Missouri Baptist
MEDICAL CENTER
BJC HealthCare

3015 N. Ballas Road
St. Louis, MO 63131

Washington University Physicians
Pain Management Center

Thank you for scheduling an appointment with the Washington University Physicians Pain Management Center at Missouri Baptist Medical Center, 3015 N. Ballas Road, St. Louis, MO.

We have enclosed a *Patient Questionnaire* for you to complete prior to coming to your first appointment. We have also enclosed a Communication Form (PHI); which tells us who we may communicate with regarding your personal health information. Please bring these forms completed along with your insurance cards to your initial appointment. We have also enclosed a sheet that provides some *information regarding the Pain Management Center*.

***The Pain Management Center* is a facility-based practice at Missouri Baptist Medical Center. Since we are facility-based, there are TWO (2) SEPARATE BILLS incurred at each visit. The PROFESSIONAL CHARGES (Hospital Based Copay) are from Washington University Physicians. The FACILITY CHARGES are from Missouri Baptist Medical Center.**

Please note that some insurance companies require an authorization. Without receiving this referral prior to your appointment, we reserve the right to reschedule your appointment. **The referral must state the treating physician, and the facility; Missouri Baptist Medical Center.**

***Please note, prescriptions are not written at the first office visit.**

If services are to be covered under **Worker's Compensation Benefits**, we require that you complete a detailed form to include the address to bill, a contact name, phone number, and a claim number. This information must be complete before your are seen.

If you do not have insurance coverage, you will be considered **Self-Pay**. At the time of your visit, you will be required to complete a **Patient Responsibility Form**. Partial payments for services for the Washington University Physician, is required at the time of service. Financial assistance is available through Washington University School of Medicine and Missouri Baptist Medical Center. Co-payments are expected at the time of services. We accept cash, checks or credit cards.

NEW PATIENT CHECKLIST (Bring to your 1st appointment)

_____ Completed New Patient Questionnaire
_____ Insurance Card(s)
_____ Referral (if required) or completed Work Comp Form (if applicable)
_____ Co-payment

We look forward to meeting you. Your appointment date and time is:_____.

The Pain Management Team

Missouri Baptist
MEDICAL CENTER
BJC HealthCare

3015 N. Ballas Road
St. Louis, MO 63131

Washington University Physicians
Pain Management Center

Phone: 314-996-7200

Fax: 314-996-7201

If you have any questions, concerning billing, please call:

(For Facility Charges)

Missouri Baptist Medical Center Patient Accounts

314-996-3600 or 800-388-9180

(For Physician Charges)

Washington University Pain Management Accounts

314-273-0500 or 800-862-9980

Missouri Baptist
MEDICAL CENTER
BJC HealthCare

PAIN MANAGEMENT CENTER
WASHINGTON UNIVERSITY PHYSICIANS

PATIENT IDENTIFICATION

Washington University Physicians
Pain Management Center

3015 N. Ballas Road
St. Louis, MO 63131

Phone: 314-996-7200

Patient's Name:

_____

To Our Patients,

The Pain Management Center is a facility-based practice located on the campus of Missouri Baptist Medical Center. As such, the physicians and the facility bill for services separately.

You will receive a bill from Washington University Physician Services for the services of your physician.

You will receive a bill from Missouri Baptist Medical Center for the use of the clinical services, diagnostic imaging, medications and overhead expenses.

_____

Patient's Signature Date

DO NOT WRITE BELOW THIS LINE

Missouri Baptist
MEDICAL CENTER
BJC HealthCare

3015 N. Ballas Road
St. Louis, MO 63131

Washington University Physicians
Pain Management Center

BLOOD THINNER QUESTIONNAIRE

Dear Patient:

Do you take any of the following medications below, frequently referred to as **"Blood Thinners"?**

☐ **NO, please check the box.**

☐ **YES, please circle the medication you are taking and if so who is the Prescribing Physician: _____ Phone #:_____**

- **Dipyridamole + Aspirin (Aggrenox)**
- **Warfarin (Coumadin)**
- **Prasugrel (Effient)**
- **Warfarin (Jantoven)**
- **Enoxaparin (Lovenox)**
- **Clopidogrel (Plavix)**
- **Cilostazol (Pletal)**
- **Dabigatran (Pradaxa)**
- **Ticlopidine (Ticlid)**

Before any procedure or injection can be scheduled, the doctor who prescribes this medication **must** be contacted. Please provide the name of your doctor who prescribes your blood thinner medication and his/her contact information. The Pain Management nurse will contact your doctor to obtain permission for you to stop your medication for the appropriate length of time prior to treatment. The nurse will then contact you to coordinate your treatment and confirm instructions regarding your **"blood thinner"**.

