Pain Management Partners

2401 River Road, Suite 101
Eugene, OR 97404
Ph: 541.344.8469 Fx: 541.687.8631

We welcome you to our office. We strive to offer the best patient care emphasizing a multidisciplinary approach. We encourage you to visit our website at: oregonpainmanagement.com

The registration, cancellation policy and medical history forms must be completed and returned to our office within two weeks. We cannot schedule your first appointment until we have these in place. Please keep the privacy policy.

Please note, we do not prescribe pain medications at the initial consultation. You will have to return for the second follow up appointment to start the process if your referring doctor would like us to take over prescribing.

Once we have received all medical records, registration forms and your medical history forms, we will call you to schedule your appointment. These are very important items. Please call if you have any questions.

When you arrive, you will meet our front office staff. Please have your insurance card and government-issued photo ID ready. We also ask that you bring and vitamins, medications, and supplements with you in their bottles. Please come prepared to give a urine sample.

We are a scent-free office and ask all of our patients and staff to refrain from wearing any perfumes or colognes.

Thank you for understanding and for becoming part of our team.

Sincerely,

Pain Management Partners

PATIENT INFORMATION

First Name: MI**:** Last Name:

Date of Birth: Age: Sex:

Marital Status: S___ M___ D___ W____ Email**:**_______________________________ Employer: ______________________________

Race: _________________________________ Ethnicity**:** □ Non-Hispanic □ Hispanic Primary Language: ________________________

Street Address:____ City/State/Zip: ____

Mailing Address (If Different): ______________________________________ City/State/Zip: ____________________________________

Home #: _____________________________Work #: ________________________ Cell#:_______________________________

RESPONSIBLE PARTY INFORMATION (if different from above)

Last Name: __________________________ First Name: __________________________ Social Security #:_________________________

Address: ____ City/State/Zip: ____

Home #: _____________________________ Work #: _____________________________ Cell#: ___________________________

Date of Birth: ________________ Relationship to Patient: _________________________________

MEDICAL INSURANCE

Primary Insurance Company:_________________________Group#:______________________ ID#: ___________________________

Subscriber Name:____ Subscriber DOB: ___________________________________

Subscriber Relationship to Patient ____ □ **Subscriber is the same as the patient**

Secondary Insurance Company:________________ Group#: ______________________ID#:_______________________________

Subscriber Name: _________________________________Subscriber DOB:____

Subscriber Relationship to Patient _______________________________________ □ **Subscriber is the same as the patient**

CASH PAY POLICY

Patients without medical insurance are required to pay $125 at the time of service to see a primary care provider, and $175 at the time of service to see a specialist or have imaging performed. **(Pain Management Partners requires a collection of $550 on the initial visit due to additional services being rendered. For cash pay patients only.**) Please note that your balance may be more than the above stated amounts, and will be determined based on actual services rendered during your office visit. Labs are billed separately. Any patient without medical insurance who is paying in cash for an office visit will receive 20% off their end balance.

By signing below you state that you have read and understand the above cash pay policy.

Patient/Guardian Signature____

CLINIC BILLING AND EXPECTATIONS

Please sign below to indicate you have read and understand the following:

1. **Responsibility for payment of your account remains with you at all times;** and although you may have a pending insurance claim, we will require you to pay regardless of the circumstances involved. Please contact us immediately if there is a problem with your claim or if your claim is related to OREGON WORKERS COMP, AUTO RELATED, OR THE RESPONSIBILITY OF A THIRD PARTY PAYOR.

2. Copays and other estimated out of pocket amounts due are to be collected at the time of service.

3. You will receive a monthly statement showing itemized charges and the total amount due on your account. Payment in full is required within 30 days of the statement date, unless arrangements are made with our billing office.

4. If you need to set up a payment plan, our Praxis Main billing phone number is (877) 708-1119.

5. A $45 fee will be charged to your account if you do not cancel your appointment 24 hours in advance. After three no show appointments, you will be subject to discharge from Praxis Medical Group.

