History and Physical

**PLEASE COMPLETE THIS FORM BEFORE YOUR VISIT. USE BLUE/BLACK INK ONLY**

NAME: _____ AGE: _____ SEX: ❑ M ❑ F

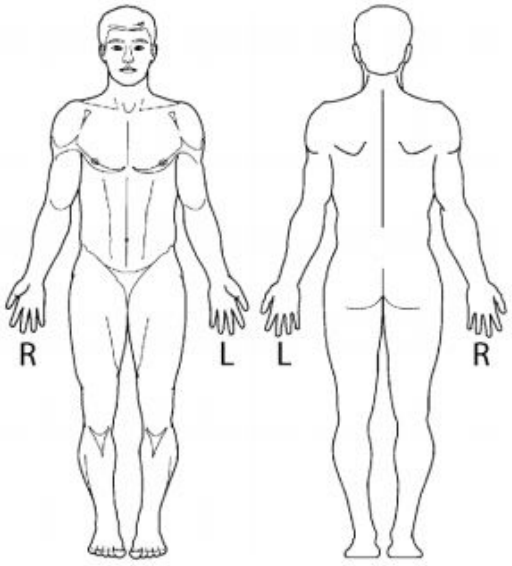
**I. Chief Complaint (CC)**

In your own words, why are you here?

**Referred by (Doctor):** _____

On the diagram, **shade** the area(s) where you *feel* pain.

**Mark** the areas which hurt the *most* with an "**X**".




**II. Check the word(s) which describes your pain.**

❑ Burning ❑ Sharp ❑ Pins & Needles
❑ Sensitive ❑ Aching ❑ Electric
❑ Throbbing ❑ Shooting ❑ Stabbing

**III. When does your pain occur?**

❑ Constantly ❑ Occasionally
❑ With stress ❑ At the same time each day
❑ Without warning ❑ When I move a certain way

**IV. History of Present Illness (HPI)**

When did the pain begin?

What do you feel caused the pain?

Do you have:

Numbness (location) _____

Tingling (location) _____

Weakness (location) _____

**Pain Scale:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| My current pain is ..... ***No pain*** - 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 - ***Extreme pain*** |
| During the **past week**, the **best** my pain has been is ..... ***No pain*** - 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 - ***Extreme pain*** |
| During the **past week**, the **worst** my pain has been is ..... ***No pain*** - 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 - ***Extreme pain*** |
| During the **past week**, my **average** pain has been ..... ***No pain*** - 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 - ***Extreme pain*** |
| During the **past 3 months**, my **average** pain has been ..... ***No pain*** - 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 - ***Extreme pain*** |

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What makes your pain worse? (Please CHECK)

❑ coughing ❑ sneezing ❑ straining
❑ walking ❑ sitting ❑ standing
❑ heat ❑ cold ❑ lying down
❑ bending forward ❑ bending backward ❑ other:

What makes your pain better? (Please CHECK)

❑ walking ❑ sitting
❑ standing ❑ lying down
❑ heat ❑ cold
❑ bending forward ❑ bending backward ❑ other:

Previous Treatments (mark the box if you have tried):

❑ Chiropractor ❑ Physical therapy ❑ Acupuncture
❑ Massage ❑ Injections or procedures (please list type of injection or procedure below)

| Procedure | Month / Year | Body Location | Physician |
|---|---|---|---|
| | | | |
| | | | |

Medicines previously tried for pain (list each medicine, include over the counter medications):

_____

## V. Past History (Medical, Surgical, Family, Social, Hospitalizations)

**Past Medical History:** Please CHECK those that apply TO YOU (not your family) and describe if indicated.

| | | | | |
|---|---|---|---|---|
| ❑ Peripheral Neuropathy | ❑ Easy Bruising/Bleeding | ❑ Heart Attacks | ❑ Heart Failure | ❑ High Blood Pressure |
| ❑ Poor Circulation | ❑ Irregular Heartbeat | ❑ Arthritis | ❑ Thyroid Disease | ❑ Diabetes |
| ❑ Reflux / GERD | ❑ Overweight | ❑ Depression | ❑ Sleep Apnea | ❑ Osteoporosis |
| ❑ Anxiety | ❑ Bipolar Disorder | ❑ Other: | | |
| ❑ Stroke(s) SIDE: ❑ Rt ❑ Lt | ❑ Kidney Disease TYPE: | ❑ Lung Disease TYPE: | ❑ Cancer TYPE: | |

