IF YOU ARE A NEW PATIENT TO PAIN MEDICINE, please arrive 45 minutes before your scheduled appointment time to complete this paperwork or you may complete it ahead of time and bring it with you.

AUSTIN REGIONAL CLINIC

PAIN MEDICINE PATIENT INTAKE FORM

Name of Patient: _____ **Date:** _____

Pain Complaint: _____

CURRENT MEDICAL SYMPTOMS

(Please mark the items you are currently having problems with.)

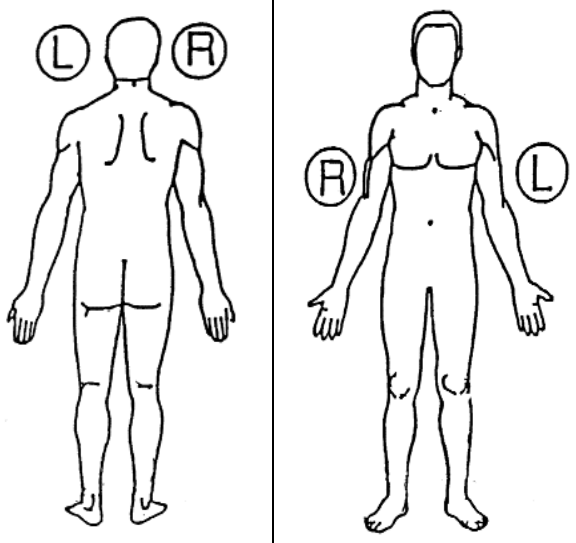
Constitution	Eyes	Gastrointestinal	Endo/Herme/Allergy
☐ Fever	☐ Blurred Vision	☐ Heartburn	☐ Easy Bruise/Bleed
☐ Chills	☐ Double Vision	☐ Nausea	☐ Environmental Allergies
☐ Weight Loss	☐ Light sensitivity	☐ Vomiting	☐ Excessive thirst
☐ Fatigue	☐ Eye Pain	☐ Abdominal Pain	**Neurological**
☐ Excessive Sweating	☐ Eye Discharge	☐ Diarrhea	☐ Dizziness
☐ Weakness	☐ Eye Redness	☐ Constipation	☐ Tingling
Skin	**Cardiovascular**	☐ Blood in Stool	☐ Tremor
☐ Rash	☐ Chest Pain	☐ Black stool	☐ Sensory Change
☐ Itching	☐ Rapid heart beat	**Genitourinary**	☐ Speech Change
Head/ENT	☐ Shortness of breath when lying down	☐ Painful urination	☐ Focal Weakness
☐ Headaches	☐ Leg discomfort in walking	☐ Sudden need to urinate	☐ Seizures
☐ Hearing loss	☐ Leg Swelling	☐ Frequency	☐ Loss of consciousness
☐ Ringing in ears	☐ Breathing difficulty at night while lying down	☐ Blood in urine	**Psychiatric**
☐ Ear Pain		☐ Pain in upper abdomen or back	☐ Depression
☐ Ear Discharge	**Respiratory**	**Musculoskeletal**	☐ Suicidal Ideas
☐ Nose bleeds	☐ Cough	☐ Muscle Pain	☐ Substance Abuse
☐ Congestion	☐ Coughing up blood	☐ Neck Pain	☐ Hallucinations
☐ High-pitch sound when breathing	☐ Excessive phlegm/mucus	☐ Back Pain	☐ Nervous/Anxious
	☐ Shortness of Breath	☐ Joint Pain	☐ Insomnia
☐ Sore throat	☐ Wheezing	☐ Falls	☐ Memory Loss

PLEASE RATE THE FOLLOWING

(please check)

Comfort Level:		
☐ Poor	☐ Fair	☐ Good
Functional Status:		
☐ Poor	☐ Fair	☐ Good
Since last visit, pain is:		
☐ Poor	☐ Fair	☐ Good

Where do you have pain? (Shade in the areas)



Date of last injection: _____ Where? _____ Percentage of Improvement? _____

Any new testing, radiology, doctor visits or hospital visits? ☐ Yes ☐ No If yes, please list: _____

