Modern Pain Consultants

Gary L. Koehn, M.D., Ph.D
Farooq A. Khan, M.D.
Shingo M. Yano, M.D.

All forms must be completed and signed prior to treatment.

GENERAL INFORMATION

Patient Name: _____
First Middle Last

Address: _____
Street City State Zip

Home Phone No: _____ Work Phone No: _____

Cell Phone No: _____ Email Address: _____

Date of Birth: _____ Social Security No: _____ Gender: Male Female
(Circle One)

Race: African American American/Alaska Indian Native Hawaiian Pacific Islander Caucasian White Other Declined
(Circle One)

Ethnicity: Hispanic/Latino Not Hispanic Preferred Language: _____
(Circle One)

Primary Care Physician: _____ Phone No: _____ City: _____

Referring Physician: _____ Phone No: _____ City: _____

Is this visit for the purpose of: Workman's Compensation Motor Vehicle Accident Personal Injury Self-Pay
(Circle One)

Marital Status: Single Seperated Married Widowed Divorced Student: Full time Part time
(Circle One) (Circle One)

Spouse Name: _____

Spouse Date of Birth: _____ Spouse Social Security No: _____

Emergency Contact: _____ Relationship: _____ Emergency Contact Phone No: _____

GUARANTOR INFORMATION

☐ Check and fill out this section **ONLY IF PATIENT IS A MINOR**.

THIS SECTION MUST BE COMPLETED BY THE **PARENT/GUARDIAN** THAT IS AUTHORIZING TREATMENT

Primary Guarantor/Parent/Guardian Name: _____

Address(If different from above): _____
Street City State Zip

Home Phone No: _____ Work Phone No: _____

Relationship to Patient: _____ Date of Birth: _____ Social Security Number: _____

INSURANCE INFORMATION

Name of Primary Insurance Company: _____ Phone No: _____

Mailing Address: _____
Street City State Zip

Policy Holder's Name: _____ ID No: _____ Group No: _____

Relationship to Patient: _____ Date of Birth: _____ Social Security Number: _____

Name of Secondary Insurance Company: _____ Phone No: _____

Mailing Address: _____
Street City State Zip

Policy Holder's Name: _____ ID No: _____ Group No: _____

Relationship to Patient: _____ Date of Birth: _____ Social Security No: _____

Preferred Pharmacy: _____ Phone No: _____ City: _____

Do you have an advanced directive such as a living will or medical power of attorney? Yes No
(Circle One)

PLACE OF EMPLOYMENT

Name of Patient/Primary Guarantor's Employer: _____ Phone No: _____

Address: _____
Street City State Zip

Is this a work related injury? Yes No (Circle One) If you answered yes, please fill out the Workman's Compensation Information Form included in the Patient Registration Packet.

Is this a motor vehicle related injury? Yes No (Circle One) If you answered yes, please fill out the Motor-Vehicle Accident Information Form included in the Patient Registration Packet.

PLEASE PROVIDE VALID PICTURE I.D. & PRIVATE INSURANCE CARD.

CONSENT TO HEALTH CARE SERVICES

I, the undersigned Patient, or undersigned person responsible for consenting on patient's behalf hereby request and consent to Modern Pain Consultants to be examined and treated by the medical, nursing and other healthcare personnel who may participate in the Patient's care.
I hereby acknowledge that all information provided herein is true to the best of my knowledge.

I hereby assign, transfer and set over to Modern Pain Consultants all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I revoke said authorization and give written notice. Modern Pain Consultants utilizes a electronic record program that accesses prescription/medication history in order to safely prescribe medication. I authorize and consent to these terms.

I understand that my co-pay, if applicable, is due prior to being seen and if my co-pay is not paid I may have to reschedule my appointment.
I understand that all cancellations of appointments must be made at least 24 hours in advance and rescheduled within the same business week whenever possible. I understand that there will be a $10.00 charge for all appointments cancelled with less than 24 hours notice, unless the appointment is rescheduled. I understand that there will be a $25.00 charge for all appointments missed with no call made cancelling the appointment. I also understand that three consecutive no show appointments may result in a discharge from Modern Pain Consultants.

