MD PAIN
SPORT, SPINE, AND PAIN MANAGEMENT

New Patient Paperwork

P: 303.750.8100 F: 303.369.1891

Save this form before entering any data to ensure your responses are not lost. Please print and sign your completed form prior to your appointment.

REFERRAL INFORMATION

Referring Physician: _____ Phone: _____ Fax: _____
Primary Care Physician: _____ Phone: _____ Fax: _____
Other provider(s) you would like MD Pain to notify of today's office visit:
Provider: _____ Phone: _____ Fax: _____
Provider: _____ Phone: _____ Fax: _____

PATIENT INFORMATION

Patient Name: _____ Appointment Date: _____
Driver's License Number/State: _____ Social Security Number: _____
Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary
Home Address: _____ City/State/Zip: _____
Mailing Address: _____ City/State/Zip: _____
Preferred Phone Number: _____ ☐ Home ☐ Mobile ☐ Work
Secondary Phone Number: _____ ☐ Home ☐ Mobile ☐ Work
Email Address: _____
Emergency Contact Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

PRIMARY INSURANCE PLAN

Insurance Company: _____ Telephone: _____
Policy/ID Number: _____ Group Number: _____
Subscriber Name: _____ Subscriber Date of Birth: _____
Relationship to Subscriber: _____

SECONDARY INSURANCE PLAN

Insurance Company: _____ Telephone: _____
Policy/ID Number: _____ Group Number: _____
Subscriber Name: _____ Subscriber Date of Birth: _____
Relationship to Subscriber: _____

WORKERS' COMPENSATION/PERSONAL INJURY CLAIM INFORMATION (fill out only if applicable)

Is this visit related to a **Workers' Compensation Claim?** ☐ Yes ☐ No
Insurance Company/Work Comp Carrier: _____ Date of Injury: _____
Claim ID: _____ Adjuster's Name: _____
Adjuster's Telephone: _____ Adjuster's Fax: _____
Claim Submission Address: _____
Is this visit related to an auto or **other accident and filed under a personal injury claim?** ☐ Yes ☐ No
Personal Injury Attorney's Name: _____ Phone: _____
Personal Injury Attorney's Practice Name: _____ Lien Company: _____

PREFERRED PHARMACY

Pharmacy Name: _____ **Phone Number:** _____
Street Address: _____ **City/State/Zip:** _____

Clinical Information

Print Patient Name: _____ **Height:** _____ **Weight:** _____ *lbs.*

HAND DOMINANCE

☐ Right hand-dominant ☐ Left hand-dominant ☐ Ambidextrous (able to use both hands equally)

PLEASE INDICATE YOUR WORST PAIN OR CHIEF COMPLAINT (Please mark only one)

☐ Headache	☐ Groin	☐ Anal/Rectal	☐ Left Shoulder
☐ Facial	☐ Neck	☐ Vaginal ☐ Scrotal	☐ Right Shoulder
☐ Chest Wall	☐ Mid Back	☐ Left Upper Extremity	☐ Left Hip
☐ Breast	☐ Low Back	☐ Right Upper Extremity	☐ Right Hip
☐ Abdominal	☐ Buttock	☐ Left Lower Extremity	☐ Left Knee
☐ Pelvic	☐ Tailbone	☐ Right Lower Extremity	☐ Right Knee

☐ Other pain location? _____

PLEASE INDICATE ALL ADDITIONAL AREAS OF PAIN (Please mark all that apply)

☐ Headache	☐ Groin	☐ Anal/Rectal	☐ Left Shoulder
☐ Facial	☐ Neck	☐ Vaginal ☐ Scrotal	☐ Right Shoulder
☐ Chest Wall	☐ Mid Back	☐ Left Upper Extremity	☐ Left Hip
☐ Breast	☐ Low Back	☐ Right Upper Extremity	☐ Right Hip
☐ Abdominal	☐ Buttock	☐ Left Lower Extremity	☐ Left Knee
☐ Pelvic	☐ Tailbone	☐ Right Lower Extremity	☐ Right Knee

☐ Other pain location? _____

HISTORY OF COMMON PAINFUL CONDITIONS OR ILLNESSES (Please mark all that apply)

Please indicate if you have had any of the following common PAIN problems: (Mark ALL that apply)

☐ Headache	☐ Neuropathy	☐ Chronic back pain	☐ Chronic abdominal/pelvic pain
☐ Fibromyalgia	☐ Scoliosis	☐ Chronic neck pain	☐ Vertebral compression fracture
☐ Osteoarthritis	☐ Stroke	☐ RSD/CRPS	☐ Cancer-related pain
☐ Rheumatoid Arthritis	☐ Hepatitis	☐ Sickle cell anemia	☐ Autoimmune disease
☐ Chronic Sciatica	☐ Crohn's disease	☐ Interstitial cystitis	☐ Post-herpetic neuralgia
☐ Kidney disease	☐ Ulcerative colitis	☐ Multiple sclerosis	☐ Other: _____

ONSET AND FREQUENCY OF PAIN

How did the current pain episode begin? ☐ Gradually ☐ Abruptly

When did your pain first begin? Exact Date: _____ or approximately: _____ ☐ Months ☐ Years ago

