Pain & Spine
Specialists of Connecticut
An affiliate of National Spine & Pain Centers

Dear Patient,

Welcome to Pain and Spine Specialists of Connecticut, an affiliate of National Spine and Pain Centers. To help facilitate your care, please complete the enclosed paperwork and bring with you to your appointment along with your insurance card(s) and a photo ID. If you have had a MRI or CT scan, please bring in the CD provided to you by the imaging facility.

Please be advised that we do not prescribe any medications at the first visit. If you are currently prescribed medication(s) by another physician, please notify their office that they will need to provide you with medications for up to two weeks after your initial consult.

Thank you.

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Pardeep Sood, MD
Kristoffer de Lara, MD
Kelly Wilber, APRN

Imran Mridha, PA
Manuel Marquez, NP

Demographics

Name (first, mi, last): _____ **DOB:** _____/_____ / _____

Address (no PO Box please):_____

_____

SSN: _____-_____ - _____ **Gender:** ❑ M ❑ F **Marital Status:** ❑ S ❑ M ❑ D ❑ W

Ethnicity: ❑ Latino ❑ Not Latino ❑ Declined

Race: ❑ White ❑ Black/African American ❑ Asian ❑ Other ❑ Declined

Primary Language: ❑ English ❑ Spanish ❑ Indian ❑ Russian ❑ Other ❑ Declined

Home #: _____ **Cell #:**_____ **Work #:** _____

Email:_____ **Occupation**: _____

Employer: _____ **Employer Address:** _____

Referring MD: _____ **Primary MD:** _____

Emergency Contact:_____ **Phone #:** _____ **Relationship:** _____

Pharmacy Name: _____ **Pharmacy Address**: _____

Pharmacy Phone: _____ **Pharmacy Fax:** _____

How did you hear about our office? _____

Insurance

Is your visit related to: 1) Worker's Comp? 2) Motor Vehicle Accident? (If yes, circle one)

Primary Health Insurance: _____ **Effective Date:** _____ / ____ / _____

Health Ins. Address: _____

Member ID#_____ **Group #:** _____

Policyholder's Name: _____ **Referral required: Y N**

Policyholder's DOB: _____/_____/_____ **SSN#**_____-_____ - _____ **Deductible $** _____

Co-Pay $_____ **Relation to Insured:** _____

Policyholder's Employer:_____

Secondary Health Insurance:_____ **Effective Date:** _____ / ____ / _____

Health Ins. Address: _____

Member ID#_____ **Group #:** _____

Policyholder's Name: _____ **Referral required: Y N**

Policyholder's DOB: _____/_____/_____ **SSN#**_____-_____ - _____ **Deductible $** _____

Co-Pay $_____ **Relation to Insured:** _____

Policyholder's Employer:_____

Please bring driver's license and insurance card along with you to your appointment*

FAIRFIELD * FARMINGTON

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FINANCIAL POLICY

The practitioners and staff of Pain and Spine Specialists of CT are dedicated to providing you with the best possible care and service, and we regard your understanding of our financial policies as an essential element of your care and treatment. Please read the following financial policy and sign. If you have any questions or concerns, please ask our staff.

INSURANCE

You, as the responsible party, are responsible for providing us with up to date insurance information. We will keep a copy of your insurance card(s) on file. Kindly report any changes in your insurance coverage immediately by telephone or upon your arrival to your appointment. If your insurance changes and you do not notify our office, you may be responsible in full for any charges incurred.

REFERRALS

If your insurance plan requires referrals from your PCP to come to our office, YOU are responsible for obtaining the referral. If you do not obtain a referral you may not been seen or you may be billed for the full amount of services rendered. Please check with your insurance company if you are not sure.

COPAYS

Copays must be paid at time of service. Please come prepared to pay the specialist copay at each visitor you may not be seen.

DEDUCTIBLES and COINSURANCES

We will submit your bills to your insurance carrier(s) for processing. All balances will be billed to you and payment is expected upon receipt. If you fail to pay any balance within 90 days, you may not been seen in the office until said balance is settled. If you require a payment plan, please contact our billing office at 203-730-0743.

