

## Locations:

### Fort Worth

7235 Boat Club Rd.  
Fort Worth, TX 76179  
817-677-9535

### Round Rock

7201 Wyoming Springs Ste. 400  
Round Rock, TX 78681  
512-498-1029

### Dripping Springs

13830 Sawyer Ranch Rd. Ste. 203  
Dripping Springs, TX 78620  
512-498-1029

### Seguin

411 S. King St.  
Seguin, TX 78155  
830-609-9478

### Waco

205 Woodhew Dr. Ste. 203  
Waco, TX 76712  
254-732-6632

### Central Austin

630 West 34<sup>th</sup> St. Ste. 303  
Austin, TX 78705  
512-498-1029

### San Marcos

601 A Leah Ave.  
San Marcos, TX 78666  
512-498-1029

### San Antonio

250 E Basse Rd. Ste. 207  
San Antonio, TX 78209  
210-614-9955

### Killeen

3202 S W.S. Young Ste. 102  
Killeen, TX 76542  
254-247-3322

### South Austin

4316 James Casey St.  
Bldg. B Ste.200  
Austin, TX 78745  
512-498-1029

### New Braunfels

213 Hunters Village  
New Braunfels, TX 78132  
830-627-3800

Even though we at Central Texas Pain Center are committed to compassionate care, we must exercise proper due diligence when prescribing opioid analgesics for chronic pain. Prescription drug abuse has reached epidemic proportions in our society. Therefore, our clinic policy is that an appropriate workup must be completed prior to the dispensing of an opioid prescription. This workup will include review of previous pharmacy/clinic records, evaluation by diagnostic and laboratory tests, and acceptable completion of a urine drug screen yielding expected results. Common examples of opioid analgesics include hydrocodone, morphine, oxycodone, fentanyl, opana, and methadone. Prescriptions for these medications will not be given at an initial visit.

- Please bring your driver's license and insurance cards along with your **completed** new patient paper work to your scheduled appointment. Payment for services are expected at the time of service (co-pays, co-insurance, private pay). We accept cash, check, money order and credit cards (Visa, American Express, MasterCard, and Discover).
- **If you have been instructed to obtain imaging reports and/or films by our staff, please bring them to your appointment. Our office requires these as part of your consultation. If we do not have your films at the time of your appointment, you may be rescheduled.**
- Your initial visit at Central Texas Pain Center is a consultation. If a doctor referred you for an injection, you must be seen for an office visit first. Procedures are scheduled after the initial consultation.
- If English is your second language, please make arrangements for someone to accompany you to your visit who can translate in order to provide you with the best healthcare service. We want you to fully understand your diagnosis and prognosis, and have any questions you may have answered.

We wish to make your visit as comfortable as possible, so please do not hesitate to contact us if you have any questions at the numbers listed above.

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

## **NEW PATIENT INTAKE**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ GENDER: \_\_\_M\_\_\_F

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

SSN: \_\_\_\_\_ DRIVERS LICENSE #: \_\_\_\_\_

ETHNICITY: Hispanic or Latino Not Hispanic or Latino PREFERRED LANGUAGE: \_\_\_\_\_

RACE: American Indian Asian Black or African American Native Hawaiian or Other Pacific Islander White Other

RELIGION: \_\_\_\_\_ EDUCATION: \_\_\_\_\_

EMAIL: \_\_\_\_\_ MARITAL STATUS: Married Widowed Single Divorced

WHAT IS YOUR PREFERRED METHOD OF COMUNICATION? Home phone Cell Phone Work Phone E-Mail

REFERRING PHYSICIAN: \_\_\_\_\_ PRIMARY CARE PHYSICIAN: \_\_\_\_\_

OTHER PHYSICIANS: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

EMERGENCY PHONE: \_\_\_\_\_ PHONE TYPE: \_\_\_\_\_

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## **RESPONSIBLE PARTY INFORMATION**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ SSN: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ EMPLOYER PHONE: \_\_\_\_\_

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## **INSURANCE or ATTORNEY (if applicable) INFORMATION**

INSURANCE COMPANY: \_\_\_\_\_ Please provide card to front desk.

