Welcome to Alliance Pain Center. We appreciate the confidence and trust that you have placed in us and look forward to meeting you personally and professionally. We are truly caring about our patients and want you to feel very comfortable with our entire staff. We recognize that each patient is an individual and our goal is to help our patients with their individual pain management treatment. We strive to be thorough in everything we do, taking time to achieve the best that we can.

Enclosed you will find our new patient information packet. Please carefully read each page and fill out and sign the forms where indicated. We will be happy to schedule your appointment as soon as we receive your completed packet. We will also need a copy of your driver's license or a photo I.D., your insurance card, and your medication prescription card at the time you deliver your new patient packet.

Appointments do not guarantee prescriptions. If you are currently on medications please be aware that you will need to continue with your current physician until you have become an established patient with Alliance Pain Center. Medications are not guaranteed on your first visit. A provider at Alliance Pain Center will discuss a treatment plan for you.

If you have any questions about the packet please call us at our Olympia office and we will be happy to answer your questions. We look forward to meeting you.
Please Print All Information

Date __________________________

Referring Provider ___________________________________________ M.D. ___ PA. ___ A.R.N.P. ___ Provider Phone: _______________________

Primary Care Physician ________________________________________ M.D. ___ PA. ___ A.R.N.P. ___ Provider Phone: _______________________

Patients Name: _______________________________________________ Male: _______ Female: _______

Address: _____________________________________________________ City _______ Zip _______

Home Phone: ___________________________ Cell Phone: ___________ Message Phone: _______________________

Email address: __________________________

Age: _____ Date of Birth: __________ Social Security Number: ___________________________ Marital Status: ______________________

Name of Employer: __________________________________________ Work Number: ___________ Occupation: __________________

Spouse or Partner Name: ______________________________________ Name of Employer: __________________________

Work Number: ___________________________ Occupation: __________

In Case of Emergency, who should be notified?

Name: __________________________________________ Phone: ___________ Relationship: ______________________

Name: __________________________________________ Phone: ___________ Relationship: ______________________

Parent Information if Patient is less than 18 years old

Parent Name: __________________________ Address: __________________________ Home Phone: __________

Cell Phone: __________________________ Work Phone: ___________ Employer: ______________________

Is Alliance Pain Center allowed to leave appointment reminders, lab and x-ray results or other health care information on your telephone answering/voicemail machine or cell phone? Yes / No

May alliance Pain Center leave messages of a financial nature? Yes / NO

How did you find out about Alliance Pain Center? Please check one of the following

Primary Care or another provider _______ Internet (Web Page) _______ Web MD _______
Facebook _______ Google Search _______
Yelp _______
Newspaper _______
A friend or relative _______
Other, please explain _______
Insurance Information

Is the pain you are experiencing from a work related or auto accident injury? Yes / No
If yes, Date of work or auto accident injury __________________________

Do you currently have an open Labor of Industries or auto accident claim? Yes / No

Have you in the past had a Labor and Industries or auto claim? Yes / No

Current or in the past please list who the claim is through, claim number, claim manager and phone number:

Primary Insurance Company Name: ____________________________
Name of Policy Holder: ____________________________ Relationship to patient: ____________________________
Date of birth of policy holder: ____________________________ Social Security number of policy holder: ____________________________
ID Number: ____________________________ Group Number: ____________________________ Policy Effective Date: ____________________________

Secondary Insurance Company Name: ____________________________
Name of Policy Holder: ____________________________ Relationship to patient: ____________________________
Date of birth of policy holder: ____________________________ Social Security number of policy holder: ____________________________
ID Number: ____________________________ Group Number: ____________________________ Policy Effective Date: ____________________________

Prescription Medication Card Name: ____________________________
Name of Policy Holder: ____________________________ Relationship to patient: ____________________________
Date of birth of policy holder: ____________________________ Social Security number of policy holder: ____________________________
ID Number: ____________________________ Rx Bin Number: ____________________________ Group Number: ____________________________ Effective Date: ____________________________

