Thank you for choosing the Barnes-Jewish Washington University Pain Management Center located in Center for Advanced Medicine. Prior to scheduling an appointment for consultation, we ask that a person is referred to us by one of their currently treating physicians who will be continuing to be involved in the person's care. This is to ensure that our efforts are well-coordinated with other aspects of a person's healthcare. Please request medical records and prior treatment, especially pain treatments be sent to our facility.

Our pain management practice provides care to hospital inpatients as well ambulatory patients. Initial consultation may take up to 2-4 hours, we recommend bringing a book or electronic device to utilize if there are delays in your visit.

We respect your right to privacy. The information you provide is secure and confidential, and your information will not be available to anyone who is not involved in your care.

1) Please arrive at least 30 minutes prior to your scheduled appointment time to review your paperwork and finalize any outstanding information required. Construction in the area may cause you a delay driving to our building. Please allow extra time to arrive at your appointment. If you are delayed due to traffic, please call: 314-362-8820.

2) If we do not have an insurance authorization at the time of your initial evaluation, we will not be able to treat you. Please confirm that your referral has been sent to our office.

3) Please bring a copy of your insurance card with you to your visit. Inform the clinical staff of any insurance changes/updates as needed during the course of your treatment with us.

4) If you are unable to keep this appointment, please call us at least 48 hours in advance in order for us to accommodate other patients who are waiting for appointments.

Pain can be very complex and difficult to understand. Our physicians provide a multidisciplinary approach, to address chronic pain. During the course of treatment you may be scheduled to meet with the clinical psychologist and or a physical therapist. As a part of the treatment plan, the pain physician will evaluate if you are a candidate for interventional pain procedures. Our physicians offer non-opioid medication recommendations to your PCP.

The Pain Management Center is jointly operated by Washington University Physicians and Barnes Jewish Hospital; therefore your insurance will receive two bills for each visit. Barnes Jewish Hospital billing may also include other services received i.e.: radiology, pharmacy, and laboratory fees. For additional information regarding your bill: please contact Washington University Financial services at 314-273-0500 or 800-862-9980 or BJC Financial Patient Service representative at 800-833-0604.

If you have any questions, please contact Barnes Jewish / Washington University Pain Management Center at (314) 362-8820.

Contact Information
Barnes Jewish/ Washington University Pain Management Center
4921 Parkview Place Suite 14C
St. Louis, MO 63110
Phone: 314-362-8820
Fax: 314-362-9471

Hours of Operation
Patient Care Hours: Monday-Friday 8:00 am - 4:00 pm

Getting here and Parking
Valet parking (under cover) for patients and their families is available at the Center's front entrance, located on Parkview Place just off Euclid Avenue. This service has a nominal fee and is free with a disabled parking tag, although garage fees still apply.

Discounted Self-parking is available in the Euclid Garage, across Euclid Avenue to the east. The parking garage connects to the CAM via a third-floor walkway. Self-parking is also available at the Laclede garage, which is connected to the Center via the fifth floor of the garage.

Wheelchairs are available at the valet entrance and on the third floor of the Euclid Garage, as well as the fifth floor of the Laclede Garage.

MetroLink
Exit at the Central West End station. Take the steps or elevator up to Euclid Avenue, turn right and proceed two blocks to the main entrance located on Parkview Place.

BJC HealthCare Washington University Physicians®

TELEHEALTH CONSENT TO TREATMENT

PURPOSE: This form obtains your consent to participate in a telemedicine consultation, also known as "Telehealth" services. Telehealth is the delivery of health care services using two-way video communications and/or the electronic exchange of information. Since this is different than in-person health care services you may typically receive, it is important for you to understand and be aware of and comfortable with the benefits and possible risks. For your Telehealth visit, a Washington University or BJC Medical Group provider will communicate using electronic and video transmissions and will have access to your medical records while you are being treated at home. This will enable your provider to determine an appropriate treatment plan for your condition. Participating in this Telehealth program will give you access to your provider without having to travel to your provider's office, for inpatient/outpatient care.

