MJ HABER MD LLC
Non-Surgical Pain Specialists

Non-Surgical Orthopedic Pain Medicine
Pain Medicine & Sports Medicine

Name: _____

Date of Birth: _____

Chief Complaint: _____

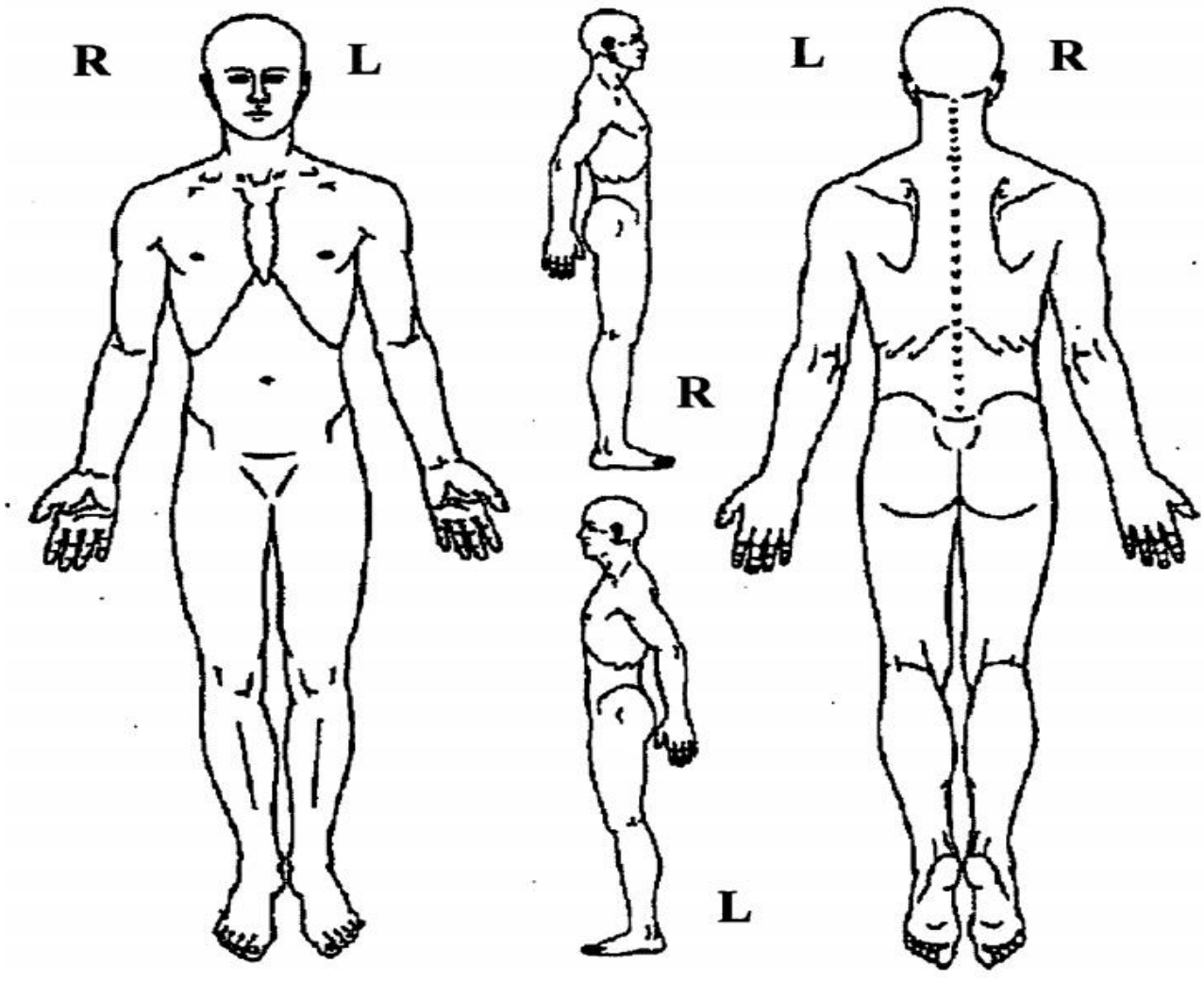
FOR OFFICE USE ONLY
DOS: _____
PCP: _____
Referring: _____
Insurance: _____