6. There is a $35 fee for all returned checks and for stop payments.

7. No credit will be extended to patients having a past due account, or to patients who have been referred to a collections agency. If your account has been referred to a collections agency two times, you will be discharged from Praxis Medical Group.

8. If you arrive more than 7 minutes late to an appointment, you may be asked to reschedule.

9. Praxis Medical Group requires 2 business days to respond to all medication refill requests. Medications will not be refilled after clinic hours. Please contact your pharmacy to initiate refill requests.

CONSENT FOR TREATMENT

By signing below, I am requesting Praxis Medical Group to provide health care related treatment and consolation to the below names patient, and that I may refuse treatment or services at any time. I understand Praxis Medical Group does not guarantee any outcome for any services or treatments, either stated or implied.

Patient Name: ____________________________________ **Patient DOB:** ___________________

____ __________________

Signature *Date*

Describe the pain you have right now (e.g. aching, burning, sharp, etc.) Where is it? What is it like?

____

____

____

When did the pain begin?____

How did pain start?

_____Accident at home _____Accident at work _____Auto accident _____ After illness

_____After surgery _____Pain "just began" _____Other: ______________________

If pain began with an injury, please describe: ____

____

____

If applicable, Employer when injured: ______________________________________

Position: ____

How long employed? ____________ Last day worked: ______________ Still employed? Y N

Have you had pain or injury in *this* part of your body before? Y N (If yes, describe :) ______________

____

Ever had any other injuries before? Y N (If yes, describe & give dates :) ______________________

____

____

SURGERY FOR THIS CONDITION APPROXIMATE DATE RESULT

____

____

____

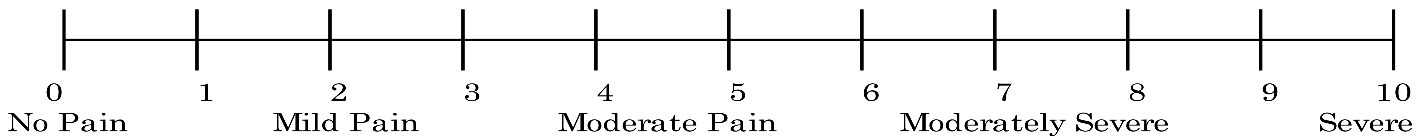
____

Total number of surgeries for your pain: _______________

How many times have you been to ER or Urgent Care in the past 6 months because of pain? ____________

How many times have you been hospitalized in the past 12 months because of pain? __________________

Rate your usual pain on a scale of 0 to 10 by putting an "x" on the line:



0 1 2 3 4 5 6 7 8 9 10

No Pain Mild Pain Moderate Pain Moderately Severe Severe

You have pain how often?

( ) Continuously ( ) Several times a day

( ) Once a day ( ) Several times a week

( ) Several times a month ( ) Once a month ( ) Less: _______

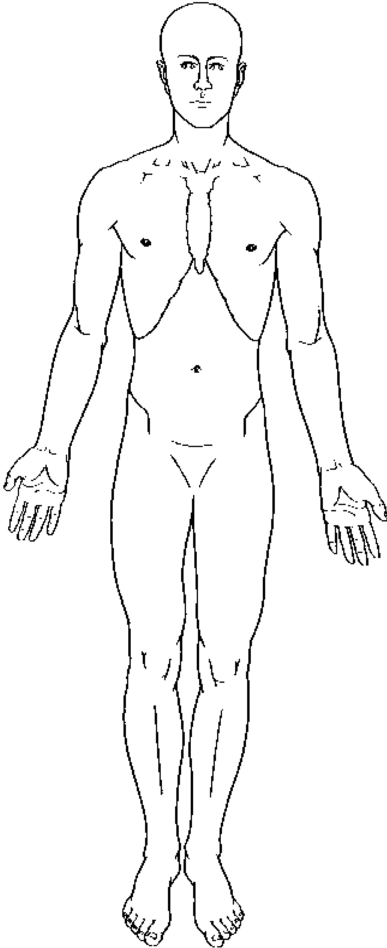
PLEASE MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS:

