



# REGISTRATION FORM

(Please Print)

Today's Date: / /

Primary Care Physician:

## PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Widow		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former Name)	Birth Date / /		Age	Race	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address		City	State	ZIP Code	Social Security		Cell Phone No: ( )	
P.O. Box		City	State	ZIP Code		Other Phone No: ( )		
E- Mail:								
Patient Occupation		Patient Employer			Employer Phone No. ( )			
Employer's Address		City	State	ZIP Code				
Referring Physician		Physician's Address		City	State	Zip Code	Referring Physician Phone ( )	

## INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			Name of Primary Insurance (if applicable):					
Subscriber's Name:		Subscriber's S.S. #	Birth Date / /		Policy #		Group #	Co-Payment \$
Patient's Relationship to Subscriber		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			
Name of Secondary Insurance		Subscriber's Name			Group #	Policy #		
Patient's Relationship to Subscriber		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			
Is this a workers' compensation Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Adjuster Name:			Adjuster Phone: ( )			
If W/C, claim #:		Date of injury:						
Party Responsible for Bill	Birth Date / /		Address (if different)			Home Phone No. ( )		
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No		( )						
Occupation	Employer	Employer Address				Employer Phone No. ( )		

## IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)		Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )
---	--	-------------------------	-----------------------	-----------------------

- The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Optimal Regenerative & Pain Medicine or my insurance company to release any information required to process my claims.
- Optimal provides the opportunity for patients to communicate by email. By providing an electronic mail address to Optimal, the patient acknowledges that medical information may be contained in these communications. Email should never be used for emergency problems. Optimal cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Optimal's intentional misconduct.

X \_\_\_\_\_ PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE

## Financial Policy

Thank you for choosing Optimal Regenerative & Pain Medicine. Our goal is to provide you with the highest quality care possible. We find that communication with our patients regarding our financial policy assists us in providing the best service to you. Therefore, we take this opportunity to answer some of the most commonly asked questions. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

### Payment Methods

Payment is expected at the time services are rendered. We accept a variety of payment methods, including cash, check, money order, or credit card Visa, Mastercard, Discover and AMEX. Credit card payments are also accepted via telephone.

### Insurance Information

We must emphasize that your health is our primary concern, regardless of your insurance. Because your insurance policy is a contract between you and your insurance company, please check with your insurance carrier to determine any pre-existing limitation or other benefit restrictions that you may have, prior to your appointment.

We will file your insurance as a courtesy and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

Most insurance companies do not cover 100% of the cost of services, and there is a portion that the patient is responsible for. There are several patient responsibility components that may apply to an insurance payment.

*Co-pay* – A set dollar amount per office visit that is the patient's responsibility. *Co-insurance* – A percentage of the charge that is the patient's responsibility. *Deductible* – A set annual amount that the patient is responsible for paying prior to his or her insurance making a payment.

Because of the contract you have with your insurance company, we are obligated to collect payment from you for your portion of the balance. All co-payments, co-insurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

To bill your insurance accurately and in a timely manner, we will need assistance from you. We ask that you provide our office with accurate demographic information (address, phone number, etc.) and proof of insurance. All patients will be required to show proof of insurance and a Government issued Photo ID.

### Insurance Changes

If there are any changes in your insurance, you are required to call our office and give the detailed changes of your insurance at least twenty-four (24) hours prior to your appointment. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance.

**Managed Care: All managed care (i.e. HMO, PPO, POS)**

Co-payment, co-insurance & deductible amounts are due at the time of check-in. If your insurance plan requires a referral authorization from a primary care physician you are responsible for obtaining prior approval from your PCP prior to treatment & will need to present this at your visit. If you request an office visit or procedure without a referral authorization, your insurance plan may deem this as non-covered treatment and you will be responsible for the charges.

**Medicare**

We accept assignment with Medicare. Medicare pays 80% of their allowed amount after satisfaction of the yearly deductible. You are responsible for 20% of Medicare's allowed amount. All co-payments or deductibles are due and payable at the time of service.

**Secondary & Tertiary Plans**

We will bill your secondary insurance as a courtesy. We do not bill tertiary insurance. If you have supplemental insurance to cover the portion of the charges that Medicare or your primary insurance carrier does not pay, please provide us with a copy of this insurance card. Medicare and secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding.

