

PAST MEDICAL HISTORY (PMH)

Do you currently have or do you have a history of any of the following:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Vision Disorder | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Back Injury | <input type="checkbox"/> False teeth/Caps |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Neck Injury | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Recent Cold |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Leg cramps/pain | <input type="checkbox"/> Steroid Use | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Varicose vein | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Motion Sickness |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Frequent Heartburn | <input type="checkbox"/> Loose Teeth |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Sexual Transmitted Disease |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> TB | |
| <input type="checkbox"/> Spinal Cord Stimulator | <input type="checkbox"/> Pacemaker | | |

List any medical problems not listed above:

Tobacco Amount: _____ Packs/day for _____ years

Alcohol Amount: _____

Street/Recreational Drugs: Types: _____

List all previous surgeries: _____

Problems with Anesthesia: Yes No

- | | |
|---|--|
| <input type="checkbox"/> High Temperature | <input type="checkbox"/> Muscle Spasms |
| <input type="checkbox"/> Allergic Reaction | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Delayed Awakening | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Prolonged Weakness | <input type="checkbox"/> Nausea and Vomiting |
| <input type="checkbox"/> Difficulty with breathing tube | <input type="checkbox"/> Excessive Bleeding |

NO KNOWN DRUG ALLERGIES

Allergies: Name Reaction

1. _____

2. _____

3. _____

4. _____

Height _____ Weight _____

Immunizations Current? Yes No

Chief Complaint/Reason for Visit: _____

Highest Level of Education _____

Do you have any cultural/religious practices that will impact your health care? Yes No

If yes, Please explain. _____

AUTHORITY TO RELEASE MEDICAL INFORMATION

I hereby authorize the release of the information contained in my medical records to: (Example: family member and or a physician)

Name/phone number or fax number: _____

I understand that my medical records may contain information that indicates that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).

With this knowledge, I give my consent to the release of all information in my medical records including and any information concerning my identity and release provider, its agents, and employees from any liability in connection with the release of information contained therein.

PATIENT NAME (PRINT)

SIGNATURE

DATE

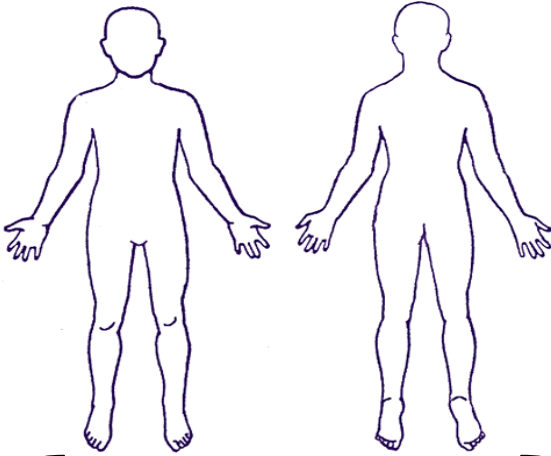
PAIN MANAGEMENT QUESTIONNAIRE (PMQ)

PATIENT NAME _____ DATE _____

REFERRING PHYSICIAN _____ DATE PAIN STARTED _____

FRONT

BACK



PLEASE INDICATE WHERE YOUR PAIN OCCURS BY SHADING IN PAINFUL AREAS

Please indicate by circling:

YOUR PAIN AT THE PRESENT TIME: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

YOUR PAIN AT ITS WORST: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

YOUR PAIN AS ITS LEAST SEVERE: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

YOUR PAIN AS IT USUALLY IS: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

SINCE YOUR PAIN BEGAN, HAS IT: Increased Decreased Stayed the same

HAVE YOU HAD ANY OF THE FOLLOWING?