MEDICARE

Medicare patients are responsible for their annual deductible, coinsurance and any non-covered services in which you agree to pay (Advanced Beneficiary Notice). We will bill your secondary insurance as appropriate to be processed in accordance with your plan. Any balances due after insurance processing will be your responsibility and will be due upon receipt. If you fail to pay any balance within 90 days, you may not been seen in the office until said balance is settled.

MOTOR VEHICLE ACCIDENT

If your charges are related to a MVA and you have med pay or PIP coverage, we will bill your auto insurance carrier. Any balances not covered by your carrier are your responsibility. We will not suspend collection of your balance until a third party claim is settled.

WORKERS COMPENSATION

If you have a work related injury, we will submit all claims to your workers compensation carrier. If your case settles, and you receive a set aside account for medical expenses, you will be billed at the current WC rates that will be due at each visit.

PATIENTS WITHOUT INSURANCE

If you do not have insurance, you may be offered a discounted rate. Payments are due upon arrival to your appointment, there are no exceptions.

LATE CANCELLATION/NO SHOW FEES

We require 24 hours notice for cancelling an appointment. If you do not give adequate notice or fail to show for your appointment, we reserve the right to charge a $75.00 fee for a missed appointment and $200.00 for a missed procedure. The fee must be paid prior to rescheduling the missed appointment.

RETURNED CHECKS

All returned checks are subject to a $25.00 service fee.

PAST DUE ACCOUNTS

We expect that you will pay your account balance in a timely manner. Any account with a balance over 90 days past due will be referred to an outside collection agency and you will be responsible for any related collection costs.

Please call our billing office at 203-730-0743 if you have any questions.

I have read, understand and agree to the financial policies of Pain and Spine Specialists of CT.

Patient signature_____Date_____

Print name_____

ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE & DESIGNATION OF DISCLOSURE

I acknowledge that I have received a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth NSPC's privacy practices and my rights regarding privacy of my protected health information.

Patient Signature_____Date_____

Print Name_____Date of Birth_____

METHOD OF COMMUNICATION

I wish to be contacted in the following manner:

□ Home Phone #_____

OK to leave message with detailed information? Yes No Leave message with call back number only Yes No

□ Cell Phone #_____

OK to leave message with detailed information? Yes No Leave message with call back number only Yes No

□ Work Phone #_____

OK to leave message with detailed information? Yes No Leave message with call back number only Yes No

ACCESS TO MY INFORMATION

Please list the names below of anyone who may need to speak to us regarding your appointments and medications. Please include anyone who may pick up prescriptions on your behalf.

PASS may release my health information to the following people:

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

The following person(s) are NOT authorized to receive or discuss my health information:

Name_____Relationship_____

Name_____Relationship_____

AUDIO/VIDEO ACKNOWLEDGEMENT

Please be advised, that in order to better enable us to assure compliance with HIPAA privacy and security laws and regulations, and in recognition of the legitimate privacy concerns of our patients and staff, the use of any audio or video recording devices in this office by patients or other visitors, including but not limited to cell phones, is strictly prohibited.

We reserve the right to terminate any patient as permitted under State law if the patient or anyone accompanying the patient is found to be in violation of this policy. We appreciate your understanding and cooperation.

Patient signature_____Date_____

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ADVANCED DIRECTIVE

PASS is dedicated to providing comprehensive care to patients and following federal guidelines regarding important public health issues. Please answer the following question.

Are you able to name a surrogate decision maker in the event the you are incapacitated?

If yes, please indicate below.

Name_____ Relationship_____

Phone number_____

If no, please check the box below.

□ I do not wish or am unable to name a surrogate decision maker.

Patient signature_____Date_____

COMMUNICATIONS CONSENT FORM

To comply with the Telephone Consumer Protection Act, consent is required to send our patients automated, phone calls and text messages.

By signing below, or otherwise providing my phone number to NSPC or receiving services from NSPC's affiliated providers or practices, I authorize and expressly consent to receive SMS/text message and phone calls from or on behalf of NSPC, its affiliated practices, and their partners and affiliates, at any telephone number I provide at this time or later. This includes texts and calls placed using automated dialing technology and pre-recorded messages, and includes (without limitation) calls and texts that contain advertising or relate to debt collection, and those relating to medical care. I understand that my consent is not a condition of purchase or receiving a service, and that I may revoke my consent at any time.

