________________

Date: ___________ Provider: _______________________________ Reason: _______________________________

Date: ___________ Provider: _______________________________ Reason: _______________________________

CURRENT MEDICATION

LIST ALL MEDICATIONS (Prescription & Non-prescription) that you are currently taking, including medications taken for reasons other than pain. Be sure to list all supplements, vitamins and any herbal preparations as well as any over-the-counter medications. State law requires you to inform us of any pain medicine you have been prescribed in the last 30 days.

Medication: _______________________ Dosage: ______________ Frequency Taken: ____________
Prescribing Physician: _______________________ Reason: _______________________
Are you currently taking this medication? Y N

Medication: _______________________ Dosage: ______________ Frequency Taken: ____________
Prescribing Physician: _______________________ Reason: _______________________
Are you currently taking this medication? Y N

Medication: _______________________ Dosage: ______________ Frequency Taken: ____________
Prescribing Physician: _______________________ Reason: _______________________
Are you currently taking this medication? Y N

Medication: _______________________ Dosage: ______________ Frequency Taken: ____________
Prescribing Physician: _______________________ Reason: _______________________
Are you currently taking this medication? Y N

Medication: _______________________ Dosage: ______________ Frequency Taken: ____________
Prescribing Physician: _______________________ Reason: _______________________
Are you currently taking this medication? Y N

Medication: _______________________ Dosage: ______________ Frequency Taken: ____________
Prescribing Physician: _______________________ Reason: _______________________
Are you currently taking this medication? Y N

Medication: _______________________ Dosage: ______________ Frequency Taken: ____________
Prescribing Physician: _______________________ Reason: _______________________
Are you currently taking this medication? Y N

Medication: _______________________ Dosage: ______________ Frequency Taken: ____________
Prescribing Physician: _______________________ Reason: _______________________
Are you currently taking this medication? Y N

Please turn this page over and write on the back if you need to add more information.

Date: ____________________ Patient Name: ______________________________ No. ______________

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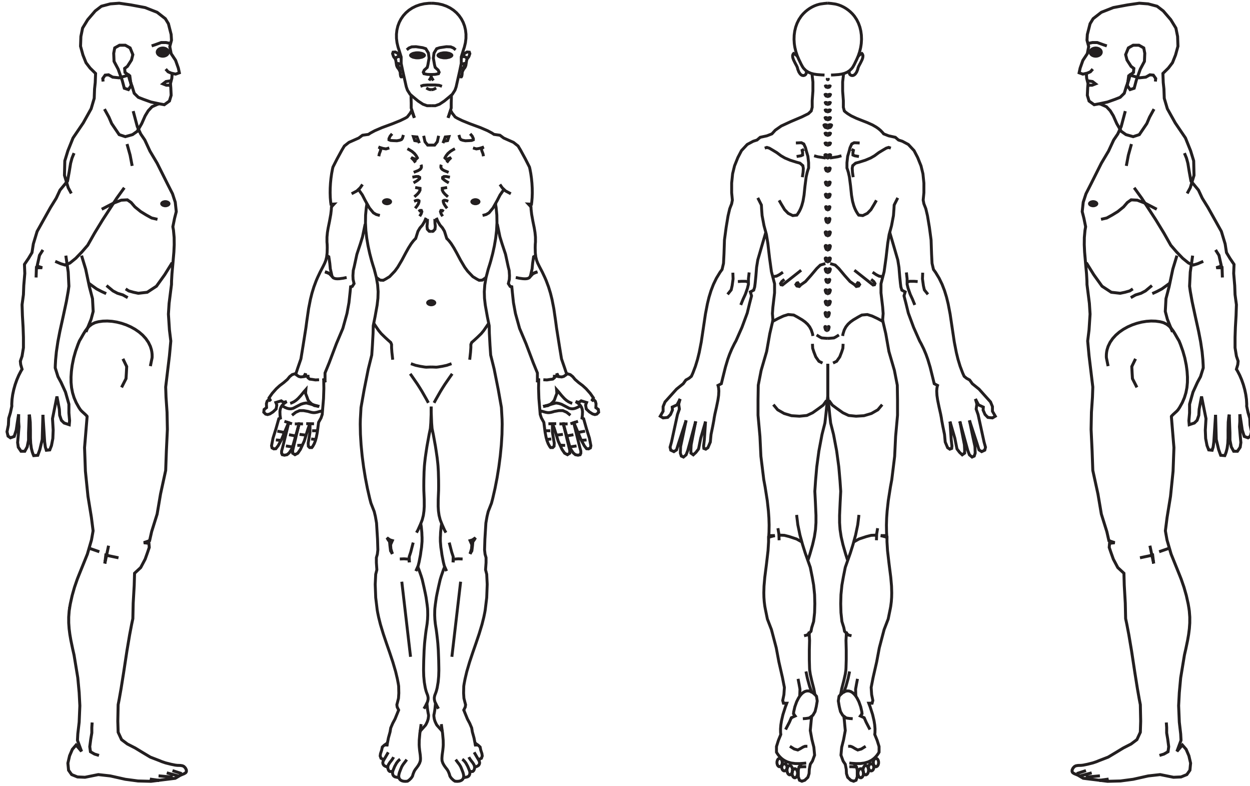
Show the location where the pain is worst. Does the pain radiate out from this location (fades from a specific point)? Or does it have a clear boundaries (you can speficially outline the area)?