REMINDER: DO NOT STOP YOUR "BLOOD THINNER" UNTIL YOU HAVE BEEN GIVEN SPECIFIC INSTRUCTION! IF SO, THIS MAY BE HAZARDOUS TO YOUR HEALTH.

Missouri Baptist
MEDICAL CENTER
BJC HealthCare

PAIN MANAGEMENT CENTER
PATIENT COMMUNICATION FORM

PATIENT IDENTIFICATION

Please fill in the blanks as needed.

1. Your Patient Health Information may be discussed with the following individual(s):

   _____

   _____

   _____

2. What is the best telephone number to reach you at regarding your appointments, medication refills, and other concerns?

   _____

   _____

   _____

3. May we leave a message on this phone ☐ Yes ☐ No

4. The following person(s) may pick up your prescriptions at the office if applicable:

   _____

   _____

   _____

5. What is your preferred pharmacy and phone number?

   _____

   _____

Patient: _____ Date: _____ Time: _____
SIGNATURE REQUIRED

DO NOT WRITE BELOW THIS LINE

Missouri Baptist MEDICAL CENTER
BJC HealthCare

PAIN MANAGEMENT CENTER
INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

PATIENT IDENTIFICATION

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

Referring Physician: _____ Telephone Number: _____

Primary Care Physician: _____ Telephone Number: _____

PATIENT 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? _____

_____

_____

QUALITY OF PAIN

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

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

DO NOT WRITE BELOW THIS LINE

Missouri Baptist
MEDICAL CENTER
BJC HealthCare

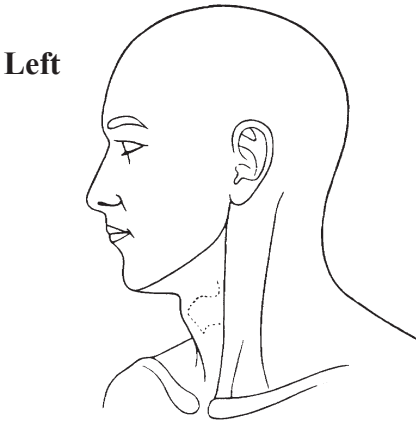
PAIN MANAGEMENT CENTER
INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

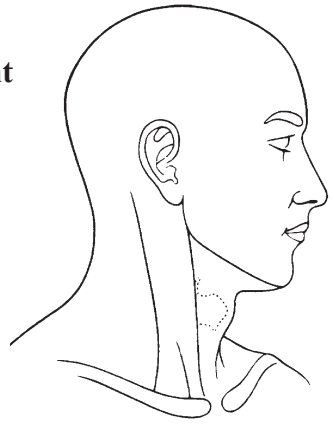
PATIENT IDENTIFICATION

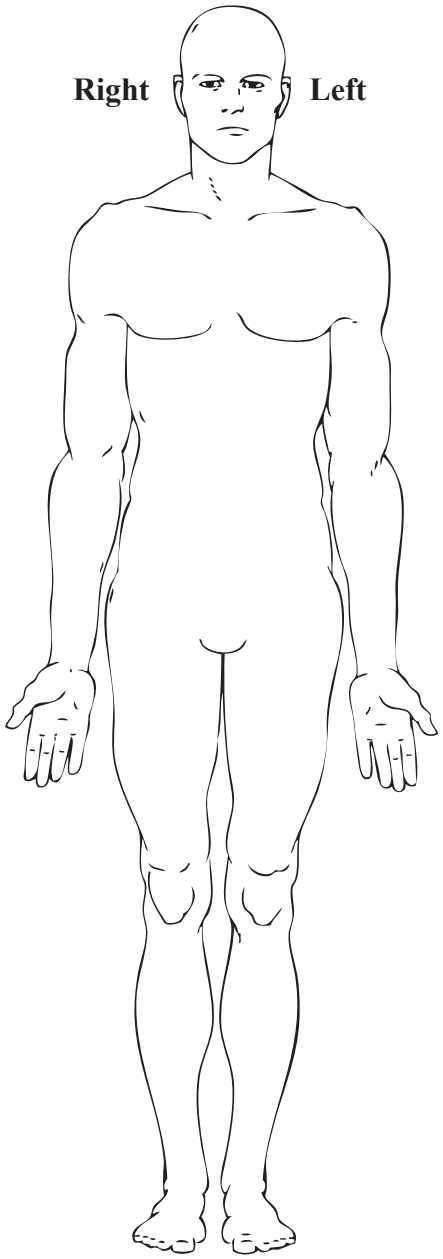
Where is your pain?

