



Center for Complex Pain Care

Patient Demographics

Date: ____ / ____ / ____		
Patient Last Name: _____	First(Legal): _____	MI: _____
Address: _____		
City: _____	State: _____	Zip: _____
Sex: <input type="radio"/> Male <input type="radio"/> Female	Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed	
SSN#: _____ - _____ - _____	DOB: ____ / ____ / ____	Age: _____
Home Phone # (____) _____	Work # (____) _____	Cell # (____) _____
Employer: _____	Occupation: _____	
Email Address: _____		
Ethnicity: <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino <input type="radio"/> Unreported/Refused to Report	Race: <input type="radio"/> White <input type="radio"/> Asian <input type="radio"/> Pacific Islander <input type="radio"/> Black/African American <input type="radio"/> Native Hawaiian <input type="radio"/> American Indian or Alaskan <input type="radio"/> More than one race <input type="radio"/> Unreported/Refused to Report	How would you like to receive your appointment reminders? <input type="radio"/> Automated Phone <input type="radio"/> Automated Text Preferred Language? _____
Pharmacy Information:		
Pharmacy Name: _____	Address: _____	
Phone #(____) _____	_____	
Previous Physician Information:		
Family Physician Name: _____	Phone #(____) _____	
Referring Physician Name: _____	Phone #(____) _____	
Emergency Contact Information:		
Name: _____	Relationship: _____	
Home Phone # (____) _____	Cell Phone #(____) _____	Work #(____) _____



Patient Demographics

Date: ___ / ___ / ___

Insurance Information

Primary Insurance: _____

Secondary Insurance: _____

ID #: _____

ID# : _____

Group #: _____

Group #: _____

Subscribers Name: _____

Subscribers Name: _____

DOB: ___ / ___ / ___ SSN: ___ - ___ - ___

DOB: ___ / ___ / ___ SSN: ___ - ___ - ___

Effective Date: ___ / ___ / ___

Effective Date: ___ / ___ / ___

Relationship to Patient:

- Self
- Spouse
- Father
- Mother
- Guardian
- Other: _____

Relationship to Patient:

- Self
- Spouse
- Father
- Mother
- Guardian
- Other: _____

Workers Compensation (Complete only if have a work comp claim or leave blank):

Has a workers compensation claim been filed for this injury?

- Yes
- No
- If yes, date of injury: _____ Claim #: _____

Adjuster Name _____ Adjuster Phone #(_____) _____

Responsible Party (under the age of 18yrs only):

Last Name: _____ First Name: _____ Middle Initial: _____

Address(If different than patient): _____

City: _____ State: _____ Zip: _____

Phone # (_____) DOB: ___ / ___ / ___ SSN#: ___ - ___ - ___

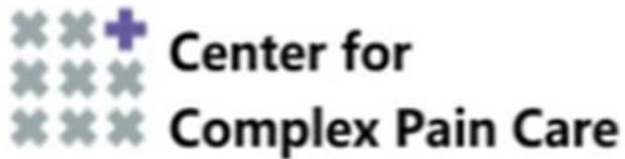
Relationship to Patient:

- Father
- Mother
- Guardian



Initial Visit

Date: ____ / ____ / ____		
Patient Last Name: _____		First(Legal): _____
MI: _____		
DOB: ____ / ____ / ____	____ FT ____ IN Height	____ LBS Weight
Medical History		
<ul style="list-style-type: none"> <input type="radio"/> Difficulty Swallowing <input type="radio"/> Sleep Apnea <input type="radio"/> Headaches <input type="radio"/> Head Trauma/Injury <input type="radio"/> Bipolar Disorder <input type="radio"/> Parkinson's Disease <input type="radio"/> Seizures <input type="radio"/> Depression <input type="radio"/> Anxiety <input type="radio"/> Spinal Cord Injury <input type="radio"/> Stroke <input type="radio"/> Pacemaker <input type="radio"/> Arrhythmia <input type="radio"/> Diabetes <input type="radio"/> Hepatitis 	<ul style="list-style-type: none"> <input type="radio"/> Heart Attack <input type="radio"/> Heart Failure <input type="radio"/> Heart Disease <input type="radio"/> Blood Clot or Phlebitis <input type="radio"/> Peripheral Vascular Disease <input type="radio"/> Hypertension <input type="radio"/> Hypercholesterolemia <input type="radio"/> Mitral Valve Prolapse <input type="radio"/> Chest Pain <input type="radio"/> Asthma <input type="radio"/> Emphysema <input type="radio"/> Pulmonary Embolism <input type="radio"/> Shortness of Breath <input type="radio"/> Hiatal Hernia <input type="radio"/> Reflux/Heartburn 	<ul style="list-style-type: none"> <input type="radio"/> Thyroid Disease <input type="radio"/> Arthritis <input type="radio"/> Renal Failure <input type="radio"/> Anemia <input type="radio"/> Cancer Type(s): _____ _____ <ul style="list-style-type: none"> <input type="radio"/> Excessive Bleeding <input type="radio"/> HIV/AIDS <input type="radio"/> MRSA <input type="radio"/> Other _____ _____ _____ _____
Surgical History		
<ul style="list-style-type: none"> <input type="radio"/> Amputation Body Part(s): _____ <ul style="list-style-type: none"> <input type="radio"/> Back Surgery <input type="radio"/> Cardiac Stent <input type="radio"/> Carpal Tunnel Release <input type="radio"/> Cholecystectomy <input type="radio"/> Heart Bypass 	<ul style="list-style-type: none"> <input type="radio"/> Hysterectomy <input type="radio"/> Joint Replacement Location: _____ <ul style="list-style-type: none"> <input type="radio"/> Partial Hysterectomy <input type="radio"/> Other _____ _____ _____	
Allergies to drugs, food, latex, and other substances? ____ Yes ____ No		
Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____		
Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____		
Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____		



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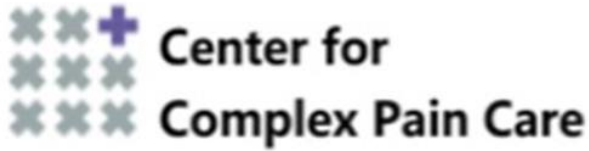
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Web: www.centerforcomplexpain.com

Welcome to the Center for Complex Pain Care

We would like to welcome you to the practice and explain an important feature of our care. During initial contact with us, it was recommended that you visit our website to review the practice policies and procedures. We hope you have done so, and if not, please take a few minutes to visit the site. We explain in detail our approach to caring for patients with complex medical needs, including those requiring chronic pain management and, when appropriate, chronic opioid therapy. This level of care requires additional time, coordination, and clinical oversight. Our membership-supported model allows us to provide enhanced access, extended visit times, and increased care coordination beyond what is typically feasible in traditional, high-volume healthcare settings.

As explained on our website, membership supports services that are not typically reimbursed or separately billable to insurance, including enhanced access, communication, care coordination, and enhanced clinical oversight and safety monitoring. Patients who choose to participate enroll in the program and make recurring membership payments. Medically necessary office visits and procedures are billed to insurance in accordance with payer requirements, and applicable copays, coinsurance, and deductibles remain the patient's responsibility.

For patients who would benefit from ongoing enhanced access and coordination, participation in the membership program is recommended. We understand that this model may not be the right fit for every patient. Participation is voluntary, and patients may choose alternative care options. We will provide appropriate support to ensure continuity of care consistent with applicable standards. If this model aligns with your preferences, we would be pleased to partner with you in your care.



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MEMBERSHIP AGREEMENT

Our practice manages complex chronic pain conditions, and our membership-supported model supports thoughtful, coordinated care. The annual membership fee is \$1,900. The fee may be paid in installments (quarterly or semi-annually). Membership supports enhanced access to care, extended appointment times, and increased care coordination beyond what is typically available in traditional insurance-based models and it supports non-covered services that are not separately reimbursed by insurance. Covered medical services will continue to be billed to insurance in accordance with payer requirements. Participation in the membership program is voluntary. Patients may choose to seek care from other providers if this model does not meet their needs or preferences. Consequently, patients who wish to be part of this practice understand and agree to the following:

- The membership fee is independent of insurance charges. Covered medical services, including office visits and procedures, will be billed to your insurance in accordance with payer requirements. Applicable copayments, coinsurance, and deductibles remain the patient's responsibility.
- All medical care will be provided based on clinical judgment and medical necessity. Membership does not guarantee specific treatments or outcomes.
- If a patient elects to pay the membership fee in installments, a valid credit or debit card must be maintained on file for scheduled payments. If payment is declined, a \$50 administrative fee may be applied. If payment issues are not resolved after reasonable notice, the practice may suspend or terminate membership participation in accordance with practice policies.
- Patients may select either the 3rd or the 15th of the month for scheduled payments. Payments will be processed on the selected date using the card on file.
- Patients are required to maintain accurate and up-to-date contact information, including a valid phone number. The ability to communicate reliably is important for safe and effective care.
- We recognize that the membership model may not meet the needs or preferences of all patients. Participation is voluntary, and patients may choose to seek care from other providers if desired.
- Continuation in the practice indicates understanding of and agreement with the membership model. Patients may discontinue participation at any time in accordance with practice policies.

I have read and understand the terms above:

Patient Name(Please Print):

➤ _____

Date ____/____/____

Signature of Patient:

➤ _____



Center for Complex Pain Care

Authorization of Treatment

- I hereby authorize medical treatment by the physician, the clinical staff, and technical employees assigned to my ongoing care.
- I authorize my treating providers to order any ancillary services deemed necessary for my care and treatment.
- I understand that I have the right and opportunity to discuss alternative plans of treatment with my physician or other healthcare provider. To ask and have answered to my satisfaction any questions or concerns.
- If a healthcare worker is exposed to my blood or body fluid in any way to transmit HIV (Human Immunodeficiency Virus), Hepatitis B, or Hepatitis C virus; I consent to the testing of my blood and/or exposed as required by Virginia state law.
- I understand Center for Complex Pain Care utilizes an electronic medical record system. I understand that this system is maintained in accordance with HIPAA and other patient privacy and health information management regulations. I understand that my healthcare providers will have access to my healthcare information across the continuum of my care.
- We may use secure, HIPAA-compliant artificial intelligence (AI) tools to assist with documentation and care coordination. Any information processed through these tools is handled in accordance with applicable privacy and security laws, and all outputs are reviewed by your provider.
- I consent to the release of my prescription history from any pharmacy or drug monitoring agency to my physician.

Payment Arrangements

- I agree to be responsible for payment of all services rendered to me or my dependents.
- By signing this document, I authorize the assignment to the medical practice of all payments under any insurance benefits otherwise payable to me for services provided under any insurance policy (hospitalization, major medical, workers compensation, or any other benefit plan).
- I agree to pay any required co-payments, co-insurance, and deductibles as well as charges for services not covered by my insurance.
- By signing this document, I authorize the release of my protected health information (PHI) to my insurance companies or other third-party payors including their representatives as necessary to determine coverage or as required for review quality improvement and/or management.
- I understand that all unpaid balances will be billed to my address on file with this office and that I am responsible for updating my registration information as necessary.
- I understand that a \$50.00 fee may be charged for returned checks.
- I understand that past due accounts will be referred to a collection agency and that I will be responsible for all collection charges, associated legal fees, and the full balance for my account.
- By signing this document, I agree to photocopies of this document are as legally binding as the original.

I have read and understand the terms above:

Patient Name: _____

DOB: ____/____/____

SSN#: ____ - ____ - ____ **Date:** ____/____/____

➤ _____

Patient or Guardian Signature	Printed Name	Relationship to Patient	Date
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Our notice of Privacy Practices (NPP) provides information about how we may use and disclose your personal health information. By signing below, you acknowledge that you have received a copy of our NPP.

➤ _____

Patient or Guardian Signature	Printed Name	Relationship to Patient	Date
--------------------------------------	---------------------	--------------------------------	-------------

Patient refuses to sign Privacy and Disclosures portion of the form, state reason below:

➤ _____



Membership Patient Enrollment Form

Enrollment Options (select one below):
\$475.00 every 3 months
\$950.00 every 6 months
\$1,900.00 for entire year
Please select whether you would prefer the 3rd or the 15th of the month. Unfortunately, no other payment arrangements can be made.
3rd of the month
15th of the month

Please complete the information below:

Patient Name: _____

Card Holder's Name: _____
(Exactly how it appears on the card)