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Name of Insured Signature: ____________________________ Hereby Authorize (Name of Ins Co) ____________________________

PATIENT FINANCIAL RESPONSIBILITY

To pay and hereby assign directly to Alliance Pain Center, all benefits, if any otherwise payable to me for their services as described on the attached form. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Alliance Pain Center, will be credited to my account, in accordance with the above said assignment. I also understand that all past due accounts are subject to finance charges. We do provide a prior authorization service as a courtesy only, however, this can be incomplete. Ultimately you are responsible for insuring authorizations with your insurance. It will be up to you as the patient to call your insurance company and find if our providers are "IN NETWORK" with your insurance. You will be responsible for any balance that may occur from our providers not being "IN NETWORK" with your insurance. If for any reason you should be sent to collections, we will charge you 40% of the amount owed, plus an additional $50.00.

I agree to pay for all services provided. I acknowledge and accept that it is my personal responsibility for payment in full for billed charges even where Alliance Pain Center has been assigned partial benefits from government programs and insurance companies. I acknowledge failure to pay my financial obligations to Alliance Pain Center may result in the referral of my account to a professional collection agency. I consent to Alliance Pain Center to obtain a copy of my credit report or any other publicly available data related to my ability to pay. In the event of any dispute regarding payment, I agree to pay all collection costs or fees including but not limited to interest at the highest rate allowable under the law and attorneys' fees in the event legal action is taken.

PHONE AUTHORIZATIONS: You hereby grant permission and consent to us, our assignees, and third party collection agents: (1) to contact you by telephone at any telephone number associated with you, including wireless numbers; (2) to leave answering machine and voicemail messages for you, and include in any such messages information required by law (including debt collection laws) and/or regarding amounts owed by you; (3) to send you text messages; (4) to use prerecorded/artificial voice messages and/or an automatic dialing device in connection with any communications made to you or related to your account.

I understand that this agreement extends to any affiliated service providers for such services provided that may be separately from Alliance Pain Center including, but not limited to: radiology, laboratory, pathology, or any other and accept my responsibility to pay these in accordance with the payment terms set forth by those providers. I understand that I have the right to ask about costs before services are provided to me and that costs are deemed liquidated once the provider has prepared and sent the first invoice to me.

Patient Signature: ____________________________ Date: ____________________________
NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT

We are committed and required by law to preserve the privacy of your personal health information. We are to provide you with Notice describing how medical information about you may be used and disclosed and how you can access this information.

We may require your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your healthcare, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization. These reasons being, you are an inmate in a correctional institution, we are so required or authorized by law.

As our patient, you have important rights relating to the inspection and copying of your medical information that we maintain, amending or correcting that information, obtaining an account of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligation under the law. We may revise our Notice from time to time. The effective date at the bottom right hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice of your medical information, please contact the office manager at (360) 866-7990 ext. 104.

Please list the family members or other persons whom we may inform about your medical condition and your diagnosis (including treatment, payment, and health care operations).

Name_________________________ Relation____________________ Phone____________________

Name_________________________ Relation____________________ Phone____________________

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home. __________________________

All correspondence from our office will be sent in sealed, security envelope to the home address unless a different address is provided above.

Patient Name__________________________ (Guardian if under 18 years old)

Patient/ Guardian Signature__________________________ Date:____________________
PAYMENT POLICY AND ELECTIONS

We accept Cash, Credit/Debit and Checks for payments.

Payments for services you receive in which you are billed for are to be paid within 30 days from the receipt of your statement. A finance fee of 12% will be added to any balance not paid within the 30 days.

Insurance:

1. We accept and bill most insurance plans. Extent of coverage may vary with each plan. Please contact your insurance company or employer regarding the extent and limitations of coverage. Any balance that may occur after the payment from insurance(s) will be the patient's responsibility. This will include any balances from immunoassay and urine drug screen testing.