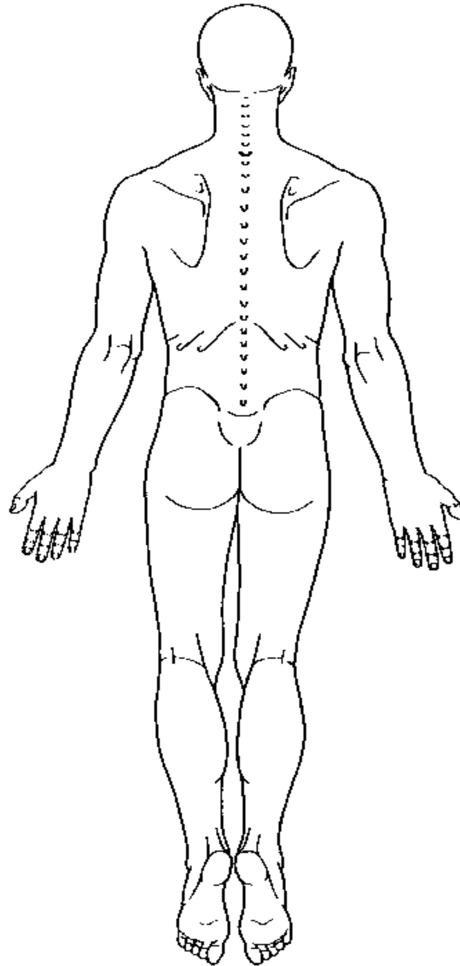
Use the following symbols. Marks areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Stabbing	Shooting/Radiating
====	00000	XXXX	/////	→→
====	00000	XXXX	/////	→→
====	00000	XXXX	/////	→→

Show main pain areas, use arrows to show spread.

PLEASE USE ANY OTHER MARKINGS FOR OTHER TYPES OF PAIN.





Comments:

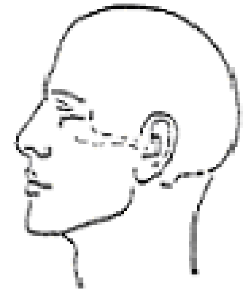
____

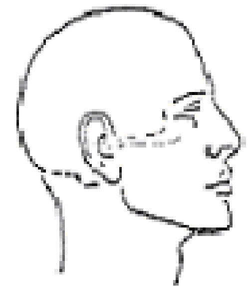
____

____

____

____





How often does your pain interfere:	work	family	chores	
	( )	( )	( )	Continuously
	( )	( )	( )	Several times a day
	( )	( )	( )	Once a day
	( )	( )	( )	Several times a week
	( )	( )	( )	Several times a month
	( )	( )	( )	Once a month
	( )	( )	( )	Less frequent: ___________

What makes your pain worse? ____

____

____

What eases or reduces your pain? ____

____

____

What do you believe is the cause of your pain?____

____

____

What do you do to manage your pain?____

____

____

Please describe any episodes of pain which were extremely frightening or in which you lost control: ________

____

Have there been times when your pain was mild or gone? When? Please describe:______________________

____

Is anyone in your family or friends able to help you with your pain? Who? ____________________________

Describe how:____

How likely is it that your pain can be removed or cured? (Circle one):

Impossible Unlikely Uncertain Likely Certain

Do you have particular fears or concerns about the future? (e.g. becoming paralyzed, crippled, needing further surgery, losing emotional control, being unable to support family, etc.) Please list: ______________________

____

PLEASE LIST THE TYPE OF PAST TREATMENTS YOU HAVE HAD AND THE RESULTS:

Treatment?	Who provided treatment?	When?	Better?	Worse?	No Change

Use	Used	Medication	Use	Used	Medication

Now	Before		Now	Before	
		Narcotics & Opiates:			**Sleeping Aids:**
		Anti-Inflammatories:			**Antidepressants:**
		Tranquilizers:			**Anti-Convulsants and Nerve Pain:**
		Migraine Medications:			**Over the Counter Medications:**
		Other medications for pain:			

List at least 3 specific GOALS of pain treatment. (What you would *realistically* expect of your pain management?)
For example, *"restorative sleep,"* "*able to work,*" "*get off pain medications,*" "*go to the movies with my family,*" etc.

