Pain Management Consortium of Ohio, Inc.
Bruce Massau, D.O., E.M.B.A.
Amy Kirk, CNP
393 East Town Street, Suite 109
Columbus OH 43215
Phone: (614) 252-1500 FAX: (614) 252-1685

Date: _____

**** Please read all information carefully ****

An appointment has been scheduled by your physician for you to be seen in our office. To provide you the best service and to assist our physician, it is very important for you to arrange to have your medical records forwarded to our office.

You will need to report to 393 East Town St., Suite 109. Parking is available in the "Orange" garage attached to our building. Please enter the garage, take a ticket and bring it into the office with you. Ohio Health provides paid parking for our patients. **Please arrive at least 20 minutes early to register and fill out any other necessary paperwork. Our office requires a (CURRENT) valid State or Federal issued photo ID to be presented at your initial appointment or you will be rescheduled.** Also, to better evaluate and provide the best care, it is our policy to not allow children in the office. **Please make child care arrangements as we cannot be responsible for their needs.**

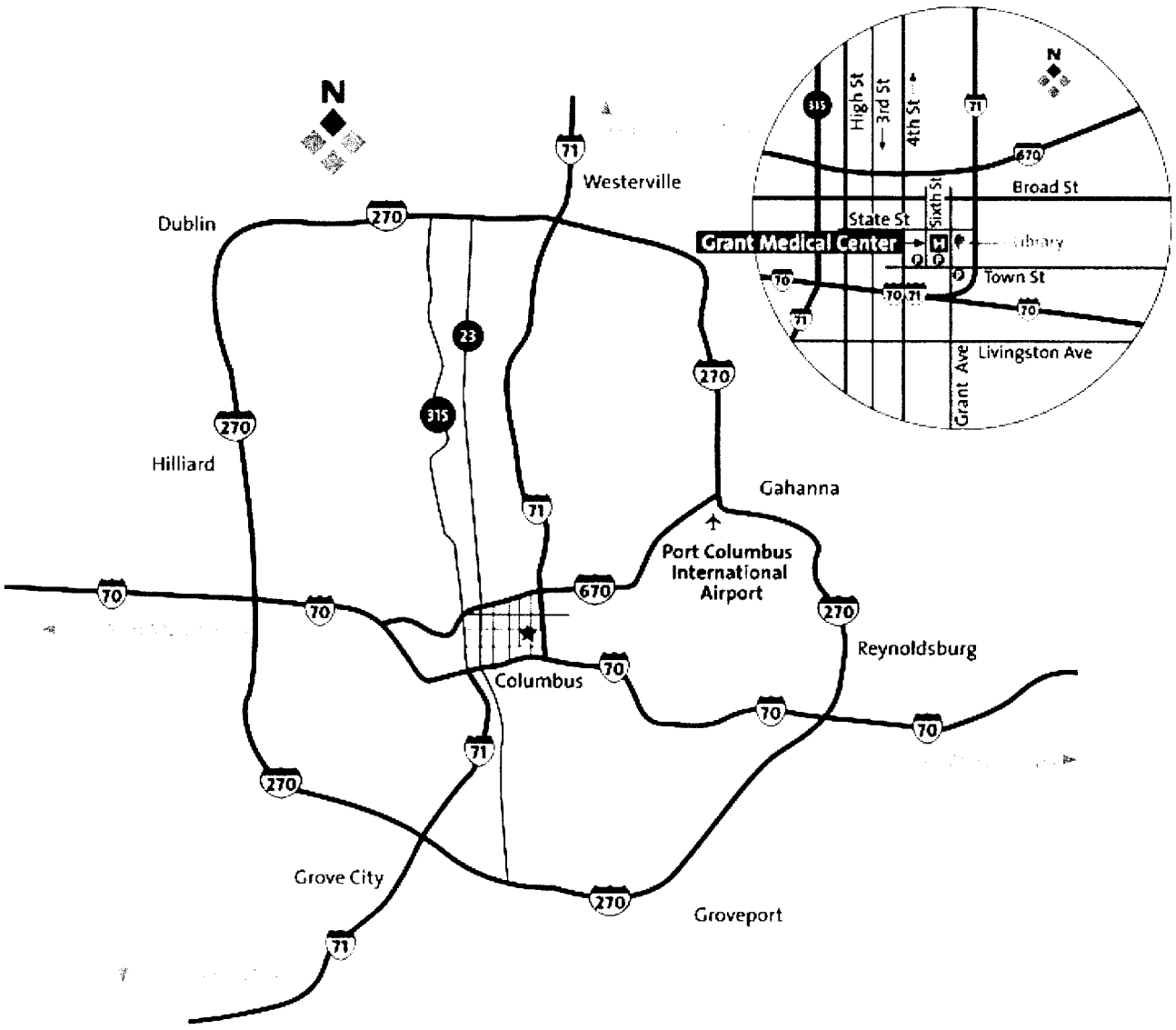
Registration forms and medical history questionnaires are included in this packet and should be filled out completely prior to the appointment and brought with you on the day of the appointment. **Also, please prepare a list of all medications** (prescription, over the counter, and vitamins) to bring with you for the doctor to review. **Per our office policy medications will not be prescribed for the first 3-4 visits in order to give us time to evaluate your prior history along with ordering any new testing that may be needed. Your referring physician should be aware of our policy and they should maintain your current medications until such time as Dr. Massau or Amy Kirk takes them over.**