_____

_____

Date of last physical therapy? _____

AUSTIN REGIONAL CLINIC

PAIN ASSESSMENT FORM

What is your average pain on a scale from 1-10 1 = No Pain - 10 = Worst Pain Imaginable										
What is your pain WITHOUT medication	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
What is your pain WITH medication	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Pain Location

☐ Abdomen	☐ Above shinbone	☐ Ankle	☐ Arm	☐ Back	☐ Belly Button	☐ Buttocks	☐ Chest	☐ Ear	☐ Elbow
☐ Finger	☐ Foot	☐ Generalized	☐ Groin	☐ Head	☐ Hip	☐ Incision	☐ Jaw	☐ Knee	☐ Leg
☐ Mouth	☐ Neck	☐ Nose	☐ Pelvis	☐ Rectum	☐ Rib Cage	☐ Sacrum	☐ Scrotum	☐ Shoulder	☐ Sternum
☐ Tailbone	☐ Throat	☐ Tibia	☐ Vagina	☐ Wrist	☐ Other:				

Pain Location Orientation

☐ Right ☐ Left ☐ Lower ☐ Mid ☐ Upper ☐ Other:

Pain Description

☐ Aching	☐ Burning	☐ Cramping	☐ Crushing	☐ Discomfort	☐ Dull
☐ Headache	☐ Heaviness	☐ Itching	☐ Jabbing	☐ Nagging	☐ Numbness
☐ Penetrating	☐ Pins & needles	☐ Pounding	☐ Pressure	☐ Radiating	☐ Sharp
☐ Shooting	☐ Sore	☐ Spasm	☐ Squeezing	☐ Stabbing	☐ Tender
☐ Throbbing	☐ Tightness	☐ Tingling	☐ Tiring	☐ Patient unable to tell	☐ Other

Pain Frequency

☐ Constant/Continuous ☐ Rarely ☐ Once a week ☐ Several days a week ☐ Intermittent ☐ Other: _____

Pain Onset	☐ Awaken from sleep ☐ Gradual ☐ Ongoing ☐ Progressive
Date Pain First Started	☐ Date
Pain Severity	☐ Mild ☐ Moderate ☐ Severe
What is pain level since your last visit	☐ No Change ☐ Gradually Worsening ☐ Gradually Improving ☐ Rapidly Worsening ☐ Rapidly Improving ☐ Resolved ☐ Other
Aggravating Factors	☐ Bending ☐ Stretching ☐ Straightening ☐ Exercise ☐ Kneeling ☐ Squatting ☐ Standing ☐ Walking ☐ Stairs ☐ Sitting ☐ Other:
Result of Injury	☐ Yes ☐ No
If yes, Date of Injury	☐ Date:
Work Related Injury?	☐ Yes ☐ No

Alleviating Factors

☐ Prescribed Medication	☐ Over the Counter Medication	☐ Heat Applied	☐ Cold Applied
☐ Repositioned	☐ Acupressure	☐ Acupuncture	☐ Ambulation/Increase
☐ Cutaneous Stimulator	☐ Declines	☐ Elevated	☐ Environmental Change
☐ Epidural Injection	☐ Herbal Therapy	☐ Massage	☐ Physical Therapy
☐ Relaxation Technique	☐ Rest	☐ Shower	☐ Splinting
☐ Tens	☐ Traction	☐ Warm Moist Pack	☐ Warm Pack
☐ Other			

Similar Problems in the Past?	☐ Yes ☐ No
Previous injury/surgery in this area?	☐ Yes ☐ No

Patient Signature: _____ Date: _____

AUSTIN REGIONAL CLINIC

PAIN MEDICINE NEW PATIENT HEALTH HISTORY

Current Primary Care Physician: _____ **Referred by:** _____

PATIENT INFORMATION

Name of patient: _____ Date of visit: _____

MRN: _____ Insurance: _____

Date of Birth: _____

HISTORY OF CHIEF COMPLAINT

1. What is the reason for your visit? _____

2. What is the exact location of your pain? _____

3. Please describe your pain. *(check all that apply)* ☐ Sharp ☐ Twisting ☐ Aching ☐ Dull ☐ Burning ☐ Pressure ☐ Other
4. How often do you have pain? _____
5. What makes your pain worse? _____
6. What makes your pain better? _____
7. Previous diagnosis for this pain? _____
8. Previous treatments for this pain? _____
9. Do you have numbness, tingling or weakness in arms/legs? ☐ Yes ☐ No

