Comprehensive Pain Management Associates

Phillip Fyman, M.D. and Alexander Weingarten, M.D., PC

2001 Marcus Avenue, Suite S20 • New Hyde Park, NY 11042 (516) 358-HOPE/4673 • Fax# (516) 358-0319
121 Eileen Way • Syosset, NY 11791 • (516) 496-4964 • Fax# (516) 496-4950

Phillip N. Fyman, M.D.
Alexander E. Weingarten, M.D.
Louis Malesardi, P.A.-C.
Joseph A. Bax, D.O.

Diplomates of:
American Board of Anesthesiology
Subspecialty Certification in Pain Management
American Academy of Pain Medicine

Please bring for New Patient Consultation:

NEW PATIENT PACKET / REFERRAL IF REQUIRED BY INSURANCE

1. Medical Records

a. Last 3 office visit notes from referring provider

b. Most recent - MRI/Cat Scan/X-Ray

c. List of medications

d. List of allergies

2. Photo ID/Insurance Card(s)

For Your Information:

1. Urine test done at every appointment

2. No prescriptions will be given at visit

3. Payment methods

a. Cash
b. Credit
c. Debit

** No Checks accepted**

*****Syosset Office Parking in rear of building******

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Physical Medicine and Rehabilitation
Hospice and Palliative Care

Date: _____

I, _____, residing at _____ authorize _____ to have access to communicate (whether verbally or in writing) with Comprehensive Pain Management Associates (Phillip Fyman, MD & Alexander Weingarten MD) with regards to my treatment, medical condition, billing issues, etc.

Patient's Signature: _____

Witness Signature: _____

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Patient Information Sheet- COMMERCIAL/ MEDICARE

DATE:_____

PERSONAL:
Last Name:_____ First Name:_____ **Date of Birth**:_____
Address:_____ City/State:_____ Zipcode:_____
Phone Number_____ Cell:_____ Sex: Male__ Female__
Social Security Number: _____- _____ - _____ Marital Status: S___ M___ D____ W____ SEP_____

EMPLOYMENT:
Employer:_____ Business Phone Number:_____
Address: _____

FAMILY INFORMATION/ EMERGENCY CONTACT:
Name of Spouse/ Nearest Relative:_____ Phone Number:_____

PRIMARY INSURANCE:
Insurance Company_____ Policy Number_____ Group#_____
Insurance Address_____
Policy Holder Name: _____ Date of Birth: _____
Relationship to Patient: Self _____ Spouse _____ Child _____ Other _____

SECONDARY INSURANCE:
Insurance Company_____ Policy Number_____ Group#_____
Insurance Address_____
Policy Holder Name: _____ Date of Birth: _____
Relationship to Patient: Self _____ Spouse _____ Child _____ Other _____

Referring Doctor or Primary Doctor: _____
Address_____ City/State_____ Zip_____
Phone Number: ( ) _____-_____

PHARMACY INFORMATION:
Name of Pharmacy: _____ Phone: _____
Address: _____ Fax: _____

How did you first learn about Comprehensive Pain Management?_____

IS THIS A WORKERS COMPENSATION CASE? _____YES _____NO

IS THIS A NO-FAULT CASE? _____YES _____NO

DO YOU HAVE ANY ALLERGIES? Please list: _____

PLEASE INDICATE CURRENT MEDICATIONS YOU ARE TAKING ON "PAIN INFORMATION SHEET"

Patient Information Sheet – page # 2

WORKERS COMPENSATION:

Insurance Carrier_____
Address_____
Claims Adjuster (*Name & Ext.)*_____
Phone Number_____ Fax#_____
Claim#_____ WCB#_____
Date of Accident: _____ Part of Body Injured_____
Briefly how did the Injury Occur?_____
_____
Are you still working?: Yes No

NO-FAULT:

Insurance Carrier_____
Address_____
Claims Adjuster (Name & Ext.)_____
Phone Number_____ Fax#_____
Claim#_____ Policy#_____
Date of Accident_____ Part of Body Injured_____
Briefly how did the injury occur? _____
_____

ATTORNEY INFORMATION:

Name_____
Address_____
Phone_____ Fax_____

AUTHORIZATION FOR RELEASE OF INFORMATION BY COMPREHENSIVE PAIN MANAGEMENT ASSOCIATES: I hereby authorize and direct the above named clinical practice, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives hereof to examine and make copies of all records relating to such treatment. I hereby authorize Comprehensive Pain Management to furnish all records, including those relating to AIDS (HIV) testing, request and results to my referring physician.

