# PAIN MANAGEMENT INITIAL CONSULTATION

Please complete this form as fully as possible. The information you provide helps the clinician understand your pain, prior treatment, overall health, and treatment goals. If a question does not apply, write N/A.

**Patient Name** _____ **Date of Birth** _____ **Date** _____

**Preferred Phone** _____ **Email** _____

## CURRENT CARE TEAM

| | Primary Care Clinician | Referring Clinician / Practice |
|---|---|---|
| Name | | |
| Phone | | |
| Address | | |

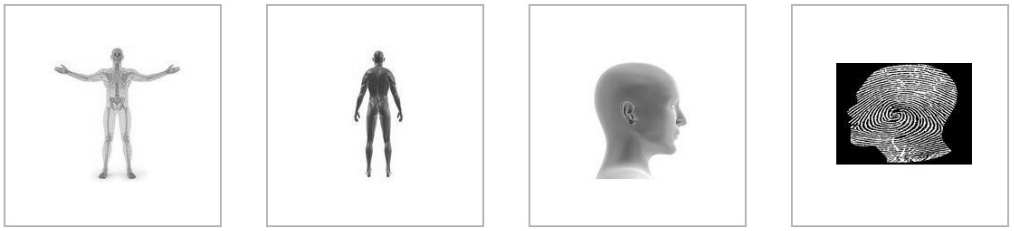
## PAIN HISTORY

1. Where do you hurt most? Describe the main location or locations.

2. When did this pain problem begin? If it followed an injury, include the date and explain what happened.

3. How did the pain first begin? For example, was it gradual, after a fall, a motor vehicle collision, a work injury, surgery, or another event?

**Mark the areas where you have pain, numbness, tingling, burning, or other symptoms.**




4. Rate your pain on a 0-10 scale, where 0 means no pain and 10 means the worst pain you can imagine.

**Average Pain** _____ **Worst Pain** _____ **Acceptable Pain** _____

5. How often is the pain present?

☐ Constant ☐ Daily but not constant ☐ Intermittent / occasional

6. Which words best describe your pain or related symptoms? Check all that apply.

☐ Dull ☐ Sharp ☐ Shooting ☐ Stabbing
☐ Burning ☐ Electric / shock-like ☐ Aching ☐ Numbness
☐ Tingling ☐ Weakness ☐ Cold sensation ☐ Muscle spasm
☐ Tightness / pressure ☐ Other

## ACTIVITIES AND FACTORS THAT AFFECT PAIN

| Activity / Factor | Worse | Better | No Change | Comments |
|---|---|---|---|---|
| Stairs | ☐ | ☐ | ☐ | |
| Exercise | ☐ | ☐ | ☐ | |
| Walking | ☐ | ☐ | ☐ | |
| Massage | ☐ | ☐ | ☐ | |
| Sitting | ☐ | ☐ | ☐ | |

| Activity / Factor | Worse | Better | No Change | Comments |
|---|---|---|---|---|
| Standing | ☐ | ☐ | ☐ | |
| Heat | ☐ | ☐ | ☐ | |
| Cold | ☐ | ☐ | ☐ | |
| Weather changes | ☐ | ☐ | ☐ | |
| Emotional stress | ☐ | ☐ | ☐ | |
| Sexual activity | ☐ | ☐ | ☐ | |
| Medication | ☐ | ☐ | ☐ | |
| Other | ☐ | ☐ | ☐ | |

## PREVIOUS PAIN TREATMENT

List pain medicines you have used in the past. Indicate whether each medicine helped and note important side effects or concerns.

| Medication | Helpful | Not Helpful | Comments / Side Effects |
|---|---|---|---|
| | ☐ | ☐ | |
| | ☐ | ☐ | |
| | ☐ | ☐ | |
| | ☐ | ☐ | |
| | ☐ | ☐ | |
| | ☐ | ☐ | |
| | ☐ | ☐ | |

Check treatments you have tried and indicate whether they were helpful.

| Treatment | Helpful | Not Helpful | Comments |
|---|---|---|---|
| Surgery | ☐ | ☐ | |
| Nerve block | ☐ | ☐ | |
| Steroid injection | ☐ | ☐ | |
| Acupuncture | ☐ | ☐ | |
| Trigger-point injection | ☐ | ☐ | |
| TENS unit | ☐ | ☐ | |
| Heat / ice | ☐ | ☐ | |
| Biofeedback | ☐ | ☐ | |
| Hypnosis | ☐ | ☐ | |
| Relaxation training | ☐ | ☐ | |
| Counseling | ☐ | ☐ | |
| Physical therapy | ☐ | ☐ | |
| Other | ☐ | ☐ | |

## MEDICAL HISTORY

Check any condition you currently have or have had in the past.

