THREE RIVERS SPINE & PAIN MEDICINE
249 THREE SPRINGS DRIVE
WEIRTON, WV 26062

PLEASE COMPLETE THE REGISTRATION AND MEDICAL HISTORY FORMS. BRING THEM TO YOUR APPOINTMENT COMPLETED. THIS WILL HELP SHORTEN YOUR APPOINTMENT TIME. ALSO, YOU WILL NEED TO PROVIDE: PHOTO ID, INSURANCE CARD (S) AND COPAY, IF YOU HAVE ONE. WE DO NOT ACCEPT PERSONAL CHECKS: CASH, DEBT OR CREDIT CARDS ARE ACCEPTED.

PLEASE NOTE: YOUR FIRST APPOINTMENT IS AN EVALUATION. PLEASE ALLOW AT LEAST ONE (1) HOUR FOR THIS APPOINTMENT. PROCEDURES, INJECTIONS AND PRESCRIPTIONS WILL ONLY BE PERFORMED OR WRITTEN AT THE DOCTOR'S DISCRETION. PRESCRIPTIONS MAY NOT BE WRITTEN UNTIL RESULTS FROM THE INITIAL URINE DRUG SCREEN ARE RECEIVED WHICH CAN TAKE UP TO FOUR (4) DAYS.

**PLEASE ARRIVE ½ HOUR BEFORE YOUR APPOINTMENT TIME.**

THANK YOU AND WE WILL SEE YOU AT YOUR SCHEDULED APPOINTMENT ON:

______________________________________________

AT OUR WEIRTON OFFICE AT: 249 THREE SPRINGS DRIVE, WEIRTON, WV 26062

**KINDLY GIVE A 48 HOUR NOTICE IF YOU NEED TO CANCEL OR RESCHEDULE
304-919-2077

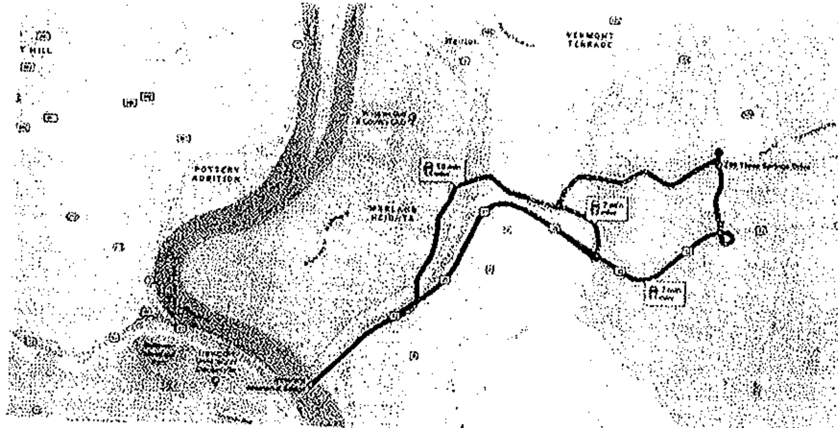
STEPHANIE H. LE, M.D.

# THREE RIVERS SPINE AND PAIN MEDICINE

249 THREE SPRINGS DRIVE
WEIRTON, WV 26062
PHONE: 304-914-2077
FAX: 304-914-4374

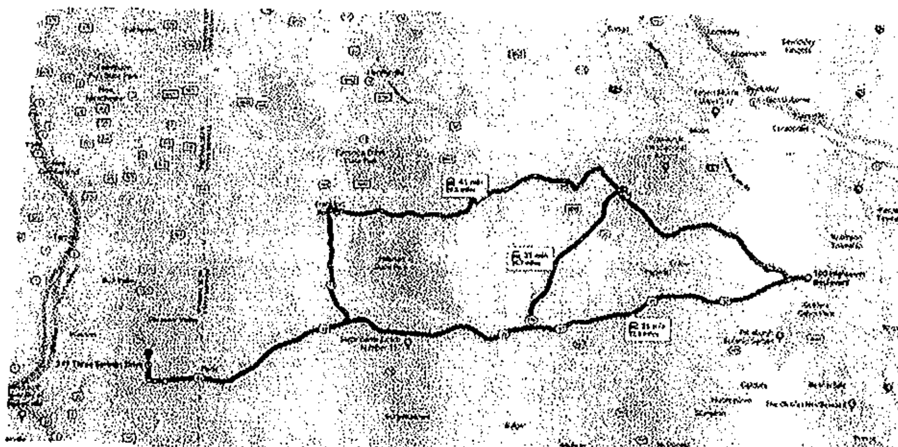
EAST BOUND DIRECTIONS FROM OHIO:

EAST BOUND ON ROUTE 22, TAKE THREE SPRINGS EXIT. AT THE EXIT, MAKE A LEFT. YOU WILL PASS THROUGH 2 RED LIGHTS, MAKE A RIGHT (BUILDING USE TO BE THE WEIRTON WAL-MART). OUR OFFICE IS NEXT TO THE CRICKET STORE.



