California Pain Consultants

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www.mycpcdoc.com

COMPREHENSIVE PAIN QUESTIONNAIRE

Last Name:__________________First:_________________MI:__________

Date of Birth:________________________________ Age:______________

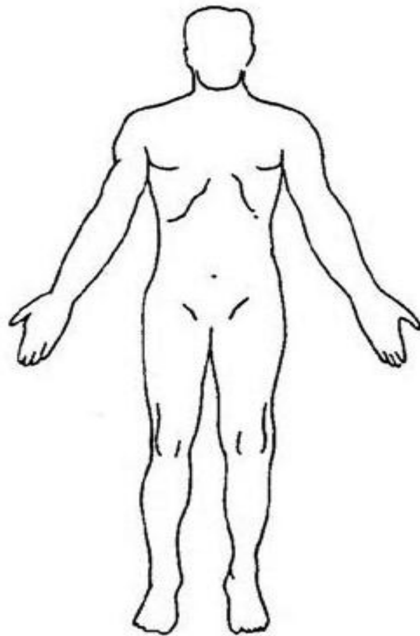
Height: __________________ Weight:________________________

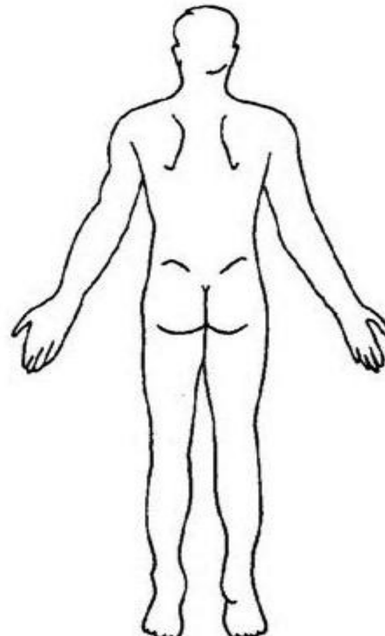
CHIEF COMPLAINT:____

____

PAIN LOCATION

Please describe the location of the pain (please mark on the diagram below):





PAIN QUALITY

How would you describe your pain?

☐ Burning	☐ Sharp	☐ Throbbing	☐ Cutting
☐ Aching	☐ Soreness	☐ Dull	☐ Pins and Needles
☐ Pressure	☐ Cramping	☐ Shooting	☐ Pressure

☐ Other____

RATE YOUR PAIN

(0-10 scale where 0 is no pain and 10 is worst imaginable pain)

My pain today is______/10
When under control, my pain is______/10
My worst pain is______/10
I could live with pain level of________/10

DURATION

How long have you had your current pain?

_____Years
_____Months
_____Weeks
_____Days

ONSET OF PAIN

How did your current pain start?

- ☐ Injury at work
- ☐ Injury not at work
- ☐ Motor vehicle accident
- ☐ Illness
- ☐ Due to other medical treatment
- ☐ Other: ____
____

TIMING OF PAIN

How often do you have the pain (please check one)

- ☐ Constantly (100% of the time)
- ☐ Nearly constantly (60-95% of the time)
- ☐ Intermittently (30-60% of the time)
- ☐ Occasionally (less than 30% of the time)

ACTIVITIES AND YOUR PAIN

Does your pain cause any of the following:

☐ Loss of bowel control ☐ Loss of bladder control ☐ Loss of sleep

How many blocks can you walk before stopping due to pain?

__________Blocks

How long can you sit before having to get up due to pain?

_____Hours________Minutes

How long can you stand before having to sit down due to pain?

_____Hours________Minutes

How often during the day do you have to lie down due to pain?

☐Never ☐Seldom ☐Sometimes ☐Often ☐ Constantly

During the past month, check the activities that you have avoided due to pain.