Some possible risks associated with the use of Telehealth services include, but may not be limited to:

- Instances in which the electronic information may not be sufficient for appropriate medical decision making by the provider.
- Equipment issues, which could cause delays in your medical evaluation and treatment.
- Although rare, security measures could fail, possibly exposing your privacy and your personal medical information.
- Finally, in some cases, Telehealth services may not be as complete as in-person services, and if your provider believes an in-person visit is necessary, he or she may recommend that you schedule an in-person visit.

It is important that you understand and agree to the following statements:

1. I understand that engaging in a telemedicine visit with my health care provider at Washington University/BJC Medical Group is optional. I have the right to discontinue this service at any time. I further understand that in place of telehealth services, I may request a face-to-face visit with my health care provider.
2. I have been informed and understand the alternatives to the Telehealth services that are available to me, and give my consent to proceed with Telehealth services.
3. I understand that my provider will be at a different location from me. I understand that a telemedicine visit will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as the consulting health care provider and the provider will not be able to physically examine me.
4. I understand that the video portion of the telehealth service will not be recorded.
5. I understand that others may also be present during the visit other than my health care provider and consulting health care provider(s) in order to operate the video equipment and/or facilitate the Telehealth consultation. I further understand that I will be informed of their presence in the visit and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask other personnel to leave the telemedicine examination room; and/or (3) end the visit at any time.
6. I understand that I have the right to request a copy of this informed consent and upon request it will be provided to me.

7. I understand there is a possible risk of an incomplete or ineffective visit due to technological issues, and that if any of the technological issues occur, the visit may end. The technological issues include but are not limited to: a) failure, interruption or disconnection of the audio/video connection; b) a picture that is not clear enough to meet the needs of the visit; and/or c) a minor risk of access to the visit through the interactive connection by electronic tampering.
8. I understand that my provider or I can stop the telemedicine visit if the telehealth connections are not adequate for the situation.

ACKNOWLEDGEMENT & CONSENT: I have read and understand this consent. I have been given an opportunity to ask questions and all of my questions have been answered to my satisfaction. The risks, benefits, and alternatives of the Telehealth visit have been explained to me and I hereby consent to participate in Telehealth services as described in this document during this course of treatment.

_____ _____

Signature of Patient or Person Authorized to Consent Date Relationship to Patient

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITIES:

I agree the information I gave to apply for payment is correct for any third-party payers, including Medicare or Medicaid. I have been given a paper listing my rights as a Medicare or Medicaid patient. I know I can ask for a review of my record to find out about any payments or charges I may owe if Medicare or Medicaid will not cover my charges.

If I receive Medicare, Medicaid or other insurance benefits, I know I am responsible to know what my insurance covers and that I can call my insurance plan if I have questions. I also understand I am responsible for any deductibles, co-insurance, and any non-covered charges. I know that I may receive separate bills for services provided by healthcare workers who are not employed by Washington University or BJC Medical Group – like a bill for laboratory testing or imaging services requested by my doctor.

I authorize direct payment to Washington University or BJC Medical Group of all insurance benefits and I authorize release of my personal health information as may be required for my insurance plan to pay such benefits. I understand that I am responsible, subject to Washington University's or BJC's Financial Assistance Policy, for portions of my bill not covered by insurance and I understand I will be held solely financially responsible if:

- ☐ All conditions and guidelines set forth by my insurance carrier are not met
- ☐ I fail to give valid insurance information within the filing guidelines set by my insurance plan
- ☐ I receive services not covered by my insurance plan
- ☐ I am covered by a plan BJC Medical Group doctors are not contracted with
- ☐ I do not have insurance

I also agree that I have received or have access to signs and/or brochures which contain information about:

- Advance Directives
- Privacy of my health care information and who may have access to my information
- Office Hours and Office Policies
- What Rights and Responsibilities I/we have as a patient or family member and who to contact if I have questions

I have read this whole form, or had it read and explained to me, and I had the opportunity to ask questions.

