ReGen Pain MANAGEMENT
REGENERATE YOUR LIFE

Today's Date:	PCP:

PATIENT INFORMATION

Last name: First:	Middle Initial:	Marital Status: Single / Married / Divorced / widowed

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ◯ M ◯ F

Address:		
Social Security no.:	Home phone no.:	Cell phone no: Email address:
Occupation:	Employer:	Employer phone no.:
Race:	Ethnicity:	Preferred Language: English / Spanish / Other: _____

Preferred Pharmacy:
(name) (address) (phone number)

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	◯ Yes ◯ No	Is this patient covered by insurance?	◯ Yes ◯ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:

Patient's relationship to subscriber: Self / Spouse / Child / Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

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PAIN MANAGEMENT COMPREHENSIVE HISTORY AND PHYSICAL

Please take a few minutes to complete this worksheet. This information will help us in providing your care.

PATIENT INFORMATION

Name: _____Date: _____

Address: _____

Phone Number: _____ Referring Physician_____

Date of Birth: _____/_____/_____Sex: _____Height: _____ Weight: _____

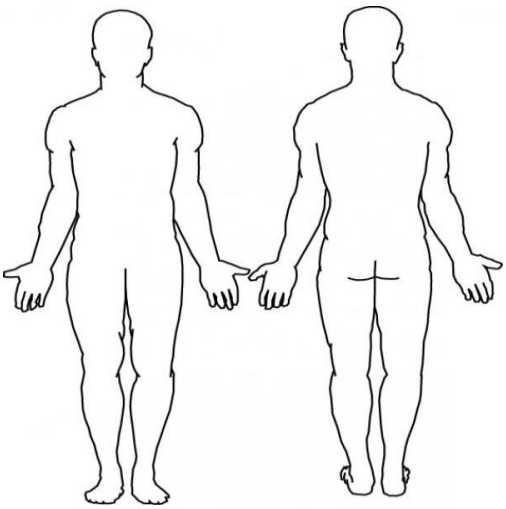
PAIN HISTORY

Chief Complaint (Reason for your visit)?_____

Does the pain radiate? If so where?_____

Please list any additional areas where you have pain:_____

Use this diagram to indicate the area(s) of your pain. Mark the location(s) with an "X"



ONSET OF SYMPTOMS

Approximately when did this pain begin? [ ] < 4 weeks [ ] 4-12 weeks [ ] 3-6 months [ ] 6-12 months
[ ] Other: _____

PAIN DESCRIPTION

Check all of the following that describe your pain:

[ ] Dull/Aching	[ ] Cramping	[ ] Squeezing
[ ] Hot/ Burning	[ ] Numbness	[ ] Tingling/Pins & Needles
[ ] Pressure	[ ] Sharp	[ ] Shooting
[ ] Stabbing/Sharp	[ ] Throbbing	[ ] Tingling

When is your pain at its worst?

[ ] Mornings [ ] Daytime [ ] Evenings [ ] Middle of the night [ ] Always the same

How often does the pain occur?

[ ] Constant [ ] Changes in severity but always present [ ] Intermittent (comes and goes)

Rate your pain at its worst: (with "0" meaning no pain, and "10" being the worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

Rate your pain at its best:

0 1 2 3 4 5 6 7 8 9 10

Rate your pain right now:

0 1 2 3 4 5 6 7 8 9 10

MARK THE EFFECT EACH OF THE FOLLOWING HAVE ON YOUR PAIN LEVEL

What makes your pain worse?

[ ] Bending forward [ ] Looking up or down [ ] Sneezing/Coughing
[ ] Bending backward [ ] Changing Position [ ] Rising from seated position
[ ] Going up/down stairs [ ] Lifting [ ] Sitting/Standing a long time
[ ]any other factors not listed here?_____

What makes your pain better?