- ☐ Going to work
- ☐ Having sexual relations
- ☐ Doing yard work or shopping
- ☐ Recreation
- ☐ Performing household chores
- ☐ Socializing with friends
- ☐ Exercising

RELIEVING AND AGGRAVATTING FACTORS

How do the following affect your pain? (Please check one for each item)

	Decrease	Increase	No change
Lying Down	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Exercising	☐	☐	☐
Medications	☐	☐	☐
Relaxing	☐	☐	☐
Thinking about something else	☐	☐	☐
Coughing/sneezing	☐	☐	☐
Bowel movements	☐	☐	☐
Urination	☐	☐	☐

PAIN TREATMENTS (*Please check off all treatments that you have tried before and then complete the appropriate column to the right to the best of your ability.)*

Treatment	Date (approximate)	No Relief	Moderate Relief	Excellent Relief
Hospital bed rest		☐	☐	☐
Surgery		☐	☐	☐
Chiropractic		☐	☐	☐
Acupuncture		☐	☐	☐
Psychotherapy		☐	☐	☐
Biofeedback		☐	☐	☐
Nerve blocks/injections		☐	☐	☐
Traction		☐	☐	☐
Physical Therapy		☐	☐	☐
TENS unit		☐	☐	☐
Exercise		☐	☐	☐
Other _______________		☐	☐	☐

DIAGNOSTIC STUDIES (*What diagnostic studies have you had?)*

☐ MRI
- Back Date: _____________
- Neck Date: _____________

☐ CT Date: _____________
☐ EMG/NCS Date: _____________
☐ X-rays Date: _____________
☐ Others Date: _____________

PRIOR CONSULTATIONS

Which physicians have you seen for your current condition – please give their names?

☐ Primary Care Physician__________ ☐ Neurosurgeon ________________
☐ Neurologist_____________________________ ☐ Physiatrist____________________
☐ Orthopedic surgeon______________________ ☐ Other________________________

REVIEW OF SYSTEMS

General
- ☐ Fever
- ☐ Loss of appetite
- ☐ Weight change
- ☐ Sweats
- ☐ Fatigue
- ☐ Insomnia

Eyes
- ☐ Vision loss
- ☐ Blurred vision
- ☐ Double vision
- ☐ Eye disease
- ☐ Glasses / contacts

ENMT
- ☐ Ringing in the ears
- ☐ Nose bleeds
- ☐ Hearing loss
- ☐ Sinus problems
- ☐ Mouth sores
- ☐ Swollen glands in head and neck

Cardiovascular
- ☐ Chest pain
- ☐ Swelling of feet or ankles
- ☐ Heart trouble
- ☐ Palpitations
- ☐ Heart murmur
- ☐ Varicose veins

Respiratory
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal
- ☐ Nausea
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Blood in the stools

Hematological
- ☐ Bleeding tendency
- ☐ Anemia
- ☐ Recurrent infections

Musculoskeletal
- ☐ Muscle cramps
- ☐ Muscle aches
- ☐ Joint pain
- ☐ Joint swelling/stiffness
- ☐ Weakness of muscles
- ☐ Difficulty walking

Skin
- ☐ Rash
- ☐ Change in hair/nails
- ☐ Change in skin color

Neurologic
- ☐ Frequent Headaches
- ☐ Tingling
- ☐ Seizures/convulsions
- ☐ Memory loss
- ☐ Paralysis / weakness
- ☐ Poor balance
- ☐ Fainting
- ☐ Tremors
- ☐ Dizzy or light headed
- ☐ Head injury

Psychiatric
- ☐ Nervousness
- ☐ Depression
- ☐ Hallucinations

Endocrine
- ☐ Heat or cold intolerance
- ☐ Excessive thirst
- ☐ Hormone or glandular problems

Genitourinary
- ☐ Frequent urination
- ☐ Sexual difficulty
- ☐ Blood in urine
- ☐ Urinary urgency
- ☐ Pain on urination
- ☐ Incontinence
- ☐ Kidney stones

PAST MEDICAL HISTORY

Please check all current and past medical problems that apply to you:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Asthma or wheezing
- ☐ Seizure or epilepsy
- ☐ Kidney Disease
- ☐ Heart Attack
- ☐ Chest pain
- ☐ Stroke/TIA
- ☐ Chronic cough
- ☐ Arthritis
- ☐ Bleeding problems
- ☐ Peripheral Vascular Disease
- ☐ Cancer, please specify which kind ______________________________
- ☐ Others: ______________________________

PAST SURGICAL HISTORY

Type of Surgery **Date** (approximate)

______________________________ ______________

______________________________ ______________

______________________________ ______________

______________________________ ______________

______________________________ ______________

ALLERGIES

☐ I am allergic to Contrast dye

Please name all medications that you might be allergic to in the space below:

____

FAMILY HISTORY (please list all medical problems that affect family members)

Father ____

Mother ____

Sibling ____

Other ____

SOCIAL HISTORY

Please respond appropriately to what applies and write N/A if not applicable to you.

