WATER'S EDGE NEW PATIENT QUESTIONNAIRE

By answering the following questions, you will help your pain provider better understand and treat your condition. Please have this filled out PRIOR to your appointment and THANK YOU for your help.

Name: _____ **Date of Birth:** _____ **Height:** _____ **Weight:** _____

Primary Physician: _____ **Referring Physician:** _____

Other Providers/Physicians: _____

PAIN HISTORY

- What is the **PRIMARY REASON** for seeing a pain specialist today (Primary pain)?

  _____

  _____

- **WHERE** is your **PRIMARY** pain (Neck, Back, Shoulder, Head, Other)? _____
- Is your pain related to a work injury (check)? ☐ **Yes /** ☐ **No**
- Is your pain related to an accident (check)? ☐ **Yes /** ☐ **No**
- **WHEN** did your pain start (approximate date)? _____/_____/_____
- Describe the injury or the cause of your pain: _____

  _____

  _____

- How often do you experience pain (check)?

  ☐ Constant ☐ Frequent ☐ Intermitent ☐ Occasional ☐ Rare

- Over the course of time is your pain changing (check)?

  ☐ Mildy Worsening ☐ Severely Worsening ☐ Improving ☐ Recurring ☐ Not Changing

- What is your level **TODAY** (circle)?

  0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

  None Worst Possible

- What is your **AVERAGE** pain over the last month (circle)?

  0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

  None Worst Possible

- What makes your pain **BETTER**? (Examples: medications, rest, stretching, heat, etc)

  _____

  _____

- What makes your pain **WORSE**? (Examples: lifting, standing, walking sleeping,etc)

  _____

  _____

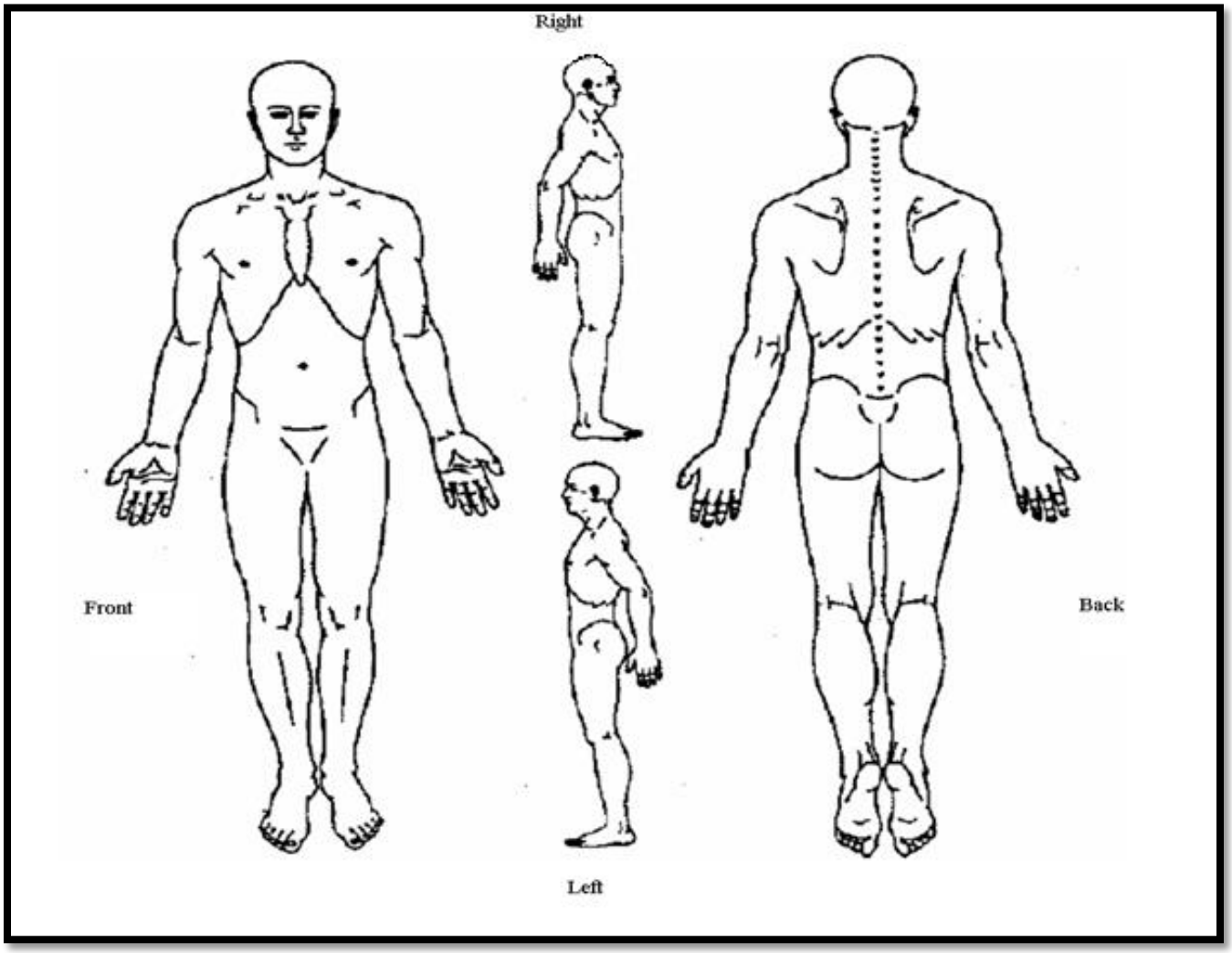
- Has your pain condition required you to go to the emergency department (check)?

