APPT:______________ be here @ _______

WELCOME!

Coastal Health Institute
915 W Laurel Ave
Foley AL 36535
251-943-5440 ● Fax 251-943-5404

Confidential Coastal Health Pain Treatment Questionnaire

GETTING READY FOR YOUR VISIT

Prior to your first visit, please send any relevant **new** medical records, X-rays, CT, or MRI scans to our office. If you have had imaging since your new patient appointment was scheduled you need to have the report from that imaging sent to our office prior to your appointment. **Please complete the attached questionnaire <u>before</u> your appointment.** It is confidential and will become part of your medical record. It asks for information about your current problems, and past medical history. This form will give your doctor a better understanding of your problem and will allow him or her to spend more time discussing treatment plans with you. We value you as a patient and are providing the following information about clinic policies in order to assist us in delivering your healthcare needs. Make sure to **bring your ID and Insurance Cards to every visit**. All payments must be cash, credit, or debit because **we do NOT accept checks**.

YOUR CARE TEAM

During your visit, you will first have your history and vital signs taken by a nurse. Then the doctor will review your medical records, interpret radiology reports or scans, and then evaluate you. He or she will work with the entire team to find the best possible treatment plan for you.

CANCELLATION POLICY

We have established the following policies in order to provide every patient care as quickly as possible.

Initial Appointments: As a new patient we will allow you to reschedule your consult appointment one time. After two cancellations/no-shows, you will not be allowed to reschedule with our clinic. If you do not show up for your initial appointment, you will be charged a $65 fee before you can reschedule.

Existing Patients: Once you become a patient of the clinic, we ask that you make your appointments carefully to ensure you are able to keep them. If you do not show for a regular appointment we charge a $25 fee, if you no-show for an epidural appointment we charge a $65 fee- both of which must be paid to reschedule. After three cancellations/no-shows you may be discharged from the clinic. This is based on the physician review of your case.

LATE POLICY

We request that you arrive one hour before your scheduled appointment time in order to allow time for registration. If you arrive past your indicated arrival time, you may be asked to reschedule.

PRESCRIPTION DRUGS

Please be aware that we may not be able to provide you with medications. If you have been prescribed a medication by another physician, it is the responsibility of that physician to continue providing you with that medication. We are not responsible for continuing a medication that another physician has prescribed. We also ask that you **bring ALL pill bottles for the medications you are currently taking to your visit**. Our physicians will determine the best possible treatment plan for you, but this may not include the continuation of current prescriptions.

PHYSICIAN PHONE CALLS

When calling the clinic to speak with your physician, a clinician who works with your doctor may call you back. These clinicians all have access to your records. Calls will be returned as quickly as possible, usually within 24 hours. If you have an emergency, we advise that you go to the nearest emergency room.

Thank you for choosing Coastal Health Institute for your healthcare needs. We look forward to working with you.

Coastal Health Institute

Occupational Medicine
Pain Management
Sports Medicine
Physical Therapy
Walk-in Clinic

915 West Laurel Ave
Foley, AL 36535
Phone: 251-943-5440
Fax: 251-943-5404

J. Steven Hankins, D.O., MPH
Diane Teal, CRNP
Amanda Brantley, CRNP

Name: ______________________________ Date: ______________

Mailing Address: ______________________________ City: ______________

State: __________ Zip: ____________ Date of Birth: ____/____/_______ Age: ______ Gender: M / F

SSN: ____-___-______ Main Phone #: Cell ☐ Landline ☐ (____)____-______ Reminder By: Text / Email

Secondary Phone: (____)____-______ Cell Phone Carrier: ______________________

Email: ____

Ethnicity: Hispanic / Non-Hispanic Race: ______________ Primary Language: ______________

Primary Care Physician: ______________________ Referring Physician: ______________

Pharmacy: ______________________________ Pharmacy Phone: (____)____-______

Employer: ______________________________ Work Phone: (____)____-______

Parent / Spouse's Name: ______________________________ DOB: ____/____/_____

Person responsible for paying bill: Patient Spouse Parent Employer Work Comp

Primary Insurance: ______________________________

Subscribers Name: ______________________________ DOB: ____/____/______

Secondary Insurance: ______________________________

Subscribers Name: ______________________________ DOB: ____/____/______

Is **this visit** the result of an accident/injury? Yes ☐ No ☐

Have you **ever** been involved/had an auto accident or work comp claim? Yes ☐ No ☐