2. Your insurance contract requires that the CO-PAYMENT be paid in full at time of service. A charge of $15.00 dollars administrative fee will be added if we have to bill you for your co-payment.

3. State law requires insurance companies to process any single claim within sixty (60) days. If payment has not been received in sixty (60) days, you will be responsible for the amount.

4. It is the responsibility of the patient to call their insurance company and confirm that their insurance is "IN NETWORK" with our providers. It will be the patient's responsibility to pay any balance that may occur because of our providers not being "IN NETWORK" with your insurance plan.

5. You are responsible for handling any delays or disputes involving your Insurance company. Our office will provide any assistance when possible. We provide a prior authorization with insurances for appointments as a courtesy only. It is ultimately up to the patient and their responsibility to check with their insurance company to insure these prior authorizations have been done prior to your appointment. If they are not, the patient is responsible for the outstanding balance that may occur.

6. It is the patient responsibility to get referrals from their primary care physician when it is required by insurance.

Patient/Guardian Signature ________________________________ Date __________________

Miscellaneous:

1. A $100.00 charge will be billed for a New Patient Appointment, cancelled without 24 hours notice. Established patients will be charged $70.00. (This fee is not covered by any insurance carrier or State agency).

2. Patients may be discharged if they have 2 or more “no show” appointments.

3. All non sufficient fund checks returned will have a $40.00 administrative fee added.

4. Alliance Pain Center uses a certain laboratory for drug screen testing. Alliance Pain Center declares, one of the providers has partial ownership in its laboratory of preference. Patients are free to choose any lab of their choice. Please contact your insurance company to be sure our lab of choice is in network with your insurance. Samples are taken at every appointment and randomly sent to the laboratory.

5. Patients could be called in for random pill counts and urine drug screen testing with any inconsistencies in urine drug screen results, aberrant behaviors, changes in medications etc. Patients will be responsible for any remaining balances.

I have read the above policy agreement and understand my responsibilities for payment of services rendered.

Patient/Guardian Signature ________________________________ Date __________________
NEW PATIENT HEALTH INFORMATION

Patient Name: ________________________________

Height __________________ Weight __________________ Sex: Male / Female

How and when did your pain begin?

Work accident __________________________ Accident at home __________________________

Surgery ________________________________ Auto accident __________________________

Following illness ______________________ Pain just began __________________________

Other _________________________________

When did symptoms begin? ________________________________

Please briefly describe your main problem/complaint. ________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Please draw in the location of your symptoms using an X to indicate pain and O to indicate numbness:

[Diagram showing front and back of a human figure with areas labeled Right, Left, and X marks for pain and O marks for numbness]
We are interested in the types of thought and feelings that you have when you are in pain. Listed below are thirteen thoughts and feelings that may be associated with pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

<table>
<thead>
<tr>
<th>Thought</th>
<th>Not at all</th>
<th>To a slight degree</th>
<th>To a moderate degree</th>
<th>To a great degree</th>
<th>all the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>I worry all the time about whether the pain will end</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I feel I can't go on</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>It's terrible and I think it's never going to get any better</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>It's awful and I feel that it overwhelms me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I feel I can't stand it anymore</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I become afraid that the pain will get worse</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I keep thinking of other painful events</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I anxiously want the pain to go away</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I can't seem to keep it out of my mind</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I keep thinking about how much it hurts</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I keep thinking about how badly I want the pain to stop</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>There's nothing I can do to reduce the intensity of the pain</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I wonder whether something serious may happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
PAIN EVALUATION

Rate your average and highest pain level in the last 2 weeks. (Indicate by circling the number below). See following page for scoring scale.