What caused your pain? ☐ Surgery ☐ A Fall ☐ Accident at work ☐ Car Accident ☐ Sports Injury ☐ Normal Aging ☐ Unknown ☐ Other: _____

Since the pain started, how has it changed? ☐ Decreased ☐ Increased ☐ Unchanged

The frequency of my pain currently is: ☐ constant and never changing ☐ fluctuating but always present ☐ fluctuating but usually present ☐ fluctuating but rarely present

PAIN SEVERITY, LOCATION, DESCRIPTION & OTHER FACTORS THAT AFFECT YOUR PAIN

How severe is your pain right now? _____ (0-10)

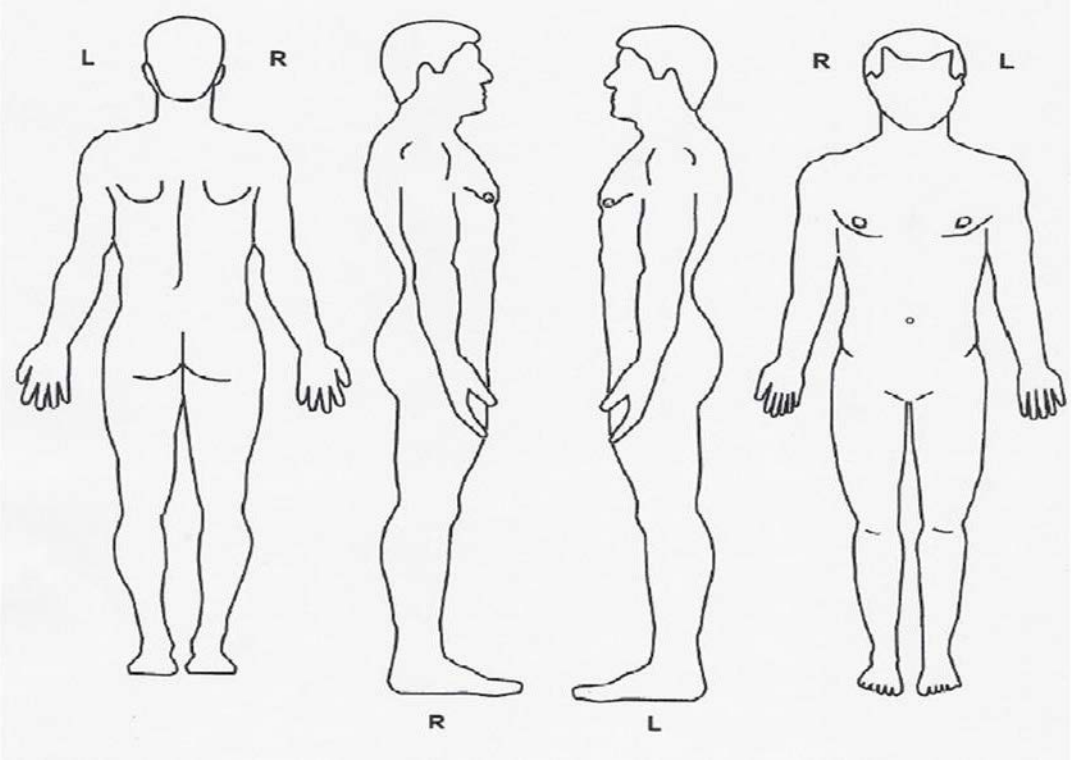
How severe is your worst pain when aggravated? _____ (0-10)

What is an acceptable pain score goal for you to perform your daily activities? _____ (0-10)

Which activities are you no longer able to do because of your pain but *would* like to be able to do again?

_____

Please mark the areas on your body where you feel your pain. Draw arrows where the pain radiates.



Describe your pain using the following letters:

Aching = A
Burning = B
Cramping = C
Dull = D
Electrical = E
Gnawing = G
Muscle Spasm = M
Numbness = N
Pins/Needles = P
Pressure = R
Sharp = H
Stabbing = S
Throbbing = T

Please indicate if the following **INCREASE** or **DECREASE** your pain:

	INCREASE	DECREASE
Heat	☐	☐
Cold	☐	☐
Weather Changes	☐	☐
Standing	☐	☐
Walking	☐	☐
Exercise	☐	☐
Bending forward	☐	☐
Leaning back	☐	☐
Twisting at waist	☐	☐
Looking up	☐	☐
Looking down	☐	☐
Turning head	☐	☐
Lying flat on back	☐	☐
Lying on side (R/L)	☐	☐
Massage	☐	☐
Physical therapy	☐	☐
Bowel movement	☐	☐
Sneezing/Coughing	☐	☐
Stress	☐	☐
Medications	☐	☐
Sitting	☐	☐

Do you have any other symptoms associated with your pain?

☐ Sweating
☐ Skin color changes
☐ Swelling
☐ Hair/nail growth changes
☐ Skin temperature changes
☐ Bowel or bladder changes
☐ Dizziness
☐ Headaches
☐ Blurred vision
☐ Other _____

In the past 3 months have you developed any new symptoms?