☐ Diabetes ☐ Arthritis ☐ Cancer

☐ Ulcer / gastritis ☐ Heart disease ☐ Bleeding disorder

☐ Kidney disease ☐ COPD / asthma ☐ Seizures

☐ Infectious disease ☐ Neurologic condition ☐ High blood pressure

☐ Other

Have you ever been treated by another pain specialist? ☐ No ☐ Yes

**Clinician / Practice:** _____

Current work status:

☐ Full-time ☐ Part-time ☐ Not working

☐ Retired ☐ Student ☐ Homemaker

**Current or Previous Occupation:** _____

Is this pain related to a workers' compensation claim? ☐ No ☐ Yes

Are you receiving or applying for disability benefits because of this condition? ☐ No ☐ Yes

Is there current or anticipated legal action related to this pain problem? ☐ No ☐ Yes

Tests completed within the past 24 months: ☐ X-ray ☐ CT ☐ MRI ☐ EMG / nerve study ☐ None

List major surgeries or significant medical procedures.

| Year | Surgery / Procedure / Reason |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

List medication or substance allergies and the reaction you experienced.

| Medication / Substance | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

## MENTAL HEALTH AND SLEEP

Check any condition for which you have been diagnosed or treated.

☐ Major depression ☐ Anxiety disorder ☐ Bipolar disorder

☐ Insomnia ☐ Obsessive-compulsive disorder ☐ Panic disorder

☐ Anorexia / eating disorder ☐ Bulimia / eating disorder ☐ Alcohol dependence

☐ Drug dependence ☐ Other

Average sleep:

☐ 7-8 hours/night ☐ 9-11 hours/night ☐ 12+ hours/night

☐ 5-6 hours/night ☐ 3-4 hours/night ☐ Severe sleep difficulty

## GENERAL HEALTH REVIEW

For each item, check Yes if you currently have the problem or have had it recently. Leave blank if No.

| Yes | Symptom / Condition | Yes | Symptom / Condition |
|---|---|---|---|
| ☐ | Blurry vision | ☐ | Glaucoma |
| ☐ | Ringing in the ears | ☐ | Teeth clenching / grinding |
| ☐ | Chest pain or tightness | ☐ | Heart disease / irregular heartbeat |
| ☐ | Need to sleep upright to breathe | ☐ | Shortness of breath |
| ☐ | Emphysema / asthma | ☐ | Abdominal pain |
| ☐ | Ulcer / gastritis | ☐ | Irregular bowel habits |
| ☐ | Irritable bowel symptoms | ☐ | Blood in stool |
| ☐ | Pelvic pain | ☐ | Frequent urination |
| ☐ | Difficulty urinating | ☐ | Seizures |

| Yes | Symptom / Condition | Yes | Symptom / Condition |
|---|---|---|---|
| ☐ | Frequent headaches | ☐ | Blackouts / fainting |
| ☐ | Unexplained fever | ☐ | Excessive fatigue |
| ☐ | Trouble falling or staying asleep | ☐ | Rash |
| ☐ | Rheumatoid arthritis / lupus / similar autoimmune condition | ☐ | Diabetes |
| ☐ | Thyroid disorder | ☐ | Depression |
| ☐ | Anxiety | | |

## EXERCISE AND ACTIVITY HISTORY

At what period of your life were you most physically active?

☐ Childhood ☐ Teenage years ☐ Young adulthood (21-39)

☐ Mid-adulthood (40-60) ☐ Later adulthood (over 60) ☐ Never regularly active

What is your current activity level?

☐ Sedentary ☐ Mildly active ☐ Moderately active ☐ Very active

What barriers make physical activity difficult for you?

☐ Medical ☐ Social ☐ Physical

☐ Family ☐ Work-related ☐ Other

Describe your usual exercise or planned physical activity.

| Activity | Minutes / Day | Days / Week |
|---|---|---|
| | | |
| | | |
| | | |

Describe regular non-exercise activity such as housework, yard work, walking for errands, or caregiving.

| Activity | Minutes / Day | Days / Week |
|---|---|---|
| | | |
| | | |
| | | |

## SOCIAL HISTORY

Tobacco / nicotine use: ☐ No ☐ Yes

☐ Up to 1/2 pack per day ☐ 1/2-1 pack per day

☐ More than 1 pack per day ☐ Other amount / nicotine product

**Details:** _____

Alcohol use: ☐ No ☐ Yes

☐ Rare (less than 6 times/year) ☐ Occasional (1-2 times/month) ☐ Weekends only

☐ Regular (2-3 times/week) ☐ Daily (1-3 drinks/day) ☐ Heavy (more than 3 drinks/day)

