MD PAIN

Pain Medical History

Date:_____ Referred By:_____ Family Doctor:_____

Patient Name:_____ Date of Birth:_____

Preferred Name:_____ Preferred Pharmacy:_____

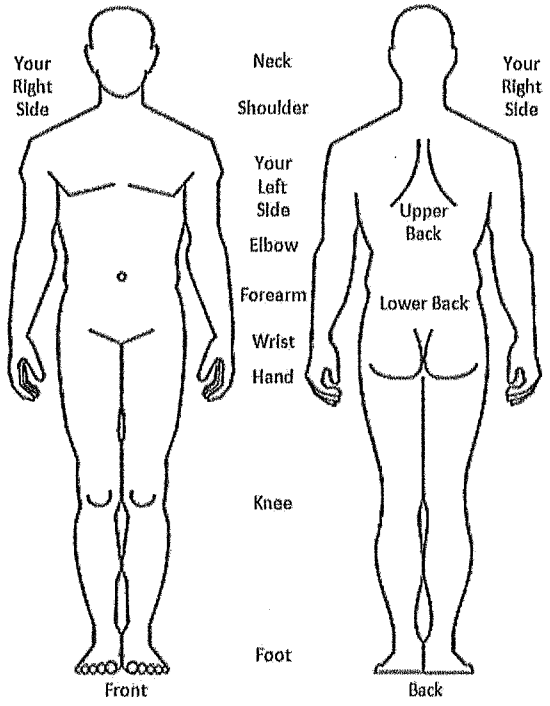
Age: _____ Height:_____ Weight:_____ Advanced Directive? YES☐ NO☐

CHIEF COMPLAINT:

Location of pain:_____Date of Onset:_____

Pain Radiates From / To:_____

Does the pain radiate: ☐ Equal Intensity **OR** ☐ One Location More Severe:_____



Please mark your pain on the above body

How did symptoms occur?

- ☐ No Injury – suddenly
- ☐ No injury – gradually
- ☐ Auto Accident
- ☐ Sports Accident
- ☐ Injury at Work
- ☐ Prior Surgery

Current Pain Level (from 0-10):_____ **Pain Level at Worst (From 1-10):**_____

What are your symptoms?

- ☐ Numbness or Tingling
- ☐ Radiating Pain
- ☐ Spasms
- ☐ Stiffness
- ☐ Weakness
- ☐ Other:_____

Do you experience any of the following?

- ☐ Balance Issues
- ☐ Bladder Incontinence
- ☐ Bowel Incontinence
- ☐ Unsteadiness when walking
- ☐ None of the above

What makes the symptoms worse?

- ☐ All Activities
- ☐ Bending
- ☐ Changing Position
- ☐ Coughing
- ☐ Driving
- ☐ Lifting
- ☐ Sitting
- ☐ Standing
- ☐ Twisting
- ☐ Walking
- ☐ Sleeping
- ☐ Other:_____

What treatment have you tried?

☐ Rest	☐ Improved	☐ Worsened
☐ Acitivity Modification	☐ Improved	☐ Worsened
☐ Bracing	☐ Improved	☐ Worsened
☐ Cold	☐ Improved	☐ Worsened
☐ Heat	☐ Improved	☐ Worsened
☐ Muscle Relaxants	☐ Improved	☐ Worsened
☐ NSAIDS	☐ Improved	☐ Worsened
☐ Prescription Pain Medications	☐ Improved	☐ Worsened
☐ Topical Creams	☐ Improved	☐ Worsened
☐ Tylenol	☐ Improved	☐ Worsened
☐ Physical Therapy	☐ Improved	☐ Worsened
☐ Chiropractic Therapy	☐ Improved	☐ Worsened
☐ Massage	☐ Improved	☐ Worsened
☐ Steroid Injections	☐ Improved	☐ Worsened
☐ Surgery	☐ Improved	☐ Worsened
☐ Other:_____	☐ Improved	☐ Worsened

Have you had any prior tests for this problem?

- ☐ No Imaging Studies
- ☐ X-Rays
- ☐ CT Scan
- ☐ MRI
- ☐ Nerve Test (EMG)
- ☐ DEXA
- ☐ Other:_____

What is your current work status?

