Initial Visit Forms ( MEDICAL HISTORY ) Date: ________________

PMO
PAIN MANAGEMENT OF OKLAHOMA

PATIENT NAME (Last, Middle, First):

| BIRTH DATE: | SEX: | HEIGHT: | WEIGHT: |
|---|---|---|---|
| / / | *Male / Female* | | |

REFFERRING DOCTOR: ________________________________

PRIMARY CARE DOCTOR: ________________________________

PRIMARY INSURANCE: ________________________________

INSURANCE/ MEMBER ID: ________________________________

GROUP NUMBER: ________________________________

ADDRESS: ________________________________

CITY: ________________________________

ZIP CODE: ____________________

SOCIAL SECURITY #: ________________________________

MOBILE PH: ________________ (OTHER): ________________

OK TO TEXT APPOINTMENT REMINDERS ? YES NO (CIRCLE)

PRIMARY INSURED NAME: ________________________________

*(If different from patient)*

RELATIONSHIP: SPOUSE OTHER ________________

PRIMARY INSURED SOCIAL SECURITY #: ____________________

## PAIN QUESTIONNAIRE

**WHERE IS YOUR PRIMARY AREA OF PAIN**

| HEAD | KNEE | BACK | MIDDLE |
|---|---|---|---|
| NECK | HIPS | BUTT | LOW |
| SHOULDER | | | |

**DOES THE PAIN RADIATE OR GO ANYWHERE ? YES / NO**

DOWN THE ARM(S) RIGHT / LEFT / BOTH

DOWN THE LEG(S) RIGHT / LEFT / BOTH

**WHEN DID YOUR PAIN START ? WHAT YEAR ?**

STARTED: GRADUALLY ? SUDDENLY ?

TIMING: CONSTANT ? COMES & GOES ?

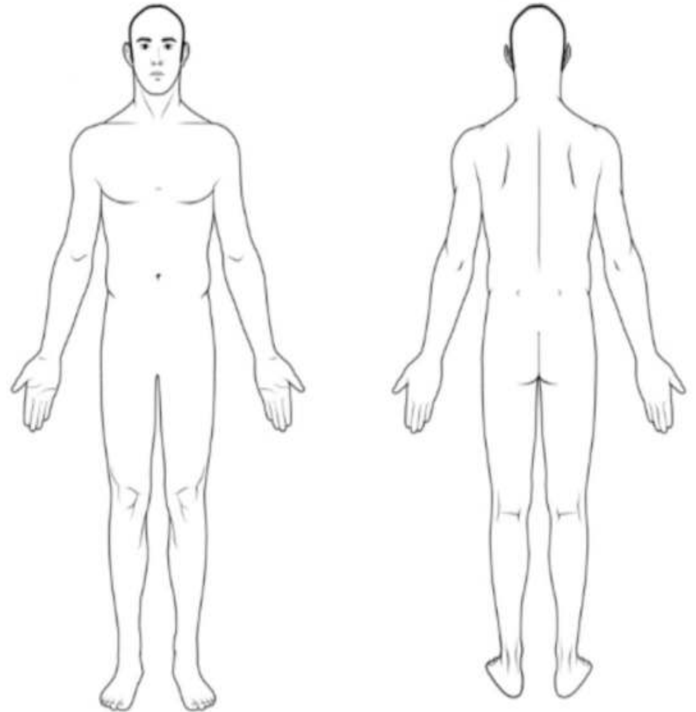
HOW LONG - HAD PAIN ? WEEKS ? MONTHS ? YEARS ?

**WHAT CAUSED YOUR PAIN INITIALLY ?**

CAR ACCIDENT

OTHER: ________________________________

***WHERE IS YOUR PRIMARY AREA OF PAIN ? ( DRAW ON DIAGRAM )***



**PAIN RATING:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| BEST: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| AVERAGE | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| WORST | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**DESCRIBE THE PAIN:**

| DULL | ACHEY | CRAMPING | THROBBING | OTHER ? |
|---|---|---|---|---|
| SHARP | STABBING | BURNING | TINGLING | NUMBING |