If Yes to either: Accident/Injury Date: ____/____/_____ Vehicle ☐ Work Comp ☐ Other ☐

I AGREE TO MAKE PAYMENTS FOR CO-PAY, CO-INSURANCE, DEDUCTIBLES, OR ANY NON-COVERED SERVICES THAT I RECEIVE FROM COASTAL HEALTH INSTITUTE. IN THE EVENT THAT I FAIL TO PAY FOR SERVICES RENDERED OR FAIL TO NOTIFY IN THE CASE OF A CHANGE IN INSURANCE, I AGREE TO PAY REASONABLE ATTORNEY'S FEE AND ALL COST OF COLLECTIONS (INCLUDING COURT COSTS) IF THIS MATTER IS REFERRED TO AN ATTORNEY.

Signature: ______________________________________ Date: _____/_____/_____

New Patient Questionnaire

Patient's Name:______________________________ MRN:__________

Date of Birth:____/____/____ Sex: ☐Male ☐Female

City:_________________________ State:_____ ZIP:______

Primary Phone:(____)____-______ Secondary Phone:(____)____-_______

Name of Primary Care Physician:______________________________

Address:____

City:____________________ State:_______ ZIP:_________

Phone#:____________________ Fax#:____________________

List other physicians that your records should be sent to:

Doctor:______________________	Doctor:______________________
Address:_____________________	Address:_____________________
City:________________________	City:________________________
State:________ ZIP:__________	State:________ ZIP:__________
Phone:____________ Fax:__________	Phone:__________ Fax:___________

CAUSES OF YOUR PAIN Please answer all questions.

Event(s) surrounding the onset of your pain	Date Pain Began	Pain intensity today
______________________________	___/___/___	☐**Better** ☐**Same** ☐**Worse**
______________________________	___/___/___	☐**Better** ☐**Same** ☐**Worse**
______________________________	___/___/___	☐**Better** ☐**Same** ☐**Worse**
______________________________	___/___/___	☐**Better** ☐**Same** ☐**Worse**

I believe my pain is due to (write description on line provided):

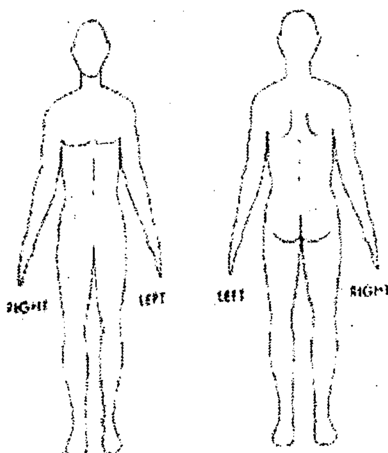
☐ The effects of treatment (e.g., medication, surgery, radiation, prosthetic device)____________________

☐ My primary disease (meaning the disease currently being treated & evaluated)____________________

☐ A medical condition unrelated to my primary disease (e.g., arthritis)____________________

PAIN DESCRIPTION

On the diagram shade in the areas where you feel pain. Put an X on the area that hurts most.



Check all the things that make your pain worse:

☐ Sitting ☐ Standing ☐ Rest ☐ Heat ☐ Cold

☐ Walking ☐ Exercise ☐ Sex ☐ Touch

☐ Other:____________________

Check all the things that make your pain better:

☐ Sitting ☐ Standing ☐ Rest Heat ☐ Cold ☐ Walking

☐ Exercise Sex ☐ Touch

☐ Other:____________________

Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, toothaches).

Have you had pain other than these everyday kinds of pain during the last week? ☐ NO ☐ YES

If YES, what kind?____________________

Please rate your pain by checking on the number that best describes your pain at its WORST in the last week.