- ☐ Disabled
- ☐ Retired
- ☐ Working a reduced schedule
- ☐ Working full time with out restrictions
- ☐ Working with restrictions

What is your occupation?_____

_____

Who referred you?

- ☐ Another Patient
- ☐ Self Referred
- ☐ Chiropractor
- ☐ Emerency Room
- ☐ Internist
- ☐ Pain Management
- ☐ Primary Care Provider
- ☐ Therapist
- ☐ Trainer
- ☐ Urgent Care Provider
- ☐ Workmans Compensation
- ☐ Other:_____

PAST MEDICAL HISTORY

Past Medical Conditions:

- ☐ None
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bipolar Disorder
- ☐ Cerebrovascular Accident
- ☐ COPD
- ☐ Chronic Pain
- ☐ Deep Venous Thrombosis
- ☐ Depressive Disorder
- ☐ Diabetic on Insulin
- ☐ Disease caused by COVID19
- ☐ End-Stage Renal Disease
- ☐ Epilepsy
- ☐ Essential Hypertension
- ☐ GERD
- ☐ Hypertension
- ☐ History of Radiation Therapy
- ☐ HIV
- ☐ High Cholesterol
- ☐ Ischemic Heart Disease
- ☐ Leukemia
- ☐ Malignant Lymphoma
- ☐ Malignant Tumor of Colon
- ☐ Obstructive Sleep Apnea Syndrome
- ☐ Primary Fibromyalgia Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Type 2 Diabetes Mellitus
- ☐ Other:_____

Past Surgeries:

- ☐ None
- ☐ Bypass of Stomach
- ☐ Cholecystecomy (Gallbadder)
- ☐ Coronary Artery Bypass Graft
- ☐ Cataract
- ☐ Hernia Repair
- ☐ Appendectomy
- ☐ Colectomy
- ☐ Tissue Graft Heart Valve Replacement
- ☐ Hysterectomy
- ☐ Mechanical Heart Valve Replacement
- ☐ Prostatectomy
- ☐ Repair of Aneurysm
- ☐ Tonsillectomy
- ☐ Other:_____

Musculoskeletal Disease History

- ☐ None/Unknown
- ☐ Adhesive Capsulitis of Shoulder
- ☐ Ankylosing Sponsylitis
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ Complex Regional Pain Syndrome
- ☐ Compression Fracture of Vertebral Column
- ☐ Epidural Steroid Injection
- ☐ Hip Fracture
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Idiopathic Scoliosis
- ☐ Osteoarthritis
- ☐ Cervical Spinal Stenosis
- ☐ Lumbar Spinal Stenosis

Musculoskeletal Surgical History:

- ☐ Decompression of Lumbar Spine
- ☐ Decompression of Median Nerve (Carpel Tunnel Release)
- ☐ Lumbar Laminectomy
- ☐ History of Arthroplasy R_____ L_____
- ☐ History of Arthroscopy of Knee Joint
- ☐ Rotator Cuff Repair of Shoulder
- ☐ Kyphoplasty: Levels_____
- ☐ Lumbar Spinal Fusion: Levels_____
- ☐ Osteotomy and Discectomy of Cervial Spine
- ☐ Hip Replacement R_____ L_____
- ☐ Total Shoulder R_____ L_____

List of Medications:_____

_____

_____

_____

Latex Allergy: ☐ Yes ☐ No

Do you have any Allergies? ☐ Yes ☐ No If Yes, please list:_____

_____

SOCIAL HISTORY:

Do you smoke? ☐ Daily ☐ Occasionally ☐ Former Smoker ☐ Never

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? _____

Do you drink alcohol? ☐ None ☐ < 1 Drink / Day ☐ 1-2 Drinks / Day ☐ 3 or more Drinks / Day

How often do you exercise?

