LOCAL HEALTHCARE

Name		Practice Member Number		Date	

PAIN MANAGEMENT INITIAL CONSULTATION FORM

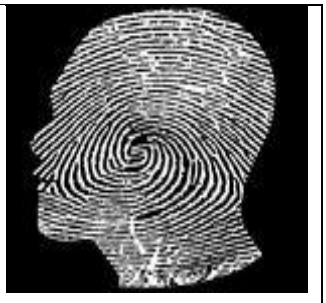
Past Medical History

Please answer the following questions. This will be of great assistance to your Local Healthcare Medical Provider in understanding your pain concerns and designing your individualized pain management treatment plan. Please provide the following information related to your other physicians/medical providers and treatment:

Primary Care Provider		**Referring Provider**	
Name:		Name:	
Address:		Address:	
Phone:		Phone:	

1. Where is the location of your pain?_____
   Please use the diagram below to indicate where your most painful areas are located. Circle or place an X on the painful areas.



2. When did your pain problem begin? Or, if your pain is related to a specific injury, what date did the injury occur? Month:_____ Day:_____ Year:_____

3. How did your pain first start? (Car accident? Fall? Job related injury? Other?)
_____
_____
_____

4. Please circle the level of your pain for the following:
   AVERAGE daily level of pain:
   0 1 2 3 4 5 6 7 8 9 10
   (0=No Pain) (10=Worst pain imaginable)

   Using the same scale, what level of pain is ACCEPTABLE for you?
   0 1 2 3 4 5 6 7 8 9 10
   (0=No Pain) (10=Worst pain imaginable)

5. How often do you have pain? Please circle one.
   Constant **Intermittent/Occasionally**

6. Circle the words below which best describe your pain and related symptoms:
   Dull Sharp Shooting Stabbing Burning Electric Aching
   Numbness Tingling Weakness Coldness Spasms Tightness

7. Are there things that influence your pain? Please check all that apply.

TREATMENT	WORSENS	RELIEVES	NO DIFFERENCE	COMMENTS
Stairs				
Exercise				
Walking				
Massage				
Sitting				
Standing				
Temperature (hot)				
Temperature (cold)				
Weather				
Emotional Stress				
Sexual Activity				
Medicines				
Other				

8. What pain medications have you tried in the past? Were they helpful or not helpful?

MEDICATION	HELPFUL	NOT HELPFUL	COMMENTS

9. What treatments have you had in the past? Please check all that apply to you.

TREATMENT	HELPFUL	NOT HELPFUL	COMMENTS
Surgery			
Nerve blocks			
Steroid injection			
Acupuncture			
Trigger point injection			
TENS unit			
Heat/ice treatment			
Biofeedback			
Hypnosis			
Relaxation training			
Counseling			
Physical therapy			
Other			

10. Please circle any of the following medical conditions you now have or have had in the past:
    Diabetes Arthritis Cancer Ulcer Heart Problems Bleeding Problems
    Kidney Problems Respiratory Problems (COPD/Asthma) Seizures
    Infectious Disease Neurogenic Disease High Blood Pressure
    Other:_____

11. Have you ever been seen by another pain specialist? **Yes No**
    If so, what is the name of the doctor or practice? _____

12. Are you currently working? **Yes No Retired**
    Describe your current or past occupation: _____

13. Are you being treated under Worker's Compensation? **Yes No**

14. Are you currently receiving or applying for disability benefits? **Yes No**

15. Are you involved in any legal action related to your pain problem or considering it in the future?
    Please circle: **Yes No**

16. Circle any of the following tests you have had in the past 24 months:
    X-ray CT Scan MRI EMG

17. Please list all of your prior surgeries and serious medical procedures

DATE/YEAR	SURGERY OR REASON FOR SURGERY

18. Please list all of your medication allergies and your reactions

MEDICATION ALLERGY	REACTION

19. Are you currently being treated for, or have you ever been diagnosed with, any of the following psychiatric problems?

Major Depression		Anxiety Disorder		Bipolar Disorder	
Insomnia		Obsessive-Compulsive Disorder		Panic Disorder	
Anorexia Nervosa		Bulimia		PMS	
Alcohol Dependence		Drug Dependence			

20. Do you have a history of or experience any of the following symptoms or problems? Please circle **Yes** or **No** for each problem.