I, hereby assign, transfer and sign over to COMPREHENSIVE PAIN MANAGEMENT ASSOCIATES all monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical costs of the care and treatment rendered to myself or my dependent.

I acknowledge that if I have to cancel or reschedule an appointment, I must do so at least 24 hours prior to the appointment or I will pay a $25.00 fee. I agree to pay a $25.00 fee for a missed appointment.

I understand that regardless of my insurance status, I'm ultimately responsible for the balance on my account for any professional services rendered. I accept financial responsibility for procedures deemed medically unnecessary by my insurance company. If for any reason my account is sent to a collection agency, I am responsible for all costs incurred. I certify that the health insurance information (commercial, no-fault, worker compensation or Medicare) that I gave to your office is true and correct. Also, I acknowledge that I am responsible for notifying this office of any and all changes in my health insurance.

SIGNATURE:_____ **DATE:**_____/_____/_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received from this provider a copy of a separate document, entitled "Notice of Privacy Practices," which sets forth this provider's privacy practices and my rights regarding privacy of my Patient Health Information (PHI).

_____ _____

PATIENT SIGNATURE DATE

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MEDICATION AGREEMENT

We have found it both necessary and helpful for the patients and clinicians to outline the terms of the medication prescription and usage. This enables the clinicians to communicate the patient's responsibilities as well as the clinicians' responsibilities. By outlining and enumerating these issues, we are better able to serve the patient.

1. Medications must be taken as directed, both on schedule and in the proper dosage. Any change in either one of these things must be discussed with prescriber.
2. No medication prescriptions will be discussed or written after hours or on weekends, or prescribed by telephone
3. Controlled pain medication prescriptions must be prescribed only from our practice. The patient must use a single pharmacy for the prescriptions.
4. Medications or prescriptions may not be replaced if lost or stolen, etc. It is the patient's obligation to safeguard their medicines.
5. The patient must inform Comprehensive Pain Management Associates if there is a serious problem with any of the medications immediately, i.e., rash, stomach upset, or any other possible side effects.
6. We may be using potent medication in your treatment such as opioids or benzodiazepines. These medications have side effects as well as the possibility of tolerance or dependence. They may also cause symptoms of withdrawal if they are suddenly stopped.
7. It is also important that you understand there are other treatment options which can be used instead of or with the medication; these will be discussed.
8. Urine specimens may be requested to help determine compliance of your treatment.
9. You agree to keep all scheduled appointments.
10. I give permission to my pain doctor to contact my other healthcare providers, for the purposes of sharing information concerning my situation, as is deemed necessary for coordinated, high quality care.
11. You agree not to use any alcohol, "street drugs", illegal drugs, including marijuana, as long as you are a patient in our practice.
12. If you have used illegal drugs, including marijuana, or abused alcohol or prescription drugs in the past, you will tell us.

Any violation of this agreement may be cause for termination from the practice.

_____ _____
Patient's Signature Date

_____ _____
Phillip N. Fyman, M.D. Alexander E. Weingarten, M.D.

_____ _____
Joseph Bax, D.O. Louis Malesardi, PA-C

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Guidelines for Controlled Substances

We are committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances are used as a therapeutic option in the management of chronic pain and related anxiety and depression, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper controlled substance use. The words "we" and "our" refer to the facility and the words "I", "you", "me" or "my" refer to you, the patient.

1. i. I understand that chronic opioid therapy has been associated with not only addiction and abuse, but also multiple medical problem including the suppression of endocrine function resulting in low hormonal levels in men and women, which may affect mood, stamina, sexual desire, and physical and sexual performance.

   ii. For female patients, if I plan to become pregnant or believe that I have become pregnant while taking this medication, I am aware that, should I carry the baby to delivery while taking these medications; the baby will be physically dependent upon opioids. I will immediately call my obstetrician and this office to inform them of my pregnancy. I am also aware that opioids may cause a birth defect, even though it is extremely rare.

