Pain Medication Screening PATIENT NAME: _____ DATE:_____

Name:		Date of Birth:	
Social Security Number:		Sex:	
Home Phone Number:		Mobile Phone Number:	
Email Address:		Referring Physician:	
Permanent Address:			

Marital Status: ___ Married ___ Divorced ___ Separated ___ Single Never Married ___ Widowed

How many children do you have? _____ Number of children over 18 years of age ___

Occupation: _____

Employer: _____

Highest Level of Education Completed: _____

Major (if applicable): _____

Please describe your pain and how your pain medication works for you:

_____

_____

_____

_____

Do you smoke?	___ Yes	___ No	How often?		How much?	
Do you drink alcohol?	___ Yes	___ No	How often?		How much?	
Do you use drugs other than those prescribed?	___ Yes	___ No	How often? What kind?		How much?	

Please CLEARLY list any current medications you are taking	**Strength**	**Dose**	**Frequency**
Example- Zithromax Z-Pack	*250 mg*	*1 Pill*	*2x daily*

On a scale of 0-10, with 10 being the highest (worst) pain rating…. Current Pain Level ___ Worst Pain Level ___

Are you currently taking your pain medication? ___ Yes ___ No

Barnabas Behavioral Healthcare Pain Medication Screening Patient Form

When is your pain at its WORST?

___ Sitting
___ Standing
___ Ambulatory
___ Physical Activity
___ Lying down
___ Touching/Pressure
___ Weather

In your own words, please tell us what you do to help relieve the stress associated with your pain: _____

Have you ever received mental health treatment? ____YES ____NO

___ Out Patient Dates _____ Name of Provider _____

___ In Patient Dates _____ Name of Provider _____

In the following area, please place a check next to each item which indicates an area of concern to you. Please place two checks by items which are most important (you may add comments.)

_____ Anxiety	_____ Troubling memories	_____ Unfairly treated by others
_____ Depressed mood	_____ Inability to relax	_____ Repetitive behaviors
_____ Guilt feelings	_____ Memory difficulties	_____ Drinking or drug problems
_____ Over activity	_____ Lack of confidence	_____ Rely too much on others
_____ Weight loss	_____ Can't make decisions	_____ Suspicious of others
_____ Weight gain	_____ Bitterness or resentment	_____ Recent loss of someone
_____ Headaches	_____ Periods of over activity	_____ Sexual problems/concerns
_____ Feelings of inferiority	_____ Eating problems	_____ Family quarreling
_____ Loss of interest	_____ Shy or awkward with others	_____ Fearful of things or situations
_____ Poor sleeping	_____ Unable to trust others	_____ Religious/spiritual concerns
_____ Repetitive ideas	_____ Change in eating habits	_____ Cardiovascular /heart problems
_____ Thought of suicide	_____ Fighting/arguing with others	_____ Alcohol/drug problem in family
_____ Wish to hurt others	_____ Can't stand up for myself	_____ Unusual/strange experiences
_____ Marital relationship	_____ Can't say "no" to others	_____ Stress from recent event
_____ Financial problems	_____ Poor adjustment to job/school	_____ Divorce/separation difficulty
_____ Lonely/too few friends	_____ Bad temper/anger problems	_____ Troubling habits/thoughts
_____ Unhappy most of the time	_____ Difficulties with opposite sex	_____ Feeling rejected by family
_____ Problem with children	_____ Stomach or bowel disturbance	_____ Other (specify)

Have you ever personally experienced:

___ Child Abuse
___ Elder Abuse
___ Sexual Abuse
___ Physical Abuse
___ Eating Disorder
___ Poor Impulse Control
___ Family Member Suicide

Barnabas Behavioral Healthcare LLC
Notice of Privacy Practices

Barnabas Behavioral Healthcare Pain Medication Screening Patient Form

This notice describes how medical, drug and alcohol and psychological related information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

General Information

Information regarding your health care, including payment for health care, is protected by two federal laws; the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320det seq,, 45 C.F.R. Part 160 & 164 and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2. Under these laws, Barnabas Behavioral Healthcare LLC may not say to a person outside Barnabas Behavioral Healthcare LLC that you attend the practice, nor may Barnabas Behavioral Healthcare LLC disclose any information identifying you as a client, or disclose any other protected information except as permitted by federal law.

Barnabas Behavioral Healthcare LLC must obtain your written consent before it can disclose information about you for payment purposes. For example, Barnabas Behavioral Healthcare LLC must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before Barnabas Behavioral Healthcare LLC can share information for treatment purposes or for health care operations. However, federal law permits Barnabas Behavioral Healthcare LLC to disclose information without your written permission in the following situations:

1. Pursuant to an agreement with a qualified service organization/ business associate
2. For research, audit or evaluations.
3. To report a crime committed on Barnabas Behavioral Healthcare LLC premises or against Barnabas Behavioral Healthcare LLC personnel.
4. To medical personnel in a medical emergency.
5. To appropriate authorities to report suspected child abuse or neglect or domestic violence.
6. As allowed by a court order.