Alcohol use: ____________# of drinks per day ______________# of days per week

Tobacco use: ____________packs/week ______________# of years smoked

Recreational Drug use: ____________________________________Drug/s of choice

Marital status: ☐Single ☐Married ☐ Widow ☐ Separated ☐ Divorced

Living arrangements: ☐ Living alone ☐ Living with spouse/partner
☐ Living with other ☐ Living with friends ☐ Living with children

EDUCATION

Your highest educational level achieved:

- ☐ Graduate or professional training (degree obtained)
- ☐ College graduate (degree obtained)
- ☐ Partial college training
- ☐ High school diploma
- ☐ GED or trade-technical social graduate
- ☐ Partial high school (10th grade through partial 12th)
- ☐ Partial junior high school (7th grade through 9th grade)
- ☐ Elementary school (6th grade or less)

EMPLOYMENT

Your current or former occupation:

- ☐ Skilled trade or clerical (e.g. carpenter, electrician, truck driver, secretary)
- ☐ Semi-skilled or unskilled (e.g. assembler, dishwasher, porter)
- ☐ Business executive or managerial
- ☐ Professional (e.g. lawyer, teacher, nurse, physician, psychologist)
- ☐ Homemaker
- ☐ Other

Current employment status (please check all that apply):

- ☐ Employed full-time
- ☐ Employed part-time
- ☐ Unemployed
- ☐ Homemaker
- ☐ Retired
- ☐ Student
- ☐ Unemployed because of pain Part-
- ☐ time because of pain

If you are currently unemployed, indicate how long you have been off work: (If employed, do not answer)

- ☐ 1-3 weeks
- ☐ 8-11 weeks
- ☐ 1-3 months
- ☐ 4-7 months
- ☐ 12-18 nths
- ☐ 19-24 months
- ☐ 25 or more months

SUBSTANCE ABUSE

Do you have a history of alcoholism?	Yes	No
Heroin abuse?	Yes	No
Cocaine abuse?	Yes	No
Methamphetamine abuse?	Yes	No
IV drug abuse?	Yes	No
Prescription drug abuse?	Yes	No
Have you ever been in a detoxification program for drug abuse?	Yes	No
Have you ever been in a detox program for alcohol abuse?	Yes	No
Alcoholics Anonymous?	Yes	No
Narcotics Anonymous?	Yes	No

LEGAL ISSUES

Please indicate any of the following claims you have filed related to your pain problem

☐ Workers' compensation
☐ Personal injury/liability (unrelated to work)
☐ Social Security Disability Insurance (SSDI)
☐ Other insurance
☐ None

ATTORNEY'S NAME AND CONTACT INFORMATION

____

____

____

PSYCHOLOGICAL TREATMENT

Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? Yes No
If yes, when?

____

Have you ever considered suicide? Yes No
If yes, when?

____

MEDICATIONS

Indicate the prescription medications you are taking by checking the box. To the best of your ability, please write the dosage and how many times a day you take the pills next to each medication.