**Past Surgical / Hospital History**

| Operation or Illness | Month / Year | Operation or Illness | Month / Year |
|---|---|---|---|
| 1) | | 3) | |
| 2) | | 4) | |

Are you on a blood thinner? ❑ Yes ❑ No If YES, which one: _____

**Allergies**: Please list any drug, food, contact or environmental allergies and reactions:

History and Physical

## VI. Review of Systems (ROS)

Please CHECK all CURRENT conditions you have. CIRCLE "*Negative*" if you have no complaints.

| General Questions | Muscles, Bones & Joints | Digestive System | Brain & Nerves |
|---|---|---|---|
| *Negative* | *Negative* | *Negative* | *Negative* |
| ❑ Weight loss | ❑ Neck pain | ❑ Diarrhea | ❑ Headaches |
| ❑ Weight gain | ❑ Back pain | ❑ Constipation | ❑ Head injuries |
| ❑ Fevers | ❑ Gout | ❑ Nausea | ❑ Fainting spells, dizziness |
| ❑ Change in sleep patterns | ❑ Tendonitis | ❑ Vomiting | ❑ Blackouts or fainting |
| ❑ Change in activity level | ❑ Swollen areas | ❑ Heartburn | ❑ Memory Loss |
| **Psychological** | ❑ Joint swelling | ❑ Abdominal pain | ❑ Tremors |
| *Negative* | ❑ Morning stiffness | ❑ Problems swallowing | ❑ Paralysis |
| ❑ Depression | ❑ Muscle aches | ❑ Vomiting blood | **Ears, Eyes, Nose & Throat** |
| ❑ Anxiety and worry | ❑ Rheumatism | ❑ Black tarry stools | *Negative* |
| ❑ Emotional outburst | ❑ Joint aches | ❑ Bloody bowel movements | ❑ Glaucoma |
| ❑ Difficulty thinking | ❑ Bursitis | **Kidneys & Bladder** | ❑ Nasal Polyps |
| ❑ Racing Thoughts | **Heart, Blood & Circulation** | *Negative* | ❑ Allergy |
| ❑ Difficulty falling asleep | *Negative* | ❑ Bloody urine | ❑ Hoarseness |
| ❑ Hearing voices | ❑ Chest pain | ❑ Dribbling after urination | ❑ Double vision |
| ❑ Repetitive Habits | ❑ Leg cramps / pain | ❑ Painful urination | ❑ Eye problems |
| **Skin** | ❑ Ankle swelling | ❑ Poor bladder control | ❑ Hearing Loss |
| *Negative* | ❑ Shortness of breath at rest | ❑ Urinating frequently | ❑ Ear discharge / pain |
| ❑ Rashes | ❑ Cold hands or feet | ❑ Difficult starting urine | ❑ Ringing in your ears |
| ❑ Psoriasis | ❑ Heart defects | ❑ Weak flow | **Lungs & Breathing** |
| ❑ Dry Skin | ❑ Heart murmurs | | *Negative* |
| ❑ Lumps | ❑ Heart palpitations | | ❑ Wheezing |
| ❑ Increased nail growth | ❑ Varicose veins | | ❑ Prolonged cough |
| ❑ Increased hair growth | ❑ Blood clots in legs / lungs | | ❑ Coughing up blood |
| ❑ Skin color changes | ❑ Anemia | | ❑ Emphysema |
| ❑ Shiny skin | | | ❑ Shortness of breath |
| | | | ❑ Lung infections |

