St. Charles Orthopedics
VLADA FRANKENBERGER, DO
Interventional Pain Medicine

Name: ____________________________ **DOB:** _______________ **Today's Date:** _____________

INSURANCE____
REFERRING DOCTOR ____
PRIMARY CARE DOCTOR____
NEUROLOGIST ____
DO YOU SEE A CARDIOLOGIST OR ONCOLOGIST? IF SO, WHO? _____________

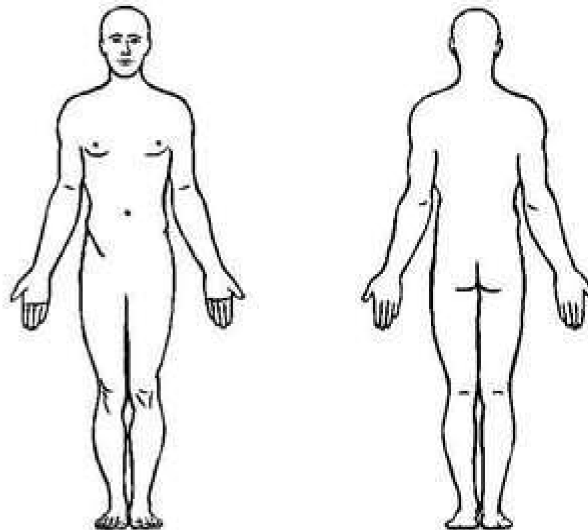
PLEASE DESCRIBE THE PROBLEM(S) FOR WHICH YOU HAVE COME TO SEE ME:
____

____

____

MARK THE AREAS BELOW THAT CORRESPOND TO WHERE YOU HAVE PAIN.

USE "**X**" TO MARK PAINFUL AREAS.
USE "**O**' TO MARK AREAS OF NUMBNESS AND TINGLING.



Who has been treating your pain?
____

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

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_____________ _____________ _____________ _____________

Please list any treatment you have had to treat your pain:

Injections/Surgeries	Dates	Treating MD	Outcome/Percentage of Relief
_____________________	________	_________________	___________________________
_____________________	________	_________________	___________________________
_____________________	________	_________________	___________________________

	# of weeks attended	Relief: mild/moderate/extreme
______Physical Therapy	_________________	___________________________
______Massage	_________________	___________________________
______Acupuncture	_________________	___________________________
______Chiropractic	_________________	___________________________
______Osteopathic	_________________	___________________________
______Tens Therapy	_________________	___________________________

Have you had any tests performed for this problem?

TEST	DATE	RESULT (If Known)
____MRI/CAT SCAN	______	_______________________________________
____CAT SCAN	______	_______________________________________
____EMG	______	_______________________________________
____X-RAY	______	_______________________________________
____BONE SCAN	______	_______________________________________
____BLOOD WORK	______	_______________________________________

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/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? ____

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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(s) do you use to describe your pain?

________ ________ ________ ________

Height__________ Weight_______ Right handed______ Left handed_______

MEDICAL HISTORY:

YES	NO		YES	NO	
___	___	A-Fibrillation	___	___	HIV/AIDS
___	___	Heart Murmur	___	___	Psychiatric Problems*
___	___	Heart Attack	___	___	Depression
___	___	Emphysema	___	___	Anxiety
___	___	Stomach Problems*	___	___	Drug/Alcohol Addiction
___	___	Asthma	___	___	Misuse of Prescription Drugs
___	___	Liver Disease	___	___	Hypertension
___	___	Lupus	___	___	Vascular Disease
___	___	Fibromyalgia	___	___	Diabetes
___	___	Stroke	___	___	Thyroid
___	___	Cancer	___	___	Ulcers
___	___	Infections*	___	___	Lyme's Disease
___	___	Bleeding Disorder	___	___	Hepatitis
___	___	Other			

***Please Specify**____

DO YOU HAVE AN ALLERGY TO ANY OF THE FOLLOWING? IF YES, PLEASE EXPLAIN.

Iodine	Yes______	No______	Shellfish	Yes______	No______
Lidocaine	Yes______	No______	Anesthesia	Yes______	No______
NSAID	Yes______	No______	Antibiotics	Yes______	No______
Adhesive	Yes______	No______	Food	Yes______	No______
Latex	Yes______	No______	Contrast Dye	Yes______	No______

Other ____

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Please list ALL medications that you take on a daily basis.
This includes all over the counter and herbal supplements

ARE YOU ON BLOOD THINNERS? Yes______ No______
Who prescribes them for you? ___________________________

DO YOU TAKE ASPIRIN? Yes______ No______
What strength? ______________ Who prescribes this for you? _________________

****PLEASE BE SURE TO HAND LIST OF MEDICATIONS TO RECEPTIONIST IF NOT LISTED IN THIS SECTION****

MEDICATION	DOSAGE

SURGICAL HISTORY:
Do you have a **Cardiac Pacemaker or Defibrillator**? Yes No
Have you had a Total Joint Replacement? Yes No Left Right
Shoulder Knee Hip
Please list all other surgeries: ____
____

SOCIAL HISTORY:

Smoker? Yes______ No______ Former______

Alcohol? Yes______ No______ Former______

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Illegal Drugs? Yes______ No______ Former______

Occupation: ____________________________________ Student? Yes No

Are you currently working? Yes______ No______

Are you or have you be on disability for this condition? Yes______ No______

When? ________________ Partially ________ Totally __________

Who has taken you out of work: _________________________________

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)

____

____

Mark each box that applies.

		Female	Male
1.	**Family History of Substance Abuse:**		
	Alcohol	____	____
	Illegal Drugs	____	____
	Prescription Drugs	____	____
2.	**Personal History of Substance Abuse:**	____	____
	Alcohol	____	____
	Illegal Drugs	____	____
	Prescription Drugs	____	____
3.	**Age (mark box if between 16-45)**	____	____
4.	**History of Preadolescent Sexual Abuse**	____	____
5.	**Psychological Disease**		
	ADD/OCD/ Bipolar/Schizophrenia	____	____
	Depression	____	____

Total Score __________

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PATIENT-PROVDER 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.
Common adverse effects and complications of long term opioid therapy include but are not limited to: opioid induced constipation, irregular menses, reduced libido, depression, fatigue, hot flashes, night sweats, unintentional opioid related overdose, opioid induced hyperglycemia, memory deficits, sleep disturbances, slow heart rate (bradycardia), impaired driving due to slowed reaction time.

- **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 understand that if this agreement is not followed it can result in me being discharged from this practice.
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 ____

Patient Name: (please print) ____

Patient Signature: ______________________________________ **Initial Here**______

Patient Referral Responsibility

Please be advised if your insurance company requires a referral for your upcoming appointment with Dr. Frankenberger, it is your responsibility to acquire it. The referral must be in our office no later than 48 hours prior to your scheduled appointment. If we do not receive the referral 48 hours prior, your appointment will be canceled and rescheduled to a later date. Referrals for initial consultations, as well as follow ups are to be generated by your primary care physician. All referrals are to be faxed to 631-827-7899 ATTN: DR FRANKENBERGER.

Emblem HIP Provider ID# 931412P

Healthcare Partners ID# 251744

Oxford ID# P5440039

Dr Frankenberger's	Tax ID	113613997
	NPI	1528217791

New patient consultation code: 99244
Follow up appointment code: 99214

Print Name: ______________________________

Signature: _____________________________________ Today's Date: ______