



**THE PAIN
TREATMENT
CENTER of the Bluegrass**

(859) 278-1316 (Phone)
(859) 276-3847 (Fax)

Physician Practices:

BALLARD WRIGHT, MD, P.S.C.

PRIMARY CLINICS:

2416 Regency Road
Lexington, KY 40503

280 Pasadena Drive
Lexington, KY 40503

2201 Regency Road, Bldg 100
Lexington, KY 40503

SOMERSET SATELLITE CLINIC:
110 Hardin Lane, #4
Somerset, KY 40503

RICHMOND SATELLITE CLINIC:
2137 Lexington Rd, B1-2
Richmond, KY 40475

PROVIDERS:

NEUROLOGY
Peter D. Wright, M.D., Medical Director

ANESTHESIOLOGY
Ballard D. Wright, M.D., Founder
Karin Rashied, M.D.
Olivia Kelley, M.D.
Rebecca Freeland, M.D.
Richard Lingren, M.D.

PHYSICAL MEDICINE & REHABILITATION
Lauren K. Larson, M.D.

PALLIATIVE CARE
Christopher Lyon, M.D.

FAMILY PRACTICE
Laura E. Hummel, M.D.

BEHAVIORAL MEDICINE
Nanda Shipp, APRN
Marie Simpson, LCSW
Joannie Cook, PMHNP-BC

PHYSICIAN ASSISTANTS
Lois A. Wright, MBA, PA-C
Celeste A. Christensen, PA-C
Shari L. Pierce, PA-C
Lara Wood, PA-C
Michael Hamilton, PA-C

NURSE PRACTITIONERS
Rebecca A. Moore, APRN
Dijana Duvall, APRN
April Lathrell, APRN
Michelle Semelle, APRN
Kay Wilson, DNP, APRN

ADMINISTRATION:
Heather Wright, Esq., Administrator &
In-House Counsel
Randy Terrell, CFO

Dear Patient:

Welcome to The Pain Treatment Center of the Bluegrass!

We are one of the largest multidisciplinary pain management centers in the region and are now an affiliate of CHI/St. Joseph Healthcare System with offices throughout Kentucky treating patients with pain.

Our Multimodal Treatment Program involves a multidisciplinary approach to pain management. Your treatment plan will be created specifically for you by one of our pain specialists. We, therefore, expect our patients to participate in the regimen recommended by your treating physicians. This will most likely include a combination of physical therapy, counseling, diagnostic testing, injections, and medication management.

Our goal is to assist you in feeling better, being more active and improving your quality of life.

Again, welcome! We look forward to working with you.

Sincerely,

The Medical Staff
The Pain Treatment Center of the Bluegrass

An Affiliate of:

CHI/St. Joseph's Health System- Lexington,
Berea, Bardonia & London

St. Joseph's Outpatient Surgery Center



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April Luttrell, APRN
Tabitha Knight, APRN
Michelle Sentelle, APRN
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ADMINISTRATION:

Heather Wright, Esq., CEO
Vince Cecil, BSN, RN, CCOO
Randy Terrell, CFO

An Affiliate of:

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Berea, Bardstown & London

St. Joseph's Outpatient Surgery Center

Enclosed is our Patient History Questionnaire. **Please complete this and bring to your first scheduled appointment.** You should plan on remaining at the Center for at least two (2) hours for this visit, because you will be filling out additional paperwork. If you require assistance, please bring someone to help you, but please limit this to one person. Also, if you require glasses for reading and writing, please bring them with you.

On the day of your appointment, you should bring the following:

Patient History Questionnaire

- Please complete the patient history questionnaire (front and back sides) and bring with you to your scheduled appointment.

Picture ID

- Please bring a picture ID with you to this appointment and to all future appointments at the Center.

Your insurance information

- Please bring all insurance cards and any information or claim numbers regarding workers' compensation to auto insurance.

Pharmacy Profile

- This can be obtained through your pharmacy and must include prescription history for the past year.

Medical Records.