**WHAT MAKES PAIN WORSE ?**

| BENDING | LIFTING | SITTING FOR A WHILE |
|---|---|---|
| WALKING | DRIVING | STANDING FOR A WHILE |
| STAIRS | OTHER | |

**WHAT MAKES PAIN BETTER ?**

| REST | SITTING | STRETCHING | CHANGING POSITION |
|---|---|---|---|
| WALKING | STANDING | EXERCISE | PHYSICAL THERAPY |
| HEAT PAD | MEDICATION | MASSAGE | CHIROPRACTIC |
| COLD/ICE | INJECTIONS | BRACE | |

Initial Visit Forms ( MEDICAL HISTORY ) Date: ____________________

PMO
PAIN MANAGEMENT OF OKLAHOMA

PATIENT NAME (Last, Middle, First):

*Circle all that apply to the PATIENT*

**HEART/CARDIOVASCULAR**

*HIGH BLOOD PRESSURE* *HEART FAILURE*
*HEART ATTACK* *HEART STENT*

**LUNG/PULMONARY:**

*ASTHMA* *COPD/EMPHYSEMA*

**LIVER/KIDNEY:**

*HEPATITIS* *CIRRHOSIS*
*LIVER FAILURE* *KIDNEY FAILURE*

**BRAIN/SPINE/NEUROLOGICAL:**

*STROKE* *SEIZURE DISORDER*
*NEUROPATHY* *TRAUMATIC BRAIN INJURY*

**STOMACH/GASTROINTESTINAL:**

*REFLUX (GERD)* *ULCERS*

**METABOLIC/ENDOCRINE:**

*DIABETES* *THYROID DISEASE*
*OTHER* *CHRONIC STEROIDS*

**BLOOD DISORDER/HEMATOLOGY:**

*BLEEDING DISORDER* *EASY BRUISING*
*DVT (BLOOD CLOT IN LEG OR ARM OR LUNG)*
*ON BLOOD THINNERS* *OTHER*

**JOINT/MUSCULOSKELETAL:**

*ARTHRITIS* *RHEUMATOID ARTHRITIS*
*OSTEOARTHRITIS* *SCOLIOSIS*

**PSYCHOLOGICAL/PHYCHIATRIC:**

*DEPRESSION* *PSYCHIATRIC HOSPITAL ?*
*ANXIETY* *BIPOLAR*

**MEDICATION ALLERGIES:**

| DRUG/SUBSTANCE: | REACTION (RASH, ITCH, ECT) |
|---|---|
| | |
| | |
| | |

**PHARMACY NAME:**

PHONE #: CITY/STATE:

**CURRENT MEDICATION LIST:**

*PAIN MEDS:*

| *NAME:* | *MG* | *Number of pills per day* |
|---|---|---|
| | | |
| | | |
| | | |

**OTHER PRESCRIBED MEDS:**

| *NAME:* | *FOR ?* |
|---|---|
| | |
| | |
| | |

**SOCIAL HISTORY:**

EMPLOYMENT:

MARITAL STATUS:

**SUBSTANCE USE:**

| SMOKING: ( # of Years ) | NEVER | CURRENT | QUIT |
|---|---|---|---|
| Alcohol: | NEVER | SOCIAL | ADDICTED |
| Cocaine | NEVER | SOCIAL | ADDICTED |
| Amphetamine | NEVER | SOCIAL | ADDICTED |

**SURGICAL HISTORY:**

| *BODY PART* | *YEAR* | *HOSPITAL* | *SURGEON* |
|---|---|---|---|

FOLLOW UP Visit Form Date: ______________________________

PAIN MANAGEMENT OF OKLAHOMA (PMO)

| PATIENT NAME (Last, Middle, First): |
|---|
| BIRTH DATE: / / |

*REVIEW OF SYSTEMS - To be completed by ALL Patients*

□ Check here if NO CHANGES since last visit ( NOT applicable to new patients )