**Preauthorization**

Please remember that it is up to you to understand the requirements of your individual insurance plan and know whether prior authorization from your insurance company is required

**Non-covered Services**

Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

**Auto Injury Cases**

This office does NOT bill auto insurance for auto accident cases. We do NOT accept liens or letters of protection (LOP's).

**Worker's Compensation**

If your injury is work-related, we will need the claim number, date of injury, employer, and worker's compensation carrier prior to your visit in order to bill the worker's compensation insurance company.

**Cash Patients**

Cash patients are accepted on a case by case basis. All uninsured patients will be required to pay in full at time of treatment.

**Surgery & Injection Fees**

All co-pays, co-insurance, deductibles, and payments for non-covered surgical procedures are due prior to surgery. We will make every attempt to determine your coinsurance amount prior to your surgery. This will be based on your insurance benefits and an estimate of the services to be provided. We will provide you with that estimate & we will expect to collect that amount prior to the time of surgery. If any changes are made to the scope of services provided and the coinsurance amount has changed, we will either refund or bill you upon final resolution of your account. Fees are ultimately the responsibility of the patient, whether your insurance company pays or not, and are due within thirty days of your receipt of Optimal Regenerative & Pain Medicine statement.

**Nonpayment**

Please be aware that patient accounts over 180 days without satisfactory payment will be turned over to a collection agency and patients will face possible termination from the program.

**Returned checks**

A \$25.00 fee will be charged for any returned checks and we will report bad checks to the District Attorney's Office. We will be unable to accept your check for any services thereafter.

**Missed appointments**

A scheduled appointment is a commitment of time between you and our practice, a time we have reserved just for you. If you are unable to keep a scheduled appointment, please cancel or reschedule your appointment at least 24 hours in advance to avoid a service charge and help us meet the needs of other patients. Patients who habitually fail to keep scheduled appointments and do not give a 24 hour cancellation notice will face treatment termination.

**Children of Divorced Parents**

Responsibilities for payment of patients, who are minor children, whose parents are divorced, rest with the parent who seeks the treatment.

**Medical Records**

Please direct all medical record requests or questions to your physicians' business office.

**Charges for Forms**

A \$30.00 fee will be charged for disability, life insurance, and other forms requested by a third party or patient.

**Special Circumstances**

We are aware that circumstances in our daily lives may vary. If you need to establish a payment plan or require additional assistance, please contact our Business Office prior to your scheduled appointment. Unless you have made prior arrangements for payment of your balance, our financial policy will stand.

**Account Billing Questions & Refunds**

Questions or concerns regarding your account or insurance claim should be directed to our business office staff. If your account has a credit balance, we will promptly release a refund check to you once your insurance carrier has processed all pending insurance claims remaining on your account. If you feel an error appears on the statement or if you have any questions or concerns please contact our billing office immediately at (972) 715-5000.

---

Printed Name

---

Signature

Date

**NOTICE OF PRIVACY PRACTICES**  
**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND**  
**DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION**  
**PLEASE REVIEW IT CAREFULLY**

Optimal Regeneration & Pain Medicine, US Anesthesia Partners, and Pinnacle Pain Medicine are affiliated entities that have entered into an Organized Health Care Arrangement and are jointly issuing this Notice of Privacy Practices about the information we share in common and your legal rights and our common duties with respect to your health information.

**OUR PLEDGE TO YOU**

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care, bill for your care, and comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether made by our staff and authorized trainees, or by your personal doctor. This notice tells you about the ways in which Optimal may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe our obligations regarding the use and disclosure of your health information.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

Optimal doctors, nurses, pharmacists, laboratory technicians, and other health care professionals may use health information about you to provide you with health care **treatment** or services. We may also disclose health information about you to others who are involved in taking care of you. For example, we may send health information about you to a specialist as part of a referral.

Optimal may use and disclose health information about you to obtain **payment** for the treatment and services you receive from us. For example, we may send billing information to your insurance company or Medicare. We may also tell your insurance company about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. Optimal may send you a statement of your account if payment is due from you. We may send the guarantor (responsible party for payment) monthly statements for charges for all patients under that guarantor.

Optimal may use and disclose health information about you to support our health care **operations**. For example, we may use health information to review the treatment and services and to evaluate the performance of our staff in caring for you. We may combine health information about many patients to decide what additional services we should offer. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

We may disclose information to notify **a family member or other person responsible for your care** about your condition, status, and location.