I hereby agree to pay the regular charges of the physician for any treatment performed on my behalf or authorized by me.
I understand that I am financially responsible for all charges whether or not they are covered by my insurance plan or fall into the insurance company's definition of usual and customary. Modern Pain Consultants is committed to providing the best treatment possible for our patients and our charges are considered usual and customary for our area. I understand that all bills are to be paid in full within 45 days of submission to my insurance company. Interest of 1½% per month up to 9% annually will be charged after 60 days. An authorized, approved payment plan will eliminate interest charges and collections. I understand that I am responsible for all costs of collection for any outstanding fees, including but not limited to any attorney fees, court costs, expenses and interest incurred from the date of my initial consultation with any physician at the Modern Pain Consultants.

_____ _____
Patient / Primary Guarantor / Parent / Guardian Signature Date

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____ SSN: _____

This notice advises you about the ways in which we may use and disclose your Protected Health Information (PHI). Protected Health Information (PHI) means any of your health information that could be used to identify you and that relates to your past, present, future physical or mental health or condition and related health care services. It also describes your rights and our duties with respect to your PHI. The law requires us to provide a copy of this notice to you which explains our legal duties and privacy practices.

My signature acknowledges that I have been offered a copy of Modern Pain Consultants Notice of Privacy Practices at the time of registration.

Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the release of any and all records of my treatment to be forwarded to the following:
(Please check all that apply)

( ) The referring occupational clinic, my employer, workers compensation representative who will be handling my claim, as well as any physicians and ancillary personnel involved in my medical care.

( ) The referring physician and any physicians and ancillary personnel involved in my medical care.

( ) My primary care physician.

( ) My private health insurance carrier and any associated entities.

( ) My employer: _____
Name of employer

Signature: _____ Date: _____

PHONE MESSAGE AND CONTACT AUTHORIZATION

At what phone numbers can we, or our representatives, call to speak with you, and or leave a message regarding appointments, billing, or any other details related to your account? (Please circle Yes or No for each option)

Home Phone: Yes No Work Phone: Yes No Cell Phone: Yes No

Would you like to llow someone, other than yourself, to receive information regarding your appointments, billing, or any other details related to your account? (Please circle Yes or No) Yes No

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Signature: _____ Date: _____

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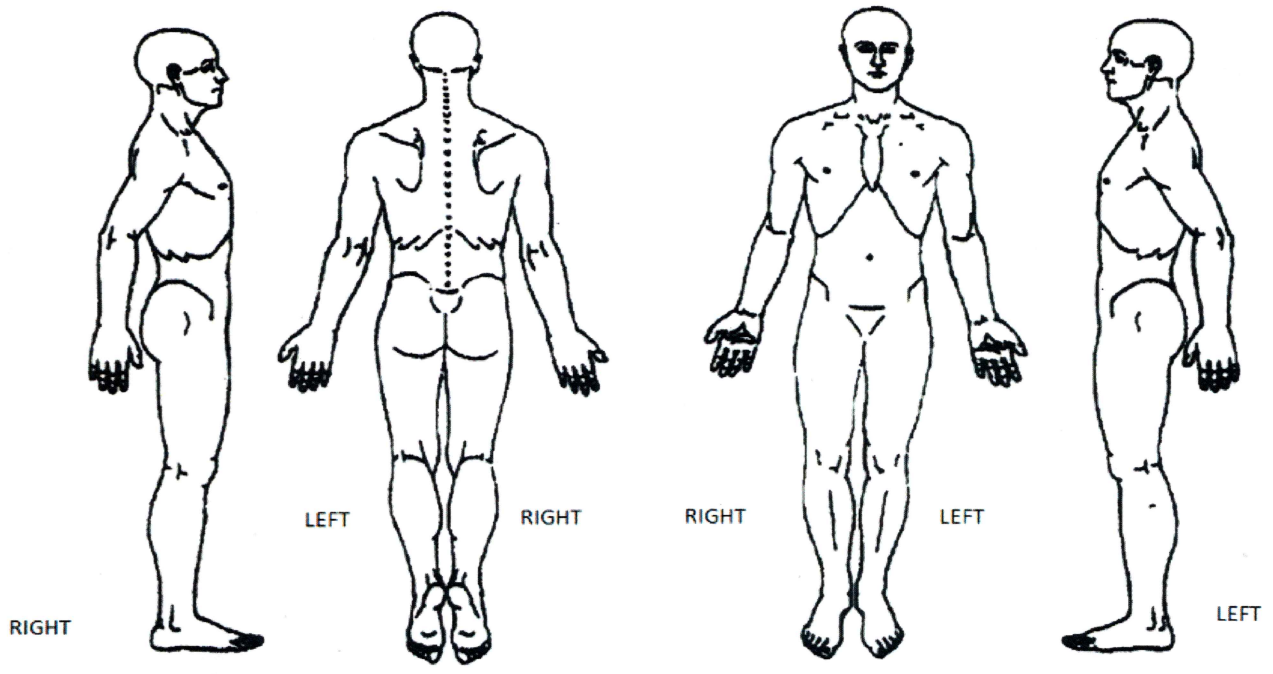
Name: _____ Age: _____