☐**0** ☐**1** ☐**2** ☐**3** ☐**4** ☐**5** ☐**6** ☐**7** ☐**8** ☐**9** ☐**10**

No Pain Worst Pain Imaginable

PAIN DESCRIPTION continued

Please rate your pain by checking the one number that best describes your pain at its ***least* this week**.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain — Worse Pain You Can Imagine

Please rate your pain by checking the one number that best describes your **pain on the average**.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain — Worse Pain You Can Imagine

Please rate pain by circling the one number that tells you how much **pain you have right now**.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain — Worse Pain You Can Imagine

For each of the following check YES or NO if that word applies to your pain.

Aching	☐**YES**	☐**NO**	Exhausting	☐**YES**	☐**NO**
Throbbing	☐**YES**	☐**NO**	Tiring	☐**YES**	☐**NO**
Shooting	☐**YES**	☐**NO**	Penetrating	☐**YES**	☐**NO**
Stabbing	☐**YES**	☐**NO**	Nagging	☐**YES**	☐**NO**
Gnawing	☐**YES**	☐**NO**	Numb	☐**YES**	☐**NO**
Sharp	☐**YES**	☐**NO**	Miserable	☐**YES**	☐**NO**
Tender	☐**YES**	☐**NO**	Unbearable	☐**YES**	☐**NO**
Burning	☐**YES**	☐**NO**			

Check the one number that describes how, during the past week, pain had interfered with your:

General Activity

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does Not Interfere — Completely Interferes

Mood

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does Not Interfere — Completely Interferes

Walking Ability

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does Not Interfere — Completely Interferes

Normal Work (include both work outside the home & housework)

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does Not Interfere — Completely Interferes

Relations with other people

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does Not Interfere — Completely Interferes

Sleep

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does Not Interfere — Completely Interferes

Enjoyment of Life

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Does Not Interfere — Completely Interferes

PAIN TREAMENT(S)

How many physicians have been involved in the treatment of your pain?

☐0-3 ☐4-5 ☐6-10 ☐11-15 ☐**16 or more**

How many emergency room visits have you had in the last year for pain?

☐0 ☐1 ☐2 ☐3 ☐4 ☐**5 or more**

Check all other methods you use to relieve your pain:

☐warm compresses ☐distraction
☐cold compresses ☐biofeedback
☐relaxation techniques ☐hypnosis

In the last week, how much **relief** have pain treatments or medications provided?

Please check the on percentage that most shows how much relief you have received.

☐**0%** ☐**10%** ☐**20%** ☐**30%** ☐**40%** ☐**50%** ☐**60%** ☐**70%** ☐**80%** ☐**90%** ☐**100%**

No Relief — Complete Relief

Check the nerve blocks, injections, or procedures that have been performed. if you've had a procedure, but you don't remember what it was called, please choose "other".

	How Many	**Date(s) Performed**
☐ Cervical (neck) epidural steroid injection	______	____________
☐ Lumbar epidural steroid injection	______	____________
☐ Caudal epidural steroid injection	______	____________
☐ Facet joint block	______	____________
☐ Facet joint dennervation	______	____________
☐ Stellate ganglion block	______	____________
☐ Lumbar sympathetic block	______	____________
☐ Trigger point injection	______	____________
☐ Discogram	______	____________
☐ Occipital nerve block	______	____________
☐ Intercostal nerve block	______	____________
☐ Spinal cord stimulator	______	____________
☐ Intrathecal pump	______	____________
☐ Other____________________	______	____________

PAIN MEDICATION

Do you have some form of pain now that requires medication each and every day? ☐**NO** ☐**YES**

Did you take pain medications in the last 7 days? ☐**NO** ☐**YES**

If you take pain medication, how many hours does it take before the pain returns? Check one.

☐**Pain medication doesn't help at all**
☐**One hour**
☐**Two hours**
☐**Three hours**
☐**Four hours**
☐**Five to twelve hours**
☐**More than twelve hours**
☐**I do not take pain medication**

Check how you prefer to take pain medicine:

☐**On a regular basis** ☐**Only when necessary**
☐**Do not take pain medication**

How do you take pain medicine over a 24-hour period? ☐**Not every day** ☐ **1 to 2 times a day** ☐ **3 to 4 times a day** ☐ **5 to 6 times a day** ☐ **More than 6 times per day**

Do you feel you need a stronger type of pain medication? ☐**NO** ☐**YES** ☐**UNCERTAIN**

Do you feel you need to take more of the pain medication than your doctor has prescribed?
☐ **NO** ☐**YES** ☐**UNCERTAIN**

Do you feel you need to receive further information about your pain medication? ☐ **NO** ☐ **YES**

PAST PAIN MEDICATION: Have you ever taken the following pain-related medications in the **PAST**?
DO NOT list current medications on this page.

