TPN Texas Pain Network

Amir Alavi, DO   Adam Arredondo,MD James Vu, MD Henrik Mike-Mayer, MD
Lara Turk, FNP   Jane Ong, FNP   Jaqueline Rush, FNP   Rachel Conner, FNP Travis Squyres, FNP Elena Walker, FNP
Shoshauna Franklin, FNP Connie Rios, FNP

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 #**: ____

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's spouse or responsible party)

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

Last Name:________________________ **First Name**:_______________________________ **MI**:______

DOB: _____________ **SS#**: _________________

Insurance Carrier:___________________________ **Policy Number**:_______________________________________

Group#:____________________________   **Insurance phone number:**_____________________________

TPN Texas Pain Network

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

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*____________Initial***

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 Falls or Direct Trauma/When?____

What Helps Alleviate Pain/Makes

Better:____

What Aggravates Pain/Makes

Worse:____

Any Other

Symptoms:____

(swelling, popping, grinding, weakness, stiffness, etc.)

<u>Medical Conditions:</u>

Diabetes	**Shingles**	**Heart Problems (CHF,MI?)______________**
High Blood Pressure	**Stroke**	**Urinary/Kidney Problems______________**

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: ____
Other:____

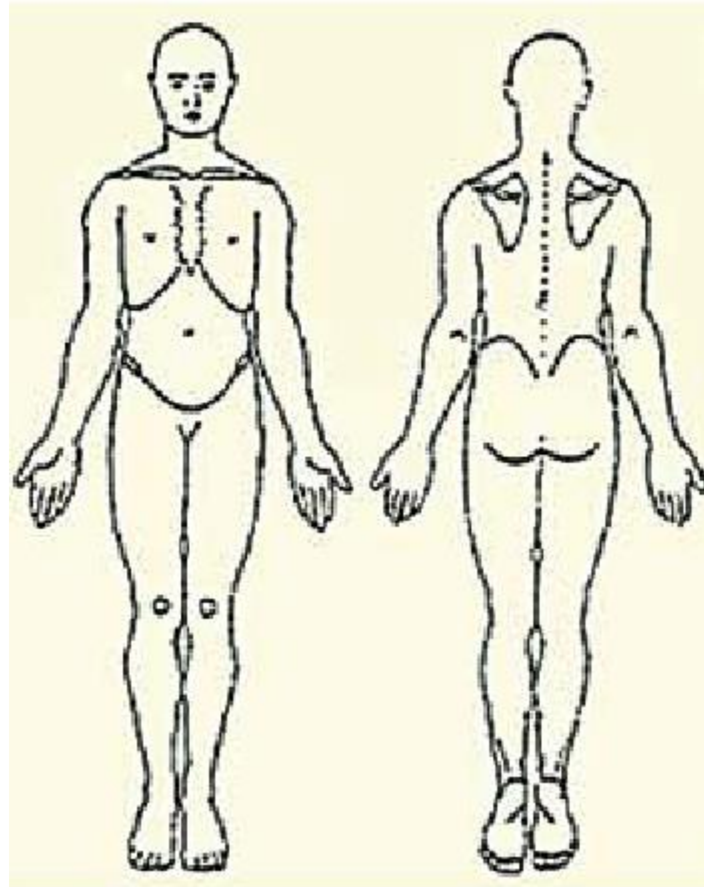
Please let us know of any other information that could be helpful in the evaluation and treatment of your care so that we can get you back to living your best life pain free!

TPN Texas Pain Network

Pain Drawing Grid Assessment

Patient Name: ___________________________ **Date**: _______________________

Please mark an "X" where your pain is located:



How did the pain start?

____
____
____
____
____

Texas Pain Network
7504 San Jacinto Place, Plano, TX 75024 – Phone 972.769.7246 – Fax 972.360.3977
128 Hwy. 77 North, Waxahachie, TX 75165 - Phone 972.938.7319 - Fax 972.923.9535
521 N. Beaton St, Corsicana, TX 75110 - Phone 903.872.4777 - Fax 903.872.8375

TPN Texas Pain Network

Please complete the following information. List all medications you are taking including over the counter medications. Print the information as it appears on your medicine bottles.

