PALM TREE
INTERVENTIONAL
PAIN MANAGEMENT
Pain Relief Starts Here

2801 17th Street, St. Cloud, FL 34769
Tel. (407) 906-1328 Fax. (407) 593-8452
Palmtreepain.com

Workers Comp Assessment Form

Name: _____ Date:_____/_____/_____ DOB:_____/_____/_____

1. Location of injury-related pain? _____
2. Date of injury? _____
3. Describe the accident. _____

_____

_____

4. How soon after the accident/injury did you develop symptoms? _____
5. How long have you been having this pain?
6. Please describe what symptoms you have? _____
7. Describe your pain (Circle all that apply):

   A spasm, aching, burning, burning, cold, cramping, dull, numb, pressure, sharp, shock-like, shooting, squeezing, stabbing, stinging, tenderness, tingling

8. Does the pain radiate anywhere? YES NO If yes, where? _____
9. How severe is your pain? (Circle which range applies)

0 (no pain) 1-**2** (tolerable without medication) **3-4** (I need to tell someone and/or take aspirin, etc.) **5-6** (mild narcotic) **7-8** (go to the ER and/or take strong narcotics) **9-10** (admit to the hospital)

10. When during the day do you have your pain? _____
11. What makes your pain better? _____
12. What makes your pain worse? _____
13. Have you received any medical care for your symptoms? YES NO

14. If yes, what treatment(s)? Physical Therapy Chiropractic Pain Management
15. Describe your treatment(s). _____
16. Has there been any change in your symptoms? (new pain, less pain, increased pain)? _____
17. Have any pains resolved? _____
18. Have you been treated by another physician for this injury? _____
19. Are you improved/same/worse? _____
20. Have you ever had neck or back surgery before? YES NO If yes, what surgery? _____

21. Are you taking any medication to help with the pain? YES NO If yes, what medications? _____
22. What NSAIDS are you taking? (Circle all that apply) Ibuprofen Naproxen Aspirin Meloxicam Diclofenac Tylenol
23. Have you had an MRI and/or X-Rays? YES NO If yes, when? _____
24. What is your job title? _____ Have you missed work? YES NO
25. What is your job description? _____
26. What was your functional status prior to the injury? _____
27. What was your functional status after the injury? _____
28. Are you working? YES NO Full duty Light Duty Restrictions? _____
29. Do you have any constipation? YES NO SOMETIMES

CURRENT MEDICATION LIST (please add dosages):

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY:

_____

_____

ALLERGIES:

_____

SURGICAL HISTORY:

_____

_____

FAMILY HISTORY:

_____

_____

Name: _____ Date: ____/____/____ DOB: ____/____/____

OPIOD RISK TOOL

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. ow often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○

16. How often have you run out of pain medication?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

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

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CONTROLLED SUBSTANCE AGREEMENT

The words we and our refer to the facility and the words I, me, or my refer to you, the patient. 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, which is strictly regulated by both state and federal agencies. Some patients have an excellent response to morphine and morphine-like drugs (opioids). These patients experience a notable decrease in their pain without interfering side effects, such as sedation and nausea. This favorable response allows these patients to increase their function. Unfortunately, not all patients have a favorable response to morphine and morphine-like medications and ay experience significant side effects that prevent further use of this type of pain medicine. Additionally, these dug do not decrease all pain syndromes. Your doctor has no way to knowing which side affects you may experience or how much pain relief you may experience. Furthermore, these medicines may cause unintended psychological effects such as a false sense of well-being and improved ability to cope with problems. Sometimes patients who experience these psychological effects may use these medicines in a way other than prescribed. There exists significant misunderstanding regarding the use of opioid analgesics. The following definitions are important for you to understand.

Physical dependence is a pharmacologic property of certain drugs, such as caffeine and opioid, that cause biochemical changes in the body such that abruptly stopping these drugs will result in a withdrawal response

Addiction is a psychological and behavioral syndrome in which there is drug craving and drug seeking behavior, for purposes other than those intended by your physician. For example, addictive behavior would include increasing your usual dose of opioid (without prior discussion with hour doctor) for psychological benefit to self-medicate during a stressful situation.

Tolerance is a pharmacologic property of certain drugs defined by the need for increasing the dose to maintain effect.

The risk of addiction in patients who do not have a prior addiction history (to any substance) is extremely low. The risk of addictive behavior is much higher in patients who have a prior history of addiction. If you do develop an addiction problem your doctor will help you with this. Your doctor may decide that you should not continue on the particular drug or may decide that you may continue on the medicine, but only with very careful treatment guidelines.

INFORMED CONSENT

I understand that the use of opioid analgesics can be safe and effective treatment for my chronic pain. I also understand that there exists a risk of developing an addiction disorder; however, I also understand that this is extremely rare in patients who have no prior addiction history. I have truthfully advised my doctor that I have no history of addiction to any narcotic medication, controlled substances, illicit drugs, alcohol, gambling or any other type of addiction.

All controlled substances must come from the physician whose signature appears below or, during his/her absence, by the covering physician, unless specific authorization is obtained for an exception, 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. I will not seek prescriptions for controlled substances from any other physicians, healthcare provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physicians' knowledge. I also understand that it is unlawful to obtain or attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to physicians, or his/her staff, or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff all controlled substances that I have been prescribed).

All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed.

You may not share, sell, or otherwise permit others; including spouse or family members, to have access to any controlled substances that you have been prescribed. You may not dispose or throw away any of your medications that you receive from our doctor for any reason; but rather, you will return any unused portion to your doctor or to your designated pharmacy. You may be subject to random pill counts. You will be notified by phone, at random, to come into the office and bring your medication in the bottles provided by the pharmacy. Once you have been contacted, you will have a 6 hour window to arrive. Your participation will be mandatory. Failure to participate will result in a breach of the Controlled Substance Agreement and will result in, but not limited to, discontinuation of opioid therapy, discharge from practice and/or referral to law enforcement.

I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescription of my medication, and I authorize my doctor to provide this information to any person or facility that he/she deems appropriate and necessary. My doctor may fax this contract to any physician involved in my care, pharmacy, ER, hospital, or any person or facility that he/she deems appropriate and necessary, even if such disclosure may be adverse to my interest (e.g. law enforcement personnel).

Unannounced urine or serum toxicology specimens 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 this facility. Also, if your prescribed medication does not appear in the urine or serum toxicology specimen you may also be discharged from the practice.

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 as specifically authorized by the physician whose signature appears below or, during his/her absence by the covering physician, as set forth in Section 1 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 substance (e.g. alcohol and prescribed drugs), which impair my driving ability, may result in DUI charges.

Medications or written prescriptions may not be replaced if they are lost, stolen, misplaced, and/or destroyed.

Prescriptions should be taken as prescribed. I understand that I will not increase my dose unless I discuss this with my doctor first. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

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

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

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

Patient Printed Name: _____

Patient Signature: _____ Date:_____

Physician Signature: _____ Date:_____

Dr. Jason Song, MD, PhD