( CIRCLE ALL THAT APPLY )

| CONSTITUTIONAL Symptoms | |
|---|---|
| *FEVER* | *FATIGUE* |
| *WEAKNESS* | *WEIGHT LOSS* |

| HEAD, EYES, EARS, NOSE, THROAT | |
|---|---|
| *HEADACHE* | *HEAD INJURY* |
| *DIZZINESS* | *VISION CHANGES* |
| *OTHER* | |

| LUNG/PULMONARY: | |
|---|---|
| *SHORT OF BREATH* | *COPD/EMPHYSEMA* |
| *OTHER* | *SLEEP APNEA* |

| HEART/CARDIOVASCULAR | |
|---|---|
| *HIGH BLOOD PRESSURE* | *HEART FAILURE* |
| *HEART ATTACK* | *HEART STENT* |
| *OTHER* | *ATRIAL FIBRILLATION* |

| STOMACH/GASTROINTESTINAL: | |
|---|---|
| *REFLUX (GERD)* | *ULCERS* |
| *LIVER DISEASE* | *HEPATITIS* |
| *OTHER* | *CONSTIPATION* |

| JOINT/MUSCULOSKELETAL: | |
|---|---|
| *ARTHRITIS* | *RHEUMATOID ARTHRITIS* |
| *OSTEOARTHRITIS* | *SCOLIOSIS* |
| *MUSCLE PAIN* | *CRAMPS* |
| *WEAKNESS* | *PARALYSIS* |
| *OTHER* | |

| PSYCHOLOGICAL/PHYCHIATRIC: | |
|---|---|
| *DEPRESSION* | *PSYCHIATRIC HOSPITAL STAY ?* |
| *ANXIETY* | *PTSD* |
| *OTHER* | *MOOD SWINGS* |

| SKIN | |
|---|---|
| *ITCHING* | *RASH* |
| *DRYNESS* | *BRUISING* |

| BRAIN/SPINE/NEUROLOGICAL: | |
|---|---|
| *STROKE* | *SEIZURE DISORDER* |
| *NEUROPATHY* | *TRAUMATIC BRAIN INJURY* |
| *UNSTEADY GAIT* | *NUMBNESS/TINGLING* |
| *TREMORS* | *NERVE DAMAGE* |
| *OTHER* | |

| METABOLIC/ENDOCRINE: | |
|---|---|
| *DIABETES* | *THYROID DISEASE* |
| *OTHER* | *CHRONIC STEROIDS* |

SOAPP-R Form

The following questions for patients being considered for pain medication. Please answer each question as honestly as possible
There are no right or wrong answers.

NAME: ________________________________ *Birth Date:* ______________ *DATE:* ______________

| | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| *How often do you have mood swings ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have you felt a need for higher doses of medication to treat your pain ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have you felt impatient with your doctors ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have you felt that things are just too overwhelming that you can't handle them ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often is there tension in the home ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have you counted pain pills to see how many are remaining ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have you been concerned that people will judge you for taking pain medication ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often do you feel bored ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have you taken more pain medication than you were supposed to ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have you worried about being left alone ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have you felt a craving for medication ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have others expressed concern over your use of medication ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have any of your close friends had a problem with alcohol or drugs ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have others told you that you had a bad temper ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have you felt consumed by the need to get pain medication ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have you run out of pain medication early ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have others kept you from getting what you deserve ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often, in your lifetime, have you had legal problems or been arrested ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have you attended an Alcoholics Anonymous or Narcotics Anonymous meeting ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have you been in an argument that was so out of control that someone got hurt ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have you been sexually abused ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have others suggested that you have a drug or alcohol problem ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have you had to borrow pain medications from your family or friends ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| *How often have you been treated for an alcohol or drug problem ?* | *Never* | *Seldom* | *Sometimes* | *Often* | *Very Often* |
| Total | | | | | |

CHRONIC PAIN & PAIN MEDICATION (controlled substances) AGREEMENT

INFORMED CONSENT FOR CONTROLLED SUBSTANCE TREATMENT

NAME: ____________________________________________ Birth Date: ______________________

It is important that you are informed regarding the risks and responsibilities of undergoing chronic pain and opioid therapy. Controlled substances, opiate pain medications and muscle relaxants may be used in treating your condition. These prescription medications have the potential for misuse and/or abuse and are strictly regulated by state and federal agencies. This agreement is meant to both inform and protect patients and provide necessary guidelines under which your treatment will be properly administered, consistent with laws governing the appropriate prescription and use of controlled substances for the treatment of chronic pain. It is required that you have read, understood, and agreed to comply with these policies in order to continue to receive treatment with our clinic. Failure to follow these policies is grounds for dismissal from the clinic. Your treating physician or professional healthcare provider also reserves the right to determine the appropriate course of treatment *regardless of continued compliance with these policies.* The words "we" and "our" refer to the clinic and staff of Pain Management of Oklahoma. The words "I", "you", "me", or "my" refer to you as the patient.