- X-RAYS
 - MYELOGRAM/DISCOGRAM (CIRCLE ALL THAT APPLY)
 - EMG
 - CAT SCAN
 - EMERGENCY ROOM VISITS
 - MRI SCAN
 - BONE SCAN
 - PHYSICAL THERAPY
 - TENS UNIT for pain
 - NERVE BLOCKS (INJECTIONS) FOR PAIN RELIEF.
- PHYSICIAN THAT PERFORMED BLOCKS:

WHICH STATEMENT BEST DESCRIBES YOUR PAIN?
(Choose One)

- Always present, always the same intensity.
- Always present, intensity varies.
- Usually present, but have short periods without pain.
- Often present, but have pain free periods lasting one to several hours.
- Often present, but am pain free most of the day.
- Occasionally present. Have pain once to several times per day, lasting a few minutes to an hour.
- Occasionally present for brief periods, a few seconds to a few minutes.

DO ANY OF THE FOLLOWING MAKE YOUR PAIN FEEL WORSE? (Check all that apply)

- Coughing, Sneezing
- Sitting
- Standing
- Lying Down
- Walking
- Physical Activity
- Sexual Activity
- Other: _____

WOULD YOU DESCRIBE YOUR PAIN AS..?

- Burning
- Sharp
- Throbbing
- Shooting
- Aching
- Other: _____

WHAT TIME OF DAY IS YOUR PAIN WORSE?

- Morning, On Arise
- Later in the morning
- Afternoon
- Evening
- Bedtime
- Night (During usual sleep hours)
- Pain is always the same
- Pain varies, But is not worse at any particular time

DO ANY OF THE FOLLOWING MAKE YOUR PAIN FEEL BETTER? (Check all that apply)

- Relaxation
- Sitting
- Standing
- Lying Down
- Alcoholic Drinks
- Sexual Activity
- Heat
- Medicines
- Walking
- Other: _____
- Nothing Makes Me Feel Better

DO YOU HAVE ANY OF THE FOLLOWING?
(Check all that apply)

- Numbness
- Tingling (Pins and Needles)
- Weakness
- Coldness
- Increased Sweating
- Muscle Spasm, Tightness
- Skin Discoloration
- Bowel or Bladder Problems

DOES PAIN INTERRUPT YOUR SLEEP?

YES NO

SLEEPING TROUBLE:

- Never (0 times a month)
- Seldom (4 times a month)
- Occasionally (5 times a month)
- Often (10 times a month)
- All the time (Every night)

WAKENING TROUBLE:

- Never (0 times a month)
- Seldom (4 times a month)
- Occasionally (5 times a month)
- Often (10 times a month)
- All the time (Every night)



**Regional Pain Care
Center**

1111 Raintree Circle Suite 170
Allen, TX 75013
214-509-9691



Regional Pain Care Center

MEDICATION LIST

Patient Name: _____

Doctor you are seeing: _____

Are you here for MRI/CT results ? Yes or No Date of last injection: _____

DID YOU BRING YOUR MEDICATION BOTTLES WITH REMAINING PILLS?

List of Medications (include over the counter)	Dosage	Times per day

On the average, how severe has your pain been during the last week?

0 1 2 3 4 5 6 7 8 9 10

Not severe at all

Extremely severe

In general how much is you pain interfering with day-to-day activities?

0 1 2 3 4 5 6 7 8 9 10

Release of information and assignment of benefits:

I hereby authorize the release of any medical information necessary to process my health insurance claims and request payment of benefits to RPCC, where services were provided. I permit a copy of this authorization to be sed in place of the original. I understand *I am financially responsible* to the center of charges not covered or denied by my insurance compnay. I further agree in the event of non-payment, to pay the cost of collection and/or court cost and reasonable fees, should this be required.

Signature: _____ Date: _____

NOTICE TO ALL PATIENTS

- Effective January 1, 2014 any and all deductible/co-insurance will be due at the time of your visit.
- Please remember to bring your medication bottles that our doctors prescribe you to each appointment.
- It is patient's responsibility to supply a medication list at each visit (we will not be able to print it off for you).

Printed Name

Signature

Date



Regional Pain Care Center

Prescription Prior Authorizations:

Effective 3/1/15

Due to the time and effort that is required for prescription prior authorizations there will be a \$25.00 charge for each prescription prior authorization that needs to be obtained by the physician.