Due to insurance restrictions, **it is necessary for you to get proper prior authorization from your insurance company and primary care physician** for any office visits and continuing care.

Your appointment is scheduled for: _____

Thank you for your cooperation in helping us to provide you with the best possible services and meeting your needs. Please contact our office at least 24 hours in advance if you are unable to keep your scheduled appointment so that other arrangements can be made.

Sincerely,
Bruce Massau, D.O.
Amy Kirk, CNP



Driving directions to Pain Management Consortium of Ohio / Dr. Bruce A. Massau/Amy Kirk office: Located at 393 East Town Street, Suite 109.

From the North

Take I-71 south to Main Street. Turn left on Main Street and continue west to Grant Avenue. Turn right on Grant Avenue and continue north to Town Street. Turn right on Town Street. Our building will be on your right and you will turn right into the ORANGE garage. Take elevator to the 1st floor.

From the South

Take I-71 North to I-70 East to Fourth Street. Turn left on Fourth Street and continue north to Town Street. Turn right on Town Street, drive through the intersection of Town and Grant. Our building will be on your right and you will turn right into the ORANGE garage. Take elevator to the 1st floor.

From the East

Take I-70 West to Fourth Street. Turn right on Fourth Street and continue north to Town Street. Turn right on Town Street and continue east, drive through the intersection of Town and Grant. Our building will be on your right and you will turn right into the ORANGE garage. Take elevator to the 1st floor.

From the West

Take I-70 East to Fourth Street. Turn left on Fourth Street and continue north to Town Street. Turn right on Town Street and continue east, drive through the intersection of Town and Grant. Our building will be on your right and you will turn right into the ORANGE garage. Take elevator to the 1st floor.

Parking

Ohio Health will be covering your parking fee when you visit our office for an appointment. You will be parking in the ORANGE garage. Please take a ticket and bring it in with you.