[ ] Leaning forward [ ] Leaning backward [ ] Lying Flat [ ] Sitting
[ ] Changing Positon [ ] Medication [ ] Cold [ ] Heat
[ ] Exercise [ ] Rest [ ] Physical therapy [ ] Injections
[ ] Massage [ ] Assistive device (i.e. cane, walker)
[ ]any other factors not listed above?_____

ASSOCIATED SYMPTOMS

Numbness/Tingling	No	Yes	Where?_____
Weakness in the arm/leg	No	Yes	_____
Balance Problems	No	Yes	_____
Bladder Incontinence	No	Yes	_____
Bowel Incontinence	No	Yes	_____
Joint Swelling/Stiffness	No	Yes	_____
Fevers/chills	No	Yes	_____

PLEASE MARK ALL OF THE FOLLOWING TREATMENTS YOU HAVE USED FOR PAIN RELIEF

[ ] Physical Therapy [ ] Chiropractic Care [ ] Psychological Therapy [ ] Brace support
[ ] Acupuncture [ ] Hot/Cold Packs [ ] Massage Therapy [ ] Medications
[ ] Injections [ ] Surgery [ ] TENS unit [ ] Other:_____

INTERVENTIONAL PAIN TREATMENT HISTORY

[ ] Epidural Steroid Injections [ ] Facet Injections [ ] Nerve blocks [ ] Radiofrequency Ablation
[ ] Trigger point injections [ ] Kyphoplasty [ ] Botox [ ] Spinal Cord Stimulation

CURRENT MEDICATIONS

Are you allergic to any medications? [ ] Yes [ ] No

If so, please list the MEDICATIONS YOU ARE ALLERGIC TO here:

Medication	Reaction (i.e. Rash, Hives, Itching)

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Are you taking any blood thinners? [ ] Yes [ ] No

If yes, which ones? [ ] Aspirin [ ] Plavix [ ] Coumadin [ ] Xarelto [ ] Other_____

Please list all the medications you are CURRENTLY TAKING including vitamins:

Medication	Dose	How often

PAST MEDICAL HISTORY

Have you ever had or been told you have (Check all that apply):

Cardiovascular/Hematologic:

[ ] Angina
[ ] Heart Disease
[ ] MI, Heart attack, Blocked artery
[ ] Congestive heart failure
[ ] High Blood Pressure
[ ] Peripheral vascular disease
[ ] Arrhythmia (i.e. Atrial Fibrillation)
[ ] Pacemaker
[ ] Angioplasty or heart catheterization
[ ] Rheumatic fever
[ ] Damaged heart valve
[ ] Anemia

Neurological:

[ ] Epilepsy or seizures
[ ] Fainting spells or dizziness
[ ] Stroke
[ ] Headache/ Migraines
[ ] Multiple Sclerosis

Gastrointestinal:

[ ] Ulcers, heartburn, reflux
[ ] Gallbladder disease
[ ] Diverticulitis or Colitis
[ ] Hepatitis (type ___)

Other:

[ ] Depression or Anxiety
[ ] Bipolar disorder
[ ] Schizophrenia

Respiratory:

[ ] Asthma
[ ] Emphysema
[ ] Tuberculosis

Metabolic:

[ ] Diabetes
[ ] Hyperthyroidism
[ ] Hypothyroidism
[ ] Steroid use
[ ] Adrenal gland problem

Musculoskeletal/Rheumatologic:

[ ] Fibromyalgia
[ ] Osteoporosis
[ ] Osteoarthritis
[ ] Rheumatoid Arthritis
[ ] Crohn's/Ulcerative colitis

Urological:

[ ] Kidney disease
[ ] Shunt, graft, fistula
[ ] Dialysis

[ ] Cancer: _____
[ ] Skin Condition:_____
[ ] Wear Dentures? [ ] Glasses? [ ] Hearing aid?

FAMILY HISTORY

[ ] Arthritis [ ] Cancer [ ] Diabetes [ ] Headaches/Migraines
[ ] High Blood Pressure [ ] Kidney Problems [ ] Liver Problems [ ] Osteoporosis
[ ] Rheumatoid Arthritis [ ] Seizures [ ] Stroke
[ ] Other medical problems: _____

PAST SURGICAL HISTORY

Please list any surgical procedures you have had done in the past including approximates dates:
_____ Date_____
_____ Date_____
[ ] I have NEVER had any surgical procedures performed

SOCIAL HISTORY

Alcohol use: [ ] Never [ ] Social use [ ] Daily use [ ] Current / Previous Alcoholic
Tobacco use: [ ] Never [ ] Current smoker [ ] Former Smoker [ ] Quit date:_____
Illicit Drug Use: [ ] Never [ ] Formerly used illicit drugs [ ] Currently using illicit drugs

