

## WELCOME & THANK YOU FOR CHOOSING PAIN SPECIALISTS OF CHARLESTON

At Pain Specialists of Charleston, our mission is to alleviate or adequately manage pain through the most up-to-date interventional pain management treatment options available. The Pain Specialists of Charleston staff, led by Edward Tavel MD and Ryan Galica MD, is highly experienced and committed to providing excellent and compassionate care to our patients.

When you choose Pain Specialists, you benefit from:

### **SPECIALIZED EXPERTISE:**

At Pain Specialists of Charleston, P.A., we understand the complexities of pain. From your unique pain diagnosis to determining the most successful non-surgical treatments, we specialize in relieving pain and restoring your quality of life

### **ADVANCED TREATMENTS AND THERAPIES:**

Our practice takes a comprehensive, multidisciplinary approach to pain medicine and offers a full range of pain management procedures and treatments including physical therapy, medical massage therapy, pain psychology, medication management and more. Our practice offers the latest interventional pain procedures as well as access to cutting-edge clinical research

### **SUPERIOR STAFF:**

Trained in some of the most prestigious medical facilities in the United States, our providers are consistently recognized as experts in the field of pain management. Our physicians are Board Certified in Anesthesia and Pain Medicine and offer a combined 35 years of pain medicine experience

### **VALUE-BASED HEALTHCARE:**

As a physician-owned practice, Pain Specialists is proud to offer high quality pain care at an affordable price. Treatment in our AAAHC accredited facility costs four times less than treatment in hospitals or surgical centers. We extend our commitment to value-based healthcare by offering low self-pay pricing and MRIs for as low as \$380

### **ALTERNATIVE THERAPIES:**

Pain Specialists of Charleston offers a full range of treatment solutions including Neurology, Diagnostic Imaging, Massage, Physical Therapy and Clinical Research

- Neurology Specialists (843) 410-0924
- MRI of Charleston (843) 737-8137
- Medical Massage Therapy (843) 818-1181
- Clinical Trials of South Carolina (843) 725-5067

Pain Specialists of Charleston is committed to quality healthcare.

If you are interested in learning more about our practice or treatment solutions, please visit [www.PainChas.com](http://www.PainChas.com)

Again, thank you for choosing Pain Specialists of Charleston and we look forward to treating you.



**Pain Specialists  
of Charleston, P.A.**

*Get back into life*

This form must be completed every **SIX** months or at any time your **PERSONAL** or **INSURANCE** information changes. This requirement meets with Federal Guidelines.

**General Patient Information**

|                    |                     |                      |                  |
|--------------------|---------------------|----------------------|------------------|
| Patient Last Name: | Patient First Name: | Patient Middle Name: | Sex:<br>M      F |
|--------------------|---------------------|----------------------|------------------|

|                                 |  |  |  |
|---------------------------------|--|--|--|
| Address, City, State, Zip Code: |  |  |  |
|---------------------------------|--|--|--|

|                |                 |                    |  |
|----------------|-----------------|--------------------|--|
| Date of Birth: | Marital Status: | Social Security #: |  |
|----------------|-----------------|--------------------|--|

|               |               |                |  |
|---------------|---------------|----------------|--|
| Home Phone #: | Cell Phone #: | Email Address: |  |
|---------------|---------------|----------------|--|

*Would you like to receive quarterly emails with News & Events from our Practice?* Yes No

|                |                                 |                                   |  |
|----------------|---------------------------------|-----------------------------------|--|
| Employer Name: | Name of Primary Care Physician: | Where did you have your last MRI? |  |
|----------------|---------------------------------|-----------------------------------|--|

|               |                              |                        |  |
|---------------|------------------------------|------------------------|--|
| Work Phone #: | Name of Referring Physician: | Date of your last MRI: |  |
|---------------|------------------------------|------------------------|--|

**Insurance Information:**

|                                  |                                    |                                   |  |
|----------------------------------|------------------------------------|-----------------------------------|--|
| Primary Insurance Provider Name: | Secondary Insurance Provider Name: | Tertiary Insurance Provider Name: |  |
|----------------------------------|------------------------------------|-----------------------------------|--|

**Are you filing under someone else's insurance, such as a spouse, parent or family member?**

|               |                            |                        |  |
|---------------|----------------------------|------------------------|--|
| Insured Name: | Insured Social Security #: | Insured Date of Birth: |  |
|---------------|----------------------------|------------------------|--|

**If this is a Workers Compensation case, please include your Adjuster's contact information:**

|                |                   |          |  |
|----------------|-------------------|----------|--|
| Adjuster Name: | Adjuster Phone #: | Claim #: |  |
|----------------|-------------------|----------|--|

