Missouri Baptist Medical Center

BJC HealthCare

Thank you for scheduling your appointment with the **Missouri Baptist Medical Center and Washington University Physicians Pain Management Center**, located at:

Missouri Baptist Medical Center
3015 N. Ballas Road
St. Louis, MO 63131

Enclosed is a new patient questionnaire and communication form. Please complete them prior to your first appointment.

This information will help our medical team assess your symptoms and provide a personalized treatment plan to effectively manage your pain.

Your appointment date and time:

Date: _____

Time: _____

Please arrive at: _____

Please note that some insurance companies require a referral (authorization) to a specialist. This must be initiated by your primary care provider. The referral must state the treating physician by name and the facility, Missouri Baptist Medical Center and Washington University Physicians Pain Management Center. The referral is required prior to your appointment.

NEW PATIENT CHECKLIST

Please bring the following with you to your appointment.

- Completed New Patient Questionnaire
- Insurance card(s) & Photo ID
- Medication List (if applicable)

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NEW PATIENT QUESTIONNAIRE AND COMMUNICATION FORM

This form gives permission to the pain management center to communicate your personal health information (PHI) with the person(s) you have designated.

Date: _____

Would you like to sign up for the BJC MyChart Patient Portal? ☐ YES or ☐ NO

If YES, please provide an email address for communication: (please print)

_____

My patient health information may be discussed with the following family members and/or friends:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Messages concerning medication refills, appointments and responses to patient calls can be left at the following phone number(s):

Home: _____Cell: _____Other: _____

Would you like to receive text messages regarding your appointment? ☐ YES or ☐ NO

Please provide an emergency contact name and phone number where we may leave a message:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

Signature: _____

Printed Name: _____Date: _____

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BLOOD THINNER QUESTIONNAIRE

Do you take any of the following medications, frequently referred to as "blood thinners"?

If YES, please circle the medication(s) you are taking.

Aggrenox (dipyridamole)	Eliquis (apixaban)	Cilostazol
Brilinta (ticagrelor)	Coumadin (Warfarin/Jan)	Pradaxa (dabigatran)
Coumadin (Warfarin)	Lovenox	Ticlid
Savaysa/Lixiana (edoxaban)	Lovenox (enoxaparin)	Fragmin (dalteparin)
Effient (prasugrel)	Plavix (clopidogrel)	Xarelto (rivaroxaban)

If you are on a blood thinner not listed above, please provide details below:

_____

Please note that before any procedures or injections can be scheduled, the physician who prescribes the medication(s) must be contacted. Please provide the name and number of your prescribing physician for the above medicines. The nurse will provide instructions regarding your "blood thinners" before a procedure.

Prescribing Physician Name: _____ Phone: _____

IMPORTANT INFORMATION

Do **NOT** stop your blood thinner until you have been given specific instructions. Stopping any medication without your healthcare team's guidance may be harmful to your health. Please sign below to acknowledge your agreement.