1 ____

2. ____

3. ____

Habits: (presently)

Have you ever used tobacco? Yes__ No__. Currently use tobacco or nicotine? Yes__ No__

Cigarettes, Pipe, Nicotine Chew/Vapor (Number/Type per day:___________________________)

_____Caffeine Coffee, Tea, Cola or soda with Caffeine (Total number of cups per day:_______________)

_____Alcohol Beers per day __________________
Wine (glasses) per day ___________
Drinks per day____________

_____Marijuana Type, Quantity & Frequency ____________

Weight control medication ... (Type and amount per day :____________________________)

_____Have previously used illegal drugs. _____ Have previously attended drug or alcohol treatment program.

If so, when and where? ____

Sleep: Hrs. per night _______ Refreshing? Y __ N __ Awaken # times: ______ Trouble falling asleep? Y__ N__

CPAP? _______ Naps? _______ O2 at night? _________

PRIOR to your injury or pain, did you exercise?

None Daily Every other day 2 times/week Weekly Monthly

Exercise Type and duration:____

Current Exercise:

None Daily Every other day 2 times/week Weekly Monthly

Exercise Type and duration:____

Current Weight: _________ Usual Weight:____________ Desired Weight: _________

Eating Habits: ____Regular ____Irregular # Meals per day______

Please List ALL Medications You Are Currently Taking: **[**SEPARATE MEDICATION LIST ATTACHED? ☐**]**

Name of Drug	Strength (mg)	# Times per Day	How Long (Wks, Mos, Yrs)
1.			
2.			
3.			
4.			
5.			
6.			

ALLERGIES: ____

MEDICAL HISTORY: (Please list approximate dates and where) **Who is your:**

Physical Therapist? ______________________________ Surgeon/Neurosurgeon? ________________________

Psychiatrist? ____________________________________Psychologist/Counselor? _______________________

Prior Pain Management Specialist: _______________________________Neurologist? ____________________

Medical Conditions/Serious Illness:____

____

____

____

Surgeries: ____

____

____

____

Injuries:____

____

____

Other Hospitalizations:____

____

____

Have you ever been:	Physically abused?	No__	Yes__	Age(s)_______
	Sexually abused?	No__	Yes__	Age(s)_______
	Emotionally abused?	No__	Yes__	Age(s)_______

WHEN & WHERE WAS:

Last full medical exam? ____

Imaging (X-ray, MRI, etc.)?____

Lab Tests?____

Results? ____

FAMILY HISTORY:

Family History	Alive? Y/N	Medical Problems	Age (or at death)
Mother			
Father			
Sister(s):			
Brother(s):			
Daughter(s):			
Son(s):			

CHECK ☐ IF ANY FAMILY MEMBERS ARE AFFECTED. PLEASE NOTE *WHO* IS AFFECTED.

☐	DISEASE	FAM. MEMBERS	☐	DISEASE	FAM. MEMBERS
☐	Alcoholism		☐	Migraines	
☐	Allergy		☐	Ulcers	
☐	Anemia/Blood Problem		☐	AIDS / HIV infected	
☐	Arthritis		☐	Gallbladder Problems	
☐	Asthma		☐	Gout	
☐	Back Pain		☐	High Blood Pressure	
☐	Bleeding Tendency		☐	Kidney Disease	
☐	Cancer/Tumor		☐	Seizures / Convulsions	
☐	Depression		☐	Stroke	
☐	Diabetes		☐	Thyroid Problem	
☐	Disabling Disease		☐	Tuberculosis	
☐	Drug Addiction		☐	Other:	
☐	Heart Attacks				

SOCIAL HISTORY: At present, are you:

Single? _______ Married?_______ Partnered?_______ Divorced?_______ Widowed?______

Number of children ______________ Their ages and sex ____

____ Number of children still living with you__________

Spouse's/Partner's name, age and health ____

Your Spouse/Partner's occupation: ____

Your Current occupation:____

Full Time______ Part Time______ Hours/Wk______ Time Loss______

Grade completed in school_______ Degree & School ______________________________________

Previous work experience (briefly):____

____

____

Hobbies: ____

RECENT HEALTH STATUS:

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU IN THE PAST 3 TO 6 MONTHS. EXPLAIN.