I understand that if I do not wish receive calls or SMS/texts or later wish to withdraw my consent, I can do so by sending an email to **Team@TreatingPain.com** , calling **(855)-836-7246**, or responding **"stop**" to an NSPC text message. By providing a phone number, I represent that I am authorized to give this consent with respect to that phone number, and do so on behalf of all users of the phone number.

If at any point you change or obtain a new cell phone number, or if you no longer maintain the phone number you originally provided to us, you agree to notify NSPC immediately of such change or risk a violation of law resulting from autodialed or artificial or pre-recorded voice calls placed to an incorrect or reassigned phone number(s), originally belonging to you or which you provided to the clinic.

I have read this disclosure in its entirety and agree that NSPC, its affiliated practices, business associates and their partners and affiliates may contact me as described above.

_____ _____

PATIENT NAME PATIENT DATE OF BIRTH

_____ _____

PATIENT SIGNATURE DATE

_____

LEGAL REPRESENTATIVE PRINTED NAME IF SIGNING FOR PATIENT (PARENT/GUARDIAN OF MINOR) AND DESCRIPTION OF AUTHORITY TO SIGN FOR PATIENT

_____ _____ _____

PATIENT CELL PHONE NUMBER PATIENT HOME PHONE NUMBER OTHER PHONE NUMBER

NATIONAL® Spine & Pain CENTERS

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth NSPC's privacy practices and my rights regarding privacy of my protected health information.

PATIENT SIGNATURE (or Representative) **DATE**

FOR OFFICE USE ONLY

We have made every possible effort to obtain written acknowledgement of receipt of our notice of privacy practices from this patient but it could not be obtained because:

- ☐ The patient refused to sign
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgement
- ☐ We were unable to communicate with the patient
- ☐ Other (please provide specific details)

_____
_____
_____
_____

_____ _____

Employee Signature Date

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*Office use * Provider _____
Appt time _____ Entered _____
Vitals _____

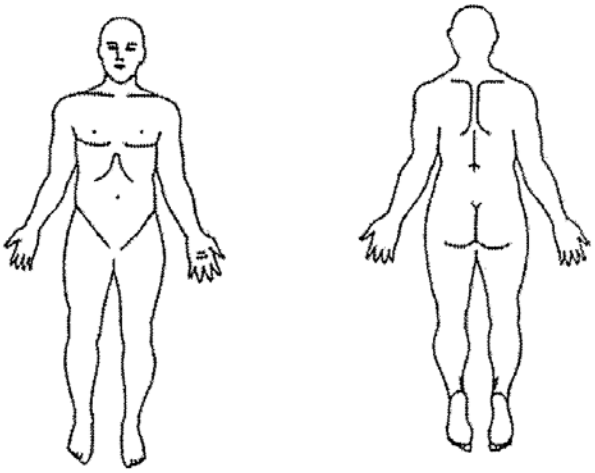
PAIN COMPREHENSIVE QUESTIONNAIRE

Patient Name _____ DOB _____ Date _____

Referring Physician _____ Primary Care Physicians _____

Chief Complaint (main problem seeking treatment) _____ Side ☐ right ☐ left

On the Diagram, shade in or circle the area where you feel pain:



R L **L R**

Preferred Pharmacy Name/Address:

_____

Preferred Pharmacy Phone:

_____

Are you pregnant or possibly pregnant?

☐Yes ☐No ☐N/A

---- (0 = no pain 10 = unbearable pain) ----

Pain level today

0 1 2 3 4 5 6 7 8 9 10

Over the last 4 weeks, please identify your pain levels below:

Severe pain level (on a bad day)

0 1 2 3 4 5 6 7 8 9 10

Average pain level (on an average day)

0 1 2 3 4 5 6 7 8 9 10

Allergies

_____

Email _____

The onset of your pain was:

☐Motor vehicle accident
Date of Accident _____
Were you wearing a seatbelt: ☐Yes ☐No
Position during the accident:
☐Driver ☐Passenger in front seat ☐Passenger in back seat

☐Falling from a height

☐Injury at work
Date of injury _____
What injury occurred? _____

☐Insidious onset ☐Lifting an object ☐Playing a sport ☐Slipping and falling ☐Trauma ☐Tripping/uneven surface