- If you have any x-rays, MRI or CT scans related to your pain problem or injury, please bring the reports **TO THIS APPOINTMENT.**
- Please bring any medical records that you have from any previous pain clinics if possible.
- If you are unable to bring your medical records to this first appointment, we will be happy to have you sign a medical release form that day.

If you are unable to make a scheduled appointment, we request that you give us at least a 24-hour notice. This will allow us to free-up space for other patients who need to be seen. Failure to keep an appointment or notify us of a cancellation may result in a missed appointment charge.

If you have any questions, please call (859)278-1316 ext. 258. We will be glad to assist you.

Thank you,
The Pain Treatment Center

If you have any questions, please call (859) 278-1316, ext. 258. We will be glad to assist you. We appreciate your cooperation in attending this pre-evaluation appointment and we assure you that it will result in faster and better care for you.

Thank you.

The Pain Treatment Center

Location and Directions

Conveniently located in Lexington, we are just one turn from Nicholasville Road. **The Pain Treatment Center of the Bluegrass** is the largest freestanding facility in the region dedicated to the treatment of acute and chronic pain. Our location provides free, convenient, adjoining parking, with easy access into our offices.

If you're coming from the North on I-75...

- Take the I-64 E ramp - go 5.0 mi
- Take the US-27/US-68 exit 113 to Paris/Lexington - go 0.6 mi
- Turn right at N Broadway - go 3.1 mi
- Turn left at W Vine St - go 0.2 mi
- Turn right at S Upper St - go 0.7 mi
- Bear right at S Limestone - go 0.8 mi
- Continue on Nicholasville Rd - go 1.8 mi

Turn right at Pasadena Dr - go 0.3 mi

If you're coming from the South on I-75...

- Take the KY-418 exit 104 to Lexington/Athens - go 0.3 mi
- Turn left at Athens Boonesboro Rd - go 2.6 mi
- Continue on Richmond Rd - go 2.7 mi
- Turn left onto the New Circle Rd ramp - go 4.2 mi
- Take the US-27 exit 19 to Nicholasville/Lexington - go 0.3 mi
- Turn right at Nicholasville Rd - go 0.4 mi

Turn left at Pasadena Dr - go 0.3 mi

If you're coming from the East on I-64...

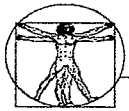
- Take the I-75 S exit 81 to Richmond/Knoxville - go 1.5 mi
- Take the US-60 exit 110 to Lexington - go 0.3 mi
- Turn right at Winchester Rd - go 1.8 mi
- Bear left onto the KY-4 S ramp - go 0.2 mi
- Continue on E New Circle Rd - go 1.7 mi
- Continue on New Circle Rd - go 4.4 mi
- Take the US-27 exit 19 to Nicholasville/Lexington - go 0.3 mi
- Turn right at Nicholasville Rd - go 0.4 mi

Turn left at Pasadena Dr - go 0.3 mi

If you're coming from the West on I-64...

- Take the US-60 exit 58 to Frankfort - go 0.3 mi
- Bear right at US-60 E - go 8.3 mi
- Continue on US-60-BYP E - go 1.6 mi
- Turn left at US-60 E - go 3.7 mi
- Bear right at Versailles Rd - go 4.4 mi
- Bear right onto the KY-4 S ramp - go 0.3 mi
- Continue on New Circle Rd - go 1.9 mi
- Take the US-68 exit 2 to Lexington/Harrodsburg - go 0.3 mi
- Turn left at Harrodsburg Rd - go 0.3 mi

Turn right at Pasadena Dr - go 1.6 mi



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2416 REGENCY ROAD
LEXINGTON, KY 40503**

