INTEGRITY PAIN CONSULTANTS | CENTER FOR REGENERATIVE MEDICINE

Life with less pain.

Medical Records Request Authorization

PATIENT INFORMATION (Please Print)

First Name: ________________________ **Last Name**: ______________________

DOB: _____/_____/_______ **SSN:** _______-______-_______

I authorize __________________________________ and its employees to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection. I hereby authorize the release of medical records to:

INTEGRITY PAIN CONSULTANTS AND CENTER FOR REGENERATIVE MEDICINE

Purpose of Disclosure: Medical/Pain Treatment

The authorization will expire on: _________________ (One Year from Today)

This request and authorization applies to:

______ All medical records

______ Health care information relating to the following treatment, condition, or dates of treatment:

____

____

_______ Specific records to be released (Ex. Labs, imaging, reports, other)

If you **DO NOT WANT** certain portions of your medical records released, please initial the box for the information you do not want released.

____ Substance abuse _____ Psychological or psychiatric treatment ____ STD/HIV/AIDS

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, expect to the extent it has acted in reliance thereon before notice of revocation. I understand that nay disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing this authorization.

I have read the above and authorize the disclosure of the protected health information as stated.

Patient Signature: _____________________________**Date:** ____/____/_____

103 Hazel Path Ct. Ste 7
Hendersonville, TN 37075
(p) 615.431.5484
(f) 615.447.5959

406 N Whitney Ave. Ste
2 Cookeville, TN 38501
(p) 931.372.1799
(f) 931.372.1866

5114 Old Hickory Blv Ste
201 Hermitage, TN 37076
(p) 615.850.6960
(f) 615.777.3393

St. Thomas West
4230 Harding Pike Ste 807
Nashville, TN 37205
(p) 615.846.9970
(f) 615.777.3393

Skyline
3443 Dickerson Pike. Ste
590 Nashville, TN 37207
(p) 615.860.3500
(f) 615.860.2420

Stonecrest
300 Stonecrest Blvd. Ste
220 Smyrna, TN 37167
(p) 615.625.5400
(f) 615.777.3393

Name: ________________________________
Date of Birth: __________________
Date of Appointment: ____________

INTEGRITY PAIN CONSULTANTS | CENTER FOR REGENERATIVE MEDICINE

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How would you describe your pain?

- ☐ Dull
- ☐ Sharp
- ☐ Stabbing
- ☐ Shooting
- ☐ Aching
- ☐ Throbbing
- ☐ Burning
- ☐ Gnawing

What is your pain score on an average?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain

What is your pain score while on pain medications?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain

Do you have any following associated symptoms?

- ☐ Numbness
- ☐ Tingles
- ☐ Pins and needles
- ☐ Weakness
- ☐ Hypersensitivity
- ☐ Allodynia (Centeal pain sensitivity)
- ☐ Paresthesia
- ☐ Photophobia (Sensitivy to light)
- ☐ Phonophobia (Sensitivity to sound)
- ☐ Aura (Intevnsive headaches)
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Temperature changes
- ☐ Paralysis
- ☐ Phantom pain
- ☐ Other symptoms

What makes you pain worse?

- ☐ Standing
- ☐ Walking
- ☐ Walking downhill
- ☐ Walking uphill
- ☐ Sitting
- ☐ Stooping
- ☐ Squatting
- ☐ Lifting
- ☐ Exercise
- ☐ Doing yard work
- ☐ Doing house chores
- ☐ Stress
- ☐ Weather changes
- ☐ Menstruation
- ☐ Medications
- ☐ Any physical activity
- ☐ others

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Date of Appointment: ___________

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Life with less pain.

What alleviates your pain?

- ☐ Sitting
- ☐ Resting
- ☐ Lying down
- ☐ Sleeping
- ☐ Others
- ☐ Exercise
- ☐ TENS unit
- ☐ Hot showers or bath
- ☐ Using heating pads
- ☐ Using cold/ice packs
- ☐ Pain medications
- ☐ Injections
- ☐ Nothing yet

How do you describe quality of your sleep?

- ☐ Sound
- ☐ Difficulty of falling asleep
- ☐ Frequent awakening
- ☐ Can't go back sleep after wake

Please check following all that you have tried to control or help your pain

- ☐ Nerve blocks
- ☐ Trigger point injections
- ☐ Epidural steroid injections
- ☐ Physical and occupational therapy
- ☐ Chiropractor
- ☐ Massage therapy
- ☐ Biofeedback and hypnosis
- ☐ Psychotherapy
- ☐ Psychiatric treatment
- ☐ Spinal cord stimulator
- ☐ Intrathecal (morphine) pump
- ☐ Acupuncture therapy
- ☐ Other remedies

____

Do you suffer from headaches? ___ Y ___ N If so, on average, how many headache(s) would you say you have each month? _____
If you suffer from more than 15 headaches per month, please fill out our headache questionnaire included to see if Botox for headaches may be an option for you.

