



**THE PAIN
TREATMENT
CENTER of the Bluegrass**

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

Physician Practice:

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 42503

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
Karim Rasheed, M.D.
Olivia Kelley, M.D.
Rebecca Freedland, M.D.
Richard Lingen, 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
Narda Shipp, APRN
Marie Simpson, LCSW
Joannie Cook, PMHNP-BC

PRACTITIONERS
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. Maure, APRN
Dijana Duvall, APRN
April Luttrell, APRN
Michelle Sende, APRN
Kay Wilson, DNP, APRN

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

An Affiliate of:

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

St. Joseph's Outpatient Surgery Center

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**



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PHYSICIAN ASSISTANTS
Lois A. Wright, MBA, PA-C
Celeste A. Christensen, PA-C
Shari L. Pierce, PA-C
Jing Ye, PA-C
Alexis Budine, PA-C

NURSE PRACTITIONERS
Rebecca A. Moore, APRN
Teri A. Partin, APRN
M. Lynne Shockey, APRN
Dijana Duvall, APRN
April Luttrell, APRN
Tabitha Knight, APRN
Michelle Sentele, APRN
Kay Wilson, DNP, APRN

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

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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...

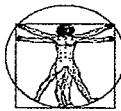
- Take the I-75 S exit 81 to Richmond/Knoxville - go 1.5 mi
- Take the US-60 exit 110 to Lexington - go 0.3 mi
- Turn right at Winchester Rd - go 1.8 mi
- Bear left onto the KY-4 S ramp - go 0.2 mi
- Continue on E New Circle Rd - go 1.7 mi
- Continue on New Circle Rd - go 4.4 mi
- Take the US-27 exit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



PATIENT HISTORY QUESTIONNAIRE

Today's Date: _____

Name: _____

Last

First

Middle

Social Security Number: _____ Date of Birth: _____

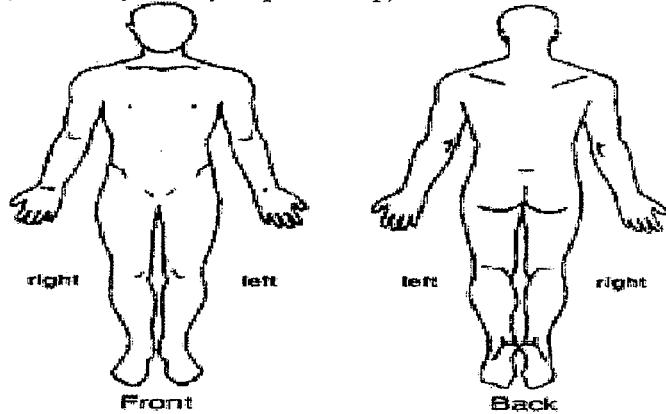
Mailing Address: _____ Phone Number: _____

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 5 Can't be ignored, but can still work and participate in social activities
1 Minor annoyance, occasional 6 Hard to concentrate, interferes with sleep
2 Occasional strong twinges 7 Physical activity limited
3 Distracting 8 Pain unbearable – tearful
4 More than 30 minutes

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

BALLARD WRIGHT, M.D., PSC
Pain History Questionnaire -- Page 2

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

VII. FAMILY HISTORY

State of health or cause of death

Is your mother Living Deceased
Is your father Living Deceased
Brothers Living Deceased
Sisters Living 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.