Universal Pain Management
Patient Information Form

Patient Last Name_____First Name_____Middle Initial___
Mailing Address_____#_____City_____State_____Zip_____
Home Address_____#_____City_____State_____Zip_____
Home Phone Number_____Work Phone Number_____
Pager/Cell Phone Number _____ Alternative Phone Number _____
Email Address _____
Birth Date_____Social Security Number_____Sex: M / F Marital Status:_____

Reason for Visit: _____
_____
_____

Were you injured at work?: ☐ Yes ☐ No (If Yes, complete Form 1A)
Were you injured in an automobile accident? ☐ Yes ☐ No
Is this visit related to a Personal injury? ☐ Yes ☐ No

Employment Status: [ ] Full Time [ ] Part Time [ ] Unemployed [ ] Retired [ ] Disabled
Employer:_____

Primary Insurance Information:
Insurance Company Name_____
Address_____Phone Number_____
Group/Policy Number_____Identification Number_____
Guarantor Name_____ Relationship to insured: Self Spouse Child Other
Guarantor's Birth Date_____Guarantor's Social Security Number_____Sex: M / F

Secondary Insurance Information:
Insurance Company Name_____
Address_____Phone Number_____
Group/Policy Number_____Identification Number_____
Guarantor Name_____ Relationship to insured: Self Spouse Child Other
Guarantor's Birth Date_____Guarantor's Social Security Number_____Sex: M / F

Universal Pain Management Provider you are seeing today_____
Referring Physician (if any)_____ Phone Number_____
Primary Care Physician_____ Phone Number_____
Referring Patient (if any)_____

Person to be contacted in case of emergency_____
Phone Number_____Relationship_____

In signing this form you agree that all of the above is true and correct as of date signed. You also understand that we bill your insurance as a courtesy to our patients. If your insurance does not pay your claims for whatever reason, you understand that you are ultimately responsible for your bill. This does not apply to injury cases.

_____ _____
Patient or Patient Representative Signature Date

_____ _____
Witness Date

Universal Pain Management
Workers Compensation Information

Patient: _____ **Date:** _____

Referral Source: _____ Phone # _____

Address: _____ Fax # _____

Primary Treating Physician For Workers' Comp: _____
Address: _____

Phone # _____ Fax # _____

Claim # _____ Date of Injury: _____

Workers' Compensation Company: _____
Address: _____
Phone # _____ **Fax #** _____

Employer at Time of Injury: _____
Address: _____
Phone # _____ **Fax#** _____

Claims Adjustor: _____

Address: _____

Phone # _____ **Fax #** _____

Medical Case Manager: _____
Address: _____

Phone # _____ **Fax #** _____

Utilization Review Department: _____
Address: _____

Phone # _____ **Fax #** _____

Patient's Attorney: _____

Address: _____

Phone # _____ **Fax #** _____

Defense Attorney: _____

Address: _____

Phone # _____ **Fax #** _____

Universal
PainManagement
A Comprehensive Approach to Pain and Rehabilitation

Patient's Name: _____

DOB: _____

READ CAREFULLY BEFORE SIGNING:

MEDICAL CONSENT: The patient is under the care of the attending physicians. The patient or patient's representative consent to any medical treatments or procedures, including invasive procedures (upon special consent), x-ray examinations, taking of medical photographs and laboratory procedures.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as the patient, that in consideration of services to be rendered to the patient, he/she hereby individually obligates himself to pay the account of Universal Pain Management and all treating physicians in accordance with the regular posted rates and the terms of Universal Pain Management.

ASSIGNMENT OF BENEFITS: I do hereby assign irrevocably to Universal Pain Management, to the full extent permitted by law, all rights and benefits payable under any insurance policies providing coverage for medical services costs in an amount not to exceed the charges I incur to my Universal Pain Management account for services during the period of my treatment. I fully understand that I am primarily responsible to Universal Pain Management/physicians for the charges in addition to those charges not paid for under the assignment, and in the event the money is due or the benefits are not paid within sixty (60) days from the date of billing for payment. I will promptly make arrangements to pay the outstanding accounts in full.

