



texas pain institute

CONSENT TO DISCLOSE OR OBTAIN PRIVATE HEALTHCARE INFORMATION FOR TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATIONS

I, \_\_\_\_\_, Social Security Number \_\_\_\_\_, date of birth \_\_\_\_\_,

\_\_\_\_\_ hereby authorize and consent for Texas Pain Institute, P.A., 1120 Dennis Street,

Houston, Texas 77004 to (\_\_\_\_\_)  RELEASE or (\_\_\_\_\_)  OBTAIN any and all medical, dental, Initials Initials

and / or psychological reports or operative notes, discharge summaries, Doctor's / Dentist orders, Nurse's notes, lab reports, test results, physical therapy progress notes, patients progress reports, diagnosis, pathology reports, x-rays, MRIs, any records reflecting treatment for studies, laboratory slides, clinical abstracts, histories, charts, and other information contained therein, any documents and opinions relevant to past, present, or future physical and mental condition, treatment, care or hospitalization, and any other personal health information regarding my medical / dental care as necessary to carry our treatment, obtain payment, and / or conduct other healthcare operations.

The release or to obtain of the matters listed above is being authorized for purposes of obtaining medical / dental treatment, payment for such services and other health care operations.

A copy of this authorization is agreed by the undersigned to have the same effect and force as an original.

This Consent to Disclose or Obtain Private Healthcare Information may be revoked in writing. However, such revocation shall not be effective on an entity that has take action in reliance upon this Consent Prior to its revocation and / or if this Consent was obtained as a condition of obtaining insurance and a law provides the insurer the right to contest a claim under the policy.

Any person, firm, or entity that releases matters pursuant to this authorization is hereby absolved from any liability that might otherwise result from the release of those matters.

I further acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the privacy regulations.

I further understand that I have the right to review Texas Pain Institute, P.A.'s privacy notice and to request restrictions.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Signature

Printed Name

Special Restrictions to withhold Medical Records

Send Medical Records to:

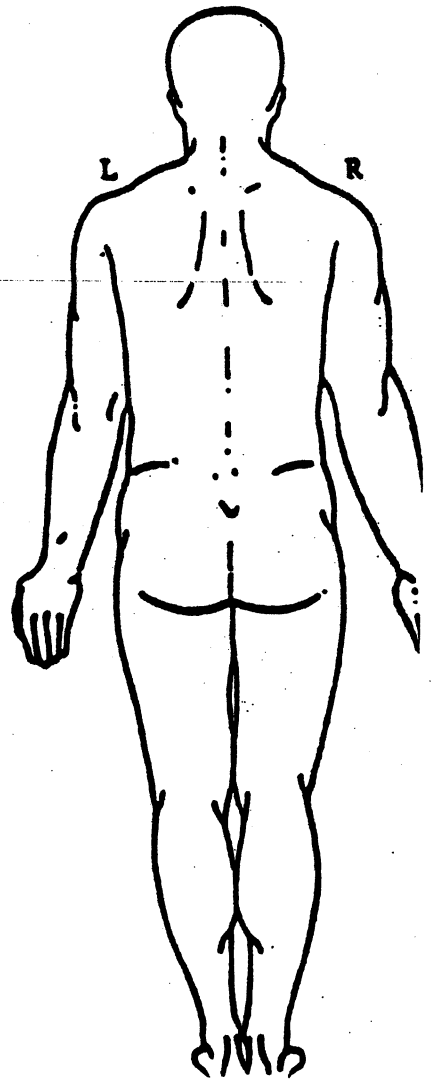
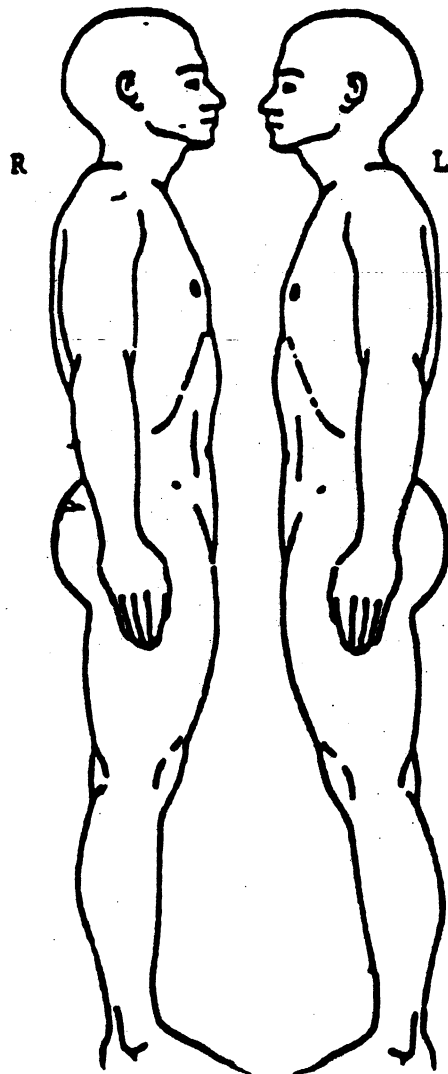
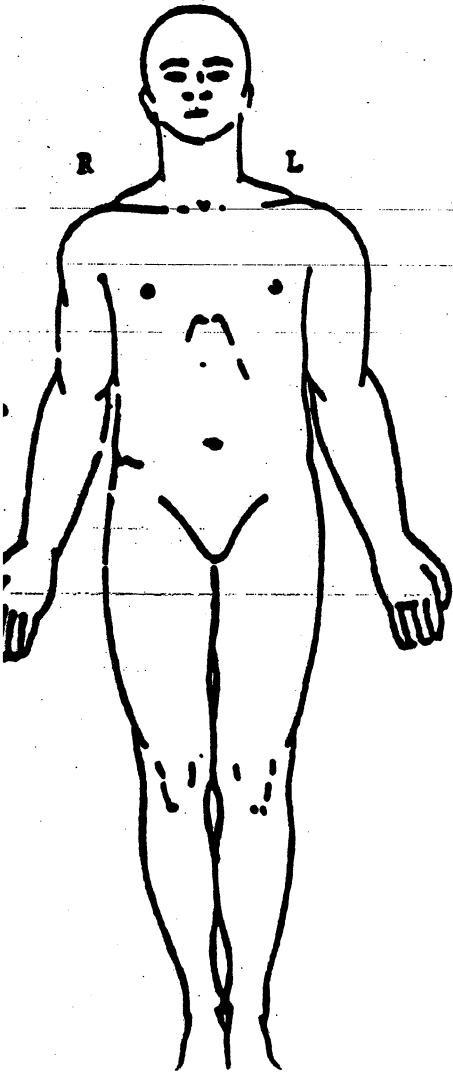
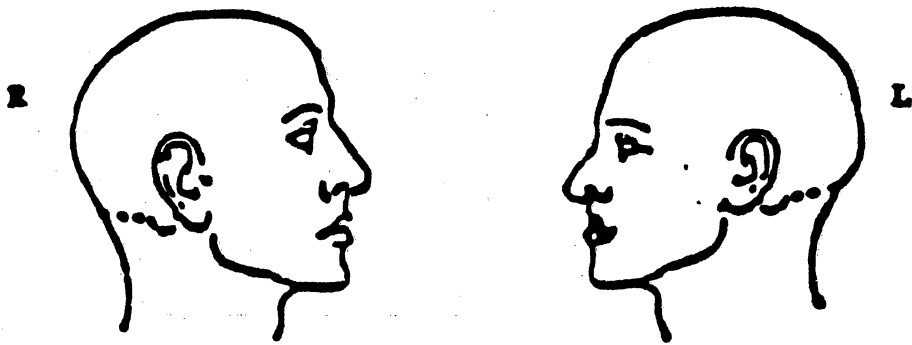
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Person or Clinic Name

Address

City, State Zip code

12. Please mark in the areas below with an X.  
Indicate the area of your worst pain with an X.





texas pain institute

Medication Management Agreement

This Agreement between \_\_\_\_\_ (“Patient”)
And Texas Pain Institute is for the sole purpose of establishing agreement between Doctor and Patient on clear conditions
for the prescription and use of pain controlling medications prescribed by the Doctor for the Patient. Doctor and Patient
agree that this Agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient
relationship.

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Doctor
for the Patient.