**Family History**: Please check any FAMILY illnesses. Only include your parents and siblings (i.e. sisters/brothers)

| Illness | Relationship | Illness | Relationship | Illness | Relationship |
|---|---|---|---|---|---|
| ❑ Stroke | ❑Mom ❑Dad ❑Sis ❑Bro | ❑ Panic Attacks | ❑Mom ❑Dad ❑Sis ❑Bro | ❑ Lung disease | ❑Mom ❑Dad ❑Sis ❑Bro |
| ❑ Diabetes | ❑Mom ❑Dad ❑Sis ❑Bro | ❑ Heart disease | ❑Mom ❑Dad ❑Sis ❑Bro | ❑ High blood pressure | ❑Mom ❑Dad ❑Sis ❑Bro |
| ❑ Obesity | ❑Mom ❑Dad ❑Sis ❑Bro | ❑ Back problems | ❑Mom ❑Dad ❑Sis ❑Bro | ❑ Depression | ❑Mom ❑Dad ❑Sis ❑Bro |
| ❑ Cancer | ❑Mom ❑Dad ❑Sis ❑Bro | ❑ Kidney disease | ❑Mom ❑Dad ❑Sis ❑Bro | ❑ Bipolar / OCD | ❑Mom ❑Dad ❑Sis ❑Bro |
| Other: | | | | | |

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**Social History:**

| | | |
|---|---|---|
| WHERE DO YOU WORK? | | ❑ Full time ❑ Part time<br>❑ Unemployed ❑ Disabled ❑ Retired |
| Do you exercise regularly? | ❑ YES<br>❑ NO | What type?<br>How often? |
| Do you smoke? | ❑ YES<br>❑ NO | If YES how often? cigs/day packs/wk |
| Do you drink alcohol? | ❑ YES<br>❑ NO | If yes, how often? drinks/day drinks/wk |
| Has your pain ever stopped you from working? | ❑ YES<br>❑ NO | If YES, please explain: |
| Are you suing anyone about your pain problem? | ❑ YES<br>❑ NO | If YES, please explain: |

**I acknowledge that I have received, read, and understood Texas Interventional Pain Institute consents, *Agreements, and Acknowledgements* including the *General Waiver of Liability, Consent for Treatment, Urine Testing,* and *Notice of Privacy Practices.***

Signature:_____ Date:_____

**Notice of Privacy Practices Acknowledgment**

I, _____, acknowledge that Texas Interventional Pain Institute provided me with a copy (upon request) of their Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature Date

**HIPAA Disclosure**

A) I hereby give consent to release my personal health information either verbally or in writing to persons of my choosing, for purposes of obtaining treatment and/ or for payment of medical services.

**Name** **Relationship to Patient**

_____ _____

_____ _____

B) I hereby give consent for Evolution Pain and Spine to leave messages with our household members, your answering machine and/or on your voicemail.

*If declining, please write N/A and sign below. Please note that you have the right to revoke this authorization, at any time by providing written notice to the office the revocation will take place on the date of the written notice and cannot be applied to prior disclosures.

_____ _____

**Signature** **Date**

I, _____, agree to the following guidelines as part of my treatment for chronic pain management with Texas Interventional Pain Institute.

1. I understand the following:
    - If I have a chronic pain problem, it may require the prescription of opioid pain medication to increase my quality of life by increasing my function and reducing my pain prescription. I understand the Opioid medication can also be prescribed for short term, temporary, acute pain problems. The risks, side effects, and benefits of the medication have been discussed with me in detail in the event that chronic opioid therapy is indicated. I agree to the policies set forth by Texas Interventional Pain Institute in accordance to the federal and state guidelines, for toxicology monitoring and diagnostic testing needed to evaluate the risks associated with opioid treatment.
    - I understand that the use of opioids in pain management is an acceptable practice, however, there is a potential for habit formation and in some instances, may result in addiction.
    - If I am treated with opioid medications, I agree to take the medications only as prescribed and I will not accept a prescription for an opioid based, controlled substance, from another physician, without approval from my provider. An exception to this would be in an emergency situation, where I will notify the ER Providers of my opioid contract with Texas Interventional Pain Institute.
    - I understand that changing pharmacies regularly is considered by the state and federal government as high risk behavior for drug aberrancy and I will comply with the office policy for toxicology testing when doing so. I understand that my provider will have access to my past prescription history, in order to confirm compliance with State laws.
    - I understand that opioids are not effective long term, as single therapy, due to tolerance and dependency. An opioid prescription will be used in conjunction with a multi-modal therapeutic plan, focused on interventional treatment options. If I am prescribed opioids, the goal is to continuously reduce and/or taper me off of them. To do so, I will meet the provider regularly to assess my progress. If the provider does not feel that opioid therapy is medically indicated, then they are not obligated to continue prescribing them.
    - I am responsible for any lost, misplaced, stolen or miscounted medications from the pharmacy. The provider will not replace my medications or refill my medications early in the event that this occurs. I will not share my medications with anyone. A stolen mediation will require a police report to be made and a notification to my provider within 48 hours of loss.
    - I agree to participate in any medical or psychological assessments recommended by my provider for assessment for dependency, aberrancy or worsening of any comorbid conditions. I also understand that I will comply with Urine Drug Testing Policies of the office, including random drug testing.
    - The use of illegal drugs can lead to immediate discontinuation of opioid therapy and possible dismissal from the practice, at the discretion of the provider and practice. If toxicology testing is indicated, I will follow the protocols for toxicology testing as well as be responsible for any financial costs, if not covered by my insurance.
    - Failure to comply with ordered procedures or tests may result in discontinuation of medications.
2. I understand that my provider may stop prescribing the medications listed if:
    - I do not show any improvement in pain or my activity has not improved.
    - I develop rapid tolerance or loss of improvement from the treatment.
    - I develop significant side effects from the medication.
    - The clinic finds that I have broken any part of this agreement.

