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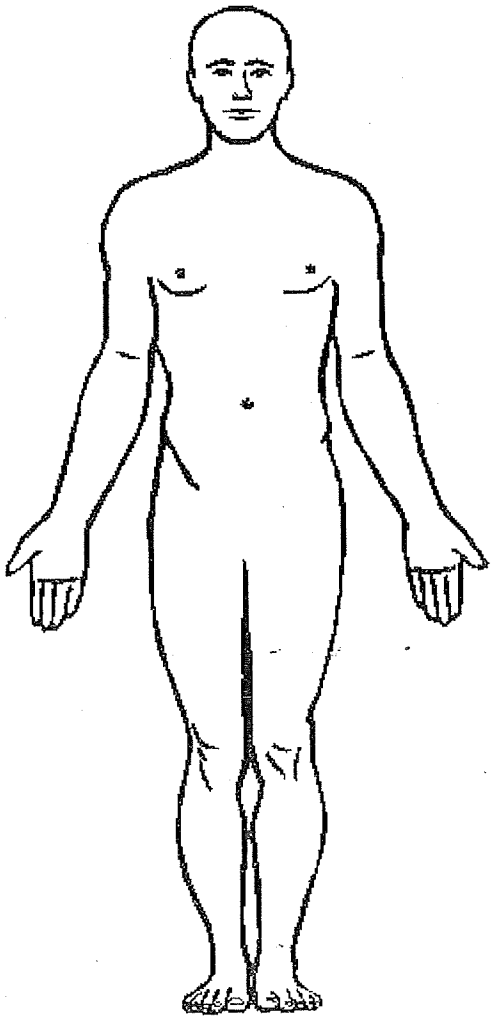
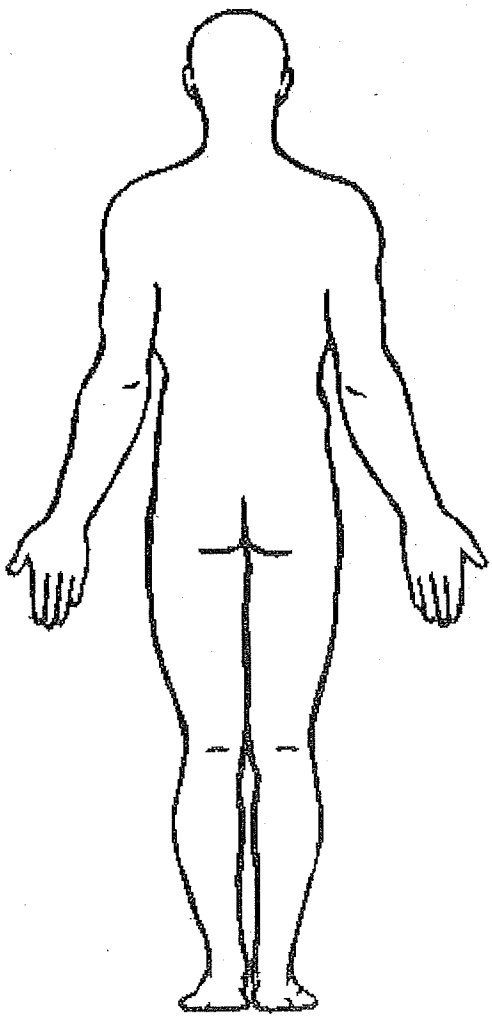
Please shade in the areas on the diagrams that correspond to your areas of pain on your body

xxxx = Pain **oooo = Numbness** **//// = Aching** **- - - - = Needles**





Patient Signature: _____ Date: _____

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Patient Name: _____ **DOB:** _____

Review of Systems

Please check if you have had any of the following ***in the past 12 months:***

Constitutional
❑ Weight gain ❑Weight loss ❑Night sweats ❑Chills ❑Fever

Skin
❑Easy bleeding ❑Easy bruising ❑Any rashes

Ear, Nose, Throat & Eyes
❑Vision changes ❑Change in smells ❑Dizziness ❑Hearing changes