	NO	YES	Why did you stop?		
Acetaminophen (Tylenol)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Actiq (Fentanyl)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Amitriptyline (Elavil)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Butorphanol (Stadol)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Capsaicin cream	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Celebrex	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Codeine (Tylenol #3)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Cymbalta	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Demerol	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Depakote	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Desipramine	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Dextromethorphan	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Dilaudid	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Effexor	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Fentanyl Patch	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Fentora (Fentanyl)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Flexeril	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Hydrocodone (Vicodin)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Ibuprofen (Motrin, Advil)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Imipramine	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Kadian	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Lamictal	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Lidoderm Patch	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Lyrica	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Methadone (Dolophine)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Mobic (Meloxicam)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Morphine (MS Contin)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Neurontin	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Nortriptyline (Pamelor)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Nucynta (Tapentadol)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Opana (Oxymorphone)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Oxycodone (Percocet)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Oxycontin	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Pentazocine HCl (Talwin)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Propoxyphene (Darvocet)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Prozac/Paxil	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Skelaxin	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Soma	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Suboxone (Buprenorphine)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Tegretol	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Topamax`	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Toradol (Ketorolac)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Trazadone (Desyrel)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Ultram (Tramdol)	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Valium	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working

Voltaren Gel	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Wellbutrin	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Xanax	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working
Zanaflex	☐	☐	☐Side effect(s)________	☐ Didn't Work	☐ Stopped working

HOSPITAL, SURGICAL, AND PRIOR MEDICAL HISTORY

Have you ever had surgery or been hospitalized? ☐NO ☐YES if yes, list each below and give year.

Reason for Surgery or Hospitalization	Year	Reason for surgery or Hospitalization	Year

Prior Medical History:

____

____

REVIEW OF SYSTEMS

Please review the list below. If you have currently or have ever had a problem in any of these areas, please check "YES" and explain in the space below. If not, please check "NO".

General/ENT

Skin	☐NO	☐YES________
Head	☐NO	☐YES________
Eyes	☐NO	☐YES________
Ears	☐NO	☐YES________
Nose/Sinus	☐NO	☐YES________

Lungs and Chest

Asthma	☐NO	☐YES________
Emphysema	☐NO	☐YES________
Lung Cancer	☐NO	☐YES________
Pneumonia	☐NO	☐YES________

Heart and Blood Vessels

Heart Attack	☐NO	☐YES________
Angina (chest pain)	☐NO	☐YES________
High Blood Pressure	☐NO	☐YES________
Irregular Heartbeat	☐NO	☐YES________
Poor circulation in legs	☐NO	☐YES________
Blood clot in legs	☐NO	☐YES________
Blood clot in lungs	☐NO	☐YES________
Sores that won't heal	☐NO	☐YES________
Swellings in legs	☐NO	☐YES________

Urinary/Genital

Kidney stones	☐NO	☐YES________
Painful urination	☐NO	☐YES________
Urinary dribbling	☐NO	☐YES________
Difficulty urinating	☐NO	☐YES________
Urinary infections	☐NO	☐YES________
Sexually trans. dis.	☐NO	☐YES________
incontinence	☐NO	☐YES________

Bones/Joints

Broken bones	☐NO	☐YES________
Arthritis	☐NO	☐YES________
Amputations	☐NO	☐YES________

Nerves/Brain

Sensation loss	☐NO	☐YES________
Fainting	☐NO	☐YES________
Seizures	☐NO	☐YES________
Stroke	☐NO	☐YES________
Spinal Cord Injury	☐NO	☐YES________
Multiple Sclerosis	☐NO	☐YES________
Headache/Migraine	☐NO	☐YES________
Coordination loss	☐NO	☐YES________
Weakness/Paralysis	☐NO	☐YES________
Disc problems	☐NO	☐YES________