A photocopy of this assignment is to be considered as valid as an original and revocable by me only in writing. I hereby authorize said assignees to release all information to secure payment.

AUTHORIZATION TO RELEASE MEDICAL RECORDS: I do hereby give my permission and consent to release any and all medical records to Universal Pain Management, upon request, and requested records be sent to Universal Pain Management within seven (7) days.

_____ _____

Signature Witness

_____ _____

Signature of Patient's Representative Relationship to Patient

_____ _____

Financial Guarantor Name of Insurance Subscriber

UNIVERSAL PAIN MANAGEMENT

PATIENT RIGHTS AND RESPONSIBILITIES
&
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received information regarding Universal Pain Management's Patient Rights and Responsibilities & Notice of Privacy Practices:

_____ _____

Patient/Parent/Legal Guardian **Date**

_____

Relationship to Patient

Complete the section below only if patient does not sign above.

Documentation of Good Faith and Effort

The patient identified below was provided with information regarding UPM's Patient Rights and Responsibilities & Notice of Privacy Practices. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the above-mentioned documents; however, acknowledgement was not obtained because:

☐ Patient refused to sign.
☐ Patient was unable to sign because: _____
☐ There was a medical emergency. UPM will attempt to obtain acknowledgement as soon as practical.
☐ Other reason: _____

Employee Signature: _____ Date: _____

UNIVERSAL PAIN MANAGEMENT
AUTHORIZATION FOR DISCLOSURE
OF PROTECTED HEALTH INFORMATION

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below. A copy of this signed form will be provided to the patient.

I hereby authorize (name of provider/address):

_____

_____

_____

I hereby authorize any and all Pharmacies to release my prescription history.

To disclose the following information from the health records of:

Name: _____
Last First MI Previous Name

Birthdate: _____ Social Security #: _____

Telephone: (H)_____(Cell)_____ (W) _____

Address: _____
Street City State Zip

Email: _____

This information is to be disclosed to:

☐ 819 Auto Center Drive, Palmdale, CA 93551 – Phone (661) 267-6876 Fax (661) 538-9483

☐ 28212 Kelly Johnson Pkwy, #155, Valencia, CA 91355 – Phone (661) 367-9788 Fax (661) 367-9789

☐ 16179 Siskiyou Road, Apple Valley, CA 92307 – Phone (760) 241-0350 Fax (760) 243-0738

☐ 5000 Van Nuys Blvd, #200, Sherman Oaks, CA 91403 – Phone (818) 850-ACHE (2243) Fax (661) 367-9789

☐ 25915 Barton Road, #204, Loma Linda, CA 92354 – Phone (909) 460-8057 Fax (909) 460-8890

Covering the periods of healthcare (Date(s) of service):

From (date)_____ to (date)_____ **Present**

For the purpose of:_____
(Not required if the disclosure is requested by the patient)

The following information may be released:

_____

☐ **All information may be released**

UNIVERSAL PAIN MANAGEMENT
AUTHORIZATION FOR DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I understand that this will include information relating to **(check and initial, if applicable):**

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

If compensation will be received: I understand that _____ will receive compensation for its use/disclosure of the information release pursuant to this authorization.
Patient's initials: _____

Affirmation of Release:

I give _____See Front_____ **or the named agency permission to release only the information I have selected on this form to the individual(s) or agency (ies) I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations.**

_____ _____
Signature of the Patient/Guardian/Legal Representative **Date Signed**

_____ _____
Signature of Witness/Relationship to Patient **Date Signed**

Expiration date:_____
One year from date signed

Universal Pain Management
PATIENT CARE TREATMENT AGREEMENT

Patient Name: _____ **DOB:** _____

This policy is enacted to ensure the safe and proper use of any controlled substances.

Please Initial:

____1. Patient will provide a complete and accurate history including past medical records, past pain treatments and hospitalizations, drug and alcohol use and drug abuse and addiction history.

____2. Patient agrees and gives permission for family members, significant others, roommates, healthcare professionals, and law enforcement officials to provide information for the purpose of obtaining information relevant to evaluating the efficacy, non-efficacy, side effects or appropriateness of the medication prescribed.

