

**Orthopedic Associates of Long Island, LLP**  
**Vlada Frankenger, DO**  
**Interventional Pain Medicine**

NAME \_\_\_\_\_ Today's Date \_\_\_\_\_

D.O.B \_\_\_\_\_ S.S # \_\_\_\_\_

ADDRESS \_\_\_\_\_

**INSURANCE** \_\_\_\_\_

**REFERRING DOCTOR** \_\_\_\_\_

**PRIMARY CARE DOCTOR** \_\_\_\_\_

**CARDIOLOGIST** \_\_\_\_\_

**ONCOLOGIST** \_\_\_\_\_

**NEUROLOGIST** \_\_\_\_\_

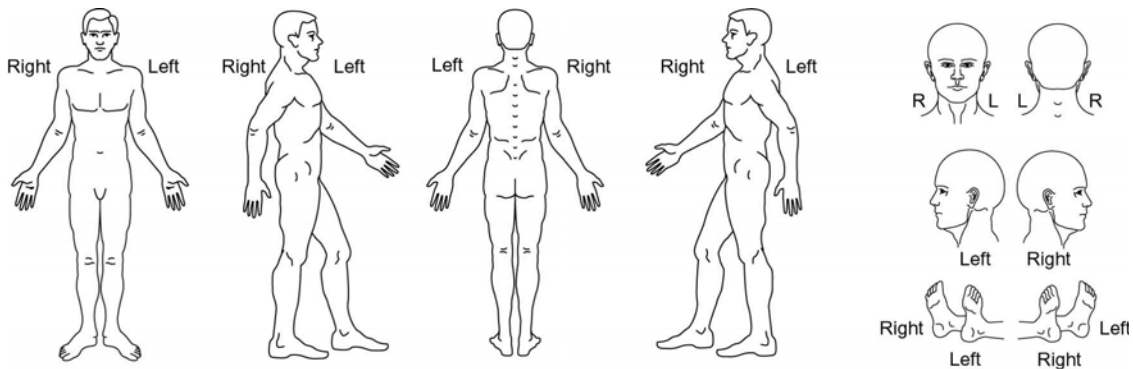
PLEASE DESCRIBE THE PROBLEM(S) FOR WHICH YOU HAVE COME TO SEE US:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_ PAIN DRAWING: MARK THE AREAS ON DRAWING THAT CORRESPOND TO WHERE YOU HAVE PAIN. USE "X" TO MARK PAINFUL AREAS. USE "O" TO MARK AREAS OF NUMBNESS AND TINGLING.



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please put a check next to other treatments that you have had for your pain?

Surgery: Name and dates of operation(s) to treat your pain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication(s) List all you have TRIED to treat your pain:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Injection(s) used to treat your pain (**For example, epidural steroid shots**)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- |                        |                                       |
|------------------------|---------------------------------------|
| _____ Physical Therapy | _____ Chiropractic or Osteopathic     |
| _____ Massage          | _____ Biofeedback/Relaxation Training |
| _____ Tens Therapy     | _____ Acupuncture                     |
| _____ Other _____      |                                       |

Who has been treating your pain?

\_\_\_\_\_

During the last year, have you had:

- |                               |                                 |
|-------------------------------|---------------------------------|
| _____ Chest Pain              | _____ Generalized Stiffness     |
| _____ Palpitations            | _____ Abdominal Pain            |
| _____ Shortness Of Breath     | _____ Abnormal Periods/Bleeding |
| _____ Difficulty Breathing    | _____ Blood In Stool Or Urine   |
| _____ Unexplained Fever       | _____ Difficulty Sleeping       |
| _____ Night Sweats            | _____ Change In Bowel Habit     |
| _____ Unexplained Weight Loss | _____ Nausea/Vomiting           |
| _____ Persistent Constipation | _____ Skin Rashes               |
| _____ Persistent Joint Pain   | _____ Breast Lumps              |
| _____ Persistent Muscle Pain  | _____ Swollen Lymph Nodes       |
|                               | _____ Other _____               |

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

Right handed \_\_\_\_\_

Left handed \_\_\_\_\_

**MEDICAL HISTORY:**

(Please check all that apply, please be specific)

\_\_\_ Irregular Heartbeat

\_\_\_ Heart Murmur

\_\_\_ Heart Attack

\_\_\_ Emphysema

\_\_\_ Bronchitis

\_\_\_ Stomach Problems\*

\*Please Specify \_\_\_\_\_

\_\_\_ Liver Disease

\_\_\_ Lupus

\_\_\_ Vascular Disease

\_\_\_ Infections\*

\*Please Specify \_\_\_\_\_

\_\_\_ HIV/AIDS

\_\_\_ Psychiatric Problems\*

\*Please specify \_\_\_\_\_

\_\_\_ Depression

\_\_\_ Anxiety

\_\_\_ Drug/Alcohol Addiction

\_\_\_ Misuse of Prescription Drugs

\_\_\_ Other \_\_\_\_\_

**SOCIAL HISTORY:**

With whom do you live? \_\_\_\_\_

Do you have children? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, please provide ages \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Are you currently employed? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you currently in school? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you, or have you been disabled? (Explain)  
For example are you out of work? Partially/Totally disabled?