List, in order of severity, the area(s) of pain: 1) ______________________ 4) ______________________
2) ______________________ 5) ______________________
3) ______________________ 6) ______________________

ONSET OF PAIN

When did your first experience your pain? Describe when and what you were doing. Please tell us your pain story.

____
____
____

Was there a specific event, accident, injury or illness that caused the pain? Y N Work related? Y N Auto accident? Y N

If Yes, approximate year of injury: ____________ Decribe injury: ______________________________

Think back to your childhood. Did you suffer any kind of accident or sports injury? Y N

If Yes, approximate year of injury: ____________ Decribe injury: ______________________________

FOOT / LOWER EXTREMITY HEALTH

Do you have neuropathy in your feet? Or, numbness, tingling, pain, swelling? Y N
Have you been told that you have one leg shorter than the other? Y N Did you wear leg braces as a child? Y N
Do you wear special shoes? Y N Do you wear heel lifts? Y N Do you wear orthotics in your shoes? Y N

Date: ____________________ Patient Name: ______________________________________ No. ______________

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Are you: ☐ Bow-legged ☐ Knock-kneed
Do you have pain in your: ☐ Foot/feet ☐ Knees ☐ Hips ☐ Sacroiliac Joint(s)
Do you have: ☐ Heel Spurs ☐ Achilles Tendonitis ☐ Plantar Fascitis ☐ Shin Splints ☐ Flat feet ☐ Foot flare
☐ Excessive arch ☐ Bunions ☐ Corns ☐ Neuropathy in your feet
Do you limp? Y N Do you think it is because of your ☐ Foot ☐ Ankle ☐ Knee ☐ Hip ☐ Spine
Do you drag your foot? Y N Do your shoes wear unevenly? Y N
Do you stand a lot? Y N Does your back or legs get tired or hurt after standing for short periods? Y N
Have you had surgery to your: ☐ Foot ☐ Ankle ☐ Knee ☐ Hip ☐ Lower back

BRACING

Please note: Over the counter elastic sleeves are not braces and do not provide adequate support. These do not generally provide relief from arthritis pain or provide stability to misaligned or unstable joints. If it was not obtained through a doctor's office or durable medical equipment company, it is not likely providing proper assistance.

Do you have low back pain or leg pain? Y N If yes, do you have a custom-fitted back brace? Y N If yes, how old is it? __________ years
Do you have hip pain? Y N If yes, do you have a custom-fitted hip brace? Y N If yes, how old is it? __________ years
Do you have knee pain? Y N If yes, do you have a custom-fitted knee brace? Y N If yes, how old is it? __________ years
Do you have neck pain or arm pain? Y N If yes, do you have an Aspen Therapy Treatment Neck Collar? Y N If yes, how old is it? __________ years
Have you had surgery to your: ☐ Foot ☐ Ankle ☐ Knee ☐ Hip ☐ Lower back ☐ Neck

Describe your pain (check all that apply)

☐ Aching	☐ Agonizing	☐ Boring	☐ Burning	☐ Constant	☐ Cramping
☐ Crushing	☐ Cutting	☐ Disabling	☐ Discouraging	☐ Distracting	☐ Dreadful
☐ Dull	☐ Electric	☐ Excruciating	☐ Incapacitating	☐ Intermittent	☐ Intolerable
☐ Nagging	☐ Numbing	☐ Pins & Needles	☐ Pinching	☐ Pressure	☐ Pulsing
☐ Radiating	☐ Sharp	☐ Shooting	☐ Spasms	☐ Splitting	☐ Squeezing
☐ Stabbing	☐ Stinging	☐ Tenderness	☐ Throbbing	☐ Tightness	☐ Tingling

☐ Other ____________________

What INCREASES your pain?

☐ Bending	☐ Cold / Ice	☐ Coughing	☐ Driving	☐ Exercise	☐ Heat Therapy
☐ Household Tasks	☐ Lifting	☐ Lying Down	☐ Medications	☐ Nothing Helps	☐ Physical Therapy
☐ Rest	☐ Sexual Activity	☐ Sitting	☐ Sneezing	☐ Stairs	☐ Standing
☐ Stress	☐ Talking About It	☐ Touching Others	☐ Walking	☐ Weather Changes	☐ Working

☐ Other ____________________

What DECREASES your pain?

☐ Bending	☐ Cold / Ice	☐ Coughing	☐ Driving	☐ Exercise	☐ Heat Therapy
☐ Household Tasks	☐ Lifting	☐ Lying Down	☐ Medications	☐ Nothing Helps	☐ Physical Therapy
☐ Rest	☐ Sexual Activity	☐ Sitting	☐ Sneezing	☐ Stairs	☐ Standing
☐ Stress	☐ Talking About It	☐ Touching Others	☐ Walking	☐ Weather Changes	☐ Working

☐ Other ____________________

When do you have pain? ☐ All the time ☐ Most of the time ☐ Some of the time ☐ Occasionally
Is there a time of day that the pain is worse? ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Nights
How has the pain changed since it first began? ☐ getting better ☐ staying the same ☐ getting worse

For your WORST pain problem:

What is your AVERAGE pain level that you feel daily?	NO PAIN	0	1	2	3	4	5	6	7	8	9	10	SEVERE PAIN
What is the HIGHEST pain level that you experience?	NO PAIN	0	1	2	3	4	5	6	7	8	9	10	SEVERE PAIN
What is the LOWEST pain level that you experience?	NO PAIN	0	1	2	3	4	5	6	7	8	9	10	SEVERE PAIN
What is your pain level RIGHT NOW	NO PAIN	0	1	2	3	4	5	6	7	8	9	10	SEVERE PAIN