☐ Balance problems
☐ Difficulty walking
☐ Bladder incontinence
☐ Bowel Incontinence
☐ Weakness; Where? _____
☐ Numbness; Where? _____
☐ Fine motor control problems (buttoning shirt, using a pencil, etc.)
☐ Falls/Near Falls; Date _____
☐ Use of assistive devices: ☐ Cane ☐ Walker ☐ Other _____
☐ Other symptoms (please explain) _____

Have you had any other concerning symptoms unrelated to your pain? ☐ Yes ☐ No If yes, please explain:

How much does your pain affect your functional abilities? (0 = Does not affect, 10 = Significant affect)

Activities of daily living, such as hygiene & household chores: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Ability to function and interact well with family and friends: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Work in my usual occupation: (☐ if not working) ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Ability to sleep well: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

PREVIOUS PAIN MANAGEMENT PROVIDERS

Have you previously been under the care of a PAIN MANAGEMENT SPECIALIST? ☐Yes ☐No

If 'Yes', please list up to the two most recent physicians you have seen:

Name	Address/City/State/Zip Code
1.	
Why are you no longer under the care of this physician?	
2.	
Why are you no longer under the care of this physician?	

CURRENT PAIN MEDICATIONS

Please list ALL CURRENT PAIN MEDICATIONS. Include all prescription and over-the-counter medications.

Medication Name	Dose (mg)	Frequency	Prescribing Provider	No Relief	Mild Relief	Moderate Relief	Excellent Relief
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

If you are currently taking pain medications, **will the prescribing provider continue to prescribe these medications?** ☐Yes ☐No

☐I am currently not taking any pain medications.

CURRENT PAIN MEDICATION EFFECTIVENESS

Overall, do your pain medications provide PAIN RELIEF? ☐Yes ☐No ☐N/A

If 'Yes', how much? ☐10% ☐20% ☐30% ☐40% ☐50% ☐60% ☐70% ☐80% ☐90% ☐100%

Overall, do your pain medications IMPROVE YOUR FUNCTION? ☐Yes ☐No ☐N/A

If 'Yes', how much? ☐10% ☐20% ☐30% ☐40% ☐50% ☐60% ☐70% ☐80% ☐90% ☐100%

Overall, do your pain medications IMPROVE YOUR QUALITY OF LIFE? ☐Yes ☐No ☐N/A

If 'Yes', how much? ☐10% ☐20% ☐30% ☐40% ☐50% ☐60% ☐70% ☐80% ☐90% ☐100%

ARE YOUR PAIN MEDICATIONS CAUSING ANY SIDE EFFECTS?

☐Yes ☐No ☐N/A If yes, please note which side effects you are experiencing.

PAIN AND RELATED MEDICATION HISTORY

Please mark all medications you have TRIED IN THE PAST FOR PAIN or PAIN-RELATED ISSUES (sleep problems, etc.) and their EFFECTIVENESS. (Mark only those that apply)

OPIOIDS ☐ I have never taken opioid medications

If you have ever been prescribed opioids, what was your age when you first started taking them? _____

	H	N	S
Fentanyl (Duragesic patch, Actiq, Fentora, Subsys)	☐	☐	☐
Morphine (Avinza, Embeda, MS Contin, Kadian, Morphabond, MSER)	☐	☐	☐
Methadone (Dolophine)	☐	☐	☐
Oxycodone (Roxicodone, Percocet, Endocet, OxyContin)	☐	☐	☐
Buprenorphine (Butrans, Belbuca, Buprenex, Suboxone, Subutex)	☐	☐	☐

	H	N	S
Propoxyphene (Darvocet, Darvon)	☐	☐	☐
Oxymorphone (Opana, Opana ER)	☐	☐	☐
Hydromorphone (Dilaudid, Exalgo)	☐	☐	☐
Hydrocodone (Vicodin, Norco, Lortab, Hysingla, Zohydro)	☐	☐	☐
Tapentadol (Nucynta, Nucynta ER)	☐	☐	☐

	H	N	S
Tramadol (Ultram, Ultram ER, Tramadol ER, Ryzolt)	☐	☐	☐
Codeine (Tylenol #3, #4)	☐	☐	☐
Meperidine (Demerol)	☐	☐	☐
Other:	☐	☐	☐

ANTI-INFLAMMATORIES ☐ I have never taken anti-inflammatories

	H	N	S
Etodolac (Lodine)	☐	☐	☐
Ibuprofen (Advil, Motrin)	☐	☐	☐
Naproxen (Aleve, Naprosyn)	☐	☐	☐
Celecoxib (Celebrex)	☐	☐	☐

	H	N	S
Oxaprozin (Daypro)	☐	☐	☐
Meloxicam (Mobic)	☐	☐	☐
Diclofenac (Arthrotec, Voltaren, Zipsor, Flector patch)	☐	☐	☐
Nabumetone (Relafen)	☐	☐	☐

	H	N	S
Piroxicam (Feldene)	☐	☐	☐
Indomethacin (Indocin)	☐	☐	☐
Ketorolac (Toradol)	☐	☐	☐
Other:	☐	☐	☐

ASPIRIN and ACETAMINOPHEN ☐ I have never taken Aspirin or acetaminophen

	H	N	S
Aspirin	☐	☐	☐

	H	N	S
Acetaminophen (Tylenol)	☐	☐	☐

MUSCLE RELAXANTS ☐ I have never taken muscle relaxants

	H	N	S
Baclofen (Lioresal)	☐	☐	☐
Cyclobenzaprine (Flexeril, Amrix)	☐	☐	☐
Methocarbamol (Robaxin)	☐	☐	☐
Carisoprodol (Soma)	☐	☐	☐

