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& SPINE SPECIALISTS

New Patient Demographics

Today's Date:_____

Primary Care Physician: _____ Ph: _____ Fax: _____

Your Name: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other:_____

Social Security Number: _____-_____-_____ Date of Birth:_____ Age _____

Mailing Address:_____

City/State/Zip:_____

Employer:_____ Occupation: _____

Your Email Address: _____

Daytime Phone # _____ ☐ Home ☐ Mobile ☐ Work

Emergency Contact Name: _____Relationship:_____

Phone Number: _____ Phone Type: ☐ Home ☐ Work ☐ Cell

How did you hear about us?

☐ Insurance Co ☐ Employer ☐ Facebook ☐Instagram

☐ Linkd In ☐ Internet Search ☐ Family/Friend ☐ Other: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sun Pain Management, PLLC or insurance company to release any information required to process my claims.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Patient or Legal Representative Name (Printed) Date

HIPAA Medical Release Authorization

Authorization for use or disclosure of health information

I _____ authorize Sun Pain Management use or disclose the following information.

_____ All of my medical-related information

_____ My medical information related to _____.

To release any and all patient medical and billing information to any physician involved in my treatment; to any health care facility to which I/the patient is discharged or transferred for treatment; to affiliates of Sun Pain Management for purposes of treatment, billing, quality assurance, collections, or defense of litigation or anticipated litigation; and to any insurance company, review organization or other entity, which is directly or indirectly responsible for payment or review of services provided by Sun Pain Management. I consent to use and disclosure of my protected health information to carry out treatment, payment or healthcare operations by the clinic and by affiliates of Sun Pain Management.

I understand information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such a release as indicated above. I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. I understand that if I agree to sign this authorization, I may keep a signed copy of the form. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. However, if my treatment is related to my participation in a research study, I understand that I may be refused treatment if I do not sign this authorization.

I have read and understood the terms of this authorization, and I have had a chance to ask questions about the use or disclosure of my health information. I authorize the named entity above to use or disclose my health information in the manner described above.

Patient Signature: _____Date: _____

Witness:_____Date:_____

Sun Pain Management Administration Policies

Consent for Treatment

By signing this form, I consent to and authorize my provider(s) at Sun Pain Management to treat me. I understand this could include lab tests, x-rays, immunizations, medication prescription and/or administration, education, other diagnostic tests, and/or behavioral health interventions. I understand that my provider is available to explain the treatment, and I have the right to refuse treatment. I understand that this consent will be valid and remain in effect if I attend any of the clinics at Sun Pain Management.

Privacy Notice and Bill of Rights

Sun Pain Management complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I acknowledge I have received the Notice of Privacy Practices and Patients' Bill of Rights.

Signature of Patient or Guardian: _____Date: _____

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SUN PAIN MANAGEMENT FINANCIAL POLICY

As a courtesy, Sun Pain Management ("SPM") verifies benefits with your insurance company. A quote of benefits is never a guarantee of payment. Your insurance company will process your claims according to your Plan Document. If you do not have a copy of your Plan Document you should obtain one as soon as possible, read and understand this contract between you and your insurance company. Should your claims process differently from any estimate you were quoted, your Plan Document will supersede any other information given verbally or in writing from the Practice.

If your Plan Document includes Pain Management benefits, we will be happy to bill your insurance. Please provide a current copy of your insurance card to the front office staff. When your insurance claim(s) are processed, you will receive an Explanation of Benefit/Payment from your insurance company. This Explanation will advise your financial responsibility for treatment. You will be held responsible for any unpaid balances by your insurance plan.

CONSENT TO BILL, ASSIGNMENT OF BENEFITS, AND PAYMENT I authorize Sun Pain Management and any of its 3rd party billing associates to file a claim with my insurance carrier for services rendered. I authorize SPM payment of benefits directly to SPM, for services provided to myself me. I understand that I am responsible for any part of the charges that are not covered/paid by my insurance, and I will be billed directly for those services

Should your insurance company pay you directly for services rendered by our practice or affiliates, you agree to endorse and return all monies to this practice within 7 days of receipt.

