NEW DAY™
PAIN MANAGEMENT CENTER
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM

Phone: 419-394-9520/ Fax: 419-394-9598
1165 South Knoxville Ave., Suite 105
Wheatland Professional Building, St. Marys, Ohio 45885
Dr. Syed S. Ali, M.D.
Amber Ball, APRN-CNP

Pain Management Clinic: Patient Information Sheet

OFFICE HOURS:

- Office hours are from **8:00 am to 4:30** pm Monday through Thursday. CLOSED ON FRIDAYS
- **Pain Management's phones are sent to voice mail from 12:00pm until 1:00pm for our lunch hour and stop taking calls after 4:00pm, Monday through Thursday.**
- On the days that staff are with patients, you may need to leave a message. PLEASE do not leave multiple messages. Please clearly state your name and date of birth, question, and a working number we may reach you at. We will get back with you by the end of the day or the next business day.

APPOINTMENT EXPECTATIONS: **Appt. Date:** _____ **Time:** _____

- You **must** give a 24-hour advance notice for cancellations.
- If you have 3 occurrences of same-day cancellations in a 12 month period and/or do not show for your scheduled appointments, you will be discharged from the practice.
- Current MRI's, X-rays, Cat Scans, and any other testing done pertaining to the condition we are treating you for. If you have had them done at JTDMH, you do not need to bring films.
- Most often, a patient comes to us because they have exhausted all other treatment alternatives. Treatment for the condition depends upon what is causing the patient's pain. In some cases, there is structural damage that cannot be reversed by these treatments.
- In such cases where the patients have failed all other treatment modalities, the goal is to reduce the pain and improve the quality of life.
- You must bring a current Insurance Card and Valid Photo ID to all appointments.
- When you arrive, a nurse will take a very thorough history. You will then be examined by the provider after she/he has reviewed your test results and history. She/He will discuss his findings with you, then recommend and explain treatment procedures.
- We attempt to run on schedule as much as possible, but there are multiple reasons why we could possibly run behind: Some patients have very complex pain pathologies and require more time. **Every patient, including you, is given the time necessary for understanding his or her pain pathology, treatment methods, and long-term goals.**

PRESCRIPTIONS AND RENEWALS:

- All prescriptions and authorizations for renewals must be requested during normal office hours.

- **Prescription requests may be left on the voicemail. Clearly state the following information: your name, date of birth, medication needed to be refilled, pharmacy, and a working number to contact you at. Please plan accordingly for these requests and renewals, as many of our prescriptions cannot be called into a pharmacy and need to be e-submitted by the provider at our office.**

- **Our Providers are not here daily. We need at least 7 business days before your prescriptions need refilled to make sure you do not run out of your medications.**
  Please call our prescription line at 419-394-9520 Monday through Thursday before 3:00 pm.

FINANCIAL POLICY & BILLING: **PLEASE READ:**

- **New Day Pain Management Center is an Outpatient Specialty Clinic. Pain management is partially owned by Joint Township District Memorial Hospital, so there will be a separate bill for the hospital, which includes a facility charge, Anesthesia charges, and any supplies and/or pharmacy charges.**

- **You will receive TWO separate bills for services received. One will be for services provided by the provider; the other is for services provided by JTDMH.**

- It is impossible to determine the full cost of the treatment before your examination. Only after reviewing the diagnostic studies, detailed history, and the physical exam can the provider determine the treatment appropriate for your condition. The procedures we do are relatively expensive due to many factors such as deciphering the particular pain process, the time required to perform the exam and procedure, the technical skills required, and the amount of risk involved.

- PRECISION PRACTICE MANAGEMENT is the physician's professional billing company, which will only bill you for the physician's services. Please contact PPM via phone **1-(866) 776-8150** for any questions or concerns with your *professional* bill. For billing issues for **JTDMH,** contact patient accounts 419-394-3387 extension 8023.

- **PLEASE NOTE:** It is **your** responsibility to check your individual insurance policy regarding the provider's participation and JTDMH in your plan and payment policies prior to your initial appointment. All unpaid balances by your insurance company will be billed to you. You may contact Precision Practice Management and JTDMH to set up payment plans.

- **We are a participating group with Medicare Plan B; we accept the amount allowed by Medicare.**

Notice of Privacy Practices

The enclosed Notice of Privacy Practices applies to services received by patients in the pain management department at Joint Township District Memorial Hospital, which is operated under a contractual relationship with Joint Township District Memorial Hospital New Day Pain Management, LLC and Pain Management Group, LLC. These entities may share protected health information with each other as necessary to carry out treatment, payment or health care operations in the pain management department.