**If you have an Attorney, please include your Attorney's contact information:**

|                |                   |  |  |
|----------------|-------------------|--|--|
| Attorney Name: | Attorney Phone #: |  |  |
|----------------|-------------------|--|--|

**Pharmacy Information:**

|                |                   |                   |  |
|----------------|-------------------|-------------------|--|
| Pharmacy Name: | Pharmacy Phone #: | Pharmacy Address: |  |
|----------------|-------------------|-------------------|--|

**Person to Notify In Case of Emergency:**

|       |              |              |  |
|-------|--------------|--------------|--|
| Name: | Telephone #: | Relationship |  |
|-------|--------------|--------------|--|

|                                 |  |  |  |
|---------------------------------|--|--|--|
| Address, City, State, Zip Code: |  |  |  |
|---------------------------------|--|--|--|

|                             |                              |                              |
|-----------------------------|------------------------------|------------------------------|
| <b>Patient Name:</b> _____  |                              |                              |
| <b>Date of Birth:</b> _____ | <b>Patient Height:</b> _____ | <b>Patient Weight:</b> _____ |

**Please List ALL Allergies:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**List All Of Your Medications & Dosages:**

**ARE YOU PRESCRIBED ANY BLOODTHINNERS?**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

- ASPIRIN
- PLAVIX
- COUMADIN (WARFARIN)
- PLETAL
- TRENAL
- AGGRENOLX
- PRADAXA
- XARELTO
- ELIQUIS

Prescribing MD: \_\_\_\_\_

ARE YOU TAKING ANY OVER-THE-COUNTER MEDICINE NOT LISTED ABOVE?

\_\_\_\_\_

**Do You Have a Medical History of:**

- HIGH BLOOD PRESSURE
- HIGH CHOLESTEROL
- HEART DISEASE
- BREATHING PROBLEMS
- STROKE
- DIABETES
- CANCER
- HIV
- HEPATITIS

- SEIZURES
- OSTEOARTHRITIS
- MEMORY LOSS
- GOUT
- SHINGLES
- NEUROPATHY
- HEADACHES
- DEPRESSION
- DRUG / ALCOHOL ABUSE

OTHER HEALTH CONDITIONS  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Social History**

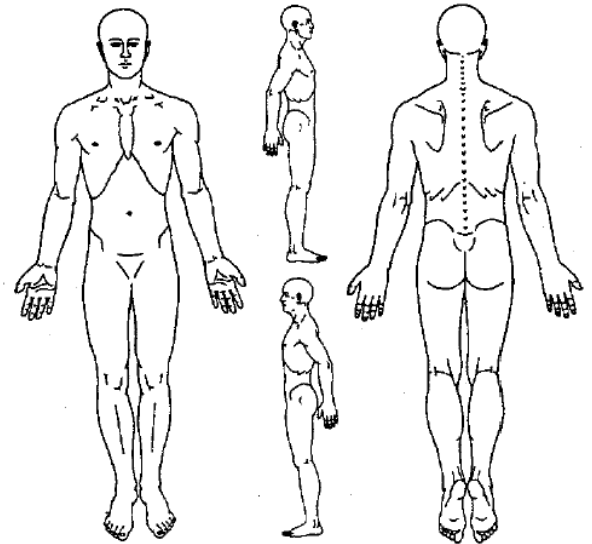
- |                                  |  |  |  |
|----------------------------------|--|--|--|
| <input type="checkbox"/> SMOKING | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> TOBACCO USE           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> ALCOHOL | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> RECREATIONAL DRUG USE | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**What Is the Primary Reason For Your Visit Today?** \_\_\_\_\_

SHADE areas of your body where the pain is most severe



SCORE your pain on your **BEST** and **WORST** day



Check the words that **BEST** describe your pain

- |                                   |                                   |
|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Achey    |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Burning  |
| <input type="checkbox"/> Dull     | <input type="checkbox"/> Numb     |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Tingling |

When did the pain start? \_\_\_\_\_

How did the pain start? \_\_\_\_\_

Was the pain the result of a work injury? \_\_\_\_\_

What makes the pain **BETTER**? \_\_\_\_\_

What makes the pain **WORSE**? \_\_\_\_\_

**Please Check Any/All Treatments You Have Received For Your Pain:**

| <u>TREATMENT</u>                                | <u>When/Comments</u> | <u>Did it help your pain?</u>                            |
|---|----------------------|--|
| <input type="checkbox"/> SURGERY                | _____                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> INJECTIONS             | _____                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> PHYSICAL THERAPY       | _____                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> HOME EXERCISE PROGRAM  | _____                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> MASSAGE THERAPY        | _____                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> TENS UNIT              | _____                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> BACK BRACE             | _____                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> TRACTION               | _____                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> ANTI-INFLAMMATORY MEDS | _____                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> NARCOTIC MEDS          | _____                | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Have You Had Any Diagnostic Testing Completed In The LAST YEAR (12 Months)**

|                                |                 |             |
|--------------------------------|-----------------|-------------|
| <input type="checkbox"/> MRI   | <u>Facility</u> | <u>Date</u> |
|                                | _____           | _____       |
| <input type="checkbox"/> X-RAY | _____           | _____       |