☐ Never ☐ Once a Day ☐ Several Times a Day ☐ Few Time a Week ☐ Few Times a Month

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REVIEW OF SYSTEMS:

Please indicate if you have experienced any of the following symptoms in the past six months:

None for all_____

☐ CON	Fatigue	Weight Loss	Fever	Chills	Weight Gain
☐ EYE	Redness	Corrective Lenses	Blurred Vision		
☐ ENT	Nose Bleeds	Ringing in Ears	Hoarseness		
☐ CARDIO	Chest Pain	Palpitations	Fainting	Heart Murmur	Leg Cramps
☐ RESP	Shortness of Breath	Wheezing	Cough	Hurts to Breathe	
☐ GI	Heartburn	Nausea/Vomiting	Constipation	Diarrhea	Bloody Stools
☐ GU	Frequent Urination	Painful Urination	Incontinence	Blood in Urine	
☐ SKIN	Poor Healing Wounds	Rash	Itching	Scarring	
☐ NEURO	Numbness	Tingling	Dizziness	Headaches	Tremors
☐ PSYCH	Nervousness	Anxiety	Depression	Hallucinations	
☐ ENDO	Excessive Thirst or Urination		Heat/Cold Intolerance		
☐ HEM	Easy Bleeding	Easy Bruising			
☐ MUSC	Joint Pain	Joint Swelling	Joint Stiffness	Unsteady Gait	

Mark All That Apply:

☐ Metal in Body ☐ Claustrophobic ☐ Pregnant ☐ Pacemaker ☐ Defibrillator
☐ Allergy to Shellfish/Iodine ☐ Allergy to Latex ☐ Allergy to Adhesive

Are you taking a blood thinner? ☐ Yes ☐ No
Please list provider who prescribes blood thinner:_____

FAMILY HISTORY:
Please list relation next to family history:

☐ None
☐ Diabetes:_____
☐ Heart Disease:_____
☐ Hypertension:_____
☐ Bleeding Problems:_____
☐ Epilepsy:_____
☐ Osteoporosis:_____
☐ Stroke:_____
☐ Cancer:_____
☐ Rheumatoid Arthritis:_____
☐ Muscular Dystrophy:_____
☐ Other:_____

DURING THE LAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY LITTLE INTEREST OR PLEASURE IN DOING THINGS?
☐ NOT AT ALL ☐ SEVERAL DAYS ☐ MORE THAN HALF THE DAYS ☐ NEARLY EVERY DAY

DURING THE PAST TWO WEEKS, HAVE YOU OFTEN BEEN BOTHERED BY FEELING DOWN, DEPRESSED, OR HOPELESS?
☐ NOT AT ALL ☐ SEVERAL DAYS ☐ MORE THAN HALF THE DAYS ☐ NEARLY EVERY DAY

Housing

1. Are you concerned that in the next two months you may not have stable housing that you own, rent or stay in as a part of your household.
   YES__ NO__

2. Think about the place you live. Do you problems with any of the following?

__ Bug infestation

__ Mold

__ Lead paint or pipes

__ Inadequate heat

__ Oven or stove not working

__No or not working smoke detectors

__ Water leaks

__ None of the above

Food

3. Within the past 12 months, you worried that your food would run out before you had money to buy more.
   __ Often true
   __ Sometimes true
   __Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have the money to buy more.
   __ Often true
   __Sometimes true
   __ Never true

Transportation

5. Do you put off or neglect going to the doctor because of distance or transportation?
   YES __ NO__

Utilities

6. In the past 12 months has the electric, gas, oil or water company threatened to shut off services in your home?
   __ YES
   __ NO
   __ Already shut off

Child Care

7. Do problems getting child care make it difficult for you to work or study?
   YES__ NO__

Education

8. Do you have a high school degree?
   YES__ NO___

Finances

9. How often does this describe you? I don't have enough money to pay my bills.
   __Never __Rarely __Sometimes
   __Often __Always

10. Do you have a job?
    YES__ NO__

Personal Safety

11. How often does anyone, including family, physically hurt you?
    __Never __Rarely __Sometimes
    __Fairly often __ Frequntly

12. How often does anyone, including family, insult or talk down to you?
    __Never __Rarely __Sometimes
    __ Fairly often __ Frequently

13. How often does anyone, including family, threaten you with harm?
    __Never __Rarely __Sometimes
    __ Fairly often __ Frequently