Patient Name: _____ Date: _____

Patient Signature: _____

RPCC PHARMACY (PI)

PLEASE TAKE A MOMENT AND READ THE FOLLOWING INFORMATION REGARDING OUR OFFICE REQUIREMENT/POLICIES

We ask that you complete paperwork and present your INSURANCE CARD and DRIVER'S LICENSE if you are the patient or the parent of a patient who is a minor. If the patient is a minor a parent or legal guardian must accompany the child. Legal guardians should bring a copy of the Consent to Treat form or the child cannot be treated.

EVERY NEW PATIENT must bring medical records (pertaining to their current problem) to the first appointment. Past medical history, X-rays, CT scans, MRI, lab reports and lists of medications you routinely take are required.

As a courtesy to our patients, we will file your insurance claims. However, you are required to bring you CURRENT INSURANCE CARD and driver's license. If you do not have your insurance card or driver's license, payment in full will be due on the date of service, or we can reschedule your appointment. Patients should know their benefits and limitations before coming to the office. We are not responsible for knowing every policy that is on the market today.

If your insurance company requires a referral from your Primary Care Physician, it is YOUR RESPONSIBILITY to obtain it. If you do not have your referral with you or one is not in the system at the time of your appointment, we will have no choice but to reschedule your appointment.

On occasion, emergencies do arise for our physicians. If this should occur, we will notify you as soon as possible to reschedule your appointment. We appreciate your consideration in this matter. A 24-hour notice is desired if you wish to cancel your appointment. Our office hours are Monday-Thursday 9:00-5:00.

NO SHOW AND CANCELLATION POLICY \$25.00 FEE

Patients who do not keep their Office visit appointments, EPS appointments, Nerve Scan appointments, Procedure appointment or **provide 24 hour notice of cancellation will be subject to a charge of \$25.00 and Procedure cancellation will be subject to a charge of \$50.00.** This is not a billable charge to any insurance company and is the responsibility to the patient. If a patient misses or cancels 3 times, we reserve the right to dismiss that patient from the care of Regional Pain Care.

PHARMACY INFORMATION (PI)

We require your pharmacy's phone number and address. If you do not know the address, please call to get the physical address. We will not call to get the information for you. We are supplying phone books at the counter for you. Again, please call your pharmacy to get the correct information the doctors are requiring for your office visit today.

Patient Name: _____ Date: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Address: _____

Family Physician: _____

Phone: _____ Fax: _____

REGIONAL PAIN CARE CENTER

Your physician may refer you to Pain Care of North Texas for treatment. Ambulatory surgery has been chosen as the most effective method for treatment.

This is to notify you that Dr. Deborah Holubec, Dr. Jerry Holubec and Dr. Wesley Merritt have financial interest in this facility.

Patients Signature: _____ Date: _____

Authorized Rep
Signature: _____ Date: _____

**Regional Pain Care Center
OPIOID CONSENT (OC)**

**INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT AS REQUIRED BY THE TEXAS
MEDICAL**

BOARD REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

3rd Edition: Developed by the Texas Pain Society, April 2008 (www.texaspain.org)

NAME OF PATIENT _____ **DATE** _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or 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 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 health care 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 medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE 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 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 it is 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 your care.

Additional risks and alternatives (to be filled in by physician as necessary): _____

For female patients only:

- 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 am 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 judgment, 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 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), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan 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 to 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 I believe that I have sufficient information to give this informed consent.

PAIN MEDICINE AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That 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 this Agreement.**

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 use only 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 refilled 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.** However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, 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 physician 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 and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, 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 addictionologist 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 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.
- I agree that **I shall inform any 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 medications 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 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 judgment.
- 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 explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain. I have read or had read to me the contents of this form.**

I understand the risks and alternatives of this procedure; I have had the opportunity to ask any questions about this treatment.

Signature of Patient _____ Date _____

Signature of Physician (or Appropriately Authorized Assistant) _____ Date _____