Pain Management Consortium of Ohio, Inc. Office Policies

- The office hours are as follows: **Monday, Tuesday, Wednesday and Thursday 8:00am to 4:00pm and Friday 8:00am to 2:30pm.** If you are experiencing a medical emergency, please go directly to the emergency room.
- You will be responsible for a **No-Call/No-Show fee of $35** for any missed appointments. If you have two (2) missed appointments, whether they are no-shows or rescheduled, you will be discharged from the office.
- You must be seen in the office for all routine medication refills. There will be no medications called in or prescriptions picked up/mailed out unless otherwise specified by the doctor.
- If you have questions or concerns regarding medications and/or problems you are experiencing, please call the office and request to speak with Linda. Leave a detailed message including your name, number and the nature of the call and Linda will return your call within **48 hours.**
- Payment is expected at the time of service. As a courtesy, we will bill your insurance company for you. If applicable, co-pays are required for each date of service. Our office accepts cash, checks, Visa, MasterCard, or money orders. There will be a $35 charge for any returned checks.
- If your insurance company requires referral authorizations for office visits, it will be necessary for you to get the authorization prior to your appointment date. **If you are under a workers' comp claim; a C-9 approval from your physician of record is required prior to your visit.** If you do not receive the proper authorizations you may be rescheduled and/or responsible for services not covered by your insurance.
- Our office follows the Ohio revised code for charges associated with the copying of medical records. The full charge for copies is dependent on the amount of records contained in the patient's chart and will be billed to the person requesting those records. All release of medical information requires a proper signed consent.
- Any medical reports that need to be completed and/or signed by the physician can be dropped off at the front desk or mailed in. **There is a $35 charge for the completion of medical reports which is due prior** to having them processed. Please allow 5-10 business days for completion. Unfortunately, we do not complete Physical/Functional Capacities forms.
- If you have a power-of-attorney (any type) and/or living will, please present this paperwork when registering at the front desk.
- Family members, guardians, and/or care-givers are welcome to accompany you during your office visit. To allow the physician to give you the best care possible, **any children will be asked to sit in the reception area during the examination.** We also ask that all cell phones be turned off, as they interfere with the medical equipment and are a disruption of your care.

These policies have been established in order to provide better service to all of our patients. We thank you and appreciate your cooperation.

Dr. Bruce A. Massau
Amy Kirk, CNP

Pain Management Consortium of Ohio, Inc.

Patient Registration Form

Please print clearly

Patient: _____

Last name **First Name** **MI**

_____

Address **City** **State** **Zip**

_____

Home Phone **Cell Phone** **E-Mail**

_____

Social Security Number **Date of Birth**

_____

Employer **Address** **City, State, Zip** **Phone**

Marital Status: Single Married Divorced Separated Widowed Partner Sex: Male Female

Referring Physician: _____

Office Phone

_____

Address City State Zip

To protect the confidentiality of your health and medical treatment, HIPPA regulations require that you specify a contact person other than yourself with whom we are permitted to leave messages with or speak to concerning your appointments, treatments, and other matters of your health. Use the reverse side for additional contacts.

Emergency Contact: _____

_____

Relationship to patient Phone

Primary Insurance: _____

_____

Policy Number Group Number

_____

Policy holder Relationship to patient

_____

Social Security Number Date of Birth of Policy Holder

Secondary Insurance: _____

_____

Policy Number Group Number

_____

Policy holder Relationship to patient

_____

Social Security Number Date of Birth of Policy Holder

********** **Complete for work related injuries** **********

Who was your employer when injured? _____

_____

BWC Claim Number Date of Injury Last Date Worked

_____

Physician of Record (POR) Allowed Conditions (ICD9 codes)

_____

MCO Name Attorney Name Phone

****

I authorize Bruce A. Massau, D.O. /Amy Kirk, CNP to provide any medical care deemed necessary according to his professional opinion. Assignment of insurance benefits: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Bruce A. Massau, DO./Amy Kirk, CNP. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

_____

Signature **Date**

Medication List

Patient Name _____

Date_____

Please include any prescription, over the counter, herbal, and vitamin medications.

	Name of Medication	**Dosage**	**Directions** *(ex. one at bedtime)*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Pain Management Consortium of Ohio, Inc. 393 East Town Street #109
Columbus, OH 43215
Phone: (614) 252-1500 Fax: (614) 252-1685

Pain Management Consortium of Ohio, Inc.
BRUCE A. MASSAU, D.O.
AMY KIRK, CNP

Patient Name: _____

Appointment Date: _____

QUESTIONS FOR THE DOCTOR AT TODAY'S VISIT: _____

_____

_____

_____

_____

_____

_____

_____

GENERAL		
Fever	☐YES	☐NO
Chills	☐YES	☐NO
Tired/fatigue	☐YES	☐NO
Night Sweats	☐YES	☐NO
Severe suffering	☐YES	☐NO

