



**Bay Area Orthopedic Surgery and Sports Medicine**  
**Bay Area Pain Treatment Center**

100 Hospital Drive  
Suite 303  
Vallejo, CA 94589  
Ph 707-645-7210 Fax 707-645-7249

**Page: 1 of 6**

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

DOB: \_\_\_\_\_

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

Dear Patient,

You are scheduled to see Dr. Natalia Balytsky our pain management physician. Your appointment is scheduled for \_\_\_\_/\_\_\_\_ at \_\_\_\_am/pm.

Please follow these instructions carefully:

- It is imperative you complete the enclosed documents prior to your appointment.
- To enable a more pleasant and efficient experience we ask that you pre-register. This can be done easily by mailing, faxing or emailing the enclosed documents after completion prior to your appointment date.
- We also request that you make available the facilities where your diagnostic studies were conducted, it may be required that you retain those records or x-rays.
- Bring ALL medications you are taking in their bottles. This includes prescription and non-prescription medications. This is a requirement for **all your appointments** with Dr. Balytsky. **Your appointment may be rescheduled if these are not furnished at your appointment.**

These forms will be reviewed by Dr. Balytsky at that time. In addition to the questionnaire enclosed are educational materials regarding pain management treatment. Please read this information carefully as Dr. Balytsky may discuss some of these as options to your pain management treatment in the future.

Bay Area Pain Treatment Center, Dr. Natalia Balytsky, evaluates patients with chronic, painful conditions. After the appropriate evaluation, Dr. Balytsky may recommend diagnostic or therapeutic treatment. If you are scheduled for an injection or an operative procedure, the purpose will be either to facilitate rehabilitation or aid in the diagnosis of specific pain generators. Dr. Balytsky may inject steroid medications to decrease inflammation and facilitate rehabilitation. Diagnostic injections are used to identify the pain generators that limit function due to pain. Once specific pain generators are identified, Dr. Balytsky may be able to design a treatment program that will help you regain function. The Doctor's intent is to help you improve your quality of life by first diagnosing the source of the pain and then improving your function using various modalities of treatment.

Please ask Dr. Balytsky for a detailed explanation regarding any specific recommendations for treatment. Each procedure has potential risk and complications, which should be clearly understood.

Thank you,  
Medical Staff  
Bay Area Pain Treatment Center



**CONTROLLED SUBSTANCE PAIN MANAGEMENT PRESCRIPTION AGREEMENT**

I understand that I have a right to comprehensive pain management. Due to the nature of prescriptions, I would like to enter a treatment agreement to prevent chemical dependency as a statements might result in Dr. Balytsky not provide ongoing care for me.

**PATIENT RESPONSIBILITIES**

\_\_\_\_\_  
INITIAL I am responsible for my medication. If the prescription or medication is lost, stolen, or misplaced, **I UNDERSTAND THAT THE MEDICATION WILL BE REPLACED ONE TIME ONLY, IF A COPY OF THE POLICE REPORT OF THE THEFT IS SUBMITTED TO THE PHYSICIAN'S OFFICE .**

\_\_\_\_\_  
INITIAL Pain medication can cause drowsiness, especially when taken with other sedating drugs. I will not drink alcohol while taking the prescribed pain medication. I will use caution when taking other sedating drugs, including over the counter non-prescription medication (such as anti-histamines).

\_\_\_\_\_  
INITIAL I will take all medication as prescribed. If my pain is relieved or lessened, I will gradually taper down the amount of medication I am taking. If I use all of the medication sooner than the duration prescribed, **I UNDERSTAND THAT THE MEDICATION WILL NOT BE REFILLED SOONER.**

\_\_\_\_\_  
INITIAL I understand that refill request must be received by noon the day prior to designated refill days. I understand that I do not run out of medications on weekends and holidays, because abrupt discontinuation of these medications **will** cause severe withdrawal syndrome. **There will be no exceptions.**

\_\_\_\_\_  
INITIAL I will contact my pharmacy 48 hours prior to the date my medication runs out. My pharmacy will FAX the request to the office for approval. I understand that my medication will not be approved if I request a refill before the 48 hours refill date.