0  1  2  3  4  5  6  7  8  9  10 average pain
0  1  2  3  4  5  6  7  8  9  10 highest pain

Please describe your pain (check all that apply):

Constant ( ) Aching ( ) Throbbing ( ) Burning ( ) Tingling ( )
Intermittent ( ) Stabbing ( ) Shooting ( ) Electrical ( ) Toothache ( )

How do these activities affect your pain:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Worsens</th>
<th>Improves</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standing for periods of time</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Sitting for periods of time</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Walking</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Bending forward</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Bending backwards</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Lying down</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Coughing</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Bowel movement</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Getting in/out of car</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Getting in/out of bathtub/shower</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Exercise</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Riding in car</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Driving</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Housework</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Lifting</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Reaching</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>other</td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>

If you have pain while standing, how long can you stand without pain?

If you have pain while walking how far can you walk without pain?

If you have pain while sitting, how long can you sit without pain?

Do you need support to help you walk? Yes / No If yes, what kind?

Have you been seen by other medical providers for your pain? Yes / No
If yes please list physicians, location, phone number and their specialty.

Have you ever been discharged from a providers office or treatment center? Yes / No If yes please explain why.

How many times have you been to the emergency room for your present pain?

Please list approximate dates of hospital visits, and treatment received:

Have you been seen at a Methadone Maintenance Clinic? Yes / No. If yes, please list when and where.
0-10 pain scale

10 "worst pain imaginable" Patient has passed out after screaming and writhing uncontrollably in pain. Ambulance is on the way or patient is already in hospital.

9 Patient is screaming out, writhing uncontrollably in pain unable to contain their pain driven actions. Generally unable to get out of bed or be moved due to severity of pain patient should be considering transport to hospital.

8 Patient is rocking and moaning. Inability to write or concentrate on conversation as all efforts is focused on containing pain reactions, sometimes unsuccessfully.

7 Patient is able to only minimally function to attend appointment. Patient does not dress beyond their bedroom attire or more than minimal attention to hygiene. Cannot work, shop or safely drive a vehicle.

6 Patient is in severe pain, able to attend to activities of daily living only (shower/bathe, dress, eat.) Patient is incapable of any other activities without significant assistance from others.

5 Patient has pain present which at times rises to a level that will temporarily require patient to stop what they are doing. Patient is able to contain pain behaviors; others are unaware or only minimally aware. Patient is able to attend to activities of daily living as well as activities of shopping, appointments without or with minimal assistance.

4 Patient has pain which is generally well controlled and interferes only after specific inciting trauma or participation in activities of an extended duration or physical nature. Patient is able to participate in all activities of daily living and self-care and work environment under appropriate circumstances. Patient may require modification in duration of participation in activities.

3 Patient is aware of pain but not to the extent that it interferes significantly with their ability to participate in most activities. Unless told other individuals would be unaware that individual has any pain issues.

2 Patient participates unrestricted in most activities. Patient will notice increased pain after participation in significant physical activity but pain remains bearable.

1 Patient has minimal awareness of pain throughout the day. Pain increases only minimally with extensive physical activity.

0 Patient has no pain

Pain rated at a level of 7 or higher will be considered for discontinuation of therapy based on ineffectiveness of opioids to control pain.
### MEDICATIONS TRIED

**Patient Name:**

<table>
<thead>
<tr>
<th>Medicine</th>
<th>YES</th>
<th>WHY STOPPED/SIDE EFFECTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ibuprofen/Naproxen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-Inflammatory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aleve/Advil</td>
<td></td>
<td></td>
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<tr>
<td>Tylenol</td>
<td></td>
<td></td>
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<tr>
<td>Gabapentin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lyrica</td>
<td></td>
<td></td>
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<tr>
<td>Cymbalta</td>
<td></td>
<td></td>
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<tr>
<td>Amitriptyline</td>
<td></td>
<td></td>
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<tr>
<td>Nortriptyline</td>
<td></td>
<td></td>
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<tr>
<td>Trazodone</td>
<td></td>
<td></td>
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<tr>
<td>Doxepin</td>
<td></td>
<td></td>
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<tr>
<td>Cyclobenzaprine</td>
<td></td>
<td></td>
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<tr>
<td>Methocarbamol</td>
<td></td>
<td></td>
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<tr>
<td>Baclofen</td>
<td></td>
<td></td>
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<tr>
<td>Tizanidine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codeine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydrocodone/Norco</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxycodone/Percocet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxycontin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nucynta</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MsContin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tramadol</td>
<td></td>
<td></td>
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<tr>
<td>Dilaudid</td>
<td></td>
<td></td>
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<tr>
<td>Hydromorphone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exalgo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methadone</td>
<td></td>
<td></td>
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<tr>
<td>Fentanyl</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opana</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxymorphone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Butrans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levorphanol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MENTAL HEALTH HISTORY

