TEXAS WELLNESS and PAIN CENTER

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Office: 817-784-7500
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Current and Past Medical History

Name_____Date_____DOB_____Who Referred you?_____

Reason for visit_____

DRUG ALLERGIES: ☐None

OTHER ALLERGIES: ☐None

☐Latex ☐Contrast
☐Iodine ☐Lidocaine
☐Adhesive

CURRENT MEDICATIONS: ☐None ☐See Attached

NAME	DOSE	HOW OFTEN	PHYSICIAN

HISTORY OF PAIN SYMPTOMS

Where do you have pain? (everywhere is not an answer)

_____

What does your pain feel like? ☐ Sharp ☐ Stabbing ☐ Dull ☐ Shooting ☐ Cramping ☐ Aching ☐ Burning ☐ Throbbing ☐Numb/Tingling ☐ Devastating ☐ Pressure ☐ Pulsing ☐ Lightning ☐ Crawling

☐ Other_____

When did you pain begin? _____

Was there a specific cause? _____

Is there a certain time of day that your pain is worse? ☐ AM ☐ PM ☐ Other

What makes your pain worse? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Twisting ☐ Lying down ☐ Coughing ☐ Other_____

What makes your pain better? ☐ Sitting ☐ Standing ☐ Lying down ☐ Rest ☐ Medication ☐ Changing positions ☐ Other_____

Do you have any of the following: ☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of Bowel Control ☐ Loss of Bladder Control ☐ Fevers ☐ Chills ☐ Sudden Weight Loss

What have you done to treat your pain?_____

Physical Therapy ☐ No ☐ Yes ☐ When _____ Did it help? ☐ No ☐ Yes ☐ Made me worse

If you had imaging (X-rays, MRIs, CT scans) done previously, where did you get them done? or who has them? Provide their city or phone number if posible. _____

Chiropractic Care ☐ No ☐ Yes ☐ When_____ Did it help? ☐ No ☐ Yes ☐ Made me worse

Massage Therapy ☐ No ☐ Yes ☐ When_____ Did it help? ☐ No ☐ Yes ☐ Made me worse

Acupuncture ☐ No ☐ Yes ☐ When_____ Did it help? ☐ No ☐ Yes ☐ Made me worse

TENS Unit ☐ No ☐ Yes ☐ When_____ Did it help? ☐ No ☐ Yes ☐ Made me worse

Accpuncture ☐ No ☐ Yes ☐ When_____ Did it help? ☐ No ☐ Yes ☐ Made me worse

Have you had back or neck injections before? ☐ No ☐ Yes If so, what/when?

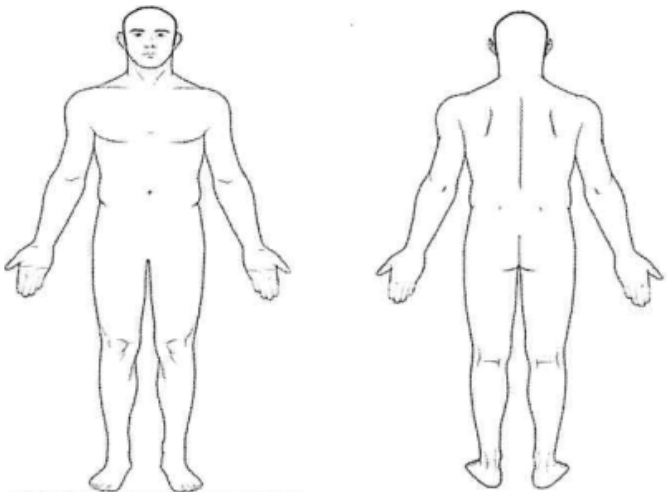
_____

Have you had back or neck surgery before? ☐ No ☐ Yes If so, what/when?

