Pain Management Services

Health Services Pavilion
2790 Clay Edwards Drive, 7th Floor
NKC, MO 64116
(816) 691-1779

We would like to take this opportunity to welcome you to North Kansas City Hospital's Pain Clinic. We understand pain is not easy to deal with and that everyone's pain is unique to them. Our primary goal is to provide you with the utmost professional care. Below are some important details about our clinic:

Our hours of operation are Monday - Friday 7:00am to 3:00pm. We are closed all major holidays. Our clinic phone number is (816) 691-1779. We see patients by appointment only. Pain Source Solutions, LLC has a separate number specifically for scheduling appointments at North Kansas City Hospital's pain clinic.

Call (816) 221-4114 to make an appointment with:

Dr. Patrick Griffith, M.D.
Dr. Sean Clinefelter, M.D
Eleece Kaiser, APNP

If you can't make it to your appointment, please call us as soon as possible. Calling, in advance to cancel your appointment, allows your provider's office to schedule another patient.

Each time you visit our clinic please check in with the receptionist. We sometimes experience delays so your patience is appreciated. **Please anticipate a minimum of 2 hours for your appointment at the pain clinic.** At each visit you will be asked to complete a two sided Follow-up Pain Assessment Form. It's very important for you to bring a complete list of the medications and the dosages that you're taking to each visit. **If you are on any medications to thin your blood (anticoagulants) please notify us as the doctor most likely will not be able to perform a spinal injection. If you have any questions as to whether your medications are blood thinners please contact us.**

Many insurance companies are now requiring preauthorization prior to performing any procedures. **You should not expect a procedure on an initial evaluation or if you have not been seen in the last few months or if there is a change in the anticipated treatment.** Your provider may need to assess you and submit a diagnosis with a treatment plan to your insurance for consideration prior to approval. This process can take 3-5 days.

Prescription refills are handled at the time of your visit and at the discretion of your physician. In general you should expect prescription changes to be done in the setting of a clinic evaluation and not through phone calls. **Please do not call the day your prescription runs out, it is your responsibility to monitor your medication supply and call at least a week before your medications run out.**

Return calls are made at the end of the day to assure that scheduled patients do not experience a delay in their appointments. A nurse, who has talked directly with your physician about your concerns, makes the return phone calls. If you feel that your call requires immediate attention please inform the secretary. Most importantly, when leaving a message, please provide your name and a number where you can be reached. This may require you leave a home, cell or work phone number.

Our clinic is a hospital based clinic. You should expect to receive a bill from both the hospital and your provider. Questions regarding your hospital bill should be directed to the hospital's billing department. Questions regarding your provider's bill should be directed to the provider.

If you should have any questions after being seen in the Pain Clinic, please refer to your physician discharge instructions or feel free to give us a call. Thank you and from all of us in the pain clinic at North Kansas City Hospital we look forward to seeing you.

PAIN CLINIC – PATIENT INTAKE FORM

Name ______________________________ Date of Birth ____/____/____ **Room #** ____

Address ______________________________ Sex __________ Age ____

______________________________ Primary Care Physician ______________

Home Phone (_______) ________-__________ Referring Physician ______________

Cell Phone (_______) ________-__________

CHIEF COMPLAINT:

Describe in your own words why you came to the Pain Clinic today: ______________________________

____

What are you expecting from your visit to the Pain Clinic today? ______________________________

____

HISTORY OF PRESENT ILLNESS:

When did you first notice your pain/problem? ______________________________

What do you think caused your pain/problem? ______________________________

____

Where is your pain? (Please draw on figure on page 6) ______

Is your pain worse on one side than the other, if so, which side? ______________________________

Describe your pain (for example, dull, sharp, burning, achy, etc.) ______________________________

____

Does your pain migrate or radiate to other parts of your body, if so, where? ______________________________

____

Please use the following scale to rate your pain below: **0-10**

0 meaning no pain and **10** meaning the worst pain you've ever had or can imagine.

My pain at BEST is ____. My pain NOW is ____. My pain at its WORST is ____.

List the things that make your pain better ______________________________

____

List the things that make your pain worse ______________________________

____

How is your sleeping? ______________________________

Have there been any changes in your mood? (for example, irritable, sad, not eating, etc.)

If so, please explain ______________________________

____

What have other physicians told you is causing your pain? ______________________________

____

____

____

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Has your physician prescribed or have you tried any of the following forms of treatments for pain relief? If so, please note the date(s) you tried or began treatment, the effectiveness (for example, good, bad, very, etc.) and the percentage of pain relief, if any.

	DATE(S)	EFFECTIVENESS	% PAIN DECREASED
Restricting Activity			0% - 100% - _______%
Medication(s)			0% - 100% - _______%
Ice / Heat			0% - 100% - _______%
Physical/Occupational Therapy			0% - 100% - _______%
Tens Unit			0% - 100% - _______%
Chiropractic			0% - 100% - _______%
Biofeedback / Counseling			0% - 100% - _______%
Nerve Blocks / Injections			0% - 100% - _______%
Surgery			0% - 100% - _______%

Is this pain the result of a work related accident? ______________________________

If yes, is legal action or an insurance settlement pending? ______________________________

If yes, describe the current status of such action ______________________________

If no, do you plan to pursue legal action or insurance settlement in the future? ______________

Have you had any of the following pain related evaluations and if so please give the date(s) and the facility in which you had the evaluations.

