**PATIENT COMFORT ASSESSMENT GUIDE**

**IMPORTANT:** You must complete this form at each visit to help us provide the best possible care for you. Please answer every question to the best of your ability.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSESEMENT OF PAIN AND CHARACTER:**

Since your last visit:

******Determine your pain level from 1 being the ***least*** and 10 being the ***worst.***

1 2 3 4 5 6 7 8 9 10

Pain at its worst: \_\_\_ Pain now: \_\_\_ Pain with medication: \_\_\_ Level when most comfortable: \_\_\_

Level that is tolerable: \_\_\_ Pain level at last office visit: \_\_\_

**CIRCLE THE WORDS THAT DESCRIBE YOUR PAIN:**  Nagging Stabbing Unbearable Sharp Shooting Exhausting Aching Burning Penetrating Tiring Gnawing Throbbing Numbness Paralyzing Tingling Deep Sudden Continuous

Since the accident, have your activities changed? If so which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

What keeps you from doing these activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**If your experiencing any of the following, please circle:** Sleeplessness Incontinence Fatigue Fainting

Muscle Spasms Anxiety Dizziness Loss of Feeling Headaches Nausea Constipation Muscle Weakness

 Weight Loss Weight Gain Distorted Vision Sexual Dysfunction Missing Work Change in Appetite Nightmares Inability to Concentrate Depression Irritability Anger Crying Suicidal Mobility

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were any of the experiences listed above present before your accident/injury? **YES / NO**

If you answered yes, identify the symptoms:

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

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Have you been exercising, stretching or continuing with physical therapy or on your own? **YES / NO**

If the pain wakes you up, can you get to sleep within 30 minutes after readjusting? **YES / NO**

**MEDICATION INFORMATION:**

Please list each medication as well as dosage and how it affects your pain level:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **No Relief 0 1 2 3 4 5 6 7 8 9 10 Complete Relief**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **No Relief 0 1 2 3 4 5 6 7 8 9 10 Complete Relief**

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **No Relief 0 1 2 3 4 5 6 7 8 9 10 Complete Relief**

Does the medication increase your level of function? **YES / NO**

Does the medication improve your daily activities of life? **YES / NO**

Does the medication improve your quality of life? **YES / NO**

How long does it take for the pain to subside? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long does the pain relief last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list adverse side effects from medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**If your experiencing any of the following, please circle:** Sleeplessness Incontinence Fatigue Fainting

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Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were any of the experiences listed above present before your accident/injury? **YES / NO**

If you answered yes, identify the symptoms:

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

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Have you been exercising, stretching or continuing with physical therapy or on your own? **YES / NO**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EFFECTS OF PAIN (DECREASED ACTIVITIES OF DAILY LIVING):**

Circle the daily physical activities you participated in before the pain began:

House Cleaning Gardening Crafts Traveling Working on Cars Sports Exercise

Hobbies: Please identify each hobby you enjoyed before the pain started:

Animals Going to the movies Sleeping Golf Socializing

Boating Hiking Swimming Gardening Fishing

Bowling Hunting Traveling Running Bicycling

Watching TV Relaxing Church Painting Walking

Reading Camping Entertaining Cooking Woodworking

Sewing Eating Out Playing Dancing Napping

Circle the one number that describes how during the past week, pain has interfered with:

General Activity: **Doesn’t Interfere** 0 1 2 3 4 5 6 7 8 9 10 **Completely Interferes**

Mood: **Doesn’t Interfere** 0 1 2 3 4 5 6 7 8 9 10 **Completely Interferes**

Normal Work: **Doesn’t Interfere** 0 1 2 3 4 5 6 7 8 9 10 **Completely Interferes**

Sleep: **Doesn’t Interfere** 0 1 2 3 4 5 6 7 8 9 10 **Completely Interferes**

Enjoyment of Life: **Doesn’t Interfere** 0 1 2 3 4 5 6 7 8 9 10 **Completely Interferes**

Ability to Concentrate: **Doesn’t Interfere** 0 1 2 3 4 5 6 7 8 9 10 **Completely Interferes**

If you are NOT working with restrictions, how does your injury keep you from performing your job duties?