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Are you receiving disability payments? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes to the above, how long have you been receiving payments? \_\_\_\_\_

Are you currently involved in a lawsuit? (Please Explain)

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Have you had any tests performed for this problem?

TEST	DATE	RESULT (If Known)
____ MRI	_____	_____
____ CAT SCAN	_____	_____
____ EMG	_____	_____
____ X-RAY	_____	_____
____ BONE SCAN	_____	_____
____ BLOOD WORK	_____	_____
____ OTHER	_____	_____

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Approximately when did your symptoms begin? \_\_\_\_\_

What do you believe is causing these symptoms? \_\_\_\_\_

Which of the following describes the circumstances related to your symptoms:

- \_\_\_\_\_ Accident at work
- \_\_\_\_\_ Accident other than work (E.G., Home, Auto)
- \_\_\_\_\_ Following illness
- \_\_\_\_\_ Following surgery
- \_\_\_\_\_ Pain just started - No obvious cause
- \_\_\_\_\_ Other (Describe) \_\_\_\_\_

What activities cause the pain to worsen?

What activities help the pain?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What activities do you usually enjoy?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pain scores (0=No pain, 10=**Worst** Imaginable Pain)

What is your average pain score over the course of the day?

0    1    2    3    4    5    6    7    8    9    10

What number represents your worst pain?

0    1    2    3    4    5    6    7    8    9    10

What number represents your least pain?

0    1    2    3    4    5    6    7    8    9    10

What word do you use to describe your pain?

\_\_\_\_\_  
\_\_\_\_\_

## DAILY MEDICATION LIST

Please list **ALL** medications that you take on a daily basis – this includes **any** Herbal Supplements

Patient Name \_\_\_\_\_ D.O.B \_\_\_\_\_

Medication	Dosage

**Please List Any Food or Drug Allergies**

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### OPIOID RISK TOOL PATIENT FORM

NAME \_\_\_\_\_ DOB \_\_\_\_\_

Mark each box that applies.

- |  |               |             |
|--|---------------|-------------|
| <b>1. Family History of Substance Abuse:</b>             | <b>Female</b> | <b>Male</b> |
| Alcohol  | _____         | _____       |
| Illegal Drugs  | _____         | _____       |
| Prescription Drugs                                       | _____         | _____       |
| <b>2. Personal History of Substance Abuse:</b>           | _____         | _____       |
| Alcohol  | _____         | _____       |
| Illegal Drugs  | _____         | _____       |
| Prescription Drugs                                       | _____         | _____       |
| <b>3. Age (mark box if between 16-45)</b>                | _____         | _____       |
| <b>4. History of Preadolescent Sexual Abuse</b>          | _____         | _____       |
| <b>5. Psychological Disease</b>                          |               |             |
| Attention Deficit Disorder                               |               |             |
| Obsessive-Compulsive Disorder,<br>Bipolar, Schizophrenia | _____         | _____       |
| Depression   | _____         | _____       |

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**PAIN MANAGEMENT AGREEMENT**

The purpose of this Agreement is to prevent any misunderstandings about certain medications you will be taking for pain management. This is to help both you and your Doctor to comply with the law regarding controlled pharmaceuticals and to create the trust and confidence necessary in a doctor/patient relationship. While all of the items listed below are required to be adhered to; please take special note of the following.

- **I UNDERSTAND THAT IF I BREAK THIS AGREEMENT, MY DOCTOR WILL STOP PRESCRIBING THESE PAIN CONTROL MEDICATIONS.**
- **I AGREE THAT REFILLS OF MY PRESCRIPTIONS FOR PAIN MEDICATION WILL BE MADE ONLY AT THE TIME OF AN OFFICE VISIT OR DURING REGULAR OFFICE HOURS. NO REFILLS WILL BE AVAILABLE DURING EVENINGS OR WEEKENDS. MEDICATIONS WILL NOT BE RENEWED OVER THE PHONE.**
- **I WILL SAFEGUARD MY PAIN MEDICATION FROM LOSS OR THEFT. LOST OR STOLEN MEDICATIONS WILL NOT BE REPLACED.**

In this case, my doctor will taper off the medication over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

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

I will not use any illegal controlled substance, including marijuana, cocaine, etc.

I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled medications including opiates, controlled stimulants, or anti-anxiety medications from any other doctor.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize my doctor to provide a copy of this Agreement to my pharmacy, I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the authorizations.

- **I AGREE THAT I WILL SUBMIT TO A BLOOD OR URINE TEST IF REQUESTED BY MY DOCTOR TO DETERMINE MY COMPLIANCE WITH MY PROGRAM OF PAIN CONTROL MEDICATION.**

I agree that I will use my medication at a rate no greater than prescribed. The use of my medication at a greater rate will result in my being without medication for a period of time.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of the Agreement is entered into on the \_\_\_\_\_ day of \_\_\_\_\_.

I agree to use \_\_\_\_\_ pharmacy

Located at \_\_\_\_\_

Telephone number \_\_\_\_\_ for filling prescriptions for all pain medication.

**Patient Name: (please print)** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_