PATIENT NAME: ____________________________________________

Please check the box of any conditions that apply now or in the past and a brief description

Depression ( ) ____________________________________________
Anxiety ( ) ______________________________________________
Stress ( ) ________________________________________________
PTSD ( ) _________________________________________________
Suicide Attempt ( ) ________________________________________
Other Conditions ( ) _______________________________________

If you are currently being treated for any of the above, please provide your provider's name and number:
Provider Name: __________________________________________ Address: __________________________________________________
Phone Number: __________________________________________ Fax Number: ____________________________________________

SLEEP APNEA SCREENING QUESTIONNAIRE

Have you ever had a sleep study? Yes No
Were you diagnosed with Obstructive Sleep Apnea? Yes No
Are you currently using a CPAP device? Yes No
Have you been told (or noticed on your own) you snore most nights? Yes No
Have you been told (or noticed on your own) you stop breathing or struggle to breathe in your sleep? Yes No
Are you tired, fatigued, or sleepy on most days? Yes No
Do you have acid indigestion or high blood pressure (or use medication to control either of these conditions?) Yes No
Are you over your ideal body weight? Yes No
Do you have diabetes? Yes No
Have you ever been told you have any of the following:
Congestive heart failure? Yes No
Coronary artery disease? Yes No
### MEDICAL HISTORY

**Have you had any or currently had any of the following?**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>If yes, when?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Arthritis</td>
<td></td>
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<td></td>
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<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Emphysema</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy (seizure)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veneral Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Cholesterol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Attack</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnant Currently</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression:</td>
<td></td>
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<td>Anxiety:</td>
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<tr>
<td>PTSD:</td>
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</table>

**Have you had any nonfatal overdose hospitalizations?** Yes/No If yes please explain.

---

**Have you had any stool impactions requiring medical attention?** Yes/No If yes please explain.

---

**Other Medical problems, please explain**

---

**Blood Transfusions** Yes/No If yes/when?

---

### SOCIAL HISTORY

**Tobacco:** Yes/No If yes/packs per day _____ How many years?___ If stopped/ how many years?____________

**Alcohol Use:** Yes/No If yes how often?_______ How Much?___________ Last time you used alcohol?__________

**Other habits or drug use:** Yes/No If yes please explain:

---

**Marital Status:** single / married / widowed / divorced/ partner How Long?____________

**Children?** Yes/No If yes, how many?____________ Ages____________

---

Page 12
CURRENT MEDICATIONS

Please PRINT ALL information

Patient Name: ____________________________________________________________

List all medications, strengths, and frequency currently taking: (over the counter & prescribed)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

__________________________________________

Pharmacy Name: _________________________________________________________

Address: _____________________________________________________________ Phone: __________________

Patient Signature ______________________________________________________ Date __________
FAMILY HISTORY

Do any health problems run in your family? Yes / No  If Yes, please list: __________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Are there any family members on chronic opioid therapy? Yes / No

Father: Alive / Deceased  Current age:___  Age of Death:___ Cause of Death:____________________

Mother: Alive / Deceased  Current age:___  Age of Death:___ Cause of Death:____________________

Brothers: Alive / Deceased  Current age:___  Age of Death:___ Cause of Death:____________________
  Alive / Deceased  Current age:___  Age of Death:___ Cause of Death:____________________
  Alive / Deceased  Current age:___  Age of Death:___ Cause of Death:____________________
  Alive / Deceased  Current age:___  Age of Death:___ Cause of Death:____________________