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

**DRUG-TAKING BEHAVIOR:**

Are you currently seeing another Doctor? **YES / NO**

Have you ever been treated for substance abuse? **YES / NO**

Do you currently have a substance abuse problem? **YES / NO**

Have you taken any other substances to assist with pain control other than the prescription medication from our clinic? **YES / NO (If yes, please identify)**

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

To get relief, have your taken more than the assigned dosage of your medication prescribed? **YES / NO**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LOCATION OF PAIN:**  Please circle each area that you experience pain as a result of your injury.

Head Chest Neck Face Abdomen Groin Upper Back Lower Back Other

**Right:** Thigh Ankle Wrist Knee Calf Arm Shoulder Buttock Foot Hand Hip

**Left:** Thigh Ankle Wrist Knee Calf Arm Shoulder Buttock Foot Hand Hip

**On the picture, mark all areas of current pain. Please indicate only the areas related to your injuries**

**CONTROLLED SUBSTANCE PRESCRIPTION AGREEMENT**

Controlled substance medications (e.g. narcotics, tranquilizers, and barbiturates) can be very useful in treating certain health conditions. They are prescribed to relieve pain, manage symptoms and improve function and/or ability to work. However, if not used properly, they can cause medical problems and contribute to addiction and crime. Therefore our office must manage these medications in ways that are medically appropriate and that meet all federal and state regulations. Please read the following carefully. By signing it, you are agreeing to follow every one of the requirements it contains.

Plese read and sign:

1. I am responsible for my controlled substance medications. If the prescription is lost, misplaced, stolen, accidentally destroyed, or if I use it up sooner than prescribed, I understand that it will not be replaced.
2. I understand that if my medication is stolen, I must file a police report with the local law enforcement agencies.
3. I will not request or accept controlled substance medications from any other physician or individual while I am receiving such medication from Dr. Arnold Morris III, D.O. or their designated provider. The only exception will be medication prescribed while I am admitted to a hospital.
4. Controlled substance medications must be obtained from the same pharmacy. Using multiple pharmacies is not acceptable. I authorize the prescribing physician to discuss all relevant healthcare information with the pharmacist at the dispensing pharmacy whenever he/she feel it is indicated.
5. I voluntarily give authorization for random drug screen testing.
6. Refills of controlled substance medications:
	1. Will be made only during regularly scheduled office hours.
	2. Will not be made after office hours, on holidays or weekends.
	3. Will not be called in.
	4. Will not be made if I “run out early”, I am responsible for taking the medication in the dose prescribed, and for keeping track of the amount remaining.
7. I understand that controlled substances can be habit forming and cause physical dependence. I further understand that should dependance become a problem, suddenly stopping the medication could cause withdrawal symptoms, including but not limited to flu-like symptoms, sleeplessness, irritability, anxiety, and in rare cases, seizures.
8. I understand that patients with a personal or family history of substance abuse, including alcohol abuse may be at greater risk for potential abuse. I have notified Dr. Arnold Morrs III, D.O. of any personal or family history of substance abuse.
9. I understand that fraudulent attempts to obtain controlled substances as well as selling, trading, or giving such medications to another person, including a family member is illegal and will be reported to the appropriate law enforcement agencies for further investigation. In such instances, doctor/patient confidentiality doesn’t prevent doctors from providing pertinent information to legal authorities.
10. I have read the contract and it has been explained to me. I have been given an opportunity to ask questions and fully understand that a violation of any of the above conditions may result in termination of my controlled substance medications and permanent dismissal from the practice.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OPIOID RISK TOOL**

Mark Each Box Item Score Item Score

 That Applies If Female If Male

1. Family History of Substance Abuse- Alcohol [ ] 1 3

Illegal Drugs [ ] 2 3

Perscription Drugs [ ] 4 4

1. Personal History of Substance Abuse- Alcohol [ ] 3 3

Illegal Drugs [ ] 4 3

Perscription Drugs [ ] 5 5

1. Age (Mark box if 16-45)- [ ] 1 1
2. History of Preadolescent Sexual Abuse- [ ] 3 0
3. Psychological Disease Attention Deficit Disorder, [ ] 2 2

Obsessive Compulsive Disorder

Bipolar, Schizophrenia

Depression [ ] 1 1

 **TOTAL \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_**

Total Score Risk Category

 Low Risk: 0-3

 Moderate Risk: 4-7

 High Risk: ≥ 8