REGISTRATION FORM

(Please Print)

Today's Date: / / Primary Care Physician:

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Widow

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Race	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security	Cell Phone No: ( ) Other Phone No: ( )

P.O. Box	City	State	ZIP Code

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? ❑ Yes ❑ 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 ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of Secondary Insurance	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

Is this a workers' compensation Injury? ❑ Yes ❑ 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? ❑ Yes ❑ 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

OPTIMAL
Pain & Regenerative Medicine

Financial Policy

Thank you for choosing Optimal Pain & Regenerative 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 $30.00 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.

____
Print 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 Pain & Regenerative Medicine, herein referred to as "Optimal" is issuing this Notice of Privacy Practices about your legal rights and our 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 who 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: Optimal Pain & Regenerative Medicine, at 800 W. Arbrook Blvd., Suite 120, Arlington, Texas, 76015, or call (817) 468-4343.

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 Optimal Pain & Regenerative Medicine at 800 W. Arbrook Blvd., Suite 120, Arlington, Texas, 76015, or call (817) 468-4343. 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 Pain & Regenerative Medicine

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

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 Pain & Regenerative 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 $50.00 for missed clinic appointments or $100.00 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 Optimal Pain & Regenerative Medicine. Your signature below constitutes acknowledgement and acceptance of the terms of these guidelines.

____ ____________________
Signature of Patient Date

____
Print Name

____
Witness Signature (office use only)

Advanced Practice Nurse/Nurse Practitioner and Physician Assistant Consent

Optimal Pain & Regenerative 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 Pain & Regenerative Medicine

OPTIMAL
Pain & Regenerative Medicine

Patient Questionnaire

Patient Name: ____ **Date of Birth:** ______________________

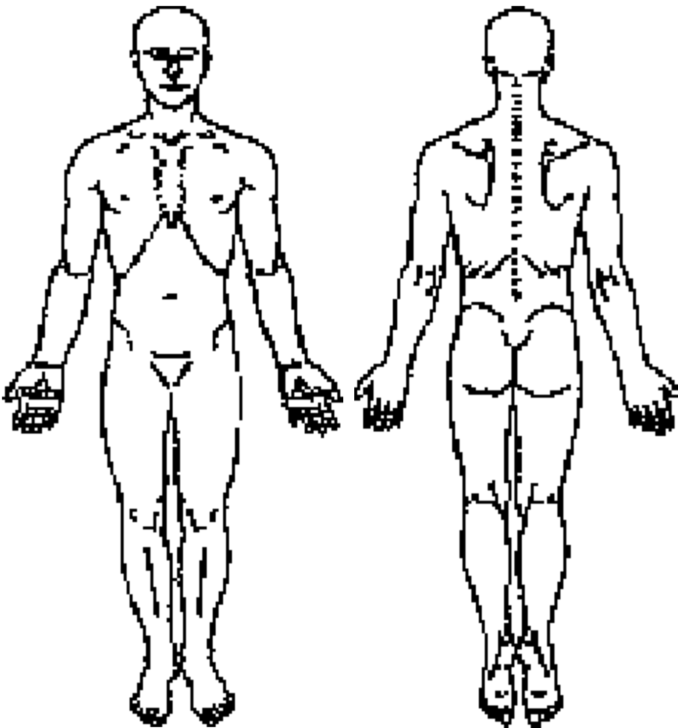
Referring Physician: ____

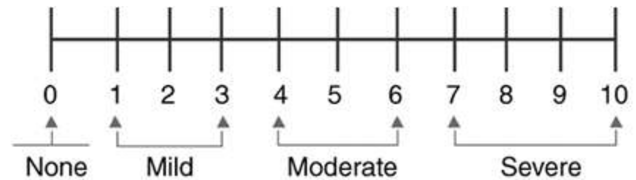
Greatest area of pain? ____

When did it start? __________________________________

Have you been to another pain clinic?
____No
____Yes Physician(s)____

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





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

For **TODAY:** ___________

At its most **SEVERE**: _______

How do you describe your pain?

☐ Aching ☐ Numbness ☐ Stinging ☐ Superficial
☐ Burning ☐ Sharp ☐ Throbbing ☐ Deep
☐ Dull ☐ Shooting ☐ Tightness
☐ Electric-like ☐ Stabbing ☐ Cramping

Which statement best describes your pain:

☐ It is constant ☐ It occurs suddenly ☐ It occurs in the morning
☐ It is intermittent ☐ It occurs gradually ☐ It occurs in the daytime
☐ It occurs occasionally ☐ It occurs at evening
☐ It occurs rarely ☐ It wakes me from sleep

OPTIMAL
Pain & Regenerative Medicine

Patient Questionnaire

Under what circumstances did your pain begin?

☐ Unknown
☐ Gradual onset
☐ Abrupt onset
☐ After a fall
☐ Lifting
☐ Over using
☐ During Exercise
☐ After Exercise
☐ Sports Injury
☐ Work Injury
☐ Motor Vehicle Accident
☐ Assault
☐ Surgical complication
☐ Following surgery

What makes your pain better?

