

Locations:

Fort Worth

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

Round Rock

7201 Wyoming Springs Ste.
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.
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.
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, Stuart 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.

- | | | |
|---|--|--|
| <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 | <input type="checkbox"/> Schizophrenia/bipolar |
| <input type="checkbox"/> Depression | beats | <input type="checkbox"/> Seizures/convulsions |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Gall bladder | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Lupus | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Menopause | <input type="checkbox"/> Urinary infection |
| <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Heart disease/attack | <input type="checkbox"/> Nervous breakdown | _____ |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Other blood abnormality | _____ |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Other venereal disease | _____ |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Panic attacks | |
| | <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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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.

General

	YES	NO
Loss of Appetite		
Fever or chills		

Eyes

Blurred Vision		
Loss of vision		

Head/Ears/Nose/Throat

Hoarseness		
Trouble Swallowing		

Cardiovascular

Chest pain		
Leg Swelling		
Varicose Veins		

Respiratory

Shortness of Breath		
Wheezing		

Gastrointestinal

Nausea or Vomiting		
Blood in Stool		
Change in Bowel Habits		

Kidney/Bladder/Urine

Painful Urination		
Frequent Urination		

Musculoskeletal

Significant Pain/Stiffness		
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Skin

Rash		
Frequent Rashes		

Neurological

Tremor		
Seizures		

Psychiatric

Depression		
Drug/Alcohol Addiction		
Difficulty with sexual activities		

Endocrine

Thyroid Disease		
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Hematological/Lymphatic

Easy Bruising		
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Immunologic

Enlarged/Swollen Lymph Glands		
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	YES	NO
Recent Weight Loss		
Low Energy/Fatigue		

Double Vision		
Eye pain		

Hearing Loss		
Ear Pain		

Palpitations		
Orthopnea		

Chronic Cough		
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Heartburn		
Constipation		
Hemorrhoids		

Blood in Urine		
Change in Urinary Pattern		

Itching		
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Dizziness		
Tingling		

Suicidal Thoughts		
Trouble Sleeping (Insomnia)		

Heat/Cold Intolerance		
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Easy Bleeding		
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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	_____	_____	_____

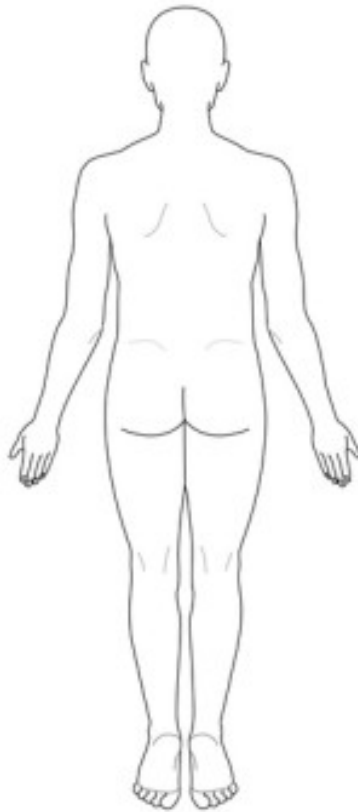
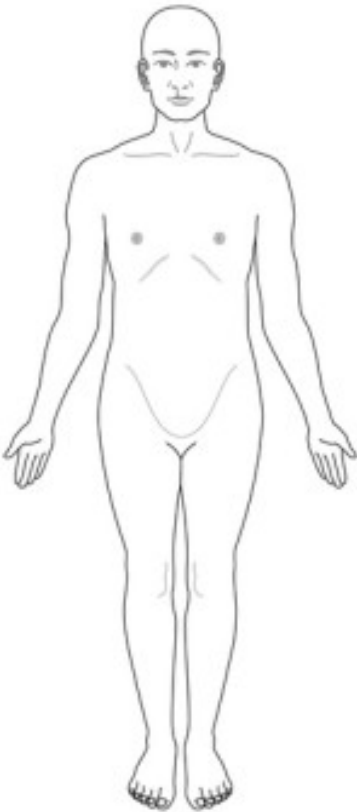
Which treatment above has helped you the most?

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

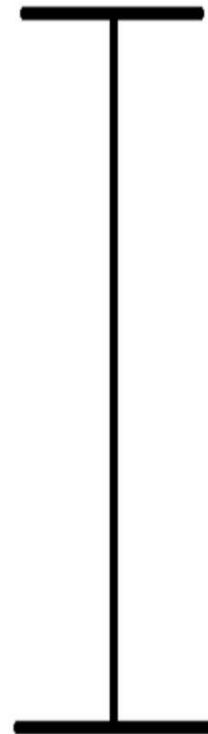
Have you tried any interventional pain modalities such as epidural or facet injections, nerve blocks or ablations, or spinal cord stimulation? If so, please indicate the type of procedure, where and when it was done, and your response:

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?



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.

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 iiiiiiiiiiiiiiiiii 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