	H	N	S
Chlorzoxazone (Parafon-Forte, Lorzone)	☐	☐	☐
Orphenadrine (Norflex)	☐	☐	☐
Metaxalone (Skelaxin)	☐	☐	☐

	H	N	S
Tizanidine (Zanaflex)	☐	☐	☐
Diazepam (Valium)	☐	☐	☐
Other:	☐	☐	☐

ANTICONVULSANTS ☐ I have never taken anticonvulsants

	H	N	S
Gabapentin (Neurontin, Gralise)	☐	☐	☐
Pregabalin (Lyrica)	☐	☐	☐
Topiramate (Topamax, Trokendi XR, Qudexy XR)	☐	☐	☐
Tiagabine (Gabatril)	☐	☐	☐

	H	N	S
Carbamazepine (Tegretol)	☐	☐	☐
Levetiracetam (Keppra)	☐	☐	☐
Zonisamide (Zonegran)	☐	☐	☐
Valproic Acic (Depakote, Depakene)	☐	☐	☐

	H	N	S
Oxcarbazepine (Trileptal)	☐	☐	☐
Lamotrigine (Lamictal)	☐	☐	☐
Other:	☐	☐	☐

KEY: H = Helpful | **N** = Not Helpful | **S** = Side Effect

ANTIDEPRESSANTS (SSRIs, SNRIs) ☐ I have never taken antidepressants

	H	N	S
Duloxetine (Cymbalta)	☐	☐	☐
Venlafaxine (Effexor, Effexor XR)	☐	☐	☐
Amitriptyline (Elavil, Endep)	☐	☐	☐
Nortriptyline (Pamelor, Aventyl)	☐	☐	☐
Mirtazapine (Remeron)	☐	☐	☐
Desipramine (Pertofran, Norpramine)	☐	☐	☐
Imipramine (Tofranil)	☐	☐	☐

	H	N	S
Bupropion (Wellbutrin)	☐	☐	☐
Citalopram (Celexa)	☐	☐	☐
Escitalopram (Lexapro)	☐	☐	☐
Sertraline (Zoloft)	☐	☐	☐
Protriptyline (Vivactil)	☐	☐	☐
Doxepin (Sinequan, Silenor)	☐	☐	☐
Paroxetine (Paxil)	☐	☐	☐

	H	N	S
Desvenlafaxine (Pristiq)	☐	☐	☐
Fluoxetine (Prozac)	☐	☐	☐
Nefazodone (Serzone)	☐	☐	☐
Milnacipran (Savella)	☐	☐	☐
Trazodone (Desyrel)	☐	☐	☐
Other:	☐	☐	☐

OTHER MEDICATIONS FOR PAIN or HEADACHES ☐ I have never taken these medications

	H	N	S
Sumatriptan/Naproxen (Treximet)	☐	☐	☐
Ergotamine (Ergostat, Cafergot, DHE, Migranal, Migergot)	☐	☐	☐
Methylsergide (Sansert)	☐	☐	☐
Diltiazem (Cardiazem)	☐	☐	☐
Verapamil (Calan, Isoptin, Verelan)	☐	☐	☐

	H	N	S
Rimipril (Altace)	☐	☐	☐
Enalapril (Vasotec)	☐	☐	☐
Candesartan (Atacand)	☐	☐	☐
Irbesartan (Avapro)	☐	☐	☐
Losartan (Cozaar)	☐	☐	☐

	H	N	S
Mexilitine (Mexitil)	☐	☐	☐
Steroids (cortisone, Medrol dose pack, prednisone)	☐	☐	☐
OnabotulinumtoxinA (BOTOX) injections	☐	☐	☐
Lithium	☐	☐	☐
Other:	☐	☐	☐

SLEEP AIDS ☐ I have never taken sleep aids

	H	N	S
Zolpidem (Ambien)	☐	☐	☐
Eszopiclone (Lunesta)	☐	☐	☐
Temazepam (Restoril)	☐	☐	☐
Zaleplon (Sonata)	☐	☐	☐

	H	N	S
Ramelteon (Rozerem)	☐	☐	☐
Sodium Oxybate (Xyrem)	☐	☐	☐
Doxepin (Silenor)	☐	☐	☐
Suvorexant (Belsomra)	☐	☐	☐

	H	N	S
Trazodone (Desyrel)	☐	☐	☐
Melatonin	☐	☐	☐
Other:	☐	☐	☐

SEDATIVES AND ANTI-ANXIETY MEDICATIONS ☐ I have never taken sleep aids

	H	N	S
Alprazolam (Xanax)	☐	☐	☐
Diazepam (Valium)	☐	☐	☐

	H	N	S
Clonazepam (Klonopin)	☐	☐	☐
Clorazepate (Tranxene)	☐	☐	☐

	H	N	S
Lorazepam (Ativan)	☐	☐	☐
Other:	☐	☐	☐

Have you ever tried **Prescription** creams such as EMLA cream, Voltaren gel, etc. for your pain? ☐ Yes ☐ No
Have you ever tried **Compounded** pain creams from a specialty pharmacy? ☐ Yes ☐ No

KEY: H = Helpful | **N** = Not Helpful | **S** = Side Effect

PREVIOUS TREATMENTS

Mark any TREATMENTS FOR YOUR PAIN that you have had and WHICH DATE(S) you had them:

