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Pain Management Program

Each page of this pain packet must be completed.

In addition to the packet, you will also need to provide our office with the following:

1. **The medical records, including MRI, X-RAY, and CT scan REPORTS (Not films or disks) from every doctor who has treated you for the problem causing your pain in the past year (1 yr)**

2. **The complete pharmacy records for all controlled substances you have received in the past year.**

3. **A written referral to our office from your doctor requesting pain management care.**

Our office will contact you within 4-6 weeks after receiving all your records. If your records are incomplete, we will contact you one time, and one time only, to inform you what is missing. We cannot make a decision without complete records. Providing us those records is your responsibility. Please do not ask us to contact your doctor or the hospital to obtain your records.

Final Points

1. **Pain management involves much more than just medication. You will be expected to attend counseling and various types of physical or occupational therapy. If you are just looking for narcotic medication, we will not be able to help you.**

2. **The number 1 reason for a delay in being accepted into the program is the failure to provide us with your complete file of needed medical records.**

Pain Management Program - Patient Information

Patient's Name:_____

Date of Birth:_____ **Gender**_____ **Marital Status**_____

Home Phone_____ **Cell Phone:**_____

Home Address_____

When did your pain begin and what caused it?

_____
_____
_____

What has been done to <u>diagnose and evaluate</u> your pain? (Include names of doctors seen, dates, and tests done - such as CT scans and MRI's) This list must be complete. Use additional pages if necessary.

_____
_____
_____
_____
_____
_____

What has been done to <u>treat</u> your pain? (Include names of doctors seen, dates, and treatments other than medication, such as operations, nerve blocks, physical therapy, etc.) This list must be complete. Use additional pages if necessary.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Pain Management Program - Insurance Information

Please include with this packet a copy of the front and back of your insurance card(s); and the front of your driver's license or other form of legal identification~ provided by the state of your residence. We need this information PRIOR scheduling appointments for verification of eligibility. Thank you.

Patient Name: _____

Primary Insurance _____

Primary Insurance Company Phone Number :_____
Insurance Company Internet Address: _____
Are you the policy holder: Y or N
If not, list the policy holder' Name: _____

Policy member's ID number:_____

Social Security number of policy Holder: _____

Date of birth of the Policy Holder:_____

***Do you have a Secondary Insurance*? Y or N**

Secondary Insurance Company Name _____

Insurance Company Internet Address: _____

Policy Holder's full name _____

Policy Holder's ID number _____ Date of Birth __/___/_____

Social Security Number of Policy Holder: _____

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Pain Management Program - Pain Scale

- **0 = No Pain**
- **1 = Very minor annoyance -occasional minor twinges. No medication needed.**
- **2 = Minor Annoyance- occasional strong twinges. No medication needed.**
- **3 = Pain annoying enough to be distracting. Mild painkillers take care of it.**
- **4 = Pain can be ignored if you are really involved in your work, but still distracting. Mild painkillers remove pain for 3-4 hours.**
- **5 = Pain cannot be ignored for more than 30 minutes. Mild painkillers improve pain for 3-4 hours.**
- **6= Pain cannot be ignored for any length of time, but you can still go to work and participate in social activities. Stronger painkillers are only partially effective.**
- **7 = Pain makes it difficult to concentrate and interferes with sleep. You can function with effort. Stronger painkillers are only partially effective.**
- **8 = Physical activity severely limited. You can read and converse with effort**
- **9 = Unable to speak. Crying out or moaning uncontrollably. Near delirium.**
- **10 = Unconscious. Pain makes you pass out.**

Pain Management Program - Pain Description

Please list the areas of your body where you have pain._____
_____
_____
_____
_____

Tell us what the pain feels like to you using your own words.
_____
_____
_____
_____

List the things that decrease your pain and help you to feel better.
_____
_____
_____
_____

List the things that increase your pain and make you feel worse.
_____
_____
_____
_____
_____

Using the previous attached Pain Scale (see pg 4) please answer the following questions:

What number best describes your pain at its <u>worst</u> during the last month: _____

What number best describes your pain at its <u>least</u> during the last month: _____

What number best describes your pain on <u>average</u> during the last month: _____

What number best describes your pain as it is <u>right now</u>: _____

Pain Management Program - Pain Experiences

In this section, we would like you to tell us how pain affects the different aspects of your life. Please answer each with a sentence or two and be specific. Each must be answered.

Tell us how your pain affects:

General Activities: _____

Mood: _____

Ability To Walk: _____

Normal Work Routine: _____

Relations With Other People: _____

Sleep:_____

_____

_____

_____

_____

_____

_____

Enjoyment of Life:_____

_____

_____

_____

_____

_____

_____

_____

Pain Management Program - Pain Diary

To give us more information about your pain, please record your pain level 3 times per day for a week. Please use the Pain Scale that is included in this packet. Please also record how your pain has affected your activities each day. Please record any side effects from pain medication(s) you may be taking.

Pain diary for the week of: _____

Sunday Pain level: Morning _____ Midday_____ Evening_____
Tell us about your day:_____
_____
_____
_____

Monday Pain level: Morning_____ Midday_____ Evening_____
Tell us about your day:
_____
_____
_____
_____

Tuesday Pain level : Morning_____ Midday_____ Evening_____
Tell us about your day:_____
_____
_____
_____

Wednesday Pain level: Morning_____ Midday_____ Evening_____
Tell us about your day:_____
_____
_____
_____

Thursday **Pain level: Morning_____ Midday_____ Evening_____**
Tell us about your day:_____
_____
_____
_____
_____

Friday **Pain level: Morning_____ Midday_____ Evening_____**
Tell us about your day:_____
_____
_____
_____

Saturday **Pain level: Morning_____ Midday_____ Evening_____**
Tell us about your day:_____
_____
_____
_____

Medication Side-Effects

Please list the medications that have caused your side effects. Tell us what those side effects were and what you and your doctor did about them.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Pain Management Program:

Ability to concentrate:

Appetite:

Finally, tell us what gives you pleasure and enjoyment in your life. Tell us about your hobbies and interests. What are your plans for the future? What is unique about you?

Pain Management Program - Treatments

In the space below, please list each treatment you have had for your pain. Tell us how successful the treatment was, if you are still getting it, when you stopped, and any problems. Treatments include medication, physical therapy, occupational therapy, nerve blocks, TENS units, acupuncture, psychotherapy with a counselor or psychologist, etc.

1._____

2._____

3._____

4._____

5._____

6._____

Please describe your:

Domestic Situation:

Who lives with you?_____
Are there any substance abuse issues in your household?_____
If yes, please explain:_____
_____

Are you able to take care of yourself?_____
If no, please enter the name and phone # of your caregiver:_____
_____

Work History:

List all your jobs for the past 10 years, including when you started and when and why you left: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Legal Matters:

Are you presently involved in any lawsuits? _____
If yes, please explain: _____
_____
_____
_____
_____
_____
_____

Substance Use/Abuse: (Past)

Past Drug Use: **Circle which drugs you have used and indicate if you used it (O) occasionally, (F) frequently, or (C) continuously:**

___Alcohol ___Amphetamines ___Barbiturates ___Cocaine ___Heroin
___Marijuana ___Pain Pills ___ Sedatives ___Tobacco
___Other (please specify)_____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Current Drug Use: **Circle which drugs you are using and indicate if you us it (O) occasionally, (F) frequently, or (C) continuously:**

___Alcohol ___ Amphetamines ___Barbiturates ___Cocaine ___Heroin
___Marijuana ___Pain Pills ___Sedatives ___Tobacco
Other (please specify)_____

_____
_____
_____
_____
_____
_____
_____