Patient Name:_______________________________ **DOB:**_______________ **Date:**________________

Name of Medication	Dose/Directions	Prescribed By	How long have you been taking this medication?

Allergies to Medications: Yes / No

If so, please list: _________________________________

Texas Pain Network
7504 San Jacinto Place, Plano, TX 75024 – Phone 972.769.7246 – Fax 972.360.3977
128 Hwy. 77 North, Waxahachie, TX 75165 - Phone 972.938.7319 - Fax 972.923.9535
521 N. Beaton St, Corsicana, TX 75110 - Phone 903.872.4777 - Fax 903.872.8375

Please take the time to fill out this questionnaire at the request of your treating physician. Having detailed background information will facilitate your visit here, enabling the physicians to focus on your principal concerns.

Medical Treatments for Pain

Check all that apply including the approximate month and year the treatment was administered

Bedrest_______________	NSAIDS_______________	Ilioinguinal nerve block________________
Chiropractic____________	Opiates_______________	Facet Joint Injection___________________
Acupuncture____________	Physical Therapy_______	Trigger Point Injection_________________
Muscle stimulator________	Muscle Relaxants_______	Stellate Ganglion Block________________
Braces_________________	Antidepressant drug_____	Bier's Block__________________________
Splints_________________	Antianxiety drug________	Cervical epidural steroid infection_______
Traction________________	Benzodiazepines________	Somatic nerve block_________________
TENS___________________	Anticonvulsants_________	Lumbar epidural steroid injections______
Spinal cord implant_______	Psychotherapy__________	Other(specify)_______________________

Number of healthcare visits during the last 6 months for your pain condition: ______________

Number of Emergency Room visits during the last 6 months for your pain condition: _________

Surgery for Pain (include date):

____

____

____

____

Have you had any tests for your current condition? Circle all that apply

X-rays	**MRI (magnetic resonance imaging)**
Bone scan	**Nerve conduction test**
CAT scan	**EMG (electromyography)**
Myelogram	

If so where and when? ______________________________

Review of Symptoms: Please circle all that apply

Unusual tiredness	**Unusual bleeding**	**Heavy cough**	**Trouble sleeping**
Fevers	**Easy bruising**	**Chest pain**	
Chills	**Lumps or bumps**	**Trouble breathing**	
Unusual sweating	**Swollen glands**	**Depression**	
Loss of appetite	**Change in Bowel habits**	**Change in vision**	
Unexplained weight loss	**Blood in the urine or stool**	**Seizures**	
Rashes	**Impotence**	**Tingling (pins & needles)**	

Females: Last menstrual period_____________________________

Could you be pregnant? Yes / No Birth control method______________________________

TPN Texas Pain Network

APPOINTMENT POLICY

To better serve our patients Texas Pain Network appointment policy states that if you are unable to make your scheduled appointment for your office visit or procedure, you must call and notify the office no later than 24 hours before the scheduled time for follow up visits and 72 hours before any scheduled procedures.

If you fail to show up or cancel your appointment as per our policy, you will be charged a **No-Show Fee of $25.00 per occurrence for follow up visits and $50.00 for in office and outpatient procedures.** This charge is not covered by insurance plans and Worker Compensation carriers, which will make this the patient's full responsibility. Repeated failure to show to appointments and cancellations may result in being discharged from Texas Pain Network.

If you have any questions or concerns about signing this form, please speak with any one of our staff.

____ ____
Patient's Printed Name Witness

____ ____
Patient/Guardian Signature Date

Medication Agreement

This agreement was developed to try to decrease the risk of problems or side effects occurring with medications prescribed through this office. Please read through each statement and initial where requested. If there are any questions, please do not hesitate to ask.

I understand that all medications have the potential risks. Although major risks will be discussed with you, it is impossible to talk about potential side effects or risk of each medication. If you want detailed information, ask us and we will give you a copy of Physician's Desk Reference information on each medication. Your pharmacist can also provide detailed information on your medications.

Initials: ___________________

TPN Texas Pain Network

I agree to take all medications as prescribed and will not deviate from the prescribed amount without consulting with my physician at Texas Pain Network. Initials:___________________

Acknowledgement of Receipt of Notice of Privacy Practices

My signature below signifies that Texas Pain Network Notice of Privacy Practices have been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations. I understand that I am entitled to receive a copy of this document upon request.