_____

Have your symptoms been getting worse? ☐ No ☐ Yes

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On the drawing to the left, please indicate where you are having pain by using the symbols below to describe your symptoms:

×× Sharp/stabbing
+++ Aching/Dull
––– Burning
/// Numb or Tingling

What is today's pain: _____/10
Average pain this week: _____, 10
Worst pain this week: _____/10
% relief from medications: _____%
Pain Medications Effective: □Yes □No

PLEASE INDICATE IF YOU HAVE USED OR TRIED THE FOLLOWING PAIN MEDICATIONS

□ Oxycodone	□ Hydrocodone	□ Tapentelol (Nucynta)	□ Fentanyl	□ Gabapentin	□ Cymbalta
□ Oxycontin	□ Morphine IR/ER	□ Buprenorphine (Butrans)	□ Methocarbamol (Robaxin)	□ Lyrica	□ Ibuprofen
□ Percocet	□ Hydromorphone (Dilaudid)	□ Levorphanol	□ Cyclobenzaprine (Flexeril)	□ Amitriptyline	□ Diclofenac
□ Hydrocodone	□ Exalgo (Dilaudid)	□ Methadone	□ Baclofen	□ Nortriptyline	□ Naproxen
□ Vicodin/Norco	□ Oxymorphone (Opana)	□ Subxone	□ Carisoprodol (Soma)	□ Effexor	□ Tylenol

PLEASE INDICATE IF YOU HAVE HAD THE FOLLOWING PAST MEDICAL HISTORY OR SURGERIES

Cardiac:	Endocrine:	Mental Health:	Gastrointestinal	Musculoskeletal:
☐ Coronary Artery Disease	☐ Diabetes I	☐ Depression	☐ GERD/ Ulcers	☐ Fibromyalgia
☐ High Blood Pressure	☐ Diabetes II	☐ Anxiety	☐ Crohn's Disease	☐ Chronic Fatigue
☐ High Cholesterol	☐ Hypothyroidism	☐ Bipolar Disorder	☐ Irritable Bowel Disease	☐ Osteoarthritis
☐ Heart Attacks	☐ Hyperthyroidism	☐ Schizophrenia	☐ Gallbladder Disease	☐ Rheumatoid Arthritis
☐ Arrhythmia / Pacemaker	☐ Adrenal Insufficiency	☐ ADHD	☐ Hepatitis A/B/C	☐ Lupus
☐ Bypass Surgery	☐ Menopause	☐ Suicide Attempts	☐ Pancreatitis	☐ Raynaud's Disease
Neurological:	Pulmonary:	ENT:	Renal:	Hematological:
☐ MS	☐ Asthma	☐ Seasonal Allergies	☐ Kidney Failure	☐ Bleeding
☐ Stroke	☐ COPD	☐ Sinus Infection	☐ Kidney Stones	☐ Anemia
☐ Migraine HA	☐ Sleep Apnea	☐ Ear Infection	☐ Incontinence	☐ Leukemia
☐ Tension HA	☐ Bronchitis	☐ Dental Problems	☐ Urinary Tract Infection	☐ Hypercoaguable Disorder
☐ Seizures	☐ Pneumonia	☐ Other Problems:		
☐ Polio/Guillain-Barre	☐ Emphysema			

HAVE YOU HAD CANCER? ☐ No ☐ Yes. If yes, type/course _____

PRIOR SURGERIES: _____

PRIOR HOSPITALIZATIONS: _____

FAMILY HISTORY:

☐ Hypertension	☐ Stroke	☐ Fibromyalgia	☐ Depression	☐ Asthma	☐ Cancer. If yes, type/course
☐ High Cholesterol	☐ Migraine HA	☐ Rheumatoid Arthritis	☐ Anxiety	☐ COPD	
☐ Heart Attacks	☐ Diabetes	☐ Lupus	☐ Bipolar Disorder	☐ Bleeding	

Mother: □ unknown □ alive □ deceased, cause of death _____ Father: □ unknown □ alive □ deceased, cause of death _____

How many siblings? brother(s) _____ sister(s) _____ How many children? son(s) _____ daughters (s) _____

SOCIAL HISTORY:

Do you use or have you used any of the following: □ THC □ Crack □ Cocaine □ Methamphetamine □ Heroin □ Ecstasy □ PCP □ other _____ If yes, please explain: _____