PATIENT HISTORY QUESTIONNAIRE

Today's Date: _____

Name: _____
Last First Middle

Social Security Number: _____ Date of Birth: _____

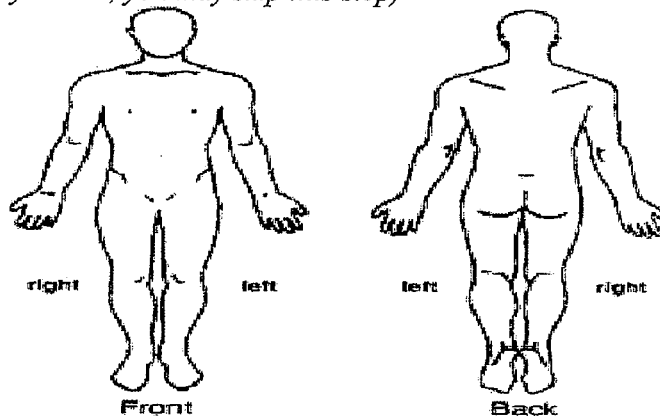
Mailing Address: _____ Phone Number: _____

Race: ☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

I. DESCRIPTION OF YOUR PAIN

1. Where is your pain? _____
2. Is your pain the result of a work injury or motor vehicle accident? ☐ Yes ☐ No
If yes, Insurance Company: _____ Insurance Phone: _____
Date of Injury: _____ Claim Number: _____
3. On the diagram below, please indicate your pain (shade in all areas of the body where you feel pain).
(If filling this out digitally/online, you may skip this step)



4. How long have you had this pain? _____
5. How would you describe your pain?
☐ Aching ☐ Burning ☐ Cramping ☐ Crushing ☐ Dull ☐ Numb ☐ Sharp
☐ Shooting ☐ Stabbing ☐ Tingling ☐ Throbbing ☐ Other: _____
6. Using the following scale, rate your pain by circling the number on the questions below:
0 Pain Free
1 Minor annoyance, occasional
2 Occasional strong twinges
3 Distracting
4 More than 30 minutes
5 Can't be ignored, but can still work and participate in social activities
6 Hard to concentrate, interferes with sleep
7 Physical activity limited
8 Pain unbearable – tearful

Your pain most of the time 0 1 2 3 4 5 6 7 8 9 10

Name: _____

7. What caused your pain? _____
8. What causes your pain to INCREASE? _____
9. What causes your pain to DECREASE? _____
10. Have you ever been treated at a pain facility before? ☐ Yes ☐ No
If Yes, where: _____ when: _____
11. Have you ever attended physical therapy for this pain problem? ☐ Yes ☐ No
If Yes, where: _____ when: _____

II. ALLERGIES

Please describe any drug allergies or bad reactions that you have had to medication.

Drug Allergies _____ Reactions _____
_____ Reactions _____
_____ Reactions _____

☐ No known drug allergies.

III. CURRENT MEDICATIONS

Medication	Dose (mg)	No. of Pills	Times Per Day

☐ No current medications

IV. MEDICAL HISTORY

1. Check illnesses or conditions you have or have had in the past. Write in any not listed.

HEART & BLOOD VESSELS: ☐ coronary artery disease ☐ high cholesterol ☐ rheumatic fever ☐ high blood pressure
☐ heart attack(s) ☐ irregular heart rhythm ☐ neck artery blockage ☐ congestive heart failure ☐ heart valve problems
☐ blood clots ☐ other: _____

SKIN: ☐ rashes ☐ eczema ☐ psoriasis ☐ cancer ☐ other: _____

GLANDS: ☐ diabetes mellitus ☐ hypothyroidism ☐ hyperthyroidism ☐ pituitary
☐ other _____

STOMACH & DIGESTIVE SYSTEM: ☐ hiatal hernia ☐ acid reflux ☐ ulcer ☐ pancreatitis ☐ poor appetite
☐ liver disease ☐ hepatitis ☐ cancer ☐ Crohn's disease ☐ obesity ☐ irritable bowel syndrome
☐ other _____

URINARY SYSTEM: ☐ kidney stones ☐ urinary tract infection ☐ kidney failure ☐ cancer
☐ other _____

FEMALE ORGANS: ☐ ovarian cysts ☐ endometriosis ☐ ovarian/uterine/cervical/breast cancer
☐ other _____