(_____-_____-_____) (_____) ____/____/____
Card Number Security Code Exp Date

Card Holders Signature: X _____ Date: ____/____/____

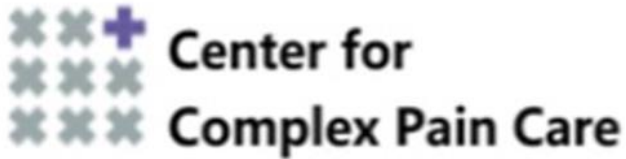
Address(street address linked with card): _____

City: _____ State: _____ Zip: _____

Home Phone #(_____) Cell Phone #(_____) _____

In the event that a patient leaves the practice for any reason, any membership fees that have been paid in advance beyond the current calendar month will be refunded or pro-rated from the date of separation. Membership fees are not refundable in the event a patient is discharged for any cause or in the event of the closure of the practice. Please initial each line below:

- I acknowledge that I must inform the office in writing if I wish to leave the practice in order to cancel any further charges on my card and receive any refund (if applicable).
I acknowledge that I understand that membership must be current to participate in membership services. Non-payment of membership fees may result in suspension of enhanced membership services, but medically necessary care will continue in accordance with applicable standards. Any insurance co-pay is also due at the time of service
I acknowledge that I may be assessed a late fee of \$50.00 if my credit card is declined. Failure to resolve payment issues may result in suspension of membership benefits in accordance with practice policy.
I acknowledge that I may pay my membership fees at any time prior to the due date in person or by phone.



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Request for Confidential Communications

I have been informed that I have the right to request that medical information about me be communicated to me in a confidential manner, such as sending mail to an address other than my home. I understand that I have responsibility to provide an address that meets the postal regulations. If I do NOT provide information that allows correspondence to reach me, then the facility may use an alternate address and/or phone number.

I am requesting that the address and/or phone number listed below be used to communicate with me:

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #(_____) _____ Cell Phone #(_____) _____

Patient Name(Please Print):

➤ _____

Date ____ / ____ / ____

Signature of Patient:

➤ _____



Center for Complex Pain Care

PHI Form

Permission to disclose private health information (PHI)

Patient Name: _____

Date: ____/____/____

SSN#: _____ - _____ - _____

DOB: ____/____/____

Date of Permission	Name of Individual	Comments or Instructions	Date of Permission Revoked	Parent or Guardian Initials	Telephone Number

In order to obtain information by telephone, the party calling the practice must be able to share the patients identifier/password with the staff.

Patient Identifier/Password: _____

Patient Name(Please Print):

➤ _____

Date ____/____/____

Signature of Patient:

➤ _____

Relationship (if not self): _____



Patient Name(Please Print): _____

Date: ____/____/____

Opioid Risk Tool

		<u>Mark Each Box That Applies</u>	<u>Item Score Female Only</u>	<u>Item Score Male Only</u>
1. Family History of Substance Abuse:	Alcohol	<input type="checkbox"/>	1	3
	Illegal Drugs	<input type="checkbox"/>	2	3
	Prescription Drugs	<input type="checkbox"/>	4	4
2. Personal History of Substance Abuse:	Alcohol	<input type="checkbox"/>	3	3
	Illegal Drugs	<input type="checkbox"/>	4	4
	Prescription Drugs	<input type="checkbox"/>	5	5
3. Age (Mark box if 16-45yrs):		<input type="checkbox"/>	1	1
4. History of Preadolescent Sexual Abuse:		<input type="checkbox"/>	3	0
5. Psychological Disease:	ADD	<input type="checkbox"/>	2	2
	OCD	<input type="checkbox"/>		
	Bipolar Disorder	<input type="checkbox"/>		
	Depression	<input type="checkbox"/>	1	1
		Total=		<input type="checkbox"/>
				<input type="checkbox"/>



