MULTiCARE
Musculoskeletal Medicine & Pain Management Associates, P.C.

Steven C. Shifreen, M.D.
Christopher P. Norval, DC, PA-C, LPTA
Julie W. Shifreen, RPT

1224 Mill Street Bldg A Suite 201, East Berlin, CT 06023
Phone: (860) 570-3400 Fax: (860) 570-0750
www.multicarephysicians.com

Opiate Contract Pain Management Agreement

The purpose of this agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This is to help you and your doctor to comply with the law regarding controlled pharmaceuticals.

_____ I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

_____ I understand that if I break this Agreement, my doctor will stop prescribing these pain control medicines.

_____ In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

_____ I would also be amendable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my doctor deems necessary.

_____ 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 medicine is helping to relieve the pain.

_____ I will not use any illegal controlled substances, including heroin, cocaine, etc., nor will I misuse or self-prescribe/medicate with any legal controlled substances. Use of alcohol will be limited to time when I am not driving, operating machinery and will be infrequent.

_____ I will not share my medication with anyone.

_____ I will not attempt to obtain any controlled narcotics/pain medicine, from any other doctor, hospital or urgent care.

_____ I will safeguard my pain medication from loss or theft. Lost or stolen medications will **not** be replaced.

I agree to use: _____

Name of Pharmacy

Located at: _____

Telephone Number: (_____) _____---_____ for filling my prescriptions for all my pain medicine.

_____ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

_____ 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 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, primary care physician and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ I agree that I will submit to a saliva or urine test if requested by my doctor to determine my compliance with my program of pain control medications.

_____ I agree that I will use my medicine at a rate of no greater that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

_____ I will bring unused pain medicine if requested by the provider.

_____ 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 this document has been given to me.

This Agreement is entered into on this _____ day of _____, 20_____
DAY MONTH YEAR

Patient Signature: _____

Physician Signature: _____

Witnessed by: _____

PATIENT COMFORT ASSESSMENT GUIDE

NAME:_____ DATE:_____/_____/_____

1. Where is your pain? _____

2. Circle the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable

Circle One Occasional Continuous

What time of day is your pain the worst? Circle one.

Morning Afternoon Evening Nighttime

3. Rate your pain by circling the number that best describes your pain at its <u>worst</u> in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

4. Rate your pain by circling the number that best describes your pain at its <u>least</u> in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

5. Rate your pain by circling the number that best describes your pain on <u>average</u> in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

6. Rate your pain by circling the number that best describes your pain <u>right now.</u>

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

7. What makes your pain <u>better</u>? _____

8. What makes your pain <u>worse</u>? _____

9. What <u>treatments</u> or <u>medications</u> are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.

a)_____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

b)_____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

c)_____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

d)_____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

10. What <u>side effects</u> or <u>symptoms</u> are you having? Circle the number that best describes your experience during the past week.

a. Nausea	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
b. Vomiting	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
c. Constipation	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
d. Lack of Appetite	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
e. Tired	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
f. Itching	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
g. Nightmares	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
h. Sweating	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
i. Difficulty Thinking	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
j. Insomnia	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine

11. Circle the one number that describes how during the past week <u>pain has interfered with your:</u>

a. General Activity	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
b. Mood	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
c. Normal Work	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
d. Sleep	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
e. Enjoyment of Life	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
f. Ability to Concentrate	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
g. Relations with Other People	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes

Please circle all areas where you are experiencing pain.