	DATE(S)	**FACILITY**
X-rays		
Cat Scans		
MRI		
Myelogram		
Bone Scan		
Nerve and Muscle Tests (EMGs)		

Previous Medical History:

Have you ever been diagnosed with any of the following medical conditions, and if so, when?

	Date Diagnosed		**Date Diagnosed**
Asthma / COPD		Diabetes	
Heart Disease		Insulin Pump	
Pacemaker / Defibrillator		Ulcers / GERD	
Kidney Problems		Hepatitis	
Bleeding Tendencies		Cancer	
High Blood Pressure		Other	

Previous Surgical History:

Please list any surgeries that you've had, and the dates of those surgeries below:

Surgery	**Date of Surgery**

Height ____________________ Weight ____________________

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Drug Allergies	**Reaction**

Medications	**Dose**

Please circle if you are currently taking any of the following prescribed medications and write next to it the date you last took it.

	Date Last Took
Coumadin (also called Warfarin)	
Aspirin	
Plavix (also called Clopidogrel)	
Pletal (also called Cilostazol)	
Pradaxa (also called Dabigatran)	
Xarelto (also called Rivaroxaban)	
Eliquis (also called Apixaban)	
Persantine (also called Dipyridamole)	
Aggranox	
Arixtra (also called Fondaparinux)	
Effient (also called Prasugrel)	
Brilinta (also called Ticagrelor)	

	Date Last Took
Elmiron	
Diclofenac (also called Voltaren)	
Ketorolac (also called Toradol)	
Lodine (also called Etodalac)	
Indomethacin	
Mobic (also called Meloxicam)	
Nabumetone (also called Relafen)	
Oxaprozin (also called Daypro)	
Feldene (also called Piroxicam)	
Reopro (also called Abciximab)	
Integrilin (also called Eptifibatide)	
Aggrastat (also called Tirofiban)	

Aspirin (also called Bayer or Excederin) ______________
Ibuprofen (also called Advil or Motrin) ______________
Aleve (also called Naproxen) ______________

Patient Pharmacy Name: ________________________________
Pharmacy Address: ________________________________
Pharmacy Phone Number: ________________________________

Are you or do you believe you are taking any medications not listed that may thin your blood? Yes / No; if so please list ________________________________

Do you take any antidepressants? Yes / No; if so please list ________________________________

Do you take any herbal supplements? Yes ? No; if so please list ________________________________

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PAIN CLINIC – PATIENT INTAKE FORM

Social History:

I work at ________________________________.
I am retired from ____________________________.
I have missed work in the last month ______________ (Y / N)
If yes, how many days? ________________________
Tobacco use Y / N ____ ppd ______ # of years ______ Quit? ___________ (Date)
Alcohol use Y / N ____ amount/day ___________ History of abuse? _______ (Y / N)
Illicit Drug use Y / N ____ History of use Y / N ____
I am: Single, Married, Divorced, Widowed? _________________
I am: Pregnant, or Planning to become Pregnant ________ (Y / N / NA) Last menstrual period __________
Does anyone live with you? _______ If so, who? _________________________
Education Background: (circle all that applies)

GED High School College Technical School Other ______________

Family History: Do any of your immediate family members have a history of a major disease? (For example: heart disease, lung disease, bone disease) if so, please list here:

Mother ____
Father ____
Sister ____
Brother ____

Review of Systems:

Do you have any of the following symptoms? Please list all symptoms that apply.

CONSTITUNTIONAL
Fever/chills/sweats/weight change ______________________________
EYES, EARS, NOSE
Headaches/eye, ear or nose problems ______________________________
CARDIOVASCULAR
Chest pains/murmur/fluttering in chest ______________________________
RESPIRATORY
Short of breath/productive cough ______________________________
GASTROINTESTIONAL
Diarrhea/constipation/incontinence ______________________________
NEUROLOGIC
Weakness/loss of balance/falls ______________________________
SKIN
Skin rash/hives/ulcers ______________________________
PSYCHIATRIC
Depression/anxiety ______________________________
ENDOCRINE
Diabetes/thyroid ______________________________
HEMATOLOGIC

PAIN CLINIC – PATIENT INTAKE FORM

Bleeding problems/anemia/swollen nodes ______________________________

ALLERGY/IMMUNOLOGIC

Seasonal allergies/asthma/hay fever ______________________________

LATEX ALLERGY

Have you ever been tested for a Latex Allergy? (Y / N) __________

If so, what were the results? (Negative / Positive) __________

Do you have eczema or problems with rashes? (Y / N) __________

Do you have swelling, itching, hives, or other symptoms after contact with:

- Balloons (Y / N) __________
- Dental Examination or Procedure (Y/ N) ______
- Vaginal or Rectal Exam (Y / N) __________
- Using a Diaphragm or Condom (Y / N) _______
- Wearing Rubber Gloves (Y / N) __________

Have you experienced an unexplained anaphylactic episode? (For example: rapid heart, swelling of your throat and respiratory distress all at the same time) (Y / N) _________

If yes, which one? ______________________________

FOOD ALLERGY

Are you allergic to any of the following? If so, indicate which ones and the reaction.