Treatment	Body Part/Area/Level	Date(s)	IMPROVEMENT/EFFECT				
			Worse	None	Mild	Moderate	Excellent
Physical Therapy			☐	☐	☐	☐	☐
Aqua/Pool Therapy			☐	☐	☐	☐	☐
Chiropractic			☐	☐	☐	☐	☐
Acupuncture			☐	☐	☐	☐	☐
Massage Therapy			☐	☐	☐	☐	☐
Weight Loss Program			☐	☐	☐	☐	☐
Neck/Back Brace			☐	☐	☐	☐	☐
TENS Unit			☐	☐	☐	☐	☐
Trigger Point Injection			☐	☐	☐	☐	☐
Epidural Steroid Injection			☐	☐	☐	☐	☐
Facet Injection			☐	☐	☐	☐	☐
Medial Branch Blocks			☐	☐	☐	☐	☐
Radiofrequency Ablation			☐	☐	☐	☐	☐
Sacroiliac Joint Injection			☐	☐	☐	☐	☐
Other Joint Injection			☐	☐	☐	☐	☐
Peripheral Nerve Block			☐	☐	☐	☐	☐
Sympathetic Nerve Block			☐	☐	☐	☐	☐
Spinal Cord Stimulator			☐	☐	☐	☐	☐
Intrathecal (Pain) Pump			☐	☐	☐	☐	☐
Ketamine Infusion			☐	☐	☐	☐	☐
Vertebroplasty			☐	☐	☐	☐	☐
Kyphoplasty			☐	☐	☐	☐	☐
Other Treatment:							

☐ I have not had any treatments for my current pain complaint(s).

DIAGNOSTIC TESTS AND IMAGING

List any TESTS or STUDIES you have had to evaluate your current pain complaint(s): (Mark ALL that apply)

Test	Body Part/Area	Date(s)	Facility
X-ray			
CT scan			
MRI			
EMG/NCV Study			
Discogram			
Other Treatment:			

☐ I have not had any treatments for my current pain complaint(s).

CURRENT NON-PAIN MEDICATIONS (such as those to treat high blood pressure, high cholesterol, etc.)

Please list ALL NON-PAIN medications. Include prescription, over-the-counter medications, and herbal supplements.
(Continue on next page and/or attach separate page if necessary)

Medication Name	Dose (mg)	Frequency

BLOOD-THINNING MEDICATION

Please indicate which, if any, of the following BLOOD THINNING medications you are taking: (Mark ALL that apply)

☐ I am not CURRENTLY taking any blood thinners.

☐ Aspirin (☐ 81 mg ☐ 325 mg)
☐ Pletal (cilostazol)
☐ Persantine (dipyridamole)
☐ Aggrenox (dipyridamole/aspirin)
☐ Arixtra (fondaparinux)
☐ Xarelto (rivaroxaban)
☐ Eliquis (apixaban)
☐ Savaysa (edoxaban)
☐ ReoPro (abciximab)
☐ Pradaxa (dabigatran)
☐ Plavix (clopidogrel)
☐ Effient (prasugrel)
☐ Anti-inflammatories
☐ Heparin
☐ Lovenox (enoxaparin)
☐ Coumadin (warfarin)
☐ Garlic
☐ Ginseng
☐ Gingko
☐ Fish oil

Please list any other blood-thinning medications not listed above: _____

Name and phone number of prescribing physician: _____

PAST MEDICAL HISTORY

Please check the following medical conditions you have or have had in the past:

☐ I have never had any medical problems.

Head/Eyes/Ears/Nose/Throat
☐ Headaches
☐ Migraines
☐ Head Injury
☐ Hyperthyroidism
☐ Hypothyroidism

Respiratory
☐ Asthma
☐ Chronic Bronchitis
☐ COPD
☐ Emphysema
☐ Lung Cancer
☐ Pneumonia

Cardiovascular
☐ Heart Attack
☐ High Blood Pressure
☐ Murmur
☐ Mitral Valve Prolapse
☐ Coronary Artery Disease
☐ Pacemaker
☐ Defibrillator
☐ Peripheral Vascular Disease
☐ Deep Vein Thrombosis

Hematologic
☐ Anemia
☐ HIV/AIDS
☐ Bleeding Disorder
☐ High Cholesterol
☐ Protein C/S Deficiency
☐ Systemic Lupus Erythematosus
☐ Protein C/S Deficiency
☐ Lymphoma
☐ Leukemia

Gastrointestinal
☐ Gastritis
☐ Gastric Ulcers
☐ GERD (Acid Reflux)
☐ Bowel Incontinence
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Liver Cancer
☐ Liver Failure
☐ Pancreatitis
☐ Diabetes Type I
☐ Diabetes Type II

Musculoskeletal
☐ Amputation
☐ Phantom Limb Pain
☐ Bursitis
☐ Carpal Tunnel Syndrome
☐ Rheumatoid Arthritis
☐ Osteoarthritis
☐ Osteopenia
☐ Osteoporosis
☐ Vertebral Body Fracture

Genitourinary/Kidney
☐ Kidney Disease
☐ Kidney Cancer
☐ Acute Renal Failure
☐ Chronic Renal Failure
☐ Kidney Stones
☐ Urinary Incontinence

Neurologic
☐ Multiple Sclerosis
☐ Alzheimer's Disease
☐ Parkinson's Disease
☐ Restless Leg Syndrome
☐ Epilepsy/Seizures
☐ Trigeminal Neuralgia
☐ Other Neuralgias
☐ Peripheral Neuropathy

Psychologic
☐ Anxiety
☐ Depression
☐ Schizophrenia
☐ Bipolar Disorder
☐ Prescription Drug Abuse
☐ Illegal Drug Use
☐ Alcohol Abuse

Please list any other medical conditions you have had that are not listed above:

PAST SURGICAL HISTORY

Please indicate any surgical procedures you have had in the past, INCLUDING DATES, type, and pertinent details.