- ☐ Actiq
- ☐ Adapin (Doxepin)
- ☐ Amrix (Cyclobenzaprine)
- ☐ Anaprox (Naproxen)
- ☐ Anexsia (Hydrocodone)
- ☐ Ativan
- ☐ Avinza
- ☐ Axert
- ☐ Baclofen (Lioresal)
- ☐ Buprenorphine
- ☐ BuSpar
- ☐ Celebrex
- ☐ Codeine
- ☐ Cymbalta (Duloxetine)
- ☐ Darvocet
- ☐ Darvon
- ☐ Desyrel (Trazadone)
- ☐ Dilaudid (Hydromorphone)
- ☐ Elavil (Amytriptyline)
- ☐ Empirin with codeine
- ☐ Endocet
- ☐ Feldene
- ☐ Fentanyl
- ☐ Fiorinal
- ☐ Fiorinal with codeine
- ☐ Flexeril
- ☐ Frova
- ☐ Halcion
- ☐ Ibuprofen (Motrin/Advil)
- ☐ Imitrex (Sumatriptan)
- ☐ Indocin
- ☐ Kadian (morphine)
- ☐ Klonopin (Clonazepam)
- ☐ Lexapro
- ☐ Lidoderm 5%
- ☐ Limbrel
- ☐ Lioresal
- ☐ Lortab
- ☐ Lyrica (pregabalin)
- ☐ Methadone
- ☐ Mobic (Meloxicam)
- ☐ Morphine
- ☐ MS Contin
- ☐ Naprelan (Naprosyn)
- ☐ Naprosyn
- ☐ Norco (Hydrocodone)
- ☐ Norflex (Ophenadrine)
- ☐ Norpramin (Desipramine)
- ☐ Opana (IR/ER)
- ☐ Oxycodone
- ☐ Oxycontin
- ☐ Pamelor (Nortriptyline)
- ☐ Percocet (Oxycodone)
- ☐ Percodan (Oxycodone)
- ☐ Provigil
- ☐ Prozac
- ☐ Restoril (Temazepam)
- ☐ Ritalin
- ☐ Robaxin
- ☐ Roxicodone
- ☐ Sinequan (Doxepin)
- ☐ Skelaxin
- ☐ Soma
- ☐ Tegretol
- ☐ Tofranil (Imipramine)
- ☐ Topamax
- ☐ Toradol
- ☐ Tylenol with codeine
- ☐ Tylox (Oxycodone)
- ☐ Valium
- ☐ Vicodin (Hydrocodone)
- ☐ Vicoprofen (Hydrocodone)
- ☐ Ultracet (tramadol)
- ☐ Ultram (tramadol)
- ☐ Xanax (Alprazolam)
- ☐ Zanaflex (Tiznidine)
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

Please list current PAIN MEDICATIONS:

____

____

____

____

____

____

____

Do you take any opioid medications? (circle) Yes No

As a result of taking the opioids I can do the following: _______________________

____

____

____

____

PHQ-9 Questionnaire

Patient Name ______________________________ **Date** ___________________

1. **Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.**

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

2. **If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not Difficult At All	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

California Pain Consultants - PATIENT REGISTRATION FORM

Patient Information

First name: ______________________Last name: _______________________Middle Initial: ________
Address:____City, State, Zip__________________
Home phone :(___) ____-________Work phone: (____) ____-_________Cell: (___) ____-______
Birth Date: ________________ Age: _______ Soc. Sec: ____________________ Sex: □ Male □ Female
Employment Status: □ Full Time □ Part Time □ Retired
Name of Employer:____________________________________ Phone: _________________________
Address:____ City, State, Zip: ______________________
Preferred Pharmacy:____
Primary Physicians Name:___________________________________Phone: (____) ____-_________
Address:____City, State, Zip__________________
Referred by: Doctor____________Attorney ________ Insurance Co.__________ Worker's comp______
Name of Referral; ____ Phone:(___) ____-________
Address:____City, State, Zip__________________
EMERGENCY CONTACT _______________________________________ Phone:(___) ____-________

Financial Responsibility (complete if other than patient)

First name: _______________________Last name: _______________________Middle Initial: ________
Address:____
City, State, Zip: ____
Home phone :(___) ____-_________Work phone: (____) ____-__________Cell: (___) ____-______
Birth Date:____________________ Soc. Sec: ____________________

Insurance Information (please provide insurance card)

Name of Policy Holder:_________________________________ Policy Holder Birth Date:______________
Relationship to patient: □ Self □ Spouse □ Child □ Other **Policy Hldr SSN/ID**:_____________________
Address (if different than patient's):____
Name of Policy Holder's Employer:_____________________________ City, State:___________________
Name of Insurance Company:_____________________________________
Address:____ City, State, Zip______________________

Secondary Insurance Information (please provide insurance card)

Name of Policy Holder:_________________________________ Policy Holder Birth Date:______________
Relationship to patient: □ Self □ Spouse □ Child □ Other **Policy Hldr SSN/ID**:_____________________
Address (if different than patient's):____
Name of Policy Holder's Employer:_____________________________ City, State:___________________
Name of Insurance Company:_____________________________________
Address:____ City, State, Zip______________________

________________________________ ______________________________ _________
Patient Signature Insured or Guardian Signature Date

California Pain Consultants - Financial & Office Policies

Patient Name: ______________________________ DOB: _____________________
Address: ________________________ Home Phone # __________________________
_________________________ Cell Phone # _________________________
e-mail: _________________________

Payment Policy:

Payment is expected at time of service. Your co-pay, coinsurance, and/or deductible is due at time of visit. You will be responsible for payment of any remaining balances from both entities after insurance is billed.