INSURED'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

INSURED'S SSN: \_\_\_\_\_ RELATIONSHIP TO PATIENT: SELF SPOUSE DEPENDENT

ATTORNEY NAME: \_\_\_\_\_ ATTORNEY PHONE: \_\_\_\_\_

ATTORNEY ADDRESS: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**Clinic Policies**

**Initials** \_\_\_\_\_ Payment is due at the time services are rendered. I understand that if I have insurance that I am the responsible party, and that having insurance does not guarantee payment of the services rendered to me. I authorize submission of my claim to the insurance company listed above.

**Initials** \_\_\_\_\_ If you are unable to make an appointment please call within 24 hours prior to your appointment time to reschedule. If you fail to notify our office prior to missing your scheduled appointment you will be charged a NO SHOW fee of \$25 for an office visit and \$50 for a procedure. Frequent NO SHOWS may result in a release from the practice.

**Initials** \_\_\_\_\_ Permission for treatment: I hereby authorize physician and assistants for the care of the patient named on this record to administer treatment as may be deemed necessary including examinations of treatments that may be ordered to be performed by the clinical personnel. I acknowledge that no guarantees have been made to me to the result of examinations or treatments to be performed.

**Acknowledgement of Review of Notice of Privacy Practices**

I have reviewed this office’s notice of privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (CTPC Employee)

\_\_\_\_\_  
Description of witness authority

\*\*\*Please list the name of any person(s) you wish to have access to your medical information, including portal access:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

### **PAST MEDICAL HISTORY**

Please indicate if you have suffered from any of the following medical conditions. Also, state the year when these occurred.

- |                                               |                                                  |                                                      |
|-----------------------------------------------|--------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> AIDS or HIV          | <input type="checkbox"/> Herpes infection        | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Pneumonia                   |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Hormone problems        | <input type="checkbox"/> Prostate enlargement        |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Insomnia                | <input type="checkbox"/> Rheumatic heart             |
| <input type="checkbox"/> Chronic skin disease | <input type="checkbox"/> Irregular heart beats   | <input type="checkbox"/> Schizophrenia/bipolar       |
| <input type="checkbox"/> Depression           | <input type="checkbox"/> Jaundice                | <input type="checkbox"/> Seizures/convulsions        |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Kidney disease          | <input type="checkbox"/> Shingles                    |
| <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Kidney stones           | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Fibromyalgia         | <input type="checkbox"/> Liver disease           | <input type="checkbox"/> Syphilis                    |
| <input type="checkbox"/> Gall bladder         | <input type="checkbox"/> Lupus                   | <input type="checkbox"/> Thyroid                     |
| <input type="checkbox"/> Gonorrhea            | <input type="checkbox"/> Menopause               | <input type="checkbox"/> Tuberculosis                |
| <input type="checkbox"/> Gout                 | <input type="checkbox"/> Multiple sclerosis      | <input type="checkbox"/> Urinary infection           |
| <input type="checkbox"/> Headaches/migraines  | <input type="checkbox"/> Nervous breakdown       | <input type="checkbox"/> Other: _____                |
| <input type="checkbox"/> Heart disease/attack | <input type="checkbox"/> Other blood abnormality | _____                                                |
| <input type="checkbox"/> Heart failure        | <input type="checkbox"/> Other venereal disease  | _____                                                |
| <input type="checkbox"/> Heart murmur         | <input type="checkbox"/> Panic attacks           | _____                                                |
| <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Peptic ulcer disease    | _____                                                |

### **PAST SURGICAL HISTORY**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### **FAMILY HISTORY**

Please list any disease, illness, or ailments in your IMMEDIATE FAMILY (i.e. mother-breast cancer, father- diabetic, grandfather-heart disease).