  ☐ **Yes /** ☐ **No** If so, how many times in the last 12 months?_____

  When was the last time? _____ Where did you go?_____

- Please mark the **LOCATION** of your pain :

Right Left Left Right



Short-Form McGill Pain Questionnaire

By: Ronald Melzack

(Please mark one item per in regards to your primary pain)

	None	Mild	Moderate	Severe
Throbbing	0)____	1)____	2)____	3)____
Shooting	0)____	1)____	2)____	3)____
Stabbing	0)____	1)____	2)____	3)____
Sharp	0)____	1)____	2)____	3)____
Cramping	0)____	1)____	2)____	3)____
Gnawing	0)____	1)____	2)____	3)____
Hot-Burning	0)____	1)____	2)____	3)____
Aching	0)____	1)____	2)____	3)____
Heavy	0)____	1)____	2)____	3)____
Tender	0)____	1)____	2)____	3)____
Splitting	0)____	1)____	2)____	3)____
Tiring-Exhausting	0)____	1)____	2)____	3)____
Sickening	0)____	1)____	2)____	3)____
Fearful	0)____	1)____	2)____	3)____
Punishing-Cruel	0)____	1)____	2)____	3)____

(Please mark a line on the scale below)

No Pain _____ Worst Possible Pain

PPI – (place a check below for pain intensity today)

0 No pain _____
1 Mild _____
2 Discomforting _____
3 Distressing _____
4 Horrible _____
5 Excruciating _____

PREVIOUS PAIN TREATMENTS

- What doctor's have treated you for your PAIN condition?

Doctor's Name/Location	Specialty	Month	Year	What was done?

- **Check** the different treatments that you have tried in the past, and then **circle** the response and note when you were last treated:

Treatment	Did You Receive Any Relief			Date of Last Treatement
☐ Physical Therapy	NO	YES	PARTIAL	
☐ Massage Therapy	NO	YES	PARTIAL	
☐ Psychology, Counseling, or Pain Education Classes (including biofeedback, cognitive beahvioral therapy (CBT), mindfulness, etc)	NO	YES	PARTIAL	
☐ Injections/Nerve ☐ blocks and other Procedures	NO	YES	PARTIAL	
☐ Surgery	NO	YES	PARTIAL	
☐ Anti-inflammatory medications (NSAIDS), such as Advil, Naproxen, etc.	NO	YES	PARTIAL	
☐ Narcotic pain medications (opioids) such as Vicodin, Codeine, Norco, etc.	NO	YES	PARTIAL	
☐ Muscle relaxants such as Flexeril, Robaxin, etc.				
☐ Other pain medications like Gapapentin, Lyrica, Cymbalta, Amitriptyline, etc.	NO	YES	PARTIAL	
☐ Over the counter medications or natural supplements, etc.	NO	YES	PARTIAL	
☐ Acupuncture or other alternative therapies	NO	YES	PARTIAL	
☐ TENS Unit (electrical stimulation)	NO	YES	PARTIAL	
☐ Chiropracter/manipulation therapy/Osteopathic treatment	NO	YES	PARTIAL	
☐ Other, please explain:	NO	YES	PARTIAL	