____
(Initials)

Insurance Policy:

We will require a digital scan of your insurance card. We will bill your insurance company. Any deductible, coinsurance or non-covered services will be your responsibility.

For those plans that are non-contracted with our office, as a courtesy, we will submit claims to your carrier; any deductible, coinsurance or non-covered services will be your responsibility.

Monthly statements will be sent to collect those balances. Please inform our staff immediately of any insurance or address changes.

____
(Initials)

Non-Covered Service Policy:

Certain services performed by our office are NOT COVERED by all insurance plans. We suggest you contact your insurance carrier to verify your benefits and understand any non-covered services will be your financial responsibility and payment will be required prior to your appointment. Medicare requires a signature on an Advanced Beneficiary Notice [ABN] for non-covered services. ________
(Initials)

Medical Records:

Should you request a copy of your medical records for a nominal fee. Please allow our office 7-10 business days for completion. ________
(Initials)

Delinquent Accounts Policy:

Delinquent accounts may be reported to our collection agency following normal collection procedures. If an account is reported to our collection agency a collection fee of 25% will be added to any outstanding balance. If a balance is over 61 days late, a 1.5% monthly interest fee will be added to the outstanding balance. The patient or guardian is responsible for payment of such collection fees and costs, including but not limited to reasonable attorney's fees, court costs, and service fees. Please inform our billing staff if you know your payment will be late in arriving or if payment arrangements are needed.

____
(Initials)

Late Arrivals:

In order for our physicians to see their patients in a timely manner your help in arriving promptly for your appointment is required. If you are more than 10 minutes late, our office will reschedule your appointment to a new date and time. Tardiness affects your patient care as well as those patients that have a scheduled time after you.

We understand your time is valuable and will do our best to respect it and see you in a timely manner. Please be aware that sometimes certain situations and emergencies can occur and cause your provider to run late. Please be patient in these circumstances.

____
(Initials)

Forms Policy:

Should you request our office to complete forms on your behalf for disability, work status, jury duty, FMLA, DMV, etc., there will be a **charge of $100.00 per form.** Payment of this charge is expected at time of completion.

____
(Initials)

Appointment Cancellations/No Shows/Reschedules:

There is a **$100.00 charge per visit** for patients who cancel, reschedule or no show for an appointment without giving 24 hours notice. We understand unusual circumstances may arise. Please contact our office as soon as possible.

____
(Initials)

Prescriptions:

Appointments are required for most medication refills. Please contact our office a minimum of 10 days prior to your scheduled refill date. Phone call refills are not allowed.

____
(Initials)

Returned Checks:

Our office charges a **$50.00 fee** for all account closed, stop payment or non-sufficient funds returned checks.

____
(Initials)

Referrals & Authorizations:

If a referral is required by your insurance carrier you will be asked to obtain the referral prior to your appointment. If no referral exists on file or your referral has not been received, your appointment may be cancelled. Our office will obtain authorization for your procedure prior to scheduling your appointment. We suggest you contact your insurance carrier to verify your coverage, benefits and preauthorization requirements prior to having any procedures performed. Claims are paid based on medical necessity. Please be aware authorizations and referrals are not a guarantee of payment.

____
(Initials)

Workman's Compensation:

Our office will require you to inform us of any changes regarding your workers compensation claim. The following information is required: Adjustors Name, claim status, (litigation, supportive care, claim closed, new injury), DOI, carrier, claim number and claims address. Please have this information available prior to your appointment time.

____
(Initials)

____
(Patient/Guarantor **Printed Name**)

___________________________________ Date____________
(Patient/Guarantor **Signature**)

California Pain Consultants
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ASSIGNMENT OF BENEFITS and CONSENT TO TREAT

It is the policy of California Pain Consultants (CPC) that all patients are presented with an assignment of benefits statement to complete and sign when a patient checks in for appointments.