   iii. I have been informed that long-term and/or high doses of pain medications may also cause increased levels of pain known as opioid induced hyperalgesia (pain medicine causing more pain) where simple touch will be predicted as pain and pain gradually increases in intensity and also the location with hurting all over the body. I understand that opioid- induced hyperalgesia is a normal, expected result of using these medicines for a long period of time. This is only treated with addition of non-steroidal anti-inflammatory drugs such as Advil, Ibuprofen, etc., or by reducing or stopping opioids.

   iv. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that is my pain medicine use is markedly decreased, stopped, or reversed by some of the agents mentioned above; I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, larger pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable, but not life threatening.

   v. I am aware that tolerance to analgesia means that 'I may require more medicine to get the same amount of pain relief'. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment, reduce the dose, or stop it.

2. i. All controlled substances must *come* from the physicians or physician assistants in this practice or during his/her absence, by covering physician, unless specific written authorization is obtained for an exception.

   ii. I understand that I must tell the physician whose signature appears below or during his/her absence, the covering physician, all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death.

   iii. I will not seek prescriptions for controlled substances from any other physician, health care provider, or dentist. I understand is it unlawful to be prescribed the same controlled medication by more than one physician at a time without each physician's knowledge.

   iv. I, also understand that it is unlawful to obtain or to attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician of his/her staff or knowingly withholding facts

from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed).

3. All controlled substances must be obtained at the same pharmacy where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you selected is:

Name of Pharmacy	Address (Street & Town if full address unknown)	Phone #

4. i. You may not share, sell, or otherwise permit other, including your spouse or family members, to have access to any controlled substances that you have been prescribed,

ii. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not make excessive phone calls for prescriptions or early refills and do not phone for refill after hours or on weekends. NO EXCEPTIONS WILL BE MADE.

iii. The patient on their own is not allowed to alter the dosing regiment of the prescription written by the physician or any covering physicians. NO medications will be refilled early due to patient increasing dose. If medication is not covering pain levels then appointment needs to be made to discuss with the physician and medication needs to be brought with you to appointment for a pill count. All pills need to be accounted for prior to discussion. No Exceptions.

iv. Unannounced pill counts, random urine or serum, or planned drug screening may be requested from you and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from the facility and its physicians' and staff.

5. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except ~specifically authorized by the physician whose signature appears below or during his/her absence, by the covering physician, as set forth in Section 2 above. I will not use, purchase, or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance or any combination of substances (e.g., alcohol and prescription drugs), which impairs my driving ability, may result in DUI charges.

6. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen, it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told the authorities is not enough.

7. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.

8. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at the facility and that law enforcement officials may be contacted.

9. I also understand that my prescribing physician has permission to discuss all diagnostic and treatment details, including medications, with dispensing pharmacists, other professionals who provide your healthcare, or appropriate drug and law enforcement agencies for the purpose of maintaining accountability.

10. I affirm that I have full right and power to sign and to be bound by this agreement, that I have read it, and understand and accept all of its terms. A copy of this document has been given to me.

Patients Full Name (Please Print)	Date
Patients Signature	Date
Physicians Signature	Date
Witness	Date

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Authorization for Disclosure of Health Information

1) I hereby authorize Dr. _____ Phone: _____

2) To disclose the following information from the health records of:

Patient's Name _____ Date of Birth: _____

Address: _____

Patient Telephone #: _____ Date(s) of service: _____

3) Information to be disclosed:

☐Complete health records	☐Discharge summary	☐Billing records
☐History & Physical	☐Progress Notes	☐x-ray reports
☐Laboratory test	☐other: _____	

I understand that this will include information relating to: (If I am authorizing the release of HIV related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law).

☐ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
☐ Behavioral health services/ psychiatric care
☐ Treatment for alcohol and/or drug abuse
☐Domestic abuse

***Patient Initials:** _____

4) At the request of the patient; this information is to be released to: COMPREHENSIVE PAIN MGMT ASSOCIATES.

5) I understand 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 12 months from the date signed. I understand that signing this authorization is voluntary. I also understand I may refuse to sign this form and that my health care and payment will not be affected.

Date: _____ ***Patient Initials:** _____

6) The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for the above disclosure of the above information to the extent indicated and authorized herein.

7) I may request a copy of this form after signing.

8) Information disclosed under this authorization might be re-disclosed by the recipient (except as noted in 3) and this re-disclosure may no longer be protected by federal or state law.