Signature of Patient or Person Authorized to Consent	Date	Relationship to Patient

Signature of Guarantor if different than above

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I acknowledge I have received or I have been provided the opportunity to receive a copy of Washington University's or BJC's Notice of Privacy Practices that explains when, where, and why my protected health information maybe used or shared by Washington University or BJC Medical Group.

https://www.bjc.org/for-patients-visitors/patient-privacy

https://wuphysicians.wustl.edu/for-patients/for-your-protection/notice-of-patient-privacy-practice-hipaa

Signature of Patient or Person Authorized to Consent	Date	Relationship to Patient

BARNES JEWISH Hospital | Washington University in St. Louis Physicians

BARNES JEWISH HOSPITAL
1 BARNES JEWISH HOSPITAL PLZ
SAINT LOUIS, MO 63110

DOB:
MR#

ECD: CSN:

PAIN MANAGEMENT CENTER
PATIENT COMMUNICATION

Please check (✓) the appropriate box(es) (☐) and fill in the blank(s) as needed.

Please provide your email address for communication: _____

_____

Would you like to sign up for the Washington University Follow My Health Patient Portal? ☐ YES ☐ NO

My patient health information may be discussed with the following family members or friends:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Messages containing health information may be left at these numbers:

Home: _____ Cell: _____

Work: _____ Other: _____

Can you receive texts via cell? ☐ YES ☐ NO

May we text you reminders including appointment and prescription refills? ☐ YES ☐ NO

The following person(s) may pick up my written prescriptions from the office: _____

_____

Preferred pharmacy name and phone number: _____

_____

Patient/Responsible Adult:

_____ _____ Date: _____ Time: _____

SIGNATURE **REQUIRED** PRINTED NAME **REQUIRED**

Nurse:

_____ _____ Date: _____ Time: _____

SIGNATURE **REQUIRED** PRINTED NAME **REQUIRED**

DO NOT WRITE BELOW THIS LINE

BJH-MR-1375

Date/Time Printed 2020-04-22 11:02:22

BARNES JEWISH Hospital | Washington University in St. Louis Physicians

BARNES JEWISH HOSPITAL
1 BARNES JEWISH HOSPITAL PLZ
SAINT LOUIS, MO 63110

DOB:
MR#

ECD: CSN:

PAIN MANAGEMENT CENTER
HEALTH RISK HISTORY

Please check (✔) the following box(es) (☐) and fill in the blank(s) as needed.

SAFETY PRECAUTIONS

1. How did you arrive to our office today? ☐ Walked
   ☐ Used Walker ☐ Used Cane ☐ Wheelchair
   ☐ Ambulance ☐ Stretcher ☐ Motorized scooter
2. Are you steady when you walk? ☐ Yes ☐ No
   If no, please explain: _____
3. Do you need assistance
   ☐ Getting in and out of your wheelchair? ☐ Standing?
   ☐ Getting on the exam table?
4. Who is with you today? ☐ Family ☐ Friend
   ☐ Other Who? _____
5. Are you on Oxygen? ☐ Yes ☐ No
   If yes, how many liters? _____

HEALTH RISK ASSESSMENT

6. Do you have an Advance Directive (Living Will)?
   ☐ Yes ☐ No
   If yes, do we have a copy on file? ☐ Yes ☐ No
   If no, would you like information about an Advance Directive (Living Will)? ☐ Yes ☐ No
7. Have you lost or gained 10 pounds or more in the last month? ☐ Yes ☐ No
   I've lost _____ pounds
   I've gained _____ pounds
8. Are you satisfied with your current weight? ☐ Yes ☐ No
9. How would you rate your appetite?
   ☐ Good ☐ Fair ☐ Poor
10. How would you rate your diet?
    ☐ Good ☐ Fair ☐ Poor
11. Are you able or do you have help to purchase and prepare balanced meals? ☐ Yes ☐ No
12. Would you like your physician to refer you to a dietician? ☐ Yes ☐ No
13. Have you experienced any of the following problems currently or recently?
    a. Difficulty walking? ☐ Yes ☐ No
       If yes, please explain: _____
    b. Difficulty getting dressed? ☐ Yes ☐ No
    c. Falling? ☐ Yes ☐ No
       If yes, how many times in the last month _____
    d. Difficulty bathing and grooming? ☐ Yes ☐ No
    e. Memory problems? ☐ Yes ☐ No
    f. Difficulty with eating such as chewing or swallowing? ☐ Yes ☐ No
    g. Difficulty speaking? ☐ Yes ☐ No
    h. Difficulty with activities of daily living? ☐ Yes ☐ No
14. Do you have concerns regarding any of the following?
    If yes, please explain: _____
    a. Getting medication? ☐ Yes ☐ No
    b. Housing? ☐ Yes ☐ No
    c. Transportation? ☐ Yes ☐ No
    d. Would you like to see a Social Worker? ☐ Yes ☐ No