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Please **Return** This Packet By: _____

If unable to return packet prior to consultation appointment, please arrive 15 minutes prior to your appointment and bring packet with you. If you do not receive packet prior to your consultation appointment, please arrive 30 minutes prior to your appointment so you can fill packet out.

It can be returned several ways!

Mail or Drop Off: We are open Monday-Thursday 8-4:30pm. If door happens to be locked, may slide under the door.

New Day Pain Management

1165 South Knoxville Ave, Suite 105, St. Marys, Ohio 45885

Fax: 419-394-9598

Email: NewDayPain@jtdmh.org

Thank You,

Sheena Warren

Clinic Secretary/Referral Coordinator

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PAIN PROFILE

Pain Scale: 1-10

Average Daily Pain Rating _____ Worst Pain Rating _____

Realistic Pain Rating GOAL _____

Duration of Pain: Circle ONE

Weeks Months Years

Timing of Pain: Circle ONE

All the time Morning Evening/Nighttime

Symptom Onset/Pattern:

- ☐ Sudden Onset
- ☐ Gradual Onset
- ☐ Continuous
- ☐ Intermittent
- ☐ Improving
- ☐ Waxing and Waning
- ☐ Worsening
- ☐ Stable

Quality:

Aching
Burning
Sharp
Sore
Stabbing
Throbbing
Symmetric
Asymmetric

Associated Signs and Symptoms: Circle all that apply.

Backache	Disability	Headache
Insomnia	Limited Joint Mobility	Joint Stiffness
Joint Swelling	Joint Tenderness	Malaise; general feeling of discomfort

Pain Radiation: _____

How long can you sit? _____ How long can you walk? _____

How long can you stand? _____

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Which of the following activities changes the nature of your pain? Circle ONE for each activity.

Sitting: Aggravates Relieves Neither **Standing:** Aggravates Relieves Neither

Walking: Aggravates Relieves Neither **Bending:** Aggravates Relieves Neither

Leaning forward: Aggravates Relieves Neither

Lying on your Side: Aggravates Relieves Neither

Lying on your back: Aggravates Relieves Neither

Lying on your stomach: Aggravates Relieves Neither

Rising from sitting: Aggravates Relieves Neither

Changing Position: Aggravates Relieves Neither

PAST TREATMENT

Physical Therapy: When_____ Where_____

Did it provide relief? YES NO % of Relief_____

Chiropractor: When_____ Where_____

Did it provide relief? YES NO % of Relief_____

Massage: When_____ Where_____

Did it provide relief? YES NO % of Relief_____

Injections: When_____ Where_____

Did it provide relief? YES NO % of Relief_____

Surgery: When_____ Where_____

Did it provide relief? YES NO % of Relief_____

NSAIDS (Motrin) When_____

Did it provide relief? YES NO % of Relief_____

Opiates (pain medication) When_____

Did it provide relief? YES NO % of Relief_____

TENS: When_____

Did it provide relief? YES NO % of Relief_____

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Pain Treatment Agreement for New Day Pain Management patients receiving an Opioid Prescription

This Agreement between _____ ("Patient") and the pain management provider is to begin an agreement outlining clear expectations for participation in the pain management program.

The Patient agrees to the following:

I understand that lowering my pain levels and improving my quality of life are goals of this program

_____ (Initials) I will get all pain medication from **ONLY ONE** health care provider. **I WILL DISCONTINUE AND DISPOSE OF ALL PREVIOUSLY USED PAIN MEDICATIONS UNLESS TOLD TO CONTINUE THEM. I will bring all unused pain medication to be counted and disposed of when requested.**

_____ (Initials) I authorize my pain provider to speak with my other treating practitioners concerning my condition or treatment.

_____ (Initials) I agree to follow the care plan prescribed by my pain provider including Physical Therapy and behavioral health referrals if recommended.

_____ (Initials) I agree to use (name of 1 Pharmacy) _____located in _____, Telephone number_____, for all of my pain medication. If I change pharmacies for any reason, I agree to notify the provider at the time I receive a prescription.

_____ (Initials) I authorize the provider and pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the board of pharmacy in any investigations of any possible misuse, sale or potential medication diversion cases.

_____ (Initials) I agree that I will use my medication as prescribed by my pain provider. Taking my medication **more than it is prescribes** may result in the medication being discontinued.

_____ (Initials) I realize that it is my responsibility to take my medication safely and I should not drive while taking pain medication or other medications prescribed to me that may make me drowsy or less alert.