My toxicology diagnostic testing reveals I am not following the recommended dosages for my prescriptions or the testing reveals I have used illegal or street drugs.

My behavior is inconsistent with the responsibilities outlined above, which may also result in being discharged from receiving further care from this clinic following guidelines set forth by the Texas State Medical Boards.

**SAFETY RISKS WHILES WORKING UNDER THE INFLUENCE OF OPIOID MEDICATION:**

There are potential adverse effects that may occur while working and taking opioid medications. These adverse effects could potentially be dangerous and cause safety risks. These include delayed reaction time, impaired judgement, drowsiness, and physical addiction. Any of these may impair your ability to drive or operate heavy machinery. These adverse effects tend to diminish over time.

**ADVERSE EFFECTS OF MIXING OPIOID MEDICATIONS:**

*These adverse effects may be made worse when mixing opioid medications with other medications, including alcohol.*

- Feeling of Anxiety
- Slowed or Difficult Breathing
- Slow Heart Rate
- Confusion
- Constipation
- Excessive Sweating
- Dizziness/Drowsiness
- Nausea
- Difficulty Urinating
- Impaired Judgment
- Vomiting
- Physical/Psych Dependence

**RISKS:**

Abruptly stopping the medication may lead to withdrawal symptoms. The symptoms below may be harmful if you are being treated with other co-morbid conditions. Please do not stop medications without the supervision of your provider.

- Runny Nose
- Difficulty Sleeping for Several Days
- Diarrhea
- Abdominal Cramps
- Sweating
- Shakes and Chills
- Rapid Heart Rate
- Nervousness

I have read the above **Medication/ Opioid Contract,** by signing this contract, I affirm that I have read, understand and accept all terms of the contract and appropriate opportunity was allocated to me by the provider to answer any and all questions that I may have prior to prescribing opioids.

Patient's Signature: _____ Date:_____

PATIENT REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED TO ANOTHER HEALTH CARE PROVIDER

Patient's Name:_____ Date of Birth: _____

Address:_____

Phone number:_____

I am writing to request copies of my medical records to Texas Interventional Pain Institute

Please fax my records to:

Name of provider:_____Alan B Swearingen, MD_____

Fax Number:__+1 877-534-3137_____ Phone number:_832-391-6870_____

Send the following items:

- ❑ Abstract of medical record
- ❑ Imaging/Radiology Reports
- ❑ Lab results
- ❑ History and Physical
- ❑ Emergency Room
- ❑ Operative/Procedure Report
- ❑ Cardiac Studies
- ❑ Discharge Summary
- ❑ Other_____

Date:_____ Signature:_____

**Authorization to Release Medical Information**

**I authorize Texas Interventional Pain Institute PLLC, to release my records and any information requested to the following individuals.**

1. _____ Relation to Patient:_____

2. _____ Relation to Patient:_____

**Authorization Regarding Messages** (please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments.

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information.

____ I authorize you to leave a message with anyone who answers the phone.

____ Messages may only be left with _____ .

____ Please do not leave any messages on my phone.

_____ _____
Patient Signature Date

_____
Patient Name (PLEASE PRINT)

Texas Interventional Pain Institute, PLLC
19002 Park Row, STE 200, Houston, TX 77084
P: (832) 391-6870 F: (877) 534-3137