*1. I agree not to seek or accept a controlled substance from any other physician, healthcare provider, dentist, or individual while I am receiving controlled substance(s) from any of our clinics.*

*2. I understand that it is illegal and may endanger my health. An exception may be granted for treatment during an inpatient hospitalization or with the advance notification and agreement of your treating physician or provider.*

*3. I am personally responsible for my medication. Prescriptions and/or medications will not be replaced if lost, stolen, or destroyed. I understand that a prescription may not be refilled until* ***28 days*** *after the date of the last prescription provided.*

*4. I agree to comply with routine drug screening in the form of urine, oral swab, or blood testing in accordance with clinic protocol or at the discretion of your treating physician or professional healthcare provider.*

*5. I understand that while taking controlled substances, my judgment and/or motor skills may be impaired which could result in harm to myself and/or others if required precautions aren't followed. I also understand that it is my responsibility to comply with all state laws including those related to refraining from driving a vehicle while impaired.*

*6. I understand that the main goal of treatment is to improve my ability to function and reduce pain. In addition, it is likely that my pain will not be completely eliminated, despite continued treatment.*

*7. I understand that the long term advantages and disadvantages of chronic controlled substance use have yet to be scientifically determined. I understand and accept that there may be unknown risks associated with long-term controlled substance use.*

*8. I will not consume alcohol, illicit drugs, or illegally obtained medications in conjunction with a prescribed controlled substance that is being provided to treat my pain. I understand that any signs or evidence of the misuse, abuse, or diversion of controlled substances are grounds for dismissal from the clinic.*

*9. I understand it is illegal to attempt to obtain or obtain a controlled substance by withholding information or providing false information to a treating physician or healthcare provider. I also understand that it is illegal to sell, divert, share, or provide a controlled substance to any individual other than the person for which the prescribed medication was intended. Any signs or evidence of this is grounds for dismissal.*

*10. I have been fully informed by my treating physician or healthcare provider of the potential for the development of tolerance, dependence, withdrawal, addiction, overdose, and/or death related to the controlled substance(s) I have been prescribed. I understand and personally accept these potential risks and side effects.*

*11. I understand that failure to comply with the responsibilities listed here may result in my dismissal from the clinic and by signing below indicate my understanding, agreement, and acceptance of the information contained in this written agreement.*

Patient Signature ____________________________________________ Date ______________

Brent Henderson, D.O.
*Pain Management*
*Board Certified, Anesthesiology*

Jeff Halford, D.O.
*Pain Management*
*Board Certified, Physical Medicine & Rehabilitation, AAPMR*

*www.PainManagementofOK.com*

## Policy Statement

*The mission of PMO is to serve patients in their management of pain through a patient-centered approach. Our goal is to ensure your healthcare needs are met while your pain level is diminished and quality of life is improved.*

As a part of your treatment plan, patients may be asked to:

1. Please give a 24 hour notice of appointment cancellation. A late-cancellation or no-show fee of $40 will be required before another appointment is made.
2. We utilize a team-approach in caring for our patients. Patients may have appointments with a Nurse Practitioner or Physician assistant for routine follow up appointments. These providers always consult with & work closely with our Physicians.
3. PMO requires each patient has a Primary Care Physician.
4. Bring your medication ONLY if you are asking for a medication change or if we ask you to bring them.
5. Your medication may be checked for compliance with a random pill count.
6. The patient may be asked to count their medication in front of PMO staff. Medication should remain in the patient's possession AT ALL TIMES.
7. To maintain high levels of care & compliance, PMO providers follow the standard of care guidelines of the following:
    - Oklahoma state department of health
    - Oklahoma Board of Narcotics & Dangerous Drugs
    - Oklahoma Prescription Monitoring Program
    - Oklahoma Anti-drug Diversion Act
    - CDC Guidelines for prescribing opioids for chronic pain