Blood

Anemia ("low blood")	☐NO	☐YES________
Abnormal clotting	☐NO	☐YES________
Easy bruising/bleeding	☐NO	☐YES________
Transfusions	☐NO	☐YES________

Stomach/Esophagus/Intestines

Heartburn	☐NO	☐YES________
Nausea/Vomiting	☐NO	☐YES________
Constipation/Vomiting	☐NO	☐YES________
Hemorrhoids	☐NO	☐YES________
Gallstones	☐NO	☐YES________
Polyps	☐NO	☐YES________
Hernia	☐NO	☐YES________
Ulcers	☐NO	☐YES________

REVIEW OF SYSTEMS continued

Psychology/Psychiatry

Depression ☐NO ☐YES________
Anxiety ☐NO ☐YES________
Panic attacks ☐NO ☐YES________
Suicidal thoughts ☐NO ☐YES________
Sleep disturbance ☐NO ☐YES________
Irritability ☐NO ☐YES________
Mood swings ☐NO ☐YES________
Counseling ☐NO ☐YES________

Endocrine

Diabetes ☐NO ☐YES________
Heat/Cold Intolerance ☐NO ☐YES________
Weight Loss/Gain ☐NO ☐YES________
Change in appetite ☐NO ☐YES________
Change in sexual desire ☐NO ☐YES________

WORK

Are you currently employed? ☐NO ☐YES
If yes: What do you do?________
How many hours per day?________
If no: How long have you been out of work?________
What was your occupation?________
How do you spend your day?________
Is unemployment due to pain? ☐NO ☐YES
Have you ever been in the Military? ☐NO ☐YES
Are you able to do household chores? ☐NO ☐YES
Explain:________

INCOME

Are you currently on Disability? ☐NO ☐YES
Are you applying for Disability? ☐NO ☐YES
Are you receiving Workers Compensation? ☐NO ☐YES
Are you applying for Workers Compensation? ☐NO ☐YES
Do you have litigations pending against an employer or individual due to accident or injury? ☐NO ☐YES

HOUSEHOLD

List your hobbies________
____
____

Your present marital status: ☐**Single** ☐**Married** ☐**Separated** ☐**Divorced** ☐**Widowed**
Do you have children? ☐NO ☐YES

Cancer

if yes, please list type(s)☐NO ☐YES________
____
____

Male

Erectile dysfunction ☐NO ☐YES________

Female

Abnormal vaginal bleeding, discharge, or pain
☐NO ☐YES________
Breast lumps, breast discharge
☐NO ☐YES________
Change in menstrual cycle
☐NO ☐YES________

DAILY ACTIVITIES

List exercises you participate in________
____
What is your activity level?
☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Inactive Very Active

SEXUAL ACTIVITIES

Are you sexually active? ☐NO ☐YES
☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Inactive Very Active

SPIRITUALITY

Do you have a religious affiliation? ☐NO ☐YES
What is your involvement in religious activities?
☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Inactive Very Active

EDUCATION

Check the highest level of education completed
☐ Grade School ☐ High School ☐ Junior College
☐ College ☐ Trade School
☐ Graduate School ☐ Professional School

If yes, how many?________ If yes, list ages________

FAMILY MEDICAL HISTORY

Please list any major illness in your family, including stroke, cancer, high blood pressure, diabetes, chronic pain, etc.

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

SOCIAL

What is your involvement in social activities?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Involvement Actively involved

Is this a change since the onset of our pain?

☐**NO** ☐**YES**

Do you currently smoke? ☐**NO** ☐**YES**

if yes: packs per day?____

how many years?____

Were you a smoker in the past? ☐**NO** ☐**YES**

if yes: How many years?___year you quit?___

Do you use alcohol? ☐**NO** ☐**YES**

If yes, on average, how many drinks do you have **per week?** ☐**3 or less** ☐**4-7** ☐**8-12** ☐**13 or more**

Did you ever or do you now use street drugs?