WEST BOUND DIRECTIONS FROM IMPERIAL/PITTSBURGH:

WEST BOUND ON ROUTE 22, TAKE THE THREE SPRINGS EXIT. MAKE A RIGHT OFF THE EXIT, PASS THROUGH 2 RED LIGHTS. BUILDING WILL BE ON THE RIGHT HAND SIDE (BUILDING USE TO BE THE WEIRTON WAL-MART). OUR OFFICE IS NEXT TO THE CRICKET STORE



249 Three Springs Drive
Weirton, WV 26062

Phone: 304-919-2077
Fax: 304-914-4374

First____________________ M_______ L ____________________________

Address______________________________________________________

City____________________________ State_______ Zip _______________

Date of Birth ___________________ SS #____________________________

Home # ______________________________________________________

Cell # ________________________________________________________

Email ________________________________________________________

Reminder:

Phone Call Cell Call Cell text Email No Reminder (select all that apply)

Gender M F (circle one)

Ethnicity ______________________

Race ______________________

Language ______________________

Married Divorced Single Widow (circle one)

Employed

Full time Part time Retired Unemployed Disabled (circle one)

Primary Care Doctor ______________________________________________

Referring Doctor _________________________________________________

# Emergency Contact

Primary Contact

Name ______________________________________________

Relationship ________________________________________

Home Phone _________________________________________

Cell Phone __________________________________________

Secondary Contact

Name ______________________________________________

Relationship ________________________________________

Home Phone _________________________________________

Cell Phone __________________________________________

# Three Rivers Spine and Pain Medline

# Authorization for disclosure of health records

1. I hereby authorize: ______________________________
2. To disclose the following information from the health records of:

Patient Name: ______________________________ D.O.B. ______________

Address: ______________________________ Phone: (___)______________

Covering the Period(s) of healthcare:

From Date: ______________________ To Date: ______________________

3. Information to be disclosed:

| | |
|---|---|
| _____ Complete Health Records | _____ Discharge Summary |
| _____ History and Physical Exams | _____ Consultation Report |
| _____ Progress Note | _____ Last Progress Note |
| _____ Radiology Reports | _____ Laboratory Testing |

Other: ______________________________

For the purpose of: ______________________________

4. This information is to be disclosed to the following: Please include name, phone and fax number or request may not be fulfilled.

***Three Rivers Spine and Pain Medicine***
***249 Three Springs Drive***
***Weirton WV 26062***
***(304)919-2077 -p***
***(304)914-4374 –f***

5. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire ninety (90) days from the date it is signed.
6. Three Rivers Spine and Pain Medicine, its employees, office and physicians are hereby released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

Patient: ______________________________ Date: ______________

Witness: ______________________________ Date: ______________

249 Three Srpings Dr.
Weirton, WV 26062
Phone: (304) 919-2077 | Fax: (304) 914-4374

## ELECTRONIC MEDICAL RECORDS ACCESS

DATE:
PATIENT NAME:
DOB:
Email:

*Due to the recent changes in health care over the last year, our office is now required to offer online medical records to all patients. You are able to access your medical records via email. You will not receive junk mail or spam from Patient fusion, you will be able to view parts of your medical record. We encourage our patients to use this opportunity to the fullest but understand if you decide to decline. If you would like to take this opportunity to sign up please list your email address and sign and date below. You will receive an email from Patient fusion. Should you decline, please check the appropriate box declining online access to your medical record and sign and date the appropriate box.*

☐ I DO NOT HAVE AN EMAIL ADDRESS
☐ Yes, I would like to access my medical records online through Patient Fusion
☐ No, I do not want to access my medical records online through Patient Fusion

Patient Name:

Patient Signature:
Patient Signature Required

249 Three Srpings Dr.
Weirton, WV 26062
Phone: **(304) 919-2077** | Fax: **(304) 914-4374**

***<u>Cancellation and No Show Appointment Policy</u>***

In order to accommodate our current and new patients, we request that you give at least 24 hours notice of cancellation for appointments. If less than 24 hours notice is provided, there will be a charge before you are seen at your next appointment. This will ensure appointments for new patients and procedures are available at their earliest date.