Date: ____________ Patient Name: ____________________ No. ____________

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PEG: A Three Item Scale Assessing Pain Intensity and Interference

What number best describes your pain on average in the past week?	NO PAIN	0	1	2	3	4	5	6	7	8	9	10	SEVERE PAIN
What number best describes how, during the past week, pain has interfered with your enjoyment of life?	NO PAIN	0	1	2	3	4	5	6	7	8	9	10	SEVERE PAIN
What number best describes how, during the past week, pain has interfered with your general activity?	NO PAIN	0	1	2	3	4	5	6	7	8	9	10	SEVERE PAIN

PAST TREATMENTS

Have you had any of these procedures or treatments for pain? (check all that you have tried)
If this procedure or treatment was helpful, please circle the "Y". If it was not helpful, please circle the "N".

- ☐ Y N Acupressure
- ☐ Y N Acupuncture
- ☐ Y N Aquatic Therapy - pool
- ☐ Y N Arthroscopic Surgery
- ☐ Y N Bed Rest
- ☐ Y N Bio Feedback
- ☐ Y N Botox
- ☐ Y N Brace
- ☐ Y N Cervical Fusion
- ☐ Y N Chiropractic
- ☐ Y N Cold Therapy
- ☐ Y N Creams - OTC
- ☐ Y N Creams - Prescription
- ☐ Y N Counseling
- ☐ Y N Epidural Injections
- ☐ Y N Exercise / Aerobics
- ☐ Y N Facet Joint Injections
- ☐ Y N Heat Therapy
- ☐ Y N Herbal Treatment
- ☐ Y N Homeopathy
- ☐ Y N Hypnosis
- ☐ Y N Joint Replacement
- ☐ Y N Lumbar Fusion
- ☐ Y N Massage Therapy
- ☐ Y N Medication
- ☐ Y N Mobilizations
- ☐ Y N Nerve Blocks
- ☐ Y N Ocupational Therapy
- ☐ Y N Orthotics
- ☐ Y N Osteopathic Treatment
- ☐ Y N Pain Pump
- ☐ Y N Physical Therapy
- ☐ Y N Prosthetics
- ☐ Y N Radiation
- ☐ Y N Radiofrequency Ablation
- ☐ Y N Spine Stim. Implant
- ☐ Y N Supports
- ☐ Y N Surgery
- ☐ Y N Tens Unit
- ☐ Y N Traction
- ☐ Y N Trigger Pt. Injections
- ☐ Y N Ultrasound
- ☐ Y N Other ____________________

Which of these treatments, if any, were most helpful in relieving your pain? 1) ____________ 2) ____________ 3) ____________

What other healthcare providers have you seen for your pain?

- ☐ Chiropractor
- ☐ Neurologist
- ☐ Orthopedic Surgeon
- ☐ Pain Physician
- ☐ Physiatrist
- ☐ Podiatrist
- ☐ Rheumatologist
- ☐ Spine Surgeon
- ☐ Family Doctor
- ☐ Psychiatrist
- ☐ Pyschologist
- ☐ Other ____________________

PAST TESTING

What diagnostic tests have you had to diagnose and evaluate your pain?

- ☐ X-Ray Facility / Provider: ____________ Date: ____________
- ☐ Bone Scan Facility / Provider: ____________ Date: ____________
- ☐ C-T Scan Facility / Provider: ____________ Date: ____________
- ☐ Discogram Facility / Provider: ____________ Date: ____________
- ☐ EMG / NCV / Nerve Facility / Provider: ____________ Date: ____________
- ☐ MRI Facility / Provider: ____________ Date: ____________
- ☐ Myelogram Facility / Provider: ____________ Date: ____________
- ☐ Other: ____________________

EXERCISE RELIEF

What kind of exercise have you tried for pain relief?

- ☐ Aerobic Exercises
- ☐ Boxing
- ☐ Calisthenics
- ☐ Cycling
- ☐ Hiking
- ☐ Martial Arts
- ☐ Stretching Exercises
- ☐ Running
- ☐ Toning Exercises
- ☐ Walking
- ☐ Weight Training
- ☐ Yoga
- ☐ I am currently performing exercise.
- ☐ I cannot exercise due to: ____________________

____

Date: ____________ Patient Name: ____________________ No. ____________

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FUNCTIONAL RATING INDEX

Please rate how much your pain effects your life. In the past month, my pain has effected . . . .

my ability to perform routine daily activities	NO EFFECT	0	1	2	3	4	5	6	7	8	9	10	PREVENTS THIS
my ability to complete household chores	NO EFFECT	0	1	2	3	4	5	6	7	8	9	10	PREVENTS THIS
my ability to stand up from a sitting position	NO EFFECT	0	1	2	3	4	5	6	7	8	9	10	PREVENTS THIS
my ability to walk across the room	NO EFFECT	0	1	2	3	4	5	6	7	8	9	10	PREVENTS THIS
my ability to walk around the block	NO EFFECT	0	1	2	3	4	5	6	7	8	9	10	PREVENTS THIS
my ability to care for myself (bathing, dressing, etc.)	NO EFFECT	0	1	2	3	4	5	6	7	8	9	10	PREVENTS THIS
my ability to do my job	NO EFFECT	0	1	2	3	4	5	6	7	8	9	10	PREVENTS THIS
my ability to enjoy life	NO EFFECT	0	1	2	3	4	5	6	7	8	9	10	PREVENTS THIS
my ability to enjoy sex	NO EFFECT	0	1	2	3	4	5	6	7	8	9	10	PREVENTS THIS
my ability to sleep	NO EFFECT	0	1	2	3	4	5	6	7	8	9	10	PREVENTS THIS
my moods	NO EFFECT	0	1	2	3	4	5	6	7	8	9	10	PREVENTS THIS
my relationships	NO EFFECT	0	1	2	3	4	5	6	7	8	9	10	PREVENTS THIS