☐**NO** ☐**YES**

If yes, list______________________

____

Have you ever been addicted to prescription drugs? ☐**NO** ☐**YES**

Does anybody in your family have a history of drug misuse/addiction? ☐**NO** ☐**YES**

Have you ever been in a treatment program for alcohol or drug abuse? ☐**NO** ☐**YES**

if yes, explain______________________

____

____

Was there ever a time in your life when you may have had an alcohol problem?☐**NO** ☐**YES**

CURRENT OPIOID THERAPY if applicable (for example, percocet, oxycontin, duragesic patch)

What percent relief do your opioids (narcotics) provide?

☐**0%** ☐**10%** ☐**20%** ☐**30%** ☐**40%** ☐**50%** ☐**60%** ☐**70%** ☐**80%** ☐**90%** ☐**100%**

Do you have any side effects from your opioids? ☐**NO** ☐**YES**

If yes, check all that apply:

☐ Constipation ☐ Itching ☐ Dry Mouth
☐ Nausea ☐ Erectile problems ☐ Vomiting
☐ Menstrual changes ☐ Dizziness
☐ Lightheadedness ☐ Sleepiness
☐ Problems urinating ☐ Appetite Change
☐ Tooth decay

Are you any more functional from using Opioids? ☐**NO** ☐**YES**

If yes, how?______________________

Are your opioids kept in a secure place?

☐**NO** ☐**YES** Where?______________________

Do you feel that your mood has improved from opioid therapy? ☐**NO** ☐**YES**

If yes, how?______________________

Has your quality of life improved? ☐**NO** ☐**YES**

if yes, how?______________________

Name & Phone Number of pharmacy listed on opioid bottle______________________

Name of doctor currently prescribing opioids?

____

Phone #:______________________

EXPECTATIONS

What are you hoping to gain from your visit with Coastal Health Institute?______________________

Circle the percentage of pain relief you would feel would make your treatment worthwhile?

☐**0%** ☐**10%** ☐**20%** ☐**30%** ☐**40%** ☐**50%** ☐**60%** ☐**70%** ☐**80%** ☐**90%** ☐**100%**

INFORMED CONSENT FOR OPIOID TREATMENT

Coastal Health Institute Pain Management Agreement

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician/health care provider comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

I have agreed to use opioids (morphine-like drugs) as part of my treatment for chronic pain. I understand that these drugs can be very useful, but have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. Because my physician/ health care provider is prescribing such medication to help manage my pain, I agree to the following conditions:

1. I am responsible for my pain medications. I agree to take the medication only as prescribed.

   a. I understand that increasing my dose without the close supervision of my physician could lead to drug overdose causing severe sedation and respiratory depression and death.

   b. I understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal. **Withdrawal symptoms** can include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh", abdominal cramps, and diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks.

2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician/health care provider at Coastal Health Institute.

3. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing).

It is my responsibility to notify my physician/health care provider for any side effects that continue or are severe (i.e., sedation, confusion). I am also responsible for notifying my pain physician immediately if I need to visit another physician or need to visit an emergency room due to pain, or if I become pregnant.

4. I understand that the opioid medication is strictly for my own use. The opioid should **never** be given or sold to others because it may endanger that person's health and is **against the law**.

5. I should inform my physician of all medications I am taking, including herbal remedies. Medications like Valium or Ativan; sedatives such as Soma, Xanax, Fiorinal; antihistamines like Benadryl; herbal remedies, alcohol, and cough syrup containing alcohol, codeine, or hydrocodone can interact with opioids and produce serious side effects.

6. I understand that opioid prescriptions **will not be mailed**. If I am unable to obtain my prescriptions monthly, I will be responsible for finding a local physician who can take over the writing of my prescriptions with consultations from my pain physician.

7. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.

8. I will communicate fully with my physician to the best of my ability at the initial and all follow-up visits my pain level and functional activity along with any side effects of the medications. This information allows my physician to adjust your treatment plan accordingly.

9. You should not use any illicit substances, such as cocaine, marijuana, etc. while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship.