   If yes, please describe: _____
10. Do you had any changes in bowel or bladder function? ☐ Yes ☐ No

    If yes, please describe: _____
11. On a scale of 1-10, *10 being the worse*, how would you rate your pain? *(please circle one)*

1 2 3 4 5 6 7 8 9 10

PAST SURGICAL HISTORY

Surgery	Details	Date & Hospital
Back Surgery		
Breast		
Gallbladder		
Hernia Repair		
Hysterectomy/Ovaries		
Tonsillectomy		
Stomach/Ulcer		
Other		

AUSTIN REGIONAL CLINIC

PAIN MEDICINE HEALTH HISTORY
(HISTORIA DE SALUD DE MEDICINA DEL DOLOR)

First Name (Nombre):	**NOTE:** This form provides information about your healthcare history, is confidential, and part of your medical record. If you do not understand a question or word, please ask for assistance. *(Este formulario proporciona información sobre su historial médico, es confidencial, y es parte de su archivo médico. Si usted no entiende alguna pregunta o alguna palabra, por favor pida ayuda.)*
Last Name (Apellido):	
Primary Care Doctor/Provider (Médico de atención primaria):	**Race/Ethnicity** (Raza/Etnicidad)**:** / **Preferred Language** (Idioma Preferido)**:**

MEDICAL HISTORY (HISTORIAL MÉDICO)

Diagnosis (Diagnóstico)	Yes (Sí)	No	Diagnosis (Diagnóstico)	Yes (Sí)	No	Diagnosis (Diagnóstico)	Yes (Sí)	No
Alcoholism (Alcoholismo)			**Asthma** (Asma)			**Bipolar disorder** (El trastorno bipolar)		
Blood thinners (Anticoagulantes)			**Cancer (type)** (Cáncer - tipo)			**Congestive Heart Failure** (Insuficiencia Cardíaca Congestiva)		
COPD (EPOC – enfermedad pulmonar crónica)			**Coronary artery disease** (Enfermedad de la arteria coronaria)			**Degenerative Changes – Cervical** (Cambios degenerativos – Cervical)		
Degenerative Changes – Lumbosacral (Cambios degenerativos – Lumbosacra)			**Degenerative Changes – Thoracic** (Cambios degenerativos – Torácica)			**Depression** (Depresión)		
Diabetes mellitus (Diabetes mellitus)			**Fibromyalgia** (Fibromialgia)			**Headaches** (Dolores de cabeza)		
Heart Disease (Enfermedad del corazón)			**HIV/AIDS** (VIH/SIDA)			**Hypertension** – high blood pressure (Alta presión arterial)		
Kidney disease (Enfermedad del riñon)			**Multiple sclerosis** (La esclerosis multiple)			**Neuropathy** (Neuropatía)		
Osteoarthritis (Osteoarthritis)			**Rheumatoid Arthritis** (La artritis reumatoide)			**Scoliosis** (Escoliosis)		
Seizures (Convulciones)			**Shingles** (Culebrilla)			**Stroke** (Derrame cerebral)		
Substance abuse (El abuso de sustancias)			**Trigeminal neuralgia** (La neuralgia del trigémino)					

Other medical history (Otro historial medico):

SURGICAL HISTORY (ANTECEDENTES QUIRÚRGICO)