***Patient Initials:** _____

Signed: _____ Date: _____
(Patient)

_____
(Signature of Witness) (Relationship to patient) (Date)

Note: Release of all confidential information is governed by State and Federal and HIPPAA Regulations.

MEDICAL HISTORY RECORD

All information is treated as confidential unless you grant permission to release it. Please print and complete all information.

TODAY'S DATE	Date of Birth	Last Name First Name	
Male _____ Female _____	Daytime Phone	Home Phone	
Address	Marital Status	Occupation	
Person to notify in emergency	Daytime Phone	Relationship	Last Physical Exam Date
By Doctor	Phone	Family or referring Doctor	Phone No.

May I contact either of these doctors for your past health records? YES _____ NO _____

What are your present medical symptoms?

Family History	Age	Health (if living) Good Fair Poor	Death Age	DEATH CAUSE
Father				
Mother				
Brothers/Sisters (circle sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
Husband ☐ Wife ☐				
Sons/Daughters (circle sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				

Any blood relatives who have or have had any of the listed conditions?

	Y	N	Relationship		Y	N	Relationship
Asthma				Hay Fever			
Arthritis				Insanity			
Allergies				Kidney Disease			
Anemia				Leukemia			
Alcoholism				Migraine			
Bleeding Tend				Nervous Break			
Cancer				Obesity			
Colitis				Rheumatism			
Congenital Heart				Rheumaitc Fever			
Diabetes				Stroke			
Epilepsy				Suicide			
Goiter				Stom. Ulcer			
High Bl. Press.				Tuberculosis			
Heart Disease							

HABITS

Do you	Yes	No	Daily Consumption:
Smoke	☐	☐	_____ pkgs.
Drink Coffee	☐	☐	_____ cups
Drink Alcohol	☐	☐	_____ oz.
Drink Beer	☐	☐	_____ oz.
Fall Asleep Easily	☐	☐	
Awaken Early	☐	☐	

MEDICATIONS

✓ **If Taken:**

Antacids ☐	Blood Thinning Pills ☐	Insulin, Diabetic Pills ☐	Thyroid Med ☐
Antibiotics ☐	Cortisone ☐	Iron/Poor Blood Med ☐	Tranquilizers ☐
Aspirin, Bufferin, Anacin ☐	Cough Medicine ☐	Laxatives ☐	Vitamins ☐
Barbiturates ☐	Digitalis ☐	Phenobarbital ☐	Water Pills ☐
Birth Control Pills ☐	Dilantin ☐	Shots ☐	Weight Reducing Pills ☐
Blood Pressure Pills ☐	Hormones ☐	Sleeping Pills ☐	Other _____ ☐

Operations you have had: Year

_____

_____

Diseases you have had requiring hospitalization: Year

_____

_____

Serious Illness not requiring hospitalization: Year

_____

_____

Drugs you are allergic to:

_____

_____

Describe any serious injuries or accidents you have had:

_____

_____

Women Only:

	Yes	No	
Are you still having regular monthly menstrual periods?	☐	☐	
Have you ever had bleeding between your periods?	☐	☐	When? _____
Do you have very heavy bleeding with your periods?	☐	☐	When? _____
Do you feel bloated & irritable before your period?	☐	☐	When? _____
Are you now or have you ever taken the birth control pill?	☐	☐	When? _____
Have you ever had a miscarriage?	☐	☐	When? _____
Have you ever had a discharge from the nipple of your breast?	☐	☐	When? _____
Do you regularly have the cancer test of the cervix?	☐	☐	Date of last test: _____

How many children born alive _____

How many stillbirths _____

How many premature births _____

Date of last menstrual period _____

How many miscarriages _____

How many cesarean operations _____

Any complications of pregnancy? Explain.