For example, Barnabas Behavioral Healthcare LLC can disclose information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a qualified services organization/ business associate agreement in place.

Barnabas Behavioral Healthcare LLC may need to share your protected health information with third party "business associates" that perform various activities such as laboratory services and billing partners. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Before Barnabas Behavioral Healthcare LLC can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing at any time.

Your Rights:

Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. At your request, Barnabas Behavioral Healthcare LLC will not disclose information to your health insurance plan about any services for which you have paid out-of-pocket. Barnabas Behavioral Healthcare LLC is not required to agree to any other restrictions you request, but if it does agree, then it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.

You have the right to request that we communicate with you by alternative means or at an alternative location. Barnabas Behavioral Healthcare LLC will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA you also have the right to inspect and copy your own health information maintained by Barnabas Behavioral Healthcare LLC, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in Barnabas Behavioral Healthcare LLC records, and to request and receive an accounting of disclosures of your health related

information made by Barnabas Behavioral Healthcare LLC during the six years prior to your request. You also have the right to receive a paper copy of this notice.

Barnabas Behavioral Healthcare LLC Duties:

Barnabas Behavioral Healthcare LLC will not share your protected health information for marketing or fundraising purposes, nor will we ever sell your protected health information without your prior approval.

Barnabas Behavioral Healthcare LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. Barnabas Behavioral Healthcare LLC is required by law to abide by the terms of this notice. Barnabas Behavioral Healthcare LLC reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. You may access a revised version by accessing our website, or you may request a copy by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, please contact our Compliance Officer Peter Zaepfel at 803-216-0850.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations. You may complain to us using the contact information listed at the end of this Notice. You also may submit a written compliant to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer. The contact information is provided below.

Contact Officer: Peter Zaepfel, Corporate Compliance Officer Telephone: 803-216-0850 Fax: 803-216-0420

Address: 409 Evelyn Drive Columbia, South Carolina 29210

Acknowledgement of Receipt of Privacy Practices

I have read, understood, and received a copy of Barnabas Behavioral Healthcare LLC Notice of Privacy Practices and a copy of this form will be retained in my medical chart.

Signed:_____ Date: _____

Printed Name: _____

Authorization to Disclose Information

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this content at any time except to the extent that action has been taken in reliance on it. This release will expire 12 months after first signed.

_____ I want my annual screening report released to my Referring Doctor

_____ I DO NOT want this information released to my Referring Doctor

Patient _____ Date _____

Parent/Guardian _____ Date _____

Witness _____ Date _____

Barnabas Behavioral Healthcare, LLC

Consent to Treatment

I _____ , (your name) give permission for **Barnabas Behavioral Healthcare, LLC** to give me psychological treatment/ assessments/ testing/ screenings/ medical treatment. I allow **Barnabas Behavioral Healthcare, LLC** to file for insurance benefits to pay for the care I receive and I am responsible for prompt payment for my portion of my bill should I not have insurance or it is determined by my insurance company to be "patient responsible".

I understand that:

Barnabas Behavioral Healthcare, LLC will have to send my medical record information to my insurance company.

I must pay my share of the costs.

I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

An assessment letter will be sent to my referring provider with the result of my assessment

I understand:

I have the right to refuse any procedure or treatment.

I have the right to discuss all medical treatments with my clinician.

I can cancel my appointment outside of 24 business hours without incurring a no show charge (business hours are M-F 8AM-5PM)

It is my responsibility to remember my appointment date and time and it is only a courtesy for me to receive a reminder call, email, or text.

Patient _____ Date _____

Parent/Guardian _____ Date _____

Barnabas Behavioral Healthcare Pain Medication Screening Patient Form

	Not at All	Several Days	More than half the days	Nearly Every Day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much.				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself- or that you are failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
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				
9. Thoughts you would be better off dead or hurting yourself				
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?			Not at all difficult	
			Somewhat difficult	
			Very difficult	
			Extremely Difficult	

SCORE: _____

Pain Medication Screening PATIENT NAME: _____ DATE:_____

Section 1 – Pain intensity

	I have no pain at the moment
	The pain is very mild at the moment
	The pain is moderate at the moment
	The pain is fairly severe at the moment
	The pain is very severe at the moment
	The pain is the worst imaginable at the moment

Section 2 – Personal care (washing, dressing etc)

	I can look after myself normally without causing extra pain
	I can look after myself normally but it causes extra pain
	It is painful to look after myself and I am slow and careful
	I need some help but manage most of my personal care
	I need help every day in most aspects of self-care
	I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