Diagnosis (Diagnóstico)	Yes (Sí)	No	Diagnosis (Diagnóstico)	Yes (Sí)	No	Diagnosis (Diagnóstico)	Yes (Sí)	No
Appendectomy (Apendectomía)			**Back surgery** (Cirugía de la espalda)			**Brain Surgery** (Cirugía cerebral)		
Breast Surgery (Cirugía de mama)			**Carpal tunnel release** (La liberación del túnel carpiano)			**Colon surgery** (Cirugía del colon)		
Epidural block (El bloqueo epidural)			**Fracture Surgery** (Cirugía por fractura)			**Heart surgery** (Cirugía de corazón)		
Hernia repair (Reparación de la hernia)			**Hysterectomy** (Histerectomía)			**Joint replacement** (Cirugía de reemplazo articular)		
Kidney transplant (Trasplante de riñón)			**Laminectomy** (Laminectomía)			**Lung Surgery** (Cirugía de pulmón)		
Mastectomy (Mastectomía)			**Neck surgery** (Cirugía del cuello)			**Spine stimulator** (Columna estimulador)		
Trigger point injections (Inyección en el punto gatillo)			**Vascular surgery** (Cirugía vascular)			**Vertebroplasty** (Vertebroplastia)		

Other surgical history (Otro historial de cirugía):

FAMILY HISTORY (ANTECEDENTES FAMILIARES)

Adopted (Adoptado/a) ☐

Relationship (Relación)	Alcohol/Drug (Alcohol/Drogas)	Arthritis (Artritis)	Asthma (Asma)	Cancer (Cáncer)	COPD (EPOC –enfermedad pulmonar crónica)	Depression (Depresión)	Diabetes (Diabetes)	Drug abuse (Abuso de Drogas)	Early death (Muerte Temprana)	Hearing loss (Pérdida Auditiva)	Heart Disease (enfermedad del corazón)	High Cholesterol (Hiperlipidemia)	High Blood Pressure (Alta presión arterial)	Kidney disease (Enfermedad del riñon)	Stroke (Derrame cerebral)						
Mother (Madre)																					
Father (Padre)																					
Sister (Hermana)																					

FAMILY HISTORY (ANTECEDENTES FAMILIARES) *cont.*

Relationship (Relación)	Alcohol/Drug (Alcohol/Drogas)	Arthritis (Artritis)	Asthma (Asma)	Cancer (Cáncer)	COPD (EPOC–enfermedad pulmonar crónica)	Depression (Depresión)	Diabetes (Diabetes)	Drug abuse (Abuso de Drogas)	Early death (Muerte Temprana)	Hearing loss (Pérdida Auditiva)	Heart Disease (enfermedad del corazón)	High Cholesterol (Hiperlipidemia)	High Blood Pressure (Alta presión arterial)	Kidney disease (Enfermedad del riñon)	Stroke (Derrame cerebral)						
Brother (Hermano)																					
Maternal Aunt (Tía Materna)																					
Maternal Uncle (Tío Materno)																					
Paternal Aunt (Tia Paterna)																					
Paternal Uncle (Tío Paterno)																					
Maternal Grandmother (Abuela Materna)																					
Maternal Grandfather (Abuelo Materno)																					
Paternal Grandmother (Abuela Paterna)																					
Paternal Grandfather (Abuelo Paterno)																					
Additional Relatives (Parientes Adicionales):																					

SOCIAL HISTORY (HISTORIA SOCIAL)

Tobacco Use (Uso del Tabaco): ☐ **Yes** (Sí) ☐ **No** **Packs per day** (Paquetes por día): ☐ **.25** ☐ **.5** ☐ **1** ☐ **1.5** ☐ **2** ☐ **3** ☐ _____

Years of use (Años de uso): ☐ **.5** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **10** ☐ **15** ☐ ____ **Quit date** (mm/dd/yyyy): _____ (Fecha de cuando dejó de usarlo - mm/dd/año)

Smokeless Tobacco (Tabaco sin humo/de mascar): ☐ **Yes** (Sí) ☐ **No** **Quit date** (mm/dd/yyyy): _____ (Fecha de cuando dejó de usarlo - mm/dd/año)

Ready to Quit (Listo para dejar de usar el tabaco) ☐ **Yes** (Sí) ☐ **No**

Comment (Comentario):

Alcohol Use (Uso de Alcohol): ☐ **Yes** (Sí) ☐ **No** **Comment** (Comentario):

Drinks/Week: (Bebidas/Semana)