PRIMARY CARE PTSD SCREEN (PC-PTSD)

Instructions:

In your life, have you ever had any experience that was so frightening, horrible or upsetting that, in the past month, you:

1. Have had nightmares about it, or thought about it when you did not want to? Y N
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? Y N
3. Were constantly on guard, watchful, or easily startled? Y N
4. Felt numb or detached from others, activities, or your surroundings? Y N

OWESTRY PAIN DISABILITY QUESTIONNAIRE

Please check one box in each section.

Section 1: Pain intensity

- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad, but I can manage without having to take pain medication.
- ☐ Pain medication provides me with complete relief from pain.
- ☐ Pain medication provides me with moderate relief from pain
- ☐ Pain medication provides me little relief from pain
- ☐ Pain medication has no effect on my pain.

Section 2: Personal care (washing, dressing etc)

- ☐ I can take care of myself normally without causing increased pain
- ☐ I can take care of myself normally, but it increases my pain
- ☐ It is painful to take care of myself, and I am slow and careful
- ☐ I need help, but I am able to manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3: Lifting

- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights, but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (eg. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights
- ☐ I cannot lift or carry anything at all

Section 4: Walking

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile (1 mile = 1.6 km).
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can walk only using a crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5: Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair for as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6: Standing

- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but it increases my pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than 1/2
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Date: ______________________ Patient Name: ____ No. ________________

Section 7: Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ I can sleep well only using pain medication
- ☐ Even when I take medication, I sleep less than 8 hours.
- ☐ Even when I take medication, I sleep less than 4 hours.
- ☐ Even when I take medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

Section 8: Social Life

- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (e.g. sports, dancing_
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

Section 9: Traveling

- ☐ I can travel anywhere without increased pain
- ☐ I can travel anywhere, but it increases my pain.
- ☐ My pain restricts my travel over 2 hours.
- ☐ My pain restricts my travel over 1 hour.
- ☐ My pain restricts my travel to short necessary journeys under 1/2 hour.
- ☐ My pain prevents me all travel except for visits to the physician/therapist or hospital.

Section 10: Employment/Homemaking

- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increases my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

What activites can you no longer do because of your pain? ______________________________

What are your goals for your treatment at Bearden Healthcare? The more specific you can be, the better. ______________________________

____

What do you believe is necessary to help your pain and function improve? ______________________________

____

Have you ever been discharged from a pain clinic? Y N Name of Clinic: ______________________________

Why? ☐ Pill Count Off ☐ Drug Test result ☐ Multiple missed appointments ☐ Other: ______________________________

Explain what happened: ______________________________

Have you transferred your care here from a pain clinic? Y N Name of Clinic: ______________________________

Why? ☐ We take your insurance ☐ Convenience ☐ Clinic Closed ☐ Inadequate pain relief ☐ Provider stopped prescribing medicine
☐ Other: ______________________________

Are you ever concerned you are taking too much medication? Y N

Explain: ______________________________

Have you ever been criminally charged or convicted regarding drugs or alcohol? Y N
(Please note: answering 'Yes' will not prevent you from being accepted as a patient)
Details: ______________________________

Are you taking your medication as prescribed? Y N Are you giving away, selling or diverting any medication prescribed to you for pain? Y N
Date of the last pain medicine prescription: ____________________ Prescribed by: ______________________________
Do you have a valid government issued photo I. D.? Y N

Date: ____________________ Patient Name: ______________________________ No. ______________

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Please check the medications that you have used to treat your pain, currently or in the past. Also please check if these medications have been or were helpful and list any side effects that you experienced while taking this medication.

