Patient Name: _____ Date of Birth: _____/_____/_____

Arkansas Spine and Pain

Pain Management Agreement

The purpose of this agreement is to prevent misunderstanding about certain medicines you will be taking for pain management. This is to help both you and your doctor comply with the law regarding controlled pharmaceuticals.

I wish to enter a treatment agreement to prevent possible chemical dependency. I understand that if I break this agreement, my doctor will stop prescribing these pain control medicines. The doctor may terminate the patient physician relationship if I have made a misrepresentation or false statements concerning my pain or my compliance with this agreement or any other disagreement that my doctor may have with me.

Please initial by each line below.

____ All new patients will submit to a urine substance screen.
____ There will be random urine substance screens. I will submit if called upon for a random urine test within 24 hours of phone call.
____ I will not share, sell, or trade my medication(s) with anyone.
____ I will not attempt to obtain any controlled medicines, including opioid pain medicines, or controlled stimulants from any other doctor.
____ I will take my medications as prescribed by my physician, There will be NO EARLY REFILLS.
____ I will be responsible for making sure that I do not run out of my medications on weekends and Holidays there will be NO after hour coverage for medication refills.
____ I will keep my scheduled appointments unless I give a notice of cancellation 24 hours in advance.
____ I will safeguard my pain medicine(s) from loss or theft. Lost or stolen medicines cannot and will not be replaced.
____ Original containers of medication should be brought in to each office visit.
____ I fully understand the risks and benefits of the controlled medicines and will also discuss any interaction of my medications with the pharmacist.
____ I will notify Arkansas Spine and Pain should I visit the ER.
____ I will be discharged from Arkansas Spine and Pain should I test positive for illicit drugs.

I agree to use _____ pharmacy, located at _____

_____ and their phone number is _____.

I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's board pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine(s). I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy of confidentiality with respect to authorizations.

Patients Signature: _____ Date: _____

Arkansas Spine and Pain

INITIAL PATIENT DATA BASE In order to help us provide the best possible care for you at Arkansas Spine and Pain, we ask for your cooperation in providing the following information.

GENERAL INFORMATION: Date form completed: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____

Height_____ft. _____in. Weight _____ Age_____ Right handed ___ Left handed ____

Date onset of pain: ___/___/___ Cause of pain:_____

Was this injury ☐ at work, Last day worked _____ ☐ auto accident ☐ other,

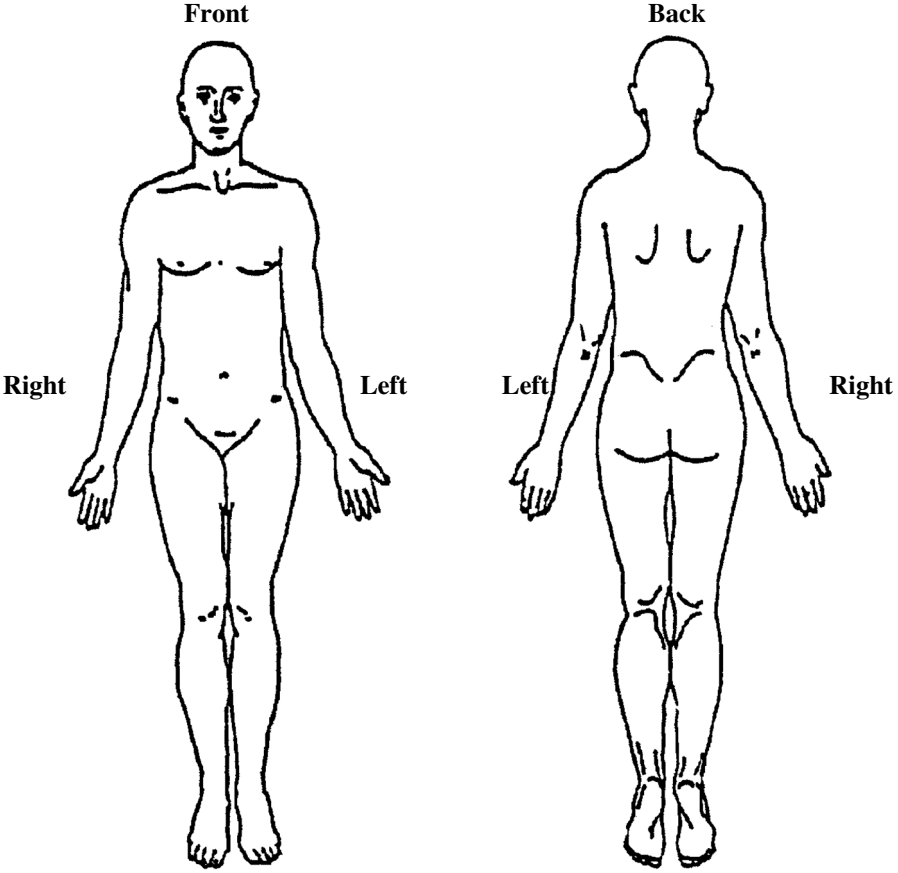
explain_____

On a scale of 1-10 Your pain at its worst:_____ Pain at its best:_____ Pain right at this moment:_____

0 = no hurt | 1-2 hurts little bit | 3-4 hurts a little more | 5-6 hurts even more | 7-8 hurts whole lot | 9-10 hurts worst

LOCATION OF YOUR PAIN

On the picture color in **all** your areas of pain.