_____ **glasses of wine** (copas de vino)

_____ **cans of beer** (latas/botes de cerveza)

_____ **shots of liquor** (tragos de licor)

_____ **drinks containing 0.5 oz of alcohol** (bebidas con un contenido de 0.5 onzas de alcohol)

Alcohol/Week (Alcohol/Semana):

Drug Use (Uso de Drogas): ☐ **Yes** (Sí) ☐ **No** **Comment:** (Comentario)

Use/Week: (Uso/Semana) _____

Types: (Tipo)

- ☐ "Crack" cocaine
- ☐ Hashish
- ☐ Marijuana
- ☐ Morphine
- ☐ Solvent inhalants
- ☐ Amphetamines
- ☐ Cocaine
- ☐ Heroin
- ☐ MDMA (Ecstacy)
- ☐ Nitrous oxide
- ☐ Other _____
- ☐ Anabolic steroids
- ☐ Fentanyl
- ☐ Hydromorphone
- ☐ Methamphetamines
- ☐ Oxycodone
- ☐ Barbituates
- ☐ Flunitrazepam
- ☐ Ketamine
- ☐ Methaqualone
- ☐ PCP
- ☐ Benzodiazepines
- ☐ GHB
- ☐ LSD
- ☐ Methylphenidate
- ☐ Psilocybin

Sexual Activity (Actividad Sexual): ☐ **Yes** (Sí) ☐ **No** ☐ **Not Currently** (No Actualmente) **Comment** (comentario):

Partners (Compañero/a (s); Pareja): ☐ **Male** (Hombre) ☐ **Female** (Mujer)

Birth Control / Protection: (Método Anticonceptivo/Protección)

- ☐ **Abstinence** (Abstinencia)
- ☐ **Coitus interruptus** (Coito interrumpido)
- ☐ **Condom** (Condón)
- ☐ **Diaphragm** (Diafragma)
- ☐ **Implant** (Implante)
- ☐ **Injection** (Inyección)
- ☐ **Inserts** (Cápsulas anticonceptivas vaginales)
- ☐ **IUD** (dispositivo intrauterino)
- ☐ **OCP** (Píldora anticonceptiva oral)
- ☐ **Patch** (Parche)
- ☐ **Post-menopausal** (posmenopausea)
- ☐ **Rhythm** (Ritmo)
- ☐ **Spermicide** (un espermicida)
- ☐ **Sponge** (Esponja)
- ☐ **Surgical** (cirugia)
- ☐ **Other** (otro)
- ☐ **None** (nada)

AUSTIN REGIONAL CLINIC

PATIENT INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT AS REQUIRED BY THE TEXAS MEDICAL BOARD
REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

3rd Edition: Developed by the Texas Pain Society, April 2008 *(www.texaspain.org)* **

Name of Patient _____ Date _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

Additional risks and altrnatives *(to be filled out by physician as necessary)*:

_____

_____

****For female patients only:**

- To the best of my knowledge I am **NOT** pregnant.
- If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment.
- I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.
- **** If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.**

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/fetus/baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS

USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

PAIN MEDICINE AGREEMENT:

****I UNDERSTAND AND AGREE TO THE FOLLOWING:**

That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

****My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:**

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the ****medication(s) may be discontinued.**
- I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician.**
- I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- **** I will not allow or assist in the misuse/diversion of my medication; nor will I give or sell them to anyone else.**
- All medication(s) must be obtained at **one pharmacy, where possible.** Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. **If either are lost or stolen, they may NOT BE REPLACED.**
- Refill(s) **will not be ordered before the scheduled refill date.** However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s).** I will not hold my physician liable for problems caused by the discontinuance of medication(s).

- **I agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.
- I agree that **I shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

**** I CERTIFY AND AGREE TO THE FOLLOWING:**

1. I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

2. I have never been involved in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

3. No guarantee or assurance has been made as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

4. I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.

I have read or had read to me the contents of this form. I understand the risks and alternatives of this procedure; I have had the opportunity to ask any questions about this treatment.

Signature of Patient	Signature of Physician
Signature of Parent or Legally Responsible Person	Signature of Witness
Relationship	Primary Care Physician
Date	