Your pain occurs: ☐constantly ☐intermittent ☐worse after activity ☐worse at the end of the day ☐worse during a activity ☐worse during cold seasons ☐worse during the day ☐worse during the night ☐worse in the morning

Describe your pain: ☐aching ☐burning ☐cramp-like ☐dull ☐in a glove distribution ☐in a stocking distribution ☐pins & needles-like ☐sharp ☐shooting ☐stabbing

Your pain has been occurring for: _____ ☐days ☐weeks ☐months ☐years

Symptoms	Associated with your pain	**Symptoms**	Associated with your pain
Arm numbness		Insomnia	
Awakens you from sleep		Leg numbness	
Changes in bladder function		Sexual Dysfunction	
Changes in bowel function		Shoulder numbness	
Changes in temperature in the affected area		Suicidal ideation	
Depression		Sweating in affected area	
Finger numbness		Toe numbness	
Flushing in affected area		Hand numbeness	

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PAIN COMPREHESIVE QUESTIONNAIRE

What activities aggravate/relieve your symptoms?

ACTIVITIES	AGGRAVATES YOUR PAIN	RELIEVES YOUR PAIN
All Movements		
Bending Forward		
Exercise		
Lifting Objects		
Lying Flat		
Rest		
Rotating the neck		
Sitting		
Standing for long periods		
Walking long distances		

What treatments have you used to treat the symptoms?

TREATMENTS	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
ACTIVITY MODIFICATION			
BRACE			
What type of Brace?	☐Back Brace ☐Neck Brace ☐Cervical traction ☐TENS unit ☐Ankle Brace (R or L) ☐Wrist Brace (R or L) ☐Knee Brace (R or L)		
How long have you had the product?			
Are you obtaining relief?			
Are your products in good condition?			
CHIROPRACTIC MANIPULATION			
PHYSICAL THERAPY			
PILATES			
WEIGHT REDUCTION			
YOGA			
HEAT TREATMENT			
ICE TREATMENT			
ACUPUNCTURE			
MEDICATIONS	Check mark all medication that apply below		

Opioids		NSAIDs/Tylenol		Muscle Relaxants
☐ Tramadol	☐ Methadone	☐ Tylenol	☐ Lodine	☐ Soma
☐ Demerol	☐ Morphine	☐ Aspirin	☐ Orudis	☐ Lorzone
☐ Codeine	☐ Nucynta	☐ Ibuprofen	☐ Relafen	☐ Flexeril
☐ Fentanyl (Duragesic)	☐ Butrans	☐ Naproxen	☐ Celebrex	☐ Baclofen
☐ Hydromorphone (Dilaudid,)	☐ Suboxone	☐ Daypro	☐ Toradol	☐ Zanaflex
☐ Hydrocodone (Vicodin)		☐ Indocin		☐ Robaxin
☐ Oxycodone (Percocet, Oxycontin)		☐ Feldene		☐ Skelaxin
☐ Oxymorphone (Opana)		☐ Voltaren		☐ Valium (Diazepam)

Antidepressants		Other	
☐ Elavil (Amitriptyline)	☐ Paxil	☐ Neurontin (Gabapentin)	☐ Lyrica
☐ Pamelor (Nortriptyline)	☐ Prozac	☐ Tegretol	☐ Ativan
☐ Desipramine	☐ Serzone	☐ Dilantin	☐ Xanax
☐ Impramine (Tofranil)	☐ Cymbalta	☐ Topamax	☐ Imitrex
☐ Zoloft	☐ Savella	☐ Depakote	☐ Ergotamine
		☐ Klonopin	☐ Mexillitine

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PAIN COMPREHESIVE QUESTIONNAIRE

Do you have any adverse effects since starting any treatment?

☐Constipation ☐Drowsiness ☐Mental slowness ☐Other

What procedures have you had to treat the pain?

PROCEDURE	Mark if applicable
No Procedure	
Epidural Steroid Injection	
Facet Joint Injection	
Medial Branch Block Trial	
Peripheral Nerve Injection	
Rhizotomy	
Fusion, anterior	
Fusion, posterior	
Fusion, combined anterior and posterior	
Laminectomy	
Microdiscectomy	
Other	

What imaging studies have you had for the pain?