Review of Systems

Patient Name: _____

Date: ____ / ____ / ____

Visual		Endocrine	
Glasses/Contacts	Yes/No	Diabetes	Yes/No
Eye Pain	Yes/No	Hair Loss	Yes/No
Double Vision	Yes/No	Weight Change	Yes/No
Cataracts	Yes/No	Heat Intolerance	Yes/No
ENT		Fatigue	Yes/No
Difficulty Hearing	Yes/No	Fever/Chills	Yes/No
Ringing in Ears	Yes/No	Cardiac	
Vertigo	Yes/No	Leg Swelling	Yes/No
Sinus Trouble	Yes/No	Chest Pain	Yes/No
Nasal Congestion	Yes/No	Irregular Heartbeat	Yes/No
Frequent Sore Throat	Yes/No	Fainting	Yes/No
Gastrointestinal		Respiratory	
Heartburn/Reflux	Yes/No	Cough	Yes/No
Nausea/Vomiting	Yes/No	Wheezing	Yes/No
Constipation	Yes/No	Chest Congestion	Yes/No
Bowel Mvmt Changes	Yes/No	Shortness of Breath	Yes/No
Abdominal Pain	Yes/No	Musculoskeletal	
Black/Bloody Stools	Yes/No	Joint Pain/Swelling	Yes/No
Jaundice	Yes/No	Stiffness	Yes/No
Urinary		Muscle Pain	Yes/No
Burning	Yes/No	Back Pain	Yes/No
Increased Frequency	Yes/No	Neurology	
Nighttime	Yes/No	Headaches	Yes/No
Kidney Stones	Yes/No	Loss of Strength	Yes/No
Blood in Urine	Yes/No	Tremors	Yes/No
Bladder Leakage	Yes/No	Memory Loss	Yes/No
Erectile Dysfunction	Yes/No	Visual Changes	Yes/No
Abnormal Discharge	Yes/No	Loss of Conscious	Yes/No
Skin		Numbness/Tingling	Yes/No
Rash	Yes/No	Sleep	
Unhealed Sores	Yes/No	Insomnia	Yes/No
Lesions	Yes/No	Snoring	Yes/No
OB/GYN		Sleep Apnea	Yes/No
Regular Periods	Yes/No	CPAP?	Yes/No
Pregnant?	Yes/No	Mental Health	
Lifestyle		Anxiety	Yes/No
Alcohol	Yes/No	Depression	Yes/No
Cigarettes	Yes/No	Sadness	Yes/No
Packs/Day		Hallucinations	Yes/No
Do you exercise?	Yes/No	Mood Changes	Yes/No
How Often?	Daily	Weekly	Eating Disorder
Monthly	Sometimes	Never	Suicidal Thoughts?
			Yes/No

Controlled Substance Information Consent and Treatment Agreement

It is the goal of this practice to return the patient to the optimal level of mobility and daily functioning with as little pain as possible. Although it is not always possible to achieve complete pain relief, we aim for the greatest improvements in quality of life. This goal is met with a relationship between patients and caregivers that is built upon trust and respect. Pain management is a daily regimen that comes with responsibilities for both patients and caregivers. Often the doctor will prescribe opioids as part of your treatment. Opioids are controlled substances which are strictly regulated by the Department of Drug Enforcement, or DEA. This document defines the responsibility guidelines for controlled substances, as well as this practice's policies for patients. Failure to adhere to these guidelines or policies will result in discharge from the practice. The following guidelines and policies are set for your safety and health to maintain the relationship of trust and respect with the practice.

Medications and Prescriptions:

- A complete list of ALL prescribed medications must be brought to each visit.
- Only recent medication including empty controlled medication from another provider (psychiatry meds, recent surgery, or other health provider). DO NOT mix current bottles with old medications; if you have old medication, continue to bring it until you are finished. If medications are forgotten, you will be asked to go home and retrieve them and/or be rescheduled for the next available appointment.
- Prescriptions of controlled substances may not be renewed by telephone.
- Lost, stolen, or damaged prescriptions may NOT be replaced.
- Prescriptions and medical records may not be altered, as this is a felony.
- The prescription utilization report from the Board of Medicine will periodically be obtained as part of the monitoring regime with opioid prescribing.
- Medications CANNOT be shared, sold, or misused.
- Use of one pharmacy is recommended.
- Very few medications are considered to be safe during pregnancy. This office needs to be consulted to see if pregnancy is planned and must be notified immediately if pregnancy occurs.
- Do NOT self-adjust your medications or overtake more if you feel that pain has not been reduced. If you feel there is a problem with the medication dose, a change needs to be discussed in an office visit. Please allow a minimum of 2 weeks for your body to adjust to the new medication(s) before scheduling another appointment.
- Caution needs to be exercised when driving or operating heavy machinery and/or equipment. The law of all states, including the Commonwealth of Virginia, forbids driving while impaired. I understand even the presence of a controlled substance in the blood or urine can be construed as "driving under the influence."