PAIN CHARACTERISTICS:

Describe your pain: ☐ Aching ☐ Burning ☐ Cramp-like ☐ Dull ☐ Tingling
☐ Sharp ☐ Shooting ☐ Stabbing ☐ Numbness ☐ Other

WHOLE BODY SYMPTOM CHART

SHADE and NUMBER the areas of your top 3 complaints. Draw an arrow to where the pain radiates.



Are you considering opioid medication for chronic pain?

☐ No

☐ Yes

If yes, REVIEW below and sign below.

NSPS OPIOID MEDICATION POLICIES Partial List 6.11.24

1. Controlled Medications are **NOT** prescribed on the first visit.
2. Patient is responsible to make sure they have a follow up appointment in time before a refill is needed.
3. **Oxycodone** containing medications (Percocet, oxycontin) are **NOT** prescribed on a continuing basis (5 days).
4. **Alcohol, Marijuana, Kratom** and **Benzodiazepine** consumption is not allowed if chronic opioids are prescribed.
5. A reasonable decrease in pain or increased activity tolerance is a maximum of 20-30% per opioid use. **These medications are not "Pain Killers". Opioids DO NOT benefit all pain types.**
6. Continued prescribing of most opioids requires a clinic visit every 3 to 4 weeks.
7. At NSPS there is rarely a reason to exceed a 50mg of morphine equivalent dose (MED) per day of opioid, and almost never a reason to exceed 90 MED.
8. Opioid related risks include, but are not limited to the following: dependence, tolerance, addiction, and accidents.
9. Patients **CANNOT take more pain medication** than prescribed per time interval- Hrs., Days, Wks.
10. **Patients cannot take any prescription medications that have NOT been prescribed to the patient.**
11. For the continuation of pain medication prescribing, only one clinician and one pharmacy are involved.
12. An office visit is required for medication changes and for providing a prescription.
13. Periodic urine/saliva drug screen tests are performed with opioid prescribing.
14. **Pill counts are done at each medication appointment.**
15. Periodic lab tests to monitor liver and kidney functions will be performed.
16. Patients are responsible to determine if they are at increased risk to themselves or others for **potentially hazardous tasks.**
17. A replacement prescription will NOT be provided for lost, stolen, or running out of pain meds early.
18. **Opioid medications are ONLY for pain, not to be taken to benefit a patient's mood.**
19. Pain medication must be kept in a secured or locked container or location.
20. The purpose of opioid medications is to support patient exercise and conditioning, and to benefit activities of daily living -- ADLs (self-hygiene, transfers, dressing, toilet, etc.).
21. The goal is to take the least amount of opioid medication to help improve ADLs.
22. **Opioids are prescribed as one part of an interdisciplinary, multimodal, treatment regimen.**
23. In the situation of a surgery, procedure, accident, or the onset of new prominent acute pain, any additional pain medication is warranted **ONLY** by the doctor managing such event. This attending doctor (emergency room, dentist, surgeon) may provide an additional short-term pain medication, **ONLY** after the patient conveys to the attending doctor that continuous prescribing of pain medication is done per NSPS.
24. Opioid medication rotation from a multi-year use of an old opioid to a new opioid prescription, is often considered every 2 to 3 years, to allow the body to reset and improve effectiveness.

Patient's Signature: _____ **DATE :** _____

Patient Name: _____

PATIENT TREATMENT AGREEMENT

Why an agreement? The medication we are prescribing has the potential to provide benefit, but it also can do harm to you or others. Misuse of pain medications is a large problem in our community. We are doing our part to ensure that our prescriptions are taken as directed.