Associated with (check all that apply):

_____Numbness/Tingling
_____Night pain
_____Weakness
_____Loss of control of bowel
_____Loss of control of bladder
_____Fever/chills
_____Unexplained weight loss
How many pounds _____

SYMPTOMS:

Neck Problems:

Neck Pain: Yes ___ No ___
Shoulder Pain: Yes ___ No ___ Right ___ Left ___
Arm Pain: Yes ___ No ___ Right ___ Left ___ How far down _____
Arm Numbness: Yes ___ No ___ Where _____
Weakness in Arm: Yes ___ No ___ Right ___ Left ___
Movement of Neck painful to: Right ___ Left ___ No ___
Difficulty resting at night? Yes ___ No ___
Headaches? Yes ___ No ___ Location _____

Back Problems:

Back Pain: Yes ___ No ___ What part of back? _____
Hip Pain: Yes ___ No ___ Right ___ Left ___
Leg Pain: Yes ___ No ___ Right ___ Left ___ Back of Leg __ Outside ___ Front ___ Inside __
How far down your leg does the pain go? _____
Numbness in leg? Yes ___ No ___ Location _____
Numbness in foot? Yes ___ No ___ Location _____
Weakness in leg? Yes ___ No ___ Right ___ Left ___

What makes your pain worse? ☐ sitting ☐ bending ☐ lifting ☐ twisting ☐ driving
☐ coughing ☐ sneezing ☐ standing ☐ walking ☐ lying down
☐ other, explain _____

Any lose of bowel or bladder control? Yes ___ No ___

What treatments have you had? _____
_____
_____

Please check any previous treatments for <u>current</u> pain:

☐ medications, list if applicable_____
☐ herbal remedies ☐ physical or occupational therapy ☐ work hardening ☐ tens unit
☐ chiropractor visits ☐ injections ☐ surgery for your pain ☐ counseling ☐ hypnosis

List any tests for your pain:

☐ x-ray ☐ CT scan ☐ MRI ☐ Myelogram ☐ Bone scan ☐ EMG
☐ other:_____

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Patient Name: _____ Date of Birth: _____/_____/_____

PAST MEDICAL HISTORY

Please check all that apply:

□ diabetes	□ bleeding disorder	□ murmur	□ Rheumatic fever	□ HIV or AIDS
□ stroke	□ heart attack	□ heart disease	□ aneurysm	□ circulation problem
□ high cholesterol	□ seizure disorder	□ cancer	□ kidney disease	□ high blood pressure
□ respiratory	□ thyroid	□ ulcer	□ liver	□ reflux
□ pacemaker	□ hepatitis	□ asthma	□ sleep apnea	□ defibrillator

□ fibromyalgia □ other please list: _____

PAST SURGICAL HISTORY

List all previous surgeries:

Date (month/year)	**Procedure:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list medications you are currently taking:

Medication / Dose	**Comments**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any medications to which you are allergic or which cause you problems:

Medication	Describe Reaction
_____	_____
_____	_____
_____	_____

Habits:	Yes	No	How Much?
Tobacco	___	___	_____
Alcohol	___	___	_____

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Occupational History:

Current Occupation: _____ For how long? _____

Are you currently working? Yes ___ No ___ If not, date last worked? _____

Family History:

Do any illnesses occur frequently in your family?

Illness:	Whom:	Comment:
_____	_____	_____
_____	_____	_____
_____	_____	_____

System Review:

Height: _____ Weight: _____

Skin	Yes	No	Comment:
Rash	____	____	_____
Easy Bruising	____	____	_____
Head			
Headache	____	____	_____
Eyes			
Recent Vision Changes	____	____	_____
Other: _____	____	____	_____
Ears			
Infections	____	____	_____
Vertigo (Dizziness)	____	____	_____
Respiratory (Lungs)			
Shortness of Breath	____	____	_____
Unusual Cough	____	____	_____
Asthma	____	____	_____
Heart			
Chest Pain (Angina)	____	____	_____
Palpitations or Fluttering	____	____	_____
Gastrointestinal (Stomach)			
Difficulty Swallowing	____	____	_____
Indigestion or Abdominal Pain	____	____	_____
Changes in Bowel Habits	____	____	_____
Genitourinary (Kidneys & Bladder)	____	____	_____
Difficulty Controlling Urination	____	____	_____
Kidney or Bladder Infection	____	____	_____
Musculoskeletal (Bone, Muscles)			
Painful or Swollen Joints	____	____	_____
Muscle or Extremity Weakness	____	____	_____
Psychiatric			
Anxiety (Nervousness)	____	____	_____
Depression	____	____	_____
Women			
Menstrual Abnormalities	____	____	_____

Arkansas Spine and Pain
CENTER OF EXCELLENCE

Notice of Privacy Practice Acknowledgement Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. Privacy Practice Notice was last updated September 23, 2013.

Name: _____

Date of Birth _____

Signature: _____

Date: _____