If you NO SHOW or are LATE CANCELLING an ***appointment***, there will be a charge of $25.00 before you are seen at your next appointment.

If you NO SHOW or are LATE CANCELLING a ***procedure***, there will be a charge of $100.0 and $200 charge for Spinal Cord Stimulator and Pump Trial before you are seen at your next appointment.

We appreciate your understanding, consideration and cooperation.

Thank you,

Dr. Stephanie H. Le, M.D.
Three Rivers Spine and Pain Medicine

______________________________

Patient Signature

Date:

Revised January 2017

249 Three Srpings Dr.
Weirton, WV 26062
Phone: (304) 919-2077 | Fax: (304) 914-4374

Authorization and release:

- I authorize the release of any information including the diagnosis and the records of any treatment to guarantors, third party and/or other health practitioners.
- I authorize you to transmit my medical records electronically/fax when necessary.
- I authorize the release of information to my primary care physician/referring physician.
- I authorize and request my insurance company to pay directly to Three Rivers Spine & Pain.
- I understand that my insurance carrier may pay less than the actual bill of services. Contractual adjustment with managed care contracts will be accepted, but I agree to be responsible for the payment of all billable services rendered on my behalf or my dependants.
- I understand that the charges incurred for additional sercvices (i.e. legal forms, letter to school/employer, insurance/disability forms, release records, attorney letters) cannot be billed to my insurance and I am financially responsible for these charges.
- I authorize by signing this that I am consenting to treatment of myself or my dependants with Three Rivers Spine & Pain.
- I hereby give Three Rivers Spine & Pain permission to leave messages on my answering machine or voice mail on my home phone or cell phone (text messages) concerning my appointment or my dependant appointment.
- I hereby authorize Three Rivers Spine & Pain to be a photographer for identification purposes only.

____________________________ Patient Signature

____________________________ Witness Signature

Date:

*<u>***This Authorization and release is valid for one year from the signature date above.***</u>*
Revised January 2017

249 Three Springs Drive
Weirton, WV 26062

Phone: 304-919-2077
Fax: 304-914-4374

# CONSENT FOR TREATMENT

I VOLUNTARILY AGREE TO RECEIVE EVALUATION/PAIN MANAGEMENT TREATMENT FROM THREE RIVERS SPINE & PAIN MEDICINE.

I UNDERSTAND AND AGREE THAT I WILL PARTICIPATE IN MY TREATMENT PLAN, AND THAT I MAY DISCONTINUE TREATMENT AND/OR WITHDRAW MY CONSENT FOR TREATMENT AT ANY TIME.

PATIENT SIGNATURE: ______________________________

PRINTED PATIENT'S SIGNATURE: ______________________

DATE: ________________

249 Three Srpings Dr.
Weirton, WV 26062
Phone: (304) 919-2077 | Fax: (304) 914-4374

## HIPAA Compliance

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law passed by Congress in 1996. It has three goals:

1. To create administrative simplification to transmit and process healthcare information.
2. To promote privacy of the patient"s protected health information (PHI).
3. To impose security measures in technology advances.

The patient privacy portion of the law became effective on April 14, 2003. The four **Patient Rights** associated with this are;

1. The right to a notice of information practices.
2. The right to obtain access to their own PHI.
3. The right to obtain access to an accounting of how their PHI has been disclosed.
4. The right to request amendment and correction of their PHI.

Three Rivers Spine and Pain Medicine policies emphasize the importance of the privacy of a patient"s health information. With the implementation of the HIPAA privacy standards, Three Rivers Spine and Pain Medicine will make available to patients a written Notice of Privacy Practices. This notice will explain the patient"s rights under HIPAA and how Three Rivers Spine and Pain Medicine protects those rights. Three Rivers Spine and Pain Medicine will maintain a signed acknowledgment form on each patient as verification that the patient was notified of the privacy policy.