Name: ________________________________
Date of Birth: ___________________
Date of Appointment: ____________

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What is your current occupation and how long have you held it?

Occupation: __________________________
Length of time in this occupation: ______________

What test(s) have you had to investigate your pain and where was this performed?

- ☐ Plain x-ray _________________________
- ☐ EMG _____________________________
- ☐ Nerve conduction studies _____________
- ☐ MRI, and where _____________________
- ☐ CT, and where ___________________
- ☐ Nyelogram ______________________
- ☐ Discogram ______________________
- ☐ Others (please specify) _____________

Do you have any of the following medical conditions (please check all that apply)?

- ☐ Heart disease (CAD)
- ☐ Hypertension (high blood pressure)
- ☐ Diabetes (type I or type II)
- ☐ Thyroid disorders (hyper-, hypo-, or cancers)
- ☐ Lungs diseases (COPD, asthma, bronchitis, and emphysema)
- ☐ Sleep apnea (sleep study, CPAP machine and home oxygen use)
- ☐ Gastrointestinal diseases (ulcers, gastritis, colitis, Crohn's disease, hiatal hernia, acid reflux)
- ☐ Liver diseases (hepatitis, cirrhosis, jaundice, ascites)
- ☐ Kidney diseases (kidney stones, infections, UTI, kidney failure, on dialysis)
- ☐ Pelvic diseases (interstitial cycstitis, endometriosis, chronic pelvic pain)
- ☐ Osteoarthritis and degenerative disk diseases
- ☐ Autoimmune diseases (rheumatoid arthritis, MS, lupus, polymyositis)
- ☐ Neurological disorders (stroke, TIA, seizures, epilepsy, neuropathy)
- ☐ Psychiatric disorders (anxiety, major depression, bipolar disease, schizophrenia)
- ☐ Blood disorders (hemophilia, sickle cells disease, lower platelets, on blood thinners)
- ☐ Others (please specify)____

Please list previous surgery you had and when?

Type of Surgery: ____________________________ Date/Year: ____________ Surgeon: ______________
Type of Surgery: ____________________________ Date/Year: ____________ Surgeon: ______________
Type of Surgery: ____________________________ Date/Year: ____________ Surgeon: ______________
Type of Surgery: ____________________________ Date/Year: ____________ Surgeon: ______________

Are you allergic to following medications (please check all that apply)?

- ☐ Antibiotics, which one
- ☐ Steroids
- ☐ Local anesthetics
- ☐ NSAIDs
- ☐ Betadine
- ☐ IVP dye
- ☐ None, NKDA
- ☐ Others (please specify) ____________________
____
____

Name: ___________________________________
Date of Birth: ____________________
Date of Appointment: _____________

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Are you depressed because of pain?

- ☐ No
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Suicidal ideation or attempts
- ☐ Previous ER or hospital admissions

Do you smoke?

- ☐ No
- ☐ Yes
- ☐ How many a day ___________
- ☐ How long _________________
- ☐ Have you quit before and how many times? _________

Do you drink alcohol?

- ☐ No
- ☐ Yes
- ☐ How much a day ____________
- ☐ How long _________________
- ☐ Have you quit before and how many times?_________

Do you use recreational drugs?

- ☐ No
- ☐ Yes
- ☐ What kind(s) ______________ _________________________

What is your marital status?

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Other _____________

Please tell us your family medical history

- ☐ Heart disease:
- ☐ Hypertension
- ☐ Diabetes
- ☐ Stroke
- ☐ OA/RA
- ☐ Cancers

Thank you for your time!

________________________	________________________	________________________
Patient Name	Patient Signature	Date

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MEDICATION LIST

PATIENT NAME: ____________________ DOB: ________ DATE: _____________

PREFERRED PHARMACY: ______________________ PHONE:_______________

PHARMACY ADDRESS: ____

Please include prescription, over the counter meds, supplements, vitamins, etc.

