Date: _____/_____/_____

Pain Management Intake Sheet

Name: _____ Chart: _____

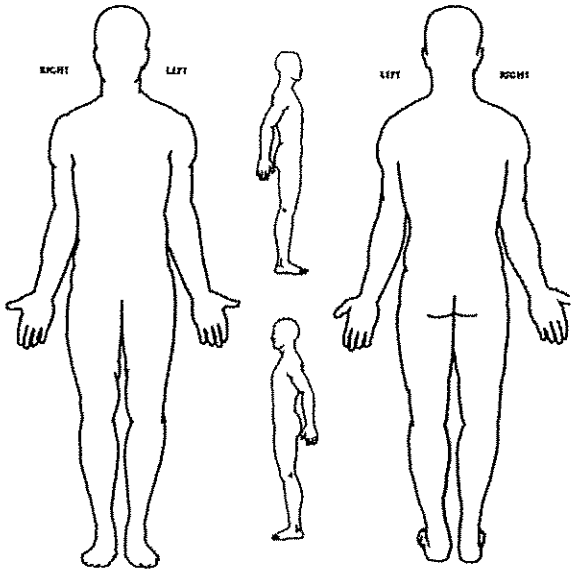
Date of Birth: _____/_____/_____ Phone #: _____

PCP: _____ When did the problem begin? _____/_____/_____

What activity triggered it? _____

Mark problem areas of pain:

xxx Aching	- - - Burning	••• Pin & Needles
>>> Shooting	/// Stabbing	ooo Throbbing



Pain Scale

Rate your pain on the scale from 1-10 with an X

NO PAIN	MINIMAL	MODERATE	INTENSE	EMERGENCY
0	1-3	4-6	7-9	10

1 2 3 4 5 6 7 8 9 10

My pain today compared to onset of problem is: The Same ____ Better____ Worse____

My pain is improved by:

☐ Sitting ☐ Standing ☐ Walking ☐ Laying ☐ Bending Forward ☐ Bending Back

Describe in detail: _____

My pain is worsened by:

☐ Sitting ☐ Standing ☐ Walking ☐ Laying ☐ Bending Forward ☐ Bending Back
☐ Sneeze/Cough ☐ Bowel Movement

Describe in detail: _____

My pain is described as:

☐ Constant ☐ Intermittent ☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Stabbing
☐ Searing ☐ Throbbing ☐ Shooting ☐ Cramping ☐ Numbness/Tingling

Describe in detail: _____

If you have low back pain and leg pain please select the statement that best fits:

_____ My back pain is greater than my leg pain.
_____ My leg pain is greater than my back pain.
_____ My back pain is equal to my leg pain.

If you have neck and arm pain please select he statement that best fits:

_____ My neck pain is greater than my arm pain.
_____ My arm pain is greater than my neck pain.
_____ My neck pain is equal to my arm pain.

Previous Pain Injections:

☐ Trigger Points ☐ Epidurals ☐ Facet Injections ☐ Discogram

Other: _____

Other Therapies:

☐ Physical Therapy ☐ Chiropractic ☐ Massage Therapy ☐ Acupuncture ☐ Biofeedback

Surgery (list type & date): _____

Other: _____

Previous Pain Medications Tried and Effect:

Medications	Dosage	Effect

Do you have any history of substance abuse? Yes ____ No ____

If yes, list substance(s) and date(s): _____

Current Medications (LIST ALL MEDICATIONS, INCLUDING VITAMINS):

Medications	Dosage	Effect

Do you take any blood thinners? (Coumadin, Plavix, Lovenox, Eliquis, Pradaxa, etc.) Yes ____ No ____

Do you have any bleeding disorders or clotting problems? Yes ____ No ____

Allergies:

☐ None ☐ Penicillin ☐ Sulfa ☐ Iodine ☐ IVP Dye/Contrast ☐ Latex ☐ Eggs

Other: _____

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Date: _____/_____/_____

Patient Name: _____

Opioid Risk Assessment

		YES	NO	Item Score if Female	Item Score if Male
1. Family History of Substance Abuse	Alcohol			1	3
	Illegal Drugs			2	3
	Prescription Drugs			4	4
2. Personal History of Substance Abuse	Alcohol			3	3
	Illegal Drugs			4	4
	Prescription Drugs			5	5
3. Age (Mark box if 16-45)				1	1
4. History of Preadolescent Sexual Abuse				3	0
5. Psychological Disease	ADD/ADHS			2	2
	OCD				
	Bipolar				
	Schizophrenia				
	Depression			1	1
			Total:		

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Opioid (Narcotic) Agreement

In select cases some patients are placed on pain medication (Opiates) as part of their treatment plan. If it is decided by you and the doctor that pain medicine will be part of your treatment plan, the following will apply:

In order to provide the best care possible for my pain treatment, there needs to be a plan of care that helps to give these medicines safely. This agreement is about my use of opioid pain medicine prescribed by my doctor. I understand that I will receive prescriptions for opioid medications only if I do the following:

1) I will use the medications only as directed by my prescribing doctor at Orthopaedic Center of South Florida (OCSF) (and nurse practitioner/physician assistant (NP/PA), if I have one as part of my care team).

