Texas Pain Network

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Date: _____

Last Name:_____ First Name:_____ MI:_____

DOB: _____ Marital Status: Married Divorced Widowed Single

Gender: Male Female

Social Security Number: _____ Driver's License Number: _____

Address:_____ City:_____ State:_____ Zip:_____

HomePhone:_____CellPhone:_____Email:_____

Pharmacy Name: _____ Pharmacy #: _____

Primary care Physician name:_____Phone#_____

How did you hear about us?

Google FB Family/Friend Insurance Company Other:

Employer Information:

Employer: _____

Work Phone: _____ May we contact you at work? Yes / No

Is this a work-related injury? Yes / No

Phone: _____ Position: _____

Insurance Policy Holder's Information

Patient relationship to policy holder: Self Spouse Child Other: _____

Last Name:_____ First Name:_____ MI:_____

DOB: _____ SS#: _____

Insurance Carrier:_____ Policy Number:_____

Group#:_____Insurance phone number:_____

In case of emergency, please list a family member and a non-relative person in which we may contact.

Name: _____ Relationship to Patient: _____ Phone: _____

***I certify the above information is correct to the best of my knowledge, I also understand that I am financially responsible for all charges whether or not covered by my insurance. THIS IS A LEGAL DOCUMENT AND MAY BE USED AGAINST ME IN A COURT OF LAW IF PAYMENT IS NOT MET.**

(PLEASE Initial here)_____.

Main Complaint:_____

Pain Score: Now __ /10 Worse ___/10

Where is pain located?_____

How long? _____ Onset: Sudden Gradual Constant Intermittent:

Nature of pain? Aching Dull Sharp Shooting Burning Throbbing Other: _____

Any Radiating Pain/Where?_____

Tingling or Numbness/Where?_____

Muscle Spasms/Where? _____

Recent Imaging/When & Where?:_____

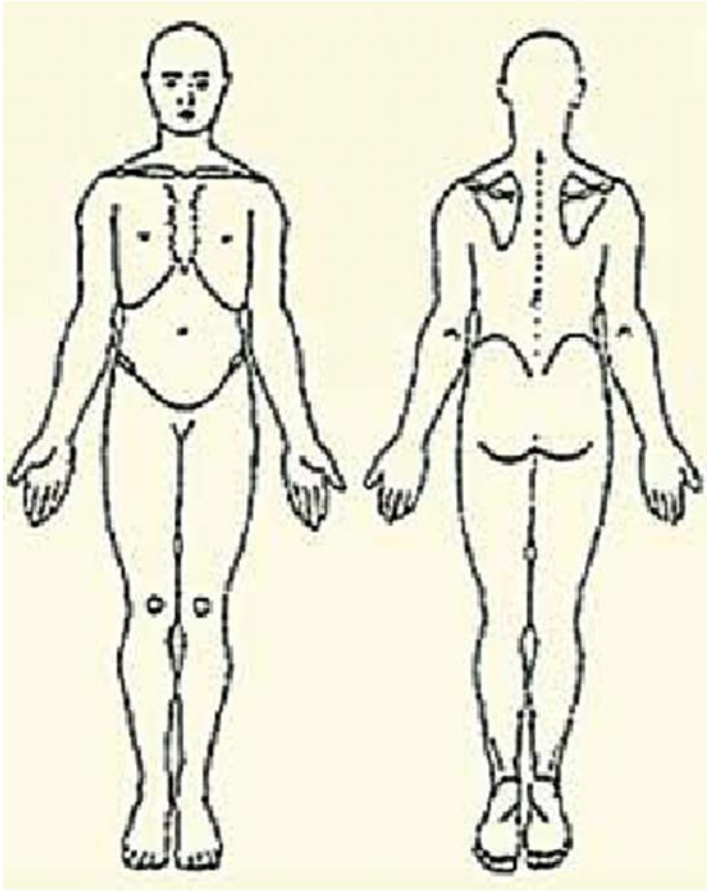
Recent Falls or Direct Trauma/When?_____

What Helps Alleviate Pain/Makes Better:_____

What Aggravates Pain/Makes Worse:_____

Any Other Symptoms:_____

Please mark all the area of pain your experiencing with an X



Medical Conditions:

Diabetes	Shingles	Heart Problems
High Blood Pressure	Stroke	Urinary/Kidney
High Cholesterol	Seizures	Cancer_____
Depression	Heartburn/GERD	Vision Prob.(glaucoma/cataracts)
Anxiety	Headaches	Blood Disorders_____
Asthma	Poor Sleep	Seasonal Allergies
COPD	Nausea/Vomiting	Osteoporosis
Shortness of Breath	Constipation/Diarrhea	Fibromyalgia

Any other
conditions:_____

Height:_____ Weight:_____

PAST SURGICAL PROCEDURES FOR THESE MEDICAL CONDITIONS (include dates)

_____

_____

Are there any diseases that run in your family? If so, what?

Mother: _____

Siblings: _____

Father: _____

Children: _____

Please let us know of any other information that could be helpful in the evaluation and treatment of your care so that we can get you back to living your best life pain free!

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT
AS REQUIRED BY THE TEXAS MEDICAL BOARD
REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22 PART 9, CHAPTER 170

NAME OF PATIENT: _____ DATE:_____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and the hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me,

as your physician. For the purpose of this agreement the use of the word “physician” is defined to include not only my physician but also my physician’s authorized associates, technical assistants, nurses, staff, and other healthcare providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician to treat my condition which has been explained to me as acute pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my acute pain if needed.

I agree to waive my privacy rights so that you may be able to inform or discuss my pain issues with my listed contacts at any needed time. I also agree to waive my privacy rights so that you may be able to inform or discuss my pain issues concerning my care with my primary care physician or any other physician participating in my care.

Patient Signature:_____
Date:_____

TPN Texas Pain Network

128 N Hwy 77 Waxahachie, TX 75165
7504 San Jacinto Pl Plano, TX 75024
521 N Beaton St Corsicana, Tx 75110
166 Heritage Pkwy Gun Barrel City, TX 75156
749 Grand Saline, TX 75140
Athens, TX