Name: ______________________________ Date: ________________

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

How often do you have mood swings?

0 1 2 3 4

How often do you smoke a cigarette within an hour after you wake up?

0 1 2 3 4

How often have you taken medication other than the way it was prescribed?

0 1 2 3 4

How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past 5 years?

0 1 2 3 4

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

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ORTHOPAEDIC ASSOCIATES
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PATIENT NAME

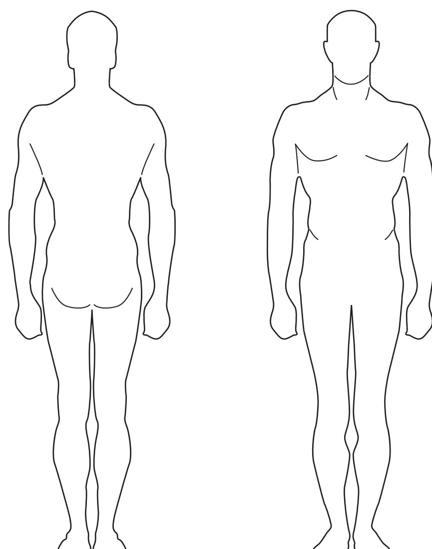
DATE OF BIRTH

REFERRING PHYSICIAN

Instructions to Patient:

Bring any relevant medical records, X-ray, MRI, or CT scan reports & images if you have them, a copy of your **current medication list with dosages and frequency**, as well as all of your **current medication bottles**, etc. Completing this pain inventory and following these suggestions will make your first visit with us smooth and productive.

Please complete the pain diagram, coloring your areas of pain. Be sure to show pain going down the arms or legs.



Tell Us About Your #1 Pain Problem

WHERE is the primary pain?

Was the onset of pain SUDDEN or GRADUAL? WHEN did the pain start?

What is your average pain score, where 0 = NO pain, and 10 = MOST SEVERE pain imaginable:

0 1 2 3 4 5 6 7 8 9 10

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Patient's Name

____

How do you describe the QUALITY of your pain?
spastic burning aching sharp shooting electrical throbbing

Does your pain radiate (travel) anywhere? (Where?)

____

Is this pain CONSTANT or INTERMITTENT?

____

What activities or positions INCREASE this pain?
walking, standing, sitting, exercise, work activities, motion of the head, other:

____

What activities or positions DECREASE this pain?
Rest, heat, ice, physical therapy, TENS, chiropractic, injections, medications, other:

____

Do you experience NEW problems with your BOWEL MOVEMENT or BLADDER FUNCTION?

____

Do you have DIFFICULTY WALKING, NUMBNESS, WEAKNESS, or BUTTOCK PAIN?

____

Have you had NECK (Cervical spine) or BACK (Lumbar spine, Thoracic spine) SURGERY?
SURGEON ____________________ PROCEDURE, DATE ____________________
SURGEON ____________________ PROCEDURE, DATE ____________________

What THERAPIES or INTERVENTION have you had for THIS PAIN problem? (circle)
X-RAYS, MRI, CAT Scan, EMG (needle testing of muscles), Nerve conduction study, Discogram, Myelogram,
Others: ____

Medical, Surgical, Family, Medication, and Social History

PAST MEDICAL HISTORY: Please tell us your most significant medical problems

____

PAST SURGICAL HISTORY: Please tell us your major surgical procedures & dates

____

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Cities Boulevard
Niceville, FL 32578*

Crestview
*5300 South Ferdon
Boulevard, Crestview,
FL 32536*

CONSENT FOR THE USE OF CONTROLLED SUBSTANCES OR CHRONIC OPIOID THERAPY

PATIENT:______________________________ DOB:_____________ MRN#______________

As a patient at Orthopaedic Associates, you may or may not be prescribed a controlled substance for short or long term pain management, including opioid medication, which is sometimes referred to as narcotic analgesics. Any decision to provide you with a controlled substance is not done lightly and the decision to provide you with a controlled substance has been made because your condition is serious or other treatments have not relieved your pain.

1. **Narcotics are drugs that act like opioids, or are similar to morphine.** Such drugs can include, but are not limited to, Lortab, Percocet, Demerol, Darcon, Ultram, and Tylenol #3. I am aware that I have been prescribed: ___________________________________ which is considered a narcotic medication. I fully understand the importance of taking this medication as prescribed. The risks, benefits, possible problems, and treatment alternatives related to my use of this medication have been thoroughly explained to me. My doctor has explained and discussed the risks, benefits, and possible problems with use of this controlled substance(s) which may include, but are not limited to, the risk of abuse, death, bodily harm to myself and others, physical dependence, overdose, symptoms of withdrawal, sedation, over-sedation, constipation, urinary retention, itching, and sweating.

2. **Risk of Abuse, Death, Physical Harm, Overdose, and Synergistic Effect of Other Medications**. I am aware that this drug is extremely dangerous; capable of being abused, and that an overdose can be lethal. I am also aware that when this drug is taken in excess, not as prescribed, or taken in combination with other medications, alcohol or other illegal drugs, I may put myself at great risk of harm including, but not limited to, the risk of death and respiratory depression. In other words, I may become sleepy, fall asleep, will be difficult or unable to arouse, and finally, will stop breathing. Therefore, by signing below, I agree to take the above-referenced medication as prescribed by this practice and only as advised by my physician. I also fully agree to inform this practice and my physician of any and all of my medications prescribed by any other physicians.