☐Bone scan

☐CT Scan

☐EMG

☐ MRI

How has the pain limited you? (check mark all that apply)

Activities	Limit Pain	Activities	Limit Pain
No limitations		Inability to attend school	
Attending school on a limited basis		Inability to perform daily activities (ADL's)	
Difficulty getting up from chair		Inability to work	
Difficulty sitting		Requiring constant assistance	
Difficulty standing		Requiring occasional assistance	
Difficulty walking		Working on a limited basis	
Difficulty with daily activities (ADL's)		Working light duty	
Difficulty with recreational sports		Other	
Functional limitations			

Who have you seen for this problem? ☐Chiropractor ☐Emergency Room ☐General Surgeon ☐ Internist

☐Orthopedic Doctor ☐Pediatrician ☐Primary care ☐ Therapist ☐Trainer ☐Urgent Care Center ☐Walk in clinic

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INTAKE AND HISTORIES

Past Medical History (please check all that apply):

- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Breast Cancer
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non-Insulin Dependent
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity, Morbid
- ☐ Obesity
- ☐ PBPH
- ☐ Prostate Cancer
- ☐ Radiation Therapy
- ☐ Seizures
- ☐ Stroke
- ☐ **None**
- ☐ Other_____

Past Surgical History (please check all that apply):

- ☐ Appendix (Appendectomy)
- ☐ Bladder Removed
- ☐ Breast: Mastectomy ☐Right ☐Left ☐Both
- ☐ Breast: Lumpectomy ☐Right ☐Left ☐Both
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Gallbladder Removal
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Removed: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Hysterectomy: Caesarean
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ **None**
- ☐ Other_____

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INTAKE AND HISTORIES

Past Orthopedic History (please check all that apply):

- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Bursitis
- ☐ DISH
- ☐ Epidural Injections, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ **None**
- ☐ Other_____

Past Orthopedic Surgery (please check all that apply):

- ☐ Ankle Fracture ORIF
  ☐Right ☐Left ☐Both
- ☐ Carpal Tunnel Decompression
  ☐Right ☐Left ☐Both
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ Distal Radius ORIF
  ☐Right ☐Left ☐Both
- ☐ Intermedullary Nailing Femur
  ☐Right ☐Left ☐Both
- ☐ Intermedullary Nailing Tibia
  ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Hip
  ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Knee
  ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Shoulder
  ☐Right ☐Left ☐Both
- ☐ Knee Arthroscopy
  ☐Right ☐Left ☐Both
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Lumbar Spine Surgery: Decompression
- ☐ Lumbar Spine Surgery: Decompression & Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement
- ☐ Rotator Cuff Repair
  ☐Right ☐Left ☐Both
- ☐ Other_____
- ☐ **None**

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INTAKE AND HISTORIES

Medications (please list all current medications or check option, which applies):

- Complete the information below regarding all medications you are currently taking, have discontinued, or modified.
- Be certain to list both prescription and non-prescription medication, including any herbals or supplements you take.

☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)
☐ Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

Allergies (please list all known allergies or check option, which applies):

☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)
☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

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INTAKE AND HISTORIES

Social History (please check all that apply):

Cigarette Smoking
- ☐ Never Smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily
  - o # packs per day_____

Alcohol Use
- ☐ Do not drink alcohol
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Exercise Frequency
- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never
- ☐ Other_____

Drug Use
- ☐ Drug Use
- ☐ IV Drug Use
  - o _____

Family History:

Please check appropriate box "Alive" or "Decease" and list ages for the following Blood Family Members. If Parents or Grandparents are deceased, please write in Age and Cause of Death, if known.

