Central Texas PAIN CENTER

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

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

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

Central Austin
630 West 34th St. Ste. 303
Austin, TX 78705
512-498-1029

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

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

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

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.

Notice of Financial Interest

This is to serve as legal notice that the physicians at this location providing my care have a financial interest in The Pain Relief SurgiCenter, Ambulatory Surgery Center of Killeen, Pain Specialists of Austin Pharmacy and Hunter's Creek Pharmacy. I understand that I am free to choose any facility for obtaining services or prescriptions that are ordered for me.

Physicians include the following: Hans Bengtson, Scott Campbell, Teddrick Dunson, Daniel Frederick, Douglas Freiberger, Genaro Gutierrez, Gary Heath, Matthew Hellman, Vivek Mahendru, Pankaj Mehta, Eric Miller, Rahul Sarna, Samuel Stevens, Derrick Wansom, Stewart Zweikoft.

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: _____

RESPONSIBLE PARTY INFORMATION

NAME:_____ DATE OF BIRTH: _____

ADDRESS: _____

PHONE:_____ SSN:_____ RELATIONSHIP:_____

EMPLOYER:_____ EMPLOYER PHONE: _____

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.

_____AIDS or HIV
_____Arthritis
_____Asthma
_____Cancer
_____Chronic skin disease
_____Depression
_____Diabetes
_____Emphysema
_____Fibromyalgia
_____Gall bladder
_____Gonorrhea
_____Gout
_____Headaches/migraines
_____Heart disease/attack
_____Heart failure
_____Heart murmur
_____Hepatitis
_____Herpes infection
_____High blood pressure
_____Hormone problems
_____Insomnia
_____Irregular heart beats
_____Jaundice
_____Kidney disease
_____Kidney stones
_____Liver disease
_____Lupus
_____Menopause
_____Multiple sclerosis
_____Nervous breakdown
_____Other blood abnormality
_____Other venereal disease
_____Panic attacks
_____Peptic ulcer disease
_____Peripheral vascular disease
_____Pneumonia
_____Prostate enlargement
_____Rheumatic heart
_____Schizophrenia/bipolar
_____Seizures/convulsions
_____Shingles
_____Stroke
_____Syphilis
_____Thyroid
_____Tuberculosis
_____Urinary infection
____Other:_____
_____
_____

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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.

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

NAME:_____ DATE OF BIRTH: _____

ADDITIONAL NOTES

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.)

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?

What makes your **pain better**?

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

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)?

_____

_____

_____

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

Treatments	**Tried (yes or no)**	**When (year)**	**Helped (yes or no)**
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?

_____

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

_____

_____

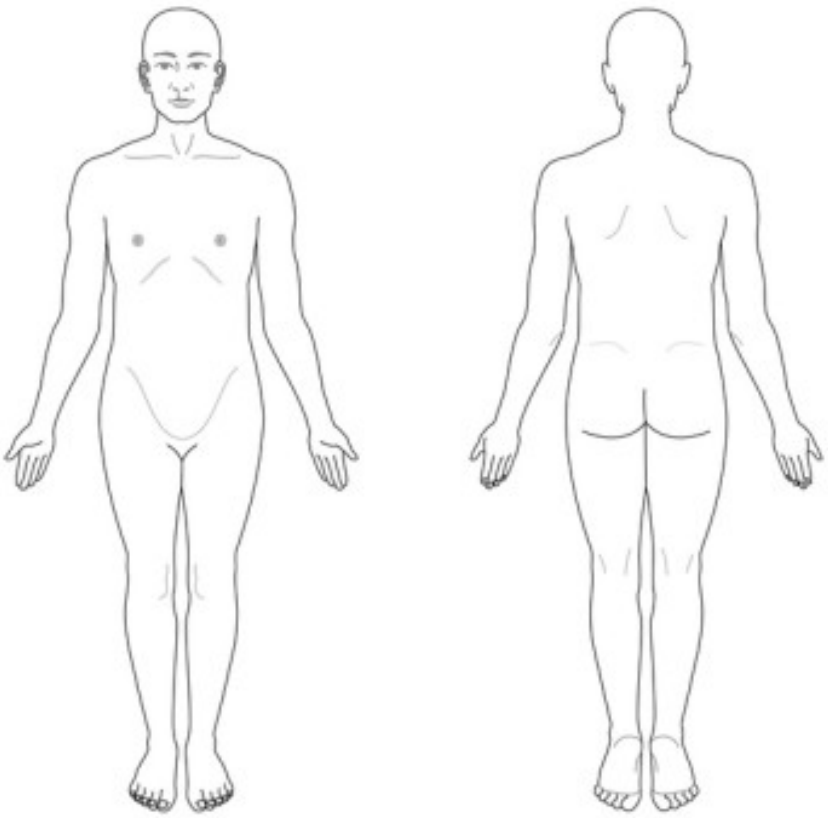
_____

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:

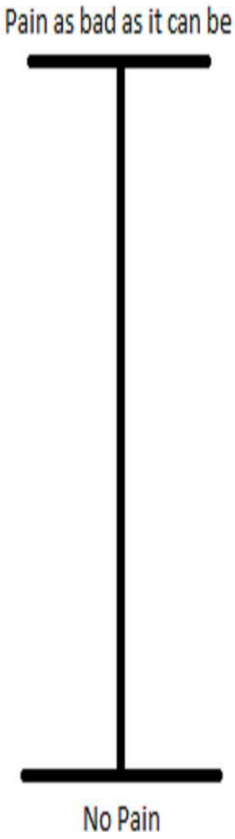
_____

_____

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**?



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

Numbness	**Pins & Needles**	**Burning**	**Aching**	**Stabbing**
----------	o o o o o o o o	^ ^ ^ ^ ^ ^	X X X X X X X	Φ Φ Φ Φ Φ Φ

Constant	**Intermittent**	**Deep**	**Superficial**
ccccccc	iiiiiiiiiiiiiii	ddddd	sssssssssss

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