____3. Patients must be seen regularly in the clinic and may be asked for a urine sample for drug screening without notice, at any visit and at any time. **FAILURE TO PROVIDE A URINE SAMPLE ON REQUEST, MAY CONSTITUTE GROUNDS FOR DISCHARGE FROM THIS CLINIC.**

____4. Patients must receive prescriptions for controlled substances from providers in this practice only. The prescriptions are to be filled at only one pharmacy.
The pharmacy name and phone number is: _____

_____

____5. Patient will inform provider of all noticed drug side effects and any concerns about the medication.

____6. Patient will **NOT** take prescribed medication in **ANY** manner, **OTHER THAN** as directed, without first contacting the provider, as this may constitute reason for terminating the prescribing relationship. Furthermore, abuse of prescriptions will prompt notification of all pertinent area providers and law enforcement authorities.

____7. Lost or stolen drugs or prescriptions will not be accepted as a reason for refill prior to the appropriate time period. This office **AND** local law enforcement agencies must be notified of such loss or theft.

____8. This mode of **TREATMENT MAY BE STOPPED IF** *any* **ONE** of the following occurs:

- Patient hoards, gives, sells or misuses these controlled drugs or **any other** illegal drug.
- Patient develops rapid tolerance or loss of effectiveness from this treatment.
- Patient develops side effects that are significant in the view of the provider.
- Patient's functional activities decrease.

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- Patient obtains any form of opiates or narcotics from sources other than the providers in this office.

Please Initial:

____9. Patient must notify this clinic if they become pregnant as this may warrant discontinuance of opiate therapy at the discretion of the treating provider.

___10. If narcotic abuse occurs, the drug may be stopped/tapered immediately and the patient may be referred to a detoxification program.

___11. Patient will not operate machinery or drive when feeling drowsy or when patient can expect to feel drowsy from medication, or at other times considered necessary at the discretion of the treating provider.

___12. Patient understands that the providers of Universal Pain Management will be reasonable but firm in interpreting all of the above policy statements.

REGARDING DRIVING OR USE OF HAZARDOUS MACHINERY: Pain medicine can decrease your alertness and thereby make certain activities such as driving more dangerous. You should take great care to avoid injury to yourself or others while taking these medicines. As each person responds differently to these medicines, it is impossible for your provider to know what is a "safe dose" for you to take while driving. Some patients will be able to drive safely once they become accustomed to their medicines, but others will not. As with the use of alcohol, you must exercise careful personal judgment to determine in which activities you may safely participate while taking your medicines. In some cases, it will become apparent to the provider that driving is not safe. In these cases, the provider will advise you against driving. If necessary, your provider will notify the Dept. of Motor Vehicles that driving privileges should be restricted.

THEREFORE, by my signature below, I affirm that I have read (or have had read to me) this Patient Care Treatment Agreement, understand it, and have had all questions answered satisfactorily, and thus, I (the patient) **CONSENT TO THE USE OF OPIATES/NARCOTICS UNDER THE TERMS AS OUTLINED IN THIS AGREEMENT.**

Patient Signature: _____

Date: _____

Witness Signature: _____

Date: _____

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Consent for Chronic Opioid Therapy

A consent form adapted from the American Academy of Pain Medicine

Dr./NP/PA _____ is prescribing opioid medicine, sometimes called narcotic analgesics, to me for a diagnosis of chronic pain:

This decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and likelihood that the medicine will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other possible treatments include non-opioid analgesics, interventional therapies and alternative medicine therapies.

I will tell my doctor about all other medicines and treatments that I am receiving.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I am aware that certain other medicines such as nalbuphine (Nubain), pentazocine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if 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, large 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.

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.

(Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(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 medicines; 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.

I have read this form or have it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.