EAR/NOSE THROAT		
Hearing Loss	☐YES	☐NO
Change in smell	☐YES	☐NO
Change in taste	☐YES	☐NO
Sinus congestion	☐YES	☐NO
Hoarseness	☐YES	☐NO
Sore throat	☐YES	☐NO
Postnasal drip	☐YES	☐NO
Ringing in the ear/tinnitus	☐YES	☐NO
Sensitive to noise	☐YES	☐NO
Nose Bleed/Epistaxis	☐YES	☐NO
Sleep Apnea	☐YES	☐NO
Smoker/Chew	☐YES	☐NO

DENTAL		
Bleeding gums	☐YES	☐NO
Sore gums	☐YES	☐NO
Mouth Ulcers	☐YES	☐NO
Multiple cavities	☐YES	☐NO
Dentures	☐YES	☐NO
No teeth	☐YES	☐NO
Healthy teeth and gums	☐YES	☐NO

RESPIRATORY		
Painful breathing	☐YES	☐NO
Wheezing	☐YES	☐NO
Cough	☐YES	☐NO
Shortness of breath	☐YES	☐NO
Mucus producing cough	☐YES	☐NO

OPHTHALMOLOGICAL		
Cataracts (Surgery?)	☐YES	☐NO
Patient is blind	☐YES	☐NO
Partial blindness	☐YES	☐NO
Eyeglasses/Contact lenses	☐YES	☐NO
Blurred vision	☐YES	☐NO
Sensitive to light	☐YES	☐NO
Drooping eyelid	☐YES	☐NO

CARDIOVASCULAR		
Chest pain	☐YES	☐NO
Fast/irregular heartbeat	☐YES	☐NO
Swelling in legs	☐YES	☐NO
Cramping in legs	☐YES	☐NO
Clogged arteries heart (CAD)	☐YES	☐NO
Mitral Valve Prolapse (MVP)	☐YES	☐NO
High blood pressure	☐YES	☐NO
Blocked Leg Vessels (PVD)	☐YES	☐NO
Recent heart attack/MI	☐YES	☐NO
Excessive sweating	☐YES	☐NO

PLEASE TURN PAGE OVER →

Clinician initials_____

GASTROINTESTINAL

Heartburn	☐YES	☐NO
Nausea/vomiting	☐YES	☐NO
Diarrhea	☐YES	☐NO
Constipation	☐YES	☐NO
Hemorrhoids	☐YES	☐NO
Change in stool	☐YES	☐NO
GERD	☐YES	☐NO
Acid Reflux	☐YES	☐NO
Loss of stool/leakage	☐YES	☐NO
Appetite change	☐YES	☐NO

ENDOCRINE/METABOLIC

Thyroid problems	☐YES	☐NO
Diabetes Mellitus	☐YES	☐NO
Diabetes Mellitus Type I	☐YES	☐NO
Diabetes Mellitus Type II	☐YES	☐NO
Lupus	☐YES	☐NO
Heat intolerance	☐YES	☐NO
Cold intolerance	☐YES	☐NO
Hair changes	☐YES	☐NO
Weight loss	☐YES	☐NO
Weight gain	☐YES	☐NO
Excessive thirst	☐YES	☐NO

HEMATOLOGIC

Bruise easily	☐YES	☐NO
Abnormal clotting	☐YES	☐NO
Sickle cell trait	☐YES	☐NO
Sickle cell disease	☐YES	☐NO

MUSCULOSKELETAL

Joint stiffness	☐YES	☐NO
Swelling	☐YES	☐NO
Joint pain	☐YES	☐NO
Bone pain	☐YES	☐NO
Restriction of joint motion	☐YES	☐NO
Muscle cramp	☐YES	☐NO
Morning stiffness	☐YES	☐NO
Side pain	☐YES	☐NO

PSYCHIATRIC

Depression	☐YES	☐NO
Mood change	☐YES	☐NO
Mood swings	☐YES	☐NO
Nervousness	☐YES	☐NO
Suicidal thoughts	☐YES	☐NO
Homicidal thoughts	☐YES	☐NO
Irritability	☐YES	☐NO
Poor Concentration	☐YES	☐NO
Schizophrenic	☐YES	☐NO
Bipolar	☐YES	☐NO
Difficulty sleeping	☐YES	☐NO