Employment Status:
[ ] Employed Full Time [ ] Employed Part Time [ ] Self Employed [ ] Retired
[ ] Temporary disability [ ] Permanent disability [ ] Unemployed for other reasons
Occupation_____ When was the last time you worked? _____
Are you currently under worker's compensation? [ ] Yes [ ] No
Is there an ongoing lawsuit related to your visit today? [ ] Yes [ ] No

REVIEW OF SYSTEMS

Mark the following symptoms that you ***currently*** suffer from:

Constitutional:	[ ] Chills [ ] Night sweats [ ] Daytime Fatigue [ ] Fevers [ ] Insomnia [ ] Low sex drive [ ] Unexplained weight loss or weight gain [ ] Skin Rash [ ] Loss of appetite
HEENT:	[ ] Recent vision changes [ ] Loss of vision [ ] Dental problems [ ] Earaches [ ] Hearing problems [ ] Nosebleeds [ ] Sinus problems [ ] Excessive snoring
Cardiovascular:	[ ] Chest pain [ ] Palpitations [ ] Shortness of breath [ ] Fainting Spells [ ] Dizziness [ ] Swelling in hands or feet [ ] Shortness of breath when lying flat
Respiratory:	[ ] Cough [ ] Wheezing [ ] Shortness of breath [ ] Sputum production [ ] Hemoptysis [ ] Frequent respiratory infections
Gastrointestinal:	[ ] Abdominal pain [ ] Diarrhea [ ] Constipation [ ] Heartburn [ ] Nausea/Vomiting [ ] Bowel incontinence
Musculoskeletal:	[ ] Back/Neck pain [ ] Joint pains [ ] Joint stiffness [ ] Joint swelling [ ] Muscle cramps [ ] muscle weakness [ ] muscle atrophy
Genitourinary:	[ ] Flank pain [ ] Blood in urine [ ] Painful urination[ ] Change in urine flow/frequency [ ] Bladder incontinence
Neurological:	[ ]Dizziness [ ]Headaches [ ]Tremors [ ]Numbness/Tingling [ ]Seizures [ ] Loss of coordination
Psychiatric:	[ ] Depressed Mood [ ] Feeling anxious/stressed [ ] Suicidal Thoughts [ ] Thoughts of harming others [ ] Difficulty Sleeping [ ] Difficulty concentrating
Skin:	[ ] Rash [ ] Open sores [ ] Dry skin [ ]Excessive sweating [ ] Red or blue discoloration of skin [ ] Hair loss [ ] Skin hypersensitivity
Endocrine:	[ ] Cold intolerance [ ] Heat intolerance [ ] Excessive thirst [ ] Excessive urination
Hematologic:	[ ] Easy bruising or bleeding [ ] Spontaneous bleeding [ ] Enlarged or tender lymph nodes

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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, APRIL 2008

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 a 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 medications include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medications 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 acknowledge that before or throughout the course of my treatment I may be asked to have further tests and examinations. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary. 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 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 RESPONSIBILTY** 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 medications have been fully explained to me and I understand that, at present, there have not been studies conducted on the long- term use of many medications 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 reason and judgement, respiratory depression (slow or no breathing), impotence, tolerance to medications, 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 treatments, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medications 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 medications on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy and improve quality of life. I realize that the treatment for some will require prolonged or continuous use of medications, but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medications. My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of medication at any time and that I will notify my physician of any discontinued use. I further understand that I will provided medical supervision if needed when discontinuing medication use.

I understand that no worry 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. Prior to the time of my next scheduled refill, even if my prescription(s) runs out.
- I will receive the 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(s).
- 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 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 addiction abuse counselor, a detoxification and rehabilitation clinic and/or cognitive behavioral therapy/psychotherapy.

- 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 abuse 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 discontinuance of the treatment.**
- **I must keep all follow-up appointments** as recommended by my physicians or my treatment may be discontinued.

I certify and agree to the following:

I. **I am not currently using illegal drugs or abusing prescription medications** and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading ad making this agreement while I full possession of my faculties and not under the influence of any substance that may impair judgement.

II. **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.)

III. **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.

IV. I have reviewed the side effects of the medications that may be used in the treatment of my chronic pain. **I fully understand that the explanations regarding the benefits and the risks of these medications and I agree to the use of these medications in the treatment of my chronic pain.**

_____ _____

Patient Signature Physician Signature (or Authorized Assistant)

_____ _____

Pharmacy Name and Phone number Pharmacy Address