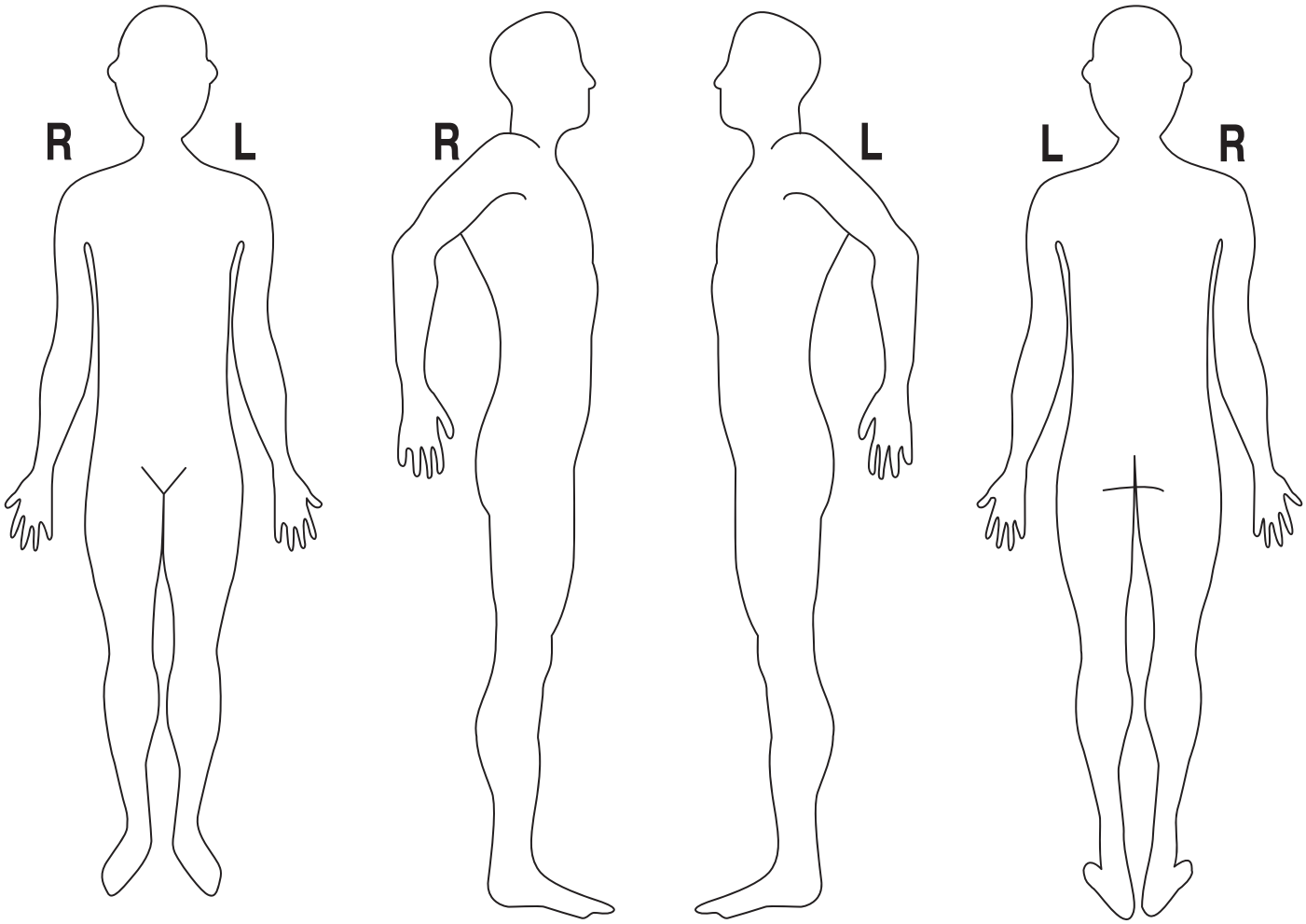
Signature: _____ Date: _____

PAIN LOCATION(S)

Please complete this questionnaire thoroughly to ensure a comprehensive evaluation and effective treatment plan. Take a moment to read each question carefully and respond to the best of your ability. Your information is part of your medical record and will remain confidential.

Where is your pain?
Please mark on the drawings the areas where you feel your pain.

Front **Back**



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DESCRIPTORS

Please choose the word(s) that best describe your pain by checking the corresponding boxes below.

- ☐ Aching
- ☐ Burning
- ☐ Cramping
- ☐ Crushing
- ☐ Discomfort
- ☐ Dull
- ☐ Headache
- ☐ Heaviness
- ☐ Itching
- ☐ Jabbing
- ☐ Nagging
- ☐ Numbness
- ☐ Penetrating
- ☐ Pins and Needles
- ☐ Pounding
- ☐ Pressure
- ☐ Radiating
- ☐ Sharp
- ☐ Shooting
- ☐ Sore
- ☐ Spasm
- ☐ Squeezing
- ☐ Stabbing
- ☐ Tender
- ☐ Throbbing
- ☐ Tightness
- ☐ Tingling
- ☐ Tiring

Other:

ACTIVITIES OF DAILY LIVING (ADL) PAIN CHART

Please answer the following questions to indicate how your pain affects your daily life.

Does not interfere with ADL's		Mildly interferes with ADL's		Somewhat interferes with ADL's		Partially interferes with ADL's		Greatly interferes with ADL's		Completely interferes with ADL's
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No Pain		Mild Pain		Moderate Pain		Severe Pain		Very Severe Pain		Worst Possible Pain
Circle the number to indicate your pain level at the present time.										
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Circle the number to indicate your pain at its worst.										
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Circle the number to indicate where your pain is at its best.										
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Circle the number to indicate your average pain.										
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Which word (s) best describe the patterns of your pain?