Chief Complaint: _____

_____

_____

Please shade the painful area(s) on the diagram below to indicate where your pain occurs:



Please circle your pain score: 0 1 2 3 4 5 6 7 8 9 10

No Pain — Moderate — Severe Pain

Check words that best describe your pain:

____ Dull	____ Numb	____ Pulling	____ Aching
____ Tearing	____ Unbearable	____ Sharp	____ Stabbing
____ Burning	____ Radiating	____ Pounding	____ Cramping

HISTORY OF PRESENT ILLNESS/INJURY

Date of Injury or when pain began: _____ How long has the pain been present: _____

How did the injury or pain occur: _____

_____

Frequency of your pain: ____ Constant ____ Intermittent Are you experiencing any weakness ____ Yes ____ No

Have you missed work due to your condition: ____ Yes ____ No If yes, what day(s): _____

Are you currently on work restrictions: ____ Yes ____ No If yes, what restrictions: _____

Is there anything that worsens the pain:

____ Bending ____ Coughing ____ Daily Activities ____ Prolonged Positions

____ Stairs ____ Twisting ____ Kneeling ____ Weather Changes

____ Lying Down ____ Neck Movement ____ Sitting ____ Walking

____ Stretching ____ Sneezing ____ Getting Dressed ____ Other

If other, explain: _____

Is there anything that makes the pain better:

____ Rest ____ Twisting ____ Massage ____ Bending Forward

____ Walking ____ Lying Down ____ Ice ____ Bending Backward

____ NSAID'S ____ Muscle Relaxant ____ Narcotics ____ Other

If other, explain: _____

Does the pain radiate: ____ Yes ____ No If yes, to where: _____

Affect on Sleep: _____

Have you ever been tested or told you have sleep apnea: ____ Yes ____ No

Other related symptoms: _____

Are you planning on getting pregnant or currently nursing: ____ Yes ____ No

Date of last mentrual period: _____ Are you on birth control: _____ Yes ____ No

Have you had any diagnostic tests related to your pain problem: ____ Yes ____ No

If yes, please check all that apply: ____ X-ray ____ MRI ____ CAT Scan ____ Bone Scan ____ EMG ____Other

If yes, please list area tested, date tested and facility: _____

Have you been seen by another pain specialist: ____ Yes ____ No

Physicians name: _____ City: _____

Please check off any treatment you had done by this pain specialist:

____ Joint Injection ____ Spine Injections ____ Ablation

____ Nerve Blocks ____ Spinal Cord Stimulator ____ Pain Pump

____ Other List other: _____

When did you have this done: Month:_____ Year: _____

Was this treatment helpful: ____ Yes ____ No Explain: _____

Do you participate in regular exercise: ____ Yes ____ No How often: _____ Is it helpful: _____

Have you or are you currently participating in physical therapy: ____ Yes ____ No Where: _____