Sisters:  Alive / Deceased  Current age:___  Age of Death:___ Cause of Death:____________________
  Alive / Deceased  Current age:___  Age of Death:___ Cause of Death:____________________
  Alive / Deceased  Current age:___  Age of Death:___ Cause of Death:____________________
  Alive / Deceased  Current age:___  Age of Death:___ Cause of Death:____________________
REVIEW OF SYSTEMS

PLEASE CHECK ALL THAT APPLY

Constitutional: ( ) Weight loss/gain ( ) Fatigue ( ) Poor Appetite ( ) Chills/Fever

Skin: ( ) Itching ( ) Hives ( ) Rash ( ) Non-healing sores

Eyes/Ears/Nose/Throat/Mouth: ( ) Hearing Loss ( ) Ringing Ears ( ) Blurred Vision
( ) Visual Change ( ) Glaucoma ( ) Nose Bleeds
( ) Chronic Sinus Problems ( ) Seasonal Allergies ( ) Dry/Sore Mouth

Respiratory: ( ) Recurrent Cough ( ) Bronchitis ( ) COPD/Emphysema ( ) Shortness of Breath

Cardiovascular: ( ) Chest Pain ( ) Passing Out ( ) Swelling of feet/Hands ( ) Poor Circulation

Endocrine: ( ) Weight gain ( ) Temperature Intolerance ( ) Excess Thirst ( ) Change in hair texture

Gastrointestinal: ( ) Nausea/Vomiting ( ) Constipation ( ) Heartburn ( ) Loss of Bowel Control

Genital/Urinary: ( ) Frequent Urination ( ) Loss of Control ( ) Burning ( ) Blood in Stool/Urine

Musculoskeletal: ( ) Muscle Cramps ( ) Stiffness ( ) Swelling of Joints ( ) Joint Pain ( ) Muscle Pain

Neurologic: ( ) Head Injury ( ) Memory Loss ( ) Paralysis ( ) Weakness ( ) Numbness

Hemo/Lymphatic: ( ) Swollen Glands ( ) Anemia ( ) Easy Bruising
PATIENT HEALTH QUESTIONNAIRE - PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle a number.

0 = Not at all    1 = Several Days    2 = More than half the days    3 = Nearly Every Day

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself, or that you are a failure and have let you and your family down
7. Trouble concentrating of things, such as reading or watching television
8. Moving or speaking slowly that other people could have noticed
9. Being so Fidgety or restless that you have been moving around a lot more than usual
10. Thoughts that you would be better off dead, or of hurting yourself in some way

If you answered 1 - 3 on any of the above, 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? Please Check one

( ) Not difficult at all     ( ) Somewhat difficult     ( ) Very Difficult     ( ) Extremely Difficult

Cage - Aid

1. Have you ever felt that you ought to cut down on your drinking?   Yes / No
2. Have you ever felt that you ought to cut down on your drug use?   Yes / No
3. Have you ever felt bad or guilty about your drinking?   Yes / No
4. Have you ever felt bad or guilty about your drug use?   Yes / No
5. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?   Yes / No
6. Have you ever used drugs first thing in the morning to steady your nerves or to get rid of a hangover?   Yes / No

Opioid Risk Tool

Please check each box that applies

1. Family History of Substance Abuse   ( ) Alcohol   Illegal Drugs ( )   ( ) Prescription Drugs
2. Personal History of Substance Abuse   ( ) Alcohol   Illegal Drugs ( )   ( ) Prescription Drugs
3. Age (mark box if between 16-45)   ( )
4. History of Preadolescent Sexual Abuse   ( )
5. Psychological Disease   ( ) Attention Deficit Disorder   ( ) Obsessive Compulsive Disorder   ( ) Bipolar
   ( ) Schizophrenia   ( ) Depression
BRIEF PAIN INVENTORY

Patient Name ___________________________ Date ___________________________

Please rate the following questions by circling 0 - 10. Zero being no pain and 10 being pain as bad as can be imagined.