14. How often does anyone, including family, scream or curse at you?
    __ Never __ Rarely __ Sometimes
    __ Fairly often __ Frequently

Assistance

15. Would you like help with any of these needs?
    YES__ NO__

Name_____ Date _____
Date of birth _____

SOAPP® Version 1.0

Name: _____ Date: _____

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings? 0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? 0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs? 0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem? 0 1 2 3 4
6. How often have you attended an AA or NA meeting? 0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem? 0 1 2 3 4
9. How often have your medications been lost or stolen? 0 1 2 3 4
10. How often have others expressed concern over your use of medication? 0 1 2 3 4
11. How often have you felt a craving for medication? 0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse? 0 1 2 3 4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? 0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

ORT

For the following questions, place a check mark on the line if it applies to you.

1. Family history of substance abuse:

   Alcohol _____

   Illegal drugs _____

   Prescription drugs _____

2. Personal history of substance abuse:

   Alcohol _____

   Illegal drugs _____

   Prescription drugs _____

3. Age (check if 16-45 years old): _____

4. History of preadolescent sexual abuse: _____

5. Psychological Disease:

   Attention-deficit disorder, obsessive-compulsive
   Disorder, bipolar disorder, or schizophrenia _____

   Depression _____

MD PAIN

John R. Massey MD
Liane E. Donovan MD

Informed Consent/Treatment Agreement for Chronic Medication Therapy

Dr. is prescribing pain medicine to me for the diagnosis of _____.

This decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it, including but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that medicine will not provide complete pain relief.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I will tell my doctor about all other medicines and treatments that I am receiving.

I am aware that addiction during opioid therapy for pain can occur and includes impaired control, craving and compulsive use, and continued use despite negative physical, mental and/or social consequences. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that development of addiction has rarely been reported in medical journals and is much more common in a person who has family or personal history of addiction. I agree to tell my complete and honest drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped, or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pian and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

(Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my moods, stamina, sexual desire, and physical and sexual performance.

(Females Only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I am responsible for requesting PRESCRIPTION REFILLS A MINIMUM OF 5 "BUSINESS" DAYS IN ADVANCE. I am aware that the telephone requests for refills must be made MONDAY-THURSDAY (8:30 am-3:00 pm). Refills will not be made at night, weekends, or holidays. Only my physician at MD Pain, LLC will prescribe any and all opioid pain medication.

I understand if in an emergency I have opioid medications prescribed by another source, the office must be notified in writing within 7 days. I am aware that I am only to fill my prescription at only ONE pharmacy of my choice. IF I FAIL TO COMPLY, I WILL BE DISCHARGED FROM MD Pain, LLC.

I must take my prescription as prescribed. Prescriptions will not be filled early and will be issued monthly when dose requirements are established.

Any opioid medication that I do NOT use because of side effects or dose adjustments should be brought to the office. I will NOT dispose of or throw away unused medication myself. I WILL NOT SHARE MY MEDICATION WITH ANYONE. IF I FAIL TO COMPLY, I WILL BE DISCHARGED FROM MD PAIN, LLC.

I am aware if I lose my medication, it will not be replaced and may result in being weaned from that medication. If medication is lost, I will write a note explaining what happened to the medication, date and sign it and send it to the office.

If my medication is stolen, a police report will be completed before any early refill, and this will be done at the discretion of my attending physician.

I understand I must comply with other recommendations, which may include psychological counseling, physical therapy, and nutrition changes as deemed necessary by my physician.

I am aware that at my physician's discretion; drug testing and serum toxicity screens may be performed. Failure to comply will result in dismissal from clinic. I understand that if my insurance does not cover urine drug screens, I will be responsible for the cost of the urine drug screen testing.

I must keep my scheduled appointments in the office if opioid medications are being maintained. Three cancellations and/or no shows can be grounds for weaning off the medications and/or may result in being discharged from MD Pain, LLC.

I have read this form and I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for treatment of my pain with pain medications.

A copy of this agreement will be given to me and may be sent to my designated pharmacy and to my other treating physicians.

Patient Name: _____

Patient Signature: _____ Date: _____

Electronically Signed By: _____

Designated Pharmacy: _____ Telephone: _____