ST. LOUIS PAIN CONSULTANTS
Anne Christopher M.D.
(314) 205-6149 (office)
(314) 590-5920 (fax)

PATIENT INFORMATION FORM

In addition to identifying and treating your health concerns, we also can evaluate and "functional" troubles you may have, such as chores, climbing stairs, bending, and twisting. The answers you give in this questionnaire will help us care for you.

Name

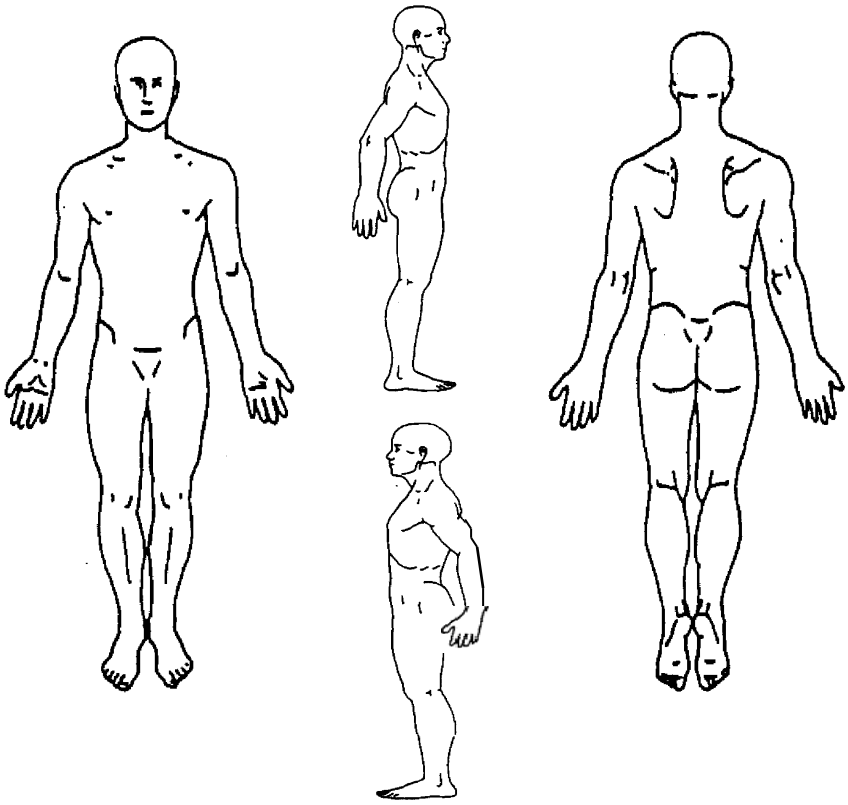
_____

Last First MI

Date of Birth _____/_____/____ Age: _____ Sex: [ ] Male [ ] Female Weight _____ Height _____ R/L Handed _____

Referring Physician: _____ Primary Care Physician: _____

X – Pain
000 -Numbness



How did your pain start? _____

What eases or eliminates the pain? (circle as many as apply)

Lying down Standing Exercise Arthritis Medicine Pain Pills

Muscle Relaxants Nothing Other _____

Please circle all the following <u>medical problems</u> that you have had: (circle as many as apply)

Heart problems	Heart Attack	High Blood Pressure	Stroke	Blood Clots
Diabetes	Asthma	Kidney problems	Liver	Thyroid
Lung ____	COPD	Depression	Headaches	Cancer
Glaucoma	Seizures	Ulcers	Hepatitis	Other _____

Please list all <u>past surgeries</u> you have had:

Year: _____/_____ Year: _____/_____
Year: _____/_____ Year: _____/_____
Year: _____/_____ Year: _____/_____
Year: _____/_____ Year: _____/_____

Please list all current <u>pain medications</u> and other medications:

Pain Medication	**Dose and Frequency**	**Other Medication**	**Dose and Frequency**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you take any of the following medications: Coumadin Aspirin Plavix Lovenox Heparin

Please list any allergies to medicines: _____

Please list any pain medicines you have tried in the past: _____

_____

Please indicate which <u>tests</u> you have had to evaluate your present pain (with date):

MRI _____ CT Scan _____ Myelogram _____

Bone Scan _____ Discogram _____ EMG _____

Other _____

Please list any injections you have received for your pain (with date):

_____

_____

Please list any other treatments you have received for pain (TENS, chiropractic, physical therapy, biofeedback):

_____

Work History: Check (√) all that apply:

? Disability ? Retired ? Fired ? Student

? Working – Part time ? Medical Leave ? Self Employed ? Other _____

? Working – Full time ? Homemaker ? Not working – why? _____

What is/was your occupation?

_____

When did you last work?

_____

If your pain is work related, what was the date of your injury?

_____

Do you currently have an attorney in regards to your pain condition? [ ]Yes [ ] No

If yes, please provide name and phone number:

_____

Social History: Please (√) all that apply:

Have you ever smoked? [ ] Yes [ ] No If yes, when did you stop smoking?

_____

Do you drink alcohol? [ ] Yes [ ] No If yes, how much in a week?