______________________________

Patient Signature

Date:

Revised January 2017

# Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY.**

Understanding Your Health Record/Information

Each time you visit a hospital. Physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment;
- Means of communication among the many health professionals who contribute to your care;
- Legal document describing the care you received;
- Means by which you or a third party payer can verify that services billed were actually provided;
- Tool in education health professional;
- Source of data for medical research;
- Source of information for public health officials charged with improving the health of the nation;
- Source of data for facility planning and marketing; and,
- Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy;
- Better understand who, what, when , where and why others may access your health information;
- Make more informed decisions when authorizing disclosures to others.

Your Health Information Rights:

Although your health record is the physical property of the healthcare practitioner or facility the compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information, upon written request;
- Receive confidential communications of protected health information;
- Obtain a paper copy of the notice of privacy practices upon request;
- Inspect and copy your health record, upon written request;
- Obtain an accounting of disclosures of your health information, upon written request;
- Request communications of your health information by alternative means or at alternative locations;
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken: and,
- File a complaint with Three Rivers Spine and Pain Medicine.

Our Responsibilities:

- Maintain the privacy of your health information;
- Provide you with the notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and,
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain.

We will not use or disclose your health information without your authorization, except as described in this notice.

For more information or to Report a Problem

If you have questions and would like additional information, you may contact our office 304-919-2077

If you believe your privacy rights have been violated, you can file a complaint with our organization.
There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations (made without your authorization)

We will use your health information for treatment. For example: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine to course of treatment that should work best for you. Your physician will document in your record his expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you leave our office.

We will use your health information for payment. For example, a bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedure and supplies used.

We will use your health information for regular health operations. For example: Members of the medical staff, the risk or quality improvement manger, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and other like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgement, many disclose to a family member other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment relates to your care.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect of food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health Risks: As required by law, we may disclose medical information about you for public health activities. These activities generally include the following:

- To Prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary for your health, and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purpose as required by law, or in response to a valid subpoena, warrant, summons, or court order.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at our office or the hospital.

Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be interest to you.

Heath-Related Benefits and Services: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Health Oversight Activities: We may disclose medical information to health oversight agency for activities authorized by law. These actives include, for example, audits, investigation, inspections, and licensure. These activities are necessary for government to monitor the health care system, government programs, and compliance with civil rights law.

National Security and Intelligence Activities: We may release medical information about you to authorized federal official for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose medical information about you to authorized federal officials so they may provide protections to the President, other authorized person or foreign heads of state or conduct special investigations.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

249 Three Springs Drive
Weirton, WV 26062

Phone: 304-919-2077
Fax: 304-914-4374

# PAIN MANAGEMENT AGEEMENT

The Purpose of this consent is to protect your access to controlled substances and to protect our ability to prescribe for you. **A violation of this agreement could result in discharge from our pratcie.**

**General**

1. I understand that multiple sources can lead to untoward drug interactions or poor coordination of treatment.
2. I understand that all controlled substances must be obtained at the same pharmacy.
3. I am expected to inform TRSPM of any new medications or medical conditions and of any adverse effects I experience from any of the medications that I take.
4. I agree to keep these medications in a secure place such as a lock box. Since the drugs may be hazardous or lethal to a person that is not tolerant to its affects, especially a child, you must keep them out of the reach of such people. Prescriptions and bottles of these medications may also be sought out by individuals with chemical dependency and should be closely safeguarded.
5. I understand it may be requested my a TRSPM provider that original containers or medications be brought into the office at each visit to document compliance and to prevent overuse.
6. **I will not use, obtain, or attempt to obtain pain medications from ANY other health care provider**. I will not use any other narcotics or sedative in conjunction with what I am currently on without first discussing in with my pain doctor.
7. I understand that **UNANNOUNCED PILL COUNT, RANDOM URINE OR SERUM TOXICOLOGY SCREENS** may be requested by TRSPM provider. **Not presenting for the pill count, refusal of such testing or any inconsistencies in a drug screen may subject you to an abrupt rapid wean schedule in order for the medication to be discontinued or prompt termination from our care.**
8. I understand that I must keep **valid contact information** updated with the TRSMP office; phone number, address, and emergency contact etc.
9. I realize that is my responsibility to keep others and myself from harm, this includes the safety of my droving, obeying all bylaws rules and regulation of department of motor vehicle in all states and the operation of machinery. I will not drive or operate heavy machinery while under the influence of narcotic and/or sedatives.
10. I will not use any illegal substances ex, cocaine, heroin, marijuana, crystal meth, ecstasy, ketamine, etc. Violation of this will result in the cessation of any prescribed controlled substance and immediate termination of care the TRSPM.
11. **I will not alter my medication in any way,** for example, crushing or chewing tablets, or use any other auto delivery such as injection or insufflation other than as prescribed by TRSPM.