1. **PAYMENT** - is expected at the time of your visit. (This includes Copayments, Deductibles, Coinsurance, Missed Appointments, Procedure Prepayment; unpaid balance after insurance has paid their portion, Past Due balances, etc). If you are unable to meet your financial responsibility, Sun Pain reserves the right to reschedule your appointment to a later date when you can meet your financial responsibility. If a prepayment is made for any services and a refund is due after your insurance pays, any outstanding balance on your account will be deducted before issuing your refund. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount or non-covered charges from your insurance company. If you do not have insurance or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We require a copy of an ID card and/or license and insurance cards.
2. **INSURANCE** - We are participating providers with several insurance plans. A list of these insurance plans is available upon request. If we submit your claims and your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you. If our doctors are not listed in your plan's network, you may be responsible for payment. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to call your insurance about your benefits prior to your appointment. We are not responsible for any erroneous information listed on insurance websites and do not guarantee your coverage. You are responsible for obtaining a properly dated referral, prior authorization (if required) from your insurer and responsible for payment if your claim rejects for the lack of specific requirements. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you are responsible for all charges. Payment is due upon receipt of a statement from our office. All procedures billed are considered covered unless limited by your specific insurance policy. If your coverage changes and you have not notified us of these changes in writing and we bill your old carrier, we may miss the time limit to receive payment. In this case, the claim becomes your responsibility for payment. Please notify us immediately if your coverage changes so we can submit your claims for appropriate reimbursement.
3. **COLLECTION** - If you have an outstanding balance over 120 days old and have failed to make payment arrangements or fall delinquent on an existing payment plan, we may turn your balance over to a collection agency and/or an attorney. This may result in reporting to credit bureaus and/or legal action. Sun Pain reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You are responsible for any expenses we incur to

collect on your account including attorney fees, collection fees, and/or contingent fees to collection agencies that can be more than 35% of the delinquent balance. Contingency fees will be added to your balance and assigned to the collection agency immediately upon your account being assigned to a collection agency of our choice. You agree that for us to service your account or to collect any amounts you may owe, we may contact you by phone at any number associated with your account including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded voice messages and/or use of an automatic dialing device._____ initials

4. **RETURNED CHECKS** - Will incur a $40.00 service charge. You will be asked to bring cash, certified funds, or a money order to cover the amount of the check plus the $40.00 service charge to pay the balance prior to receiving any future services from our staff or the physicians. Stop payments or overturned chargebacks on your credit card constitute a breach of payment and are subject to the $40.00 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted by the governing laws in Maricopa County.
5. **ACCOUNTING PRINCIPALS** - Payment and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service.
6. **FORMS AND CONSULT FEES** - Completing insurance forms, copying medical records, etc... requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter or communication. On occasion, our staff may be asked to provide a deposition and/or other testimony or actions concerning your care. There is a separate fee schedule for such activity. The fees for such activity are to be paid by the patient regardless of the party requesting the activity.
7. **CANCELLATIONS OR MISSED APPOINTMENTS** - If you do not cancel your appointment at least 24 hours in advance or if you no-show, we will assess a $25.00 missed appointment fee. If you do not cancel your procedure with at least 24 hours' notice, you will be assessed a $25.00 missed procedure fee. Multiple no-shows/missed procedures may result in your formal discharge from the practice. Initials _____
8. **RESPONSIBILITY FOR PAYMENT** - I understand that I personally am financially responsible to Sun Pain for charges not covered by the assignment of insurance benefits. Initials _____
9. **ASSIGNMENT OF INSURANCE BENEFITS** - I hereby assign, transfer, and set over directly to Sun Pain sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said practice. I authorize Sun Pain to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Sun Pain. I authorize Sun Pain to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.
10. **RELEASE OF INFORMATION** - I hereby authorize the and direct Sun Pain to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.
11. **AGREEMENT AND UNDERSTANDING:** I have read and understand the practice's financial policy of Sun Pain and I agree to be bound by its terms. I understand that I am financially responsible for ALL services I receive from Sun Pain. I hereby assign all medical and surgical benefits and authorize my insurance carrier (s) to issue payment directly to Sun Pain. This financial policy is binding upon me, my estate, executors and/or administrators, if applicable. I also understand and agree that such terms may be amended by the practice from time to time and I may be asked to read, understand, and sign any updates.

