Cheyenne Regional Medical Group
Medical Specialty Clinic

Pain Management

2301 House Ave., Suite 201 • Cheyenne, WY 82001 • (307) 638-7757 • cheyenneregional.org

Patient Name _____Date: _____

Provider you will be seeing: _____

PLEASE ARRIVE AT _____FOR YOUR CHECK IN TIME

Appointment Date: _____

To assist us in providing the best care possible, we ask for your assistance in the following areas:

1. Please ask your referring provider to send any records, labs, radiology reports, etc. that may pertain to their referral.
2. Please show up **AT YOUR CHECK IN TIME** for your appointment so our front office staff will be able to check you in in a timely manner. **Patients that are more than 10 minutes late may be rescheduled to a later time or date.**
3. Please bring a list of your current medications, prescribed and over the counter.

Please bring your **Insurance Card**, **Copayment** and a **Photo ID.**

If you do not have Medical Insurance or CRMC Charity Care your **NEW PATIENT VISIT DEPOSIT IS $180.00** and your **FOLLOW UP VISIT DEPOSIT IS $120.00.** This is required at the time of service and is not the total cost of your appointment.

We look forward to seeing you soon. If you have any questions or need to reschedule your appointment, **please call the office at 307-638-7757.**

Thank you,

The Medical Specialty Clinic Staff

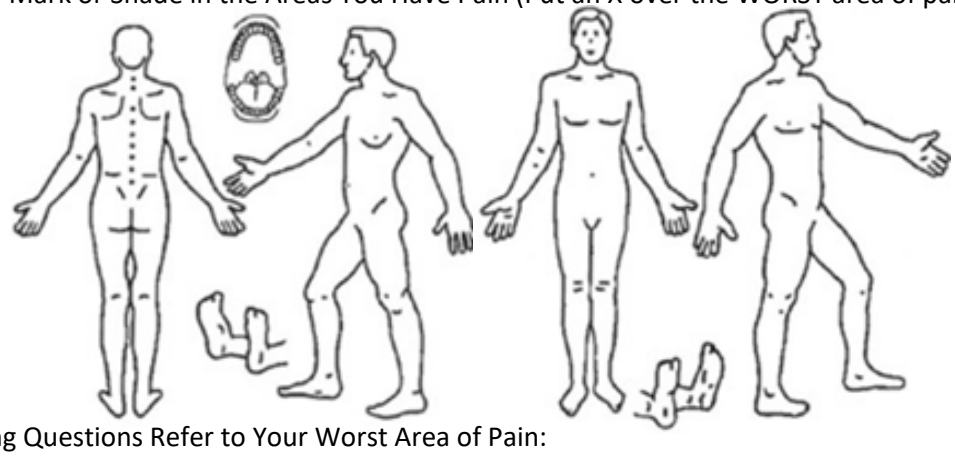
Patient Name: _____ Date of Birth: _____ Today's Date: _____

Pain Management Initial Evaluation

What is your main or worst pain problem: _____

Please list any other (secondary) areas of pain: _____

Pain History: Mark or Shade in the Areas You Have Pain (Put an X over the WORST area of pain)



The Following Questions Refer to Your Worst Area of Pain:

How Did Your Pain Start: Gradual / Sudden Is the Pain Related to an Injury: NO YES

Explain When Your Pain Started:_____

Has the Pain Increased or Changed Recently: NO YES If Yes, Describe: _____

On a Scale from 0 (No Pain) to 10 (Worst Pain Imaginable) Please Rate Your Pain When:

Your Pain is at its Worst: _____ Your Pain at its Best: _____

Your Pain on Average: _____ Your Goal for Pain Level: _____

How Often Do You Have Your Pain: All of the Time / Continuously, but Gets Better & Worse / Sometimes

How Would You Describe Your Pain: (Check All That Apply)

- O Aching
- O Burning
- O Cramping
- O Dull
- O Pressure
- O Sharp
- O Shooting
- O Squeezing
- O Throbbing
- O Tight
- O Numbness
- O Tingling
- O Changing
- O Other: _____

Which of these Activities Make Your Pain Better: (Check All That Apply)

- O Distraction
- O Heat
- O Ice
- O Massage
- O Meditation
- O Movement
- O Relaxation
- O Rest
- O Sleep
- O Medications
- O Nothing
- O Other: _____

Which of these Activities Make Your Pain Worse: (Check All That Apply)

- O Nothing
- O Rest
- O Changing Position
- O Standing
- O Sitting
- O Walking
- O Bending
- O Twisting
- O Stairs
- O Activity / Movement
- O Stress
- O Weather
- O Straining
- O Intercourse
- O Other: _____

