ADMISSION

INTRACTABLE PAIN PROGRAM

INSTRUCTIONS TO PATIENT:
Please complete this form to apply to our intractable pain program.
USE BLACK INK ONLY!

I. BASIC DATA

Patient's Name_____ Today's Date_____
Last *First*

Address_____ Phone Number_____

City_____ State_____ Zip_____

Name of Emergency Contact_____ Phone Number_____

Address_____

Age_____ Employed? □ Yes □ No Marital Status_____ No. Years Education_____

How will payment for service be made? _____

II. REFERRING PHYSICIAN

Name of Emergency Physician_____ Phone Number_____

Address_____

City_____ State_____ Zip_____

III. REASON FOR INTRACTABLE PAIN

List the specific cause(s) of your intractable pain

1._____
2._____
3._____

IV. INTRACTABLE PAIN MEDICINES ─OPIOID

List the main opioid, narcotic, or pain reliever which you currently take for your intractable pain:

_____

Do you believe you are addicted or dependent on it? (check) □ Yes □ No □ Don't Know

What is your dosage: _____mg

How many do you take a day?_____

V. DESCRIPTION OF INTRACTABLE PAIN

A. Location of intractable pain on body_____

B. How long does it last?_____

C. Intensity (dull, sharp, aching)_____

D. Does intractable pain lessen or increase when you push on the painful spots?_____

E. Time of day you usually have intractable pain?_____

F. List everything that causes your intractable pain to worsen (stress, food, rest, exercise, etc.)

_____

_____

G. List everything that makes your intractable pain better (pressure, rest, exercise, heat, medication, etc.)

_____

_____

H. Are you currently involved in litigation or lawsuit related to your intractable pain? Yes No

If yes, which type (check:

□ Worker's Compensation □ Malpractice □ Personal Injury □ Other

VI. CURRENT TREATMENTS AND MEDICATIONS

A. Check all the opioid medications that you have taken in the past week:

□ Fentanyl	□ Morphine	□ Codeine Compounds
□ Hydromorphone	□ Oxycodone	□ Methadone
□ Hydrocodone	□ Oxymorphone	□ Meperidine

□ Other_____

B. List all other medications, including antidepressants, anti-inflammatories, and nerve agents.

Name of Drug

1._____ _____

2._____

3._____ _____

4._____

5._____

6._____ _____

7._____ _____

C. Besides medications, list all the things you have done to help your intractable pain in the past week (Check all that apply):

□ Brace □ Rest □ Crutches/Cane □ Exercise □ Physical Therapy
□ Massage □ Heat □ Other (List)_____

D. Is there anyone living in your household, including spouse, parents, children, siblings, or friend:

1. Who is: (check all that apply)

   □ A heroin addict □ An alcoholic
   □ A cocaine addict □ A marijuana addict

2. Who takes any of the opioids listed in Question VI. A. above?

   a. If so, who?_____

   b. Why?_____

   a. What opioid?_____

VI. PAST HISTORY

A. When did your intractable pain begin?_____

B. What caused your intractable pain to begin? (If accident or injury, describe detail)_____

_____

_____

_____

_____

_____

C. Have you ever been operated on for your intractable pain problem? □ Yes □ No

1. If yes, how many times?_____
2. Describe your surgery:_____
3. List all surgeries you have had before:_____

   a. _____

   b._____

   c._____

D. Drugs Previously Taken for Intractable Pain

INSTRUCTIONS TO PATIENT:
You are to review all the drugs below. We need to know whether you have ever taken the drug and whether it helped your intractable pain.

	Have you Taken		How Effective In Reducing Intractable Pain? (Check One)				Have you Taken		How Effective In Reducing Intractable Pain? (Check One)		
Drug	**Yes**	**No**	**A Little**	**A Lot**	**No Help**	**Drug**	**Yes**	**No**	**A Little**	**A Lot**	**No Help**
Xanax®						Naprosyn®					
Lexapro®						Oxycodone®					
Baclofen®						Percocet®					
Tramadol®						Percodan®					
Clonidine						Prednisone					
Codeine						Ritalin®					
Cortisone						Robaxin®					
Opana®						Exalgos®					
Demerol®						Soma®					
Dilaudid®						Cymbalta®					
Norco®						Adderall®					
Duragesic® Patch						Tegrotol®					
Ellavil®						Dextroamphetamine					
Flexeril®						Neurontin®					
Suboxone®						Actiq®					
Nucynta®						Fentora®					
Halcion®						Ativan®					
Lortab®						Valium®					
Methadone						Vicodin®					
Morphine						Vistaril®					
Motrin®						Zoloft®					
Lyrica®						Other (List)					