Medication Name Generic Name (Brand Name)	Currently Taking	Taken In The Past	Helpful	Not Helpful	Side Effects
Short Acting Opioids					
☐ Codine (Tylenol #3, #4)	☐	☐	☐	☐	____________
☐ Fentanyl (Actiq, Fentora)	☐	☐	☐	☐	____________
☐ Hydrocodone (Vicodin, Norco)	☐	☐	☐	☐	____________
☐ Hydromorphone (Dilaudid)	☐	☐	☐	☐	____________
☐ Meperidine (Demerol)	☐	☐	☐	☐	____________
☐ Morphine IR (MSIR)	☐	☐	☐	☐	____________
☐ Oxycodone (Percocet, Roxicet)	☐	☐	☐	☐	____________
☐ Tapentadol (Nucynta)	☐	☐	☐	☐	____________
☐ Tramadol (Ultram, Ultram ER)	☐	☐	☐	☐	____________
Long Acting Opioids					
☐ Buprenorphine (Butrans)	☐	☐	☐	☐	____________
☐ Buprenorphine/Naloxone (Suboxone)	☐	☐	☐	☐	____________
☐ Fentanyl Patch (Duragesic)	☐	☐	☐	☐	____________
☐ Levorphanol (Levodromoran)	☐	☐	☐	☐	____________
☐ Methadone (Dolophine)	☐	☐	☐	☐	____________
☐ LA Morphine (AMS Contin, Kadian, Avinza, Oramorph	☐	☐	☐	☐	____________
☐ LA Oxmorphone (Opana ER)	☐	☐	☐	☐	____________
☐ CR Oxycodone (Oxycontin)	☐	☐	☐	☐	____________
Benzodiazepines					
☐ Alpazolam (Xanax)	☐	☐	☐	☐	____________
☐ Chlordiazepoxide (Librium)	☐	☐	☐	☐	____________
☐ Clonazepam (Klonopin)	☐	☐	☐	☐	____________
☐ Diazepam (Valium)	☐	☐	☐	☐	____________
☐ Lorazepam (Ativan)	☐	☐	☐	☐	____________
Muscle Relaxants					
☐ Baclofen (Kemstro, Lioresal, Liofen, Gablofen, Lyflex, Beklo)	☐	☐	☐	☐	____________
☐ Carlsoprodol (Soma)	☐	☐	☐	☐	____________
☐ Cyclobenzaprine (Flexeril)	☐	☐	☐	☐	____________
☐ Metaxalone (Skelaxin)	☐	☐	☐	☐	____________
☐ Methocarbamol (Robaxin)	☐	☐	☐	☐	____________
☐ Orphenadrine (Norflex)	☐	☐	☐	☐	____________
☐ Tizanidine (Zanaflex)	☐	☐	☐	☐	____________
Antidepressants					
☐ Amitripyline (Elavil)	☐	☐	☐	☐	____________
☐ Desipramine (Norpramin)	☐	☐	☐	☐	____________
☐ Doxepin (Deptran, Sinequan, Prudoxin, Zonalon)	☐	☐	☐	☐	____________
☐ Imipramine (Tofranil)	☐	☐	☐	☐	____________
☐ Nortipyline (Pamelor)	☐	☐	☐	☐	____________
☐ Trazadone (Desyrel, Oleptro)	☐	☐	☐	☐	____________

Date: ____________ Patient Name: ______________________________ No. ____________

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Medications Continued

Medication Name Generic Name (Brand Name)	Currently Taking	Taken In The Past	Helpful	Not Helpful	Side Effects
Anticonvulsants					
☐ Carbamazepine (Tegretol)	☐	☐	☐	☐	________
☐ Gabapentin (Neurontin)	☐	☐	☐	☐	________
☐ Levetiracetam (Keppra)	☐	☐	☐	☐	________
☐ Pregabalin (Lyrica)	☐	☐	☐	☐	________
☐ Topiramate (Topamax)	☐	☐	☐	☐	________
SNRI					
☐ Duloxetine (Cymbalta)	☐	☐	☐	☐	________
☐ Milnacipran (Savella)	☐	☐	☐	☐	________
☐ Venlafaxine (Effexor)	☐	☐	☐	☐	________
Topicals					
☐ Flector/Pennsaid Patch	☐	☐	☐	☐	________
☐ Lidoderm Patch	☐	☐	☐	☐	________
☐ Topical Creams	☐	☐	☐	☐	________
Migraine					
☐ Amidrin (Duradrin, Epidrine, Nodolor)	☐	☐	☐	☐	________
☐ Ergotamine (Cafergot, DHE45)	☐	☐	☐	☐	________
☐ Fioricet / Esgic	☐	☐	☐	☐	________
☐ Frovatriptan (Frova)	☐	☐	☐	☐	________
☐ Naratriptan (Amerge)	☐	☐	☐	☐	________
☐ Rizatriptan (Maxalt)	☐	☐	☐	☐	________
☐ Sumatriptan (Imitrex)	☐	☐	☐	☐	________
Sleep Aids					
☐ Diphenhydramine (Nytol, Sominex)	☐	☐	☐	☐	________
☐ Ramelton (Rozerem)	☐	☐	☐	☐	________
☐ Temazapan (Restoril)	☐	☐	☐	☐	________
☐ Triazolam (Halcion)	☐	☐	☐	☐	________
☐ Zaleplon (Sonata)	☐	☐	☐	☐	________
☐ Zolpidem (Ambien)	☐	☐	☐	☐	________
☐ OTC Sleep Aid: ________	☐	☐	☐	☐	________
Stimulants					
☐ Amphetamine (Adderall)	☐	☐	☐	☐	________
☐ Astmoxetine (Strattera)	☐	☐	☐	☐	________
☐ Methylphenidate (Ritalin, Concerta)	☐	☐	☐	☐	________
☐ Modafinil (Provigil)	☐	☐	☐	☐	________
Atypical					
☐ Haloperidol (Haldol)	☐	☐	☐	☐	________
☐ Olanzapine (Zyprexa)	☐	☐	☐	☐	________
☐ Ziprasidone (Geodon)	☐	☐	☐	☐	________

Date: ____________ Patient Name: ______________________ No. __________

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PHARMACOGENETIC TESTING

Have you had pharmacogenetic testing to evaluate how your body metabolizes medications? Y N ☐ Not sure Clinic performed? ________________