3. **Risk Physical Dependence and Withdrawal.** I am fully aware that this drug(s) can cause physical dependence. This means when you stop taking the drug you will experience a withdrawal reaction. A withdrawal reaction can be characterized by severe nausea, vomiting, diarrhea, abdominal pain, muscle aches, low-grade fever, tremor, rapid heart rate, sweating, and chills. Physical dependence is not the same as addiction. Physical dependence means that if you suddenly stop using the drug, you will develop a withdrawal reaction (nausea, diarrhea, sweats, shaky and flu-like symptoms). I understand that physical dependence can be a normal and expected result of using controlled substances or opioid therapy for a long time.

4. **Risk of Developing a Tolerance to the Controlled Substance.** I am aware that tolerance to analgesics is not necessarily a significant risk for patients with chronic pain; however, it is still a risk and may occur. If I develop a tolerance, increasing doses may not always help and may cause unacceptable side effects. If I develop a tolerance or fail to respond well to the controlled substance(s) which have been prescribed to me, it may cause my physician to choose or recommend another form of treatment.

5. **Risk of Addiction.** I am aware that physical dependence is different from addiction. Although the risk of addiction is low, I am aware that the risk of addiction is associated with many controlled substances. Addiction is a psychological diagnosis characterized by cravings for the drug, uncontrollable use of the drug even when it causes harm to you and/or others. I understand that if I develop signs or symptoms of addiction, or if I am at high risk for developing an addiction based upon my history, I will be referred to an addiction specialist or psychiatrist. Should I not agree to such a referral, I understand that I may be discharged from the practice.

6. **Other Side Effects and Risks.** There are numerous side effects which can occur as a consequence of the use of a controlled substance. These side effects include, but are not limited to:

   A. **Sedation.** If I experience this side effect, even slightly, I understand that I am not to be involved in any activity that may be dangerous to myself or someone else. Such activities include, the use of heavy equipment, operating a motor vehicle, working at unprotected heights or being responsible for another individual who is a minor or is unable to care for themselves. If confusion, mental changes, or excessive sleepiness occur, report this to your physician or present to the nearest hospital's emergency department immediately.

   B. **Constipation.** If this occurs you will not adapt to this effect. You should drink eight (8) eight-ounce glasses of water per day, take daily doses of Senokot S or Dulcolax, use milk of Magnesia no more than every third day for no bowel movement, and notify your physician that you are experiencing this complication. People over the age of 60 are especially at risk for this complication.

   C. **Urinary retention.** This means it is difficult to start your stream. Males over the age of 60 are especially at risk for this complication.

   D. **Itching.** These drugs can cause itching in some patients.

   E. **Sweating.** Profuse sweating can occur at any time with the use of these medications.

   F. **Nausea and vomiting.** If this occurs, notify your physician.

   G. **Decreased sex drive.** (See below for further details).

   H. **Mild suppression of the immune response.**

7. **MALES ONLY:** I am aware that the use of controlled substances has been associated with low testosterone levels in males. I am aware that this may affect my mood, stamina, and sexual desire, as well as physical and sexual performance. I understand that my physician may make a referral to a specialist for further evaluation should I develop any of these symptoms.

8. **FEMALES ONLY:** If I plan to become pregnant or believe that I have become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call this practice and my obstetrician/gynecologist. I am aware that, should I carry a baby to delivery while taking this medicine, the baby may be physically dependent on opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects, as birth defects can occur whether or not the mother is taking any opioids or medications, However, the risk of birth defects is always a possibility when I am taking an opioid or any other number of medications.

9. **Substance Abuse Agreement.** I understand that along with this consent, I am required to read and abide by the terms of the Substance Abuse Agreement and Protocol that is in place at this practice if I am to be maintained on any controlled substance for a significant length of time or as a treatment for chronic pain. Should I fail to adhere to the Substance Abuse Agreement, I understand that I will be discharged from this practice.

By signing below, I consent to receive the controlled substance(s) or chronic opioid therapy referenced above. I certify that I have read this consent or have had it read to me in a language that I understand; that I have had an opportunity to ask questions; that all my questions have been answered to my satisfaction; and that I knowingly and willingly give my consent to receive this medication and wish to proceed with the use thereof. I understand the risks, benefits, cautions, potential problems, and alternatives, and I give my full consent to receive this medication and understand that I must take the above-referenced medication as prescribed by my doctor.