MEDICAL HISTORY AND REVIEW OF SYSTEMS

- **Allergies:** Medication Allergies (check): ☐ **Yes /** ☐ **No**
  - **If yes, please list the name and reaction**

Name of Medication	Reaction

- Do you have any **other allergies**? □ Food □ Latex □ Iodine □ Seasonal □ Other _____

- **Current Medications** (Please attach a separate sheet if more space is needed):

NAME	DOSE or STRENGTH	FREQUENCY
Pain Medications		
Routine Medications		

Over The Counter Medications		
Vitamins/Minerals/Herbs		

- **Past Medical History:** Check all that apply

  ☐ **No known medical conditions**

Musculo-skeletal
☐ Arthritis (Osteo)
☐ Osteoporosis
☐ Muscle disease

Neurology
☐ Stroke
☐ Seizures/Epilepsy
☐ Dementia
☐ Parkinson's
☐ Head injury

Psychiatric
☐ Anxiety disorder
☐ Depression
☐ Bipolar disorder
☐ Schizophrenia

Rheumatology
☐ Fibromyalgia
☐ Rheumatoid Arthritis
☐ Lupus

Endocrine
☐ Thyroid disorder
☐ Diabetes

Lungs/Pulmonary
☐ Asthma
☐ Chronic bronchitis
☐ Emphysema/COPD
☐ Sleep apnea

Heart/Cardiac
☐ Anemia
☐ Atrial fibrillation
☐ Bleeding problems
☐ Congestive heart failure
☐ Elevated cholesterol
☐ Heart attack
☐ Heart murmur
☐ High blood pressure
☐ Heart rhythm problems

Circulation
☐ Blood clots or DVTs
☐ Pulmonary embolus
☐ Peripheral vascular disease

Cancer
☐ None
☐ Type: _____

Gastrointestinal
☐ Crohn's disease
☐ Ulcerative colitis
☐ Irritable bowel disease
☐ Liver disease
☐ Hepatitis
☐ Stomach ulcers
☐ Reflux/Heartburn/GERD

Kidneys/Urinary
☐ Chronic urinary infections
☐ Chronic renal failure
☐ Prostate problems
☐ Urinary Incontinence

Other
☐ Hearing problems
☐ Vision problems
☐ Skin conditions
☐ Immunosuppression
☐ HIV/AIDS
☐ Tuberculosis
☐ Other:_____

- **Surgical History:** Check all that apply

☐ **No prior surgeries**

☐ Low Back Surgery (Laminectomy, Fusion, Other): _____

How many times: _____ Approximate dates: _____

☐ Neck (Cervical Spine) Surgery: _____

☐ Cancer Surgery (Type): _____

☐ Cataracts/Eye
☐ Appendectomy
☐ Gall bladder
☐ Pacemaker
☐ Defibrillator
☐ Heart bypass
☐ Heart valve

☐ Chest Surgery
☐ C-section
☐ Carpal Tunnel
☐ Joint (Location) _____
☐ Hand/Foot
☐ Hernia Repair

☐ Tonsillectomy
☐ Thyroid
☐ Hysterectomy
☐ Tubal ligation
☐ Cosmetic
☐ Hemorrhoids
☐ Vascular

☐ Abdominal or Stomach
☐ Bowel or colon
☐ Bariatric or weight loss
☐ Prostate
☐ Brain Surgery

☐ Other:_____

- **Family History:**

Relationship	**Date of Birth**	**Status (living or deceased)**	**Medical Conditions**
Father			
Mother			
Siblings: Brother(s)			
Sister(s)			
Children: Son(s)			
Daughter(s)			