_____	_____
Print Patient Name	Date
_____	_____
Patient Signature	Date
_____	_____
Witness Signature	Date

Universal Pain Management

A Comprehensive Approach to Pain and Rehabilitation

URINE DRUG SCREEN POLICY

The Guidelines for Prescribing Controlled Substances published by the Medical Board of California requires that urine drug screens be administered periodically to patients on chronic opioid therapy. As a result, we cannot prescribe opioid analgesics to our patients without obtaining regular, random urine drug screens. The frequency of testing is determined by an individualized assessment of risk for opioid abuse. This is based on our clinical assessment as well as the dose prescribed. If a patient's insurance does not pay for urine drug screens, the patient will be charged accordingly. (Excludes workers compensation insurance)

By my signature below, I affirm that I have read (or have had read to me) the Urine Drug Screen policy, understand it, and have had all questions answered satisfactorily, and thus, I (the patient) ***CONSENT TO THE USE OF OPIATES/NARCOTICS UNDER THE TERMS AS OUTLINED IN THIS POLICY.***

Patient Name: _____

Patient Signature: _____

Date: _____

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Universal Pain Management

A Comprehensive Approach to Pain and Rehabilitation

Notice to Our Valued Patients

Missed Appointment Policy

In order for us to serve you better, it is important for you to give us at least 24 hours' notice if you will not be able to make your appointment. You will be charged if cancelation does not occur within 24 hours (weekday) of your appointment. As a courtesy, you will receive a reminder call, but it is your responsibility to know your appointment date and time and cancel with notice.

Missed Appointment Fee

Office Visit -	$50.00
Procedure -	$150.00

By signing below, I understand that if I miss my appointment and run out of medication, I will not receive a refill or bridge of medications until I am seen. I further understand that I will be referred to another pain management practice for continuous violations of this policy.

_____

Print Patient's Name

_____ _____

Patient or Guardian's Signature Date

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FORM 1-A Initial Evaluation

Universal Pain Management

Name:_____ **Date:**_____

Pain History:

What is the primary pain/problem that bothers/hurts you the most?_____

When did the pain start? _____

How did the current pain start? ☐Gradually ☐Suddenly

Did anything cause your pain to start in the first place? If so, please explain further. _____

_____

On a scale from 0 to 10 ("0" means 'NO' pain and "10" means 'the worst pain' ever):

Pain level right now?_____ Lowest pain level?_____ Highest pain level?_____

Please **mark** the activities you have trouble with: ☐Dressing ☐Bathing ☐Grooming ☐Walking ☐Shopping ☐Eating ☐Doing chores/housework

Please **mark** how your pain feels: ☐Sharp/stabbing ☐Dull ☐Achy ☐Pressure ☐Burning ☐Throbbing

Please **mark** how often your pain happens: ☐Constantly ☐Off and on

What makes your pain better? ☐Heat ☐Cold ☐Massage ☐Movement ☐Sitting ☐Lying down

What makes your pain worse? ☐Weather changes ☐Physical Activity ☐Sitting ☐Walking ☐Standing

Does the pain radiate/travel anywhere? ☐Yes ☐No If so, where?_____

Do you have any numbness or tingling? ☐Yes ☐No If so, where?_____

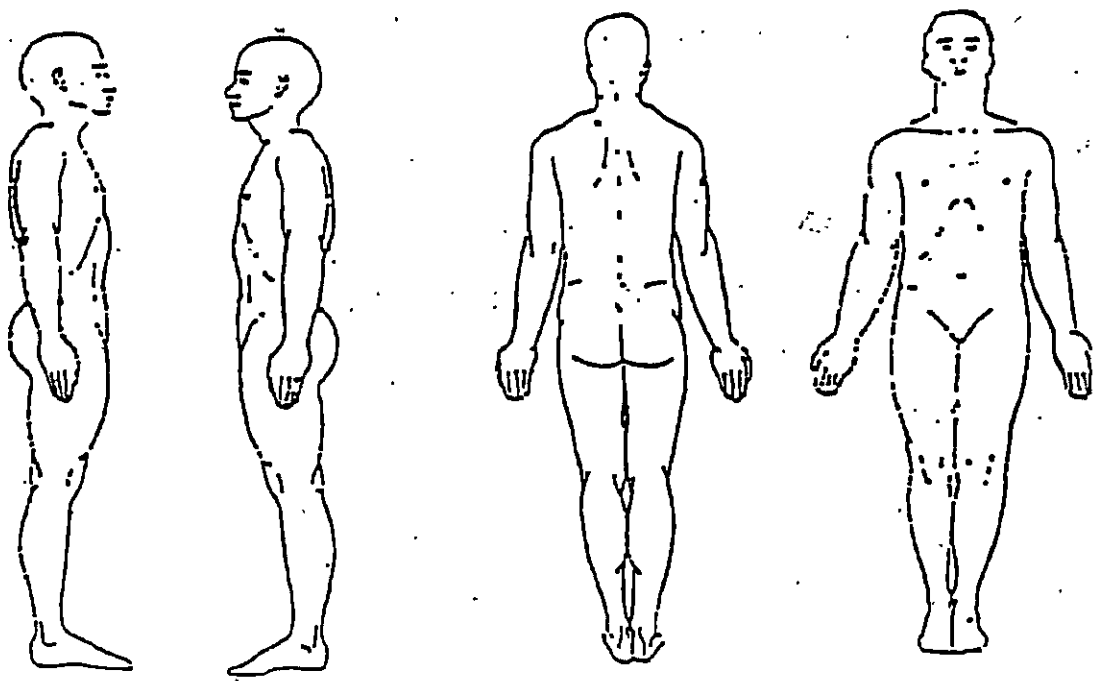
What goals do you want to achieve with Pain Management? ☐Decrease pain ☐Improve activity levels