PAIN ASSESSMENT

15. Are you having pain today? ☐ Yes ☐ No
    If yes, what is your pain score? _____
    Where is your pain located? _____
16. How often do you experience this pain?
    ☐ Occasionally ☐ Frequently ☐ Constantly
17. How would you describe your pain? ☐ Aching
    ☐ Burning ☐ Crushing ☐ Dull ☐ Sharp
18. What makes your pain better? _____
19. What makes your pain worse? _____
20. Are you in a relationship with someone who makes you feel afraid, unsafe or is hurting you? ☐ Yes ☐ No
21. What is the best way for you to learn something new?
    ☐ Reading ☐ Listening ☐ Pictures
    ☐ Demonstration
22. What are barriers to your learning?
    ☐ Language ☐ Hearing ☐ Dexterity ☐ Memory
    ☐ Vision ☐ Emotional ☐ Cognitive limitations
    ☐ Culture/Religious

DATE	TIME	SIGNATURE OF PATIENT *OR* PERSON AUTHORIZED TO SIGN/RELATIONSHIP	PRINTED NAME
___/___/___	___:___		
___/___/___	___:___	NURSE SIGNATURE	PRINTED NAME

DO NOT WRITE BELOW THIS LINE

BJH-MR-1363

Date/Time Printed 2020-04-22 11:02:23

BARNES JEWISH Hospital BJC HealthCare | Washington University in St. Louis Physicians

BARNES JEWISH HOSPITAL
1 BARNES JEWISH HOSPITAL PLZ
SAINT LOUIS, MO 63110

DOB:
MR#

ECD: CSN:

PAIN MANAGEMENT CENTER – INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

Please check (✓) the appropriate box(es) (☐) and fill in the blank(s) as needed.

Date: _____

Patient Name: _____ **Date of Birth:** _____

Please complete the questionnaire as fully as possible to assist us with your evaluation and treatment. Please read each question carefully and answer to the best of your ability. This information is part of your medical record, and will not be released without your permission.

Referring Physician: _____ Telephone Number: _____

Primary Care Physician: _____ Telephone Number: _____

PAIN HISTORY

Briefly describe your pain: _____

When did your pain first begin? (date): _____

Under what circumstances did the pain begin:

☐ Accident at work ☐ At work, but not an accident
☐ Accident at home ☐ Auto accident
☐ Following surgery ☐ Following an illness
☐ Pain just began Other reason: _____

Briefly describe the circumstance(s) you checked: _____

Are you receiving compensation or disability payments now? ☐ Yes ☐ No
Are you involved in a lawsuit because of your pain or injury? ☐ Yes ☐ No
Have you contacted a lawyer because of your pain or injury? ☐ Yes ☐ No

