COLUMBIA TREATMENT CENTER

Columbia Addictions Center, LLC DBA
Columbia Treatment Center
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Pain Management Support

Today's Date _____

Client Name _____ Date of Birth _____

Street Address _____

City _____ State _____ Zip Code _____

Phone # _____

E-mail _____

Referring Physician _____

Phone # of Your Pain Management Specialist _____

Reason for Today's Visit _____

_____

What are your goals for today's session? _____

Onset of Symptoms

Approximately when did your pain begin? _____

List Medications and prescriptions:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Pain Description

Describe your pain:

When is your pain at its worst?

☐ Mornings ☐ Daytime ☐ Evening
☐ Middle of the night ☐ Always the same

How often does the pain occur?

☐ Constant ☐ Intermittent (comes and goes)
☐ Changed in severity but always present

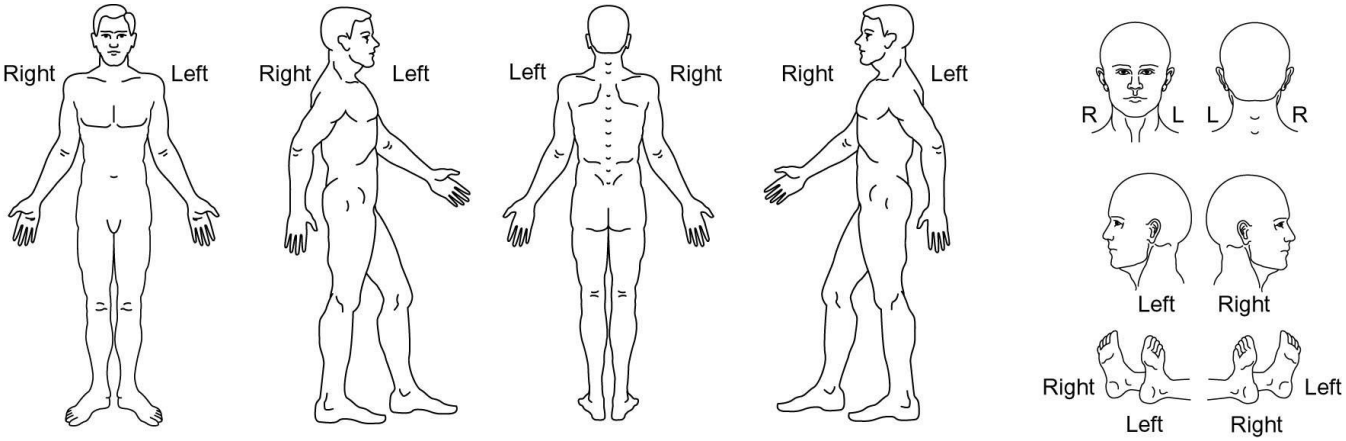
Non- Pharmaceutical Approached to Pain Management

Please mark all of the following treatments you have used for pain relief and how they helped:

	Year Tried	No Change	Worsened Pain	Helped Pain
Physical Therapy	_____	☐	☐	☐
Chiropractic Care	_____	☐	☐	☐
Psychological Therapy	_____	☐	☐	☐
Massage Therapy	_____	☐	☐	☐
Acupuncture	_____	☐	☐	☐
Biofeedback	_____	☐	☐	☐
Massage	_____	☐	☐	☐
Yoga	_____	☐	☐	☐
Mindfulness	_____	☐	☐	☐
Anti-Inflammatory Diet	_____	☐	☐	☐
Supplements	_____	☐	☐	☐
Hypnotherapy	_____	☐	☐	☐
Meditation	_____	☐	☐	☐
Tai-Chi	_____	☐	☐	☐

Initial Pain Assessment Tool

1. LOCATION: Mark drawing



2. INTENSITY: Rate your pain _____

Present pain:____ Worst pain gets: _____ Best pain gets: _____ Acceptable level of pain: _____

3. Is this pain constant? YES_____ NO_____ If not, how often does it occur? _____

4. QUALITY: (For example: ache, dee, sharp, hot, cold, like sensitive skin, sharp, itchy) _____

5. Onset, duration, variations, rhythms: _____

_____

6. Manner of expressing pain: _____

_____

7. What relieves pain? _____

_____

8. What causes or increases the pain? _____

_____

9. Effects of pain: (Note decreased function, decreased quality of life)
Accompanying symptoms (e.g., nausea) _____

Sleep _____

Appetite _____

Physical Activity _____

Relationship with others (e.g., irritability) _____

Emotions (e.g., anger, suicidal, crying) _____

Concentration _____

Evaluation of Common Stressors

Evaluate your stress level in the following circumstances:

	None	Slight	Moderate	Pronounced	Extensive
Family					
Significant Relationships					
Health					
Finances					
Legal Situation					
Work					
School					
Other					

Evaluation of Coping Mechanisms

How often do you engage in, or use and of, the following activities too much, or as a way of escaping:

	Rarely	Sometimes	Frequently
Computer			
Television			
Work			
Video Games			
Drugs			
Alcohol			
Eating food			
Eating chocolate and other sweets			
Eating bread and other carbs			
Shopping			
Gambling			
Tobacco			
Drinking lattes, coffee, caffeine			
Sex			
Sleep			

Michigan Alcoholism Screening Test (MAST)

	YES	NO
1. Do you feel that you are a normal drinker? (You drink less or the same as most other people)	_____	_____
2. Have you ever awakened the morning after drinking and found that you could not remember part of the previous evening?	_____	_____
3. Does a relative ever complain about or worry about your drinking?	_____	_____
4. Can you stop drinking after one or two drinks without a struggle?	_____	_____
5. Do you feel guilty about your drinking?	_____	_____
6. Do friends or relatives think you are a normal drinker?	_____	_____
7. Are you able to stop drinking when you want to?	_____	_____
8. Have you ever attended a meeting of Alcoholic Anonymous (AA)?	_____	_____
9. Have you gotten into physical fights while drinking?	_____	_____
10. Has your drinking ever created problems between you and your spouse, parents, or other relative?	_____	_____
11. Has any family member ever sought help regarding <u>your</u> drinking?	_____	_____
12. Have you ever lost friends because of your drinking?	_____	_____
13. Have you ever gotten into trouble at school or work because of drinking?	_____	_____
14. Have you ever lost a job because of drinking?	_____	_____
15. Have you ever neglected your obligations (such as family or work) for two or more days in a row because of your drinking?	_____	_____
16. Do you drink before noon fairly often?	_____	_____
17. Have you ever been told that you have liver trouble? Cirrhosis?	_____	_____
18. After heavy drinking, have you ever had Delirium Tremors (DTs), severe shaking, or hallucinations?	_____	_____
19. Have you ever gone to anyone for help about your drinking?	_____	_____
20. Have you ever been in a hospital because of your drinking?	_____	_____
21. Have you ever been in a psychiatric hospital as a result of drinking?	_____	_____
22. Have you ever been seen at a psychiatric or mental health clinic, or by a doctor, social worker, or clergyman for help with an emotional issue where drinking was part of the problem?	_____	_____
23. Have you ever been arrested for drunk or impaired driving? If YES, how many times?	_____	_____
24. Have you ever been arrested for any other alcohol related offense? If YES, how many times?	_____	_____

Client Signature: _____ Date: _____

Drug Use Questionnaire / DAST

Thinking of this PAST YEAR, please answer the following questions.
Do not include alcoholic beverages.

1. Have you used drugs other than those required for medical reasons?	YES	NO
2. Have you abused prescription drugs?	YES	NO
3. Do you abuse more than one drug at a time?	YES	NO
4. Can you get through the week without using drugs (other than medical reasons)?	YES	NO
5. Are you always able to stop using drugs when you want to?	YES	NO
6. Have you had "blackouts" or "flashbacks" as a result of drug use?	YES	NO
7. Do you ever feel bad or guilty about your drug abuse?	YES	NO
8. Does your spouse, partner or parents ever complain about your involvement with drugs?	YES	NO
9. Has drug abuse ever created problems between you and your spouse, partner or parents?	YES	NO
10. Have you ever lost friends because of your use of drugs?	YES	NO
11. Have you ever neglected your family or missed work because of your use of drugs?	YES	NO
12. Have you ever been in trouble at work or school because of drug abuse?	YES	NO
13. Have you ever lost a job because of drug abuse?	YES	NO
14. Have you gotten into fights when under the influence of drugs?	YES	NO
15. Have you engaged in illegal activities in order to obtain drugs?	YES	NO
16. Have you ever been arrested for possession of illegal drugs?	YES	NO
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	YES	NO
18. Have you had medical problems or been hospitalized as a result of your drug use (memory loss, hepatitis, convulsions, etc.)?	YES	NO
19. Have you ever gone to anyone for help for a drug problem?	YES	NO
20. Have you ever been in a treatment program specifically related to drug use or been in a hospital for medical	YES	NO

Client Signature: _____ Date: _____

Consent for the Release of Confidential Information

NAME: _____

(Circle One: Spouse, Parent, Attorney, Probation Officer, Counselor, Physician, Other/Please State)

PLEASE ENTER ONLY ONE NAME ABOVE; A <u>SEPARATE FORM</u> MUST BE COMPLETED FOR EACH PERSON TO WHOM YOU ARE ALLOWING INFORMATION TO BE RELEASED

PHONE: _____

FAX: _____

<u>FULL RELEASE</u>

☐ I authorize Columbia Treatment Center to release information to, and to obtain information from, the person or organization I have written above.

-OR-

<u>LIMITED RELEASE</u>

☐ I authorize Columbia Treatment to release ***only*** the following information to the person or organization I have written above:

_____Appointment Dates/Times

_____Account Balance

_____Initial Evaluation

_____Progress, Attendance, Completion and Discharge Reports

_____Urinalysis or Breathalyzer Results

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Print Patient's Name — Date

This authorization will be valid for one year unless I otherwise specify.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.