1. Throughout our lives most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain? Yes / No

2. Please rate your pain that best describes it at its worst in the past 24 hours. 0 1 2 3 4 5 6 7 8 9 10

3. Please rate your pain that best describes it at its least in the past 24 hours. 0 1 2 3 4 5 6 7 8 9 10

4. Please rate your pain that best describes it on the average. 0 1 2 3 4 5 6 7 8 9 10

5. Please rate your pain that tells how much you have right now. 0 1 2 3 4 5 6 7 8 9 10

Please circle the one number from 0 - 10, zero being does not interfere to 10 being complete interference that best describes how, during the past 24 hours, pain has interfered with the following:

1. General Activity 0 1 2 3 4 5 6 7 8 9 10

2. Mood 0 1 2 3 4 5 6 7 8 9 10

3. Walking ability 0 1 2 3 4 5 6 7 8 9 10

4. Normal work (includes both work outside the home and housework) 0 1 2 3 4 5 6 7 8 9 10

5. Relations with other people 0 1 2 3 4 5 6 7 8 9 10

6. Sleep 0 1 2 3 4 5 6 7 8 9 10

7. Enjoyment of life 0 1 2 3 4 5 6 7 8 9 10

In the past 24 hours, how much relief have pain treatments or medications provided: Please circle the on percentage that most shows how much relief you have received, zero percent being no relief and 100% being complete relief:

0% 10 20 30 40 50 60 70 80 90 100%
SOAPP-R QUESTIONNAIRE

The following are some questions given to all patients at Alliance Pain 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 drug or alcohol problem? 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 medications? 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 in the past five years?
   (e.g., cocaine, heroin, methamphetamines) 0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

Patient Signature ___________________________ Date ___________________
Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking one box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply, but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1: Pain Intensity

— I have no pain at the moment
— The pain is very mild at the moment
— The pain is moderate at the moment
— The pain is fairly severe at the moment
— The pain is the worst imaginable at the moment

Section 2: Personal Care (eg, washing, dressing)

— I can look after myself normally without causing extra pain
— I can look after myself normally but it causes extra pain
— It is painful to look after myself and I am slow and careful
— I need some help but can manage most of my personal care
— I need help every day in most aspects of self-care
— I do not get dressed, wash with difficulty and stay in bed

Section 3: Walking*

— Pain does not prevent me walking any distance
— Pain prevents me from walking more than 1 mile
— Pain prevents me from walking more than 1/2 mile
— Pain prevents me from walking more than 100 yards
— I can only walk using a stick or crutches
— I am in bed most of the time

Section 5: Sitting

— I can sit in any chair as long as I like
— I can only sit in my favorite chair as long as I like
— Pain prevents me sitting more than 30 minutes
— Pain prevents me from sitting for more than 10 minutes
— Pain prevents me from sitting at all

Section 6: Standing

— I can stand as long as I want without extra pain
— I can stand as long as I want but it gives me extra pain
— Pain prevents me from standing for more than 1 hour
— Pain prevents me from standing for more than 30 minutes
— Pain prevents me from standing for more than 10 minutes
— Pain prevents me from standing at all

Section 7: Sleeping

— My sleep is never disturbed by pain
— My sleep is occasionally disturbed by pain
— Because of pain I have less than 6 hours sleep
— Because of pain I have less than 4 hours sleep
— Because of pain I have less than 2 hours sleep
— Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

— My sex life is normal and causes no extra pain
— My sex life is normal but causes some extra pain
— My sex life is nearly normal but is very painful
— My sex life is severely restricted by pain
— My sex life is nearly absent because of pain
— Pain prevents any sex life at all

Section 9: Social Life

— My social life is normal and gives me no extra pain
— My social life is normal but increases the degree of pain
— Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
— Pain has restricted my social life and I do not go out as often
— Pain has restricted my social life to my home
— I have no social life because of pain

