Today's Date:_____

Last Name/ Apellido:_____ First Name/ Nombre: _____ MI/ I: _____

DOB/ Fecha de Nacimiento: _____ SS#/Numero de S.Social:_____

Marital Status/Estado Marital: S___ M___D___ SEX: Male___ Female: ___

Address/ Dirección:_____

City/Ciudad: _____State/Estado: _____Zip Code/ Codigo Postal:_____

Phone Number/ Telefono: _____ E-mail:_____

Ethnicity: ___ Nonhispanic___ Hispanic ___ Other Race: _____

Language Spoken: _____

Primary Insurance Carrier/Seguro Primario: _____

Secondary Insurance/ Seguro Secundario:_____

Subscriber ID Number/Numero de Subscriber: _____

Responsible Party Last Name/ Apellido: _____First Name/Nombre:_____

Responsible Party DOB: _____ SS#_____

Do you have a preferred pharmacy?

_____

Do you have a primary care physician?

_____

□ I give TIPI my permission to check outside sources regarding my prescription history

□ I have received TIPI's HIPAA Compliance Regulations

Signature/ Firma: _____Date/Fecha:_____

Witness Signature: _____Date: _____

History and Physical

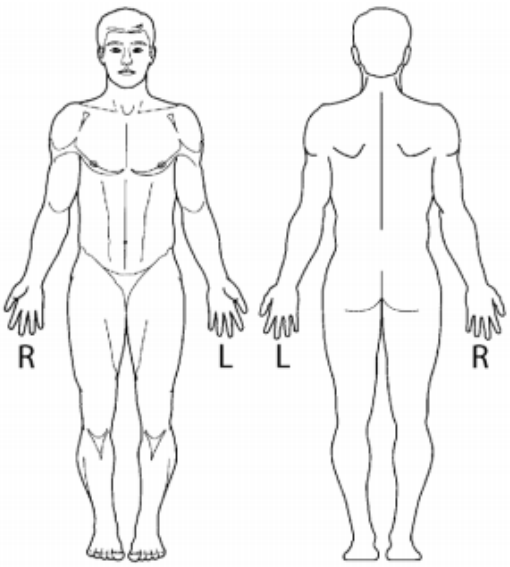
PLEASE COMPLETE THIS FORM BEFORE YOUR VISIT. USE BLUE/BLACK INK ONLY

NAME: _____ AGE: _____ SEX: ❑ M ❑ F

I. Chief Complaint (CC) **Referred by (Doctor):**_____

In your own words, why are you here?

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***

History and Physical

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:					

History and Physical

Social History:

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

NO SHOW AND CANCELLATION POLICY

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us, and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Texas Interventional Pain Institute sends text message and email reminders 3 days and 24 hours in advance of the appointment time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours notice.

If you do not cancel or reschedule your appointment with at least 24 hours notice, we may assess a $30 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

I understand the "no-show" policy of Texas Interventional Pain Institute and agree to provide a credit card number, which may be charged $30 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show charge to the credit card provided.

_____ _____

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

Medical Records Request Fee

Texas Interventional Pain Institute will provide your records to you once you have completed the "Authorization to Release Medical Information" form. You can find this form in our new patient paperwork, on our website or you may contact our office for a copy. Please be sure to sign the form. Unsigned requests cannot be processed.

Your request will be processed and fulfilled within 15 business days. You may pick up the completed forms or we will fax the records to you or another recipient you have listed as authorized on the form, per your preference.

Listed below are charges for copying medical records:

Pages 1-20 $15.00

Pages 21-50 $25.00

Pages 51+ $40.00

Form and Letter Fee

This is to notify you that Texas Interventional Pain Institute will apply a base fee of $50 for the first page and $10 per additional page to your account for patients, companies, family members, insurance carriers or other persons requesting completion of medical forms and/or letters.

In order to comply with federal laws including HIPAA as well as Texas state and federal statutes, this office must have a signed "Authorization to Release Medical Information" stating to whom we are authorized to release information. You can find this form on our website or you can contact our office and we can mail or fax the form to you. Please be sure to sign the form. Unsigned requests cannot be processed.

_____ _____

Patient Signature Date

_____

Patient Name (PLEASE PRINT)

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