__ Do you smoke? □ Yes □ No □ Quit □ When? _____ Do you drink alcohol? □ Yes □ No □ Quit □ When?_____

Do you work? □ Yes □ No □ Retired □ Disabled If yes? □ Full time □ Part time

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING SYMPTOMS TODAY:

Constitutional:	Cardiac:	Mental Health:	Hematologic:	Integument:
☐ Fevers	☐ Chest Pain	☐ Depression	☐ Taking Blood Thinners	☐ Rash
☐ Chills	☐ Palpitations	☐ Anxiety	☐ Easy Bruising	☐ Hives
☐ Night Sweats	☐ Fast Heart Rate	☐ Suicidal Thoughts	☐ Excessive Bleeding	☐ Other
☐ Slow Heart Rate	☐ Slow Heart Rate	☐ Homicidal Thoughts	☐ Swollen Glands	Endocrine:
☐ Edema (Swelling)	☐ Edema (Swelling)	☐ Sleep Difficulty	☐ Other	☐ Hair Loss
☐ Weight Gain/Loss	☐ Other	☐ Restlessness	Musculoskeletal:	☐ Excessive Thirst
☐ Other	Neurological:	☐ Crying	☐ Neck Pain	☐ Other
ENT:	☐ Numbness/Tingling	☐ Agitation	☐ Low Back Pain	Gastrointestinal
☐ Hearing Difficulty	☐ Seizures	☐ Insomnia	☐ Muscle Pain	☐ Diarrhea
☐ Visual Changes	☐ Memory Impairment	☐ Other	☐ Muscle Weakness	☐ Constipation
☐ Swallowing Difficulty	☐ Weakness	Pulmonary:	☐ Morning Stiffness	☐ Nausea / Vomiting
☐ Dental Problems	☐ Incontinence	☐ Cough	☐ Joint Pain	☐ Abdominal Pain
☐ Hoarseness	☐ Loss of Balance	☐ Wheezing	☐ Joint Stiffness	☐ Jaundice
☐ Headache	☐ Loss of Coordination	☐ Shortness of Breath	☐ Difficulty walking	☐ Reflux
☐ Other	☐ Other	☐ Other	☐ Other	☐ Other

ARE YOU PREGNANT OR IS THERE A CHANCE YOU MAY BE PREGNANT? ☐Yes ☐No ☐NA

Patient Signature: _____ Date: _____

Height:
Feet: _____ Inches: _____

Weight:
_____ pounds

PEG: A Three-Item Scale Assessing Pain Intensity and Interference

1. **What number best describes your <u>pain on average</u> in the past week?**

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

2. **What number best describes how, during the past week, pain has interfered with your <u>enjoyment of life?</u>**

0	1	2	3	4	5	6	7	8	9	10
Full Enjoyment										No enjoyment in life.

3. **What number best describes how, during the past week, pain has interfered with your <u>general activity</u>?**

0	1	2	3	4	5	6	7	8	9	10
Full General Activity										No General Actvity

From Krebs et al., 2009.

ORT Score

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Name: _____ Date of Birth:_____ Gender: Male or Female

1. Is there a family history of alcohol abuse? Yes No
2. Is there a family history of Illicit substance abuse? Yes No
3. Is there a family history of prescription drug abuse? Yes No
4. Do you have a personal history of alcohol abuse? Yes No
5. Do you have a personal history of illicit substance abuse? Yes No
6. Do you have a personal history of prescription drug abuse? Yes No
7. Are you between the ages of 16 and 45 years old? Yes No
8. Is there a personal history of adolescent sexual abuse? Yes No
9. Do have a personal history of depression? Yes No
10. Do you have a diagnosis of ADD, OCD, Bipolar Disorder, or Schizophrenia? Yes No

Score: ☐

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

©Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk tool. Pain Med. 2005; 6 (6) : 432



CONSENT FOR TREATMENT

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment at TEXAS WELNESS AND PAIN CENTER

PRIVACY NOTICE ACKNOWLEDGEMENT

During your treatment it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

During treatment, we may find it necessary to acquire a laboratory analysis.
During your treatment, a referral to other services may be necessary.
During health care operations, we may need a second opinion.
During the payment process, we may need to release notes and other laboratory results.
Release information to legal authorities or case workers.