GENITOURINARY

Sexual/erectile dysfunction (MEN)	☐YES	☐NO
Painful urination	☐YES	☐NO
Urinary frequency	☐YES	☐NO
Urinary leakage	☐YES	☐NO
Problem starting urine stream	☐YES	☐NO
Feeling urgent need to urinate	☐YES	☐NO
Blood in urine	☐YES	☐NO

SKIN/INTEGUMENTARY

Skin redness	☐YES	☐NO
Excessive sweating	☐YES	☐NO
Abnormal nails (fingers/toes)	☐YES	☐NO
Abnormal hair growth	☐YES	☐NO
Skin temperature change	☐YES	☐NO
Skin Rash	☐YES	☐NO
Skin sores (New/Old)	☐YES	☐NO

NEUROLOGICAL

Headache	☐YES	☐NO
Migraine headache	☐YES	☐NO
Dizziness	☐YES	☐NO
Feeling off balance (lack of balance)	☐YES	☐NO
Fainting	☐YES	☐NO
Change in taste	☐YES	☐NO
Weakness	☐YES	☐NO
Paralysis	☐YES	☐NO
Tremor/Shaking	☐YES	☐NO
Sensation change	☐YES	☐NO
Sensation loss	☐YES	☐NO
Memory loss	☐YES	☐NO

NAME: _____

DATE: _____

Clinician initials_____

History of Complaint

Please provide complete information for ***ALL*** questions

Name_____ Date_____

How long have you been in pain?

_____Days _____Weeks _____Months _____Years

Have you been hospitalized with this pain? (please circle) *Yes* *No* **If yes**, date____/____/____

Have you ever had back, neck or knee surgery? (please circle) *Yes* *No* **If yes,** date____/____/____

Have you seen other health practitioners for this pain? (please circle) *Yes* *No*

If yes, please give names and the type of doctor:

_____

_____

What diagnostic tests have you had for this pain? (with dates)

- O MRI ____/____/____
- O CT Scan ____/____/____
- O X-Ray ____/____/____
- O EMG/SEPP ____/____/____
- O Myelogram ____/____/____
- O Other _____ ____/____/____

Are you working now? (please circle) *Yes* *No* **If No**, since when? ____/____/____

Cause and Onset of Pain

How did your problem begin? (Use the lines to explain in further detail)

- O Accident (What type?) _____
  _____
- O Fall _____
- O Hit in back _____
- O Sports related _____
- O No apparent cause _____
- O Stress/worries _____
- O Pulling _____
- O Lifting _____
- O Bending _____
- O Twisting _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE **Clinician Initials_____**

Date: _____/_____/_____

Patient Name: _____ **SS#**_____ **DOB**_____

Initial Visit Medical History Form (pg. 1). Please provide the following information to the best of you ability.

Age: _____

List any allergies to medications:

_____

_____

_____

What problems are you here for today?

_____

_____

_____

PAST MEDICAL HISTORY:

1). Please check the "Yes" or "No" box to indicate if you have any of the following illnesses, for "Yes" answers, please explain.

Diabetes	☐ Yes	☐ No	Stomach/intestinal problems	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No	Allergies	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No	Kidney problems	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Neurological problems	☐ Yes	☐ No
Respiratory problems	☐ Yes	☐ No	Other medical diagnosis	☐ Yes	☐ No
Bleeding disorder	☐ Yes	☐ No			

_____

_____

2. Please list any operations (&date) you ever had (including tonsils adenoids):

_____

_____

SOCIAL HISTORY:

Do you smoke? ☐Yes ☐No If "yes" how much? _____

If "no" did you previously smoke? How long ago and when?_____

Do you drink? ☐Yes ☐No If "yes" how often? _____

What is your occupation? _____

FAMILY HISTORY:

Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses.
If yes, please indicate while relative(s) have or had the problem(s).