If you are admitted and unless you tell us otherwise, we may provide your name, location in the hospital, and your general condition (good, fair, etc.) for information to be included in a **patient directory** and make this information available to anyone who asks for you by name.

We may use and disclose health information to contact you for an **appointment reminder**, to tell you about **health-related services** or recommend **possible treatment options or alternatives** that may be of interest to you, or to contact you about supporting **our fundraising** efforts.

Subject to certain requirements, we may use or disclose health information about you **without your prior authorization** for other reasons:

We may give out health information about you for **public health** purposes; to **report abuse or neglect**; for **health oversight reviews**; in **research** studies; for **funeral arrangements** and **organ donation**; in response to special **law enforcement** requests, valid judicial or administrative orders, or for authorized national security and intelligence activities; for **workers' compensation** purposes; to **avert a serious threat** to your health or safety or those of the public or another person; and when **required by law**. If you are or were a member of the armed forces, we may release information about you as required by military command authorities or the Department of Veterans Affairs. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official.

In any other situation not covered by this notice, we will ask for your written **authorization** before using or disclosing your health information. You may **revoke** this authorization for any subsequent disclosures by notifying us in writing.

## YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the right to request in writing that you **inspect and obtain a copy** of the health information that we use to make decisions about your care. We may charge a fee for the costs of copying, mailing or other supplies and services associated with your request. If we deny your request to inspect or obtain a copy in certain limited circumstances, you may request that the denial be reviewed. Another licensed health care professional chosen by Optimal will review your request and the denial and we will comply with the outcome of that review.

If you believe that health information we have about you is incorrect or incomplete, you may make a written request to ask us to **amend information**. The request should state the reason for the amendment and specific information to be amended. The amendment must be limited to one page. Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously stated.

We may deny your request for an amendment if the information to be amended was not created by us, is no longer maintained by us, is not part of the information which you would be permitted to inspect and copy; or is accurate and complete. We will notify you if we deny your request for amendment and you may appeal, in writing, our decision. Any statements of disagreement or rebuttal will be linked to your health information and made a part of any subsequent disclosure we make of such information.

You have the right to make a written request for a **list of disclosures** we have made of your health information, except for uses and disclosures for treatment, payment, and health care operations, as previously described, and those for which you have authorized disclosure. Your request must state a time period which may not be longer than six years and may not include dates prior to April 14, 2003. We will not charge you for the first list you request within a 12-month period, additional requests will be charged according to our cost for producing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to **request a restriction** on the health information we use or disclose about you for treatment, payment, or health care operations. There may be risks associated with such restrictions and we may ask you to acknowledge these risks in writing for certain requests you may make. ***We are not required to agree to your request for restrictions*** if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

You have the right to request, in writing without requiring you to state a reason, that **confidential communications** with you be made in an alternative manner or location. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

#### WRITTEN REQUESTS

If you have any questions about this notice, please contact: US Anesthesia Partners, to the attention of the Privacy Officer at 13737 Noel Road, Suite 1400, Dallas, Texas, 75240, or call (972) 715-5000.

#### COPIES OF NOTICE AND CHANGES

You have the right to obtain a paper copy of this notice at any time.

We reserve the right to change this notice, and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future.

#### COMPLAINTS

If you are concerned that your privacy rights may have been violated or you disagree with a decision we make about your health information, you may contact US Anesthesia Partner's Privacy Officer at 13737 Noel Road, Suite 1400, Dallas, Texas, 75240, or call (972) 715-5000. You may also send a written complaint to the U.S. Department of Health and Human Services. We can provide you with the address.

**Under no circumstances will we ever ask you to waive your rights under this notice or retaliate against you in any manner for filing a complaint.**

Please sign the attached acknowledgement that you have received our Notice of Privacy Practices, effective April 14, 2003.