☐ **Always present** ☐ **Comes and goes** ☐ **Occasionally** ☐ **Frequently**

Is your pain usually WORSE during a certain time of the day? ☐ **Yes** ☐ **No**

If yes, when? ☐ **Morning** ☐ **Midday** ☐ **Evening** ☐ **Night**

Is your pain usually Better during a certain time of the day? ☐ **Yes** ☐ **No**

If yes, when? ☐ **Morning** ☐ **Midday** ☐ **Evening** ☐ **Night**

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PRIOR TREATMENT FOR PAIN (*Check all that apply*)

Treatment	Helpful	Comments	Facility/Dates performed
☐ Surgery	☐ YES or ☐ NO		
☐ TENS/MENS	☐ YES or ☐ NO		
☐ Physical therapy	☐ YES or ☐ NO		
☐ Occupational Therapy	☐ YES or ☐ NO		
☐ Biofeedback/Relaxation therapy	☐ YES or ☐ NO		
☐ Acupuncture	☐ YES or ☐ NO		
☐ Chiropractor	☐ YES or ☐ NO		
☐ Other Pain Center (s)	☐ YES or ☐ NO		
☐ Professional Psychological Support	☐ YES or ☐ NO		
☐ Other:	☐ YES or ☐ NO		

MEDICATIONS TRIED IN THE PAST *(Check all that apply)*

Medication	Helpful	Medication	Helpful
Gabapentinoids		**Muscle Relaxants**	
☐ Gabapentin (Neurontin)	☐ YES or ☐ NO	☐ Baclofen (Lioresal)	☐ YES or ☐ NO
☐ Pregabalin (Lyrica)	☐ YES or ☐ NO	☐ Buprenorphine(Belbuca, Bultran)	☐ YES or ☐ NO
TCA		☐ Carisoprodol (Soma)	☐ YES or ☐ NO
☐ Amitriptyline (Elavil)	☐ YES or ☐ NO	☐ Cyclobenzaprine (Flexeril)	☐ YES or ☐ NO
☐ Desipramine (Norpramin)	☐ YES or ☐ NO	☐ Diazepam (Valium)	☐ YES or ☐ NO
☐ Imipramine (Tofranil)	☐ YES or ☐ NO	☐ Fentanyl Patch (Duragesic)	☐ YES or ☐ NO
☐ Nortriptyline (Pamelor)	☐ YES or ☐ NO	☐ Hydrocodone/APAP (Norco)	☐ YES or ☐ NO
SNRI		☐ Metaxalone (Skelaxin)	☐ YES or ☐ NO
☐ Duloxetine (Cymbalta)	☐ YES or ☐ NO	☐ Methadone	☐ YES or ☐ NO
☐ Milnacipran (Savella)	☐ YES or ☐ NO	☐ Methocarbamol (Robaxin)	☐ YES or ☐ NO
☐ Venlafaxine (Effexor)	☐ YES or ☐ NO	☐ Oxycodone/APAP (Percocet)	☐ YES or ☐ NO
Others		☐ Tapentadol (Nucynta)	☐ YES or ☐ NO
☐ Acetaminophen (Tylenol)	☐ YES or ☐ NO	☐ Tizanidine (Zanaflex)	☐ YES or ☐ NO
☐ Lidoderm	☐ YES or ☐ NO	☐ Tramadol (Ultram)	☐ YES or ☐ NO
☐ Low dose naltrexone	☐ YES or ☐ NO	☐ Codeine/APAP (Tylenol#3, Tylenol#4)	☐ YES or ☐ NO
☐ Topical patch and cream	☐ YES or ☐ NO	**NSAIDS**	
Anticonvulsants		☐ Diclofenac (Voltaren)	☐ YES or ☐ NO
☐ Carbamazepine (Tegretol)	☐ YES or ☐ NO	☐ Etodolac	☐ YES or ☐ NO
☐ Lamotrigine (Lamictal)	☐ YES or ☐ NO	☐ Ibuprofen (Advil, Motrin)	☐ YES or ☐ NO
☐ Levetiracetam (Keppra)	☐ YES or ☐ NO	☐ Indomethacin (Tivorbex)	☐ YES or ☐ NO
☐ Mexiletine (Mexitil)	☐ YES or ☐ NO	☐ Meloxicam (Mobic)	☐ YES or ☐ NO
☐ Oxcarbazepine (Trileptal)	☐ YES or ☐ NO	☐ Nabumetone (Relafen)	☐ YES or ☐ NO
☐ Topiramate (Topamax)	☐ YES or ☐ NO	☐ Naproxen (Aleve)	☐ YES or ☐ NO
☐ Valproate (Depakote)	☐ YES or ☐ NO	Other:	☐ YES or ☐ NO

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OSWESTRY DISABILITY QUESTIONNAIRE (ODI)

Please check the **ONE** box in each section that **BEST** answers the question.