Do you have any other goals with pain management? _____

*If you have **back pain**, please answer the following*:

Do you lean forward to relieve your back pain?	☐Yes	☐No
Do you have morning stiffness?	☐Yes	☐No
Do you have unexplained weight loss?	☐Yes	☐No
Do you have loss of bladder or bowel control?	☐Yes	☐No
Do you have fevers/night sweats with your pain?	☐Yes	☐No

Please **mark** the location of your problem/pain with "X":



Current Medications:

Are you taking any blood thinners or anti-coagulants? ☐Yes ☐No

☐Aspirin ☐Plavix/Clopidogrel ☐Warfarin/Coumadin ☐Eliquis ☐Lovenox/Heparin

☐Other:_____

Please list all medications you currently take, including vitamins and supplements:

	Medication Name	Dose
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Please list all PRIOR pain medications you no longer take and **mark** they were helpful:

	Medication Name	Helpful?
1.		☐Yes ☐No
2.		☐Yes ☐No
3.		☐Yes ☐No
4.		☐Yes ☐No
5.		☐Yes ☐No

Allergies:

Do you have any medication allergies? ☐Yes ☐No

If so, please list allergies below:

	Medication Name	Reaction
1.		
2.		
3.		
4.		

Please **mark** if you have allergies to: ☐Latex ☐Iodine ☐Tape ☐IV/X-RAY Contrast

Please **mark** any Interventional Pain Treatments you have had:

☐Epidural steroid injection (**mark** the level): ☐Neck ☐Mid-back ☐Low back

☐Facet/Medial branch injections (**mark** level): ☐Neck ☐Mid-back ☐Low back

☐Radiofrequency Nerve Ablation (RFA): ☐Neck ☐Mid-back ☐Low back

☐Nerve block injections (**specify** nerve):_____

☐Spinal Cord Stimulator SCS (**mark** applicable): ☐Trial ☐Implant SCS Company:_____

☐MILD procedure (**indicate** levels): _____

☐Intracept procedure (**indicate** levels): _____

☐Vertebroplasty/Kyphoplasty (**indicate** levels):_____

☐ Joint injections (shoulder, knees, elbow, wrist, etc.) _____

☐Any other pain injections/procedures? _____

Please **mark** any prior treatments you have had for your Current Pain Problem:

☐Physical Therapy ☐Chiropractic Therapy ☐Acupuncture ☐Psychological Therapy

☐TENS unit ☐Other: _____

Past Medical History:

Please **mark** the conditions you have been diagnosed with:

☐Anemia	☐Bleeding disorder	☐Breathing issues	☐Cancer:_____	☐Diabetes
☐GERD	☐Headache	☐Heart Attack	☐Hepatitis	☐HIV
☐High Blood Pressure		☐Kidney Disease	☐Osteoporosis	☐Pacemaker/Defibrillator
☐Thyroid Disease		☐Pregnant Currently	☐Anxiety	☐Depression

Past Surgical History: Please list any surgeries you have had.
☐ I have not had any surgery in my life.