**Acknowledgement of Receipt of Notice of Privacy Practices  
Optimal Regenerative & Pain Medicine  
US Anesthesia Partners  
Pinnacle Pain Medicine**

I received a copy of the Notice of Privacy Practices from the above noted entities.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Personal Representative: \_\_\_\_\_

If personal representative, please note relationship to patient: \_\_\_\_\_

**Prescription Pick-up Authorization**

If you would like to give consent for another individual to pick up your prescriptions or documentations, please provide that name below:

\_\_\_\_\_ I give consent for my provider to discuss my medical care with the persons listed below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_

*(Authorized Representative must present valid photo ID upon pick up)*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_

*(Authorized Representative must present valid photo ID upon pick up)*

FOR OFFICE USE ONLY

By: \_\_\_\_\_

Date: \_\_\_\_\_



## PATIENT RESPONSIBILITIES

To better serve you and maintain a professional environment, Optimal Regenerative & Pain Medicine has established guidelines to outline patient responsibilities. The guidelines have been established so that our patients can fully benefit from treatment received in our clinic. Your responsibilities as a patient of our clinic are as follows:

1. Please arrive at least 15 minutes (30 minutes on your first visit) prior to your appointment time for clinic appointments in order to take care of any insurance issues or required paperwork. If you are 15 minutes or more late for your appointment time and/or your initial paperwork is not complete by your appointment time, your appointment will be rescheduled.
2. We require at least 24 hours' notice for cancellations/rescheduling of appointments. A missed clinic appointment or appointment for a scheduled procedure without calling to reschedule will be considered a "no show" for the appointment. "No shows" will be charged \$25.00 for missed clinic appointments or \$100 for a missed scheduled procedure. Patients who consistently fail to show up for their scheduled appointments without providing 24 hour advanced notice can be terminated from the program.
3. Prescriptions will only be filled during office hours by appointment only. No prescriptions will be filled after hours, on weekends, or holidays.
4. State law requires compliance and close monitoring for narcotic medications. If these are prescribed for you, you will be asked to sign a *Patient Responsibility Agreement for Controlled Substance Prescriptions*.
5. Payment is due at the time services are rendered to the patient. Failure to settle past due balances, pay at the time of service, etc., can result in the patient's termination from the treatment program.

Noncompliance with these guidelines will result in discharge from treatment at Pinnacle Pain Medicine. Your signature below constitutes acknowledgement and acceptance of the terms of these guidelines.

---

Patient Name

Date

---

Signature of Patient/Legally Responsible Person

Signature of Witness

## **Advanced Practice Nurse/Nurse Practitioner and Physician Assistant Consent**

Optimal Regenerative & Pain Medicine would like you to know that we employ Advanced Practice Nurses, also known as Nurse Practitioners, and Physician Assistants to assist us in a team approach to deliver our high quality of medical care.

An Advanced Practice Nurse (APN)/Nurse Practitioner (NP) and Physician Assistants (PA) are mid-level practitioners who have received advanced education and training in the provision of health care. Advanced Practice Nurses/Nurse Practitioners or Physician Assistants are not doctors. They can however, diagnose, treat, and monitor routine and complex pain disorders. If you are seen by an APN/NP or PA, your doctor will review your care with the APN/NP or PA as part of the care plan.

I have read the above and understand that in this practice a team approach is used, with my unique needs presented and discussed with one or more physicians in the development of my care plan. I also understand that typically one physician will direct my overall care, but that from time to time I may be seen by any or all the practitioners in this practice, including a APN/NP or PA.

I hereby consent to the services of an Advanced Practice Nurse/Nurse Practitioner or Physician Assistant for my healthcare needs.

I understand that I can refuse to see the APN/NP or PA and request to see a Physician. I understand that this may require my appointment to be rescheduled or require a longer wait time for an appointment.

***Please check this box to acknowledge that you have read and accept the above.***

---

Signature

Date

Optimal Regenerative & Pain Medicine  
13737 Noel Road, Suite 1400  
Dallas, TX 75240