Yes	**No**	Blurry vision
Yes	**No**	Glaucoma
Yes	**No**	Ringing in your ears
Yes	**No**	Clenching your teeth
Yes	**No**	Tightness in your chest or chest pain
Yes	**No**	Heart disease or irregular heart beats
Yes	**No**	Need to sleep sitting up in order to get your breath
Yes	**No**	Difficulty breathing
Yes	**No**	Emphysema or asthma
Yes	**No**	Abdominal pain
Yes	**No**	Stomach ulcers or gastritis
Yes	**No**	Irregular bowels
Yes	**No**	Irritable bowel disease
Yes	**No**	Blood in your stools
Yes	**No**	Pelvic pain
Yes	**No**	Frequent urination
Yes	**No**	Inability to urinate
Yes	**No**	Seizures
Yes	**No**	Frequent headaches
Yes	**No**	Episodes of blacking out or passing out
Yes	**No**	Unexplained fevers
Yes	**No**	Excessive fatigue
Yes	**No**	Difficulty falling or staying asleep
Yes	**No**	Rashes
Yes	**No**	Rheumatoid arthritis, lupus, sarcoid or scleroderma
Yes	**No**	Diabetes
Yes	**No**	Thyroid problems
Yes	**No**	Depression
Yes	**No**	Anxiety

Exercise History

1. At what period of your life were you most active?

Childhood		Puberty/Teenage Years		Young Adulthood (21-39)	
Mid Adulthood (40-60)		Late Adulthood (>60)		Never active	

2. What is your current exercise/activity level?

None (Sedentary)		Mildly Active	
Moderately Active		Very Active	

3. What barriers to you have regarding participation in physical activity?

Medical	
Social	
Physical	
Family	
Vocational	

4. Describe your current exercise activities

Activity	Minutes/Day	Days/Week

5. Describe your current non-exercise activities (housework, gardening, etc.)

Activity	Minutes/Day	Days/Week

Social History

1. Do you use tobacco products? If so, please state the amount.	Yes		No		

Up to ½ pack/day		½-1 pack/day		> 1 pack/day	

2. Do you use alcohol? If so, please state the amount.	Yes		No		

Rare (< 6 x/year)		Occasional (1-2 x/month)		Weekends only	
Regular (2-3 x/week)		Daily (1-3 drinks/day)		Heavy (>3 drinks/day)	

3. Do you use illegal drugs? If so, please state type & amount.	Yes		No		

Marijuana		Opiates		Benzodiazepines	
Hallucinogens		Amphetamines		Inhalants	

4. Please reflect your family setting by selecting the appropriate box.

Single		Married		Divorced	
Separated		Widowed		Cohabitating	

5. Please reflect your work situation by selecting the appropriate box.

Homemaker		Part-time		Full-time	
Unemployed		Retired		Student	

6. Please reflect your work hours by selecting the appropriate box.

None		<20 hours/week		2-39 hours/week	
40 hours/week		41-60 hours/week		> 60 hours/week	

7. Please reflect your sleep situation by selecting the appropriate box.

7-8 hours/night		9-11 hours/night		12 or more hours/night	
5-6 hours/night		3-4 hours/night		Severe sleep problems	

Family History

1. Please provide a listing of your family members' medical concerns.

FAMILY MEMBER	MEDICAL PROBLEMS
Father	
Mother	
Brother	
Brother	
Sister	
Sister	
Paternal Grandfather	
Paternal Grandmother	
Maternal Grandfather	
Maternal Grandmother	

Medical Systems Review

Have you had problems with any of the following in the prior 6 months? If so, please place in X in the corresponding box underneath. Check the "none" box (□) if nothing in this category applies to you.

(1) Constitutional				□ (none)			
fever	chills	Sweating	fatigue	body-aches	feel bad		
(2) Head, Eyes, Ears, Nose, Throat							
hearing v	ear pain	eye pain	vision v	runny nose	nosebleed	sore throat	mouth ulcer
(3) Neck				□ (none)			
swelling	stiffness	Pain	knots				
(4) Respiratory (Lungs)				□ (none)			
cough	short of breath	Wheezing	chest tightness	coughing up blood	congestion	heavy snoring	slow breathing
(5) Cardiovascular (Heart and Blood Vessels)				□ (none)			
chest pain	heart races	Palpitation	chest pressure	chest tightness	varicose veins	slow heart rate	fast heart rate