☐ I have ***never*** had any surgical procedures.

Abdominal Surgery:
- ☐ Gallbladder removal _____
- ☐ Appendix removal _____
- ☐ Hernia repair _____
- ☐ Laparotomy _____
- ☐ Gastric bypass _____
- ☐ Other _____

Cardiovascular Surgery:
- ☐ Coronary artery bypass _____
- ☐ Valve replacement _____
- ☐ Stent placement _____
- ☐ Aneurysm repair _____
- ☐ Peripheral vascular surgery _____
- ☐ Other _____

Orthopedic/Joint Surgery:
- ☐ Foot/Ankle surgery _____
- ☐ Knee scope/repair _____
- ☐ Knee replacement _____
- ☐ Hip scope/repair _____
- ☐ Hip replacement _____
- ☐ Shoulder surgery _____
- ☐ Other _____

Gynecological Surgery:
- ☐ Hysterectomy _____
- ☐ Tubal Ligation _____
- ☐ C-section _____
- ☐ Laparoscopy _____
- ☐ Other _____

Spine & Back Surgery:
- ☐ Cervical (neck) fusion _____
- ☐ Lumbar (lower back) fusion _____
- ☐ Laminectomy _____
- ☐ Discectomy _____
- ☐ Other _____

Common Surgery:
- ☐ Prostatectomy _____
- ☐ Thyroidectomy _____
- ☐ Tonsillectomy _____

Please list any other surgical procedures you have had not listed above:

ANESTHESIA AND PAIN PROCEDURE HISTORY

Have you ever had any problems or adverse reaction to anesthesia? ☐ Yes ☐ No ☐ Never had anesthesia.

If 'Yes', which type of anesthesia? _____; what was the reaction? _____

Have you ever had an adverse reaction to the iodine contrast used during a pain procedure? ☐ Yes ☐ No

If 'Yes', what was the reaction? _____

ALLERGIES

Do you have any drug allergies? ☐ Yes ☐ No If 'Yes', please list all drugs and the allergic reactions:

Drug/Medication	Allergic Reaction

SOCIAL HISTORY

Alcohol Use ☐ Never ☐ Occasional ☐ Daily ☐ History of Alcoholism

Tobacco Use ☐ Never ☐ Occasional ☐ Daily, how many packs per week? _____

Illegal Drug Use ☐ Never ☐ Occasional ☐ Daily ☐ History of Drug use, What Drug? _____

Any problems with prescription medication misuse, abuse, addiction? ☐ Yes, currently ☐ Yes, in past ☐ No

If 'Yes', which prescription medications? _____

What is your current work status? ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled (% disabled ____)

Occupation (if employed): _____ **If you are unemployed, employed part-time, or have work restrictions, is this due to your current pain condition?** ☐ Yes ☐ No

Are you currently involved in litigation related to this pain?

☐ No ☐ Yes, Attorney's Name and Phone Number: _____

PSYCHIATRIC HISTORY

Do you currently see a psychiatrist, psychologist, or therapist? ☐ Yes ☐ No If yes, who? _____

Have you had any recent thoughts of hurting yourself or others? ☐ Yes ☐ No

Do you suffer from the following psychiatric conditions?

☐ Depression
☐ Anxiety
☐ Bipolar Disorder
☐ Substance abuse/Addiction
☐ Attention Deficit/Hyperactivity Disorder (ADD/ADHD)
☐ Obsessive-Compulsive Disorder (OCD)
☐ Personality Disorder
☐ Schizophrenia

Do you have a personal history of physical, emotional, or sexual abuse or other trauma? ☐ Yes ☐ No

☐ Prefer not to answer (If 'Yes' and pertinent to your pain, please discuss with your provider).

PREVENTATIVE MEDICINE: FALLS RISK SCREENING – If you are 65 or older, please check all that apply to you.

Have you had any falls in the last year?

☐ No falls in the past year
☐ One fall with injury in the past year
☐ Two or more falls with injury in the past year
☐ 1 fall without injury in the past year
☐ 2 or more falls without injury in the past year

MEDICAL HISTORY AND CONSENT FOR TREATMENT

I certify that the above information is accurate, complete, and true. I authorize MD Pain and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for MD Pain to retrieve and review my medication history. I understand that this will become part of my medical record. I acknowledge that I have had the opportunity to review the Notice of Privacy Practices of MD Pain, which is displayed for public inspection at its facility and on its website. This Notice describes how protected health information may be used and disclosed, and how I may access my health records. I authorize the MD Pain to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize MD Pain to release any information required in obtaining procedure authorization or the processing of any insurance claims. I understand that MD Pain will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website. If I am asked to provide urine, saliva and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine, saliva and/or blood sample as requested. I have the right to refuse specific tests but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare, or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether they are covered by my insurance or not. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected 30 days of being notified of any balance due. Please note that if you fail to make payment when due on my account balance, this account will be referred to a collection agency for collections. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe. MD Pain may refuse appointments if balances are not paid.