**Please List Your Surgical History**

| <u>Surgery</u> | <u>Facility/Physician</u> | <u>Date</u> |
|----------------|---------------------------|-------------|
| _____          | _____                     | _____       |
| _____          | _____                     | _____       |
| _____          | _____                     | _____       |

**Please List Any Recent Hospitalizations**

| <u>Reason</u> | <u>Facility/Physician</u> | <u>Date</u> |
|---------------|---------------------------|-------------|
| _____         | _____                     | _____       |
| _____         | _____                     | _____       |
| _____         | _____                     | _____       |

**Check Symptoms You Have Had In the Last Three Months:**

**Overall Health**

- FEVER
- LOSS OF APPETITE
- INSOMNIA
- WEAKNESS
- FATIGUE
- RASH

**Musculoskeletal**

- JOINT PAIN
- JOINT SWELLING
- JOINT STIFFNESS
- LEG CRAMPS
- MUSCLE ACHES
- MUSCLE SPASMS

**Neurological**

- NUMBNESS/TINGLING
- DIZZINESS
- POOR BALANCE
- BLURRED VISION
- WEAKNESS IN ARMS
- WEAKNESS IN LEGS

**Cardiovascular**

- CHEST PAIN
- SHORTNESS OF BREATH
- DIZZINESS
- SWELLING IN THE ANKLES
- IRREGULAR HEARTBEATS
- COLD EXTREMITIES

**Gastrointestinal**

- NAUSEA/VOMITING
- DIARRHEA
- CONSTIPATION
- BLACK OR TARRY STOOLS
- DIFFICULTY SWALLOWING
- HEARTBURN

**Respiratory**

- WHEEZING
- DIFFICULTY BREATHING
- COUGH
- USE OF INHALERS

**The Future of Medicine Starts with YOU! Join a Clinical Trial Today**

Clinical Trials of South Carolina is an independent, multi-therapeutic outpatient clinical research site, which conducts Phase II, III and IV clinical trials. Are you interested in learning about and/or participating in Clinical Trials with Clinical Trials of South Carolina? Please check the area of diagnosis in which you apply:

- Back Pain (including Sciatica and/or Herniated Disc)
- Migraines
- Overactive Bladder
- Neuropathy
- GERD/Acid Reflux
- Constipation
- Other Condition You Would be Interested In: \_\_\_\_\_

Or visit [www.ClinicalTrialsSC.com](http://www.ClinicalTrialsSC.com) to enroll or request more study information



**SOAPP® Version 1.0-14Q**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

*The following are questions given to all patients at Pain Specialists of Charleston P.A. who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.*

Please answer the questions below using the following scale:

**0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often**

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. How often do you have mood swings?  | 0 | 1 | 2 | 3 | 4 |
| 2. How often do you smoke a cigarette within an hour after you wake up?  | 0 | 1 | 2 | 3 | 4 |
| 3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? | 0 | 1 | 2 | 3 | 4 |
| 4. How often have any of your close friends had a problem with alcohol or drugs?                                       | 0 | 1 | 2 | 3 | 4 |
| 5. How often have others suggested that you have a drug or alcohol problem?  | 0 | 1 | 2 | 3 | 4 |
| 6. How often have you attended an AA or NA meeting?  | 0 | 1 | 2 | 3 | 4 |
| 7. How often have you taken medication other than the way that it was prescribed?                                      | 0 | 1 | 2 | 3 | 4 |
| 8. How often have you been treated for an alcohol or drug problem?   | 0 | 1 | 2 | 3 | 4 |
| 9. How often have your medications been lost or stolen?  | 0 | 1 | 2 | 3 | 4 |
| 10. How often have others expressed concern over your use of medication?   | 0 | 1 | 2 | 3 | 4 |
| 11. How often have you felt a craving for medication?  | 0 | 1 | 2 | 3 | 4 |
| 12. How often have you been asked to give a urine screen for substance abuse?  | 0 | 1 | 2 | 3 | 4 |
| 13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?              | 0 | 1 | 2 | 3 | 4 |
| 14. How often, in your lifetime, have you had legal problems or been arrested?   | 0 | 1 | 2 | 3 | 4 |

*Please include any additional information you wish about the above answers. Thank you.*

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