What are the benefits of opiate treatment? Opiates, also called opioids, provide relief from pain and a sense of well-being. They can allow you to perform activities that you might otherwise find limited due to pain. While often (not always) opioids may decrease pain (for hours or days), long term use can increase pain.

What are the risks of opioid treatment? Opioids produce physical dependency with prolonged use. That means that you may experience discomfort if you discontinue these medications abruptly after taking them for over a few weeks. Some individuals have a hard time remining medication free after being on long term opioids for that reason. Opioids may decrease your ability to breathe deeply. This is especially true when they are combined with other sedating drugs like alcohol and some tranquilizers. This can lead to accidental overdose deaths.

Less serious side effects may include: constipation, decrease in sexual interests and performance, weight gain, sleepiness, urination difficulties, and itchiness. As with any medication, there is the rare possibility of a severe allergic reaction.

Opioid medications are not for everyone, nor for each type of pain. Some people are at risk of abusing these medications and may feel compelled to take them for their pleasurable effect. Therefore we are obliged to provide safeguards to protect you from these potential risks.

Why are those safeguards? Our clinic has the following regulations for all patients taking long- term opioids. We will not prescribe these medications for chronic use without first:

- Obtaining all pertinent medical records.
- Obtaining a urine drug screening (UDS) that must be done within 48 hours of request by clinic.
- Reviewing your medical condition and past history.
- Having a signed agreement between a clinician and yourself outlining the expectations of both parties.
- Financial responsibility, per client. Most, but not all insurances provide partial cover.

What Can I expect from the clinic? Our clinic agrees to provide you with appropriate doses of medication in a timely fashion and on an ongoing basis as long as there are no contraindications. You will be treated respectfully and professionally.

What does the clinic expect from me? The clinic expects all patients will agree to the following:

- Agree to have only one prescriber of opioids and use only one pharmacy.
- Bring their pill bottles to every clinic visit.
- Have a valid phone number available to our staff and respond within 24 business hours to the clinic if asked.
- Agree to a chemical dependency or other specialist consultation should your provider feel that would be appropriate.
- Allow open communication between this clinic and other providers concerning the use of these medications.
- Advise other treatment providers of the medication you are taking and to inform this clinic of any health care emergencies requiring pain or anxiety treatment.
- Agree to treat our staff respectfully and courteously.

Suggestions for safely handling your prescription: These medications can be dangerous if combined with other sedating substances. These medications are sought after by drug abusers. Therefore, we ask that you follow these suggestions to provide safety for you and your medications:

- Keep all medicines in a safe, preferably locked container, out of sight and out of the reach of children.
- Never share these medicines with others. Never take other people's medications.
- No drinking alcohol while prescribed these controlled medications.
- Never combine these medications with other opioids or benzodiazepines (tranquilizers like lorazepam/ Ativan, alprazolam/Xanax, diazepam/Valium, clonazepam/Klonopin) unless approved by your pain medicine prescriber.
- Never use illicit drugs or marijuana if being prescribed these medications.
- Be aware that opioids may affect your judgement and driving skills, particularly when your dose is increasing. Patients are responsible to determine if they can perform hazardous tasks safely. i.e. driving, stairs, holding a baby, ect.

How will I obtain my refills? The clinics policy on refills is:

- Refill prescriptions will only be written at a clinic visit. Therefore, refills will not take place over the phone, through mail, or by calling the pharmacist.
- All dosage changes occur at the next clinic visit, not over the phone. Patient is responsible to make sure they have a follow up appointment in time before a refill is needed.
- Lost or stolen medications may not be refilled until the next scheduled visit. Medication that is out early will NOT be filled early.

Will this medication relieve my pain? It is unrealistic to expect opioids to relieve all discomfort; at best 30%. We hope to reduce your pain so that you can regain function; that is to allow you to enjoy activities that you participated in prior to the onset of your pain. We will continue to ask that you participate in activities that improve your ability to perform daily activities. We may, in the course of your treatment, ask you to exercise, attend classes, or see a specialist of your choosing.