10. The use of alcohol together with opioid medications is contraindicated.

11. I am responsible for my opioid prescriptions. I understand that:

a. Refill prescriptions can be written for a maximum of one month supply and will be filled at the **same pharmacy**.
Pharmacy: ______________________________Phone#:______________________________

b. **It is my responsibility to schedule appointments for the next opioid refill before I leave the clinic or within 3 days of the last clinic visit.**

c. I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. I will then report the stolen medication to my physician. If my medications are lost, misplaced, or stolen my physician may choose not to replace the medications or to taper and discontinue the medications.

d. Refills will not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow".

e. Refills can only be filled by a pharmacy in the State of Alabama, even if I am a resident of another state.

f. Prescriptions for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours. No refills of any medications will be done during the evening or on weekends.

g. **You must bring back all opioid medications and adjunctive medications prescribed by your physician in the original containers/bottles at every visit.**

h. Prescriptions will not be written in advance due to vacations, meetings, or other commitments.

i. If an appointment for a prescription refill is missed, another appointment will be made as soon as possible. Immediate or emergency appointments will not be granted.

j. No "walk-in" appointments for opioid refills will be granted.

12. While physical dependence is to be expected after long-term use of opioids, **signs of addiction, abuse, or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the opioids.**

a. **Physical dependence** is common to many drugs such as blood pressure medications, anti-seizure medications, and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal response. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

b. **Addiction** is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life. If the patient exhibits such behavior, the drug will be tapered and such a patient is not a candidate for an opioid trial. He/she will be referred to an addiction medicine specialist.

c. **Tolerance** means a state of adaptation in which exposure to the drug induces changes that result in a lessening of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.

13. If it appears to the physician/health care provider that there is no improvement in my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the physician.

14. If I have a history of alcohol or drug misuse/addiction, I must notify the physician of such history since the treatment with opioids for pain **may** increase the possibility of relapse. A

history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for **recovery is a necessity**.

15. I will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, and sometimes two to three days extra if the prescription ends on a weekend or holiday. This extra medication is not to be used without the explicit permission of the prescribing physician unless an emergency requires your appointment to be deferred one or two days.

16. I agree and understand that my physician reserves the right to perform random or unannounced urine drug testing. If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample I understand that my doctor may change my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the doctor/patient relationship. The presence of a non-prescribed drug(s) or illicit drug(s) in the urine can be grounds for termination of the doctor/patient relationship. Urine testing is not forensic testing, but is done for my benefit as a diagnostic tool in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

17. I agree to allow my physician/health care provider to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care actions if the physician feels it is necessary.

a. I agree to a family conference or a conference with a close friend or significant other if the physician feels it is necessary.

b. I understand that non-compliance with the above conditions may result in a re-evaluation of my treatment plan and discontinuation of opioid therapy. I may be gradually taken off these medications, or even discharged from the clinic.

18. **I understand that my ability to drive or operate machinery may be impaired when I am taking my medication. Driving or operating machinery while I am taking my medication may present a danger to myself and others, and may constitute DUI.**

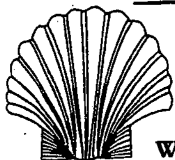
I ____ have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy & acknowledge receipt of this document.

Patient's Signature__________________________________ Date______________________

Physicians Signature________________________________ Date______________________

Witness's
Signature____ Date______________________

COASTAL HEALTH INSTITUTE



OCCUPATIONAL MEDICINE
PAIN MANAGEMENT
SPORTS MEDICINE
REHABILITATION
WEIGHT LOSS & WELLNESS CENTER

Patient Request for Confidential Communication

Please fill out this form for any person that you would like us to speak to regarding your care. This will allow us to give this person(s) test results, communicate information from your office visit and other Protected Health Information. We **will not** release a copy of your medical record to this person(s) without your specific written request. This request may be revoked at any time, by written or verbal request.

I ______________________ hereby request confidential communication of my protected health information to the following individual(s):

Communications with the patient named above can be directed to:

Additional Point of Contact: ______________________

Contact Address: ______________________

Contact Phone: ______________________

Relationship to Patient: ______________________

Methods of Communication (Please Circle): **Phone** **Mail**

Additional Point of Contact: ______________________

Contact Address: ______________________

Contact Phone: ______________________

Relationship to Patient: ______________________

Methods of Communication (Please Circle): **Phone** **Mail**

Patient Signature: ______________________

Patient DOB: ______________________

Date: ______________________

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