Signature: _____ **Date:** _____

(Patient, guardian, or patient representative)

Print Name: _____

MD Rx PAIN

SPORT, SPINE, AND PAIN MANAGEMENT

Cancellation and No-Show Policy

We understand that situations may arise which makes it necessary to cancel your appointment. Accordingly, **we request that you provide at least 24-hour notice of cancellation** to avoid any fees. This will enable the physicians **to offer that time slot to other patients who need care.** Appointments with our specialists are in high demand, and your early cancellation will give another person access to timely medical care.

The Cancellation and No-Show fees are the sole responsibility of the guarantor and cannot be billed to the insurance company.

Cancellation Fees:

- Any established patient that did not call and cancel 24 hours prior to the appointment is subject to a $40.00 cancellation fee.
- Any procedural appointments (at the surgery center) not cancelled 48 hours prior to the scheduled appointment time are subject to a $100.00 cancellation fee.

No Show Fees:

Patients who do not show up for their appointment or cancel SAME DAY of the appointment will be considered a **No-Show** and are subject to a **No-Show** fee. Patients who "**No Show**" for two or more appointments within a 12-month period may be dismissed from the practice.

- **$50.00 New Patient *No-Show fee***
- **$40.00 Established Patient *No-Show fee***
- **$100.00 Surgical Procedure (performed outside of office at surgery center) *No-Show fee***

Payments can be made directly to our Billing Office (303.422.9438) or to our Main Office (303.750.8100).

Credit Card #: _____ **Exp:** _____ **CVV on Back:** _____

Billing Zip Code: _____

Please sign to indicate you have read and understand the above Cancellation and No-Show Policy.

Patient or Guardian Name (please print): _____

Patient or Guardian Signature: _____

Date: _____

Opioid Therapy Statement

Print Name: _____ **Date:** _____

Welcome to MD Pain. This document contains the Opioid and Controlled Medications Agreement/Contract, the Informed Consent for the Treatment of Chronic Pain with Opioid Pain Medications, and the Opioid Therapy Statement. If you plan to ask for an opioid or other controlled substance for the treatment of your pain, then please read all three of these documents carefully and sign or initial where indicated. If you have any questions, please do not hesitate to ask a provider or staff member.

MD Pain is a comprehensive pain clinic which includes medication management and the full range interventional procedures. To ensure patient safety and optimize outcomes we require our patients to receive their care from only one pain practice. Hence, if we are providing medication management, we also require patients to undergo interventional procedures with us as well.

At MD Pain, it is the goal of our physicians and staff to help give you your life back by reducing your pain and improving your daily functioning. We accomplish these goals with customized, safe, comprehensive, and effective treatment plans that reduce risks and maximize benefits.

To protect our patients from the significant risks associated with opioid therapies including addiction, we follow recommendations and applicable guidelines from the Drug Enforcement Agency (DEA), Colorado state regulatory agencies and the Colorado Medical Board regarding the safe and responsible prescribing of these medications. We first try non opioid medications and other treatments before progressing to treating pain with opiates. Furthermore, we only prescribe opioid medications if, after thorough screening, risk stratification from the forms you fill out, and after thorough history and physical, we determine that a patient's pathology warrants their use, they meet specific criteria, and other treatment options, including alternative non-opioid pain medications, have failed to achieve satisfactory results.

The opioid therapy statement and patient agreement serve to document that both you and your clinician agree on a care plan so that controlled substances are used in a way that is safe and effective in treating your pain.

MD Pain takes a conservative approach to opioid therapy. Depending on a patient's specific situation, these medications may not be prescribed at all, may be prescribed at a lower dose, or changed to a safer, more appropriate alternative opioid. Research results continue to demonstrate conflicting evidence for the long-term use of opioid medications for chronic non-cancer pain. High doses or ever-escalating doses can result in a greater risk of physical dependence, tolerance addiction, and increased pain (opioid induced hyperalgesia). The lowest effective dosage of opioids used in conjunction with non-opioid medications in concert with pain management procedures, physical therapy, mental health therapy and other conservative treatments have been shown to produce the best long-term, effective results.

We track our treatment outcomes to do our best to ensure that our patients are being helped. We are proud of our results and believe that if you suffer from chronic pain, we can help you. We provide a multidisciplinary approach to pain management that is safe, minimally invasive, and clinically proven to be effective.

Side Effects of Opioid Medications

I understand that the medication I will be taking may cause side effects to include, but not limited to sleepiness or drowsiness, constipation, inability to urinate, nausea, vomiting, dizziness, an allergic reaction, immune

suppression, hormone deficiencies, sexual problems, lack of coordination, kidney or liver disease, and bone thinning/weakness. Furthermore, the medication may cause my reflexes and reaction time to slow down. Finally, the medication may cause my breathing to become shallow and slower, leading to decreased oxygen supply to my body, which may lead to permanent neurological, mental, cognitive, and physical deficits and possibly death.