\_\_\_\_\_  
INITIAL Only **one health care provider** (MD, PA, or NP) will prescribe all narcotic type medication at any given time. I understand that if I receive narcotic medication from multiple providers that is grounds for **IMMEDIATE TERMINATION FROM CARE.**

\_\_\_\_\_  
INITIAL I will receive all controlled substance medication (narcotics) from **one pharmacy. I AGREE TO NOT EXCEED THE AMOUNT OF MEDICATION PRESCRIBED. I AGREE TO REFRAIN FROM ALL MIND/MOOD ALTERING/ILLCIT/ADDICTING drugs including ALCOHOL unless authorized by provider.**

\_\_\_\_\_  
INITIAL I consent to **urine/blood/hair drug screens** as ordered by provider.  
I have read and fully understand the above policy on medication refills.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

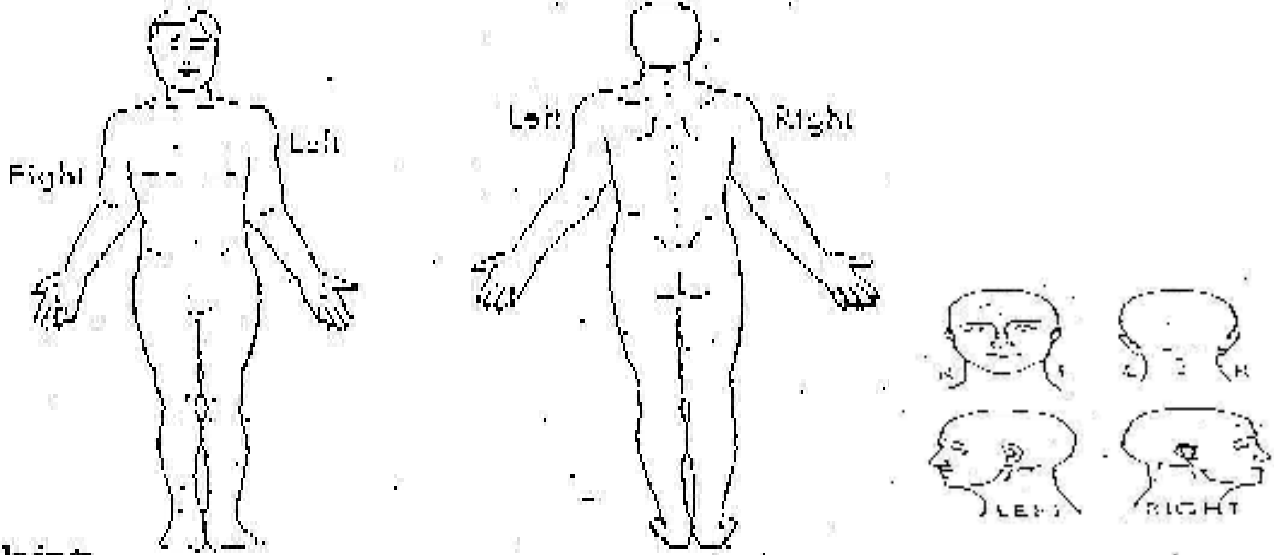


**Pain Treatment Questionnaire**

Questionnaire Completed Date: \_\_\_\_\_

**Pain History:**

Location: Use the figures below to shade in the areas where you have pain. If you pain moves around put an "X" and draw an arrow to where it spreads.



**Chief Complaint:**

- |                                  |                                     |                                |                                                       |
|----------------------------------|-------------------------------------|--------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Head    | <input type="checkbox"/> Upper Back | <input type="checkbox"/> Legs  | <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> Neck    | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Arms  | <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> Chest   | <input type="checkbox"/> Groin      | <input type="checkbox"/> Hands | <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Buttocks   | <input type="checkbox"/> Feet  | <input type="checkbox"/> R <input type="checkbox"/> L |

**Duration - Please Date:**

When did your current pain problem begin: \_\_\_\_\_

When did it begin to get progressively worse: \_\_\_\_\_

**Onset - How injury occurred:**

- Job injury    Sports Injury    Car Accident    Unknown
- Disease \_\_\_\_\_
- Cancer \_\_\_\_\_
- Other \_\_\_\_\_