2) I will receive opioid prescriptions from only my prescribing doctors as OCSF and NP/PA, not from other doctors or nurses or other clinics or emergency departments.

3) If I do receive opioids from any other source (such as after surgery, or from an emergency visit due to a broken bone, etc.), I will let my prescribing doctor at OCSF know about this in person or by a phone call prior to filling that prescription. If it is after hours, on the weekend or a holiday I will notify him/her the next business day.

4) I understand that my prescription is to be taken as directed, and should last until my next refill date. If my pain is increasing, I will call my doctor to talk about this. I won't increase my dose except under the direction of my OCSF doctor or NP/PA.

5) I will not expect to receive replacement prescriptions for any medications that I have lost or that have been stolen regardless of the circumstances.

6) Refills will NOT be made at night, on holidays or weekends.

7) I agree that when I get my medicine at the pharmacy, I will count the pills to make sure I have received the correct amount. I will not expect my OCSF doctor or NP/PA to give me a new prescription just because the amount isn't right.

8) I will accept generic brands of my prescription medication, when my OCSF doctor or NP/PA decides that this is appropriate.

9) If it appears that there are no clear benefits to my daily function or quality of life from the pain medicine, I will taper or stop my medication as directed by my OCSF doctor or NP/PA.

10) I understand that my OCSF doctor or NP/PA may stop my opioids if, in their professional judgment, they determine that stopping opioids is in my best interest.

11) I agree to have urine and blood drug tests as requested by my OCSF doctor or NP/PA, or nurses/medical assistants acting on their behalf. I understand in addition to a preliminary drug screen, urine and blood tests will be sent to an independent lab for confirmatory results where I may incur a separate bill.

Patient Initials: _____ **1/2**

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12) I recognize that pain can be a complex problem. My pain may be helped by other treatments (such as physical therapy (PT), counseling, behavioral medicine strategies, interventional therapies, etc.). I agree to actively participate in all parts of my treatment as recommended by my OCSF doctor or NP/PA to improve my level of functioning and to improve coping.

13) As discussed in the office, I understand that I need to demonstrate that the opioid pain medication is helping to improve my function. I am expected to walk or exercise for 20 minutes at a time at least 5 times a week.

14) I agree to schedule and keep follow-up appointments with my OCSF doctor and NP/PA at the recommended intervals (initially every month and at least every 3 months). Renewals are contingent on keeping scheduled appointments. Advance notice of 2 business days is required for refills of prescriptions.

15) I agree to use only one pharmacy for filling all of my opioid prescriptions, and will contact the prescribing doctor at OCSF or NP/PA if any exception is to be made (prior to the filling of the prescription).

16) I have been counseled by my OCSF doctor or NP/PA not to drive or operate machinery while on this medication until I know how it will affect me.

17) I understand that these medications have profound side effects, including, but not limited to, respiratory depression (stop breathing), constipation, sedation, increased pain, decreased libido (sex drive), nausea and vomiting, pinpoint pupils, pruritus (itching), urinary retention, decreased blood pressure and death.

18) I understand it is my responsibility to place the medicine in a safe place, especially out of the reach of children, my doctor strongly recommends a lock box.

If the violation of this agreement involves obtaining controlled substances from another individual or if you engage in any illegal activity, such as altering a prescription, it is understood that incident may be reported to other physicians caring for you, local medical facilities, pharmacies, and other authorities, such as the local police department, Drug Enforcement Agency, etc.

I understand that this Narcotic Agreement will become part of my permanent medical record.

I have had the chance to ask my doctor and/or NP/PA questions about my pain and my pain medication. I will ask more questions as they arise over the course of my care. THIS AGREEMENT WILL SUPERSEDE ALL OTHER AGREEMENTS. BY SIGNING BELOW I INDICATE THAT I UNDERSTAND AND AGREE TO ALL THE TERMS OF THE ABOVE CONTRACT.

Patient	Date
Physician/NP/PA	Date
Witness	Date

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