❑ Decreased Hearing	❑ Leg Pain	❑ Discharge from urethra	❑ High risk for HIV/AIDS
❑ Ears Ringing	❑ Swelling ankles	❑ Sexually transmitted dz	❑ Blood transfusion
❑ Dizziness	❑ Fainting spells	❑ Thyroid problems	❑ Easy bruising
❑ Ear Infections	❑ Loss of appetite	❑ Enlarging lumps	❑ Fears
❑ Blurred Vision	❑ Weight loss	❑ Muscle weakness or cramps	Women--Last menses began:___________
❑ Failing Vision	❑ Weight gain	❑ Numbness/tingling	❑ Periods regular ❑Irreg
❑ Eye Pain	❑ Indigestion	❑ Joint swelling/pain	❑ Heavy ❑Light ❑Mod
❑ Eye Infections	❑ Heartburn	❑ Broken bone/injury	❑ Age onset ________
❑ Nose Bleeds	❑ Abdominal Pain	❑ Tremor/shaking	❑ Painful/Cramps
❑ Sinus Trouble	❑ Change in bowels	❑ Chronic Fatigue	❑ Days of flow
❑ Sore Throats	❑ Constipation	❑ Difficulty sleeping	❑ Length of cycle
❑ Allergies/Hay fever	❑ Diarrhea	❑ Nervous	❑ Breast lumps
❑ Asthma	❑ Blood in stools	❑ Unhappy or Depressed	❑ Enlarged lymph glands
❑ Bronchitis	❑ Black stools	❑ Memory difficulty	❑ Sexual difficulty
❑ Hoarseness	❑ Hemorrhoids	❑ Concentrating difficulty	❑ --Too painful
❑ Cough	❑ Jaundice	❑ Mood swings	❑ --Loss of desire
❑ Chest Pain	❑ Hernia	❑ Trouble falling asleep	❑ --Erection difficulty
❑ Shortness of Breath	❑ Painful Urination	❑ Wake up frequently	❑ Loss of energy
❑ Palpitations	❑ Blood in Urine	❑ Irritable, easily angered	❑ Phobias
❑ High Blood Pressure	❑ Urinating frequently	❑ Emotions close to surface	❑ Panic Attacks
❑ Grinding teeth	❑ Kidney stones	❑ Cold hands/feet	❑ Other:______________
❑ Clenching jaw	❑ Back pain	❑ Sweating, hot flashes	❑ ___________________

Explanations or anything else important to your health_________________________________

____

____

____

The following is a list of things you may experience when your pain is the **worst**. For each item, please circle the number which indicates whether it:

(1) Never (2) Almost Never (3) Sometimes (4) Almost Always (5) Always

Happens when your pain is worst.

Remember: Respond to each item of this list in regard to its ability to describe **how you feel when your pain is at it's worst.**

		Never	Almost Never	Sometimes	Almost Always	Always
1.	Nauseated	1	2	3	4	5
2.	Shooting sensations	1	2	3	4	5
3.	Frustrated	1	2	3	4	5
4.	Pounding sensations	1	2	3	4	5
5.	Want to be left alone	1	2	3	4	5
6.	Feel like I'm being cut	1	2	3	4	5
7.	See spots	1	2	3	4	5
8.	Pressure in parts of my body	1	2	3	4	5
9.	Anxious	1	2	3	4	5
10.	Not interested in things	1	2	3	4	5
11.	Scalding sensations	1	2	3	4	5
12.	Nervous	1	2	3	4	5
13.	Angry	1	2	3	4	5
14.	Burning sensations	1	2	3	4	5
15.	Feel like I'm being tortured	1	2	3	4	5
16.	Don't want to be bothered	1	2	3	4	5
17.	Fatigue	1	2	3	4	5
18.	Weakness	1	2	3	4	5
19.	Feel hopeless	1	2	3	4	5
20.	Blurred vision	1	2	3	4	5
21.	Tingling sensations	1	2	3	4	5
22.	Feel guilty	1	2	3	4	5
23.	Can't move	1	2	3	4	5
24.	Stinging sensations	1	2	3	4	5
25.	Forget recent things	1	2	3	4	5
26.	Light-headed	1	2	3	4	5
27.	Tired	1	2	3	4	5
28.	Ringing in ears	1	2	3	4	5
29.	Avoid physical activity	1	2	3	4	5
30.	Decreased sensation	1	2	3	4	5
31.	Stabbing sensations	1	2	3	4	5