12. I understand that changing the date, quantity or strength of medications or altering a prescription in any way, shape or form is against the law. Forged prescriptions or the providers' signature is also against the law.
13. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacist or other professionals who provide your health care for purposes of maintaining accountability.
14. I will keep all scheduled appointments in the TRSPM clinic. Three or more cancellations with less than forty-eight (48) hours' notice can result in termination of my treatment by TRSPM.
15. If a female of childbearing age: I certify that I am not pregnant and will use appropriate contraceptive measures during the course of treatment with TRSPM. If I believe that I have become pregnant while undergoing treatment with TRSPM, I will immediately call TRSPM, my obstetrician and/or primary care physician to inform them. I acknowledge that medications and/or treatments through TRSPM may be detrimental to the health and welfare of my unborn child. All opioids cross the placenta though no teratogenic effaced have been observed. Neonatal central nervous system depression can occur with opioids use. Avoid opioid use while breastfeeding.
16. I understand and accept that strong medications, which may include opiates and other controlled substances, may be prescribed for pain relief.
17. I understand that there are potential risks and side effects with taking any medications, including the risks of addiction and other unknown risks of long term usage.

    Possible side effects may include but no limited to : a sense of emotional well-being and euphoria, drowsiness, sedation, and sleep disturbance, hallucinations, potential for diminished psychomotor performance, dysphoria, agitation, dizziness, seizures, aberrant behavior, hyperalgesia, respiratory depression is rate but the most serious adverse effect and may result in toxicity, diminution of pain or pain relief by other modalities may exacerbate respiratory depression, constriction of the pupil of the eye, constipation, nausea, vomiting, delayed gastric emptying, urinary retention, hormonal and sexual dysfunction, decreased blood pressure, slowed heart rate, peripheral edema (swelling), muscle rigidity and contractions, osteoporosis, itching, suppression of the immune system, decreased duration of analgesia and then decreased effectiveness, withdrawal symptoms may occur with abrupt opioid cessation and can include runny nose, shivering, "gooseflesh," diarrhea, and dilation of the pupil of the eye.

**Specific Off-Label Uses – Prescription medications are often used for conditions not listed on their labels. This called "off label" use of medication. It is legal for your health care professional to use a medication "off label," but your insurer, health plan, or pharmacist may question its use as recommended by your health care professional. A drug is used off-label when the health care professional prescribes that drug for a medical use other than the one that received FDA approval. Off-label prescribing is a commonly used and accepted medical practice. These drugs do have FDA approval, but for different use. For example, health care professionals frequently prescribe FDA approved anticonvulsant medications for persons who do not have seizures, but who need a mood stabilizer or for pain management. When your health care professional prescribes an anticonvulsant medication for use as mood stabilizer or for pain, it may be considered an off-label use.**

**Any and all off-Label use of drugs is covered by this agreement including but not limited to the following:**

1. The use of anti-depressants, anti-epileptics, muscle relaxants, tranquilizers, and nutraceuticals for pain relief.
2. The administration of sustained release preparations of morphine and oxycodone use more frequently than every 12 hours.

3. Maximal dosage of opioids is to be determined by therapeutic effect rather than any arbitrary, published maximal dosing level.
4. Topical use of morphine, methadone, naloxone, carisoprodol, and ketamine.