What Are You Currently Using to Treat Your Pain (Medications, Heat/Ice, Activity, Therapies, etc.): _____

_____

Pain History: Check the Box that Best Describes Your Past Treatment and its Effects on Your Pain

Treatment	Effect of Treatment			
	Helped	Didn't Help	Made Pain Worse	Not Tried
Physical Therapy				
Chiropractic				
Massage				
Water / Pool Therapy				
Acupuncture / Acupressure				
TENS Unit				
Injections (Please Specify: Spine, Muscle, Joint, Nerve, other)				
Other Professional Treatment				
Surgery (Type & Date)				
Behavioral Therapy				
Other				

Sleep (Check All That Apply)

Overall Quality: Good / Fair / Poor Total Hours per Night: _____ Total Hours At a Time: _____
Difficulty Falling Asleep: Never / Sometimes / Always
Frequent Nighttime Awakenings: Never / Sometimes / Always
Difficulty Falling Asleep if Awakened: Never / Sometimes / Always
Sleep Medications You are Using: _____ Past Sleep Medications: _____

Mood (Check All That Apply)

Please Describe Your General Mood Over the Last Week: (Check All That Apply)

- Normal
- Generally Happy
- Sad
- Depressed
- Helpless
- Lack of Enjoyment
- Irritable
- Anxious
- Fearful
- Guilty
- Worried
- Angry
- Hopeless
- Up and Down
- Other: _____

Do You Have a History of Mood Problems (Anxiety, Depression, Other): NO YES If Yes, Describe: _____
Are You Currently Being Treated for Mood Problems: NO YES If Yes, By Who: _____
Mood Medications that You are Currently Taking: _____
Past Mood Medications: _____

Function

Currently, I am Able to:
Care for My Basic Needs (Bathe, Dress, Eat): Always / Most of the Time / Sometimes / Never
Care for Myself at Home (Cook, Clean, Laundry) : Always / Most of the Time / Sometimes / Never
Drive Short Distances and Run Errands: Always / Most of the Time / Sometimes / Never
Do Light Activity (Yard Work, Walk 15 minutes) : Always / Most of the Time / Sometimes / Never
Do Moderate Activity (Active for 30 minutes or More) : Always / Most of the Time / Sometimes / Never

On a Scale from 0 (Bed-Bound) to 100 (Doing Everything You Want to Do) Please Rate Your Overall Function: _____
Please List Any Activity Restrictions: _____
Do You Do Any Regular Physical Activity: NO YES If Yes, Describe: _____
My Goal is to be Able to: _____

Pain Medications

Current Pain Medication	Dosage	Frequency

Previous Pain Medication	Did It Help	Why was it Stopped
	Yes / Some / No	Didn't Help / Side Effects (List):
	Yes / Some / No	Didn't Help / Side Effects (List):
	Yes / Some / No	Didn't Help / Side Effects (List):
	Yes / Some / No	Didn't Help / Side Effects (List):
	Yes / Some / No	Didn't Help / Side Effects (List):

Medication Goal: _____

Past & Current Medical History (Check All That Apply)

- O Alcohol Abuse
- O Anesthesia Problems
- O Anxiety
- O Arthritis
- O Asthma
- O Bleeding Disorder
- O Bowel Problems
- O Cancer
- O Chest Pain
- O Colostomy
- O Congestive Heart Failure
- O COPD
- O Depression
- O Diabetes
- O Dizziness
- O Emphysema
- O Fainting
- O Heart Attack
- O Heart Valve Problems
- O Hepatitis
- O Hiatal Hernia
- O High Blood Pressure
- O HIV
- O Irregular Heartbeat
- O Kidney Problems
- O Liver Problems
- O Malignant Hyperthermia
- O TIA (Mini stroke)
- O Reflux Disease
- O Obesity
- O Seizure
- O Stroke Illness
- O Thyroid
- O Transfusion
- O Ulcer
- O Urinary Problems
- O Urostomy
- O Pancreatitis
- O Migraine / Headache
- O Other: _____

Past Surgical History (Check All That Apply)

- O Appendectomy
- O Coronary Bypass
- O Gall Bladder Removed
- O Hernia Repair
- O Hysterectomy
- O Tonsils & Adenoids
- O Joint Surgery: _____
- O Joint Replacement: _____
- O Spine Surgery: _____
- O Other: _____

Family History (List Any Major Illnesses That Run in Your Family)

Family Member	Living / Deceased	Major Illnesses
Father:		
Mother:		
Siblings: # Sisters _____ Brothers____		
Children: # Daughters ____ Sons_____		