What are your expectations from the Pain Center? _____

DO NOT WRITE BELOW THIS LINE

BARNES JEWISH Hospital | Washington University in St. Louis Physicians

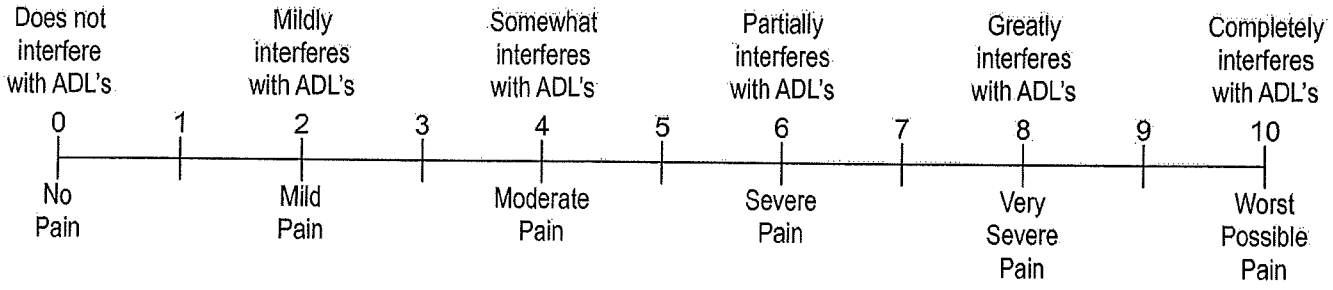
BARNES JEWISH HOSPITAL
1 BARNES JEWISH HOSPITAL PLZ
SAINT LOUIS, MO 63110

DOB:
MR#

ECD: CSN:

PAIN MANAGEMENT CENTER – INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

Please answer the following questions on how your pain affects your activities of daily living (ADL)'s, using the ADL Pain Chart below.



PAIN INTENSITY

Check (✓) the box to indicate your pain level at the present time.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Check (✓) the box where your pain is its worst.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Check (✓) the box where your pain is at its least.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Check (✓) the box of your average pain.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

DO NOT WRITE BELOW THIS LINE

BJH-MR-1243

Date/Time Printed 2020-04-22 11:02:23

BARNES JEWISH HOSPITAL
1 BARNES JEWISH HOSPITAL PLZ
SAINT LOUIS, MO 63110

DOB:
MR#

ECD: CSN:

PAIN MANAGEMENT CENTER – INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

PAIN INTENSITY

Which word (or words) best describe the patterns of your pain:

☐ Always present
☐ Comes and goes

Is your pain usually WORSE during a certain time of day? ☐ Yes ☐ No
If yes, when: ☐ Morning ☐ Midday ☐ Evening ☐ Night

Is your pain usually BETTER during a certain time of day? ☐ Yes ☐ No
If yes, when: ☐ Morning ☐ Midday ☐ Evening ☐ Night

QUALITY OF PAIN

Please describe your pain. Check (✓) all that apply:

	Yes	No		Yes	No
Throbbing			Heavy		
Shooting			Tender		
Stabbing			Splitting		
Cramping			Tiring-Exhausting		
Gnawing			Sickening		
Hot-Burning			Fearful		
Aching			Punishing-Cruel		

INCREASES/DECREASES PAIN

Please check (✓) how your pain reacts to the following:

	Better	Worse	No Change
Walking			
Lifting			
Bending			
Lying			
Weather/Temperature change			
Standing			
Sitting			
Stress/Worry			
Heat			
Ice			
Rest			
Medications			
Light touch			
Cough			
Sneeze			
Strain			
Other:			