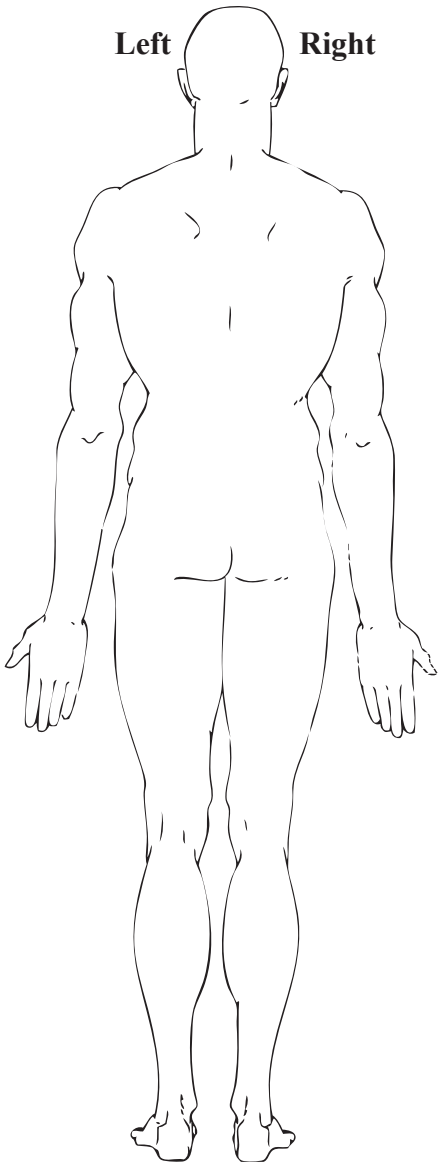
Using the symbols listed below, mark on the drawings the areas where you feel pain. If you feel more than one sensation in the same area, mark over that area with additional symbols that apply. Show all affected areas.

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

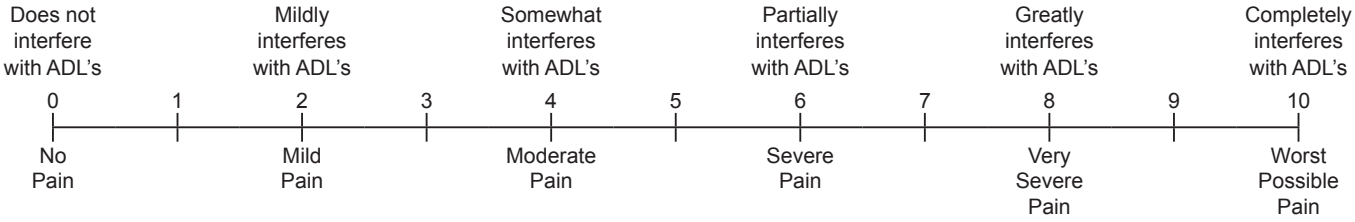
Missouri Baptist MEDICAL CENTER
BJC HealthCare

PAIN MANAGEMENT CENTER
INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

PATIENT IDENTIFICATION

PAIN INTENSITY

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



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 at its worst.

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

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

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
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

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

☐ Always present ☐ Comes and goes ☐ Occasionally ☐ Frequently

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

DO NOT WRITE BELOW THIS LINE

Missouri Baptist MEDICAL CENTER
BJC HealthCare

PAIN MANAGEMENT CENTER
INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

PATIENT IDENTIFICATION

INCREASES / DECREASES PAIN

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

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

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	☐	☐	☐	☐	☐

PSYCHOLOGICAL

Over the past 2 weeks, how often have you been bothered by any of the following problems? ***(Circle the best answer for each question.)***	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worry	0	1	2	3

Have you been treated for depression, anxiety, or any other mental health condition?
☐ Never ☐ Yes, medications ☐ Yes, psychotherapy

Are you currently being treated?
☐ No ☐ Yes, medications ☐ Yes, psychotherapy

Have you ever been hospitalized for a mental health condition?
☐ No ☐ Yes, in the past ☐ Yes, recently

When you are in pain, how often is your spouse/family supportive and encouraging?
☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always

DO NOT WRITE BELOW THIS LINE

Missouri Baptist
MEDICAL CENTER
BJC HealthCare

PAIN MANAGEMENT CENTER
INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

PATIENT IDENTIFICATION

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

DIAGNOSTIC TESTS

	Date	Facility
☐ MRI		
☐ CAT SCAN		
☐ X-RAY		
☐ EMG		
☐ Nerve Conduction Study		
Other:		