(6) Gastrointestinal (Stomach and Intestines)				□ (none)			
nausea	vomiting	belly pain	heartburn	bloody stool	gas	diarrhea	constipation
(7) Genitourinary (Bladder and Kidneys)				□ (none)			
painful urination	frequent urination	blood in urine	incontinence	urinary hesitation	incomplete voiding	^ nightly urination	
(8a.) Female Genital				□ (none)			
blisters	discharge	painful periods	absent periods	irregular periods	itching/rash	spotting	pain
(8b.) Male Genital				□ (none)			
blisters	discharge	testicle lump	testicle swelling	testicle pain	scrotal lump	scrotal swelling	itching/rash
(9) Musculoskeletal (Bones and Joints)				□ (none)			
knee pain	back pain	hip pain	foot pain	legs swell	feet swell	ankles swell	joint aches
(10) Endocrine (Glands and Hormones)				□ (none)			
increased drinking	increased eating	increased urination	dizziness	thinning hair	cold intolerance	heat intolerance	dry skin
depression	full neck		Women >>	infertility	facial hair	low voice	acne
(11) Hematologic/Immunologic (Blood)				□ (none)			
pallor	fatigue	bruising	weakness	itchy skin	itchy eyes, ears, nose	lymph nodes	frequent infections
(12) Neurological (Nervous System)				□ (none)			
headaches	dizziness	foot numbness	leg numbness	hand numbness	tremor		
(13) Psychiatric (Mental)				□ (none)			
sadness	low mood	crying spells	difficulty concentrating	V interest in life	reduced sex drive	sleeping too little	sleeping too much
anxiety	worrying	irritability	panic attacks	Low energy	suicidal?		
(14) Dermatologic (Skin)				□ (none)			
frequent boils	lower leg rash	groin rash		skinfold rashes	rash V breasts	infected leg rash	

I have reviewed this form with the patient_____
(For physician use only) Physician Signature/Date and Time

“HIPAA” Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

_____

Date Initials Reason

_____

Informed Consent for Chronic Opioid Therapy

NP Diane Goedecke is prescribing opioid medicine, sometimes called narcotic analgesics,
to (patient name)_____ for a diagnosis of _____

_____

_____ This decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medication has certain side effects associated with it, including, but not limited to:

- Confusion or other change in thinking abilities
- Nausea &/or Vomiting
- Constipation
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles. Dizziness.
- Sleepiness or drowsiness
- Aggravation or depression
- Breathing too slowly – overdose can stop your breathing and lead to death
- Dry mouth
- Sexual Dysfunction
- Itching &/or Skin Rash
- Physical Dependence. Tolerance. Addiction and the possibility that the medication will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed include:

_____

I will tell my provider about all other medicines and treatments that I am receiving.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for him/her self.

I am aware that certain other medication such as, but not limited to: nalbuphine (Nubain), pentazocine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol), may reverse the action of the medication I am using for pain control. Taking any of these or other medications while I am taking my pain medicine can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medications and to tell any other health care provider that I am taking an opioid as my pain medication and cannot take any medication that may cause this syndrome.

Risks

While physical dependence is to be expected after long-term use of opioids, signs of addiction, abuse, or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the opioids.

- Physical dependence is common to many drugs such as blood pressure medications, anti-seizure medications, and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal response. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone. Withdrawal symptoms: Runny nose, Diarrhea, Sweating, Rapid Heart Rate, Difficulty sleeping for several days, Abdominal cramping, “Goose Bumps”, and Nervousness are a few.

- Addiction is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one’s quality of life. If the patient exhibits such behavior, the drug will be tapered and such a patient is not a candidate for an opioid trial. He/she will be referred to an addiction medicine specialist.

- Tolerance means a state of adaptation in which exposure to the drug induces changes that result in a lessening of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.

Males — I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my provider may check my blood to see if my testosterone level is normal.

Females — If I plan to become pregnant or believe that I have become pregnant while taking pain medication, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medications; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medication and there is always the possibility that the child will have a birth defect if opioids are taken

I _____ have read this document or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy and acknowledge receipt of this document.

Patient's Signature _____ Date _____

Provider's Signature _____ Date _____

Witness Signature _____ Date _____

Patient Name Printed _____

Chronic Pain Management Agreement

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

- I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.
- I understand that this agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this agreement.
- I understand that if I break this agreement, my provider will stop prescribing these pain control medications.
    - In this case, my provider will prescribe detox medication, to avoid withdrawal symptoms. Also, a drug-dependence treatment program maybe recommended.
- I will actively participate in any program designed to improve function (including social, physical, psychological and daily or work activities).
- I agree to participate in psychiatric or psychological assessment if necessary.
- I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve my pain.
- I will not share my medication with **anyone.**
- I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider (including but not limited to - the ER, Urgent Care or Dentist).
- I will provide a safe locked container to protect my medication from loss, theft, or unintentional use by others, including youth. **Lost or stolen prescriptions or medications WILL NOT BE REPLACED.**
- I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my provider to provide a copy of this agreement to my pharmacy, and primary care provider. 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 blood or urine test if requested by my provider to determine my compliance with my program of pain control medications.
- I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program throughout my treatment.
- I agree that I will use my medication as prescribed by my provider, and that use of my medication at a greater rate will result in my being without medication for a period of time.
- It is my responsibility to schedule appointments for the next opioid refill before I leave the clinic or within 3 days of the last clinic visit.