_____

Men Only: Have you ever had:

	Yes	No		Yes	No
Loss of sexual activity? For how long? _____	☐	☐	Hernia (rupture)? _____	☐	☐
Treatment for genitals (private parts): _____	☐	☐	Prostate trouble? _____	☐	☐
Discharge from penis? _____	☐	☐			

MEN and WOMEN:

	Yes	No
Do you frequently have severe headaches?	☐	☐
(If yes, answer the following):		
Do they cause visual trouble?	☐	☐
Do they occur on one side of the head?	☐	☐
Do they awaken you at night?	☐	☐
Do they feel like a tight hat band?	☐	☐
Do they hurt most in the back of the head and neck?	☐	☐
Does aspirin relieve them?	☐	☐

	Yes	No
Have you ever fainted?	☐	☐
Spells of dizziness?	☐	☐
Spells of weakness of arm or leg?	☐	☐
Ringing in ears?	☐	☐

Have you ever had shortness of breath:

	Yes	No
Doing your usual work?	☐	☐
Climbing a flight of stairs?	☐	☐
Which awakens you at night?	☐	☐
Do you have a chronic cough?	☐	☐
Which causes you to cough?	☐	☐
Accompanied by wheezing?	☐	☐
Have you ever coughed blood?	☐	☐
Do you cough up much sputum?	☐	☐

Have you had:

	Yes	No
Burning when urinating?	☐	☐
Loss of control of bladder?	☐	☐
Blood in the urine?	☐	☐
Dark colored urine?	☐	☐
Trouble starting to urinate?	☐	☐
Trouble holding the urine?	☐	☐
To get up frequently at night?	☐	☐
Passed a kidney stone?	☐	☐

If you have had a change in bowel habit recently answer the following:

	Yes	No
Crampy pain in the abdomen?	☐	☐
Alternating diarrhea and constipation?	☐	☐
Pain during or after bowel movement?	☐	☐
Mucous in the stool?	☐	☐
Ribbon like stools?	☐	☐
Black stools?	☐	☐
Require use of strong laxatives or enemas?	☐	☐

Have you recently had pain in the stomach which:

	Yes	No
Occurs 1-2 hours after a meal?	☐	☐
Is brought on by eating fried foods, gassy foods?	☐	☐
Awakens you at night?	☐	☐
Is relieved by antacid medications?	☐	☐
Occurs while eating or immediately after?	☐	☐
Is relieved by a bowel movement?	☐	☐
Causes loss of appetite?	☐	☐

Do you frequently have:

	Yes	No
Bleeding gums?	☐	☐
Trouble swallowing?	☐	☐
Hoarseness?	☐	☐
A sore tongue?	☐	☐
Nausea and vomiting?	☐	☐

Have you ever had pain or tightness in the chest which begins:

	Yes	No
When exerting yourself?	☐	☐
When walking against a wind?	☐	☐
When walking up a hill?	☐	☐
After a heavy meal?	☐	☐
When upset or excited?	☐	☐
Palpitations?	☐	☐
Do you sleep on more than 1 pillow?	☐	☐

	Yes	No
Radiates down the arm?	☐	☐
Disappears if you rest?	☐	☐
Occurs only at rest?	☐	☐
When walking fast?	☐	☐
When walking in cold weather?	☐	☐

If you have chest pain/tightness, please explain: _____

Have you recently had:

	Yes	No	When or since when?
Pain in calves of legs when walking?	☐	☐	_____
Cramps in legs at night?	☐	☐	_____
Pain in the big toe?	☐	☐	_____
Varicose veins?	☐	☐	_____
Phlebitis or inflamed leg veins?	☐	☐	_____
Swelling in ankles?	☐	☐	_____

Describe briefly your present medical symptoms and anything else we should know about your health.

_____

_____

_____

_____

_____

_____

_____

_____

_____

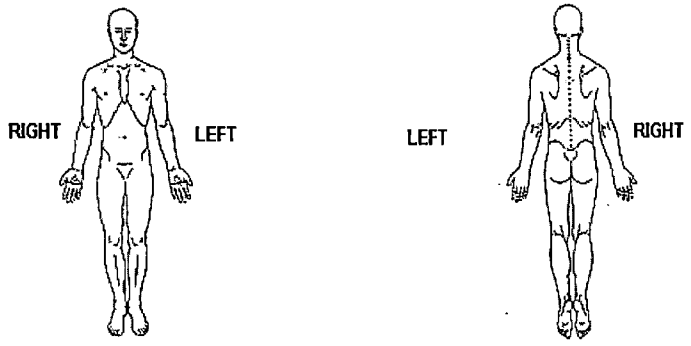
_____

PAIN INFORMATION SHEET

Patient Name: _____ **Date:** _____/_____/_____

Please answer the following questions about your pain. This will help your doctor and others on your healthcare team understand your pain and plan your treatment.