Section 10: Traveling

— I can travel anywhere without pain
— I can travel anywhere but it gives me extra pain
— Pain is bad but I manage journeys over 2 hours
— Pain restricts me to journeys of less than 1 hour
— Pain restricts me to short necessary journeys under 30 minutes
— Pain prevents me from travelling except to receive treatment
TREATMENT INFORMATION

PATIENT NAME______________________________

Indicate which diagnosis test you have had for your pain, (please give dates if known):

MRI ( ) CT SCAN ( ) BONE SCAN ( ) MYELOGRAM ( )

X-RAY ( ) BIOPSY ( ) EMG/NCS ( )

OTHER____________________________________

Please indicate which treatments you have had for your present pain problems in the past.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Yes</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>Pool Therapy</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>Massage Therapy</td>
<td>( )</td>
<td></td>
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<tr>
<td>TENS Unit</td>
<td>( )</td>
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<tr>
<td>Chiropractic</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>Trigger Injections</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>Acupuncture</td>
<td>( )</td>
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<tr>
<td>Spinal Injections</td>
<td>( )</td>
<td></td>
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<tr>
<td>Facet Injections</td>
<td>( )</td>
<td></td>
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<tr>
<td>Burning of the nerves</td>
<td>( )</td>
<td></td>
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<tr>
<td>Spinal Stimulator</td>
<td>( )</td>
<td></td>
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<tr>
<td>Intrathecal Pain Pump</td>
<td>( )</td>
<td></td>
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<tr>
<td>Home Exercise</td>
<td>( )</td>
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</tr>
<tr>
<td>Surgery</td>
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<tr>
<td>Inpatient Rehab</td>
<td>( )</td>
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<tr>
<td>Cognitive Behavioral Therapy</td>
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</tbody>
</table>

Other_____________________________________________________________________

_______________________________________________________________________
Proper Disposal of Medication Education

When your medicines are no longer needed, they should be disposed of promptly. Consumers and caregivers should remove expired, unwanted, or unused medicines from their home as quickly as possible to help reduce the chance that others accidentally take or intentionally misuse the unneeded medicine, and to help reduce drugs from entering the environment.

Medicine take-back options are the preferred way to safely dispose of most types of unneeded medicines. There are generally two kinds of take-back options: periodic events and permanent collection sites. In your community, authorized permanent collection sites may be in retail pharmacies, hospital and law enforcement facilities. Our clinic offers a mail-back program to assist you in safely disposing of your unused pain medicines at a nominal fee.

If no take-back programs or DEA-registered collectors are available in your area, and there are no specific disposal instructions in the product package insert, you can also follow these simple steps to dispose of most medicines in the household trash:

- Mix medicines (do not crush tablets or capsules) with an unpalatable substance such as dirt, cat litter, or used coffee grounds;
- Place the mixture in a container such as a sealed plastic bag;
- Throw the container in your household trash; and
- Delete all personal information on the prescription label of empty pill bottles or medicine packaging, then dispose of the container.

Some medicines come with disposal instructions. If you received disposal instructions for a medicine, you should dispose of that medicine as directed by those instructions.

DO NOT flush your medications down the toilet or sink.

For more information refer to the following resource:

[https://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187.htm](https://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187.htm)

Information provided by FDA website October 31, 2018.
Non-Pharmacological Treatment Modalities

State of Washington requires we collect this information and provide education regarding proper disposal of medications pursuant to new opioid prescribing rules.

Please indicate which treatments you have had for your present pain problems in the last year:

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
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<tr>
<td>Cognitive Behavioral Therapy</td>
<td>(   )</td>
<td></td>
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<tr>
<td>Kinesio Tape</td>
<td>(   )</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

Proper Disposal of Medication Education

By signing below I am attesting to having received the education sheet regarding Proper Disposal of Medication Education related to unused medications and all my questions were answered.

Signature: ________________________________