PRIOR TREATMENTS

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

	Helpful	Not Helpful	Facility where it was performed?
☐ Surgery	☐	☐	
☐ Nerve Block	☐	☐	
☐ TENS/MENS	☐	☐	
☐ Physical Therapy	☐	☐	
☐ Occupational Therapy	☐	☐	
☐ Biofeedback/Relaxation Therapy	☐	☐	
☐ Acupuncture	☐	☐	
☐ Chiropractor	☐	☐	
☐ Other Pain Center(s)	☐	☐	
☐ Professional Psychological Support	☐	☐	

Other: _____

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

Missouri Baptist
MEDICAL CENTER
BJC HealthCare

PAIN MANAGEMENT CENTER
INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

PATIENT IDENTIFICATION

MEDICAL HISTORY/ PAST SURGERIES

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

CURRENT MEDICATIONS

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

OVER THE COUNTER MEDICATIONS

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

DO NOT WRITE BELOW THIS LINE

Missouri Baptist MEDICAL CENTER
BJC HealthCare

PAIN MANAGEMENT CENTER
INITIAL OFFICE NOTE
PATIENT HEALTH QUESTIONNAIRE

PATIENT IDENTIFICATION

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
☐ Abnormal heart rhythm ☐ Heart attack
☐ Mitral valve prolapse
☐ Swelling of ankles
☐ Use of blood thinners ☐ Blood clot

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

Gastrointestinal
☐ Abnormal 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
☐ Sweat ☐ 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 ever 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 addiction/Drug abuse					
Heart disease					
High blood pressure					
Physical/Verbal abuse					
Stroke					
Suicide					
Thyroid disease					
Cause of death					

Form completed by (Patient/Other): _____ _____ _____ _____
SIGNATURE RELATIONSHIP DATE TIME

DO NOT WRITE BELOW THIS LINE

Missouri Baptist MEDICAL CENTER
BJC HealthCare

PAIN MANAGEMENT CENTER
PATIENT HEALTH RISK HISTORY

PATIENT IDENTIFICATION

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

Please complete the following questions and bring completed form with you for your new patient appointment.

Do you have an Advance Directive (Living Will)?		☐ Yes	☐ No
If you answered no, would you like information about a living will?		☐ Yes	☐ No
Have you lost or gained 10 pounds or more in the last month? If yes, how much	☐ Yes	☐ No	Lost_____lbs Gain_____lbs
Are you satisfied with your current weight?	☐ Yes	☐ No	
How is your appetite?	☐ Good	☐ Fair	☐ Poor
How do you rate your diet?	☐ Good	☐ Fair	☐ Poor
Are you able to purchase and prepare balanced meals?	☐ Yes	☐ No	
Would you like to see a dietitian?	☐ Yes	☐ No	

Have you experienced any of the following problems recently?

Difficulty walking?	☐ Yes	☐ No
Difficulty getting dressed?	☐ Yes	☐ No
Falling?	☐ Yes	☐ No
Difficulty bathing/grooming?	☐ Yes	☐ No
Memory problems?	☐ Yes	☐ No
Eating or feeding problems?	☐ Yes	☐ No
Difficulty speaking?	☐ Yes	☐ No
Difficulty with activities of daily living: cooking, shopping, driving?	☐ Yes	☐ No

Do you have concerns regarding any of the following?

Getting Medications?	☐ Yes	☐ No
Housing?	☐ Yes	☐ No
Transportation?	☐ Yes	☐ No
Would you like to speak with a social worker?	☐ Yes	☐ No
Do you use tobacco?	☐ Yes	☐ No
Specify type:	Amount/day	# of years:
Are you interested in quitting?	☐ Yes	☐ No
Would you like information on how to stop smoking?	☐ Yes	☐ No

Do you use alcohol? ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently Do you use recreational drugs? ☐ Yes ☐ No

Are you having pain today?	☐ Yes ☐ No	If Yes, specify location:

How often do you experience this pain? ☐ Occasionally ☐ Frequently ☐ Constantly

How does your pain feel? ☐ Aching ☐ Burning ☐ Crushing ☐ Dull ☐ Sharp

Are you in a relationship with someone who makes you feel afraid, unsafe, or is hurting you?	☐ Yes	☐ No

Patient or Representative Signature:_____ **Date:**_____ **Time:**_____

Nurse Signature:_____ **Date:**_____ **Time:**_____

DO NOT WRITE BELOW THIS LINE