St. Charles Orthopedics
VLADA FRANKENBERGER, DO
Interventional Pain Medicine

NAME ____ Today‘s Date _______________

D.O.B _______________________________S.S # _____________________________________

ADDRESS ____

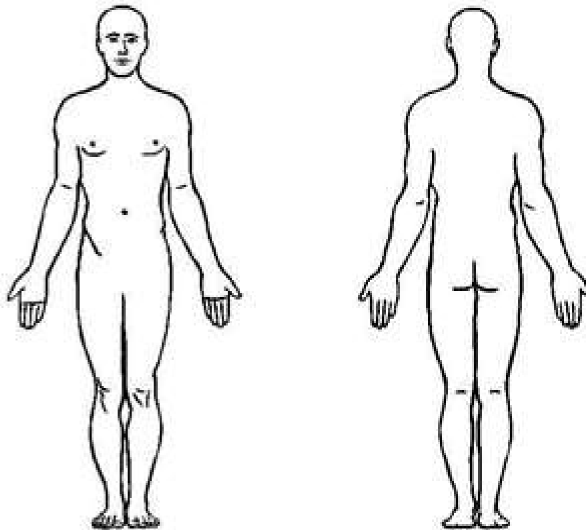
INSURANCE____
REFERRING DOCTOR ____
PRIMARY CARE DOCTOR____
CARDIOLOGIST ____
ONCOLOGIST ____
NEUROLOGIST ____

PLEASE DESCRIBE THE PROBLEM(S) FOR WHICH YOU HAVE COME TO SEE US:
____

____

____

PAIN DRAWING: MARK THE AREAS ON DRAWING THAT CORRESPOND TO WHERE YOU HAVE PAIN. USE “X” TO MARK PAINFUL AREAS. USE “O’ TO MARK AREAS OF NUMBNESS AND TINGLING.



Name:__________________________________ Date of Birth:_________________

Please put a check next to other treatments that you have had for your pain?

Surgery: Name and dates of operation(s) to treat your pain:

____
____
____

Medication(s) List all you have TRIED to treat your pain:

____________ ____________ ____________ ____________

____________ ____________ ____________ ____________

Injection(s) used to treat your pain (**For example, epidural steroid shots**)
____
____
____

______Physical Therapy ______Chiropractic or Osteopathic
______Massage ______Biofeedback/Relaxation Training
______Tens Therapy ______Acupuncture
______ Other____________________

Who has been treating your pain?
____

During the last year, have you had:

_____Chest Pain
_____Palpitations
_____Shortness Of Breath
_____Difficulty Breathing
_____Unexplained Fever
_____Night Sweats
_____Unexplained Weight Loss
_____Persistent Constipation
_____Persistent Joint Pain
_____Persistent Muscle Pain
_____Generalized Stiffness
_____Abdominal Pain
_____Abnormal Periods/Bleeding
_____Blood In Stool Or Urine
_____Difficulty Sleeping
_____Change In Bowel Habit
_____Nausea/Vomiting
_____Skin Rashes
_____Breast Lumps
_____Swollen Lymph Nodes
_____Other__________________________

Name:_______________________________________ Date of Birth:__________

Height__________ Weight_______ Right handed______ Left handed_______

MEDICAL HISTORY:

YES	NO		YES	NO	
___	___	Irregular Heartbeat	___	___	HIV/AIDS
___	___	Heart Murmur	___	___	Psychiatric Problems*
___	___	Heart Attack			***Please Specify** ______ _________________________
___	___	Emphysema	___	___	Depression
___	___	Bronchitis			
___	___	Stomach Problems*	___	___	Anxiety
		***Please Specify**_____ ______________________________	___	___	Drug/Alcohol Addiction
___	___	Liver Disease	___	___	Misuse of Prescription Drugs
___	___	Lupus	___	___	Other _________________
___	___	Vascular Disease			
___	___	Infections*			
		***Please Specify**___________ _____________________________________			

SOCIAL HISTORY:

With whom do you live?__________________________

Do you have children? Yes______ No______

If Yes, please provide ages________________________

Name:______________________ Date of Birth:_____________________

Are you currently employed? Yes______ No________

Are you currently in school? Yes______ No________

Are you, or have you been disabled? (Explain)
For example are you out of work? Partially/Totally disabled?

____

____

Are you receiving disability payments? Yes______ No________

If yes to the above, how long have you been receiving payments?_____________

Are you currently involved in a lawsuit? (Please Explain)

____

____

Have you had any tests performed for this problem?