I acknowledge that I have had the opportunity to review a copy of the TEXAS WELLNESS AND PAIN CENTER NOTICE OF PRIVACY PRACTICES. I understand that I am responsible for reading this notice and for notifying Texas Wellness and Pain Center in writing of any request for restrictions in the use or disclosure of my individually identifiable health information. I understand that the notice includes electronic access to my medication history. Texas Wellness and Pain Center has the right to revise this notice at any time and will post a copy of the current notice in the office in a visible location at all times. Texas Wellness and Pain Center may also provide me with a copy of its most recent notice upon my request.

CONSENT FOR DISCLOSURES

We understand that at times you may need members of your family or friends to contact the office to make inquiries about your health status, diagnosis, treatment options, schedule, reschedule, cancel appointments or to be contacted in the event of an emergency. To do so, please list the person, or persons you are authorizing to make such inquires or changes. Please be advised that we may require them to confirm personal information to verify their authorization, such as your date of birth.

Name:_____ Relationship:_____ Contact #: _____

Name:_____ Relationshi_:_____ Contact #:_____

I DO NOT give authorization for medical information, lab work results and any other information regarding my appointments or treatment to be released to anyone (Your Initials)

MEDICAID INSURANCE WAIVER

If you decide to seek treatment at Texas Wellness and Pain Center **you are required to sign this waiver in acknowledgment that you have received this waiver (even if you do not have Medicaid insurance),** and that you will be responsible for any portion of your bill that is not covered by any other insurance.



FINANCIAL POLICY AND AGREEMENT

I understand that in consideration of the services provided to me, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered by TEXAS WELLNESS AND PAIN CENTER. I am responsible for any applicable deductible, co-payments and coinsurance prior to the provision of services. Texas Wellness and Pain Center may file ALL claims for payment with my insurance company as a courtesy to me. If the insurance company fails to pay in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts due.

I hereby authorize and assign all payments, insurance or Medicare benefits for medical services and/or procedures rendered to the me, directly to Texas Wellness and Pain Center. I hereby authorize Texas Wellness and Pain Center to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance company or Medicare.

If my insurance company requires me to obtain referrals/authorizations, it is my responsibility to obtain such and if not, then I will be responsible for any unpaid balance.

By signing this agreement, I acknowledge that I have carefully read, understand and agree to the above terms and conditions. I also understand that it is mandatory to tell Texas Wellness and Pain Center if another party is responsible for paying for my treatment (i.e. Automobile Insurance, Workers' Compensation, slip and fall). Section 1128B of Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

FEE POLICY

Appointment Cancellation/No Show Fees:
If you do not call within 24hrs of your scheduled appointment to cancel, reschedule, or if you "no show" for a scheduled appointment, the following fees will apply:

Follow up = $25.00
Procedure = $100.00
Radiofrequency Ablation= $300.00

Paperwork Fees: (Disability FMLA, etc.)
Physician Progress Report or Functional Capacity Evaluation $50.00 per page

Medical Records Fees:
$1.00 per page for the first 25 pages, $0.25 per page thereafter

By signing this agreement, I acknowledge that I have carefully read, understand, and agree to the terms and conditions of the Consent for Treatment Agreement, the Privacy Notice Acknowledgment, the Consent for Disclosure, the Financial Policy and Agreement, the Medicaid Insurance Waiver, and the Fee Policy. I have completed these forms accurately and to the best of my knowledge and will be financially responsible if I have failed to provide Texas Wellness and Pain Center with all of my applicable insurance information.

_____

Patient/Legal Guardian Signature: _____ **Date:** _____

TEXAS WELLNESS and PAIN CENTER

Pain Treatment with Opioid Medications: Patient Agreement

I, _____, understand and voluntarily agree that:
(Put initials next to each statement after reviewing).