32.	Aggravated	1	2	3	4	5
33.	Parts of my body get cold	1	2	3	4	5
34.	Dizzy	1	2	3	4	5
35.	Tense	1	2	3	4	5
36.	Upset	1	2	3	4	5
37.	Deep ache	1	2	3	4	5
38.	Sleep heavily	1	2	3	4	5
39.	Bored	1	2	3	4	5
40.	Loss of balance	1	2	3	4	5
41.	Feel rejected	1	2	3	4	5
42.	Bothered by noise	1	2	3	4	5
43.	Scared	1	2	3	4	5
44.	Poor vision	1	2	3	4	5
45.	Worried	1	2	3	4	5
46.	Tearing sensations	1	2	3	4	5
47.	Mad at the world	1	2	3	4	5
48.	Feel spacey	1	2	3	4	5
49.	Want to die	1	2	3	4	5
50.	Don’t want to do anything	1	2	3	4	5
51.	Trouble remembering things	1	2	3	4	5
52.	Frightened	1	2	3	4	5
53.	Worry about things	1	2	3	4	5
54.	Depressed	1	2	3	4	5
55.	Feel helpless	1	2	3	4	5
56.	Sharp aches	1	2	3	4	5
57.	Feel bothered	1	2	3	4	5
58.	Want to get away from it all	1	2	3	4	5
59.	Bad dreams	1	2	3	4	5
60.	Restless	1	2	3	4	5
61.	Unable to enjoy others	1	2	3	4	5
62.	Poor sleep	1	2	3	4	5
63.	Feel agitated	1	2	3	4	5
64.	Poor appetite	1	2	3	4	5
65.	Feel like giving up	1	2	3	4	5
66.	Upset with myself	1	2	3	4	5
67.	Touchy	1	2	3	4	5
68.	Want to go to sleep	1	2	3	4	5
69.	Afraid of being left alone	1	2	3	4	5
70.	Not interested in sex	1	2	3	4	5

71.	Feel bitter	1	2	3	4	5
72.	No energy	1	2	3	4	5
73.	Double vision	1	2	3	4	5
74.	Afraid of dying	1	2	3	4	5
75.	Numbness is parts of my body	1	2	3	4	5
76.	Swelling in parts of my body	1	2	3	4	5
77.	Feel very warm and sweat	1	2	3	4	5
78.	Feel weak	1	2	3	4	5
79.	Feel like I have to move	1	2	3	4	5
80.	Not interested in food	1	2	3	4	5
81.	Poor memory	1	2	3	4	5
82.	Get confused	1	2	3	4	5
83.	Jumpy	1	2	3	4	5
84.	Cramping sensations	1	2	3	4	5
85.	Mad	1	2	3	4	5
86.	Feel like I’ll blackout	1	2	3	4	5
87.	Mad at myself	1	2	3	4	5
88.	Trouble falling asleep	1	2	3	4	5
89.	Lonely	1	2	3	4	5
90.	Panicky	1	2	3	4	5
91.	See flashing lights	1	2	3	4	5
92.	Forgetful	1	2	3	4	5
93.	Disturbed Sleep	1	2	3	4	5
94.	Feel like an invalid	1	2	3	4	5
95.	Disgusted	1	2	3	4	5
96.	Cranky	1	2	3	4	5
97.	Feel like I’m being punished	1	2	3	4	5
98.	Short tempered	1	2	3	4	5
99.	Trouble concentrating	1	2	3	4	5

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