DO NOT WRITE BELOW THIS LINE

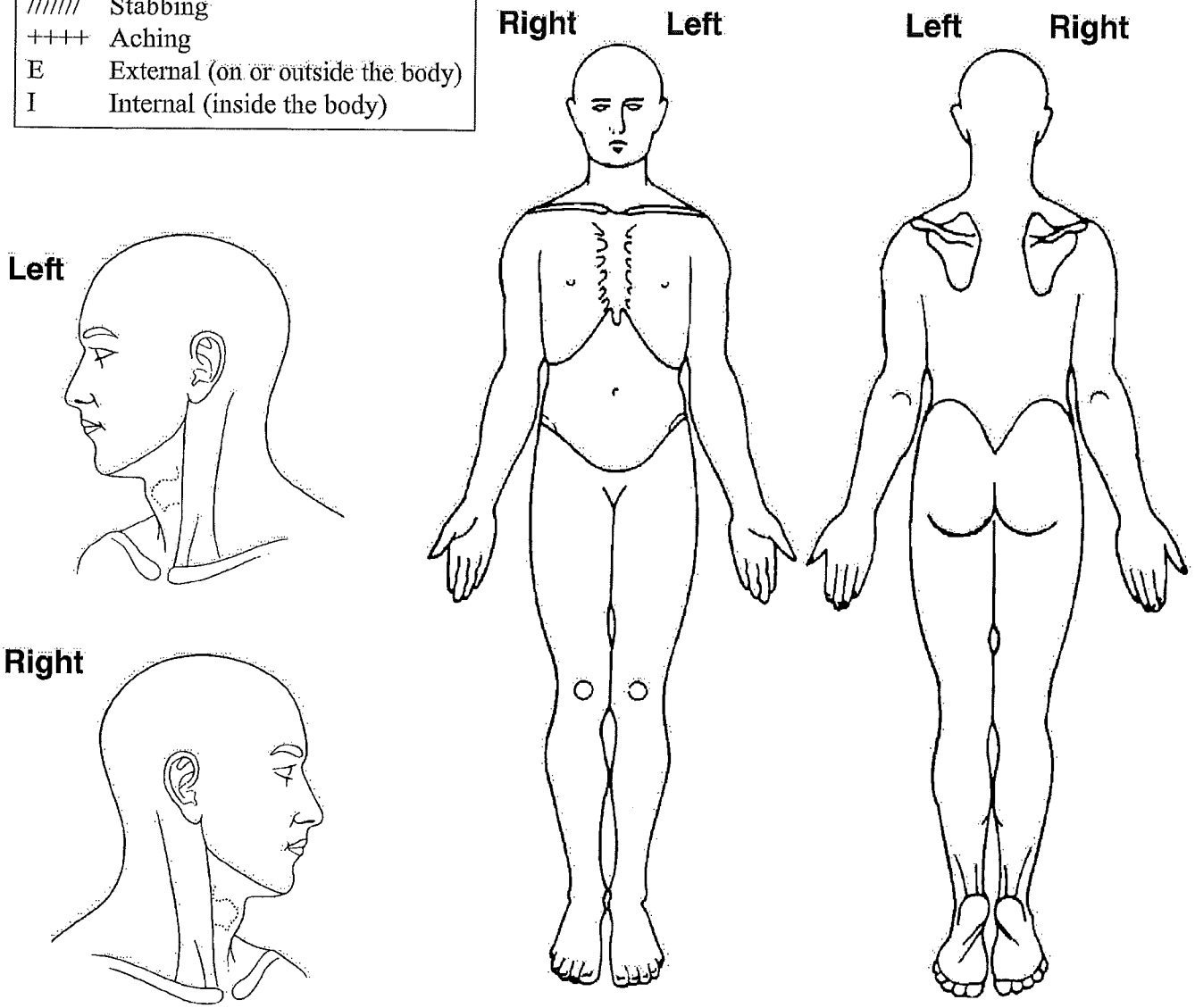
Date/Time Printed 2020-04-22 11:02:23

PAIN MANAGEMENT CENTER–INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

Where is your pain?

Using the symbols listed below, mark on the drawings the areas where you feel pain. If you feel more than one sensation in the same area, mark over that area with additional symbols that apply. Show all affected areas.

SYMBOLS	
——	Numbness
0000	Pins and needles
xxxx	Burning
///////	Stabbing
++++	Aching
E	External (on or outside the body)
I	Internal (inside the body)



DO NOT WRITE BELOW THIS LINE

BARNES JEWISH Hospital BJC HealthCare | Washington University in St. Louis Physicians

BARNES JEWISH HOSPITAL
1 BARNES JEWISH HOSPITAL PLZ
SAINT LOUIS, MO 63110

DOB:
MR#

ECD: CSN:

PAIN MANAGEMENT CENTER – INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

LIFESTYLE CHANGES

During the past month, how much did pain interfere with the following activities? Check (✔) the box for each of the questions that best describes your situation.

	Not at All	A Little Bit	Moderately	Quite a Bit	Extremely
Going to work	☐	☐	☐	☐	☐
Performing household chores	☐	☐	☐	☐	☐
Yard work or shopping	☐	☐	☐	☐	☐
Socializing with friends	☐	☐	☐	☐	☐
Recreation and hobbies	☐	☐	☐	☐	☐
Having sexual relations	☐	☐	☐	☐	☐
Physical exercise	☐	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	☐
Appetite	☐	☐	☐	☐	☐

PRIOR TREATMENTS

Prior treatments for pain, check (✔) all the boxes that apply.