______________________________ ______________________________

Patient Print Name Date

______________________________ ______________________________

Patient Signature Date

______________________________ ______________________________

Witness Signature Date

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SUBSTANCE ABUSE PROTOCOL AND AGREEMENT

PATIENT:___________________________ DOB:_______________ MRN#_______________

As a patient at Orthopaedic Associates, you may or may not be prescribed a controlled substance, including opioid medicine, sometimes called narcotic analgesics, for pain management. Any decision to provide you with a controlled substance is not done lightly and the decision to provide you with a controlled substance has been made because your condition is serious or other treatments have not relieved your pain. If you are prescribed a controlled substance, we ask that you agree to our controlled substance abuse protocol. If you will not accept our protocol, or fail to follow the terms of this substance abuse agreement, we cannot treat you and you will need to work with another physician.
Any violations of this protocol will result in immediate dismissal from our practice, as necessary.

Controlled substance medications (i.e. opioids, narcotic analgesics, tranquilizers, and barbiturates) are very useful; however, they have high potential for misuse and are therefore closely controlled by our office as well as local, state, and federal governments. They are intended to relieve pain, to improve function, and/or ability to work, not simply to feel good. By signing below, I acknowledge and agree to the following:

1. I will be prescribed a thirty (30) day supply of my medication(s) which will not be filled earlier than one (1) month.
2. I am responsible for my controlled substance medications. If my medication is lost, misplaced, stolen, or used sooner than prescribed, I understand that it will not be replaced.
3. I agree to provide copies of all my medical records from previous and concurrent physicians as requested.
4. I agree to provide a full and current medical history to my physician at Orthopaedic Associates, including any personal history and/or family history of substance abuse.
5. I agree to provide a full and current list of medications to my physician at Orthopaedic Associates and to any other physician who provides me with medical care or treatment.
6. I will not request or accept controlled substance medication from any other physician or individual while I am receiving medication from the physicians affiliated with Orthopaedic Associates.
7. I understand that my physician may have access to a record of the controlled substances prescribed to me through participation in E-FORCSE or through communication made directly to my physician by various pharmacies. If it is determined that I have received prescriptions from other physician(s) in violation of this agreement, or have attempted to obtain medications from multiple pharmacies improperly, I understand that I will be immediately discharged from this practice
8. My medication will be kept in a locked location in the original containers from the pharmacy for each medication.

9. If requested, I will bring the original containers of all medication prescribed to me, even if there is no medication remaining.
10. Refills of controlled substance medication will be made only during regular office hours, Monday through Friday, 8 am to 4 pm. Refills will not be made at night, on holidays, or weekends. I will call at least seventy-two (72) hours ahead if I need assistance with a controlled substance medication prescription. Refill calls made on Friday will be filled and addressed the following week.
11. Refills of controlled substance medications will not be made if I "run out early." I am responsible for taking medication in the dose prescribed and for keeping track of the amount remaining.
12. I understand that refills of my controlled substance medications will not be made as an "emergency," and that a follow-up visit to the office will likely be required for a refill. (i.e. on Friday afternoon because I suddenly realize I will "run out tomorrow").
13. I understand that no trustworthy physician-patient relationship can be present when a patient abuses illegal drugs. The use of "street drugs" such as marijuana, cocaine, amphetamines, etc. are dangerous and illegal in this state. I understand that mixing any of my medication prescribed for pain management with "street drugs," may be lethal. Therefore, use of any "street drugs" during the course of the physician-patient relationship will not be tolerated at this practice. I understand that discovery of my use of illegal "street drugs" will result in immediate dismissal from the practice.
14. I understand that I will be submitted to random drug screens during the course of my use of controlled substance medications. If my urine drug screen test is positive for any medication not prescribed as part of my pain management therapy by this practice, I will be discharged as a patient at the discretion of my physician.
15. Also, upon request from my physician, if narcotic abuse is suspected, I may be asked to submit to a urine drug screen. If I decline, it will be the sole discretion of Orthopaedic Associates to discontinue my narcotic pain medication or discharge me from the practice.
16. Under Florida law, I understand that I am obligated, at minimum, to follow-up with my physician at three (3) month intervals to assess my condition and treatment plan. I will attend these visits and understand that my failure to attend a follow-up appointment may result in my discharge from the practice, depending on the circumstances surrounding the scheduled visit.
17. I understand that I may be referred to an addiction specialist or psychiatrist, if indicated, during the course of my use of controlled substances. If I refuse such a referral or fail to follow through with a referral to an addiction specialist or psychiatrist, I will be discharged from the practice.
18. I understand that my physician may recommend alternative therapies and treatment modalities to treat my chronic pain in an effort to reduce or limit my long-term reliance on and/or tolerance to controlled substances. As a patient of this practice, I will remain open to these alternative treatment recommendations.

19. I also acknowledge that my physician may require diagnostic imaging studies during the course of my care, and I agree to obtain such studies as recommended by my physician. If I fail to follow any physician orders for such recommendations I understand that I may be discharged from the practice.
20. I understand that the main treatment goal is to improve my ability to function and/or work. 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 my doctor's instructions regarding my healthcare.

I have read this agreement. I understand that if I do not follow the rules of this agreement, I will no longer be able to obtain medications from Orthopaedic Associates. I understand that if I violate any of the rules or terms of this agreement, I will be discharged from the practice.

______________________________ ______________________________
Patient Print Name Date

______________________________ ______________________________
Patient Signature Date

______________________________ ______________________________
Employee Witness Date

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