# Patient Questionnaire

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

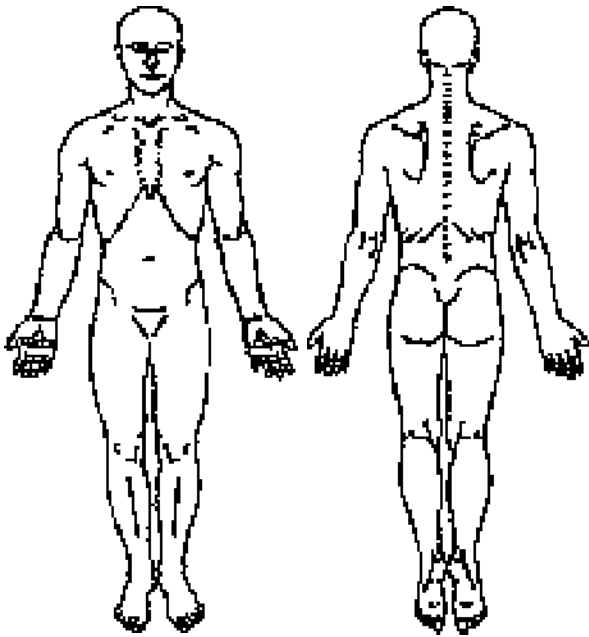
Family Doctor: \_\_\_\_\_

Greatest area of pain? \_\_\_\_\_

Other areas of pain? \_\_\_\_\_

When did it start? \_\_\_\_\_ Are there any legal actions involved? \_\_\_\_\_

**Please shade in your areas of pain in the diagrams below:**



**Using the scales and examples at the bottom of this page,**

Please rate your pain on a scale of 0 to 10 for **TODAY** :

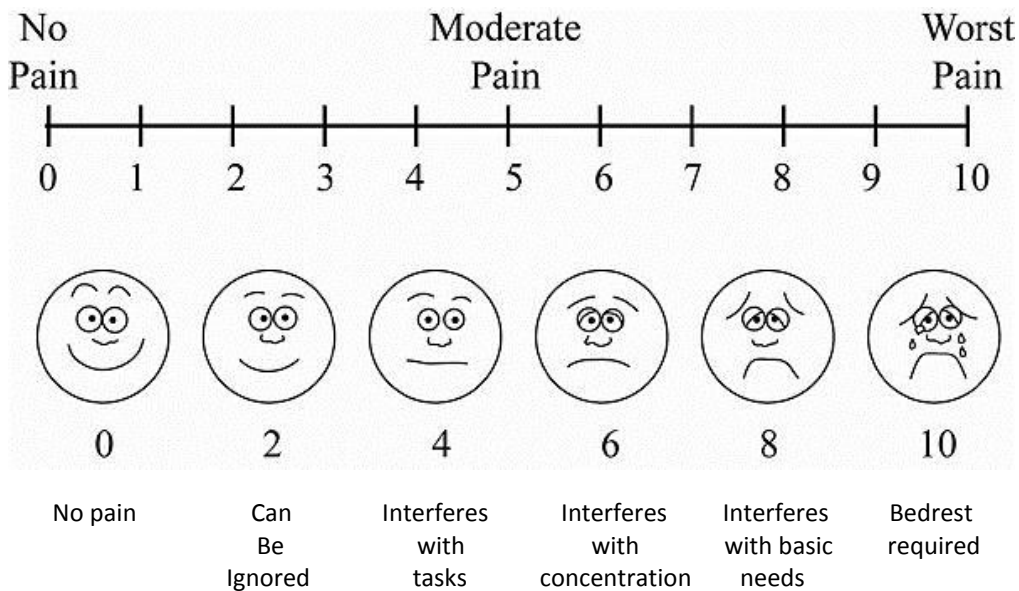
\_\_\_\_\_

Please rate your pain on a scale of 0 to 10 at its most **SEVERE**:

\_\_\_\_\_

Please rate your pain on a scale of 0 to 10 at its **BEST**:

\_\_\_\_\_



**How do you describe your pain?**

- Aching  Burning  Electrical  Knifelike  Sharp  Shooting  Stabbing  Stinging  Throbbing  Tingling  
 Toothache

**What makes your pain worse?**

- Arching  Bending  Bowel Movements  Cooking  Coughing  Getting out of chair  Lying down  Sex  Sitting  
 Sneezing  Standing  Twisting  Vacuuming  Walking  Climbing Stairs  Walking down a hill  Driving  Lifting

**What makes you pain better?**

- Activity  Sitting  Standing  Lying down  Walking  Stretching  Hot bath or shower  Application of heat  
 Ice  Relaxation  Massage  TENS unit  Acupuncture  Chiropractor  Previous Injections  Pain medication  
 Physical Therapy  Rest