BALLARD WRIGHT, M.D., PSC
Pain History Questionnaire -- Page 3

Name: _____

MALE ORGANS: ☐ enlarged prostate ☐ prostate/testicular cancer

☐ other _____

EYES: ☐ cataracts ☐ injury ☐ glaucoma ☐ vision loss/difficulty

☐ other _____

EARS, NOSE, THROAT: ☐ sinus/allergy problems ☐ hearing loss ☐ inner ear disease ☐ dentures ☐ TMJ disease ☐ speech difficulty

☐ other _____

BLOOD: ☐ anemia ☐ bleeding easily ☐ blood clots ☐ leukemia

☐ other _____

ALLERGY/IMMUNE: ☐ rheumatoid arthritis ☐ fibromyalgia ☐ HIV

☐ other _____

MUSCULOSKELETAL: ☐ osteoarthritis ☐ broken bone ☐ rotator cuff disease ☐ carpal tunnel syndrome ☐ scoliosis
☐ osteoporosis ☐ degenerative disc disease ☐ degenerative joint

☐ other _____

NEUROLOGICAL: ☐ headache ☐ migraine ☐ seizure ☐ epilepsy ☐ stroke ☐ tumor ☐ meningitis ☐ head injury

☐ blackouts ☐ multiple sclerosis ☐ organic brain disease ☐ confusion ☐ memory loss

☐ other _____

LUNGS: ☐ asthma ☐ emphysema ☐ cancer ☐ bronchitis ☐ tuberculosis ☐ COPD ☐ black lung ☐ sleep

☐ other _____

PSYCHIATRIC: ☐ depression ☐ anxiety/panic ☐ bipolar disease ☐ schizophrenia ☐ PTSD

☐ other _____

2. Have you ever seen a psychologist, psychiatrist, or other mental health counselor?

☐ No

☐ Yes, in the past When: _____

☐ Yes, currently Who: _____

If yes, what problems were you seen for? _____

V. SURGERIES

List all surgeries you have had (except those listed previously relating to your Pain Problem)?

Date	Operation	Surgeon/Where

☐ No previous surgeries

Name: _____

VII. FAMILY HISTORY

State of health or cause of death

Is your mother	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased	_____
Is your father	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased	_____
Brothers	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased	_____
Sisters	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased	_____

VII. SOCIAL HISTORY

1. What is your current marital status? ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
2. Do you have any relatives who are, or have been patients at The Pain Treatment Center?
☐ Yes ☐ No If Yes, who/relation: _____
3. With whom do you currently live? ☐ Spouse ☐ Children ☐ Parents ☐ Other relatives
☐ Friends ☐ Alone ☐ Other: _____
4. Highest years of school: ☐ grade school ☐ high school ☐ college ☐ post college
5. What is your present work situation? (check and provide details, if needed)
☐ Disabled: ☐ Temporary ☐ Permanent Date declared disabled: _____
☐ Employed full-time
☐ Employed part-time/light duty
☐ Caregiver
☐ Unemployed
☐ In school
☐ Retired
6. Do you smoke cigarettes? ☐ Yes ☐ No
If Yes, how many packs per day? _____ How many years have you smoked cigarettes? _____
7. How often do you drink alcohol?
☐ Not at all ☐ Occasionally Explain _____ ☐ Everyday _____
8. How much do you drink: # _____ drinks per day # _____ drinks per week
9. What effect does alcohol have on your pain? _____
10. Have you used illegal drugs in the past (marijuana, cocaine, amphetamines)? ☐ Yes ☐ No
Illegal drug used: _____ Date last used: _____
11. Have you been diagnosed or treated for substance abuse problems (alcoholism, drug addiction, etc.?)
☐ Yes ☐ No If yes, when and where? _____
12. Have you been arrested for an alcohol or drug-related offense (DUI, public intoxication, possession, diversion, trafficking, etc.)? ☐ Yes ☐ No
If yes, what was the offense: _____ Date of the arrest: _____
13. Have you ever been arrested for any other reason? ☐ Yes ☐ No
If yes, explain: _____ Date of the arrest: _____
14. How does your pain interfere with your sleep? ☐ always ☐ occasionally ☐ never

Thank you for taking the time to complete this questionnaire.