Signature of Patient or Guardian: _____ Date: _____
Witnessed by: _____ Date:_____

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Telehealth Policy

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, the transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

- I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.
- I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.
- I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.
- I understand that telehealth services can only be provided to patients, including myself, who are residents of or physically located in the state of Arizona at the time of this service.
- I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.
- I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:
- It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
- Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
- Despite reasonable efforts on the part of my healthcare provider, the transmission of
- Medical information could be disrupted or distorted by technical failures.
- I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.
- I understand that medical information, including medical records, is governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).
- I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.
- The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.
- I agree that I have verified my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.
- I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

- I understand that electronic communication cannot be used for emergencies or time-sensitive matters.
- I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's.
- ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations, including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.
- I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).
- I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.
- By beginning the visit, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.
- I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.
- To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.
- I certify that I have read and understand this agreement and that I have had the opportunity to have questions answered to my satisfaction.

Patient Signature_____ Date:_____

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Consent to Release Protected Health Information

Patient Name: _____ DOB: _____ Date: _____

Initials_____	I authorize Sun Pain Management to use/disclose my personal health information to the individual(s) listed on this form.		
Initials_____	I understand that Sun Pain Management staff may leave detailed messages on my voicemail.		
1. Contact Name: ***(Emergency Contact)***			
Phone:		*Phone (other):*	
Address:			
Relationship: ☐Spouse ☐Family (describe)_____ ☐Friend ☐Other (describe)_____			
2. Contact Name:			
Phone:		*Phone (other):*	
Address:			
Relationship: ☐Spouse ☐Family (describe)_____ ☐Friend ☐Other (describe)_____			
3. **Contact Name:**			
Phone:		*Phone (other):*	
Address:			
Relationship: ☐Spouse ☐Family (describe)_____ ☐Friend ☐Other (describe)_____			

I hereby authorize Sun Pain Management to use and disclose my personal health information to the individuals identified on this form.
I understand this authorization does not expire unless written notice is mailed to 11047 N 19th Ave, Phoenix, AZ 85029 to the attention of the Practice Administrator.
I understand this may include information relating to communicable diseases, such as HIV/AIDS, sexually transmitted diseases, behavioral or mental health, alcohol and/or drug abuse treatment, and genetic testing information, if any records exist.
I understand that the individuals identified on this form will be treated by Sun Pain Management as individuals involved directly in my care and as such, Sun Pain Management will be allowed to release my personal health information to these individuals and additionally for the purposes of treatment, payment, and healthcare operations to include the request of medical records from/to any other healthcare providers and/or institutions.
I understand that I have a right to request and receive a Notice of Privacy Practices from Sun Pain Management.
I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original.
I voluntarily sign this authorization, and I understand that my ability to obtain health care from Sun Pain Management will not be affected if I refuse to sign this authorization.

Patient Signature: _____ Date: _____

Personal Representative Signature: _____ Date: _____

Relationship to Patient: _____

Date:

Patient Name:

DOB:

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Sun Pain Management Narcotic Agreement

Controlled substance medications such as narcotics (opioids), benzodiazepines (diazepam, clonazepam, alprazolam, lorazepam, temazepam) and barbiturates (carisoprodol) may be useful but have a high potential for misuse and abuse. They are closely controlled by the local, state and federal governments. They are intended to decrease pain and to improve function and/or ability to work, not simply to feel good. Because Sun Pain Management is prescribing such medication for me, to help manage my pain as part of a comprehensive plan of care, I agree to the following conditions:

1. I am responsible for my controlled substance medications. If the prescription or medication is lost, stolen or misplaced, or if I use it sooner than prescribed (self-escalation), I understand that it may not be replaced.
2. I will not request or accept controlled substance medication from any other physician or person while I am receiving such medication from Sun Pain Management. Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted in a hospital. Given extenuating circumstances any other prescription should be communicated with Sun Pain Management prior to filling.
3. I will keep my controlled substances safe and dispose of them properly.
4. Refills of controlled substance medication:
    a. Will be made only during regular business hours. Refills will not be made at night, weekends, or on holidays.
    b. May not be made if I "run out early". I am responsible for taking the medication in the dose prescribed and for keeping track of the remaining amount.
    c. I will keep track of my medication and plan ahead. I will call at least 1 week ahead if I need assistance with a controlled substance medication prescription.
    d. Sun Pain Management typically provides 30 day weaning refills of medications based on clinical judgement.
5. Abusive and aggressive behavior will not be tolerated and will result in being discharged from the practice.
6. There is to be ***NO*** use of alcohol and/or benzodiazepine and/or carisoprodol (soma) while being prescribed narcotics. The use of narcotics with alcohol and/or benzodiazepine can cause over sedation and/or death. Any use of alcohol and/or benzodiazepine while on controlled substances should be discussed with the provider so that proper management can be determined.
7. I have been encouraged not to drive or operate heavy equipment while on controlled substances.
8. I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatment at Sun Pain Management may be ended immediately. If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to my referring provider, primary care physician, local medical facilities, and other authorities. *Illicit drugs (examples including but not limited to: marijuana, methamphetamine, heroin, cocaine, crack cocaine) will **NOT** be tolerated.*
9. I understand that the main treatment goal is to improve my ability to function and/or work. In consideration of that goal, and that I am being given narcotics to reach that goal, I agree to help myself by following better health habits such as proper diet, approved exercise, and controlled use of tobacco. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome of my treatment. I am solely responsible for updating my provider on any changes in my medications or medical condition(s).

I have been fully informed by Sun Pain Management about psychological dependence (addiction) of a controlled substance, which I understand is possible. I know that some persons may develop tolerance, which is the need to increase the dose of the medication to achieve the same effect of pain control, and I do know I many become physically dependent on the medication. This may occur if I am on the medication for several weeks, and when I stop the medication. I must do so slowly and under medical supervision or I may have withdrawal symptoms.

Sun Pain Management has my permission to view external medication history from all sources.

_____ _____

Patient Name (Printed) Patient Name (Signature)

_____ _____

Sun Pain Management Witness/Title (Printed) Sun Pain Management Witness (Signature)

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11047 N 19th Ave
Phoenix, AZ 85029
Phone: 602-589-0500
Fax: 602-314-4552

MEDICAL RECORDS REQUEST

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT'S NAME: _____ **DOB:** _____

PREVIOUS NAME: _____

TO RELEASE HEALTHCARE INFORMATION OF THE PATIENT FROM:

NAME: _____ **ADDRESS:** _____

PHONE: _____ **FAX:** _____

I REQUEST MY MEDICAL RECORDS BE SENT TO:

SUN PAIN MANAGEMENT
SECURE FAX: 602-314-4552

TYPE OF INFORMATION TO BE DISCLOSE:

OFFICE VISITS
XRAYS/MRI'S/ CT REPORTS/ EMG REPORTS
PERTINENT LAB REPORTS
HISTORY AND PHYSICAL
CONSULTATION REPORTS
CURRENT MEDICATIONS

__ BEHAVIORAL HEALTH
__ SUBSTANCE ABUSE

DATE RANGE TO RELEASE (Please choose one):

__ ALL
__ LAST 2 YEARS
__ DATE RANGE: _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

PATIENTS SIGNATURE: _____ **DATE:** _____

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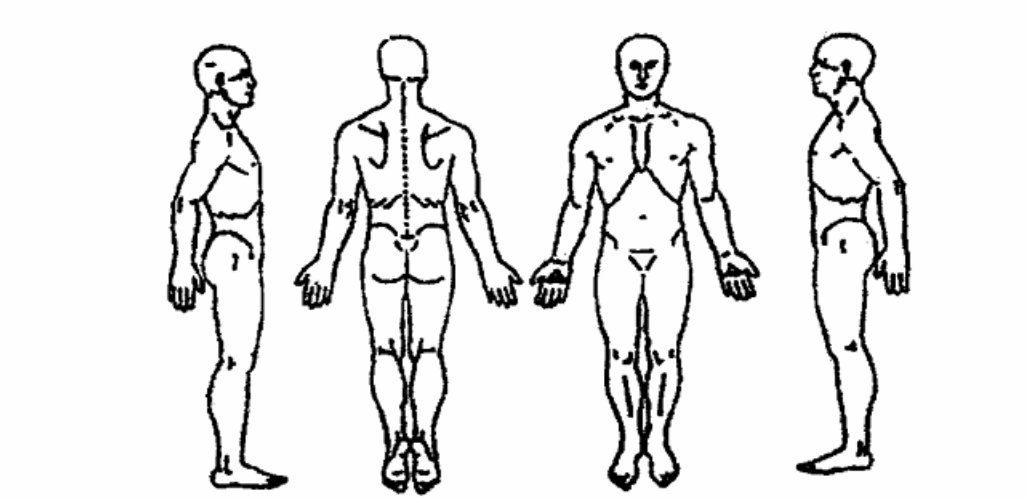
Medical Information

Please answer all questions as COMPLETELY as possible. An incomplete form may delay your medical treatment.