I have read, understand, and acknowledge the MD Pain Opiate Therapy Statement.

Printed Patient Name: _____

Patient Signature: _____ **Date:** _____

Opioid and Controlled Substances Provider-Patient Agreement
Consent for Treatment

I, _____, understand and voluntarily agree that:

Identification of Alternative Treatment Options: I am aware that my physician and his staff have discussed the possible benefits and risks of other treatments that do not include opioid therapy. These treatments include, but are not limited to, non-opioid medications, injections, physical therapy, mental health therapy and surgery, among others.

I understand my condition and I voluntarily request that my physician/ provider and his/her staff treat my condition. I further authorize my provider to administer or write prescriptions of controlled substances/ opioids/ "pain killers" to me for the purpose of treating my chronic pain. I agree with taking these medications and in no way did my provider require me or talk me into taking these medications.

I understand all controlled substances can be addictive and can lead to death.

I understand the side effects of opioids listed in the Opioid Therapy Statement and will ask questions if needed.

I will participate in all other types of treatment that I am asked to participate in within reason.

I will be responsible for my medicines and will keep the medicine safe, secure, locked, and out of the reach of children.

I will not sell my medicine or share it with others. I understand that if I do, my treatment will be stopped, and authorities may be called.

If my medicine is lost or stolen, I understand it will not be replaced until my next appointment and may not be replaced at all.

I will not take anyone else's medicine.

I will not self-adjust my medication. I understand that I must request an appointment in order to have changes made to my medications. I am aware that I may be asked to bring to my appointment my pharmacy-labeled prescription bottles with any remaining pills I may have. I authorize MD Pain to count my pills if necessary.

I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to MD Pain in the original bottle, even if there are no pills left.

I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

I will not call between appointments, or at night or on the weekends looking for refills and I understand that no early or emergency refills may be made.

I understand that prescriptions will be filled only during scheduled office visits with the treatment team. I will make sure I have an appointment for refills.

I will always treat the staff at the office respectfully. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

I will tell the doctor all other medicines that I take and let him/her know right away if I have a prescription for a new medicine.

I will not obtain any non-opioid pain medicines or other prescription medicines for treatment of anxiety or pain, from other providers without permission from my MD Pain provider. If taken with opiates, I understand these drugs, such as benzodiazepines (Klonopin/clonazepam, Xanax/alprazolam, and Valium/diazepam) or stimulants (Ritalin, amphetamine), can be addictive, dangerous to my health, or even cause death.

I will not use illegal drugs such as kratom, heroin, cocaine, or amphetamines. I understand that if I do, my treatment may be stopped.

I will come in for drug testing and counting of my pills within 24 hours of being called (random testing). I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.

I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore. I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Provider communication consent: I authorize my provider to talk with my other providers, pharmacists, attorneys, when appropriate for my care. I give them permission to discuss my opioid use as it pertains to my care. I know my provider or MD Pain staff will review the CO-PDMP and I will sign a release form to let the doctor speak to all other doctors or providers that I see.

I will use only one pharmacy to get all on my medicines and I will notify the office of MD Pain in writing if I wish to change pharmacy.

Right to Discontinue Treatment or Medication

I understand that I may discontinue using my medication at any time and I agree to notify physician and/or his staff immediately upon discontinuing the use of my medication. I understand that I may be provided supervision if needed by my physician and/or his staff if I choose to discontinue my medication. In this situation, alternative care by other pain or addiction providers will be suggested and you will then be released of this agreement.

I know that these opioid and controlled medications will be stopped by the MD Pain providers if any of the following occurs:

- I trade, sell, give away, misuse, or abuse these medications.
- MD Pain finds that I have broken any part of this agreement.
- I do not present immediately for a blood, urine or saliva test, or pill count, if requested by MD Pain. I will authorize MD pain staff to count my pills if necessary.
- My blood, urine, or saliva tests show the presence of controlled or non-controlled medications that have not been previously reported to MD Pain, the presence of illegal drugs or alcohol, or fail to show opioid and other controlled medications that I am being prescribed by MD Pain.
- I receive prescriptions for opioid and controlled medications from sources other than MD Pain, unless arranged and discussed previously with my MD Pain physician or provider.
- Any member of the professional staff at MD Pain feels that it is in my best interest, from a safety or accountability standpoint, that opioid and controlled medication treatment be discontinued.
- I demonstrate ANY aggressive, belligerent, or unacceptable behavior toward any physician, provider, patient, or staff member at MD Pain.
- I consistently miss scheduled appointments at MD Pain, including office visits and procedures scheduled at MD Pain or any other facility utilized by MD Pain.
- Illicit Drug use (i.e., cocaine, methamphetamine, heroin, kratom).
- Misrepresenting or lying about medical history including not disclosing risks to addiction such as family history of abuse, prior abuse of drugs or alcohol, or prior military experience.

My signature indicates that I understand and agree to abide by each issue displayed on this page and I understand that if I fail to abide by any issue displayed on this page, I may be discharged from this clinic.

_____

Patient Printed Name

_____ _____

Patient Signature **Date**

I attest that I have explained each issue displayed on this page to said patient and said patient indicated their understanding of each issue by signing each indicated area on this form.

_____ _____

Staff Signature Date **Date**