What are the consequences of not following these agreements? Per your clinician's discretion, these medications will be provided as long as deemed appropriate, but also has the obligation to protect you and the community from abuse of these substances. In the event of suspected misuse, your provider may insist on a referral to a specialist in the assessment and treatment of drug dependency or may immediately discontinue prescribing. Lack of improvement in function or to achieve adequate pain control may also necessitate the discontinuing of opioid medications.

I will receive my prescriptions at the following pharmacy only:

Name and phone: _____

I agree to allow the following health care facilities to share information (including any pertinent mental health, drug or alcohol history or conditions) with my provider, and to allow my health care provider to freely share pertinent health care information with these facilities for the purpose of coordinating my medical care.

Facility: _____
Facility: _____
Facility: _____

By signing below, I am agreeing to abide by the conditions of this agreement.

Patient's Signature: _____ Date: _____

M Joshua Haber, MD: _____ Date: _____

PAIN POTENCY AND AFFECT

Read through the 11 descriptions on the left-hand side. Select the TWO boxes that best describes how you have felt over the last 7 DAYS.

a. Place a **"L"** in the circle that correlates with the description that best describes your **lowest pain.**

b. Place a **"W"** in the circle that correlates with the description that best describes your **worst pain**.

i. **ONLY CHECK TWO BOXES**

ii **ONE FOR LEAST PAIN "L" AND ONE FOR WORST PAIN "W"**

-	Pain free	◯
	Minor annoyance	◯
-	Annoying and distracting	◯
	Can be ignored if you are busy with activities	◯
-	Cannot be ignored	◯
	25% activity reduced, can work, & socialize	◯
-	Challenging to work and concentrate	◯
	Unable to concentrate with the pain	◯
-	Cannot; common tasks-drive, shop, cook, transport	◯
	Cannot; personal tasks-toilet hygiene, eat, dress -need assist transfers positions	◯
-	Cannot move, induces lose consciousness	◯

OSWESTRY QUESTIONNAIRE

Select the box at each section that most closely describes how you are feeling over the last 2 to 3 days.

1 Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

2 Personal Care
0. I do not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increases the pain, but I manage not to change my way of doing it.
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

3 Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on the table.
4. Pain prevents me lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

4 Walking
0. I have no pain on walking.
1. I have some pain on walking, but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

5 Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately .

6 Standing
0. I can stand as long as I want without extra pain.
1. I have some pain on standing, but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

OSWESTRY QUESTIONNAIRE cont.

7 Sleeping

0. My sleep is never disturbed by pain.
1. I get pain in bed, but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

8 Sex Life

0. My sex life is normal and causes me no extra pain.
1. My sex life is normal, but causes some extra pain.
2. My sex life is nearly normal, but is very painful.
3. My sex life is severely restricted by pain.
4. My sex life is nearly absent because of pain.
5. Pain prevents any sex life at all.

9 Social Life

0. My social life is normal and gives me no pain.
1. My social life is normal, but it increase the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests. e.g., dancing. etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

10 Traveling

0. I get no pain when traveling.
1. I get some pain when traveling, but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling, but it does not compel me to seek alternate modes of travel.
3. I get extra pain while traveling which compels me to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

/50 /45

SOAPP

The following are some questions given to all patients at Non-Surgical Pain Specialists who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below 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 that 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 felt a craving for medication?	0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
13. How often have you used illegal drugs (for example, 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

CATASTROPHIZING QUESTIONNAIRE

	When I am in pain... STATEMENT	0 Not at all	1 To a slight degree	2 To a moderate degree	3 To a great degree	4 All the time
1	I worry all the time about whether the pain will end.					
2	I feel I can't go on.					
3	It's terrible and I think it's never going to get any better.					
4	It's awful and I feel that it overwhelms me.					
5	I feel I can't stand it anymore.					
6	I become afraid that the pain will get worse.					
7	I keep thinking of other painful events.					
8	I anxiously want the pain to go away.					
9	I can't seem to keep it out of my mind.					
10	I keep thinking about how much it hurts.					
11	I keep thinking about how badly I want the pain to stop.					
12	There's nothing I can do to reduce the intensity of the pain.					
13	I wonder whether something serious may happen.					

