INTERVENTIONAL PAIN SOLUTIONS

- **10 Governors Lane, Chico, CA 95926 · (530) 343-4757**
- **1158 N. Court Street, Redding, CA 96001 · (530) 768-1722**
- **110 W. Castle Street, Suite 100, Mt. Shasta, CA 96067 · (530) 968-1039**
- **831 Sterling Parkway, Suite 100, Lincoln, CA 95648 · (916) 253-9227**

Welcome,

Your health is very important to us. Our goal is to reduce your pain, improve functionality, quality of life, and preserve your overall health with treatment methods alternative to narcotics or opioids.

Interventional Pain Solutions believes in utilizing the most modern, peer reviewed and accepted techniques to care for you. We are committed to following the most recent guidelines as issued by the Centers for Disease Control and endorsed by the Surgeon General of the United States.

Appt Date: _____Time: _____ A.M./P.M.

Your first visit with us is a consultation. We DO NOT prescribe medications or do injections on the first visit. We will establish care with you, review your history, and look at any radiology exams you have had in order to decide the best course of action for you. Please bring recent imaging reports with you to your appointments to avoid delay in treatment. If you have not had recent imaging, we can order this for you.

We strongly discourage the use of benzodiazepines (Valium, Xanax, Ambien etc.) and similar medications. We may choose to use alternative methods to reduce your pain if you are taking these medicines.

- **We ask that you arrive 10-15 minutes prior to your first appointment to complete registration.**
- **Please make sure the enclosed paperwork is complete BEFORE arriving and prior to your appointment time.**
- **Bring your insurance cards and photo ID.**

If you have a co-pay or patient responsibility, we will collect it at check-in.

If you have any questions or need to reschedule, please call the office 48 hours in advance.

For the safety of our patients and providers, the following tests/evaluations are or ordered, and can be done in our office:

-Vital System Assessment Test (VSAT)
-Functional Assessment by a psychologist *(This is ordered to assess how your pain is affecting your daily life activities and functionality).*
-Urine Toxicology and Drug Screening

See you soon!

Registration

Full Legal Name: _____ **D.O.B**.: _____

(If Different) Insurance Card: _____ **S.S.N**.: _____

Age: _____ **Gender**: F M Unidentified **Race**: _____ **Marital Status**: _____

Height: _____ Weight: _____

Residential Address: _____ **City**: _____

State: _____ **Zip Code**: _____ **Email**: _____

Telephone: Mobile: (_____)_____ Home: (_____)_____

_____ (Patient Initials) I consent to receive text and email messages from this practice.

Spouse Name: _____ **Phone Number**: _____

Emergency Contact (if different than above): _____ **Ph. #:** _____

_____ (Patient Initials) I consent to allow this practice to communicate with the parties listed above in the event of an emergency.

Insurance

Primary Insurance Carrier: _____ (Select One) HMO PPO EPO Other

ID# _____ Group #: _____

Primary Subscriber if not Self: _____ D.O.B.: _____

Secondary Insurance Carrier: _____ (Select One) HMO PPO EPO Other

ID# _____ Group #: _____

Primary Subscriber if not Self: _____ D.O.B.: _____

Worker Comp./ Lien:

Carrier: _____ Date of Injury: _____/_____/_____

Claim #: _____ Employer at DOI: _____

Adjuster Name: _____ Ph.: _____ Fx.: _____

****It is YOUR responsibility to provide the correct billing information to our office to ensure accurate and timely filing.**

Pharmacy Name: _____ **Location:** _____

Primary Care Doctor: _____ **Location:** _____ **Phone #:** _____

Provider Who Referred You: _____

Current Medications: **□ Med. List Attached**

Drug *Ex. Advil*	**Strength** *Ex. 200mg*	**Frequency** *Ex. Twice daily*	**Quantity Prescribed**	**Prescribed By**

Please indicate any medications you have taken in the PAST:

□ Advil/Motrin/Ibuprofen	□ Dilaudid	□ Mobic/Meloxicam	□ Prozac
□ Aleve/Naproxen	□ Effexor	□ Morphine	□ Relafen/Nabumetone
□ Ambien/Zolpidem	□ Elavil	□ MS Contin	□ Remeron
□ Aspercream	□ Exalgo	□ Neurontin	□ Restoril/Temazepam
□ Aspirin	□ Fentanyl Patch	□ Norco/Vicodin/Lortab	□ Ritalin
□ Ativan/Lorezapam	□ Flector Patch	□ Nortriptyline	□ Robaxin/Methocarbamol
□ Avinza/Duramorph	□ Flexeril/Cyclobenzaprine	□ Nucynta	□ Skelaxin/Metaxalone
□ Baclofen	□ Gabapentin	□ Nuvigil	□ Soma/Carisoprodol
□ BenGay	□ Hydrocodone	□ Opana	□ Suboxone
□ Butrans Patch	□ Hydromorphone	□ Oxycodone	□ Trazodone
□ Capsaicin	□ Kadian/Embeda	□ Oxycontin	□ Tramadol/Ultram
□ Celexa/Citalopram	□ Klonopin/Clonazepam	□ Parafon Forte/ Chlorzoxazone	□ Valium/Diazepam
□ Celebrex	□ Lexapro	□ Paxil	□ Voltaren Gel
□ Cymbalta	□ Lidoderm Patch	□ Pennsaid	□ Voltaren/Diclofenac
□ Codeine	□ Lunesta	□ Percocet/Percodan	□ Wellbutrin/Bupropion
□ Darvocet	□ Methadone	□ Provigil	□ Xanax/Alprazolam
□ Zanaflex/Tizanidine	□ Zoloft/Sertraline		

Other Medications tried in past:

_____

Medication Allergies/Reaction:

_____

Surgical History: **□ List Attached**

Date	**Type of Surgery**	**Location Where Performed**	**Surgeon**

Any complications? Y / N If Yes: _____

Past Medical History

Please indicate if you're currently experiencing any of these conditions, or have in the past:

High Blood Pressure/Hypertension	**C / P**	Asthma	**C / P**	Ulcers	**C / P**	Major Accident:
Diabetes	**C / P**	Chest Pain/Angina	**C / P**	Hepatitis/Jaundice	**C / P**	Other:
Heart Attack/MI	**C / P**	Thyroid Issues	**C / P**	Sudden Weight Loss	**C / P**	
Stroke/CVA/TIA	**C / P**	Depression	**C / P**	Anxiety	**C / P**	
Obesity	**C / P**	Renal/Kidney Issues	**C / P**	Cancer	**C / P**	

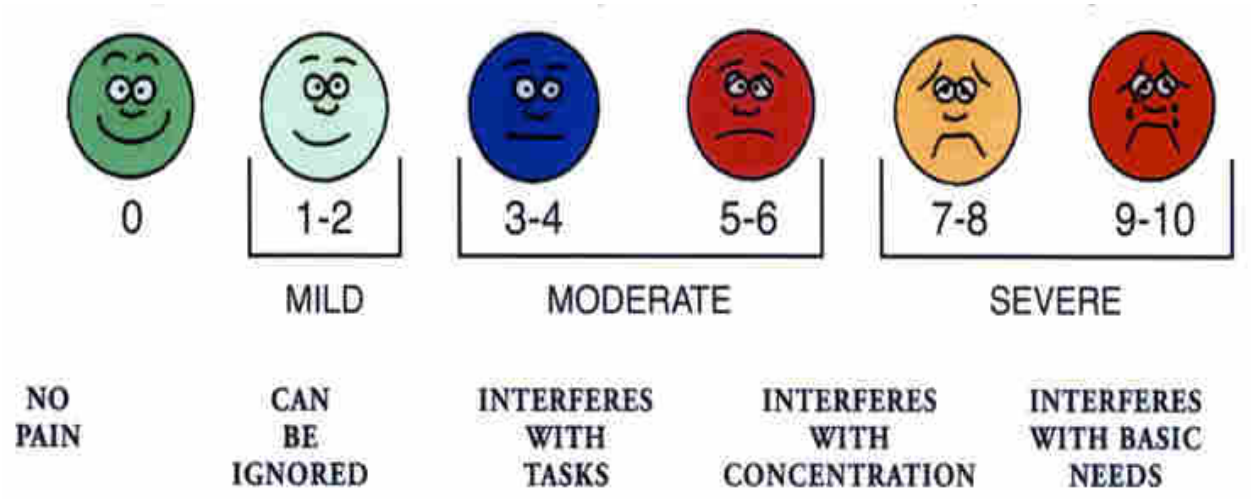
Current= C **Past= P**

Location of Pain (Body part): _____

Details about your pain:

My pain started after: □ An injury □After surgery □ Auto accident □Event □Gradually over time □Unknown

Please explain: _____



My WORST Pain Score (circle): 0 1 2 3 4 5 6 7 8 9 10

My USUAL/AVERAGE Pain Score (circle): 0 1 2 3 4 5 6 7 8 9 10

My pain is (select ONE answer):