_____

Do you have a history of alcohol, street drugs, or prescription medicine abuse? [ ] Yes [ ] No

Sleep and Mood: Please (√) all that apply:

How many hours a night do you sleep? _____
Have you ever been diagnosed with depression, psychosis, schizophrenia, or bipolar disorder? If yes, which one?

_____
Are you seeing a psychiatrist or psychologist? [ ] Yes [ ] No If yes, for what?

_____
Do you have any thoughts of hurting yourself or others? [ ] Yes [ ] No

Do you have <u>family history</u> of any of these problems? (Circle as many as apply)

Alcoholism	**Depression**	**Substance Abuse**	**Mental Illness**
Cancer	**Heart Problems**	**Stroke**	**Other**

_____

Please provide any further information that you feel will help us in managing your pain.

_____
_____

_____
_____

Are your mother and father still living? What are/were their ages? Did they have any significant health problems?

Do you have any brother or sisters? If so, how many?

Do you have any children? How many and what gender?

We thank you for taking the time to complete this questionnaire. The information you have provided us will be beneficial and helpful in managing your pain, and as always, all the information given is held in the strictest of confidence.

Notes:

What does your pain feel like?

Some of the words listed below may describe your pain right now. Circle only **<u>one</u>** word in each word grouping that best describes it. Leave out any work group that is not suitable. **Use only one word in each group that applies…the one that fits best.**

1. (S) flickering quivering pulsing throbbing beating pounding	2. (S) jumping flashing shooting	3. (S) pricking boring drilling stabbing lacerating	4. (S) sharp cutting lacerating	5. (S) pinching pressing gnawing cramping crushing
6. (S) tugging pulling wrenching	7. (S) hot burning scalding scarring	8. (S) tingling itchy smarting stinging	9. (S) dull sore hurting aching heavy	10. (S) tender taut rasping splitting
11. (A) tiring exhausting	12. (A) sickening suffocating	13. (A) fearful frightful terrifying	14. (A) punishing grueling cruel vicious killing	15. (A) wretched blinding
16. (E) annoying troublesome miserable intense unbearable	17. (M) spreading radiating penetrating piercing	18. (M) tight numb squeezing	19. (M) cool cold	20. (M) nagging nauseating agonizing dreadful

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Notice of Privacy Practices

The physicians, nurses and all employees of ST. LOUIS PAIN CONSULTANTS; are committed to protecting the privacy of your protected health information (PHI). Federal Law requires that we provide you with a Notice of our Privacy Practices that explains when, where, and why your confidential health information may be used or shared. By signing below, you acknowledge that you have been provided an opportunity to view, and take with you if you choose, a copy of our Notice.

By Law we are permitted to use Protected Health Information for purposes of Treatment, Payment and Healthcare Operations such as sharing confidential health information with others in order to treat you, in order to arrange for payment of my bill and for issues that concern ST. LOUIS PAIN CONSULTANTS operations and responsibilities. You must authorize any other use or disclosure.

☐ If you wish to restrict the use or disclosure of your PHI please check here and request the necessary forms.

☐ If you wish to Request alternative means or locations to receive confidential communications about your PHI, check here and complete the necessary forms.

☐ You have the right to Access, Amend and request an Accounting of certain disclosures...the necessary forms are available from the office. There will be a charge for these services except for the first Accounting of Disclosures.

☐ Check here if you do not authorize ST. LOUIS PAIN CONSULTANTS, its physicians, nurses and employees to contact you by telephone, and, if you are not available, to leave an appropriate message on a voicemail recorder.

☐ It is the policy of ST. LOUIS PAIN CONSULTANTS to not to use Internet e-mail to transmit or receive PHI due to the vulnerable nature of this medium. If you wish to use e-mail, you must complete an authorization form specifically allowing this.

You have a right to privacy. **If someone is in the room during your evaluation, ST. LOUIS PAIN CONSULTANTS will regard this as implied consent that you authorize the disclosure of information to those present.** Any other disclosure, even to members of your family, requires an authorization. Please notify us now whom you authorize us to discuss your Protected Health Information within the future, either in person or by telephone.

If you have any concerns about the Privacy of your Protected Health Information please contact the Privacy Officer at:

ST. LOUIS PAIN CONSULTANTS.
121 St. Luke's Center Drive, Suite 403
Chesterfield, MO. 63017

I hereby acknowledge that I have had an opportunity to review and receive the ST. LOUIS PAIN CONSULTANTS. Notice of Privacy Practices and am aware that I have certain rights regarding my PHI.