- The use of extended-release opioid medications in the context of underlying lung and respiratory conditions (e.g., COPD and obstructive sleep apnea), significantly increases the risk of respiratory depression.
- Concomitant use of benzodiazepines and opioid medications increase the risk of respiratory depression, the use of these to medications must be done with caution.
- Never discontinue a medication without notifying your provider. This can be dangerous to your health. Withdrawal medications can be properly given to taper off any controlled medications.
- Appointments must be made; we do not accept walk-ins unless an appointment was made in error.
- All patients MUST arrive 15 minutes prior to their scheduled appointment time. Any patient who is more than 10 minutes late will incur a \$50_late fee and may be rescheduled.
- Random drug tests will be performed throughout your treatment periodically to monitor your compliance. It is necessary to report testing within the same business day of notification, failure to report will result in termination. Results of the urine/saliva tests will determine changes in treatment plans which could include tapering off controlled substances in a medically safe manner and/or continuing treatment with a non-opioid medication. Refusing a drug test can result in discharge.
- You will agree to random drug tests and pill counts. You MUST have a working phone number and voicemail at all times so that we may contact you. If you are called and do not show by the end of the business day, it will result in discharge. You will only have that business day to show. There are NO excuses or exceptions.
- You will take controlled medications ONLY as prescribed.
- Short fills or partial prescriptions are not advised but are allowed.
- You will NOT use any illegal substances during treatment with controlled medications.
- You will NOT use, misuse, or abuse alcohol during treatment with controlled medications due to risk of increased sedation and impairment. Increased sedation could result in “driving while impaired” arrest.
- You will only use opioid medication prescribed by us for chronic pain, NOT for acute pain and/or any surgical procedures. Your surgeon or doctor should cover you for any upcoming procedures or acute pain related incidents, NOT pain management. If you overtake your medication for anything other than prescribed, you will NOT get a replacement and must wait until your next fill date.
- This office may share our treatment history including the use, misuse, or abuse of controlled medications with other healthcare providers within the HIPAA guidelines.
- FAILURE to comply with all policies of this office may result in termination of treatment.

Please print, sign, and date below:

Print Patient Name: _____ Date: ____/____/____

Sign Patient Name: _____

Witness: _____

**Center for
Complex Pain Care**

PREVIOUS PAIN TREATMENTS: (check all that apply)

- Surgery Nerve Block/Injection Physical Therapy Exercise Biofeedback
 Heat Treatment Cold/Ice Treatment Psychotherapy TENS Massage
 Psychotherapy Chiropractic Manipulation Oral/Topical Medication Acupuncture
 Alternative Medicine/Herbal therapy Bracing/Traction Other: _____

PRIOR PAIN MEDICATIONS: Please check ALL medications you have ever used in the past for treatment.