Respiratory
❑Shortness of breath ❑Wheezing ❑Cough ❑Increased mucus

Cardiovascular
❑Chest pain ❑Palpitations ❑Heart murmur ❑Feet swelling

Gastrointestinal
❑Nausea ❑Vomiting ❑Diarrhea ❑Dark/bloody stools

Musculoskeletal
❑Cramps ❑Joint pain ❑Joint swelling ❑Stiffness in the morning ❑Weakness

Nervous System
❑Numbness/tingling in feet ❑Numbness/tingling in hands ❑Problems sleeping

Genitourinary
❑Blood in urine ❑Incontinence (bowel or bladder) ❑Urinary tract infection

For Females: ❑Abnormal vaginal bleeding ❑Breast biopsy ❑Nipple discharge
Last menstrual period: _____

For Males: ❑Prostatitis ❑Difficulty urinating
Date of last prostate exam/PSA: _____ Results: _____

I hereby acknowledge that the above information is complete and accurate to the best of my knowledge.

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Pain Management Contract

Patient's Name: _____ Date of Birth: _____

PLEASE INITIAL EACH PARAGRAPH SIGNIFYING CONSENT AND UNDERSTANDING

_____TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

_____CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain. It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

_____THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF - LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

_____I HAVE BEEN INFORMED AND UNDERSTAND that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

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_____I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension (low blood pressure), arrhythmias (irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

_____The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

_____The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life.

_____I REALIZE that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce and manage (but probably not eliminate) my pain so that I can enjoy an improved quality of life.

_____I REALIZE that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. Comparing my plan to that of another person is not logical.

_____I UNDERSTAND that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use.

_____I FURTHER UNDERSTAND that I will be provided medical supervision if needed when discontinuing medication use

_____I UNDERSTAND that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit.

_____I HAVE BEEN GIVEN THE OPPORTUNITY to **ask questions** about my condition and treatment, risks of non - treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

_____I UNDERSTAND that this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician.

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_____I UNDERSTAND that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.

_____I UNDERSTAND that my physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be **IMMEDIATELY** for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the medication(s) may be discontinued.
- I will disclose to my physician all medication(s) that I take at any time, prescribed by any physician.
- I will use the medication(s) exactly **as directed** by my physician.
- I agree **not to share, sell** or otherwise permit others, including my family and friends, to have access to these medications. I will not allow or assist in the misuse/diversion of my medication; nor will I give or sell them to anyone else.
- All medication(s) must be obtained at one pharmacy, where possible. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. **If either are lost or stolen, they may not be replaced.**
- Refill(s) WILL NOT be ordered before the scheduled refill date. I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) only from ONE physician unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment. Written documentation of emergency treatment **will be required** for the continuation of treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then my physician may try alternative medication(s) or may taper me off all medication(s). I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- I agree to submit to **urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning, I understand they ARE MANDATORY. If I do not **take the test on the required date** or if I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., **treatment for chronic pain may be terminated**. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize that my active participation in the management of my pain is extremely important. **I agree to actively participate** in all aspects of the pain

management program recommended by my physician to achieve increased function and improved quality of life.

- I agree that I shall inform any doctor who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. **Any unauthorized increase in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.**
- I must keep all follow-up appointments as recommended by my physician or my treatment may be discontinued.

_____I CERTIFY that I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse.

_____I AM READING AND MAKING THIS AGREEMENT while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

_____I CERTIFY that I have never been involved in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

_____I UNDERSTAND that no guarantee or assurance has been made as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks.

_____I CONSENT to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

_____I HAVE REVIEWED the side effects of the medication(s) that may be used in the treatment of my chronic pain.

_____I FULLY UNDERSTAND the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.

I HAVE READ AND UNDERSTAND THIS AGREEMENT and have received a copy for my records.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Pharmacy: (Name and Address)

SOAPP® Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

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

 The SOAPP® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

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

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

Please include any additional information you wish about the above answers. Thank you.

Date _____

Patient Name _____

OPIOID RISK TOOL

		Mark each box that applies	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	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
TOTAL		[ ]		