Current or past non-prescribed / illegal drug use: ☐ No ☐ Yes

☐ Marijuana / cannabis ☐ Opiates ☐ Benzodiazepines

☐ Hallucinogens ☐ Amphetamines ☐ Inhalants

☐ Other

**Type / Amount:** _____

Relationship / household status:

☐ Single ☐ Married / partnered ☐ Divorced

☐ Separated ☐ Widowed ☐ Cohabitating

Work situation:

☐ Homemaker ☐ Part-time ☐ Full-time

☐ Unemployed ☐ Retired ☐ Student

Typical work hours each week:

☐ None ☐ Under 20 ☐ 20-39

☐ 40 ☐ 41-60 ☐ More than 60

## FAMILY MEDICAL HISTORY

List important medical problems for the family members below, if known.

| Family Member | Important Medical Problems |
|---|---|
| Father | |
| Mother | |
| Brother(s) | |
| Sister(s) | |
| Paternal Grandfather | |
| Paternal Grandmother | |
| Maternal Grandfather | |
| Maternal Grandmother | |

## REVIEW OF SYSTEMS - PAST 6 MONTHS

Check symptoms you have experienced during the past six months. If none apply in a category, check None.

### Constitutional

☐ None ☐ Fever ☐ Chills ☐ Sweating
☐ Fatigue ☐ Body aches ☐ General feeling of illness

### Head / Eyes / Ears / Nose / Throat

☐ None ☐ Hearing change ☐ Ear pain ☐ Eye pain
☐ Vision change ☐ Runny nose ☐ Nosebleeds ☐ Sore throat
☐ Mouth sores

### Neck

☐ None ☐ Swelling ☐ Stiffness ☐ Pain
☐ Knots / tight muscles

### Respiratory

☐ None ☐ Cough ☐ Shortness of breath ☐ Wheezing
☐ Chest tightness ☐ Coughing blood ☐ Congestion ☐ Heavy snoring
☐ Slow breathing

### Cardiovascular

☐ None ☐ Chest pain ☐ Racing heart ☐ Palpitations
☐ Chest pressure ☐ Chest tightness ☐ Varicose veins ☐ Slow heart rate
☐ Fast heart rate

### Gastrointestinal

☐ None ☐ Nausea ☐ Vomiting ☐ Abdominal pain
☐ Heartburn ☐ Blood in stool ☐ Gas ☐ Diarrhea
☐ Constipation

### Genitourinary

☐ None ☐ Painful urination ☐ Frequent urination ☐ Blood in urine
☐ Incontinence ☐ Difficulty starting urine ☐ Incomplete emptying ☐ Nighttime urination

### Female Genital

☐ None ☐ Blisters ☐ Discharge ☐ Painful periods
☐ Absent periods ☐ Irregular periods ☐ Itching / rash ☐ Spotting
☐ Pelvic pain

### Male Genital

☐ None ☐ Blisters ☐ Discharge ☐ Testicular lump

☐ Testicular swelling ☐ Testicular pain ☐ Scrotal lump ☐ Scrotal swelling
☐ Itching / rash

### Musculoskeletal

☐ None ☐ Knee pain ☐ Back pain ☐ Hip pain
☐ Foot pain ☐ Leg swelling ☐ Foot swelling ☐ Ankle swelling
☐ Joint aches

### Endocrine

☐ None ☐ Increased thirst ☐ Increased appetite ☐ Frequent urination
☐ Dizziness ☐ Thinning hair ☐ Cold intolerance ☐ Heat intolerance
☐ Dry skin ☐ Depressed mood ☐ Neck fullness ☐ Infertility
☐ Facial hair change ☐ Voice change ☐ Acne

### Blood / Immune

☐ None ☐ Pale skin ☐ Fatigue ☐ Easy bruising
☐ Weakness ☐ Itchy skin ☐ Itchy eyes / ears / nose ☐ Swollen lymph nodes
☐ Frequent infections

### Neurologic

☐ None ☐ Headaches ☐ Dizziness ☐ Foot numbness
☐ Leg numbness ☐ Hand numbness ☐ Tremor

### Mental / Emotional

☐ None ☐ Sadness ☐ Low mood ☐ Crying spells
☐ Difficulty concentrating ☐ Reduced interest / pleasure ☐ Reduced sex drive ☐ Too little sleep
☐ Too much sleep ☐ Anxiety ☐ Excessive worry ☐ Irritability
☐ Panic attacks ☐ Low energy ☐ Thoughts of self-harm

### Skin

☐ None ☐ Frequent boils ☐ Lower-leg rash ☐ Groin rash
☐ Skin-fold rash ☐ Rash under breasts ☐ Infected skin / leg rash

**Clinician review completed with patient:** _____

**Clinician Signature** _____ **Date / Time** _____

## ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I understand that my health information may be used or shared as permitted by law for treatment, payment, and routine health care operations. This can include coordinating care with health professionals involved in my treatment, obtaining payment when applicable, and carrying out normal clinical and administrative activities.