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

## **SOCIAL HISTORY**

Occupation: \_\_\_\_\_

Do you smoke? Yes No how many pack(s) day? \_\_\_\_\_ Years? \_\_\_\_\_

Drink alcohol? Yes No if yes how much? \_\_\_\_\_

Do you use any other drug (Marijuana, Cocaine, etc.)? Yes No

If yes, which drug? \_\_\_\_\_

Marital status? Single Married Divorced Widowed

Do you live alone? Yes No If no, who do you live with? \_\_\_\_\_

## **REPRODUCTIVE HISTORY**

**Women:** Your age when menstrual cycle began? \_\_\_\_\_

Date of last period? \_\_\_\_\_ Difficulty with periods? \_\_\_\_\_

Total pregnancies you have had? \_\_\_\_\_ How many live births? \_\_\_\_\_

Miscarriages or abortions? Yes No How many? \_\_\_\_\_

Any medical problems associated with pregnancy or any other gynecological illnesses? Yes No

Do you have any history with breast disease? Yes No

Do you perform regular breast exams? Yes No

Date of last Pap smear? \_\_\_\_\_ Date of last mammogram? \_\_\_\_\_

**Men:** Do you perform regular testicular self-exams? Yes No

Have you had problems with testicular, prostate or infertility? Yes No

If yes, please explain? \_\_\_\_\_

## **ALLERGIES**

## **PHARMACY NAME AND LOCATION**

## **CURRENT MEDICATIONS**

\*\*Please include dosage and frequency of each medication. \*\*

Medication

Dosage

Frequency

\_\_\_\_\_

\_\_\_\_\_

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NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

## REVIEW OF SYSTEMS

In the past few months, have you had any of the following symptoms or difficulties? If you have any difficulty that bears further explanation, please indicate so and explain in the additional notes section.

<b>General</b>	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
Loss of Appetite			Recent Weight Loss		
Fever or chills			Low Energy/Fatigue		
<b>Eyes</b>					
Blurred Vision			Double Vision		
Loss of vision			Eye pain		
<b>Head/Ears/Nose/Throat</b>					
Hoarseness			Hearing Loss		
Trouble Swallowing			Ear Pain		
<b>Cardiovascular</b>					
Chest pain			Palpitations		
Leg Swelling			Orthopnea		
Varicose Veins					
<b>Respiratory</b>					
Shortness of Breath			Chronic Cough		
Wheezing					
<b>Gastrointestinal</b>					
Nausea or Vomiting			Heartburn		
Blood in Stool			Constipation		
Change in Bowel Habits			Hemorrhoids		
<b>Kidney/Bladder/Urine</b>					
Painful Urination			Blood in Urine		
Frequent Urination			Change in Urinary Pattern		
<b>Musculoskeletal</b>					
Significant Pain/Stiffness					
<b>Skin</b>					
Rash			Itching		
Frequent Rashes					
<b>Neurological</b>					
Tremor			Dizziness		
Seizures			Tingling		
<b>Psychiatric</b>					
Depression			Suicidal Thoughts		
Drug/Alcohol Addiction			Trouble Sleeping (Insomnia)		
Difficulty with sexual activities					
<b>Endocrine</b>					
Thyroid Disease			Heat/Cold Intolerance		
<b>Hematological/Lymphatic</b>					
Easy Bruising			Easy Bleeding		
<b>Immunologic</b>					
Enlarged/Swollen Lymph Glands					

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**ADDITIONAL NOTES**

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**Pain Evaluation**

Is there an ongoing lawsuit related to your visit today?       YES       NO

Are you currently under worker's compensation?       YES       NO

Location of your pain: \_\_\_\_\_

When did it start? \_\_\_\_\_

What happened and when? (Car accident, fall, nothing, etc.)

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From scale of 0 to 10 (0=no pain and 10= severe pain) how bad is your pain today? \_\_\_\_\_ over the past 30 days what was your average pain score? \_\_\_\_\_

What **aggravates** your pain?

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What makes your **pain better**?

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What medications (including over the counter drugs) have you tried to treat this pain with? Were the medications helpful or unhelpful?

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NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

How has this pain affected your physical function, quality of life and ability to participate in activities (including activities required for daily living and self-care)?