E. List all the non-medical treatments you have taken for your intractable pain:(check all that apply)

Treatment	Did it work?		
□ Acupuncture	□ Yes	□ No	□ A Little
□ Physical Therapy	□ Yes	□ No	□ A Little
□ Electrical Stimulation (TENS)	□ Yes	□ No	□ A Little
□ Injection-Cortisone	□ Yes	□ No	□ A Little
□ Deconditioning/Psychologic	□ Yes	□ No	□ A Little
□ Mental	□ Yes	□ No	□ A Little
□ Exercise	□ Yes	□ No	□ A Little
□ Nerve Block	□ Yes	□ No	□ A Little
□ Ultrasound	□ Yes	□ No	□ A Little
□ Other (List)			
_____	□ Yes	□ No	□ A Little
_____	□ Yes	□ No	□ A Little
_____	□ Yes	□ No	□ A Little

F. Have you been or are you any of the following:

Heroin Addict	□ Yes	□ No
Methadone Patient	□ Yes	□ No
Cocaine Addict	□ Yes	□ No

G. Do you currently, or have you in the past, used any or the following:

Cocaine	□ Yes	□ No
Marijuana	□ Yes	□ No
PCP	□ Yes	□ No
Methamphetamine	□ Yes	□ No
Heroin	□ Yes	□ No

VII. INTRACTABLE PAIN TREAMENT DESIRED

A. List all of your current medications that you want to continue taking:

_____ _____

_____ _____

B. List any medication you would like to try:

_____ _____

C. List all the non-drug treatments you would like to try at this time: (check all that apply)

□ Stretching □ Weight Lifting □ Topical Medication □ Cortisone Injection

□ Ultrasound □ Other (list)_____

VIII. ANCILLARY MEDICAL HISTORY

A. Besides your intractable pain problem, do you, to your knowledge, have any other medical condition?

If so, what:_____

_____

B. Do you have any of the following conditions? (check all that apply)

□ Alcohol Abuse	□ Cancer	□ Cigarette Use	□ High Blood Pressure
□ Insomnia	□ Alcohol Abuse	□ Mental Problems	□ Kidney Disease
□ Diabetes	□ Drug Abuse	□ Lung Problems	□ Heart Disease

□ Females: Gynecologic Problem

C. Are you currently attending any other physician or clinics: (If so, list)

Name of Clinic or Doctor	Purpose	List Medications and Treatment Given
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. List two hospitals, clinics, or doctors where we may obtain records relative to your intractable pain problem:

1. Name_____ 2. Name_____

Address_____ Address_____

Phone_____ Phone_____

E. From which pharmacy will you obtain any medication prescribed to you by our clinic?

Name_____

Address_____
Street City State Zip

Phone_____

IX. CONSENT

A. I, the undersigned, request opioid treatment for my intractable pain problem at Veract Intractable Pain Medical Clinic. I understand that the Veract Intractable Pain Clinic only provides outpatient care.

B. I full understand that completion of this form does not guarantee that I will be accepted as a patient at Veract Intractable Pain Medical Clinic. I am aware that my acceptance will be based on a review of my case after 4 monthly visits as to whether the program is suitable for me.

C. In the event my case is not accepted, I understand it will be because I am ineligible for intractable pain treatment or that the clinic believes they are not qualified to treat my case.

D. It is understood that during my 4 month assessment and evaluation period, the clinic reserves the right to reject my application.

E. I give my permission to send a report and give all information about my case to my referring physician and pharmacist.

F. I fully understand that my acceptance in this program is done with the full understanding that I will follow all the rules and agree to all the stipulations in the clinic's consent form. I understand that I will be discharged from this program if I do not follow the rules.

G. I understand that all fees are due in advance and that there are no refunds. I fully understand that worker's compensation, insurance, and government programs will not pay the full cost of intractable pain treatment and that I agree to make up the difference.

H. I understand that the Veract Intractable Pain Medical Clinic is only for Intractable Pain Care and the clinic's doctor is not my primary care doctor. I have a primary care medical provider or doctor who will do my general medical care including any hospitalization that I may require.

Patient's Signature_____ Today's Date_____

I assisted the patient in completing this form, and I attest to the truthfulness and accuracy of all questions. Furthermore, I agree to all the rules of the program.

Name_____ Today's Date_____

Relationship to Patient_____

Address_____

Street City State Zip

Phone_____