I acknowledge that I have been offered or given access to the Notice of Privacy Practices, which explains how protected health information may be used and disclosed and describes patient privacy rights.

I understand that the Notice of Privacy Practices may be updated from time to time and that I may request a current copy. I may ask in writing for limits on certain uses or disclosures of my information. I understand that a requested restriction is not always required to be accepted, but an accepted restriction will be followed as required by law.

By signing below, I acknowledge receipt or availability of the Notice of Privacy Practices and confirm that I have had an opportunity to ask questions.

**Patient Name** _____ **Relationship to Patient** _____

**Signature** _____ **Date** _____

**Office Use Only - If the acknowledgment could not be obtained, document the reason below.**

| Date | Staff Initials | Reason Signature Was Not Obtained |
|---|---|---|
| | | |
| | | |

# INFORMED CONSENT FOR OPIOID MEDICATION THERAPY

Opioid medicine may be considered as one part of a treatment plan for persistent pain when the expected benefit is greater than the potential risk. Opioids do not eliminate all pain and may not improve function for every person. Non-opioid medicines, physical therapy, exercise, behavioral strategies, procedures, or specialist care may also be appropriate.

**Patient Name** _____ **Condition / Reason** _____

**Other treatments discussed / considered:** _____

I understand that opioid medicines can cause confusion or slowed thinking, nausea, vomiting, constipation, dizziness, drowsiness, reduced coordination or balance, dry mouth, itching, rash, sexual problems, mood changes, physical dependence, tolerance, addiction, and slowed breathing. An overdose can stop breathing and can be fatal.

I will not drive, operate dangerous equipment, work at unprotected heights, or take responsibility for another person if I feel drowsy, impaired, or unable to think clearly. I understand that reaction time may be slowed even when I do not notice obvious impairment.

I will tell my clinician about all prescription and non-prescription medicines, supplements, alcohol, cannabis, and other substances I use. I understand that some medicines can interfere with opioid treatment or trigger withdrawal and that I should ask a qualified clinician before making important medication changes.

I understand that physical dependence can occur with long-term opioid use and is not the same as addiction. Stopping opioids suddenly after dependence develops may cause withdrawal symptoms such as runny nose, diarrhea, sweating, rapid heart rate, sleep difficulty, abdominal cramping, goose bumps, anxiety, and other flu-like symptoms.

I understand that addiction is a chronic condition that may include impaired control over drug use, compulsive use, craving, or continued use despite harm. If concerning behavior, misuse, diversion, or addiction develops, opioid treatment may be changed or tapered and referral for substance-use treatment may be recommended.

I understand that tolerance means the body may adapt to a medicine so that its effects change over time. The dose may need to be adjusted up or down based on safety, function, side effects, and treatment response.

For males: I understand that chronic opioid use may be associated with lower testosterone levels and may affect mood, stamina, sexual desire, and physical or sexual performance. Laboratory testing may be recommended when clinically appropriate.

For females: If I am pregnant, planning pregnancy, or believe I may be pregnant, I will promptly notify the prescribing clinician and my obstetric clinician. Ongoing opioid use during pregnancy can cause physical dependence in a newborn and may require special medical care after delivery.

I have had an opportunity to discuss the expected benefits, important risks, reasonable alternatives, and my questions about opioid therapy. I consent to treatment when prescribed and understand that continued prescribing depends on clinical judgment, safety, meaningful benefit, and my ability to follow the treatment plan.

**Patient Signature** _____ **Date** _____

# CONTROLLED MEDICATION TREATMENT AGREEMENT

This agreement is intended to prevent misunderstandings and establish clear expectations when controlled medicines are used for pain treatment. I understand that these medicines require careful monitoring and that continued treatment depends on safety, appropriate use, and meaningful clinical benefit.