Heart problems/murmurs	☐Yes	☐No	_____
Allergies	☐Yes	☐No	_____
Diabetes	☐Yes	☐No	_____
Cancer	☐Yes	☐No	_____
Bleeding disorder	☐Yes	☐No	_____
Anesthesia problems	☐Yes	☐No	_____

Reviewed By: _____

Patient Comfort Assessment Guide

Name_____ Date_____

Where is your pain? _____

Circle the words that describe your pain…

aching	sharp	penetrating
throbbing	tender	nagging
shooting	burning	numb
stabbing	exhausting	miserable
gnawing	tiring	unbearable

Circle what time of day your pain is the worst?

morning afternoon evening nighttime

Rate your pain by choosing the number on a scale of 0-10

No pain 0----------10 pain as bad as you can imagine

Describe your pain, at its worst, in the last month _____

Describe your pain, at its least, in the last month _____

Describe your pain, on average, in last month _____

Describe your pain right now _____

What makes your pain ***better***? _____

What makes your pain ***worse***? _____

What treatments or medicines are you receiving for your pain? (Please include natural/herbal treatments)

_____ _____

_____ _____

_____ _____

_____ _____

Indicate the number that describes how, during the past week, pain has interfered with your…

Does not interfere 0----------10 completely interferes

General activity _____ Mood _____

Normal work _____ Sleep _____

Enjoyment of life _____ Ability to concentrate _____

Relations with other people _____

Clinician Initials_____

Patient Name _____ ***Date*** _____

Was there any time in the last month when you experienced any of the following?

____Loss of appetite or weight loss
____Increased appetite or weight gain
____Unable to get to sleep
____Unable to sleep through the night
____Sleeping too much
____Loss of energy, fatigue
____Loss of interest or pleasure in sex
____Loss of enjoyment in usual activities
____Extreme guilt
____Feeling worthless
____Trouble thinking or concentrating
____Thoughts of suicide

During the past year…

How many times were you hospitalized? _____
For what? _____

How many times did you go to the emergency room for pain relief? _____

How many visits have you made to a doctor's office or clinic for pain relief? _____

Please list the names of any medications you have tried <u>in the past</u> that have been unsuccessful…

_____

_____

_____

Are you allergic to any medications? If so, which ones?

_____

_____

_____

Please list your current Pharmacy

Pharmacy name _____

Phone number _____

Clinician Initials _____

The Drug Abuse Screening Test (DAST)

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

	YES	NO
1. Have you used drugs other than those required for medical reasons?	___	___
2. Have you abused prescription drugs?	___	___
3. Do you abuse more than one drug at a time?	___	___
4. Can you get through the week without using drugs (other than those required for medical reasons)?	___	___
5. Are you always able to stop using drugs when you want to?	___	___
6. Do you abuse drugs on a continuous basis?	___	___
7. Do you try to limit your drug use to certain situations?	___	___
8. Have you had "blackouts" or "flashbacks" as a result of drug use?	___	___
9. Do you ever feel bad about your drug abuse?	___	___
10. Does your spouse (or parents) ever complain about your involvement with drugs?	___	___
11. Do your friends or relatives know or suspect you abuse drugs?	___	___
12. Has drug abuse ever created problems between you and your spouse?	___	___
13. Has any family member ever sought help for problems related to your drug use?	___	___
14. Have you ever lost friends because of your use of drugs?	___	___
15. Have you ever neglected your family or missed work because of your use of drugs?	___	___
16. Have you ever been in trouble at work because of drug abuse?	___	___
17. Have you ever lost a job because of drug abuse?	___	___
18. Have you gotten into fights when under the influence of drugs?	___	___
19. Have you ever been arrested because of unusual behavior while under the influence of drugs?	___	___
20. Have you ever been arrested for driving while under the influence of drugs?	___	___
21. Have you engaged in illegal activities in order to obtain drug?	___	___
22. Have you ever been arrested for possession of illegal drugs?	___	___
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	___	___
24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	___	___
25. Have you ever gone to anyone for help for a drug problem?	___	___
26. Have you ever been in a hospital for medical problems related to your drug use?	___	___
27. Have you ever been involved in a treatment program specifically related to drug use?	___	___
28. Have you been treated as an outpatient for problems related to drug abuse?	___	___

PATIENT NAME _____ **DATE** _____