PAYMENTS

I hereby direct my health insurance plans/network/organization/plan, Medicare, or third party administrator of any such health care plan (hereinafter separately or collectively referred to as "Plans") to direct payments directly to California Pain Consultants on my behalf, whenever possible. If you receive payment from insurance for our services, we must be paid immediately. Failure to do so might result in immediate referral to a collection agency.

ASSIGNEMNT OF BENEFITS

In consideration of services provided, I hereby assign, CPC, the benefits due me My Health Care costs and expenses otherwise payable to me, for the Plan(s), policy or policies that I have in effect for Plan(s) coverage, insurance coverage and policy(s) named, whichever applicable.

CONSENT TO TREAT

I hereby authorize California Pain Consultants and all persons acting as agents thereof, as well as all medical personnel to whom I am referred, to furnish all forms of reasonable diagnostic, preventive, therapeutic and medical treatment to me.

Patient Name: ____

Patient/Legal Guardian Signature:______________________ Dated: ___________

CONSENT TO DISCUSS OR RELEASE MEDICAL INFORMATION

I, ______________________________, give Dr. Goswami and his office permission to discuss and/or disclose my medical history and information with the following people (e.g. family members):

1) ____

2) ____

3) ____

Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

☐ **Phone ____** Preferred

I want you to contact me by telephone at ______________________________

☐ Do ☐ Do not leave messages on my answering machine.
☐ Do ☐ Do not leave messages with any other person.

☐ **Mail ____** Preferred

Address: _____________________________________

____

☐ **E-mail ____** Preferred

E-mail address: ____________________________________

☐ **Fax ____** Preferred

Fax number: ______________________________________

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

I understand that I have the right to receive a copy of this authorization.

Signed: ____ Dated: ______________________

Print Name: ________________________________

If not signed by the patient, please indicate relationship: ___________________________

This is an agreement between ____(the patient) and Dr. Amitabh U. Goswami (California Pain Consultants) concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of a chronic pain problem. The medication will probably not completely eliminate my pain, but is expected to reduce it enough that I may become more functional and improve my quality of life.

1. I understand that opioid analgesics are strong medications for pain relief and have been informed of the risks and side effects involved with taking them.

2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition.

   I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids and withdrawal can be life-threatening for a baby.

3. Overdose on this medication may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know I have taken narcotic pain-killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information.

4. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.

5. I understand it is my responsibility to inform the doctor of any and all side effects I have from this medication.

6. I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication and may be reasons for the doctor to discontinue prescribing to me.

7. I agree that the opioids will be prescribed by only <u>one</u> doctor and I agree to fill my prescriptions at only <u>one</u> pharmacy. I agree not to take any pain medication or mind-altering medication prescribed by any other physician without first discussing it with the above-named doctor. I give permission for the doctor to verify that I am not seeing other doctors for opioid medication or going to other pharmacies.

8. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.

9. I agree not to sell, lend, or in any way give my medication to any other person. I also agree to random urine drug screens under discression of the doctor to ensure medication compliance.

10. I agree not to drink alcohol or take other mood-altering drugs while I am taking opioid analgesic medication. I agree to submit a urine specimen at any time that my doctor requests and give my permission for it to be tested for alcohol and drugs.

11. I agree that I will attend all required follow-up visits with the doctor to monitor this medication and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my doctor.

12. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

I understand that the common side effects of opioid therapy include nausea, constipation, sweating, itching, dry mouth and rash. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.

I understand that the use of any mood-modifying substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens) can cause adverse effects or interfere with opioid therapy. Therefore, I agree to refrain from the use of all these substances without first discussing it with my physicians.

I also understand that I may be discharged from care if I use any of these substances. If I use medicinal marijuana then I will not drive under the influence of cannabis. I agree not to provide my prescribed medication to any other person at the result in being discharged as a patient. I also understand that lost or stolen medications will not be refilled until the proper due date. If I break this agreement, my physician reserves the right to stop prescribing opioid medications for me and may discharge me from care. I hereby agree that my physician has the authority to disclose the prescribing information in my patient file to other health care professionals when it is deemed medically necessary in the physician's judgment.

I have read the above, asked questions, and understand the agreement.

Pharmacy

Name: ____

Location: ____

Number: ___________________________

____
Patient signature

____
Amitabh Goswami, DO, MPH
California Pain Consultants

____
Date Signed