	I can lift heavy weights without extra pain
	I can lift heavy weights but it gives extra pain
	Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed, eg. on a table
	Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently
	I can lift very light weights
	I cannot lift or carry anything at all

Section 4 – Walking

	Pain does not prevent me walking any distance
	Pain prevents me from walking more than1 mile
	Pain prevents me from walking more than 1/2 mile
	Pain prevents me from walking more than 100 yards
	I can only walk using a stick or crutches
	I am in bed most of the time

Section 5 – Sitting

	I can sit in any chair as long as I like
	I can only sit in my favourite chair as long as I like
	Pain prevents me sitting more than one hour
	Pain prevents me from sitting more than 30 minutes
	Pain prevents me from sitting more than 10 minutes
	Pain prevents me from sitting at all

Section 6 – Standing

	I can stand as long as I want without extra pain
	I can stand as long as I want but it gives me extra pain
	Pain prevents me from standing for more than 1 hour
	Pain prevents me from standing for more than 30 minutes
	Pain prevents me from standing for more than 10 minutes
	Pain prevents me from standing at all

Sections Completed: _____
Total Score Page 1: _____

Section 7 – Sleeping

	My sleep is never disturbed by pain
	My sleep is occasionally disturbed by pain
	Because of pain I have less than 6 hours sleep
	Because of pain I have less than 4 hours sleep
	Because of pain I have less than 2 hours sleep
	Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

	My sex life is normal and causes no extra pain
	My sex life is normal but causes some extra pain
	My sex life is nearly normal but is very painful
	My sex life is severely restricted by pain
	My sex life is nearly absent because of pain
	Pain prevents any sex life at all

Section 9 – Social life

	My social life is normal and gives me no extra pain
	My social life is normal but increases the degree of pain
	Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sports
	Pain has restricted my social life and I do not go out as often
	Pain has restricted my social life to my home
	I have no social life because of pain

Section 10 – Travelling

	I can travel anywhere without pain
	I can travel anywhere but it gives me extra pain
	Pain is bad but I manage journeys over two hours
	Pain restricts me to journeys of less than one hour
	Pain restricts me to short necessary journeys under 30 minutes
	Pain prevents me from travelling except to receive treatment

Sections Completed Page 1 _____ X 5 = _____

Sections Completed Page 2 _____ X 5 = _____

Add Above

Total [ ]

Total Score Page 1 _____

Total Score Page 2 _____

Add Above

Total [ ] X 100=_____ /Total Section Completed Score =_____%

Pain Medication Screening PATIENT NAME: _____ DATE:_____

Pain Medication Questionnaire

Consider the following statement and indicate rather you
Disagree, Somewhat Disagree, are Neutral, Sometimes Agree, Agree
by placing a mark in the corresponding box to the right of the statement.

		Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree
1.	I believe I am receiving enough medication to relieve my pain					
2.	My doctor spends enough time talking to me about my pain medication during appointments.					
3.	I believe I would feel better with a higher dosage of my pain medication.					
4.	In the past, I have had some difficulty getting the medication I need from my doctor(s)					
5.	I wouldn't mind quitting my current pain medication and trying a new one, if my doctor recommends it.					
6.	I have clear preferences about the type of pain medication I need.					
7.	Family members seem to think that I may be too dependent on my pain medication.					
8.	It is important to me to try ways of managing my pain in addition to the medication (relaxation, biofeedback, physical therapy, TENS unit, etc.)					
9.	At times, I take pain medication when I feel anxious and sad, or when I need help sleeping.					
10.	At times, I drink alcohol to help control my pain.					
11.	My pain medication makes it hard for me to think clearly sometimes					
12.	I find it necessary to go to the emergency room to get treatment for my pain					
13.	My pain medication makes me nauseated and constipated sometimes.					
14.	At times, I need to borrow pain medication from friends or family to get relief.					
15.	I get pain medication from more than one doctor in order to have enough medication for my pain.					
16.	At times, I think I may be too dependent on my pain medication					
17.	To help me out, family members have obtained pain medications for me from their own doctors.					
18.	At times, I need to take pain medication more often than it is prescribed in order to relieve my pain					
19.	I save any unused pain medication I have in case I need it later.					
20.	I find it helpful to call my doctor or clinic to talk about how my pain medication is working.					
21.	At times, I run out of pain medication early and have to call my doctor for refills					
22.	I find it useful to take additional medications (such as sedatives) to help my pain medication work better.					
23.	How many painful conditions (injured body parts or illnesses) do you have?					
24.	How many times in the past year have you asked your doctor to increase your prescribed dosage of pain medication in order to get relief?					
25.	How many times in the past year have you run out of pain medication early and had to request an early refill?					
26.	How many times in the past year have you accidentally misplaced your prescription for pain medication and had to ask for another?					