When: _____ How long: _____ Is it helpful: _____

Have you seen a spine surgeon: ____ Yes ____ No

Physicians name: _____ City: _____

Previous surgeries: _____

Are you currently under the care of a psychiatrist: ____ Yes ____ No

Physicians name: _____ City: _____

What does pain prevent you from doing: _____

FAMILY/SOCIAL HISTORY

Current occupation: _____ ____ Full Time ____ Part Time

Marital Status: ____ Single ____ Seperated ____ Married ____ Widowed ____ Divorced

Do any family members have chronic pain: ____ Yes ____ No

Do you smoke: ____ Yes ____ No How often: _____ Quantity: _____ Duration: _____

Do you drink alcohol: ____ Yes ____ No How often: _____ Quantity: _____

Do you use street drugs: ____ Yes ____ No Type: _____ How often: _____ Quantity: _____

Have you ever suffered from addiction to pain medication, street drugs, or alcohol: _____ Yes _____ No

Have you ever suffered from verbal, physical, or sexual abuse: ____ Yes ____ No

Diet (including restrictions): _____

Allergies: _____

REVIEW OF SYSTEMS

General (Constitutional)

Chills ___ Yes ___ No
Fatigue ___ Yes ___ No
Fever ___ Yes ___ No
Night Sweats ___ Yes ___ No
Weight Change ___ Yes ___ No

Cardiovascular

Chest Pain ___ Yes ___ No
Dizziness ___ Yes ___ No
Palpitations ___ Yes ___ No

Genitourinary System

Abdominal Pain ___ Yes ___ No
Bloating ___ Yes ___ No
Pain w/urination ___ Yes ___ No

Endocrine

Enlarged Hands ___ Yes ___ No
Enlarged Feet ___ Yes ___ No
Hot/Cold Intolerant ___ Yes ___ No
Hair Loss ___ Yes ___ No

Eyes

Blurred Vision ___ Yes ___ No
Eye Pain ___ Yes ___ No
Eye Drainage ___ Yes ___ No

Respiatory

Cough ___ Yes ___ No
Wheezing ___ Yes ___ No
Short of Breathe ___ Yes ___ No

Musculoskeletal

Back Pain ___ Yes ___ No
Joint Stiffness ___ Yes ___ No
Limb Pain ___ Yes ___ No

Hematology

Bleeding ___ Yes ___ No
Bruising ___ Yes ___ No

Ears

Loss of Hearing ___ Yes ___ No
Ringing ___ Yes ___ No

Psychiatric

Anxiety ___ Yes ___ No
Depression ___ Yes ___ No
Mood Change ___ Yes ___ No

Gastrointestinal

Nausea ___ Yes ___ No
Vomiting ___ Yes ___ No
Diarrhea ___ Yes ___ No
Constipation ___ Yes ___ No

Skin (Integumentary)

Rash ___ Yes ___ No
Atypical Mole ___ Yes ___ No
Change in Nails ___ Yes ___ No

Neurologic

Dizziness ___ Yes ___ No
Headache ___ Yes ___ No
Seizures ___ Yes ___ No

HISTORY OF PAIN MEDICATION

List all pain medications you have tried in the past or are currently taking:	Currently taking?	Did you have any side effects?	List side effects:	Helps a lot:	Helps some:	Did not help:

CURRENT MEDICATIONS - Including over the counter medications, vitamins and supplements

Name of Medication:	Dosage	Frequency:	How long have you been taking this medication?	Helps a lot:	Helps some:	Has not helped:

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NAME:_____ DATE:_____

SOAPP-R INITIAL RISK ASSESSMENT

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.

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 have you felt a need for higher doses of medication to treat your pain? 0 1 2 3 4

3. How often have you felt impatient with your doctors? 0 1 2 3 4

4. How often have you felt that things are just too overwhelming that you can't handle them?

   0 1 2 3 4

5. How often is there tension in the home? 0 1 2 3 4

6. How often have you counted pain pills to see how many are remaining? 0 1 2 3 4

7. How often have you been concerned that people will judge you for taking pain medication?

   0 1 2 3 4

8. How often do you feel bored? 0 1 2 3 4

9. How often have you taken more pain medication than you were supposed to? 0 1 2 3 4

10. How often have you worried about being left alone? 0 1 2 3 4

11. How often have you felt a craving for medication? 0 1 2 3 4

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12. How often have others expressed concern over your use of medication? 0 1 2 3 4

