Corpus Christi Pain Medicine

PATIENT REGISTRATION INFORMATION
PLEASE COMPLETE ALL SECTIONS BELOW

Name:_____ Sex:____Male____Female
Last First Middle

Marital Status:_____Single_____Married____Divorced_____Widowed
Street Address:_____City:_____State:_____Zip:_____
Home/Cell#_____/_____WorK#_____SS#_____
Date of Birth:____/____/_____ Driver's License(Number & State)_____
Race: _____White_____Black_____Asian_____American Ind._____Other_____
Ethnicity: _____Hispanic _____Non-Hispanic _____unknown
Language: _____ English ____Spanish _____Other:_____
Employer/Name of School_____Full Time___Part Time____
Occupation:_____ Spouse's Name_____Spouse's Phone:_____

RESPONSIBLE PARTY INFORMATION (Primary Insurance Cardholder)

Responsible Party Name:_____ Date of Birth___/____/_____
Relationship to Patient: ___Spouse ____Parent_____Other(_____)SS#:_____
Employer's Name_____ Phone Number_____
Occupation:_____ Employer's Address_____

PATIENT'S INSURANCE INFORMATION

Primary Insurance Company Name:_____
Name of Insured:_____ Insurance ID:_____Group ID:_____
Secondary Insurance Company Name:_____
Name of Insured:_____ Insurance ID:_____Group ID:_____

EMERGENCY CONTACT: Person not living with you

Name:_____Home#_____Work#_____Cell#_____

Relationship to you:_____

REFERRAL INFORMATION

Referred BY: ____Caller Times ____El Tejano Magazine ____Yellow Pages ____Website ____Other
_____Doctor _____Friend/Relative Please Name: _____

List of Persons I authorize to pick-up prescriptions in the event I am not able to:
Name:_____ Relationship: _____

Name: _____Relationship:_____

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Health Maintenance:

Tobacco Use: _____Yes _____No, #of Years _____ , #of packs per day _____
Alcohol Use: More than 2-3 times per week? _____Yes _____ No
Previous History of Alcoholism? _____ Yes ____ No
Family History of Alcoholism? _____Yes_____ No
Use of Alcohol with medications? _____Yes _____No
Illicit drug us? _____Yes _____No
Treatment for chemical dependency? _____Yes _____No
Pregnant or attempting pregnancy? _____Yes _____No

Family History:

Mother-Past medical history:_____
Father-Past medical history: _____

Social History:

Marital Status: _____Single _____Married _____Separated _____Divorced _____Widowed
Education: ____High School Diploma _____College ____Post Graduate
Currently Employed? ___Yes __No ____Retired ____Disability
Current / Last Job: _____
Last day of employment: _____/_____/_____ Returning to work? ____Yes ____No

Past Surgical History:

Please list all surgeries you have had: (Surgery type, Date, Physician)_____
_____
_____

Medical History:

Are you currently experiencing any of the following medical conditions?

○ Fever	○ Shortness of Breath	○ Problems with bowel movement	○ Chest Pain
○ Sore Throat	○ Diabetes	○ Loss of appetite	○ Bleeding problems
○ Cough	○ Bladder infection	○ Loss of sensation	○ Cancer
○ Swelling (hands, feet)	○ Problems with Urination	○ Insomnia	○ _____
○ Night Sweats		○ Earache	

Have you ever had any of the following medical conditions?

○ Heart Disease	○ Heartburn	○ Fibromyalgia	○ Cancer
○ High Blood pressure	○ Ulcers	○ Rheumatoid Arthritis	○ Heart murmur
○ Low blood pressure	○ Thyroid Disease	○ Osteoarthritis	○ HIV
○ Lung Disease (COPD)	○ Asthma	○ Spinal Stenosis	○ Emphysema
○ Heart Attack	○ Diabetes	○ End Stage Kidney Disease	○ Bronchitis
○ Liver problems	○ Depression	○ Kidney problems	○ _____
○ Hepatitis (A,B,C)	○ Anxiety	_____	
○ Anemia	○ Stroke		
	○ Seizures		
	○ Bleeding problems		