Where is your pain?
On the diagram below, shade all areas where you feel pain. Mark an "X" where it hurts the most.



Is your pain mainly:
☐ On the surface ☐ Down deep ☐ Somewhere in-between

What does your pain feel like?
Circle all the words that describe your pain or write your own words. Check off degree of pain.

	Mild	Moderate	Severe		Mild	Moderate	Severe
Aching	___	___	___	Prickling	___	___	___
Dull	___	___	___	Gnawing	___	___	___
Tender	___	___	___	Burning	___	___	___
Cramping	___	___	___	Pounding	___	___	___
Tightness	___	___	___	Electric	___	___	___
Throbbing	___	___	___	Sharp	___	___	___
Knotlike	___	___	___	Crushing	___	___	___
Pressing	___	___	___	Stabbing	___	___	___
Pinching	___	___	___	Shooting	___	___	___
Pulsing	___	___	___	Other	___	___	___

How much pain do you feel?
Using the scale, choose the number that best shows how much pain you feel when you have the **worst** pain.

_____

0 1 2 3 4 5 6 7 8 9 10
None Mild Moderate Severe Worst

Using the scale, choose the number that best shows how much pain you feel when you have the **least** pain.

_____

Using the scale, choose the number that best shows **the kind of pain you can live with on a daily basis.**

_____

When do you feel pain:
Please write brief answers to the following questions:

What time of the day does the pain start? _____
Do you feel pain all the time? _____
Does the pain change during the day? If so, how?

_____
_____
_____

What makes the pain better? _____
_____

What makes the pain worse? _____
_____

What medicines are you taking for pain relief? Please write the name of each medicine you are taking, the amount (dose), how often you take it, and the effect it has on your pain.

Name of medicine	Amount	How often do you take it?	Do you get relief?		
_____	_____	_____	None	Some	Total
_____	_____	_____	None	Some	Total
_____	_____	_____	None	Some	Total
_____	_____	_____	None	Some	Total
_____	_____	_____	None	Some	Total

Do you have side effects from your pain medicines? Circle all the side effects you are currently experiencing.

Light-headed Irritable Extremely tired Sweating Constipation Nausea Vomiting
Trouble thinking Low energy Hard to breathe Itching Poor appetite Trouble sleeping Other: _____

How has pain changed your normal activities? Circle those areas where pain has interfered with your life.

Sleeping Dressing Work/ housework Relationship with other people Exercising Hobbies
Eating Walking Mood Enjoyment of life Sports Other: _____

Comprehensive Pain Management Associates

Phillip Fyman, MD and Alexander Weingarten, MD, PC

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____ Phillip N Fyman, M.D. ___ Alexander E. Weingarten, M.D.
___ Joseph Bax, D.O. ___ Louis Malesardi, PA-C

DATE: _____

SOAPP Version 1.0-14Q

The following are some questions give to all patients at the Pain Management 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. Thank you.

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 problem with alcohol or drugs?	0 1 2 3 4
5.	How often have others suggested that you have a drug of alcohol problem?	0 1 2 3 4
6.	How often have you attended an AA or NA meetings?	0 1 2 3 4
7.	How often have you taken medication other than the way 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 medication?	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 (for example marijuana, cocaine, etc) in the past five years?	0 1 2 3 4
14.	How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you!

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OPIOID RISK TOOL

			Mark each box that applies	Item Score if female	Item Score if male
1.	**Family History of Substance Abuse**	Alcohol	[ ]	1	3
		Illegal Drugs	[ ]	2	3
		Prescription Drugs	[ ]	4	4
2.	**Personal History of Substance Abuse**	Alcohol	[ ]	3	3
		Illegal Drugs	[ ]	4	4
		Prescription Drugs	[ ]	5	5
3.	**Age** (mark box if 16 – 45)		[ ]	1	1
4.	**History of Preadolescent Sexual Abuse**		[ ]	3	0
5.	**Psychological Disease**	Attention Deficit Disorder Obsessive Compulsive Disorder Disorder, Bipolar Schizophrenia	[ ]	2	2
		Depressions	[ ]	1	1
			TOTAL	_____	_____

Total Score Risk Category
Low Risk 0 – 3
Moderate Risk 4 – 7
High Risk >8

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine.* 2005;6(6):432-442. Used with permission.