_____ _____

Signature of Patient Date

St. Louis Pain Consultants
Anne Christopher M.D.
Pain Management
(314) 205-6149 (office)
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OPIOID (NARCOTIC) AGREEMENT

1. I understand that I have a chronic pain problem, which currently requires the prescription of opioid (narcotic) pain medication designed to help me improve my ability to function. I understand that the long-term risks of dependency and tolerance outweigh the benefits unless function is improved along with the pain, therefore the medication will not be continued if my level of function fails to improve even if my pain is reduced.
2. In the event that I develop a psychological dependency or addiction to the medication or, in the opinion of my physician, I display any drug seeking behavior or other evidence of potential addiction, the medication will be tapered in a manner that will avoid withdrawal side effects and then discontinued. If I am unable to control the intake of my pain medication, I agree to undergo inpatient withdrawal (detox).
3. I will obtain prescriptions for opioids (narcotics) and other controlled medications only from my physician Anne Christopher MD and/or Justin Gasper D.O. at St. Louis Pain Consultants.
4. To the extent possible, I will have prescriptions filled at only one pharmacy and tell my physician, Anne Christopher MD and/or Justin Gasper D.O. at St. Louis Pain Consultants the name, address, and phone number of the pharmacy.
5. I will take the medication only as prescribed and will promptly notify my physician Anne Christopher MD and/or Justin Gasper D.O. at St. Louis Pain Consultants if I cannot.
6. I agree to random urine or blood tests to assess my compliance with the planned treatment.
7. I understand that the eventual goal is to taper to the lowest level of opioid (narcotic) medication needed to increase my level of functioning and, if possible, to discontinue the medication.
8. I will meet regularly with my physician Anne Christopher MD and/or Justin Gasper D.O. at St. Louis Pain Consultants to assess my progress. The frequency of visits is dependent on my response to the treatment program.
9. I will not share my medication with others.
10. I understand that it is my responsibility to take care of my medications and that lost, misplaced or stolen medications will not be replaced. If my medications are stolen, I agree to file a police report and deliver a copy of this report to my doctor.
11. I understand that prescription refills will not be given early for any reason unless my physician has cleared it. I understand that refills of medication must be made in an office visit.
12. If I deviate from these guidelines or the medication loses its effectiveness in increasing my function, I understand that it will be promptly tapered and stopped.
13. If I am unable to tolerate any narcotic medication that is prescribed for me, I will bring the unused portion of my prescription in to the clinic so that it may disposed of prior to my receiving another narcotic medication as a substitute.
14. If requested by my physician, I agree to have another individual keep control of the medication and dispense it to me.

Signature: _____ **Date**_____

Printed name: _____

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AUTHORIZATION AND CONSENT

FOR RELEASE OF MEDICAL RECORDS

PLEASE FAX RECORDS TO 314-590-5920

If you are unable to fax medical records due to the size of a chart, please call our office or send a note by fax to inform us of the status of the request.

RECORDS HOLDER: _____

FAX: _____

Being competent, eighteen (18) years of age or older and duly authorized, the undersigned willfully and voluntarily authorized the release of medical records and medical information to:

Anne Christopher, M.D.
121 St. Luke's Center Drive
Suite 403
Chesterfield, MO 63017
314-205-6149 phone
314-590-5920 fax

THE UNDERSIGNED AUTHORIZES MEDICAL INFORMATION FOR RELEASE THAT MAY INCLUDE INFORMATION THAT MAY BE CONSIDERED A COMMUNICABLE OR VENEREAL DISEASE. SUCH DISEASES MAY OR MAY NOT INCLUDE DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND HUMAN IMMUNODEFICIENCY VIRUS (HIV) RELATED CONDITIONS, SUCH AS HIV SEROPOSITIVITY AND ACQUIRED IMMUNE DEFICIENCY SYNDROME OR (AIDS).
THE UNDERSIGNED HOLDS ANNE CHRISTOPHER, M.D., AND ST. LOUIS PAIN CONSULTANTS HARMLESS FOR THE RELEASE OF SAID MEDICAL RECORDS.

Date: _____

Full Name of Patient: _____

Authorized Signature: _____

Social Security Number: _____

URINE DRUG SCREENING

WHAT TO EXPECT:

1. It is part of the standard protocol at ST. LOUIS PAIN CONSULTANTS, to perform a urine drug screen analysis on every new patient. If you are prescribed any medication during your treatment at ST. LOUIS PAIN CONSULTANTS, you will be given repeated urine drug screenings at least once every three months. The urine drug screen will be billed to your insurance company along with the office visit. Most insurance companies cover the cost of the urine drug screen; however, if you have not met your deductible, in some cases there may be a portion of the bill that you are financially responsible for.

2. Once our office obtains a urine sample, this sample gets sent to a laboratory to be analyzed. The laboratory will additionally bill your insurance company for the cost to perform the analysis. These costs can be rather high because of the expensive equipment involved in performing this analysis. The laboratory accepts the amount your insurance company pays and does not charge the patient for any remaining balance. If you should happen to receive a bill from the laboratory after your insurance company pays their portion, please call the laboratory to discuss any remaining balance.

I understand I will be asked to submit to a urine drug screening at the time of my first visit with St. Louis Pain Consultants. I additionally understand I may be asked to submit to subsequent random urine drug screenings per the discretion of medical staff of St. Louis Pain Consultants.

_____ _____

Patient Date

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Cancellation Policy

If you cannot make it to your appointment please contact us 24 hours in advance to cancel your appointment.

If you do not cancel 24 hours in advance you will be charged a no-show fee of $50.00.

I, _____ understand and agree to above stated policy.
(Patient name)

_____
(Date)