- □ Constant, always present, always the same intensity
- □ Constant, intensity varies
- □ Occasional/Intermittent, short periods with little to no pain
- □ Occasional/Intermittent, pain is only felt when
- □ Worse in the morning
- □ Worse in the evening/night
- □ Time of day has NO association with pain

The type of pain I feel is:

- □ Burning
- □ Stabbing
- □ Throbbing
- □ Sharp
- □ Shooting
- □ Aching
- □ Tight
- □ Electric Shock

I also have associated:

- □ Numbness
- □ Tingling
- □ Stiffness
- □ Weakness
- □ Spasms
- □ Coldness
- □ Sensitivity to Touch
- □ Increased Sweating
- □ Feeling of Pins/Needles

My pain gets worse with:

- □ Sitting
- □ Leaning forward
- □ Standing
- □ Walking
- □ Laying down
- □ Straining
- □ Arching backward
- □ Coughing/sneezing

My pain gets better with:

- □ Rest
- □ Stretching
- □ Exercise
- □ Medications
- □ Lying flat
- □ Laying on the certain side
- □ Heat
- □ Ice pack
- □ Medical Marijuana

My Pain is interfering with my:

- □ Sleep:
- □ Falling Asleep
- □ Staying asleep
- □ Waking up frequently
- □ Work performance
- □ Driving
- □ Family life
- □ Relationship w/ Friends/Co-workers
- □ Relationship w/ Spouse/Partner

My goals with pain control are to:

- □ Achieve a better quality of life
- □ Avoid surgery
- □ Go back to work
- □ Increase activity level/family time
- □ Reduce/Get off medications
- □ Have more restful sleep
- □ Perform household duties
- □ Travel, play sports

NECK PAIN ONLY

My neck/shoulder pain is:

- □ Worse when looking LEFT
- □ Worse when looking RIGHT
- □ The same/no change when looking left or right
- □ Worse when looking UP
- □ Worse when looking DOWN
- □ The same/no change when looking up or down

HEADACHES ONLY

My headaches are mostly:

- □ On the Left
- □ In the back of the skull
- □ On the Right
- □ In the front (behind eyes)
- □ On top of head

When having headaches:

- □ Bright lights bother/worsen headache
- □ Loud noises bother/worsen headache
- □ I have more than 15 headaches per month
- □ My headaches last longer than 4 hours per day

TREATMENTS TRIED:

- □ **Physical Therapy (circle):** Relief? Y / N
  When?: 1-3 months ago 4-6 months ago 7-12 months ago
  Frequency**:** _____ times for _____ weeks. ☐ Could not tolerate due to pain caused
- □ **Chiropractic Care:** Relief? Y / N
- □ **Massage Therapy:** Relief? Y / N
- □ **Acupuncture/ Yoga:** Relief? Y / N
- □ **Medications:** Relief? Y / N
- □ **Psychotherapy:** Relief? Y / N
- □ **Previous Injections:** Relief? Y / N How much relief? 80-100% 50-70% < 50%
  Dates & Types of injections**:** _____
  _____
  Who performed the injections? (Doctor & Facility): _____
- □ **Surgery**: Relief? Y / N
  Dates & Types of injections**:** _____
  _____
  Who performed the surgery? (Doctor & Facility): _____

I have seen the following specialist(s) for my pain:

- □ Neurosurgeon
- □ Neurologist
- □ Pain Clinic
- □ Physiatrist
- □ Orthopedic Surgeon
- □ Other: _____

I have had the following tests performed for my pain:

- □ X-ray
- □ MRI Scan
- □ CT Scan
- □ Nerve Testing (EMG/NCS)
- □ Bone Scan/Dexa Scan
- □ CT Myelogram

WHEN: _____ WHERE: _____

Family History

Father:	□ Alive	□ Passed Away	□ Healthy	□ Major Health Problems
Mother:	□ Alive	□ Passed Away	□ Healthy	□ Major Health Problems
Brother(s):	□ Alive	□ Passed Away	□ Healthy	□ Major Health Problems
Sister(s):	□ Alive	□ Passed Away	□ Healthy	□ Major Health Problems

Social History

Tobacco/ Nicotine Status:

- □ Non-Smoker
- □ Current Smoker: Number Per Day on Average: _____ □ 1 Pack Per Day or More
  Tried to Quit? □ Yes □ No
- □ Social Smoker
- □ Former/ Past Smoker: Age/ Year Started Smoking: Age/ Year Quit Smoking: _____

