Ross E. Vogelgesang, M.D
James C. Fleming, M.D
Erin Henderson, ARNP
Kei Batangan PA-C

Please remit to:
P.O.BOX 11789
Olympia, WA 98508

Physical Address:
3240 14th Ave N.W.
Olympia, WA 98502

www.alliancepain.com
Phone: (360) 866-7990
Fax: (360) 866-4577

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 truly care 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. 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 so that we have the information to best care for you. 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 other current photo I.D., your insurance card(s), 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. A provider at Alliance Pain Center will discuss a treatment plan for you.

Behavior Expectations: We at APC will always strive to be professional and understanding. However, we are intolerant of abusive behavior or sexual harassment. Please do not yell, threaten, demand, disrespect, nor condescending behaviors with staff.

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.

Sincerely,
Karyl Woodward
Office Manager

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 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	☐	**Web MD**	☐
Internet (Web Page)	☐	**Google Search**	☐
Facebook	☐	**Newspaper**	☐
Yelp	☐	**A friend or relative**	☐
Other, please explain	☐		

Insurance Information

Is the pain you are experiencing from a work related injury? ☐**Yes** ☐**No** **If yes**, Date of work injury_____
Do you currently have an open Labor of Industries claim? ☐ Yes ☐ No
Have you in the past had a Labor and Industries claim? ☐Yes ☐ No If yes, Date claim was closed or pensioned_____

Please leave detail information about your L&I claim current or in the past please list who the claim is through, claim number, claim manager and phone number:

_____
_____

Is the pain you are experiencing from a auto accident injury? ☐**Yes** ☐**No** **If yes**, Date of auto accident_____
Do you currently have an open auto claim? ☐ Yes ☐ No Have you in the past had an auto claim? ☐Yes ☐ No

Please list in detail about current or past motor vehicle accident claim 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:_____

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 serviced 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 bill 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 Signautre_____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. For example: you are an inmate in a correctional institution, we are required by law to provide your healthcare information.

As our patient, you have important rights relating to the inspection and copying of your medical information that we maintain to include: amend or correct 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 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 to meet changes in federal and state laws. 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 would like 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 Karyl, 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_____

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 another means is worked out with the office manager.

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 are now accepted through our website www.alliancepain.com, mailed into P.O.Box 11789 Olympia, WA 98508, our front desk at time of service, and or through calling The Billing Office at 360-491-5055

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 varies with your individual plan. Please contact your insurance company or employer regarding the extent and limitations of coverage. Any balance that may occur after insurance(s) is the patient's responsibility. This will include any balances from immunoassay and urine drug screen testing which are expected for patients on controlled substances.

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. Please be prepared to pay this at time of service.

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. You may need to contact your health insurance for reimbursement yourself.

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. We can help answer these questions.

5. You are responsible for handling any delays or disputes involving your Insurance Company. Our office will provide 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 ensure these prior authorizations have been completed prior to your appointment. If they are not completed, 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. "No Show Policy": No show is one who does not show for scheduled appointment time and fail to provide 24 hours notice. A **$300.00 charge for "No Show"** will be billed for a New Patient Appointment and will be paid prior to making a new appointment. Established patients will be charged **$100.00 for "No Show" office visits** and **$250.00 for "No Show" procedure appointments.** (This fee is not covered by any insurance carrier or state agency). Patients may be discharged if they have 2 or more "no show" appointments.

2. All non-sufficient fund checks will have **a $40.00** administrative fee added.

3. 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 ensure our lab of choice is in network with your insurance. Samples are taken intermittently and sent to the laboratory.

4. Patients can be called in for pill counts and urine drug screen testing for any inconsistencies in urine drug screen results, aberrant behaviors, changes in medications, randomly, etc. Patients will have 24 hours to respond.

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?_____

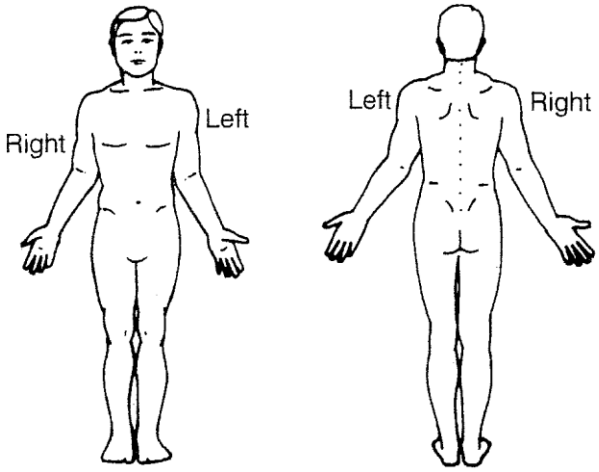
Please briefly describe your main problem/complaint._____