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____
4. _____ Date:_____
5. _____ Date:_____

Diagnostic Testing and Imaging
Please **mark** all of the following tests that you have had done for your primary problem/pain:
☐ I have not had any diagnostic testing done for my current pain problem.

☐XRAY of the _____ Date:_____ Location: _____
☐MRI of the_____ Date:_____ Location: _____
☐CT of the _____ Date:_____ Location: _____
☐EMG/nerve study of the _____ Date:_____ Location: _____
☐Bone Density (DEXA) _____ Date:_____ Location: _____
☐Other test_____ Date:_____ Location: _____

Family History: Please write any medical conditions related to your parents and siblings
Mother:_____
Father:_____
Siblings: _____

Social History:
Marital Status: ☐Single ☐Married ☐Divorced ☐Domestic Partner ☐Widow
Are you employed? ☐Yes ☐No; if yes, what is your occupation? _____
Do you live alone? ☐Yes ☐No; if no, who do you live with? ☐Spouse ☐Children ☐Roommate
Tobacco use: ☐ Current user ☐ Former user ☐ Never used
If yes, how many packs per day? _____ How many years used?_____
Alcohol use: ☐Socially ☐Daily use ☐History of alcoholism ☐Current alcoholism ☐Never used
Marijuana Use:☐Socially ☐Daily use ☐Medicinally (for example anxiety, pain, cancer, etc.)?_____
Illegal Drug use: ☐Denies use ☐Former user of: _____ ☐Current user of: _____
Have you ever abused narcotic or prescription medication? ☐Yes ☐No
Are you currently on disability? ☐Yes ☐No; if yes, please specify: _____

Review of Systems:
Please **mark** all of the following symptoms that affect you:
☐I do not have any of the below conditions

Constitutional: ☐Chills ☐Sweats ☐Fatigue ☐Decreased Activity ☐Difficulty sleeping
Eyes: ☐Blurriness ☐Double vision
Ears/Nose/Throat: ☐Hearing problems ☐Sinus problems ☐Sore throat ☐Nosebleeds
Respiratory: ☐Shortness of breath ☐Cough ☐Sputum production ☐Wheezing
Cardiovascular: ☐Chest pain ☐Swelling ☐Bleeding disorder ☐Blood clots
Gastrointestinal: ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Heartburn
Musculoskeletal: ☐Muscle spasm ☐Joint stiffness ☐Joint swelling ☐Redness
Skin: ☐Rash ☐Itching ☐Bruising
Neurological: ☐Dizziness ☐Headaches ☐Loss of coordination ☐Memory loss ☐Seizures
Psychiatric: ☐Feeling anxious ☐Depressed mood ☐Hallucinations

UNIVERSAL PAIN MANAGEMENT
Pain Disability Index

The rating series below are designed to measure the degrees to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain on your life, not just when the pain is at its worst.

For each category, please *circle the number* which describes the level of disability you typically experience. A score of "0" means no disability at all, and a score of "10" means that all the activities in which you would normally be involved in have been totally disrupted or prevented by your pain.

1. Family/home responsibilities. Activities related to the home or family, including chores and duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school.)
   0 1 2 3 4 5 6 7 8 9 10
   No Disability Total Disability

2. Recreation. Hobbies, sports, and similar leisure time activities
   0 1 2 3 4 5 6 7 8 9 10
   No Disability Total Disability

3. Social Activity. Participation with friends and acquaintances *other than family members* including theater, dining out, and other social functions.
   0 1 2 3 4 5 6 7 8 9 10
   No Disability Total Disability

4. Occupation. Activities that are a part of or are directly related to one's including non-paying jobs such as that of a homemaker or volunteer work.
   0 1 2 3 4 5 6 7 8 9 10
   No Disability Total Disability

5. Sexual activity. This category refers to the frequency and quality of one's sex life.
   0 1 2 3 4 5 6 7 8 9 10
   No Disability Total Disability

6. Self Care. Activities of personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.).
   0 1 2 3 4 5 6 7 8 9 10
   No Disability Total Disability

7. Life support activities. Basic life support behaviors such as eating, sleeping, and breathing.
   0 1 2 3 4 5 6 7 8 9 10
   Life Disability Total Disability

Print Name: _____ Date: _____

Signature: _____

UNIVERSAL PAIN MANAGEMENT

NAME: **DATE:**

AGE: **SEX:** **OCCUPATION:**

Please describe how you have felt during the PAST WEEK by placing a check (✓) in the appropriate box. Do not think too long before answering.