13. How often have any of your close friends had a problem with alcohol or drugs? 0 1 2 3 4

14. How often have others told you that you had a bad temper? 0 1 2 3 4

15. How often have you felt consumed by the need to get pain medication? 0 1 2 3 4

16. How often have you run out of pain medication early? 0 1 2 3 4

17. How often have others kept you from getting what you deserve? 0 1 2 3 4

18. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

19. How often have you attended an AA or NA meeting? 0 1 2 3 4

20. How often have you been in an argument that was so out of control that someone got hurt? 0 1 2 3 4

21. How often have you been sexually abused? 0 1 2 3 4

22. How often have others suggested that you have a drug or alcohol problem? 0 1 2 3 4

23. How often have you had to borrow pain medications from your family or friends? 0 1 2 3 4

24. How often have you been treated for an alcohol or drug problem? 0 1 2 3 4

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

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Informed Consent for Opioid Treatment for Non-Cancer/Cancer Pain

I, _____(the patient) have agreed to use opioids as part of my treatment plan for chronic pain. I understand that these drugs can be very useful, but have a high potential for misuse and are therefore CLOSELY monitored by local, state, and federal government. Because my physician/healthcare provider is prescribing such medication to help manage my pain, I agree to the following conditions:

1. **I am responsible for my pain medications**. I agree to take the medication only as prescribed.
    a. I understand that increasing my dose or frequency of opioids with and without the direct and close supervision of my physician/healthcare provider could lead to drug overdose causing severe sedation, altered mental status, respiratory depression, and death.
    b. I understand that decreasing or stopping my medications abruptly without the close supervision of my physician/healthcare provider can lead to withdrawal. Withdrawal symptoms can include: runny nose, yawning, large pupils, goose bumps, abdominal pain, cramping, diarrhea, irritability, aches throughout body (flu like symptoms), hot and cold flashes. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks.
    c. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine consumption is reduced, stopped, or reversed, I will experience withdrawal symptoms (as described above).
    d. I have been informed that long term and and/or high doses of pain medications may also cause increased levels of pain known as opioid induced hyperalgesia (analgesic medication causing more pain) where simple touch will be predicted as pain and pain gradually increases in intensity and also the location with hurting all over the body. I understand that opioid induced hyperalgesia is a normal, expected result of using these medications for a long period of time. This is only treated with addition of non-steroidal anti-inflammatory drugs and/or reducing or stopping opioid therapy.

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2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician/healthcare provider at Modern Pain Consultants.
3. There are side effects with opioid therapy, which may include, but are not limited to: rash, constipation, sexual dysfunction, sleep disturbances, sweating, swelling, sedation, impaired cognitive function, altered mental status, confusion, coma, respiratory depression, and death.
    a. It is my responsibility to notify my physician/health care provider of any side effects that occur. I am responsible for notifying my pain physician/health care provider immediately if I need to visit another physician or need to visit an emergency room for pain related complaints.
    b. Any unintentional/intentional overdoses of opioid analgesics therapy MAY/CAN result in cessation of opioid therapy.
    c. For female patients, if I plan to become pregnant or believe that I may be pregnant while taking medication, I will notify the prescriber immediately. Opioid therapy will be weaned and eliminated. Alteration of this guideline will be at the discretion of the physician with close contact with patients OB/GYN.
4. I understand that the opioid medication is strictly for my own use. The opioid should **NEVER** be given or sold to others (including but not limited to: friends, family, children, spouses, parents) because it may endanger that person's health and is **against the law.**
5. I should inform my physician of all medications I am taking, including herbal remedies. Mediations such as benzodiazepines: Valium (diazepam), Ativan (lorazepam), Xanax (alprazolam); muscle relaxants: flexeril (cyclobenzaprine), Robaxin (Methocarbamol), Baclofen, Tizanidine (Zanaflex); antihistamines such as Benadryl or other allergy related medicine; herbal remedies, alcohol, and cough syrup containing alcohol, codeine, or hydrocodone can interact with opioids and produce serious adverse side effects. The combination of these medication classes **may/can** result in opioid cessation.
6. If dose of opioids is being adjusted, I will be expected to return the clinic as instructed by my clinic physician.
7. I understand that opioid prescriptions will NOT be faxed, mailed, phoned in or e-scribed.
8. Any evidence of aberrant behaviors such as drug hoarding, attainment of any opioid medication or adjunctive analgesia from other physicians (including ER

physicians), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement CAN result in the cessation of opioid prescriptions or the termination of the provider/patient relationship.