_____ (Initials) I will bring in pain medication to be counted whenever requested.

_____ (Initials) I will not share, sell, or trade my medication for money, goods, or services.

_____ (Initials) I will keep my medication safe from loss and theft and understand if I fail to do so I may no longer be prescribed pain medication.

_____ (Initials) I understand my pain medication dosage may be tapered if not effective.

_____ (Initials) I agree that I will submit to a blood, saliva or urine test if requested by pain provider. If called in for a drug screen, I agree to come to the office (1165 Knoxville Ave Suite 105) within 24 hours to provide a sample. If I fail to do so I may no longer be prescribed pain medication.

_____ (Initials) I will not use any illegal controlled substances (by federal law), including marijuana, cocaine, etc.

_____ (Initials) I understand that if I use medical or recreational marijuana, I will **not** be prescribed any opioids.

_____ (Initials) I understand that the use of **CBD products may contain low levels of THC** (the primary compound in marijuana) that may be revealed in my urinalysis, and I will not be a candidate for opioid medication. Examples of CBD products may include but are not limited to: oils, lotions, gummies, edibles, capsules, etc.

_____ (Initials) I agree not to take all mind/mood altering/illicit/addicting drugs, including alcohol and Benzodiazepines (Xanax, Ativan, Valium) unless authorized by this pain center provider.

_____ (Initials) I agree that refills of my prescriptions of pain medicine will be made only at the time of an office visit or during regular office hours. I agree to give at least **7 business days' notice for refill requests.** No refills will be available during evenings or on weekends.

_____ (Initials) **I will treat the staff at the office/hospital respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment can be stopped.**

_____ (Initials) I agree that missed appointments or multiple cancellations may lead to being discharged from the pain practice. After 2 occurrences of same-day cancellations in a 12 month period and/or do not show for scheduled appointments, you will receive a warning letter. After a third occurrence, you will be discharged from the practice.

SAFETY RISKS WHILE UNDER THE INFLUENCE OF OPIOID MEDICATIONS: There are potential adverse effects of opioid medications that are potentially dangerous. These include delayed reaction time, impaired judgment, drowsiness, physical addiction, difficulty breathing, and death. ADVERSE EFFECTS OF OPIOID MEDICATIONS: These adverse effects may be made worse when mixing opioid medications with other medications, including alcohol! • Feelings of anxiety • Slowed or difficult breathing • Slow heart rate • Confusion • Constipation • Excess sweating • Dizziness or drowsiness • Nausea • Difficulty urinating • Impaired judgment • Vomiting • Physical or psychological dependence RISKS • Physical dependence. This means that abruptly stopping the medication may lead to withdrawal symptoms which may include: - Runny nose - Difficulty sleeping for several days - Diarrhea - Abdominal cramps - Sweating - Shakes and chills - Rapid heart rate - Nervousness.

- I am aware that chronic opioid use has been associated with lower testosterone and estrogen levels. This may affect my mood, stamina, sexual desire, and physical and sexual performance. I understand that my doctor may check my blood to monitor my hormone levels.
- **(FEMALES only)** If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medications; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

Provider and Patient agree that this Agreement is essential to the Provider's ability to treat the Patient's pain effectively and that ***failure of the Patient to abide by the terms of this Agreement*** *will result in corrective adjustments to the treatment plan and* ***may result in the withdrawal of all prescribed medication by the Provider, possibly causing Patient to experience withdrawal symptoms and the termination of the Provider-Patient relationship.*** Have you read and do you understand this document? (Initial one)

____ I was satisfied with the above description and did not want any more information.

____ I requested and received further explanation about the treatment, alternatives, or risks.

I agree to follow the terms of this agreement and I understand the risks, alternatives, and additional therapy associated with the use of controlled substances to treat my pain. I understand this document will be maintained as a permanent component of my chart.

Patient Signature _____ Date_____ Time_____

Staff Signature _____ Date_____ Time_____

Provider Signature_____ Date_____ Time_____

You will get a copy of this form and we will keep a copy of it in your patient file.

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SOAPP® Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given 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 or alcohol problem? 0 1 2 3 4
6. How often have you attended an AA or NA meeting? 0 1 2 3 4
7. How often have you taken medication other than the way that 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

PainEDU.org

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

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

Total: _____

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

Scoring Instructions for the SOAPP® Version 1.0-14Q

To score the SOAPP® V.1- 14Q, simply add the ratings of all the questions:

A score of 7 or higher is considered positive.

Sum of Questions	SOAPP® Indication
> or = 7	+
< 7	-

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(place sticker here)

Health History Questionnaire

Please provide identifying information, then answer ALL the following questions (both pages), about your health.
Circle NO or YES to each question. If you answer "YES" to a particular question, mark any of the options listed below the question that apply to you.