CAGE QUESTIONNAIRE

1 .	Have you ever felt you should cut down on your drinking?	Yes	No
2 .	Have people annoyed you by criticizing your drinking?	Yes	No
3 .	Have you ever felt bad or guilty about your drinking?	Yes	No
4 .	Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?	Yes	No

OPIOID RISK TOOL -ORT

Mark each box that applies	YES	NO
FAMILY HISTORY OF SUBSTANCE ABUSE Immediate Family- Blood Related: Parents, Siblings, Son/Daughters		
Alcohol	1	0
Illegal drugs	1	0
Rx Drugs	1	0
PERSONAL HISTORY OF SUBSTANCE ABUSE		
Alcohol	1	0
Illegal drugs	1	0
Rx Drugs	1	0
Age between 16-45 years	1	0
PSYCHOLOGICAL DISEASE		
ADD, OCD, Bipolar, Schizophrenia	1	0
Depression	1	0
Scoring Total		

PATIENT HEALTH QUESTIONNAIRE -9 (PHQ-9)

Over the last **2 weeks**, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling, staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

For office coding: _____ + _____ + _____ + _____

Total Score= _____

Adverse Childhood Experience Questionnaire for Adults

Our relationships and experiences - even those in childhood - can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday.	
1. Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	☐
2. Did you lose a parent through divorce, abandonment, death, or other reason?	☐
3. Did you live with anyone who was depressed, mentally ill, or attempted suicide?	☐
4. Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	☐
5. Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	☐
6. Did you live with anyone who went to jail or prison?	☐
7. Did a parent or adult in your home ever swear at you, insult you, or put you down?	☐
8. Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	☐
9. Did you feel that no one in your family loved you or thought you were special?	☐
10. Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	☐

REVIEW OF SYSTEMS

During the **Last Week,**

Only check off if condition is present:

GENERAL

- Fever >100.5
- Insomnia/Sleep Problems
- Always Tired, Fatigued
- Weight Loss -Unintentional >15 lbs/Month

MUSCULOSKELETAL

- Muscle Cramps
- Muscle Pain
- Back Pain
- Hip Pain
- Knee Pain
- Foot and Ankle Pain
- Neck Pain
- Shoulder Pain
- Elbow Pain
- Hand Wrist Pain

GU

- Prominent Consistent Urine Loss -Need Depends/Diapers
- Painful Urination
- Blood in Urine

GI

- Frequent Nausea
- Heartburn
- Consistent Constipation
- Repeated Vomiting
- Black Tarry Stools
- Bright Red Blood per Rectal

REVIEW OF SYSTEMS cont.

CARDIOVASCULAR

- Chest Pain
- Taking Anticoagulant Medications
- Deep Vein Thrombosis
- High Blood Pressure
- Breathless Lying on Back
- New Heart Murmur

NEUROLOGY

- Seizures (witnessed)
- No Feeling in Groin
- Headache
- Both Legs Give Away with Fall
- Fall to Ground Repeatedly Daily

PSYCHIATRIC/PSYCHOLOGIC

- Depression
- Anxiety
- Much Confusion
- Much Memory Loss
- Plan Harm Self
- Plan Harm Other

RESPIRATORY

- Sleep Apnea
- Wheezing
- Prominent Persistent Cough
- Painful Breathing

HEENT

- Allergies (seasonal)
- Dizziness, Balanced Challenge
- Vertigo, World Appears Spinning
- No Longer Have Taste/Smell