1. PAIN INTENSITY
- ☐ 0 I can tolerate the pain I have without having to use pain killers
- ☐ 1 The pain is bad but I manage without taking pain killers
- ☐ 2 Pain killers give complete relief from pain
- ☐ 3 Pain killers give moderate relief from pain
- ☐ 4 Pain killers give very little relief from pain
- ☐ 5 Pain killers have no effect on the pain, and I do not use them

2. PERSONAL CARE (e.g., Washing, Dressing)
- ☐ 0 I can look after myself normally without causing extra pain
- ☐ 1 I can look after myself normally, but it causes extra pain
- ☐ 2 It is painful to look after myself and I am slow and careful
- ☐ 3 I need some help but manage most of my personal care
- ☐ 4 I need help every day in most aspects of self-care
- ☐ 5 I don't get dressed, I wash with difficulty and stay in bed

3. LIFTING
- ☐ 0 I can lift heavy weights without extra pain
- ☐ 1 I can lift heavy weights, but it gives extra pain
- ☐ 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e., on a table
- ☐ 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ 4 I can lift very light weights
- ☐ 5 I cannot lift or carry anything at all

4. WALKING
- ☐ 0 Pain does not prevent me walking any distance
- ☐ 1 Pain prevents me walking more than one mile
- ☐ 2 Pain prevents me walking more than ½ mile
- ☐ 3 Pain prevents me walking more than ¼ mile
- ☐ 4 I can only walk using a stick or crutches
- ☐ 5 I am in bed most of the time and must crawl to the toilet

5. SITTING
- ☐ 0 I can sit in any chair as long as I like
- ☐ 1 I can only sit in my favorite chair as long as I like
- ☐ 2 Pain prevents me from sitting more than one hour
- ☐ 3 Pain prevents me from sitting more than ½ hour
- ☐ 4 Pain prevents me from sitting more than 10 minutes
- ☐ 5 Pain prevents me from sitting at all

6. STANDING
- ☐ 0 I can stand as long as I want without extra pain
- ☐ 1 I can stand as long as I want but it gives me extra pain
- ☐ 2 Pain prevents me from standing for more than one hour
- ☐ 3 Pain prevents me from standing for more than 30 minutes
- ☐ 4 Pain prevents me from standing for more than 10 minutes
- ☐ 5 Pain prevents me from standing at all

7. SLEEPING
- ☐ 0 Pain does not prevent me from sleeping well
- ☐ 1 I can sleep well only by using medication
- ☐ 2 Even when I take medication, I have less than 6 hrs sleep
- ☐ 3 Even when I take medication, I have less than 4 hrs sleep
- ☐ 4 Even when I take medication, I have less than 2 hrs sleep
- ☐ 5 Pain prevents me from sleeping at all

8. SOCIAL LIFE
- ☐ 0 My social life is normal and gives me no extra pain
- ☐ 1 My social life is normal but increases the degree of pain
- ☐ 2 Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e., dancing, etc.
- ☐ 3 Pain has restricted my social life and I do not go out as often
- ☐ 4 Pain has restricted my social life to my home
- ☐ 5 I have no social life because of pain

9. TRAVELING
- ☐ 0 I can travel anywhere without extra pain
- ☐ 1 I can travel anywhere but it gives me extra pain
- ☐ 2 Pain is bad, but I manage journeys over 2 hours
- ☐ 3 Pain restricts me to journeys of less than 1 hour
- ☐ 4 Pain restricts me to short necessary journeys under 30 minutes
- ☐ 5 Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/HOMEMAKING
- ☐ 0 My normal homemaking/ job activities do not cause pain
- ☐ 1 My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me
- ☐ 2 I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming)
- ☐ 3 Pain prevents me from doing anything but light duties
- ☐ 4 Pain prevents me from doing even light duties
- ☐ 5 Pain prevents me from performing any job or homemaking chores

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PAIN MANAGEMENT CENTER

The Pain Management Center is a facility-based practice located at Missouri Baptist Medical Center, which means you will be billed separately for medical services.

You will receive a separate bill from the hospital for these services, in addition to your physician charges.

_____ _____

Patient's Signature Date

BJC HealthCare Facility Charges
Please contact the billing department for inquiries about your bill.

BILLING AND FINANCIAL ASSISTANCE
(**314) 362-8400** or toll-free **855-362-8400**
PRICE ESTIMATES
(314) 747-8845

Washington University Provider Charges
Please call the patient service line for inquiries about your bill.
PATIENT BILLING
(314) 273-0500 or toll-free **(800) 862-9980**
PRICE ESTIMATES
(800) 862-9980