______________________________	_________________________________
Signature of Patient	Signature of Patient's Representative
______________________________	___________________________________
Printed Name of Patient	Printed Name of Patient's Representative
______________________________	___________________________________
Date:	Relationship to Patient

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 (name at bottom of agreement) to treat my condition which has been explained to me as chronic 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 chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medications.

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE ME WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS/ HER TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND UNDERSTAND that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from care.

<u>For female patients only:</u>

To the best of my knowledge **I am NOT pregnant**.
If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment.
I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.
If I am pregnant or uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.
All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/fetus/baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING:

Constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension (low blood pressure), arrhythmias (irregular heartbeat), insomnia, depression,

impairment of reasoning and judgement, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and that there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and believe that I have sufficient information to give this informed consent.

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:

This pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in the Agreement and my care plan of my provider.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued.**
- I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician. I will use the medication(s) **exactly as directed by my physician.**
- I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will **not allow or assist in the misuse/diversion of my medication; nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible.** Should the need arise to change pharmacies, my physician must be informed. I will only use one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be filled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. **If either are lost or stolen, they may NOT BE REPLACED.**
- Refill(s) **will not be ordered before the scheduled refill date.** I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physicians that there are no demonstrable benefits to my daily function or quality of life from the medication(s), **then my physician may try alternative medication(s) or may taper me off all medication(s).** I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- **I agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time without prior warning. If I test positive for illegal substance(s), such as marijuana, methamphetamine, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addiction specialist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain thru therapy, injections & procedures is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.

TPN Texas Pain Network

- I agree that **I shall inform my doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medication(s) prescribed by my other physician(s)
- I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

I can certify and agree to the following:

1. I am **not currently using illegal drugs or abusing prescription medication(s)** and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgement.
2. I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.).
3. **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.
4. I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the expectations regarding the benefits and the risks of the medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

______________________________________ ______________________________

Patient Signature Date

______________________________________ ______________________________

Physician Signature (or Appropriate Authorized Assistant) Date

TPN Texas Pain Network

Dear Patient:

Quality medical care and our state licensing board obligations require us to ask you questions about your history of chemical and substance abuse. Likewise, we are obligated to ask you these same questions as it pertains to your immediate family (1st degree blood relatives). Please complete this form and give it back to our staff. We will treat your information confidentially, according to all relevant laws and regulations. If you do not fill out this form when asked, we will not be able to consider the use of opioid medication(s) or similar medications to treat your pain

<u>Check the applicable Response and Fill in the Requested Information:</u>

How many drinks of alcohol do you have per day____________ per week__________ per month_______

Have you ever received treatment (medical or mental health; in-patient or out-patient, AA or otherwise) relating to your use of alcohol?

_____yes _________no. If you answered yes, please indicate, in the space below, the nature of the treatment you received and state when and where:

Have you ever used illegal drugs? _____yes ______no. If you answered yes, please indicate, in the space below, the names of illegal drugs you have used and state when:

Have you ever used opioids Kadian, Oxycontin, Methadone, Actiq, or any other triplicate medications?

________yes _________no. If you answered yes, please indicate, in the space below, the names of the medications you used and where you obtained them:

Have you ever used benzodiazepines (Xanax, Valium, and their generic equivalents)? _____yes ______no. If you answered yes, please indicate, in the space below, the names of the medications you used and where you obtained them:

Have you ever received treatment medical or mental health; in-patient or out-patient or otherwise relating to your use of illegal drugs or opioid medications? _______yes ________no If you answered yes, please indicate, in the space below, the nature of the treatment you received and state when and where:

Has any family member or friend ever voiced a concern to you over your use of alcohol or any drug (prescription drug or otherwise)? __________yes __________no If you answered yes, please state details below:

Please give the names of three (3) relatives or friends that you will designate to help you proceed through your pain management at our clinic.

First Name, Last Name	Address	Phone Number
1.		
2.		
3.		

Primary Care Physician	Address	Phone Number
1.		
Other Caring Physicians	**Address**	**Phone Number**

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

Patient Signature:____ Date:_______________________

Reviewed by:____ Date:________________________