Describe the speed of onset of your pain  Sudden  Abrupt  Gradual



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**Frequency:**

How often do you have this pain :  Constant  Intermittant

What time of day is your pain the worst:  Morning  Afternoon  Evening  Night

**Severity:**

Rate the severity of your pain **right now** by circling the corresponding number below

0 1 2 3 4 5 6 7 8 9 10  
(no pain) (worst pain imaginable)

Rate the severity of your pain **on average** by circling the corresponding number below

0 1 2 3 4 5 6 7 8 9 10  
(no pain) (worst pain imaginable)

**Character:**

Dull  Shooting  Stabbing  Sharp  Burning  Aching

**Associated Signs and Symptoms:** Are you experiencing any of the following please check all that apply:

- Muscle Weakness  Numbness or Tingling  Bladder/Bowel Dysfunctions  Rash  Fever
- Visual Disturbance  Color Change  Abnormal Sweating  Skin Changes  Hair Changes
- Other: \_\_\_\_\_  None Apply

**Aggravating and Alleviating Factors:** What activities or factors improve or worsen your pain (check all that apply)

Activity	Worsens	Relieves	No Change	Activity	Worsens	Relieves	No Change
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bright Lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting/Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weather Change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough/Sneeze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Touch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
None Apply	<input type="checkbox"/>						



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**Effects on Activities of Daily Living:**

Are their areas of you life that have been adversely affected by your pain problem (check below all those that apply):

- Sleep  Appetite  Relationships  Work  Finances  Physical Activity  Use of Alcohol/Drugs

Other \_\_\_\_\_

None Apply

**Treatments:**What treatments have you received for you pain in the past:

- Surgery  Nerve Block  Steroid Injection  Trigger Point injection  Acupuncture  TENS Unit  
 Heat  Ice  Biofeedback  Hypnosis  Relaxation Training  Counseling  Traction  
 Chiropractic Treatment  Occupational Therapy  Physical Therapy  None

Medications (tried and failed) \_\_\_\_\_

Other(explain): \_\_\_\_\_

**Diagnostic Testing:**Have you had any of the following test performed within the past 24 months:

Test	Date	Facility	Test	Date	Facility
X-Ray	_____	_____	CT Scan	_____	_____
MRI	_____	_____	Labs	_____	_____
EMG	_____	_____	Nerve	_____	_____
Conduction	_____	_____	Discogram	_____	_____
Myelogram	_____	_____	Other:	_____	_____

None

**Education:**What is the highest level of education completed: \_\_\_\_\_

**Employment:** Are you currently employed:  YES  NO Occupation: \_\_\_\_\_

Is this the same occupation you had before your pain started:  YES  No

If you are not working has pain forced you to stop working:  YES  No

If you are not working what was your occupation before you pain became a problem: \_\_\_\_\_

Does your spouse work:  YES  NO Occupation: \_\_\_\_\_

Are you being treated under workers compensation:  YES  NO

Are you currently receiving disability benefits:  YES  NO



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**Systems Review:**

Please check below if you are experience or have recently experienced any of the following:

**General:**

- Weight loss/gain \_\_\_\_\_
- Chills
- None

**Ears Nose and Throat:**

- Sinus pressure/drainage
- Sore Throat
- Difficulty Hearing
- Vision Problems
- None

**Pulmonary and Cardiovascular:**

- Chest Pain
- Cough
- Trouble Breathing
- None

**Gastrointestinal**

- Abdominal
- Nausea/Vomiting
- Diarrhea
- Constipation
- Black or bloody stools
- None

**Genitourinary:**

- Trouble urinating
- Frequent Urination
- Bloody Urine
- None

**Women:**

- Vaginal bleeding
- Vaginal discharge
- Could you be pregnant?
- Are you trying to become pregnant?
- Last Normal Period \_\_\_\_\_
- None

**Neurological and Psychological:**

- Headache
- Blackout
- Confusion
- Depression
- Suicidal Thoughts
- Suicidal Attempts
- None

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_