Medication Name	Dosage	Directions

INTEGRITY PAIN CONSULTANTS
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Kenneth Homolya, MD / Brandon Tolman, DO
Rachel Forsythe, ACNP / Angela Allen, ACNP
Ashley Nutt, NP / Dana Hunley, NP
Danielle Molina, PA / Courtney Hatfield, NP
Benjamin Sell, PA-C / Stacey Pappas- NP

Name: ______________________________ DOB:___/___/____ Date:____________

Please answer the questions using the following scale:

0 =NEVER   1 =SELDOM   2 =SOMETIMES   3 =OFTEN   4 =VERY OFTEN

1. How often do you have mood swings? **0 1 2 3 4**

2. How often do you smoke a cigarette within an hour after you wake up? **0 1 2 3 4**

3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? **0 1 2 3 4**

4. How often have any of your close friends had a problem with alcohol or drugs? **0 1 2 3 4**

5. How often have others suggested that you have a drug or alcohol problem? **0 1 2 3 4**

6. How often have you attended an AA or NA meeting? **0 1 2 3 4**

7. How often have you taken medication other than the way it was prescribed? **0 1 2 3 4**

8. How often have you been treated for an alcohol or drug problem? **0 1 2 3 4**

9. How often have your medications been lost or stolen? **0 1 2 3 4**

10. How often have others expressed concern over your use of medication? **0 1 2 3 4**

11. How often have you had a craving for medication? **0 1 2 3 4**

12. How often have you been asked to give a urine drug screen for substance abuse? **0 1 2 3 4**

13. How often have you used illegal drugs (Marijuana, cocaine, etc.) in the past five years? **0 1 2 3 4**

14. How often, in your lifetime, have you had legal problems or been arrested? **0 1 2 3 4**

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3443 Dickerson Pike. Ste 590, Nashville, TN 37207 / 300 Stonecrest Blvd. Ste 220, Smyrna, TN 37167

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CONSENT FOR CHRONIC OPIOID THERAPY

Integrity Pain Consultants may prescribe Opioid Medicine, sometimes called narcotic analgesics to me for pain management. This decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it, including but not limited to, sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of Opioids. I will tell my physician about all other medicines and treatments that I am receiving. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: Using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for his/herself.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has family or personal history of addiction. I agree to tell my physician my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling.

I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help, and may cause unacceptable side effects. Tolerance or failure to respond well to Opioids may cause my physician to choose another form of treatment.

MALES ONLY: I am aware that chronic Opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my physician or family physician may check my blood to see if my testosterone level is normal.

FEMALES ONLY: If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric physician and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medications the baby could become physically dependent on opioids and experience withdrawal symptoms, fetal distress, and/or fetal demise. In addition, I understand that there are potential risks of stopping opioid medication on my own during pregnancy which include: risk of relapse, risk of preterm delivery, intrauterine withdrawal, fetal distress, and fetal demise. We highly recommend reliable contraception such as long term reversible contraception. I will notify my provider and an appropriate referral will be made if I am not currently using contraception.

Name (print) ______________________________ Signature: _________________________ Date: ___________

Provider Signature: _________________________ Date: ___________

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Opiate/Pain Management Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This Agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals.

_____ I will bring unused pain medicine to EVERY OFFICE VISIT in their original bottle for PILL COUNTS. I will NEVER DISPOSE of controlled substances myself. I will dispose of them in this office. If I do not bring my medications in for pill counts I understand I will be rescheduled.

_____ I will not attempt to obtain any other pain medications from any other provider (including Surgeons, ER Physicians, Dentists), family member, or friend.

_____ I will safeguard my pain medication from loss, theft, or unintentional use by others. Lost or stolen medications will not be replaced. I understand if I take more medication than is prescribed to me I will run out of my medication early and it will not be replaced or refilled early. I do also understand this may result in withdrawal from the opioids (nausea, vomiting, chills or sweating). I understand this may result in dismissal from this clinic.

_____I understand I must ensure this office that I have a valid and working telephone number If this office attempts to contact me for a midmonth Pill Count and they are unable to reach me, I understand it may result is dismal from this clinic.

_____ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

_____ I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

_____ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances.

_____ I will not share my medication with anyone and take my medication as prescribed.

_____ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

_____ I agree that I will submit to a urine test if requested by my provider to determine my compliance with my program of pain control medications.

____I will keep all my scheduled appointments. If I must reschedule I will provide **24 hour notice** to this NO SHOWS will result in a $25.00 fee. This fee must be paid prior to their next appointment.

_____If I am abusive or belligerent to the staff, I will be discharged from the practice.

_____ I understand that if I break this Agreement, my provider will stop prescribing any pain control medicines and a Discharge Letter will be provided.

_____ I agree to use this pharmacy ________________________________ for filling my pain prescriptions per Tennessee State Law. **In the event that the above stated pharmacy does not have my medication and it is time for a refill I may go to another pharmacy. However, I will call and notify this office of the new pharmacy and reason why I am not going to the above mentioned pharmacy per state guidelines. I will then return to the above mentioned pharmacy the following month per state law.**

This form will expire on: ______________________

Name (print) ______________________________ Signature: _________________________ Date: ___________

Provider Signature: _________________________ Date: ___________