Modalities Used to Help Quit: □ Nicotine patch/ gum □ Prescription (Chantix, Zyban, etc.) □ Support Group □ Self Determination □ Hypnosis □ Other: _____

- □ If a Current or Former Smoker please select Type or product below:

□ Cigarettes □ Cigar □ Pipe □ Chewing Tobacco □ Electronic Cigarette □ Other: _____

In the past year, I have used: □ Marijuana □ Meth/speed □ cocaine □ Heroin □ None
I have/ had problems with: □ Alcohol Abuse □ Drug abuse □ Prescription drug abuse □ None

If you have used tobacco within the past 24 months (cigarette, cigar, snuff or chew), are you interested in receiving additional information today in order to help you quit?
(1-800-NO BUTTS 1-800-662-8887)

Alcohol Use:

- □ Don't Drink
- □ Social Drinker
- □ Occasional-Amount per Year/Month: _____
- □ Heavy-Amount per day: _____

Marital Status:

- □ Married
- □ Single
- □ Divorced
- □ Separated
- □ Widow/Widower

Work Status:

- □ Full-Time: Hours per Week_____
- □ Part-Time: Hours per Week_____
- □ Retired
- □ Off-Work Due to Injury/Illness
- □ Unemployed
- □ Occupation: _____

Exercise:

- □ None
- □ Daily: Hour/Mins/Activity_____
- □ Weekly: Hour/Mins/Activity_____
- □ Monthly: Hours/Mins/Activity_____

Medication Management Agreement

This agreement renders all previous agreements null and void.

Because Interventional Pain Solutions is prescribing such medication for me to help manage my pain, when I sign this form I acknowledge that I understand and agree to the following conditions to make my treatment as safe and successful as possible (please initial each numbered item):

_____ 1. I am aware that the use of such medicine has certain risks associated with it, including but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia (pain reduction), addiction, and the possibility that the medicines will not provide complete pain relief.

_____ 2. I understand that the main treatment goal is to improve my ability to function by reducing pain. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by following better health habits: **exercising, controlling my weight, and avoiding the use of alcohol and tobacco. I understand that only by following a healthier lifestyle can I hope to have the most successful outcome to my pain management treatment.**

_____ 3. I understand that the long-term use of opioids has been associated with increased pain, decreased functioning, neurological compromise, and cardiovascular risk. As such **I agree** that I will endeavor to reduce my reliance of opioid pain medications by utilizing alternative modalities such as Injections, Physical Therapy, Psychotherapy, and Adjunctive medications. Further, **I understand** that Interventional Pain Solutions does **not** practice nor endorse long-term pain management utilizing opioids and they will not be made available to me.

_____ 4. I agree to tell my doctor about all other medicines and treatments that I am receiving. **I will not request or accept controlled substances/medications from any other physician or individual** while I am receiving such medications from Interventional Pain Solutions. To do so may endanger my health and/or our physician/patient relationship. This includes obtaining medication from Urgent Cares or the Emergency Department. Post-operative pain medications for **planned** surgical procedures must be arranged in advance.

_____ 5. I understand the following refill policy:

   a. ***Medications will not be refilled early, even if they have been lost or stolen.***
   b. ***Medications will not be refilled by other physicians.***
   c. ***It is the YOUR responsibility to make appointments in a timely manner to give ample time for medications to be refilled.***

_____ 6. I agree to use a single pharmacy for all my pain medications. If I change pharmacies for any reason, I agree to notify the doctor at the time I receive a prescription and advise my new pharmacy of my prior pharmacy's address and telephone number.

_____ 7. I agree to **keep all scheduled appointments**, including planned procedures, and appointments with providers we refer you to including, but not limited to, Physical Therapy, Psychology, and Specialists.

_____ 8. I must keep Interventional Pain Solutions fully informed of any changes, Emergency Room visits, lost or stolen medications or any other circumstances affecting my health and well-being.

_____ 9. Interventional Pain Solutions may refer me to another physician for a second opinion while I am receiving controlled substances. I understand that if I do not obtain this second opinion, Interventional Pain Solutions may discontinue my medications or refill them with a tapering dose to therapeutically and safely discontinue my use of them.

_____ 10. I agree that if given a prescription for Narcan (naloxone); the antidote for opioid overdoses, I will fill the prescription and keep it available

_____ 11. I understand that driving a motor vehicle may be hazardous while taking controlled substances and that it is my responsibility to comply with the laws of this state and conduct myself safely while taking the medication prescribed.