TEST	DATE	RESULT (If Known)
____MRI	______	____________________________________
____CAT SCAN	______	____________________________________
____EMG	______	____________________________________
____X-RAY	______	____________________________________
____BONE SCAN	______	____________________________________
____BLOOD WORK	______	____________________________________
____OTHER	______	____________________________________

Name:___________________________________ Date of Birth:________________

Approximately when did your symptoms begin? ______________________________

What do you believe is causing these symptoms? _____________________________

Which of the following describes the circumstances related to your symptoms:

_____ Accident at work
_____ Accident other than work (E.G., Home, Auto)
_____ Following illness
_____ Following surgery
_____ Pain just started - No obvious cause
_____ Other (Describe) ____

What activities cause the pain to worsen?

____
____
____

What activities help the pain?

____
____
____

What activities do you usually enjoy?

____
____
____

Pain scores (0=No pain, 10=**Worst** Imaginable Pain)

What is your average pain score over the course of the day?
0 1 2 3 4 5 6 7 8 9 10

What number represents your worst pain?
0 1 2 3 4 5 6 7 8 9 10

What number represents your least pain?
0 1 2 3 4 5 6 7 8 9 10

What word do you use to describe your pain?

________ ________ ________ ________

DAILY MEDICATION LIST

Please list **ALL** medications that you take on a daily basis – this includes **any** Herbal Supplements

Patient Name ________________________________ D.O.B___________

Medication	Dosage

Please List Any Food or Drug Allergies or Write NONE

____

____

____

____

OPIOID RISK TOOL PATIENT FORM

NAME________________________________DOB________________

Mark each box that applies.

		Female	Male
1.	**Family History of Substance Abuse:**		
	Alcohol	____	____
	Illegal Drugs	____	____
	Prescription Drugs	____	____
2.	**Personal History of Substance Abuse:**	____	____
	Alcohol	____	____
	Illegal Drugs	____	____
	Prescription Drugs	____	____
3.	**Age (mark box if between 16-45)**	____	____
4.	**History of Preadolescent Sexual Abuse**	____	____
5.	**Psychological Disease**		
	Attention Deficit Disorder Obsessive-Compulsive Disorder, Bipolar, Schizophrenia	____	____
	Depression	____	____

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PAIN MANAGEMENT AGREEMENT

The purpose of this Agreement is to prevent any misunderstandings about certain medications you will be taking for pain management. This is to help both you and your Doctor to comply with the law regarding controlled pharmaceuticals and to create the trust and confidence necessary in a doctor/patient relationship.
While all of the items listed below are required to be adhered to; please take special note of the following.

- **I UNDERSTAND THAT IF I BREAK THIS AGREEMENT, MY DOCTOR WILL STOP PRESCRIBING THESE PAIN CONTROL MEDICATIONS.**
- **I AGREE THAT REFILLS OF MY PRESCRIPTIONS FOR PAIN MEDICATION WILL BE MADE ONLY AT THE TIME OF AN OFFICE VISIT OR DURING REGULAR OFFICE HOURS. NO REFILLS WILL BE AVAILABLE DURING EVENINGS OR WEEKENDS. MEDICATIONS WILL NOT BE RENEWED OVER THE PHONE.**
- **I WILL SAFEGUARD MY PAIN MEDICATION FROM LOSS OR THEFT. LOST OR STOLEN MEDICATIONS WILL NOT BE REPLACED.**

In this case, my doctor will taper off the medication over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.
I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve the pain.
I will not use any illegal controlled substance, including marijuana, cocaine, etc.
I will not share, sell or trade my medication with anyone.
I will not attempt to obtain any controlled medications including opiates, controlled stimulants, or anti-anxiety medications from any other doctor.
I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize my doctor to provide a copy of this Agreement to my pharmacy, I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the authorizations.
Common adverse effects and complications of long term opioid therapy include but are not limited to: opioid induced constipation, irregular menses, reduced libido, depression, fatigue, hot flashes, night sweats, unintentional opioid related overdose, opioid induced hyperglycemia, memory deficits, sleep disturbances, slow heart rate (bradycardia)

- **I AGREE THAT I WILL SUBMIT TO A BLOOD OR URINE TEST IF REQUESTED BY MY DOCTOR TO DETERMINE MY COMPLIANCE WITH MY PROGRAM OF PAIN CONTROL MEDICATION.**

I agree that I will use my medication at a rate no greater than prescribed. The use of my medication at a greater rate will result in my being without medication for a period of time. I understand that if this agreement is not followed it can result in me being discharged from this practice.
I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of the Agreement is entered into on the __________day of ______________________.

I agree to use ____pharmacy
Located at ____
Telephone number __________________for filling prescriptions for all pain medication.

Patient Name: (please print) ____

Patient Signature: ____INITIAL HERE______

Medical Information Release Form

(HIPAA Release Form)

Name: ________________________________ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse____________________________________

[ ] Child(ren)_________________________________

[ ] Other_____________________________________

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:__________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ______________________________________

The best time to reach me is (*day*)__________________ between (*time*)_________

Signed: __________________________________ Date: ____/____/_____

Witness:__________________________________ Date: ___/____/______