- **Social and Occupational History:** (please check or print responses)
  - ❖ Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Civil Union
  - ❖ Who do you live with?_____
  - ❖ Number of children with ages and gender:_____

    _____
  - ❖ Religious Affiliation (optional):_____

- ❖ Highest level of Education:_____
- ❖ Are you currently working ☐ **YES /** ☐ **NO**
- ❖ Current Occupation:_____ Years at Occupation:_____
- ❖ Source of Income: ☐ Current Job ☐ Permanent Disability ☐ Temporary Disability
  ☐ L/I Benefits ☐ Retirement Benefits ☐ Spouse☐ Other:_____
- ❖ Are you currently involved in any litigation or lawsuit related to an injury or medical malpractice? ☐ **YES /** ☐ **NO**
- ❖ Do you have a lawyer or legal representative? ☐ **YES /** ☐ **NO** __

- Substance Use History:
  - ❖ Tobacco/Cigarettes/Nicotine: ☐ **YES** ☐ **NO** ☐ **QUIT**
    If yes: How many packs per day? _____ When did you start? _____
    If you quit, when was the last time? _____
  - ❖ Alcohol: ☐ **YES** ☐ **NO** ☐ **QUIT**
    If yes, what do you usually drink? _____
    How many drinks per day? _____ When did you start? _____
  - ❖ Have you ever abused alcohol? ☐ **YES** ☐ **NO**
  - ❖ Have you ever used alcohol for pain? ☐ **YES** ☐ **NO**
  - ❖ Do you use Marijuana? ☐ **YES** ☐ **NO** ☐ **QUIT**
  - ❖ Do you use Illegal/Illicit Drugs? ☐ **YES** ☐ **NO** ☐ **QUIT**
    If yes, which substance? _____ When did you start? _____
  - ❖ Have you ever abused Prescription Medications such as oxycodone, Percocet, or others?
    _____ ☐ **YES** ☐ **NO**
  - ❖ Have you ever been discharged from a medical practice for VIOLATION of a pain medication contract or for any OTHER reason? ☐ **YES** ☐ **NO**
    If yes, please explain: _____
  - ❖ Do you exercise (check)?
    ☐ Never ☐ Rarely ☐ Once/week ☐ 2-4 days/week ☐ 5-7 days/week

- **Recent Imaging and Tests, please note approximate:** (Date and Location)

MRI		
CAT/CT Scan		
X-rays		
Bone Scan		
Dexa Scan		
EMG/Nerve Conduction Study		
Ultrasound		
Mammogram		
Colonoscopy		

- **Review of Systems:** (Circle any recent changes to your health)

General	Weight Loss Weight Gain	Fever Fatigue	Loss of appetite Chills	Night Sweats
Skin	Rash	Easy bruising	Skin ulcers	
Eyes	Vision loss	Double vision		
Ears/Nose/Mouth	Hearing loss Ringing	Nose bleeds	Mouth/nose sores Sore throat	Difficulty swallowing
Cardiac/Heart	Chest pain	Irregular heartbeat	Palpitations	
Respiratory	Shortness of breath	Wheezing	Chronic cough	
GI/Stomach	Stomach Pain Ulcers Heartburn	Nausea Vomiting	Constipation Diarrhea Rectal bleeding	Bowel Incontinence
Urinary	Retention	Incontinence	Urgency	
Blood/Lymph	Bleeding disorder	Sickle cell disease	Lymphoma/Leukemia	
Immunological	Recent infections	Frequent/persistent infections	Immuno-compromised	
Neurological	Headaches Dizziness Weakness	Seizures Balance issues Numbness/tingling	Sleep problems	Memory problems
Psychological	Depression Bipolar	Anxiety Increased stress	PTSD	Panic Attacks
Musculoskeletal	Joint pain	Joint Stiffness or swelling	Muscle or joint weakness	Muscle pain or cramps
Other symptoms, please explain				

- **Recent Vaccinations:** (Date and Location)

Flu Vaccine		
Pneumonia Vaccine		

Oswestry Disability Index (Please mark one box per section)

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 additional pain.
- □ I can look after myself normally but it is very painful.
- □ 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 my personal care.
- □ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 -Lifting

- □ I can lift heavy weights without additional pain.
- □ I can lift heavy weights but it gives me additional pain.
- □ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
- □ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- □ I can only lift very light weights.
- □ I cannot lift or carry anything at all.