- ☐ I understand that controlled medicines can cause physical dependence and addiction and that these risks increase when medicines are misused or combined with other substances.
- ☐ I will participate in treatment intended to improve function, which may include physical activity, physical therapy, behavioral health care, diagnostic testing, procedures, or other recommended services.
- ☐ I will take medicine only as prescribed and will not change the dose, frequency, or method of use without approval.
- ☐ I will accurately describe my pain, daily function, medication benefit, side effects, and problems using the medicine as directed.
- ☐ I will not share, sell, trade, lend, or give medicine to anyone. I will store it securely to prevent loss, theft, or access by children or other people.
- ☐ I understand that lost, stolen, spilled, damaged, or misused controlled medicine may not be replaced.
- ☐ I will not obtain controlled pain medicine, stimulants, or anti-anxiety medicine from another prescriber without informing the pain clinician. If emergency, urgent, hospital, dental, or other care results in a controlled prescription, I will report it promptly.
- ☐ I will provide a complete list of prescription medicines, over-the-counter products, supplements, and other substances I use and will bring medication containers when requested.
- ☐ I agree to use one prescriber or prescribing practice and one pharmacy for controlled pain medicine when requested. I understand that prescription-monitoring records may be reviewed as permitted by law.
- ☐ I agree to urine, blood, or other drug testing when clinically indicated to help assess medication safety and adherence.
- ☐ I will keep scheduled appointments. Routine controlled-medication prescriptions and refills are normally handled during scheduled visits. Walk-in, after-hours, early, emergency, vacation, or advance refills are not guaranteed.
- ☐ If I miss a refill visit, I understand that another appointment may need to be scheduled and an immediate replacement prescription may not be available.
- ☐ I will not use more medicine than prescribed. If I use medicine too quickly, I may be without medication until the next appropriate refill date.
- ☐ I will not use illegal substances and will follow medical advice regarding alcohol, cannabis, sedatives, or other substances that may make treatment unsafe.
- ☐ I understand that treatment may be changed or stopped if the risks outweigh the benefits, there is inadequate improvement, unsafe use is identified, monitoring requirements are not met, or I do not follow this agreement.
- ☐ I understand that threatening, harassing, deceptive, disrespectful, or unsafe behavior can interfere with care and may affect whether treatment can continue.
- ☐ I understand that tampering with medication, prescriptions, laboratory specimens, drug screens, or monitoring procedures may result in discontinuation of controlled-medication treatment.

**Preferred Pharmacy** _____ **Phone** _____

**Pharmacy Address / Location:** _____

I have read this agreement, or it has been read to me. I understand the expectations above, have had an opportunity to ask questions, and agree to follow these terms while receiving controlled-medication treatment.

**Patient Signature** _____ **Date** _____

# GENERAL PRACTICE POLICIES

## Effective 06/01/2026

**1.** All prior authorization requests must be initiated through the CoverMyMeds platform by the patient's pharmacy or insurance carrier unless another arrangement has been approved in advance. If the pharmacy or insurance carrier does not participate with CoverMyMeds, the office does not process the prior authorization request.

**2.** Payment is due at the time of every office or phone visit. If payment has not been made, any prescription written during that visit will not be sent. The purpose of the visit is medical evaluation and treatment, not simply obtaining a prescription.

**3.** If a pharmacy cannot fill the prescribed quantity, the office will make one additional attempt to rewrite or redirect the prescription. The patient is responsible for locating a replacement pharmacy that can fill it.

**4.** Text messages are accepted from 9:00 a.m. to 5:00 p.m., Monday through Friday. The office is not open on weekends except for an extreme emergency. Texting is the preferred method of communication; one phone call and one text message are generally sufficient.

**5.** Do not contact the provider directly unless you have been instructed to do so. The office should always be your first point of contact.

**6.** Phone visits are reserved for extreme emergencies and may occur no more than once every three months.

**7.** Early refills require arrangements to be made in advance. An early refill will not be available without prior approval.

**8.** Notify the office immediately if your phone number or address changes.

**9.** You are responsible for knowing the date and time of your next scheduled appointment.

**10.** Tell the office about every prescription you receive from another medical provider.

**11.** You are required to maintain a Primary Care Provider and have that provider registered with the office. The provider seeing you for this appointment does not provide primary care services.

**12.** Medication will not be increased without appropriate supporting documentation.

**13.** A $25 fee applies to a no-call/no-show appointment. You are responsible for knowing and keeping your next scheduled appointment.

**14.** A $50 credit will be applied to your next visit for each person you refer after that person completes their first appointment. You are responsible for notifying the office of the referral.

I have reviewed these general practice policies and understand my responsibilities as a patient.

**Patient Name** _____ **Date** _____

Patient Signature _____

# PRIMARY CARE & REFERRAL PROGRAM

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## REFERRAL PROGRAM

Refer a qualified person and receive a $50 cash discount on your next visit after the referred patient completes their first paid visit. Submit the referral information below or text the information to the office.

**Name** _____ **Phone Number** _____

**Name** _____ **Phone Number** _____