**REFILLS**

1. **Prescriptions will not be phoned in.**
2. Timely requests for refills of medications are solely the patient's responsibility.
3. I agree that I will use my dedication at a rate no greater than the prescribed rate unless it is discussed directly with a TRSPM staff member at an office visit.
4. The prescribing provider will be the only one to decide when and how the patient is to increase or decrease various pain medications.
5. **EARLY REFILL WILL NOT BE GIVEN**. The patient is responsible for taking the medications as prescribed. No unauthorized increase in medications will be tolerated.
6. Refills will not be made as emergencies. **There is a three (3) day minimal request to refill prescriptions on non-narcotics.**
7. Changes in prescriptions/refills will be made only during scheduled appointment and not via phone, at night, on weekends, or over holidays.
8. I agree that continued refills of medications may be contingent upon compliance with other chronic pain treatment modalities recommended by my doctor/physician assistant and with the program in general.
9. Refills will not be made for reasons such as: running out early, losing prescriptions or my prescriptions were spilled, damaged, misplaced or stolen medication. The patient is responsible for taking the medications in the dose prescribed and for keeping track of the amount remaining.
10. **Stolen medication(s) will NOT be replaced even with a police report**.
11. I understand that I must contact a TRSPM prescriber/provider before taking tranquilizers or prescription sleeping medication. I understand that the combined use of the various drugs, opiates as well as alcohol, may produce confusion, profound sedation, respiratory depression, blood pressure decrease and even death.
12. I understand that if I am discharge from TRSPM, I MAY be provided with a thirty (30) day supply of my medicine at the discretion of my prescribing provider/physician. I will have (1) month to find a physician who will take over my care and prescribed my medications.

**PHARMACY**

**I AGREE TO USE DECARIA PHARMACY INC. (PORTERS, A&B, FAMCARE, MARLAND HEIGHTS AND HERCHE BLOOR) FOR ALL MY PAIN MEDICATION.**
**LOCATED AT EITHER MOON PA, STEUBENVILLE OH, BURGETOWN PA, WEIRTON WV AND EAST LIVERPOOL OH**

**COMPLIANCE**

1. I understand that phone calls after hours should be for issues such as post-procedure, post-surgical complications, significant medication side effects and other urgent matter. For the true medical emergency, "911" should be called and/or emergency department treatment should be sought. For non-emergency matters the clinic should be called during normal business hours.
2. I understand that **the main treatment goal is to improve my ability to function and/or to work and/or to reduce pain. I must also comply with the treatment plan as prescribed by my doctor**. I understand that through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

3. **I agree to fully comply with all aspects of my treatment program,** including behavioral, medicinal and physical therapy.
4. I have thoroughly read, understand and accept all of the above provisions. Any question I had regarding this agreement have been answered to my satisfaction by the TRSPM prescribing provider**. I also agree to random testing and detoxification.**
5. You are informed that you have the right and power to sign and be bound by this agreement and that you have read, understand and except all of its terms.

TRSPM physicians/physician assistants understand that emergencies can occur and under SOME circumstances exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.

If at any time you are concerned about your medications or side effects of your medication you may call TRSPM at 304-919-2077.

IF I CHANGE MY PHARMACY FOR ANY REASON, I AGREE TO MOTIFY TRSPM IN WRITING AT THE TIME I RECEIVE A PRESCRIPTION. I WILL ALSO ADVISE MY NEW PHARMANY OF MY PRIOR PHARMACIES ADDRESS AND PHONE NUMBER.

Name: ________________________________________

Date: ________________________________________

Name: ______________________________ Date: ____________________

**HPI**

What is your main reason you're looking for pain management?

________________________________________

________________________________________

________________________________________

________________________________________

When did this begin? ____________________

________________________________________

Was this due to an injury? ______________

explain: ______________________________

________________________________________

Rate 1-10 on pain level

- ____ Pain Intensity
- ____ Average Daily Pain
- ____ Worse Pain Ever

- ____ Pain with Activities
- ____ Pain with Rest
- ____ Pain with Meds
- ____ Pain without Meds

**Character**

| | |
|---|---|
| Aching | Burning |
| Dull | Sharp |
| Stabbing | Throbbing |
| Pressure | Crushing |

**Circle all that apply**

| | |
|---|---|
| Cramping | Spasmodic |
| Pulling | Tender |
| Tight | Knife Like |
| Hot | Sore |

**Symptoms associated with pain**

| | |
|---|---|
| Fatigue | Loss of bladder |
| Loss of bowel | Nausea |

**Circle all that apply**

| | |
|---|---|
| Numbness | Parenthesis |
| Spasm | Weakness |

**Exacerbating factors**

| | |
|---|---|
| Bending | Exercise |
| Getting out of chair | Lifting |
| Lying down | Moderate activity |
| Physical activity | Position Change |

**Circle all that apply**

| | |
|---|---|
| Reaching | Significant activity |
| Sitting | Standing |
| Twisting | Walking |

**Alleviating factors**

| | |
|---|---|
| Bending | Lying down |
| Moving | Position Change |
| Rest | Sitting |

**Circle all that apply**

| | |
|---|---|
| Medication | Injections |
| Physical Activity | Procedures |
| Standing | |