	Alive	Age (if known)	Deceased	Age at Death	If deceased, cause of death	Unknown Status
Father						
Mother						
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						

	Number Alive	Age (if known)	Number Deceased	Age at Death	If deceased, cause of death	Unknown Status
Brothers						
Sisters						
Sons						
Daughters						

Family History (continued):

Please mark YES or NO if a Blood Family Member has ever had any of these conditions. If you mark YES, please mark the box under the relationship of the person to you

				Relationship of Person to you				
	YES	NO	DO NOT KNOW	Father	Mother	Grandparent	Brother /Sister	Son/ Daughter
Cancer								
Heart Disease								
Diabetes								
High Blood Pressure								
Stroke/TIA								
Alcohol Abuse								
Drug Abuse								
Psychiatric Illness								
Seizures								
Depression/Suicide								
Osteoarthritis								
Osteoporosis								
Scoliosis								
Other Conditions								

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INTAKE AND HISTORIES

Review of Systems* (check yes or no if you are currently experiencing any of the following):

Symptom	Yes	No	Symptom	Yes	No
Joint pains			Pain w/ breathing		
Joint swelling			Palpitations		
Difficulty Walking			Ankle Swelling		
Muscle Pain			Labored breathing w/exertion		
Weakness			Nausea		
Numbness			Vomiting		
Tingling			Diarrhea		
Fever			Constipation		
Weight Gain			Heartburn		
Rash			Ulcers		
Chest Pain			Blood in Stool		
Incontinence			Urinary Incontinence		
Shortness of Breath			Urinary hesitancy		
Suicidal thoughts			Urinary retention		
Weight loss			Blood in urine		
Chills			Genital pain		
Fatigue			Excessive bruising		
Discoloration			Excessive bleeding		
Scarring			Cancer		
Environmental Allergies			Excessive thirst		
Immunosuppression			Heat/Cold intolerance		
HIV/AIDS			Diabetes		
Blurred Vision			Thyroid Disease		
Double Vision			Joint Stiffness		
Glaucoma			Dizziness		
Eye pain			Fainting		
Ringing in the Ears			Headaches		
Loss of hearing			Tremor		
Nose bleeds			Seizure		
Hoarseness			Memory Loss		
Difficulty Swallowing			Depression		
Cough			Anxiety		
Wheezing			Hallucinations		

Other Medical Conditions* (check yes or no for the following):

*Please inform the physician, medical assistant or front desk staff of any other medical conditions or concerns.

Symptom	Yes	No	Symptom	Yes	No
Blood Thinners			Rheumatoid Arthritis		
Pacemaker			Hepatitis B or C		
Defibrillator			HIV/ADS		
Premedicate Prior to Procedure			Diabetes		
Hepatitis B or C					

Patient Name_____

Signature_____Date_____

SOAPP®-R

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

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	☐	☐	☐	☐	☐
2. How often have you felt a need for higher doses of medication to treat your pain?	☐	☐	☐	☐	☐
3. How often have you felt impatient with your doctors?	☐	☐	☐	☐	☐
4. How often have you felt that things are just too overwhelming that you can't handle them?	☐	☐	☐	☐	☐
5. How often is there tension in the home?	☐	☐	☐	☐	☐
6. How often have you counted pain pills to see how many are remaining?	☐	☐	☐	☐	☐
7. How often have you been concerned that people will judge you for taking pain medication?	☐	☐	☐	☐	☐
8. How often do you feel bored?	☐	☐	☐	☐	☐
9. How often have you taken more pain medication than you were supposed to?	☐	☐	☐	☐	☐
10. How often have you worried about being left alone?	☐	☐	☐	☐	☐
11. How often have you felt a craving for medication?	☐	☐	☐	☐	☐
12. How often have others expressed concern over your use of medication?	☐	☐	☐	☐	☐

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	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	☐	☐	☐	☐	☐
14. How often have others told you that you had a bad temper?	☐	☐	☐	☐	☐
15. How often have you felt consumed by the need to get pain medication?	☐	☐	☐	☐	☐
16. How often have you run out of pain medication early?	☐	☐	☐	☐	☐
17. How often have others kept you from getting what you deserve?	☐	☐	☐	☐	☐
18. How often, in your lifetime, have you had legal problems or been arrested?	☐	☐	☐	☐	☐
19. How often have you attended an AA or NA meeting?	☐	☐	☐	☐	☐
20. How often have you been in an argument that was so out of control that someone got hurt?	☐	☐	☐	☐	☐
21. How often have you been sexually abused?	☐	☐	☐	☐	☐
22. How often have others suggested that you have a drug or alcohol problem?	☐	☐	☐	☐	☐
23. How often have you had to borrow pain medications from your family or friends?	☐	☐	☐	☐	☐
24. How often have you been treated for an alcohol or drug problem?	☐	☐	☐	☐	☐

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

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