Section 4 -Walking

- □ Pain does not prevent me from walking any distance.
- □ Pain prevents me from walking more than one mile.
- □Pain prevents me from walking more than a quarter of a mile.
- □ Pain prevents me from walking more than 100 yards.
- □ I can only walk using a cane or crutches.
- □ I am in bed most of the time and have to crawl to the toilet.

Section 5 -Sitting

- □ I can sit in any chair as long as I like.
- □ I can sit in my favorite chair as long as I like.
- □ Pain prevents me from sitting for more than 1 hour.
- □ Pain prevents me from sitting for more than half an hour.
- □ Pain prevents me from sitting for more than 10 minutes.
- □ Pain prevents me from sitting at all.

Section 6 -Standing

- □ I can stand as long as I want without additional pain.
- □ I can stand as long as I want but it gives me additional pain.
- □ Pain prevents me from standing for more than 1 hour.
- □ Pain prevents me from standing for more than half an hour.
- □ Pain prevents me from standing for more than 10 minutes.
- □ Pain prevents me from standing at all.

Section 7 -Sleeping

- □ My sleep is never interrupted by pain.
- □ My sleep is occasionally interrupted 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 additional pain.
- □ My sex life is normal but causes some additional pain.
- □ My sex life is nearly normal but is very painful.
- □ My sex life is severely restricted by pain.
- □ My sex life is nearly non existent because of pain.
- □ Pain prevents me from having any sex life at all.

Section 9 -Social life

- □ My social life is normal and causes me no additional 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, e.g. sport, etc.
- □ Pain has restricted my social life and I do not go out as often.
- □ Pain has restricted my social life to home.
- □ I have no social life because of pain.

Section 10 - Traveling

- □ I can travel anywhere without pain.
- □ I can travel anywhere but it gives me additional pain.
- □ Pain is bad but I am able to manage trips over two hours.
- □ Pain restricts me to trips of less than one hour.
- □ Pain restricts me to short necessary trips of under 30 minutes.
- □ Pain prevents me from traveling except to receive treatment.

PHQ-4

- **Please mark a box in each line:**

Over the past 2 weeks, have you been bother by these problems?

	Not at all 0	Several days 1	More days than not 2	Nearly every day 3
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐
Little interest or pleasure in doing things	☐	☐	☐	☐

ORT

- **Please mark or check the boxes that apply:**

			Clinic Use ONLY	
			Male	**Female**
1. Family History of Substance Abuse				
	Alcohol	[ ]	3	1
	Illegal Drugs	[ ]	3	2
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse				
	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. **Age. Please mark if you are 16-45 years old**		[ ]	1	1
4. History of Pre-Adolescent Sexual Abuse		[ ]	0	3
5. Psychological Conditions.				
	Attention Deficit Disorder, Bipolar Disorder, Obsessive Compulsive Disorder, Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
	TOTAL		____	____

WATER'S EDGE ATTENDANCE AND DISMISSAL POLICY

Effective 7/1/15

PURPOSE:

To establish a standardized process for the dismissal of patients from a provider's practice that enhances access and care provision to all patients as well as maximizes efficiency and overall performance of the clinic.

DEFINITIONS:

No Show – patient does not show for a scheduled appointment, arrives 10 minutes after the scheduled start time, or fails to cancel within 1 business day of the scheduled visit

Cancellation – patient cancels any time prior to 1 business day before their scheduled appointment

Patient Reschedule – patient must reschedule their appointment more than 1 business day in advance of the original

Clinic Reschedule – patient appointment must be rescheduled by Water's Edge

POLICY:

I. Water's Edge managers or their designee will monitor "no shows" and cancelations via monthly reports. The specific patient data will be shared with the patient's provider as necessary and a joint decision will be made regarding dismissal for excessive no shows and/or cancellations as outlined below. Water's Edge strives to provide compassionate and excellent care for all patients, but in the event that a patient is unable to comply, the following policy may be enforced.