Patient Name:	Date of Birth:	Age:	Sex:	Height:	Weight:
Completed By (Sign):	Relationship to Patient: ☐ Self ☐ Other			Date:	

1. **Do you have any Special Need in in any of the following areas?** NO YES

☐ Reading ☐ Vision ☐ Hearing ☐ Mobility (e.g. wheelchair, walker, etc.) ☐ Communication (e.g. need for a translator)
(Describe):_____

2. **Current Employment Status**

☐ Full time ☐ Part-time ☐ at home/Homemaker ☐ Looking ☐ Disabled ☐ Retired ☐ Student
Current Occupation _____ Former Occupation (if retired) _____
Employer: _____

3. **Have you ever had a HEART condition, procedure, or HIGH BLOOD PRESSURE?** NO YES

☐ Heart attack.....Date: ____/____/____ ☐ High blood pressure ☐ High cholesterol
☐ Angina or chest pain ☐ Heart murmur ☐ Abnormal EKG
☐ Irregular heart beat or palpitations ☐ Heart valve problem ☐ Heart or bypass surgery
☐ Congestive heart failure ☐ Congenital heart disease ☐ Pacemaker /defibrillator
☐ Other heart condition or procedure (DESCRIBE):_____

4. **Have you had BREATHING problems or a LUNG condition?** (select any that apply below) NO YES

☐ Asthma ☐ Short of breath when lying down flat ☐ Chronic cough
☐ Emphysema or COPD ☐ Sleep apnea or very loud snoring
☐ Recent cold, respiratory infection, fever ☐ Home ventilator, CPAP or BiPAP
☐ Other lung or breathing problem (DESCRIBE):_____

5. **Do you have a LIVER, KIDNEY, or PROSTATE condition?** (select any that apply below) NO YES

☐ Kidney failure ☐ Hepatitis or Jaundice ☐ Prostate cancer
☐ Blood hemodialysis ☐ Peritoneal dialysis ☐ Cirrhosis of the liver
☐ Enlarged prostate ☐ Other (DESCRIBE):____ ☐ Kidney Stone

6. **Do you have DIABETES, or a THYROID condition?** (select any that apply below) NO YES

☐ Diabetes (blood sugar _____) ☐ Hypothyroid (under active thyroid)
☐ Insulin treatment ☐ Hyperthyroid (overactive thyroid)
☐ Other (DESCRIBE):_____

7. **Do you have an ORAL, DIGESTIVE, or WEIGHT problem?** (select any that apply below) NO YES

☐ Chipped, loose, or fragile teeth ☐ Take diet medications ☐ Obesity (overweight)
☐ Acid reflux, heartburn or hiatal hernia ☐ Severe weight loss ☐ Dentures/partials
☐ Other (DESCRIBE):_____

8. **Do you have a BRAIN, NERVE, MUSCLE, or MENTAL HEALTH condition?** NO YES

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(place sticker here)

☐ Stroke or TIA ☐ Muscle disease ☐ Numbness or weakness ☐ Myasthenia gravis
☐ Anxiety (severe) ☐ Carpal tunnel ☐ Seizures or epilepsy ☐ Multiple sclerosis
☐ Depression ☐ Glaucoma ☐ Hearing Deficit ☐ Suicide History/Thoughts
☐ Personal or family history of psychiatric problems:_____
☐ Other (DESCRIBE):_____

9. Do you have a BLOOD disorder or history of cancer? (select all that apply below) NO YES

☐ Anemia (low blood count) ☐ Abnormal bleeding or bruising ☐ Other:_____
☐ Sickle cell disease ☐ Thrombosis (blood clot)

10. Do you have ARTHRITIS, SPINE, or JOINT problems? (select all that apply below) NO YES

☐ Rheumatoid arthritis ☐ TMJ (jaw joint problems) ☐ Spine problems: ☐ Neck
☐ Osteoarthritis (degenerative) arthritis ☐ Upper back ☐ Lower back
☐ Other (DESCRIBE)_____ ☐ Amputee
☐ Do you get regular exercise? ☐ No ☐ Yes, What kind of exercise?_____ How often? _____

11. Do you use TOBACCO, ALCOHOL, or DRUGS? NO YES

_____ packs per day _____ years of smoking _____ drinks per week
☐ Personal or family history of recreational/prescription drug or Alcohol abuse:
(Describe):_____
☐ Marijuana ☐ Cocaine ☐ Other drugs