9. I will not use ANY illicit substances, such as cocaine, marijuana, amphetamines, etc. while taking these medications. This will result in a change of your treatment plan, including but not limited to: safe discontinuation of opioid therapy when applicable or termination of provider/patient relationship.
10. Alcohol consumption with opioid medications in contraindicated. The concurrent consumption of both CAN cause cessation of opioid therapy or termination of provider/patient relationship.
11. **I am responsible for my medications. I understand that:**
    a. **It is my responsibility to schedule appointments for the next opioid refill before I leave the clinic or within 2-3 days of last appointment.**
    b. **If an appointment for a prescription refill is missed, another appointment will be made as soon as possible. *Immediate* or *Emergent* appointments will not be granted.**
    c. **No "walk in" appointments for opioid refills will be granted.**
    d. **Refills can only be filled in the state of Illinois, even if I am a resident of another state, unless otherwise determined by your physician/provider.**
    e. **Prescriptions for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours. No refills of any medications will be done during the evening or on weekends.**
    f. **I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from theft or loss. I am responsible for taking the medications in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will report this to my local police department and obtain a police report. I will then report the stolen medication to my physician. If my medications are lost, misplaced, unaccounted for, or stolen, my physician/provider may choose to not provide a refill or choose to taper and eliminate the opioid regiment.**
    g. **Prescriptions will not be written in advance due to vacations, meetings, or other commitments.**

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12. Physical dependence is to be expected after long-term use of opioids, signs of addiction, abuse, or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the opioids.
    a. **Physical Dependence** is a common to many drugs such as blood pressure medications, anti-seizures medications, and opioids. It results in a bio-chemical change such that abruptly stopping these medications will cause a withdrawal response. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes, or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.
    b. **Addiction** is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm and craving. This means the drug decreases one's quality of life. You are exhibiting such behaviors, the provider will taper and eliminate your opioids, as you are not a candidate for an opioid trial or continuance. You will be referred to an addictionologist.
    c. **Tolerance** means a state of adaptation in which exposure to the drug induces changes that result in a lessening of one or more of the drug's effects over time. The dose of the opioid may have to be titrated higher or lower that produces maximum function and a realistic decrease of the patients' pain.
13. If it appears to the physician/health care provider that there is no improvement in daily function or quality of life from the controlled substances, my opioids may be discontinued. I will gradually taper my medications as prescribed by the physician.
14. If I have a history of alcohol or drug misuse/addiction, I must notify the physician/provider of such history since the treatment with opioids for pain may increase the risk of relapse. A history of addiction does not necessarily disqualify me from receiving opioids, however I must start or continue a program for recovery.
15. I agree and understand that my physician reserves the right to perform random or unannounced urine drug testing. If requested to provide urine sampling, I agree to comply. Urine testing is not forensic testing, but is done for my benefit. As a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

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16. The presence of a non-prescribed drug or opioid, illicit drug, or absence of prescribed drug, I understand that my treatment plan may change with cessation of my opioid treatment and possible termination of provider/patient relationship.

17. I agree to allow my provider to contact any health care professional, family member, pharmacy, legal authority, or regulatory agencies to provide information about my care or actions if the physician feels it is necessary.

18. I agree to a family conference or a conference with a close friend or significant other *if the physician/provider* feels it is necessary.

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I understand that the non-compliance with the above conditions may result in a re-evaluation of my treatment plan and discontinuation of opioid therapy. I may be gradually tapered off of these medications, with possible discharge from the clinic.

I, _____have read the above information or it has been read to me and all of my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy and acknowledge receipt of this document.

PPA Revision 2018

_____ Date : _____

Patients Signature (SIGN)

_____ Date: _____

Providers Signature