**Do you have:**

- Numbness  Tingling  Weakness  New Bowel or bladder problems

**Pain is:**

- Constant  Intermittent

**When is your pain the worst?**

- Morning  Midday  Evening  Night

**Have you tried any of the following treatments for you pain?**

- Bracing  Chiropractor  Injections  Medication  Oral Steroids  Physical Therapy  Surgery  TENS unit

**Do you have any of the following symptoms?**

- Abnormal bruising  Allergic rash  Anxiety  Bleeding  Chest pain  Cold intolerance  Confusion  Constipation  
 Cough  Cramps  Depression  Diarrhea  Diplopia-Double vision  Edema  Fatigue  Fever  Headaches  
 Hearing loss  Heat intolerance  Incontinence  Indigestion-Heart burn  Insomnia-Sleep difficulty  Itching  Joint pain  
 Memory loss  Nausea  Pain at night  Palpitations  Rash  Recurrent infections  Restless legs  Sexual dysfunction  
 Shortness of breath  Sore throat  Sweats  Syncope-dizziness  Tinnitus-Ringing in the ears  Tremors  
 Unusual weight gain  Unusual weight loss  Urinary frequency  Urinary hesitancy  Vertigo  Vision loss  
 Weakness  Wheezing

**Have you tried any of the following for your pain?**

- Acupuncture  Bracing  Chiropractor  Epidural steroid injections  Facet injections  Other injections  Oral steroids  
 Medications  Physical therapy  Surgery  TENS unit  Trigger point injections

**Do you have or had any of the following?**

- Alcoholism    Atrial fibrillation    Asthma    Bleeding disorder    Chest pain (angina)    COPD (emphysema)
- Congestive heart failure    Diabetes (insulin  Yes or  No)    Drug addiction    Hepatitis    Heart attack    Hypertension
- HIV or immune diseases    Kidney failure/disease    Liver disease    Lung disease    Multiple sclerosis    Peptic ulcer
- Psychiatric disorders    Seizures    Stroke or TIA    Sickle cell disease    Thyroid disorder
- Other \_\_\_\_\_

**Have you had surgery before?**

- Appendectomy    Brain surgery    Breast biopsy    Cancer surgery    Cardiac bypass    Cardiac angioplasty
- Cardiac AICD/Pacemaker    Carpal tunnel surgery    Cesarean section    Cholecystectomy    Hernia Repair
- Hysterectomy    Hip replacement    Lung surgery    Knee arthroscopy    Knee replacement    Shoulder surgery
- Cervical/Neck surgery    Thoracic surgery    Lumbar/low back surgery    Tonsillectomy
- Other \_\_\_\_\_

**Family History:**

<u>Family Member</u>	<u>Please list their major health problems</u>
Mother	_____
Father	_____
Brothers	_____
Sisters	_____
Children	_____

**Personal History:**

Marital Status:    Married    Single    Divorced    Widowed  

Occupation: \_\_\_\_\_

Are you receiving disability?    Yes    No      Disability diagnosis: \_\_\_\_\_

Do you live:    Independently    Require home assistance    Assisted facility

Do you smoke?    Yes    No      Amount \_\_\_\_\_

Do you drink alcohol?    Yes    No      Amount \_\_\_\_\_

Do you use illegal drugs?    Yes    No      Amount \_\_\_\_\_

Did you, in the past year, want or need to *cut* down on controlled substance or alcohol use?       Yes       No

Have you been *annoyed* or *angered* by someone else complaining about your drug or alcohol use?       Yes       No

Have you felt *guilty* about the consequences of prescription drug or alcohol use?       Yes       No

Do you use a drug or alcohol in the morning as an "*eye opener*" for "*withdrawal*" or "*hangover*"?       Yes       No

**Allergies to medications:** \_\_\_\_\_

**Please list all medications you are taking now:**

<u>Medication</u>	<u>Dose</u>	<u>How many times a day</u>

**Please list any medications you have tried for your pain:**

<u>Medication</u>	<u>Did it help?</u>	
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Have you had side effects from pain medications?**

<u>Medication</u>	<u>Side effect</u>

# SOAPP® Version 1.0

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.*

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 |
| 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 |

©2008 Inflexion, Inc. Permission granted solely for use in published format by individual practitioners in clinical practice. No other uses or alterations are authorized or permitted by copyright holder. Permissions [questions: PainEDU@inflexion.com](mailto:questions:PainEDU@inflexion.com). The SOAPP® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.