_____ 12. I will not be involved in activities that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include but are not limited to: using heavy equipment or operating a motor vehicle, working at unprotected heights, or being responsible for another individual who is unable to care for himself or herself.

_____ 13. I have been fully **informed** by Interventional Pain Solutions regarding the potential psychological **dependence** on a controlled substance. I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the desired effect. I know that I may become physically dependent on the medication. This will occur if I am on the medication for several weeks. I understand that tolerance, and decreased efficacy, are not justification to increase doses.

_____ 14. I agree that I will not use benzodiazepines (Valium, Xanax, Ativan, Librium) or consume alcohol in any amount while taking opioid pain medications.

_____ 15. I agree that periodic urine drug screens and/or pill counts will be asked of me to ensure medications are being taken appropriately and not presenting a health hazard. I agree that I will comply with these measures.

_____ 16. **I understand that if I fail to comply** with the guidelines in this agreement and on my prescription labels; if I obtain narcotics elsewhere (even from a physician); if I use illicit drugs; if I share narcotics with others; or if I alter a prescription, our doctor-patient relationship will be terminated. Further, illegal or dangerous activity will result in no further medications being prescribed.

_____ 17. I will not adjust the medications by myself. I will discuss with my provider any change in dosage I feel I need. Some patients may develop tolerance, which is the need to increase the dose of the medication to achieve the same effect in terms of pain relief. As a result of other treatment modalities or the natural course of my disease process, my pain may decrease. My medication doses will have to be adjusted by Interventional Pain Solutions

I have read this agreement. I fully understand the consequences of violating this agreement. Interventional Pain Solutions has answered my questions and I agree to the terms of the agreement.

Patient name: _____

Patient signature and date: _____

□ Copy given to patient

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

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

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

A2663B 10-04-2005

HIPPA Notice of Privacy Practices

Medical practices are required, by law, to maintain the privacy of your protected health information and to provide you with a notice of privacy practices.

I, _____, hereby acknowledge that a copy of this medical practice's Notice of Privacy Practices will be made available in the reception area. I further acknowledge that a copy of any amended Notice of Practices will be made available at each appointment.

Print Name: _____

Signed: _____**Date:** _____

Medical Records Release of Authorization

I authorize any medical office, hospital, pharmacy, insurance company, organization, and/or employer to release any information necessary in regard to my ongoing medical treatment and the processing of my claims.

I certify that the information I furnish is true and correct to the best of my knowledge. I know that this is a crime to fill out this form with facts that I know are false or to leave out facts that I know to be important.

Signed: _____**Date:** _____

IPS Cancellation/No Show Policy

If you are unable to keep your appointment you must call the office at least 24 - 48 hours prior to your scheduled appointment. If you fail to do so you may be charged our cancellation fee of $100. This will need to be paid prior to being seen or rescheduled. As a Pain Management office, our goal is to get a patient scheduled as soon as possible. When a patient does not give advanced notice of intent to cancel the appointment, it prevents the staff from scheduling a fellow pain patient and delays treatment. Emergency situations are exempt from this fee.

If we receive no call and you do not show up to your appointment.

A $100 No Show Fee will be applied.

Sign: _____**Date:** _____

Copays Are Due at Time of Check In for Each Visit.

Copays will be collected prior to being seen by our providers. You are responsible for knowing your insurance benefits and paying your copay, and any patient responsibility due at time of service.

Acknowledgement of Medication Risks

It is very important to us that you understand that there are risks associated with taking medications. You may already be taking one or more of the following medications, however, it may be necessary to change the dosage and/or frequency at any time.

Opioids/Narcotics, Tricyclic Antidepressants, Anti-Seizure form of medications, Sedatives/Benzodiazepines, Muscle Relaxants, Anti-Depressants

Other medications as deemed necessary.

Warning: *Taking medications containing aspirin, acetaminophen, ibuprofen, or other anit-flammatory meds with alcohol may impair your liver and/or other organs. Medications can cause impairment of mental and/or physical abilities that are necessary when driving or operating heavy equipment. These effects may be enhanced by use of alcohol and/or other Central Nervous System depressants. Stopping some of the medications suddenly can cause serious health problems. Please consult a physician or pharmacist if you have any questions or need further information about the side effects and risks associated with the use if these medications.*

I have read and understand the implications of using the above-mentioned medications.

Signed: _____Date: _____

IPS Prescription Policy

ABSOLUTELY NO EARLY MEDICATION REFILLS. We will only fill your prescription refills when you are due to have them filled.

Your signature below acknowledges that you understand and will abide by this policy.

Print: _____

Sign: _____Date: _____