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What treatments have you tried in the past? When did you have these treatments? Did it help? (Indicate below)

<b>Treatments</b>	<b>Tried (yes or no)</b>	<b>When (year)</b>	<b>Helped (yes or no)</b>
Chiropractor	_____	_____	_____
Traction	_____	_____	_____
Braces	_____	_____	_____
Nerve Block	_____	_____	_____
Physical Therapy	_____	_____	_____
Hypnosis	_____	_____	_____
Acupuncture	_____	_____	_____
Biofeedback	_____	_____	_____
Ice/heat Pack	_____	_____	_____
Opioids	_____	_____	_____
Massage	_____	_____	_____
Religious Counseling	_____	_____	_____
Psychological Counseling	_____	_____	_____
TENS/ Electrical Stimulation	_____	_____	_____
Pain Medication	_____	_____	_____
Surgery	_____	_____	_____

Which treatment above has helped you the most?

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If you have had surgery for the pain, please list what kind, how many, when, and if it helped:

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Have you tried any interventional pain modalities such as epidural or facet injections, nerve blocks or ablations, or spinal cord stimulation? If so, please indicate the type of procedure, where and when it was done, and your response:

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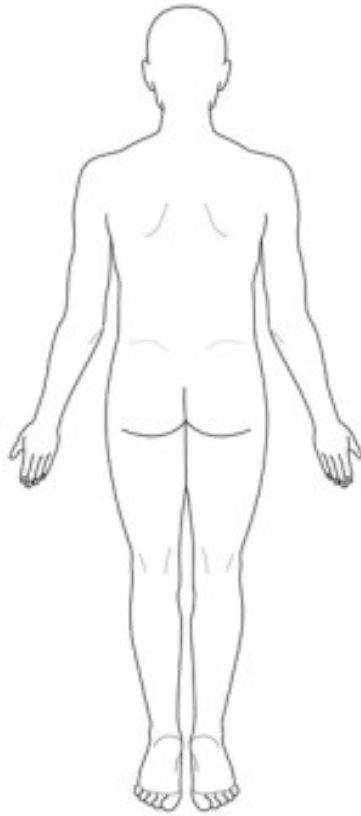
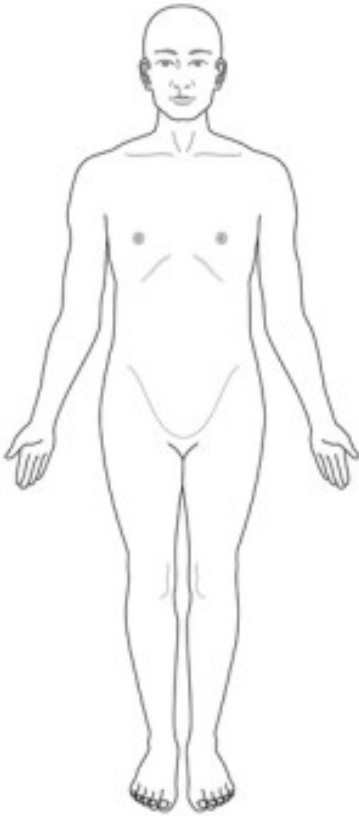
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NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

If the top of the line indicates "pain as bad as it can be" and the bottom is "no pain." Where on that line would your pain be, right now?



Pain as bad as it can be



No Pain

Using the appropriate symbol, mark the area(s) on your body where you feel each of the sensations above.

<b>Numbness</b>	<b>Pins &amp; Needles</b>	<b>Burning</b>	<b>Aching</b>	<b>Stabbing</b>
-----	oooooooo	^^^^^^	XXXXXXXXX	ΦΦΦΦΦΦ
	<b>Constant</b>	<b>Intermittent</b>	<b>Deep</b>	<b>Superficial</b>
	cccccc	iiiiiiiiiiii	dddd	ssssssssss

How long can you be comfortable until pain increases?

Sitting	0 min	1-30 min	31-60 min	1 hour
Standing	0 min	1-30 min	31-60 min	1 hour
Resting or reclining	0 min	1-30 min	31-60 min	1 hour

How much time do you spend each day....?

Sitting	Less than 2 hrs	2-5 hrs	5-8 hrs	8-12 hrs	12 hrs
Standing/Walking	Less than 2 hrs	2-5 hrs	5-8 hrs	8-12 hrs	12 hrs