- Refills will not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow".
- Prescriptions for your medication will be done only during your scheduled visit.
- I will bring my opioid medications and adjunctive medications prescribed by your physician in the original containers/bottles at every visit.
- Prescriptions will not be written in advance due to vacations, meetings, or other commitments.
- If an appointment for a prescription refill is missed, another appointment will be made as soon as possible. *Immediate or emergency* appointments will not be granted.
- **No** "walk-in" appointments for opioid refills will be granted.
- I will not use any illegal controlled substances including marijuana, cocaine, etc. Medical marijuana may be used if you have a medical marijuana card on file with this office.
- I will provide my provider with a full list of all medications I am taking, including herbal remedies, and over the counter pharmaceuticals.
- I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.
- I agree that refills of my prescriptions for my pain medications will be made only at the time of an office visit. **I agree to use _____Pharmacy, located at _____, telephone number _____,** for filling prescriptions for all of my pain medication.
- The use of alcohol together with opioid medications is contraindicated.
- I understand this treatment will be stopped if any of the following occurs:
    - **I give away, sell, or misuse the drugs or use other peoples' drugs or illegal substances**
    - **I am noncompliant with any of the terms of this agreement**
    - **I disrespect or harass clinic personnel or anyone involved in your care**
    - **I do not follow up regularly as requested by my provider**
    - **I tamper in any way with drug screening**

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to perform activities of daily living and work.

I have read this agreement, fully understand it, and have had all questions answered satisfactorily and fully. I consent to the use of opioids under the terms outlined in this agreement.

Patient Signature _____ Date _____

Provider Signature _____ Date _____

Witness Signature _____ Date _____

Rules Effective 01/01/2026

1. Please note there will be a price increase for your next appointment, with follow-up visits priced up to $170.

2. If you do not have payment at the time of your office or phone visit, your prescription, if one is written, will not be sent. You are here for an examination, not for a prescription. All visits must be paid at time of appointment

3. One additional try for rewriting a prescription if the pharmacy does not have the quantity for your prescription. The patient must find the replacement pharmacy.

4. Text hours are from 9am until 5pm Monday through Friday. We are NOT open on weekends unless it an extreme emergency. Text is the preferred mode of communication. Please, one phone call and one text are all that is needed.

5. DO NOT call the provider unless instructed to, the office is always the first call.

6. Phone visits are only in a case of extreme emergency, and only can happen once every three months.

7. Early refill cannot be picked up unless prior arrangements are made ahead of time.

8. We need to be notified with any phone change or address change immediately.

9. You are responsible for your next scheduled appointment.

10. All prior authorization must go through the app "Cover My Meds" through your pharmacy. Unless other arrangements have been made beforehand.

11. We need to be made aware of all prescriptions that you receive outside of this office.

12. You are required to have a Primary Care Provider and they must be registered with this office. The provider scheduled for your current appointment is not able to provide primary care services. There will be no increase in medication without proper documentation.

13. $25 for no call, no show for appointments. It is your responsibility for knowing your next appointment.

14. We will give a $50 credit for your next visit to anyone you recommend to this office after the complete their 1st appointment. You are responsible for notifying the office.

Name _____ Signature _____

Local Healthcare

🏥 **Local Healthcare — Now Offering Primary Care!**
We're proud to provide **high-quality primary care at the best price in town.**
Affordable. Reliable. Patient-focused.
✅ Wellness exams & preventive care
✅ Chronic condition management (diabetes, hypertension, thyroid, etc.)
✅ Sick visits & urgent concerns
✅ Lab testing & screenings
✅ Medication management
✅ Specialist referrals when needed
✅ Pain Management if needed
✅ Affordable weight loss programs are available
✅ No insurance hastles!
📍 Conveniently located in Central Tucson
📞 Call us today to schedule your appointment: **520-885-2822**
Local Healthcare — Your Health. Your Care. Nice Price.

Referral Program

Refer any qualified person and receive either $50 cash discount on your next visit after the new patient has their first paid visit. Either fill this form out or text me the information

Name _____ Phone number _____

Name _____ Phone number _____