12. Have you ever had surgery? (Please list with DATES) NO YES

1._____ 3._____
2._____ 4._____
5._____ 6._____

13. Any previous DIFFICULTIES or COMPLICATIONS with anesthesia or surgery? NO YES

☐ Difficult intubation ☐ Severe nausea or vomiting ☐ Malignant hyperthermia
☐ Family member had anesthesia problem ☐ Awareness (memory of surgery) ☐ Difficulty waking up
☐ Other (DESCRIBE):_____

14. Are you HIV positive? DO you have AIDS or any other infectious disease? NO YES

☐ HIV positive ☐ AIDS ☐ Other_____

15. WOMEN: Is there any chance that you are now PREGNANT? NO YES

Please provide the date of your last menstrual period: _____/_____/_____

16. Have you seen your doctor or had medical tests in the last 3 months? NO YES

☐ Blood tests ☐ EKG ☐ EMG ☐ X-Ray, what body part? _____ ☐ Chest X-Ray ☐ MRI
☐ Location where tests were done_____
☐ Name of Primary Physician_____ Telephone_____

17. Have you ever had any specialized HEART tests? NO YES

☐ Stress test ☐ Echocardiogram ☐ Heart catheterization

18. Do you have any ALLERGIES to medicines or to latex rubber? NO YES

1._____ Reaction:_____ 2._____ Reaction:_____
3._____ Reaction:_____ 4._____ Reaction:_____
5._____ Reaction:_____ 6._____ Reaction:_____

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Please list ALL Prescription and OTC Medications This MUST be done

MEDICATION LIST

Patient Name: _____ DOB: _____

Pharmacy: _____ Allergies: _____

Medication	Dose	Frequency

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Oswestry Disability Index 2.0

Name: _____ Date: _____

Please circle (only one answer please) in each section that most closely describes your problem at present.

Section 1 - Pain Intensity

0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst pain imaginable at the moment.

Section 2 - Personal Care

0. I can look after myself normally without causing extra pain.
1. I can look after myself normally, but it is very painful.
2. It is painful to look after myself and I am slow and careful.
3. I need some help but manage most of my personal care.
4. I need help every day in most aspects of self-care.
5. I do not get dressed, wash with difficulty, and stay in bed.

Section 3 – Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it gives extra pain.
2. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, for example on a table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift only very light weights.
5. I cannot lift or carry anything at all.

Section 4 – Walking

0. Pain does not prevent me walking any distance.
1. Pain prevents me walking more than 1 mile.
2. Pain prevents me walking more than 0.5 miles.
3. Pain prevents me walking more than 100 yards.
4. I can walk only using a stick or crutches.
5. I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

0. I can sit in any chair as long as I like.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me sitting more than 1 hour.
3. Pain prevents me from sitting more than 0.5 hours.
4. Pain prevents me from sitting more than 10 minutes.
5. Pain prevents me from sitting at all.

Section 6 – Standing

0. I can stand as long as I want without extra pain.
1. I can stand as long as I want but it gives me extra pain.
2. Pain prevents me from standing for more than 1 hour.
3. Pain prevents me from standing for more than 30 minutes.
4. Pain prevents me from standing for more than 10 minutes.
5. Pain prevents me from standing at all.

Section 7 – Sleeping

0. My sleep is never disturbed by pain.
1. My sleep is occasionally disturbed by pain.
2. Because of pain I have less than 6 hours of sleep.
3. Because of pain I have less than 4 hours of sleep.
4. Because of pain I have less than 2 hours of sleep.
5. Pain prevents me from sleeping at all.

Section 8 – Sex Life (if applicable)

0. My sex life is normal and causes no extra pain.
1. My sex life is normal but causes some extra pain.
2. My sex life is nearly normal but is very painful.
3. My sex life is severely restricted by pain.
4. My sex life is nearly absent because of pain.
5. Pain prevents any sex life at all.

Section 9 – Social Life

0. My social life is normal and gives me no extra pain.
1. My social life is normal but increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting energetic interests, e.g., sport, etc.
3. Pain has restricted my social life and I do not go out as often.
4. Pain has restricted my social life to my home.
5. I have no social life because of pain.

Section 10 – Travelling

0. I can travel anywhere without pain.
1. I can travel anywhere but it gives me extra pain.
2. Pain is bad but I manage journeys over 2 hours.
3. Pain restricts me to journeys of less than 1 hour.
4. Pain restricts me to short necessary journeys under 30 minutes.
5. Pain prevents me from traveling except to receive treatment.

FOR STAFF USE ONLY

_____ Total

_____ODI Score (Should be a percentage)