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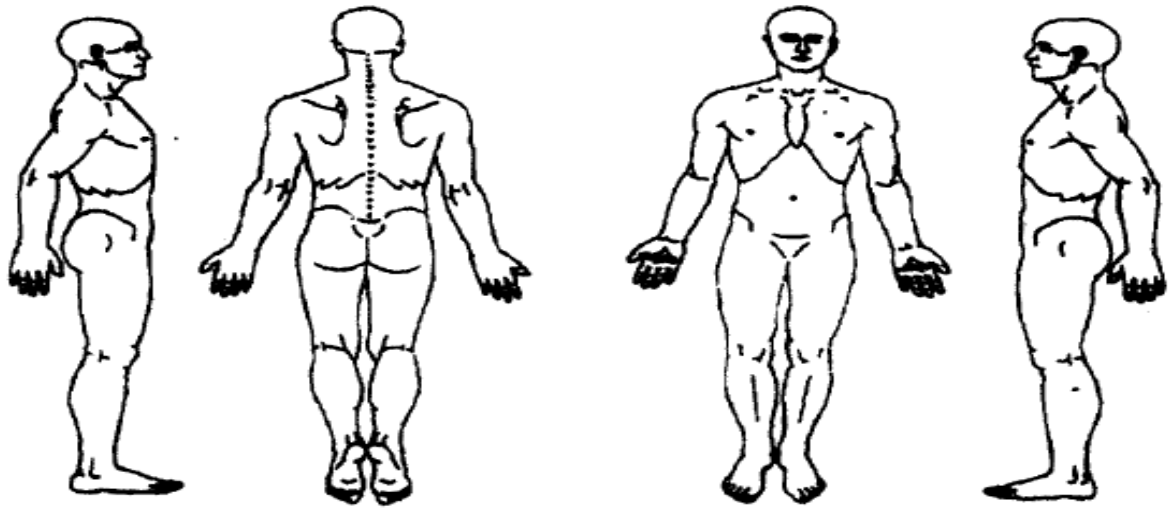
PAIN TREATMENT DESCRIPTION

Is your pain a result of a work related injury? ____Yes ____No
Have you filed for Work Comp. claim? _____Yes ____No
Is there a lawyer involved in your case? ____Yes ____No If yes, Name of Lawyer: _____

Have you ever tried any of the following for your pain?

Treatment Description	Circle Correct Answer		Was it helpful?	
Pain Clinic or Pain Specialist, Name:_____	Yes	No	Yes	No
Anti-Inflammatories (ex. Acetaminophen, Tylenol, etc)	Yes	No	Yes	No
Anti-Depressant Medications	Yes	No	Yes	No
Trigger Point Injections	Yes	No	Yes	No
Epidural Steroids/Nerve Blocks	Yes	No	Yes	No
Psychiatrist or Psychologist	Yes	No	Yes	No
Home Exercises	Yes	No	Yes	No
Pain Medications	Yes	No	Yes	No
Physical Therapy	Yes	No	Yes	No
Surgery	Yes	No	Yes	No

Mark the areas on this body where you feel pain.



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Corpus Christi Pain Medicine

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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, April2008 (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.

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 MANAGEMENT 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.**

_____

Patient Signature

_____

Physician Signature (or Appropriately Authorized Assistant)

_____

_____

Name and contact information for pharmacy

Corpus Christi Pain Medicine

Initial Patient Physical

Today's Date: _____

Patient's Name: _____ Age: _____ DOB: _____
First Middle Last

Primary Physician: _____ Referring Physician: _____

Are you currently on any blood thinners? _____Yes _____No

Please list all medications you are currently taking:

Medication	Dose	Frequency	Date Started

Please list any medications you have taken in the past:

Medication	Dose	Frequency	Date Stopped

Do you have any allergies to medications? _____Yes _____No If Yes, please list:

Medication	Reaction