	NOT AT ALL	A LITTLE/ SLIGHTLY	A GREAT DEAL/ QUITE A BIT	EXTREMELY/ COULD NOT HAVE BEEN WORSE
1. Feeling hot all over				
2. Sweating all over				
3. Dizziness				
4. Blurring of vision				
5. Feeling Faint				
6. Nausea				
7. Pain in Stomach				
8. Churning in Stomach				
9. Mouth becoming dry				
10. Neck muscles aching				
11. Legs feeling weak				
12. Muscles twitching & jumping				
13. Tense feelings across forehead				

SUBTOTAL:_____

On the following, put a check (✓) in the box according to how it relates to you and your feelings during the PAST WEEK or so.

	NONE OR A LITTLE OF THE TIME	SOME OF THE TIME	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
1. I feel down-hearted, blue & sad				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping through the night.				
5. I eat as much as I used to.				
6. I enjoy looking at, talking to and being with attractive women/men				
7. I notice that I am losing weight.				
8. I have trouble with constipation.				
9. My heart beat faster than usual.				
10. I get tired for no reason.				
11. My mind is as clear as it used to be.				
12. I find it easy to do the things I used to.				
13. I am restless and can't keep still.				
14. I feel hopeful about the future.				
15. I am more irritable than usual.				
16. I find it easy to make decisions.				
17. I feel that I am useful and needed.				
18. My life is pretty full.				
19. I feel that others would be better off if I were dead.				
20. I still enjoy the things I used to do.				

SUBTOTAL:_____

TOTAL:_____

DISPOSITION:_____

Name: _____

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1 –Pain Intensity

- ☐ I have no pain at the moment (0)
- ☐ the pain it very mild at the moment (1)
- ☐ The pain is moderate at the moment (2)
- ☐ The pain is fairly severe at the moment (3)
- ☐ The pain is very severe at the moment (4)
- ☐ The pain is worst imaginable at the moment (5)

Section 2 –Personal care (washing, dressing etc)

- ☐ I can look after myself normally without causing extra pain (0)
- ☐ I can look after myself normally but it causes extra pain (1)
- ☐ I can look after myself and I am slow and careful (2)
- ☐ I need some help but manage most of my personal care (3)
- ☐ I need help every day in most aspect of self-care (4)
- ☐ I do not get dressed, I wash with difficulty and stay in bed (5)

Section 3-Lifting

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

☐ **Section 4-Walking***

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

Section 5 –Sitting

- ☐ I can sit in any chair as long as I like (0)
- ☐ I can only sit in my favorite chair as long as I like (1)
- ☐ Pain prevents me sitting more than 1 hour (2)
- ☐ Pain prevents me sitting more than 30 minutes (3)
- ☐ Pain prevents me sitting more than 10 minutes (4)
- ☐ Pain prevents me sitting at all (5)

Section 6 –Standing

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

Section 7 – Sleeping

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

Section 8 –Sex Life (if applicable)

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

Section 9 –Social Life

- ☐ My social life is normal and gives me no extra pain. (0)
- ☐ My social life is normal increases the degree if pain. (1)
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests eg. Sport (2)
- ☐ Pain has restricted my social life and I do not go out as often. (3)
- ☐ Pain has restricted my social life to my home. (4)
  I have no social life because of my pain. (5)

Section 10 -Traveling

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

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ*: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOOSE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

SECTION 2 -Personal Care (Washing, Dressing, etc.)

