SOUTHWEST
Pain Management

## Southwest New Patient Packet

Welcome to Southwest Pain Management!
In an effort to best serve our patients, the public, and community we kindly ask that you read over our practice policies. Each individual's plan of care will be carefully tailored based on many factors such as condition, co-morbidities, history and adjunct medications in a collaborative multidisciplinary approach. Thank you.

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In 2016 the Centers for Disease Control and Prevention began strong efforts to control and reduce the number of opioids being prescribed by physicians for the treatment of chronic pain. The rationale behind these efforts was based on the staggering numbers of opioid-related harms and deaths occurring annually in the United States (CDC, 2021). Drug-related deaths by mainly synthetic opioids accounted for over 67,000 fatalities in 2018 alone (CDC, 2021).
The issued guidelines for healthcare providers include treatment methodologies based primarily on nonpharmacologic and non-opioid approaches which show sustained improvements in pain reduction and function without apparent risks (CDC, 2021). Southwest Pain Management follows these recommendations with the use of pain medication for our patients' chronic pain "treatment plans" when indicated.

All patients should be educated and involved in their plan and treatment of care while addressing the mental/emotional factors associated with the pain in their life. Pain can be debilitating and therefore effective strategies for optimal health promotion should be employed. The patient's understanding of their options and willingness to participate is highly important for overall compliance, success, and outcomes (CDC, 2021).

I, _____have read and understand the Southwest Pain Management policy regarding controlled substances used in current patient treatment plans.

Patient Signature: _____ Date: _____

Name /Nombre:_____ Date/Fecha:_____

DOB/Fecha de nacimiento:_____ Email:_____

Address/ *Direccion*:_____

City/ *Ciudad*:_____

State, Zip/ *Estado, Codigo Postal*:_____

Phone/ *Numero*:_____

Referring Dr./*Doctor Familiar:* _____

Phone;_____

**Chief Complaint / *La Queja principal*:**

A particular condition or diagnosis? ¿ Una *condición o un diagnóstico particular?*

**What medications are you currently taking ?**/ *Que tipo de medicina está tomando para este problema?*

_____

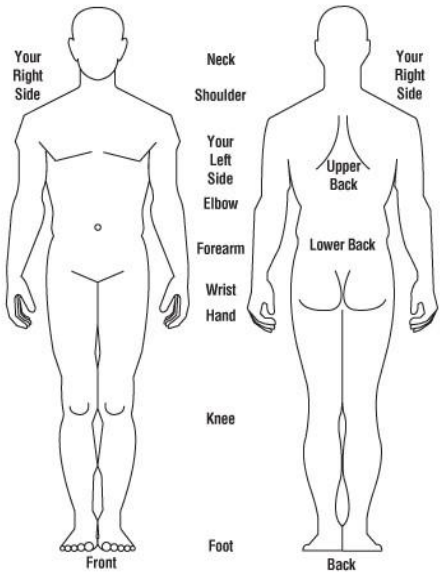
_____

_____

**List all allergies to MEDICATIONS/ *Lista de allergias de LAS MEDICINAS***

_____

Indicate on the drawing where your pain is.
*Indica en los dibujos su dolor.*



Is your problem/Su problema es: Constant- intermittent-frequent -occasional? *constante - intermitente - frecuente -en ocasiones?*

Is the pain/El dolor es: Sharp, dull, aching, throbbing, burning, tingling, shooting, stabbing? *Tu problema es: agudo, embora, dolor, latir,quemar,sentir, hormigueo,disparar, apuñalar, eléctrico?*

How would you rate your average pain on a scale of 0-10? *Valore su dolor 0-10, Oser nada de dolor 10 el poor?*

How long have you been experiencing this problem? *¿Cuánto tiempo ha tenido dolor?* Any tests have been done. *¿Qué pruebas ha tenido usted para el problema ?* MRI: CT Scan; X rays: EMG/NCS:

_____

- ❏ Surgery / Cirugia _____
- ❏ Physical therapy/ I terapia fisica _____
- ❏ Injections or nerve blocks / Inyecciones or nervio bloquea _____
- ❏ Psychological / Behavioral pain / Psicológico/ gestión conductista de dolor _____
- ❏ Osteopathic/ Chiropractic / Osteopático/manipulación de quiropractica o acupuntura _____
- ❏ Other/Otro_____

Family History / *La Historia familiar* _____

**CAGE Questionnaire - Answer if applicable**

Do you smoke? Do you drink alcohol?

Have you ever felt that you should cut down on your drinking (or drug use)? _____

Have people annoyed you by criticizing your drinking (or drug use)?_____

Have you ever felt bad or guilty about your drinking (or drug use)?_____

Have you ever had a drink or drug first thing in the morning to steady your nerves or get rid of a hangover? _____

**Do you have any of the following medical problems?**

¿Tiene alguno de los siguientes problemas médicos? por favor verifique si es así

| | |
|---|---|
| ❑ High blood pressure/alta presion | ❑ Diabetes |
| ❑ High cholesterol/alto cholesterol | ❑ Pancreatitis |
| ❑ Irregular heartbeat/insuficiencia cardiaca | ❑ Hepatitis |
| ❑ Congestive heart failure/congestiva de golpe Corazon | ❑ HIV/SIDA |
| ❑ Heart attack/Infarto de Corazon | ❑ Stomach ulcers/Ulceras de estomago |
| ❑ Sleep apnea/Problemas para dormir | ❑ GERD/agruras |
| ❑ Asthma/asma | ❑ Thyroid disorder/Desorden de tiroides |
| ❑ Bronchitis/Emphysema/COPD La bronquitis/enfisema | ❑ Kidney disease/Enfermedad renal |
| ❑ Pneumonia/Pulmonia | ❑ Other |
| ❑ Tuberculosis | ❑ Osteoarthritis |
| ❑ Lupus | ❑ Rheumatoid arthritis/Reuma articular |
| ❑ Scleroderma | ❑ Bleeding disorder/Sangrar desorden |
| ❑ Vision Problems/Problemas de vision | ❑ Carpal Tunnel Syndrome/Sindrome del tunel carpiano |
| ❑ Seizures/Tomas | ❑ Stroke/Golpe |
| ❑ Depression | ❑ Headaches/Dolores de cabeza |
| ❑ Autoimmune disorder | ❑ Anxiety/ La ansiedad se asusta desorden |

When you visit our office, it is important that you feel safe in telling your doctor any personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have shared with us. HIPAA requires that we provide our patients with our "Notice of Privacy Practices'. This notice describes how medical information we receive from you may be used and disclosed by our practice and your rights related to access to this information. By signing below you acknowledge our privacy practices as stated above. You are entitled to a personal notice upon request. Additionally, I allow anyone who comes into the examination and/or consultation room with me to participate in the examination(s) and/or discussion regarding my health care while in my presence. I acknowledge that I have reviewed the Southwest Pain Management's Practice Policies and Notice of Privacy/ HIPAA compliant practices.

⇛ **Patient Name (please print)** _____

⇛ **Signature** _____**Date**_____