☐ Nothing helps
☐ Heat
☐ Ice
☐ Rest
☐ Sitting
☐ Standing
☐ Lying down
☐ Walking
☐ Position change
☐ while being active
☐ leaning forward
☐ Stretching
☐ Physical therapy
☐ Chiropractic care
☐ Over the counter medication
☐ Prescription medication
☐ Oral steroids
☐ Steroid injections
☐ Anti-inflammatories/NSAID
☐ Narcotic medication

What makes your pain worse?

☐ Nothing
☐ Sitting
☐ Standing
☐ Walking
☐ Lying down
☐ Lifting
☐ Twisting
☐ Movement
☐ Pushing/Pulling
☐ Gripping
☐ Exercise
☐ Flexion
☐ Extension
☐ Getting out of bed
☐ Going from sitting to standing
☐ Cold Weather
☐ Damp Weather

Do you have any of these symptoms with your pain?

☐ weakness
☐ numbness
☐ Tingling
☐ Swelling
☐ Redness
☐ Warmth
☐ bruising
☐ Bowel or bladder changes

Have you had any of the following treatments for your pain?

☐ Physical Therapy ☐ Did not help ☐ Helped a little ☐ Helped significantly ☐ Helped temporarily
☐ Chiropractic Therapy ☐ Did not help ☐ Helped a little ☐ Helped significantly ☐ Helped temporarily
☐ Epidural Steroid Injection ☐ Did not help ☐ Helped a little ☐ Helped significantly ☐ Helped temporarily
☐ Facet Injection ☐ Did not help ☐ Helped a little ☐ Helped significantly ☐ Helped temporarily
☐ Facet Ablation ☐ Did not help ☐ Helped a little ☐ Helped significantly ☐ Helped temporarily
☐ Sacroiliac Joint Injection ☐ Did not help ☐ Helped a little ☐ Helped significantly ☐ Helped temporarily
☐ Steroid Injection ☐ Did not help ☐ Helped a little ☐ Helped significantly ☐ Helped temporarily
☐ Synvisc/Euflexxa/Hyalgan ☐ Did not help ☐ Helped a little ☐ Helped significantly ☐ Helped temporarily

Other________________________ ☐ Did not help ☐ Helped a little ☐ Helped significantly ☐ Helped temporarily

Other________________________ ☐ Did not help ☐ Helped a little ☐ Helped significantly ☐ Helped temporarily

OPTIMAL
Pain & Regenerative Medicine

Patient Questionnaire

Do you currently have any of the following symptoms?

Constitutional: ☐ Fever ☐ Night sweats ☐ significant weight gain ☐ significant weight loss ☐ Chills
Eyes: ☐ Abrupt vision change ☐ Eye irritation ☐ Eye discharge
Ears/Nose/Mouth: ☐ Ear pain ☐ Frequent nosebleeds ☐ Sore throat ☐ Mouth ulcers
Cardiovascular: ☐ Chest pain ☐ Arm pain on exertion ☐ Shortness of breath when walking ☐ Heart murmur ☐ Ankle swelling
Respiratory: ☐ Cough ☐ Shortness of breath
Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Dyspepsia (heartburn)
Genitourinary: ☐ Incontinence ☐ Difficulty urinating ☐ Increased frequency ☐ Blood in urine
Skin: ☐ Yellowing of skin ☐ Rashes ☐ Non healing areas ☐ Changes in hair/nails
Neurologic: ☐ Seizures ☐ Dizziness ☐ Tremor
Psychiatric: ☐ Depression ☐ Hallucinations ☐ Suicidal thoughts ☐ Memory loss
Endocrine: ☐ Fatigue☐ Increased thirst ☐ Abnormal hair loss
Hematologic/Lymphatic: ☐ Swollen glands ☐ Bruising ☐ Excessive bleeding
Allergy/Immunologic: ☐ Hives ☐ Itching ☐ Frequent colds/flu

Please list ALL medical illnesses that you may have:

_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________

Please list ALL surgeries you have undergone:

_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________

Family History:

Family Member — Please list their major health problems

Mother ____
Father ____
Brothers ____
Sisters ____
Children ____

OPTIMAL
Pain & Regenerative Medicine

Patient Questionnaire

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 ___________________________

Have you had a history of: ☐Alcoholism ☐Drug Addiction

Allergies to medications: ____

Please list any medications you have tried for your pain:

Medication	Did it help?		Side Effects?
________________________	☐Yes	☐No	________________________
________________________	☐Yes	☐No	________________________
________________________	☐Yes	☐No	________________________
________________________	☐Yes	☐No	________________________
________________________	☐Yes	☐No	________________________
________________________	☐Yes	☐No	________________________
________________________	☐Yes	☐No	________________________
________________________	☐Yes	☐No	________________________

Please list or attach a copy of all medications you are taking now:

Medication	Dose	How many times a day

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

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PainEDU.org
IMPROVING PAIN TREATMENT THROUGH EDUCATION