Do you know the name of the lab doing the test? Y N Name: ________________

Do you know the results? Y N Results: ________________

Do you know if there was a CYP450 Chromosome Metabolic Abnormality? ☐ Yes, there was ☐ I do not know ☐ No

CIRCULATION

Are you normally too warm or too cool when others around you are comfortable? ☐ Neither. I am comfortable. ☐ Too Warm ☐ Too Cool

What body parts are too cool or too warm? ☐ Hands ☐ Feet ☐ Extremities ☐ Whole Body

Do you have tingling or numbness? ☐ Hands ☐ Feet ☐ Extremities ☐ Whole Body

SELF EVALUATION

How often do you feel tired?	NEVER	0	1	2	3	4	5	6	7	8	9	10	ALWAYS
How often do you feel sad?	NEVER	0	1	2	3	4	5	6	7	8	9	10	ALWAYS
How often do you feel pessimistic?	NEVER	0	1	2	3	4	5	6	7	8	9	10	ALWAYS
How often do you feel like a failure?	NEVER	0	1	2	3	4	5	6	7	8	9	10	ALWAYS
How often do you feel dislike for yourself?	NEVER	0	1	2	3	4	5	6	7	8	9	10	ALWAYS
How often do you feel self critical?	NEVER	0	1	2	3	4	5	6	7	8	9	10	ALWAYS
How often do you feel suicidal?	NEVER	0	1	2	3	4	5	6	7	8	9	10	ALWAYS
How often do you feel a lack of interest?	NEVER	0	1	2	3	4	5	6	7	8	9	10	ALWAYS
How often do you feel stressed?	NEVER	0	1	2	3	4	5	6	7	8	9	10	ALWAYS
How often do you feel anxiety?	NEVER	0	1	2	3	4	5	6	7	8	9	10	ALWAYS

CANCER HISTORY

Have you been diagnosed with cancer? Y N What type? ________________ Area of the body: ________________

Type of treatment: ________________ Do you have pain in this area? Y N

Provider that treated you: ________________ Clinic Name: ________________

Phone #: ________________ Fax #: ________________

For Office Use Only
- See Screener and Opioid Assessment for Patients with Pain (SOAPP-R)
- See Alcohol Use Disorders Identification Test (AUDIT)

Date: ________________ Patient Name: ________________ No. ________________

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ADDITIONAL HEALTH REVIEW

Do you now, or have you had in the past, any of the following issues:

Addiction to any drug?	Y	N	☐ Past	☐ Current
Addiction to alcohol?	Y	N	☐ Past	☐ Current
Suffer from depression?	Y	N	☐ Past	☐ Current
Suffer from anxiety?	Y	N	☐ Past	☐ Current
Respiratory disorder / COPD?	Y	N	☐ Past	☐ Current

Are you currently taking a benzodiazepene medication? Y N Name(s): ____________________

Have you been diagnosed with a personality disorder? Y N Diagnosis: ____________________

Have you been diagnosed with sleep apnea? Y N Are you being treated? Y N

How: ____________________

Do you have kidney (renal) disease? Y N Type: ____________________

Do you have liver (hepatic) disease? Y N Type: ____________________

Do you smoke? Y N

Date: ______________ Patient Name: ____________________ No. ______________

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RAND 36-Item Short-Form Health Survey

Health Risk Assessment (96160)

Choose one option for each questionnaire item.

1. In general, would you say your health is:
- ☐ 1 - Excellent
- ☐ 2 - Very good
- ☐ 3 - Good
- ☐ 4 - Fair
- ☐ 5 - Poor

2. **Compared to one year ago**, how would you rate your health in general **now**?
- ☐ 1 - Much better now than one year ago
- ☐ 2 - Somewhat better now than one year ago
- ☐ 3 - About the same
- ☐ 4 - Somewhat worse now than one year ago
- ☐ 5 - Much worse now than one year ago

The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
3. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	☐ 1	☐ 2	☐ 3
4. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐ 1	☐ 2	☐ 3
5. Lifting or carrying groceries	☐ 1	☐ 2	☐ 3
6. Climbing **several** flights of stairs	☐ 1	☐ 2	☐ 3
7. Climbing **one** flight of stairs	☐ 1	☐ 2	☐ 3
8. Bending, kneeling, or stooping	☐ 1	☐ 2	☐ 3
9. Walking **more than a mile**	☐ 1	☐ 2	☐ 3
10. Walking **several blocks**	☐ 1	☐ 2	☐ 3
11. Walking **one block**	☐ 1	☐ 2	☐ 3
12. Bathing or dressing yourself	☐ 1	☐ 2	☐ 3

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

	Yes	No
13. Cut down the amount of time you spent on work or other activities	☐ 1	☐ 2
14. Accomplished less than you would like	☐ 1	☐ 2
15. Were limited in the kind of work or other activities	☐ 1	☐ 2
16. Had difficulty performing the work or other activities (for example, it took extra effort)	☐ 1	☐ 2

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

	Yes	No
17. Cut down the amount of time you spent on work or other activities	☐ 1	☐ 2
18. Accomplished less than you would like	☐ 1	☐ 2
19. Didn't do work or other activities as carefully as usual	☐ 1	☐ 2

20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?
- ☐ 1 - Not at all
- ☐ 2 - Slightly
- ☐ 3 - Moderately
- ☐ 4 - Quite a bit
- ☐ 5 - Extremely