_____ _____

Last Name First Name Middle Initial DOB

Please mark the area of your pain on the diagram:



Past Medical History:
Please check the box if you had, or currently have, any of the following medial conditions (Listed are examples and not a complete list of possible conditions):

Head/Neck: ☐ Headaches ☐Sinusitis ☐Tinnitus ☐Other_____
Heart: ☐ High Blood Pressure ☐ Coronary Artery Disease ☐ Heart Attack ☐ Chest Pain
Lungs: ☐ Emphysema ☐ Chronic Bronchitis ☐ COPD ☐ Asthma ☐ Other_____
Kidney: ☐ Stones ☐ Insufficiency ☐ Cysts ☐ Pain ☐ Other _____
Liver: ☐ Cirrhosis ☐ Hepatitis ☐ Fatty ☐ Other _____
Digestion: ☐ GERD ☐ Peptic Ulcer Disease ☐ Diarrhea ☐ Constipation ☐ Pain ☐ Other_____
Muscles/Bones: ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Other _____
Skin/Breasts: ☐ Psoriasis ☐ Skin Cancer ☐ Fibrocystic Disease ☐ Other _____
Nervous System: ☐ Stroke ☐ TIA ☐ Seizures ☐ Multiple Sclerosis ☐ Other _____
Psychological: ☐ Anxiety ☐ Depression ☐ Bipolar ☐ Schizophrenia ☐ Other _____
Blood System: ☐ Anemia ☐ Hemophilia ☐ Clotting ☐ Other _____
Endocrine: ☐ Diabetes ☐ Cushing ☐ Addison ☐ Other _____
Immune System: ☐ HIV ☐ AIDS ☐ Infections ☐ Other _____
Any Other: _____

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Medications: (Check here if you attached a copy of your medication list ☐)

Name of Medication	Strength	# of Pills Per Day	Date Last Prescribed

Allergies: (No Known Allergies ☐)

Name	Side Effects

Past Surgical History:

Date:	Type:	Date:	Type:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History:

Please check the box if your family member has a history of the below-mentioned conditions.

Family	Alive	Deceased	Age	Diabetes	Hypertension	Heart Disease	Stroke	Mental Health	Cancer	Other*
Mother	☐	☐	___	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	___	☐	☐	☐	☐	☐	☐	☐
Brother 1	☐	☐	___	☐	☐	☐	☐	☐	☐	☐
Brother 2	☐	☐	___	☐	☐	☐	☐	☐	☐	☐
Sister 1	☐	☐	___	☐	☐	☐	☐	☐	☐	☐
Sister 2	☐	☐	___	☐	☐	☐	☐	☐	☐	☐

*If you checked other for any of your family members, please provide further details below.

_____

_____

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Review Of Systems

Please indicate if you are experiencing any of the following:

General/Constitutional:

☐ Change in Appetite ☐ Chills ☐ Fevers ☐ Night Sweats ☐ Sleep Disturbances

Allergy/Immunology

☐ Blistering of Skin ☐ Congestion ☐ Cough ☐ Rash

ENT:

☐ Blocked Ear ☐ Nosebleeds ☐ Swollen Glands

Endocrine:

☐ Excessive Sweating ☐ Excessive Thirst ☐ Heat Intolerance

Respiratory:

☐ Chest Pain ☐ Sputum Production

Cardiovascular:

☐ Irregular Heartbeat ☐ Palpitations

Gastrointestinal:

☐ Constipation ☐ Diarrhea ☐ Difficulty Swallowing ☐ Vomiting

Genitourinary:

☐ Bowel/Bladder Incontinence ☐ Difficulty Urinating

Musculoskeletal:

☐ Leg Cramps ☐ Weakness

Skin:

☐ Discoloration ☐ Itching

Neurological:

☐ Balance Difficulty ☐ Difficulty Speaking

Psychiatric:

☐ Anxiety ☐ Depressed Mood

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SOAPP® Version 1.0

The following are some questions given to all patients at Sun Pain Management who are on or are 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 feel that your pain is "out of control?" ☐0 ☐1 ☐2 ☐3 ☐4
2. How often do you have mood swings? ☐0 ☐1 ☐2 ☐3 ☐4
3. How often do you do things that you later regret? ☐0 ☐1 ☐2 ☐3 ☐4
4. How often has your family been supportive and encouraging? ☐0 ☐1 ☐2 ☐3 ☐4
5. How often have others told you that you have a bad temper? ☐0 ☐1 ☐2 ☐3 ☐4
6. Compared with other people, how often have you been in a car accident? ☐0 ☐1 ☐2 ☐3 ☐4
7. How often do you smoke a cigarette within an hour after you wake up? ☐0 ☐1 ☐2 ☐3 ☐4
8. How often have you felt a need for higher doses of medication to treat your pain? ☐0 ☐1 ☐2 ☐3 ☐4
9. How often do you take more medication than you are supposed to? ☐0 ☐1 ☐2 ☐3 ☐4
10. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? ☐0 ☐1 ☐2 ☐3 ☐4
11. How often have any of your close friends had a problem with alcohol or drugs? ☐0 ☐1 ☐2 ☐3 ☐4
12. How often have others suggested that you have a drug or alcohol problem? ☐0 ☐1 ☐2 ☐3 ☐4

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

13. How often have you attended an AA or NA meeting?	☐0 ☐1 ☐2 ☐3 ☐4
14. How often have you had a problem getting along with the doctors who prescribed your medicines?	☐0 ☐1 ☐2 ☐3 ☐4
15. How often have you taken medication other than the way that it was prescribed?	☐0 ☐1 ☐2 ☐3 ☐4
16. How often have you been seen by a psychiatrist or a mental health counselor?	☐0 ☐1 ☐2 ☐3 ☐4
17. How often have you been treated for an alcohol or drug problem?	☐0 ☐1 ☐2 ☐3 ☐4
18. How often have your medications been lost or stolen?	☐0 ☐1 ☐2 ☐3 ☐4
19. How often have others expressed concern over your use of medication?	☐0 ☐1 ☐2 ☐3 ☐4
20. How often have you felt a craving for medication?	☐0 ☐1 ☐2 ☐3 ☐4
21. How often has more than one doctor prescribed pain medication for you at the same time?	☐0 ☐1 ☐2 ☐3 ☐4
22. How often have you been asked to give a urine screen for substance abuse?	☐0 ☐1 ☐2 ☐3 ☐4
23. How often have you used illegal drugs (for example, cocaine, etc.) in the past five years?	☐0 ☐1 ☐2 ☐3 ☐4
24. How often, in your lifetime, have you had legal problems or been arrested?	☐0 ☐1 ☐2 ☐3 ☐4

Total Score_____

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

PHQ-9 & GAD-7

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		Not at all	Several Days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or over eating	0	1	2	3
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

PHQ9 – Total Score

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		Not at all	Several Days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3

GAD7 – Total Score

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PAIN MANAGEMENT
& SPINE SPECIALISTS

What is your Snore Score™?

Your answers to this quiz will help you decide whether you may suffer from sleep apnea.

1. **Are you a loud and/or regular snorer?** ☐Yes ☐ No
2. **Have you ever been observed to gasp or stop breathing during sleep?** ☐Yes ☐ No
3. **Do you feel tired or groggy upon awakening, or do you awaken with a headache?** ☐Yes ☐ No
4. **Are you often tired or fatigued during waking?** ☐Yes ☐ No
5. **Do you fall asleep sitting, reading, watching TV, or driving?** ☐Yes ☐ No
6. **Do you often have problems with memory or concentration?** ☐Yes ☐ No

If you have one or more of these symptoms, you are at higher risk for having obstructive sleep apnea. If you are also overweight, have a large neck and/or have high blood pressure the risk increases even further.

If you or someone close to you answers “yes” to any of the above questions, you should discuss your symptoms with your physician or a sleep specialist or turn to the American Sleep Apnea Association for more information on the diagnosis and treatment of sleep apnea. Different treatment options exist; the appropriate treatment choice for you depends upon the severity of your apnea and other aspects of the disorder. Talk to your doctor about choices. Untreated, obstructive sleep apnea can be extremely serious and cannot be ignored.