	Helpful	Not Helpful
☐ Surgery	☐	☐
☐ Nerve Block	☐	☐
☐ TENS/MENS	☐	☐
☐ Physical Therapy	☐	☐
☐ Occupational Therapy	☐	☐
☐ Biofeedback/Relaxation Therapy	☐	☐
☐ Acupuncture	☐	☐

Facility where it was performed? _____

☐ Chiropractor	☐	☐
☐ Other Pain Center(s)	☐	☐
☐ Professional Psychological Support	☐	☐

Other: _____

DIAGNOSTIC TESTS

	Date	Facility
☐ MRI	_____	_____
☐ CAT SCAN	_____	_____
☐ XRAY	_____	_____
☐ EMG	_____	_____
☐ Nerve Conduction Study	_____	_____
Other:	_____	_____

DO NOT WRITE BELOW THIS LINE

BARNES JEWISH Hospital | Washington University in St. Louis Physicians

BARNES JEWISH HOSPITAL
1 BARNES JEWISH HOSPITAL PLZ
SAINT LOUIS, MO 63110

DOB:
MR#

ECD: CSN:

PAIN MANAGEMENT CENTER – INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

Please check (✔) all conditions which you currently have.

MEDICAL HISTORY

Constitutional Symptoms
☐ Fever ☐ Fatigue

Nutritional Assessment
☐ Weight loss/gain
☐ Poor appetite
☐ Nutritional supplement use

Eyes
☐ Eye Pain ☐ Blurred Vision
☐ Glaucoma ☐ Eye Discharge
☐ Glasses or Contacts
☐ Light Sensitivity

Ears/Nose/Mouth/Throat
☐ Ear Discharge ☐ Ringing or Pain
☐ Hearing difficulty or aid
☐ Nose Pain ☐ Nose Drainage
☐ Nose Congestion
☐ Nose Bleeds ☐ Sinus Infections
☐ Dentures ☐ Jaw/Tooth Pain
☐ Mouth Sores ☐ Sore Throat
☐ Hoarseness

Cardiovascular
☐ High blood pressure
☐ Chest pain
☐ Heart attack
☐ Abnormal heart rhythm
☐ Swelling of ankles
☐ Mitral Valve Prolapse
☐ Blood clot
☐ Use of blood thinners

Respiratory
☐ Painful breathing
☐ Productive cough
☐ Emphysema
☐ Shortness of breath
☐ Tuberculosis
☐ Asthma

Gastrointestinal
☐ Abdominal pain
☐ Heartburn ☐ Hiatal hernia
☐ Nausea and vomiting
☐ Constipation ☐ Diarrhea
☐ Ulcers
☐ Liver, gallbladder problems, black, bloody stools

Genitourinary
☐ Painful urination
☐ Bladder infection
☐ Difficult urination
☐ Frequent urination
☐ Blood in urine
☐ Sexually transmitted disease

Musculoskeletal
☐ Arthritis ☐ Swollen joints
☐ Muscle pain

Integumentary (skin or breast)
☐ Rash ☐ Itching
☐ Bruise easily ☐ Shingles
☐ Skin cancer

Neurological
☐ Headache ☐ Multiple sclerosis
☐ Seizures ☐ Head injury
☐ Stroke ☐ Tremors
☐ Weakness/numbness/tingling
☐ Dizziness ☐ Loss of coordination

Psychiatric
☐ Memory loss ☐ Alzheimer's
☐ Depression ☐ Anxiety/Panic Attacks
☐ Alcoholism ☐ Thoughts of suicide
☐ Irritability

Endocrine
☐ Sweats ☐ Thyroid disease
☐ Diabetes

Hematologic/Lymphatic
☐ Leukemia ☐ Bruising
☐ Bleeding disorder
☐ Swollen glands
☐ Hepatitis

Immunologic/Allergies
☐ AIDS/HIV
☐ Cancer: _____

PHYSICIAN ONLY
☐ "All others negative"

FAMILY MEDICAL HISTORY

Has anyone in your family every had any of the following conditions? Please check all that apply.