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21. How much **bodily** pain have you had during the **past 4 weeks**?
    - ☐ 1 - None
    - ☐ 2 - Very mild
    - ☐ 3 - Mild
    - ☐ 4 - Moderate
    - ☐ 5 - Severe
    - ☐ 6 - Very severe

22. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?
    - ☐ 1 - Not at all
    - ☐ 2 - A little bit
    - ☐ 3 - Moderately
    - ☐ 4 - Quite a bit
    - ☐ 5 - Extremely

These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the **past 4 weeks**...	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
23. Did you feel full of pep?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
24. Have you been a very nervous person?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
25. Have you felt so down in the dumps that nothing could cheer you up?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
26. Have you felt calm and peaceful?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
27. Did you have a lot of energy?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
28. Have you felt downhearted and blue?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
29. Did you feel worn out?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
30. Have you been a happy person?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
31. Did you feel tired?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

32. During the **past 4 weeks**, how much of the time has **your physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?
    - ☐ 1 - All of the time
    - ☐ 2 - Most of the time
    - ☐ 3 - Some of the time
    - ☐ 4 - A little of the time
    - ☐ 5 - None of the time

How TRUE or FALSE is **each** of the following statements for you.	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
33. I seem to get sick a little easier than other people	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
34. I am as healthy as anybody I know	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
35. I expect my health to get worse	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
36. My health is excellent	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

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Over the last two 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 of 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 asleep 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 Feeking 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 figety 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 thoughts of hurting yourself	0	1	2	3
	Add columns	+	+	

Provider: For interpretation of TOTAL, please refer to the accompanying score card.

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
10 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 mwith other people.	________	________	________	________

Date: __________________ Patient Name: ____________________________________ No. ____________

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Informed Consent: Controlled Substance Treatment

Please read the information below carefully and ask your provider if you have any questions relating to the medication prescribed to you.

Using Controlled Medications to Treat Pain

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

How Do Opioids Work?

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

How Do Benzodiazepines Work?

1. The benzodiazepines are a class of drugs with varying properties, which act by slowing down the central nervous system.
2. Benzodiazepines are useful in treating anxiety, insomnia, agitation, seizures and muscle spasms. While benzodiazepines do not treat acute or chronic pain, they are taken by patients with pain for other issues (such as anxiety or muscle spasms).
3. These medications may work differently on different people because of a number of factors.
4. Side effects and complications will also vary individually.

What To Expect When you Take Controlled Mediations for Pain and Related Conditions

1. Pain relief - reduction
2. Reduction of anxiety and stress caused by pain
3. Side effects

What Should NOT be expected From Treatment with Controlled Medications

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

Negative Effects of Controlled Medications in Different People

1. Opioid Side Effects
   a. Common side effects include:
      - constipation
      - dry mouth
      - sweating
      - nausea
      - drowsiness
      - euphoria
      - forgetfulness
      - difficulty urinating
      - itching
   b. Uncommon side effects include:
      - confusion
      - hallucinations
      - shortness of breath
      - depression
      - lack of motivation
2. Benzodiazepines Side Effects
   a. The most common side effects include:
      - clumsiness or unsteadiness
      - dizziness, lightheadedness, drowsiness
      - slurred speech
   b. Less common side effects include:
      - anxiety
      - confusion (may be common in the elderly(
      - fast, pounding or irregular heartbeat
      - mental depression
      - abdominal or stomach cramps or pain
      - blurred vision or other changes in vision
      - changes in sexual desire or ability
      - constipation
      - diarrhea
      - dryness of mouth or increased thirst
      - false sense of well being
      - headache
      - increased bronchial secretions or saliva
      - muscle spasms
      - nausea or vomiting
      - problems with urination
      - trembling or shaking
      - unusual tiredness or weakness
3. Physical Dependency
   a. Opioid medications will cause a physical dependency marked by abstinence syndrome when they are stopped abruptly. If these medications are stopped or rapidly decreased the patient will experience chills, goose bumps, profuse sweating, increased pain,

Date: ___________________ Patient Name: ___________________________________ No. ______________

irritability, anxiety, agitation and diarrhea. The medicines will not cause these symptoms if taken as prescribed and any decision to stop these medicines should be done under the supervision of your provider in a slow downward taper.

b. Benzodiazepines may be habit-forming (causing mental or physical dependence), especially when taken for a long time or in high doses. Some signs of dependence on benzodiazepines are a strong desire or need to continue taking the medicine and a need to increase the dose to receive the effects of the medicine. Withdrawal effects occurring, for example: irritability, nervousness, trouble sleeping, abdominal or stomach cramps, trembling or shaking.

4. Misuse Of Medication: 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.
5. Diversion
   It is illegal to share your controlled medications with other people. It is illegal to provide false information to a prescriber in an attempt to obtain controlled medication. It is illegal to doctor shop, or visit multiple doctors in an attempt to obtain controlled medications. Federal and state laws exist to address diversion problems. We are required by law to report suspected doctor shopping. It is critical that you safeguard your controlled medications and use them only as prescribed by your doctor.
6. Driving
   Studies of patients with chronic pain demonstrate improved driving skills when taking certain controlled substances, but individuals 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 controlled medications. This is especially important if your work involves driving, making decisions that effect others, etc.