_____ I will keep track and be on time for all of my scheduled appointments with the doctor and other members of the treatment team.

_____ I will keep my medication safe, secure, and out of the reach of children. If my medication is lost or stolen, I understand that Dr. Sheikh **will not replace** my prescription until my next appointment or may not be replaced at all.

_____ The narcotics prescribed will be taken exactly as directed with adjustment made only if as instructed.

_____ I will not call in between appointments, at night, or on weekends requesting refills before the fill date. I understand that prescriptions will be only be sent to the pharmacy during scheduled office visits with the treatment team.

_____ I will make sure I have an appointment according to my refill schedule. If I am having trouble making an appointment, I will notify a member of the TWPC team immediately.

_____ I will treat the office staff respectfully at all times. I understand that if I am disrespectful to the TWPC staff or disruptive in any way to the care and treatment of other patients, my treatment plan with Dr. Sheikh will be terminated immediately.

_____ I will not obtain narcotics, alter my prescription, or sell my prescription medication with others. If I do, my treatment plan will be terminated immediately. Narcotics are only to be used by me.

_____ I will sign a release form to let Dr. Sheikh speak to all other doctors/providers that I see or have seen.

_____ I will tell Dr. Sheikh all other medications that I take and will let her know right away if I have a prescription for a new medication.

_____ I will not get any other opioid medications or any other medications that can be addictive such as benzodiazepines (klonopin, xanax, valium) or stimulants (ritalin, amphetamine) without telling a member of the TWPC team **before I fill that prescription**. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

_____ I will not use any illegal drugs such as heroin, cocaine, marijuana, or amphetamines. If I do my treatment will be terminated immediately.

_____ My progress will be periodically reviewed and, if the medication(s) do not appear to be improving my quality of life, in my physician's opinion, the medication(s) may be discontinued, altered, or changed.

_____ If I take my medication inappropriately, I risk immediate discharge from Dr. Naureen Sheikh's office.

_____I agree to submit my urine screens to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning or notice. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, any street drug, or positive for any pain medication or any other ancillary medication not authorized by the physician, treatment will be terminated. I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, and/or other medical care.

_____ I will keep up to date with any owed balances from the office and tell Dr. Sheikh or TWPC staff immediately if my insurance is no longer active, has changed, or I am unable to afford to pay my copay/coinsurance anymore.

_____ I understand that I may lose my right to receive treatment at Texas Wellness and Pain Center if I breach this pain management agreement in anyway.

_____ I will only use the one listed pharmacy below to get all my medications. If I need to change pharmacies, I will fill out another patient agreement form again. Any transfer of of prescriptions must be done with Dr. Naureen Sheikhs approval within ten (10) business days of advanced warning. Dr. Naureen Sheikh will discuss my care and use of medication with the pharmacist, as she deems neccessary.

_____ I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain, including any off label use of medications. I fully understand the explanation regarding the benefits and the risks of these medication(s) and I voluntarily and knowingly agree to the use of these medication(s) in the treatment of my chronic pain.

_____ 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 and to this Pain Management.

Pharmacy Name Phone Address

_____ _____ _____

Pain Treatment Program Statement:

We here at Texas Wellness and Pain Center are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medication refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment. We will make sure that your treatment plan is as safe as possible. We will check regularly to make sure you are not having any side effects.

We will keep track of your prescriptions and randomly drug test you this is to ensure consistency in your set treatment plan as well as to help you feel as if you are being well monitored.

We will help connect you with other forms of treatment to help you with your condition.

We will help set treatment goals and monitor your progress in achieving these goals.

We will work with any other doctors/providers you are seeing so that they can treat you safely and effectively.

We will work with your medical insurance provider to make sure you do not go without medication because of prior authorizations or other things, they may ask for.

If you become addicted to your medications, we will help you get treatment and get off of the medications that are causing you problems safely, without you having to go through withdrawal.

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_____ _____ _____

Patient Signature Patient Name Printed Date

_____ _____ _____

Office Signature Office Name Printed Date