II. A patient may be dismissed from a provider's practice due to any of the following:
   i. Persistent or broad failure to adhere to medical advice and treatment
   ii. Seeking controlled substances without clinical justification or providing false or knowingly withholding information regarding controlled substances
   iii. Acting in a threatening, disruptive and/or inappropriate manner toward provider, staff or others either in the office or on the phone
   iv. Excessive no shows (more than 3 in a 12 month period) and cancellations (more than 7 in a 12 month period) will trigger a review.
   v. Failure to attend 2 scheduled "New Patient" appointments will result in immediate dismissal from Waters Edge and notification to the referring provider office
   vi. Any other reason that the provider feels prevents them from maintaining a therapeutic relationship with the patient which includes provider patient trust

PROCEDURE:

I. All no shows, cancellations and reschedules will be recorded in the appointment located in eCW. The clinic staff recording the no show, cancellation or reschedule will record patient's reason, the person giving the information, time and date.

II. Patients with a history of no shows (2 or more in a rolling 12 month period) upon provider approval will receive an attendance warning letter. Following a 3rd no show, the provider will be notified to make the final decision to dismiss the patient. Upon provider approval, a dismissal letter would be sent by the clinic manager on behalf of the clinic.

III. The dismissal letter will contain, at minimum, the following components:
    i. Reason for discharge
    ii. An offer to assist with transfer of medical records
    iii. Upon review by medical personnel, 30 days of continued emergent service may be available

IV. The letter will be mailed to the patient via registered mail, with a return receipt requested. A duplicate will be sent to the patient's primary care provider. A copy of the letter will be scanned into the patients chart, along with the returned receipt. In the event the patient's registered letter is returned to the clinic, this original will also be scanned into the chart.

V. When a patient is dismissed from the practice a Global Alert "DNS WE" will be entered into the patients chart. In addition a DNS alert will be applied in Soarian.

VI. For patients previously dismissed from the clinic who request to re-establish on going care:
    i. Will require a new referral from the patient's primary care physician
    ii. Prior approval from a multidisciplinary panel is required.
    iii. A agreement will be established between the provider and the patient regarding compliance

MESSAGE TO PATIENTS:

You, the patient, are the leader of your healthcare team. Regularly attending all of your appointments at Water's Edge and elsewhere is essential to the success of our multi-disciplinary treatment team. Water's Edge cannot effectively treat you if your attendance is erratic. Pain problems respond best to treatment approaches that require your careful cooperation and attendance. We urge you to take your scheduled appointments very seriously, as we do. If you miss an appointment, it may be several days before we can fit you into the schedule, and you may experience medication withdrawal because we do not refill prescriptions over the telephone.

Please notify our office at least one business day in advance of any appointment you are unable to keep by calling (509) 574-3805. Cancelling your appointment less than one business day in advance will be considered a "no show," and more than 3 no shows in a rolling 12 month period could lead to dismissal from the practice.

Reserved appointments are provided to minimize waiting and ensure continuity of your care. Our policy is strict, but also designed to be flexible in case of emergencies. We are committed to providing you with high quality care and ask that you please let us know how we can help you maintain an active role in your health.

Print Name:_____ **Date:**

_____

Patient Signature: _____

Patient Date of Birth: _____

Notice of Privacy Practices Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose to others unless you direct us to do so or unless the law authorizes or compels us to do so. You see your record or get more information about it by contacting our Privacy Officer at 509-249-5062

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

In addition, do we have your permission to:

Leave a message on your answering machine at home?

☐ **YES** ☐ **NO** ☐ **Do not have an answering machine**

Leave a message at your place of employment:

☐ **YES** ☐ **NO** ☐ **Retired/Not Employed**

Send an appointment reminder post card to your home address?

☐ **YES** ☐ **NO**

Discuss your medical condition with a member(s) of your family?

☐ **YES, please print the name of those members below**

☐ **NO**

☐ **Does Not Apply**

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature Date and Time

_____ _____

Patient name if signed on behalf of the patient Relationship (Parent, Legal Guardian, personal Representative)