Name: ______________________________ Date: ________________

## SOCIAL HISTORY

**Marital Status:** Circle which applies
Single Married Widow Divorced

**Education:** Circle which applies
Elementary High School GED College Degree

**Tobacco Use:** Circle which applies
Smoker Non Smoker Quit Smoking Chew
Cigarettes/day________
Chew/day________
Total years_________

**Employment:** Circle which applies
Retired Full Time Part Time Disabled
Self Employed Student

**Living Arrangements:** Circle which applies
Alone Spouse Family Children Parents

Are you able to care for yourself? _________

**Alcohol Use:** Circle which applies
None Rarely Socially Daily

**Drug Use:** Circle **ALL** that apply

| | | |
|---|---|---|
| Marijuana | Current | Past |
| Cocaine | Current | Past |
| Heroin | Current | Past |
| Morphine | Current | Past |
| Meth | Current | Past |
| LSD | Current | Past |
| Mushrooms | Current | Past |
| Ecstasy | Current | Past |

Other: ______________________

## ROS

### Circle ALL that apply

**Constitutional:**
Fever Chills Fatigue Poor Appetite
Poor Sleep Weight Gain Weight Loss
Weakness

**HEENT:**
Hearing Loss Sore Throat Blurred Vision
Decreased Vision

**Respiratory:**
Wheezing Cough Edema

**Cardiovascular:**
Chest Pain Palpitations

**Skin:**
Rash Itching Lesions Bruises

**Musculoskeletal:**
Joint Pain Joint Swelling Stiffness Weakness

**Gastrointestinal:**
Abdominal Pain Nausea Diarrhea Heartburn
Constipation

**Genitourinary:**
Sexual dysfunction Urinary hesitancy

**Neurologic:**
Headache Dizziness Loss of Consciousness
Weakness Numbness Tingling

**Psychiatric:**
Depression Anxiety

Additional Comments: ___________________

Name: ______________________________ Date: ______________________

## Past Medical History

**Circle all that apply**

**HEENT:**
Headaches Migraines Seasonal Allergies
Sinusitis

**Cardiovascular:**
Angina Arrhythmia CAD DVT HTN
Hyperlipidemia MI Mitral Valve Prolapse
Murmur Pacemaker PVD

**Respiratory:**
Asthma COPD Sleep Apnea

**Gastrointestinal:**
Gallstones GERD GI Bleed Hiatal Hernia
IBS Pancreatitis Ulcers

**Genitourinary:**
BPH Frequent Bladder Infections
Kidney Stones Renal Failure
Renal Insufficiency

**Endocrine:**
Anemia Bleeding Disorder Transfusions

**Infections:**
Hepatitis HIV Shingles

**Neurological:**
CVA Parkinson's Peripheral Neuropathy
Seizure Disorder TIA

**Psychological:**
ADD Anxiety Bi-polar Disorder Dementia
Depression Schizophrenia

**Cancer:**
Bladder Breast Colon Lung Melanoma
Prostate

**Musculoskeletal:**
Back Pain Connective tissue Fibromyalgia
Kyphoscoliosis Osteoarthritis Osteoporosis
Rheumatoid Arthritis Scoliosis Neck Pain

**Comments:**

______________________________________

______________________________________

**Allergies:** List All

______________________________________

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______________________________________

**Surgical History:** List All

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______________________________________

**Current Medications:** List ALL

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**Name:** ______________________ **Date:** ______________

**Family History** **Circle all that apply**

**Arthritis:**
Mother Father Brother Sister Other

**Asthma:**
Mother Father Brother Sister Other

**Bleeding DX:**
Mother Father Brother Sister Other

**CAD:**
Mother Father Brother Sister Other

**Cancer:**
Mother Father Brother Sister Other

**CHF:**
Mother Father Brother Sister Other

**COPD:**
Mother Father Brother Sister Other

**Diabetes:**
Mother Father Brother Sister Other

**Hypertension:**
Mother Father Brother Sister Other

**IBS:**
Mother Father Brother Sister Other

**Kidney DX:**
Mother Father Brother Sister Other

**MI:**
Mother Father Brother Sister Other

**PAD:**
Mother Father Brother Sister Other

**Stroke:**
Mother Father Brother Sister Other

**Thyroid DX:**
Mother Father Brother Sister Other

**Comments:**
______________________________
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______________________________

**Unknown**