_____

_____

_____

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



MEDICAL HISTORY

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

Hepatitis	Yes☐	No☐	If yes, when?_____
Anemia	Yes☐	No☐	If yes, when?_____
Arthritis	Yes☐	No☐	If yes, when? _____
Asthma	Yes☐	No☐	If yes, when? _____
Cancer	Yes☐	No☐	If yes, when? _____ What type? _____
Emphysema	Yes☐	No☐	If yes, when? _____
Diabetes	Yes☐	No☐	If yes, When? _____
Epilepsy (seizure)	Yes☐	No☐	If yes, when? _____
Venereal Disease	Yes☐	No☐	Type? _____When?_____
High Blood Pressure	Yes☐	No☐	If yes, when? _____
High Cholesterol	Yes☐	No☐	If yes, when? _____
Heart Attack	Yes☐	No☐	If yes, when? _____
Kidney Disease	Yes☐	No☐	If yes, when? _____
Pregnant Currently	Yes☐	No☐	If yes, due date? _____
Stroke	Yes☐	No☐	If yes, when? _____
Depression:	Yes☐	No☐	If yes, how long?_____
Anxiety:	Yes☐	No☐	If yes, how long?_____
PTSD:	Yes☐	No☐	If yes, how long?_____

-

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?_____

Surgeries: 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:_____

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:_____

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 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_____

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_____

Allergies: _____

_____

_____

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.

PAIN EVALUATION

Patient name_____

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:	**Worsens**	**Improves**
Standing for periods of time_____	☐	☐
Sitting for periods of time_____	☐	☐
Walking_____	☐	☐
Bending forward_____	☐	☐
Bending backwards_____	☐	☐
Lying down_____	☐	☐
Coughing_____	☐	☐
Bowel movement_____	☐	☐
Getting in/out of car_____	☐	☐
Getting in/out of bathtub/shower_____	☐	☐
Exercise_____	☐	☐
Riding in car_____	☐	☐
Driving_____	☐	☐
Housework_____	☐	☐
Lifting_____	☐	☐
Reaching_____	☐	☐
other_____	☐	☐

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 provider's 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.

_____

_____

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.

	Yes	DATE
Physical Therapy	☐	_____
Pool Therapy	☐	_____
Massage Therapy	☐	_____
TENS Unit	☐	_____
Chiropractic	☐	_____
Trigger Injections	☐	_____
Acupuncture	☐	_____
Spinal Injections	☐	_____
Facet Injections	☐	_____
Burning of the nerves	☐	_____
Spinal Stimulator	☐	_____
Intrathecal Pain Pump	☐	_____
Home Exercise	☐	_____
Surgery	☐	_____
Inpatient Rehab	☐	_____
Cognitive Behavioral Therapy	☐	_____

Other_____
_____
_____

MEDICATIONS TRIED

Patient Name: _____

	YES	WHY STOPPED/SIDE EFFECTS
Ibuprofen/Naproxen	☐	
Anti-Inflammatory	☐	
Aleve/Advil	☐	
Tylenol	☐	
Gabapentin	☐	
Lyrica	☐	
Cymbalta	☐	
Amitriptyline	☐	
Nortriptyline	☐	
Trazodone	☐	
Doxepin	☐	
Cyclobenzaprine	☐	
Methocarbamol	☐	
Baclofen	☐	
Tizanidine	☐	
Codeine	☐	
Hydrocodone/Norco	☐	
Oxycodone/Percocet	☐	
Oxycontin	☐	
Nucynta	☐	
MsContin	☐	
Morphine	☐	
Tramadol	☐	
Dilaudid	☐	
Hydromorphone	☐	
Exalgo	☐	
Methadone	☐	
Fentanyl	☐	
Opana	☐	
Oxymorphone	☐	
Butrans	☐	
Levorphanol	☐	
Other	☐	

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

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	0 1 2 3
2.	Feeling down, depressed, or hopeless	0 1 2 3
3.	Trouble falling or staying asleep, or sleeping too much	0 1 2 3
4.	Feeling tired or having little energy	0 1 2 3
5.	poor appetite or overeating	0 1 2 3
6.	Feeling bad about yourself, or that you are a failure and have let you and your family down	0 1 2 3
7.	Trouble concentrating of things, such as reading or watching television	0 1 2 3
8.	Moving or speaking slowly that other people could have noticed	0 1 2 3
9.	Being so Fidgety or restless that you have been moving around a lot more than usual	0 1 2 3
10.	Thoughts that you would be better off dead, or of hurting yourself in some way	0 1 2 3

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		

SOAPP-R QUESTIONAIRE

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 1 hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting 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 1hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

Catastrophizing

Patient Name: _____

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.

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

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

Pleas 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 3 0 40 50 60 70 80 90 100%

Alliance Pain Center

Ross E. Vogelgesang, M.D
Erin Henderson, ARNP
Kei Batangan PA-C

3240 14th Ave. NW
Olympia, WA 98502

Phone: (360) 866-7990
Fax: (360) 866-4577

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

Information provided by FDA website October 1, 2020.

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.

Patient Signature: _____ Date: _____