Opioids	NSAIDs / Tylenol	Anti-Depressants/ Anti-Anxiety
<input type="checkbox"/> Hydrocodone/Vicodin/Norco	<input type="checkbox"/> Acetaminophen/Tylenol	<input type="checkbox"/> Trifluoperazine/Stelazine
<input type="checkbox"/> Propoxyphene/Darvocet	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Risperidone/Risperdal
<input type="checkbox"/> Codeine/Tylenol #3	<input type="checkbox"/> Ibuprofen/Motrin	<input type="checkbox"/> Olanzapine/Zyprexa
<input type="checkbox"/> Fentanyl	<input type="checkbox"/> Naproxen/Aleve/Anaprox	<input type="checkbox"/> Ziprasidone/Geodon
<input type="checkbox"/> Hydromorphone/Dilaudid	<input type="checkbox"/> Etodolac/Lodine	<input type="checkbox"/> Quetiapine/Seroquel
<input type="checkbox"/> Morphine/MS Contin	<input type="checkbox"/> Indomethacin/Indocin	<input type="checkbox"/> Lurasidone/Latuda
<input type="checkbox"/> Meperidine/Demerol	<input type="checkbox"/> Ketoprofen	<input type="checkbox"/> Fluoxetine/Prozac
<input type="checkbox"/> Levorphanol/Levo Dromoran	<input type="checkbox"/> Nabumetone/Relafen	<input type="checkbox"/> Escitalopram/Lexapro
<input type="checkbox"/> Methadone	<input type="checkbox"/> Piroxicam/Feldene	<input type="checkbox"/> Sertraline/Zoloft
<input type="checkbox"/> Oxycodone/Percocet	<input type="checkbox"/> Celecoxib/Celebrex	<input type="checkbox"/> Citalopram/Celexa
<input type="checkbox"/> OxyContin	<input type="checkbox"/> Diclofenac/Voltaren	<input type="checkbox"/> Venlafaxine/Effexor
<input type="checkbox"/> Tramadol/Ultram	<input type="checkbox"/> Oxaprozin/Daypro	<input type="checkbox"/> Bupropion/Wellbutrin
<input type="checkbox"/> Tapentadol/Nucynta	<input type="checkbox"/> Ketorolac/Toradol	<input type="checkbox"/> Paroxetine/Paxil
<input type="checkbox"/> Oxymorphone/Opana	<input type="checkbox"/> Meloxicam/Mobic	<input type="checkbox"/> Vortioxetine/Trintellix
<input type="checkbox"/> Buprenorphine/Butrans	<input type="checkbox"/> Vioxx	<input type="checkbox"/> Clonazepam/Klonopin
<input type="checkbox"/> Suboxone/Belbuca	<input type="checkbox"/> Salsalate/Trilisate	<input type="checkbox"/> Diazepam/Valium
<input type="checkbox"/> Butorphanol/Stadol	<input type="checkbox"/> Sulindac/Clinoril	<input type="checkbox"/> Chlordiazepoxide/Librium
<input type="checkbox"/> Pentazocine/Talwin	<input type="checkbox"/> Tolmetin	<input type="checkbox"/> Lorazepam/Ativan
<input type="checkbox"/> Nalbuphine/Nubain	<input type="checkbox"/> Meclofenamate	<input type="checkbox"/> Temazepam/Restoril
Muscle Relaxers	<input type="checkbox"/> Flurbiprofen/Ansald	<input type="checkbox"/> Alprazolam/Xanax
<input type="checkbox"/> Baclofen/Ozobax	<input type="checkbox"/> Mefenamic acid/Ponstel	<input type="checkbox"/> Hydroxyzine/Vistaril/Atarax
<input type="checkbox"/> Carisoprodol/Soma	<input type="checkbox"/> Fenoprofen/Nalfon	<input type="checkbox"/> Buspirone/BuSpar
<input type="checkbox"/> Cyclobenzaprine/Flexeril	<input type="checkbox"/> Arthrotec	<input type="checkbox"/> Doxepin
<input type="checkbox"/> Amrix	<input type="checkbox"/> Cataflam	<input type="checkbox"/> Trazodone/Oleptro
<input type="checkbox"/> Methocarbamol/Robaxin	Neuroleptics/Nerve Pain	<input type="checkbox"/> Maprotiline
<input type="checkbox"/> Metaxalone/Skelaxin	<input type="checkbox"/> Gabapentin/Neurontin	<input type="checkbox"/> Aripiprazole/Abilify
<input type="checkbox"/> Chlorzoxazone/Lorzone	<input type="checkbox"/> Horizant	<input type="checkbox"/> Desvenlafaxine/Pristiq
<input type="checkbox"/> Parafon Forte	<input type="checkbox"/> Pregabalin/Lyrica	<input type="checkbox"/> Duloxetine/Cymbalta
<input type="checkbox"/> Orphenadrine	<input type="checkbox"/> Carbamazepine	<input type="checkbox"/> Amitriptyline/Elavil
<input type="checkbox"/> Tizanidine/Zanaflex	<input type="checkbox"/> Milnacipran/Savella	<input type="checkbox"/> Nortriptyline/Pamelor
<input type="checkbox"/> Dantrolene/Dantrium	<input type="checkbox"/> Oxcarbazepine	<input type="checkbox"/> Imipramine/Tofranil