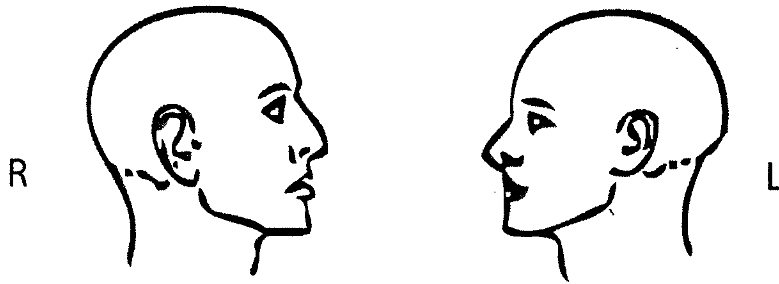
Bananas / Avocados ______________________________

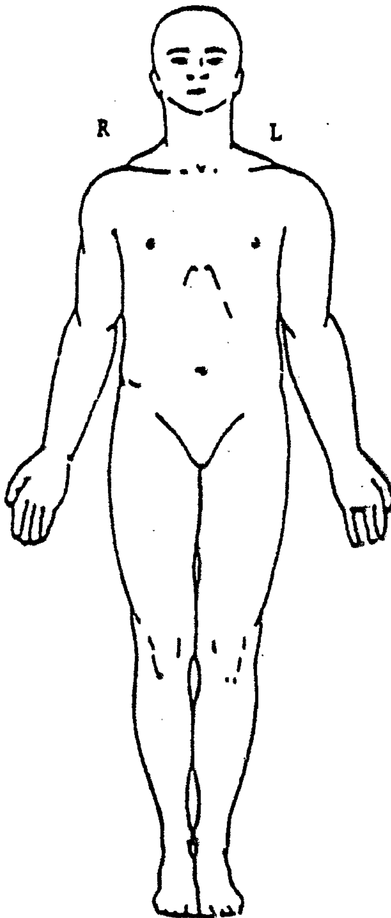
Kiwi Fruit / Chestnuts ______________________________

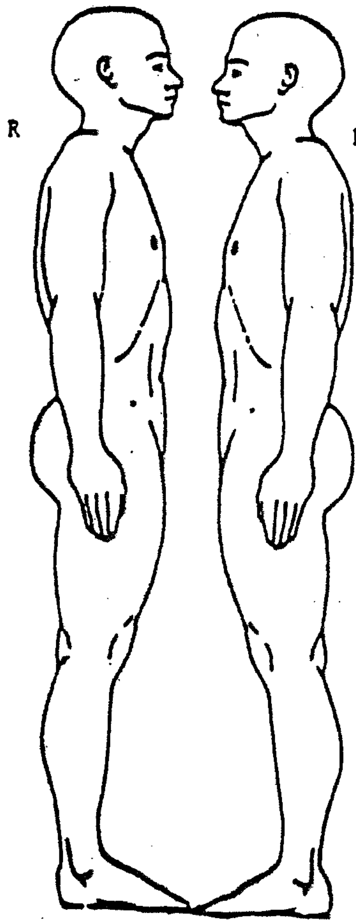
****Nursing**** If patient answers yes to BOTH a **<u>LATEX ALLERGY</u>** and **ANY** of the above questions were answered yes, NOTE **LATEX ALLERGY** on the front of the chart.

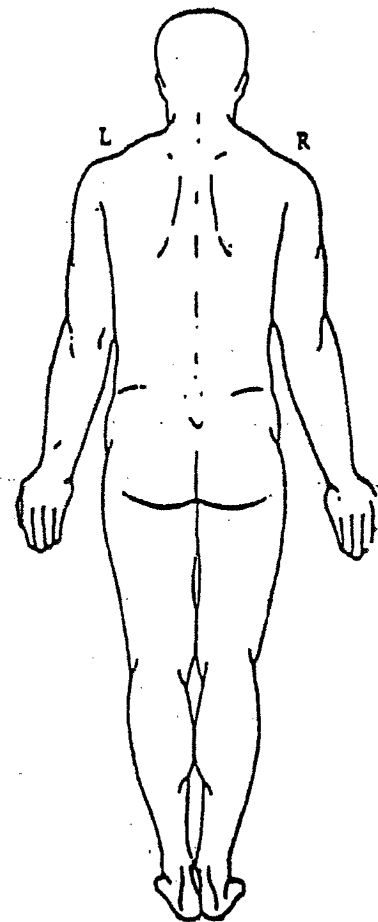
PAIN CLINIC – PATIENT INTAKE FORM

Please SHADE in, on the drawings below, the areas where you feel pain.









Intake form completed per patient responses.

Date ____________________ RN Signature ____

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DIAGNOSIS: ____

____

____

____

PLAN: ____

____

____

____

______________________________ ______________

PHYSICIAN SIGNATURE **DATE**

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