	Father	Mother	Brother	Sister	Grandparent
Anxiety					
Cancer					
Chronic pain					
Depression/Mental Illness					
Diabetes					
Disability					
Drug Addition/Drug Abuse					
Heart disease					
High blood pressure					
Physical/Verbal Abuse					
Stroke					
Suicide					
Thyroid disease					
Cause of Death					

DO NOT WRITE BELOW THIS LINE

BJH-MR-1243

Date/Time Printed 2020-04-22 11:02:23

BARNES JEWISH Hospital BJC HealthCare | Washington University in St. Louis Physicians

BARNES JEWISH HOSPITAL
1 BARNES JEWISH HOSPITAL PLZ
SAINT LOUIS, MO 63110

DOB:
MR#

ECD: CSN:

PAIN MANAGEMENT CENTER – INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

OTHER MEDICAL HISTORY/ PAST SURGERIES

Other Medical Conditions Now or Past	Surgeries	Date

Do you have any medical devices implanted in your body? ☐ Yes ☐ No
(i.e. pacemaker, portacath, pump, rods, prosthesis, stimulator etc.) _____

ALLERGIES

Allergies/Sensitivities	Reaction	Allergies/Sensitivities	Reaction

CURRENT PAIN MEDICATIONS

Date Started	Medication	Dose/How often do you take medication?	Benefit

Are you afraid of becoming addicted to your medications? ☐ Yes ☐ No
Are you on any blood thinners? ☐ Yes ☐ No

OTHER CURRENT MEDICATIONS

Date Started	Medication	Dose/How often do you take medication?

PREVIOUS PAIN MEDICATIONS

Previous Medication Taken for Pain (Important please contact your Physician or Pharmacy for Lists)

Medication	Dose	Reason Discontinued

DO NOT WRITE BELOW THIS LINE

BJH-MR-1243

Date/Time Printed 2020-04-22 11:02:23

BARNES JEWISH Hospital | Washington University in St. Louis Physicians

BARNES JEWISH HOSPITAL
1 BARNES JEWISH HOSPITAL PLZ
SAINT LOUIS, MO 63110

DOB:
MR#

ECD: CSN:

PAIN MANAGEMENT CENTER – INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

PSYCHOSOCIAL

Significant other: _____
Relationship: _____
Do you take care of other family members? ☐ Yes ☐ No
(i.e. parents, children, etc.) _____
Do you live alone? ☐ Yes ☐ No
Education Level: _____
Are you currently working? ☐ Yes ☐ No If no, why? _____
Previous/Current Occupation: _____
Do you smoke? ☐ Never ☐ Previously, but quit ☐ Daily ☐ Less than daily
Number of years smoking? _____ Number of packs per day? _____
Have you ever used recreational drugs? ☐ Yes ☐ No If yes, please indicate which drugs:
☐ Marijuana ☐ Heroin ☐ Ecstasy ☐ Cocaine ☐ Speed
☐ Crack ☐ Other: _____
Do you drink alcohol? ☐ Never ☐ Currently ☐ Daily ☐ Rarely
How much per week? _____
☐ Previously, but quit. When did you quit: _____
Have you ever been in a 12 step recovery program? ☐ Yes ☐ No

PSYCHOLOGICAL

Please check (✔) the box which describes how you have been feeling.
During the past month have you been tense or anxious?
☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always
During the past month have you been depressed or discouraged?
☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always
Hospital Admission for Mental Illness? ☐ Yes ☐ No
During the past month have you been irritable or upset?
☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always
When you are in pain, how often is your husband/wife/other family supportive and encouraging?
☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always
When you are in pain, how often does your husband/wife/other family ignore you or become angry?
☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always

I have received the Patient Bill of Rights ☐ Yes ☐ No

Form completed by
(Patient/Other): _____ _____
Signature Relationship

_____ _____
Date Time

DO NOT WRITE BELOW THIS LINE