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self-care.
F I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

SECTION 4 - Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want to with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

SECTION 5 - Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

SECTION 6 - Concentration

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7 - Work

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

SECTION 8 - Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9 - Sleeping

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours)

SECTION 10 - Recreation

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities with some pain in my neck.
C I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D I am able to engage in a few of my recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

COMMENTS: _____

_____

_____

NAME: _____ **DATE:** _____ **SCORE:** _____

SCORING TECHNIQUE FOR THE OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE AND NECK DISABILITY INDEX

1. **Each of the 10 sections is scored separately (0 to 5 points each) and then added up (max. total = 50).**

***EXAMPLE*:**

Section 1. Pain Intensity		Point Value
A.	_____ I have no pain at the moment	0
B.	_____ The pain is very mild at the moment	1
C.	_____ The pain is moderate at the moment	2
D.	_____ The pain is fairly severe at the moment	3
E.	_____ The pain is very severe at the moment	4
F.	_____ The pain is the worst imaginable	5

2. **If all 10 sections are completed, simply double the patients score.**
3. **If a section is omitted, divide the patient's total score by the number of sections completed times 5.**

***FORMULA*:** $\frac{\text{PATIENT'S SCORE}}{\text{\# OF SECTIONS COMPLETED X 5}}$ X 100 = _____ % DISABILITY

***EXAMPLE*:**

If 9 of 10 sections are completed, divide the patient's score by 9 X 5 = 45; if.....

Patient's Score: 22

Number of sections completed: 9 (9 X 5 = 45)

22/45 X 100 = 48 % disability

4. **Interpretation of disability scores (from original article):**

SCORE	INTERPRETATION OF THE OSWESTRY LBP DISABILITY QUESTIONNAIRE
0-20% Minimal Disability	Can cope w/ most ADL's. Usually no treatment needed, apart from advice on lifting, sitting, posture, physical fitness and diet. In this group, some patients have particular difficulty with sitting and this may be important if their occupation is sedentary (typist, driver, etc.)
20-40% Moderate Disability	This group experiences more pain and problems with sitting, lifting and standing. Travel and social life are more difficult and they may well be off work. Personal care, sexual activity and sleeping are not grossly affected, and the back condition can usually be managed by conservative means.
40-60% Severe Disability	Pain remains the main problem in this group of patients by travel, personal care, social life, sexual activity and sleep are also affected. These patients require detailed investigation.
60-80% Crippled	Back pain impinges on all aspects of these patients' lives both at home and at work. *Positive intervention is required.*
80-100%	These patients are either bed-bound or exaggerating their symptoms. This can be evaluated by careful observation of the patient during the medical examination.

Reference: Fairbanks CT, Couper C, Davies JB, O'Brien JP. The Oswestry low back pain disability questionnaire. Physio Ther 1980;66:271-273.

Universal Pain Management

(661) 267-6878 x 174

Automatic Payment Authorization Form

"This does not apply to Workers Compensation Insurance."

As a convenience to you, please schedule your payment to be automatically deducted from your bank account, or charged to your credit card. Just complete and sign this form to get started!

Automatic Payments Will Make Your Life Easier:

- **It's convenient** saving you time and postage
- Your payment is always on time (even if you're out of town), **eliminating late charges or any finance charges**

Here's How Recurring Payments Work:

This will occur ONLY on any charges you owe. You authorize scheduled charges to your checking/savings account or credit card. You will ONLY be charged the amount agreed upon. A receipt for each payment will be sent to you and the charge will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I _____ authorize Universal Pain Management to charge my credit card
(full name) or checking / Savings Account.

Deductible and/or Co-insurance or any other services provided by Universal Pain Management.

Payment in Full _____ or $_____ on the _____ of each Week, Biweekly, Monthly
(Please circle one)

Billing Address _____ Phone#_____

City, State, Zip _____ Email _____

Checking/ Savings Account

☐ Checking ☐ Savings

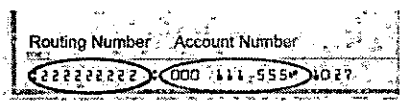
Name on Acct _____

Bank Name _____

Account Number _____

Bank Routing # _____

Bank City/State _____



Credit Card

☐ Visa ☐ MasterCard

☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Exp. Date _____

CVV Number _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Universal Pain Management in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Universal Pain Management may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.