Diagnostic Tests Which of the Following Tests for This Pain Have Been Done (List Most Recent Tests)

Diagnostic Test	Body Part	Approximate Date	Where Was it Done
X-Ray			
CT Scan			
MRI Scan			
EMG/Nerve Study			
Other _____			

Social / Occupational History

Do You Smoke or Use Tobacco: NO / FORMER / YES If Yes, How Much: _____ For How Long: _____
Do You Drink Alcohol: NO / FORMER / YES If Yes, How Much: _____ For How Long: _____
Do You Use Illegal Drugs: NO / FORMER / YES If Yes, How Much: _____ For How Long: _____

Marital Status: Married / Single / Separated / Divorced / Widowed
Children: None / # Daughters _____ / # Sons _____
Living Situation: Alone / Spouse / Children / Parents / Roommate / Other / # People Living in Home: _____

Employment: Full-Time / Part-Time / Unemployed / Retired / Disability Since: _____
Employer: _____ For This Pain, Are You Involved in: Litigation / Worker's Compensation
If You are Not Working, Do You Plan to: Return to Your Old Job / Take a Different Job / Not Return To Work

Please List Any Concerns or Things We Should Know About Your Pain: _____
_____

Review of Symptoms (In the Last Month Have You Had: Check All That Apply)

Constitution
- O Fever
- O Chills
- O Weight Loss
- O Fatigue
- O Excessive Sweating
- O Weakness

Skin
- O Rash
- O Itching

Head/Ear/Nose/Throat
- O Hearing Loss
- O Ringing in Ears
- O Ear Pain
- O Ear Discharge
- O Nosebleeds
- O Congestion
- O Sinus Pain
- O Vibrating Nose When Breathing
- O Sore Throat

Eyes
- O Blurred Vision
- O Light Sensitivity
- O Eye Pain
- O Eye Discharge
- O Eye Redness

Cardiovascular
- O Chest Pain
- O Palpitations
- O Shortness of Breath When Laying Down
- O Pain or Cramping in Legs with Elevation
- O Shortness of Breath & Coughing at Night

Respiratory
- O Cough
- O Coughing Up Blood
- O Coughing Up Mucus
- O Shortness of Breath
- O Wheezing

Gastroenterology
- O Heartburn
- O Nausea
- O Vomiting
- O Abdominal Pain
- O Diarrhea
- O Constipation
- O Blood in Stool
- O Dark Stool

Genitourinary
- O Painful / Difficult Urination
- O Urgency
- O Frequency
- O Blood in Urine
- O Flank Pain

Musculoskeletal
- O Muscle pain
- O Neck Pain
- O Back Pain
- O Joint Pain
- O Falls

Endocrinology
- O Easy Bruising / Bleeding
- O Environmental Allergies
- O Excessive Thirst

Neurological
- O Dizziness
- O Headaches
- O Tingling
- O Tremor
- O Sensory Change
- O Speech Change
- O Weakness in One Extremity or Muscle Group
- O Seizures
- O Loss of Consciousness

Psychiatric
- O Depression
- O Suicidal Ideas
- O Substance Abuse
- O Hallucinations
- O Nervous / Anxious
- O Insomnia
- O Memory Loss

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CANCELLATION AND MISSED APPOINTMENT/NO SHOW PROCEDURE

Dear Valued Patient,
Our goal is to provide timely quality medical care. No-Shows and late cancellations inconvenience those who need access to medical care in a timely manner. This policy enables us to better utilize available appointments for all patients.

CANCELLATION OF AN APPOINTMENT
In order to be respectful of the medical needs of other patients, please be courteous and call the Medical Specialty Clinic promptly if you are unable to show up for an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely medical care.

HOW TO CANCEL YOUR APPOINTMENT
To cancel an appointment, please call (307) 638-7757. If you do not reach the receptionist, you may leave a detailed message on our voicemail. Please leave your name and phone number and we will return your call to give you the next available appointment time.

LATE CANCELLATION
A late cancellation is someone who does not cancel their appointment before 24 hours of their scheduled appointment time.

NO-SHOW PROCEDURE
A "no-show" is someone who fails to arrive for a scheduled appointment without cancelling the appointment prior to the scheduled time.

- First no show: There will be no charge
- Second no show: May result in a $25 fee billed to your account
- Third no show: May result in an additional $25 fee billed to your account and dismissal from our practice.

I have read and understand the Medical Specialty Clinic Cancellation and Missed Appointment/No Show Procedure.

_____ _____
Patient Printed Name Date of Birth

_____ _____
Patient Signature Today's Date

The Medical Specialty Clinic values you as a patient and strives to provide you with excellent medical services! Thank you for your support of this process.