Common Sense Rules for Using Controlled Medications

1. Follow your provider's recommendations
2. Do not take more or fewer pills than prescribed, without discussing this first with your physician and receive permission to do so.
3. Do not share medication with family or friends.
4. Do not take medication from family or friends.
5. Do not stop these medications abruptly. Dose reductions need to be discussed and cleared by your provider. This is important, no matter which controlled mediation you take.
6. Do not sell medications.
7. Do not take medications in any manner other than prescribed. For example, do not chew or inject your medications.
8. Keep all medications out of reach of children.
9. Do not leave your prescription or controlled medications lying around unprotected for others to steal and abuse them.
10. 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.
11. Alcohol use should be curtailed when using controlled medications.

Continued use of controlled medication is based on your provider's judgment and a determination of whether the benefits to you 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 mediations in this process. When used properly, controlled mediations 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 him or her about your pain control needs. By doing so, medications can be used safely and successfully.

By your signature below, you are acknowledging that you have read and reviewed these matters with your provider and that you have sufficient information to make a decision 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 use of controlled medications and how they fit in to your pain management treatment plan.

Patient Name: ____________________

Patient Signature: ____________________

Provider Signature: ____________________

Date: ____________________

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Patient Agreement: Controlled Substance Treatment

I understand that this agreement between myself, ______________________________ and Bearden Healthcare Associates, is intended to clarify the manner in which chronic (long-term) controlled substances will be used to manage my chronic pain. Chronic controlled substance therapy for patients who do not suffer from cancer pain is a controversial issue.

I understand that there are side effects to this therapy. These include, but are not limited to, allergic reactions, depression, sedation, decreased mental ability, itching, difficulty in urinating, nausea and vomiting, loss of energy, decreased balance and greater risk of falling, constipation, decreased sexual desire and function, potential for overdose and death. Care should be taken when operating machinery or driving a car while taking these medications. When controlled substances are used long term, some particular concerns include the development of physical dependence and addiction. I understand these risks and have had all my questions answered by my provider.

I understand that my BHA provider will prescribe controlled substances only if the following rules are adhered to:

- All controlled substance prescriptions must be obtained from your BHA provider. If a new condition develops, such as trauma or surgery, then the provider caring for that problem may prescribe narcotics for the increase in pain that may be expected. I will notify my BHA provider within 48 hours of my receiving a narcotic or any other controlled substance from any other physician or other licensed medical provider.
- For females only: If I become pregnant while taking this medicine, I will immediately inform my obstetrician and obtain counseling on the risks to the baby.
- I will submit urine, saliva and/or blood on request for testing at any time without prior notification to detect the use of non-prescribed drugs and medications, and confirm the use of prescribed ones. I will submit to pill counts without notice as per provider's request. I will pay any portion of the costs associated with urine and blood testing that is not covered by my insurance.
- All prescriptions must be filled at the same pharmacy, which is authorized to release a record of my medications to this office upon request. A copy of this agreement will be sent to my pharmacy.
- Pharmacy Name: ______________________________
  Pharmacy Address: ______________________________
  Pharmacy Tel #: ______________________________
- The daily dose may not be changed without my BHA provider's consent. This includes either **increasing** or **decreasing** the daily dose. Please call the office if you need guidance.
- Prescription refills will not be given prior to the planned date determined by the dose and quantity prescribed. I will accept generic medications.
- Accidental destruction, loss of medications or prescriptions will not be a reason to refill medications or rewrite prescriptions early. I will safeguard my controlled substance mediations from use by family members, children or unauthorized persons.
- You may be asked to have an evaluation by either a psychiatrist, psychologist or pain specialist to help manage your medication needs.
- If your provider determines that you are not a good candidate to coordinate with the medication, you may be referred to a detoxification program or evaluation by a pain management medicine specialist.
- These medications may be discontinued or adjusted at your provider's discretion.
- I understand that it is my provider's policy that all appointments must be kept or cancelled at least 2 working days in advance. I understand that the original bottle of each prescribed controlled substance medication must be brought to every visit, if requested.

Opioid Therapy Statement

BHA's goal for all our patients is to give you back your life by reducing your pain and improving your daily functioning. We accomplish this goal with a customized, comprehensive and effective treatment plan that reduces risks and maximizes benefits.

To protect our patients from the significant risks associated with opioid therapies (also known as narcotic medications). We stringently follow Federal DEA recommendations regarding the prescribing of opioid medications. Furthermore, we only prescribe these medications if, after a thorough screening of your current and past medical history, our providers determine that opioid therapy is medically warranted.

BHA takes a conservative approach to opioid therapy, typically prescribing a lower dose of medications. Research results continue to demonstrate that a regimen of higher doses can result in greater risk of physical dependence, tolerance and addiction versus a more positive and long-lasting outcome with a treatment plan that includes lower doses.

We track our treatment outcomes to ensure that our patients are being helped. We are proud of our results and believe that if you suffer from chronic pain, we can absolutely help you. We provide a multidisciplinary approach to chronic pain that is safe, minimally invasive and clinically proven to be highly effective.

I understand I am responsible for meeting the terms of this agreement and that failure to do so may result in medication changes or my discharge as a patient of BHA. Grounds for opioid medication being dicontinued or being discharged include, but are not limited to: evidence of recreational use, evidence of drug diversion, of altering prescriptions (this may result in criminal prosecution), of obtaining controlled substance prescriptions from other doctors without notifying this office, abusive language towards staff, development of progressive tolerance, use of alcohol or intoxicants, engagement in criminal activities, etc.

Patient Signature: ______________________________ Date: ______________

Date: ______________ Patient Name: ______________________________ No. ______________