Patients Signature ______________________________ Date ________________

Brent Henderson, D.O.
*Pain Management*
*Board Certified, Anesthesiology*

Jeff Halford, D.O.
*Pain Management*
*Board Certified, Physical Medicine & Rehabilitation, AAPMR*

*www.PainManagementofOK.com*

## OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

**Patient Name** ______________________ Social Security # ______________________

Date of Birth ______________________

I hereby authorize ______________________________________________
(Person/Organization Disclosing PHI)

to release the following information to Pain Management of Oklahoma ______________
(Person/Organization Receiving PHI)

**Information to be shared:**

☐ MRI / CT / X-ray(s) ☐ Other: ______________________

☐ Entire Medical Record ☐ Billing Information for ______________________

☐ Psychotherapy Notes (if checking this box, no other boxes may be checked) ☐ Substance Abuse Records

☐ Mental Health Records ☐ Medical information compiled between __________ and __________

**The information may be disclosed for the following purpose(s) only:**

☐ Continued Treatment ☐ Insurance ☐ Legal ☐ At my or my representative's request

**I understand that by voluntarily signing this authorization:**

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation. Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event: ______________________.

**Signature of Patient or Legal Representative** ______________________

Description of Legal Representative's Authority ______________________

**Date** ______________________

*** PLEASE RETURN RECORDS VIA FAX TO ______________________

# ORT

PMO
PAIN MANAGEMENT OF OKLAHOMA

Patient Name ______________________________ Date of Visit _________________________

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

| Mark each box that applies | Female | Male |
|---|---|---|
| Family history of substance abuse | | |
| Alcohol | 1 | 3 |
| Illegal drugs | 2 | 3 |
| Rx drugs | 4 | 4 |
| Personal history of substance abuse | | |
| Alcohol | 3 | 3 |
| Illegal drugs | 4 | 4 |
| Rx drugs | 5 | 5 |
| Age between 16—45 years | 1 | 1 |
| History of preadolescent sexual abuse | 3 | 0 |
| Psychological disease | | |
| ADD, OCD, bipolar, schizophrenia | 2 | 2 |
| Depression | 1 | 1 |
| Scoring totals | | |

# GAD-7

PMO
PAIN MANAGEMENT OF OKLAHOMA

**Over the last 2 weeks, how often have you been bothered by the following problems?**

*( Circle a number to indicate your answer )*

| | Not at all | Several Days | More than days half the days | Nearly every day |
|---|---|---|---|---|
| 1.Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| 2.Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3.Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4.Trouble relaxing | 0 | 1 | 2 | 3 |
| 5.Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6.Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7.Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

***For office coding: Total Score*** _____ _ _____ _____ _____

Total

## The Patient Health Questionnaire PHQ-9

Patient Name ______________________________________ Date of Visit ________________

### Over the past 2 weeks, how often have you been bothered by any of the following problems?

| | Not At all | Several Days | More Than Half the Days | Nearly Every Day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling asleep, staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so dgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |
| ______ + _____ + _____ ______________________ | | | | |

TOTAL Score

* OFFICE Staff will total

10. If you checked off any problems, how dif cult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

Not dif cult at all Somewhat dif cult Very dif cult Extremely dif cult

PMO

PAIN MANAGEMENT
OF OKLAHOMA

# HIPAA RELEASE OF PROTECTED HEALTH INFORMATION

______________________________________________

Patient or Patient Legal Representative Signature		Date

**Please provide us with a list of names of whom you would allow our office to release medical information to and to pick up scripts.**

Name:______________________ Relation to Patient:______________________

Phone Number: ______________________

Name:______________________ Relation to Patient:______________________

Phone Number: ______________________

Name:______________________ Relation to Patient:______________________

Phone Number: ______________________

Name:______________________ Relation to Patient:______________________

Phone Number: ______________________

Name:______________________ Relation to Patient:______________________

Phone Number: ______________________

Name:______________________ Relation to Patient:______________________

Phone Number: ______________________