- I understand that a reduction in the intensity of my pain and improvement in my quality of life are the goals of
this program
I realize that all of the medication have potential side effects, such as addiction, liver damage, kidney damage,
allergic reaction, drowsiness, and mental impairment
I realize that it is my responsibility to keep myself and others from harm, including the safety of my driving or
operation of a machinery. If there is any question of impairment of my ability to safely perform any activity, I
agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or
I have used my medication for at least four days
I will not use any illegal controlled substances, including marijuana, cocaine, and so forth
I will not share, sell, or trade my medication for money, goods, or services
I will not attempt to get pain medication form any other health care provider without telling them I am taking
pain medication prescribed by the Doctor. I understand it is against the law to do so. If my primary care
physician is willing to prescribe my medications, the Doctor will have to approve the arrangements to make
sure there is no duplication
I will safeguard my medication from loss or theft and agree that the consequences of my failure to do so is that I
will be without my prescribed medication for a period of time
I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of
my pain medication and I authorize the Doctor and my pharmacy to cooperate fully with any city, state, or
federal law enforcement agency, including the Texas Board of Pharmacy, in the investigation of any possible
misuse, sale, or other diversion of my pain medication. I authorize the Doctor to provide a copy of this
Agreement to my pharmacy.
I agree that I will submit to a blood or urine test if requested by my Doctor to determine my compliance with
my regimen of pain control
I agree that I will use my medication at a rate no greater than the prescribed rate and that use of medication at a
greater rate will result in my being without medication for a period of time. I will not call for refills at any time-
under any condition. I understand that I will need to be re-evaluated for different medications.
I understand that this medication regimen will be continued for a period of one month. My case will be
reviewed at the end of the period. If there is no evidence that I am improving or that progress is being made to
improve my function or my quality of life, the regimen will be tapered to my pre-trial medications and my care
will be referred back to my primary care physician.
I agree not to consume alcohol while being prescribed pain medication.

Doctor and patient agree that this Agreement is essential to the Doctor’s ability to treat Patient’s Pain effectively and
that failure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed
medication by the Doctor and the termination of the Doctor/Patient relationship.

This Agreement is entered into on this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

PATIENT SIGNATURE

DOCTOR SIGNATURE

WITNESS SIGNATURE

I ACKNOWLEDGE RECIEPT OF THIS AGREEMENT ON THE DATES STATED ABOVE.

20. Which of the following tests have you had to evaluate your present pain problem?

TEST	DATE	WHERE	RESULTS	
			NEGATIVE	PROBLEM FOUND
X-rays	_____	_____	_____	_____
CTScan	_____	_____	_____	_____
Bone scan	_____	_____	_____	_____
Myelogram	_____	_____	_____	_____
EMG nerve test	_____	_____	_____	_____
Thermogram	_____	_____	_____	_____
Blood studies	_____	_____	_____	_____
MRI	_____	_____	_____	_____
Discogram	_____	_____	_____	_____
Other	_____	_____	_____	_____

21. What has been done to treat your pain problem?

PROCEDURE	PRESENTLY	WHERE	HOW HELPFUL?		
			VERY	SOME	NOT AT ALL
Nerve block	_____	_____	_____	_____	_____
Physical therapy	_____	_____	_____	_____	_____
Chiropractor	_____	_____	_____	_____	_____
Biofeedback	_____	_____	_____	_____	_____
Hypnosis	_____	_____	_____	_____	_____
Counseling	_____	_____	_____	_____	_____
TNS transcutaneous nerve stimulator	_____	_____	_____	_____	_____

Have you been in any other pain program? \_\_\_\_\_

Other \_\_\_\_\_

1. Name you prefer to be called. \_\_\_\_\_

2. Age \_\_\_\_\_

3. Referring physician \_\_\_\_\_

Address \_\_\_\_\_

4. When did the pain begin (approximate date)? \_\_\_\_\_

5. What were you doing when the pain began? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. Have you had any accidents or injuries before or since this pain problem began that may have had an affect on your current condition?

no \_\_\_\_\_ yes \_\_\_\_\_ explain \_\_\_\_\_

7. When did you first seek treatment for the pain? \_\_\_\_\_

8. List all the physicians you have seen for this pain problem

Name \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

9. Did your pain change after treatment? \_\_\_\_\_

If yes, please explain. \_\_\_\_\_

\_\_\_\_\_

10. Describe what your pain feels like by checking all that apply:

sharp _____	shooting _____	constant _____	not always there _____
traveling _____	stabbing _____	dull _____	electrical _____
pounding _____	throbbing _____	aching _____	crawling _____
burning _____	numbness _____	prickly _____	tingling _____
Other _____			

11. Which time of day is the pain the worst?

no relation to time of day \_\_\_\_\_

morning before getting out of bed \_\_\_\_\_

morning after getting out of bed \_\_\_\_\_

morning after moving around \_\_\_\_\_

midday \_\_\_\_\_ evening \_\_\_\_\_ night \_\_\_\_\_

22. List any operations you have had for your pain, include dates.

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23. List any other operations or illnesses you have had that required you to go to a hospital?

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24. Height \_\_\_\_\_

25. Weight \_\_\_\_\_

26. Medical/Family physician \_\_\_\_\_

Address \_\_\_\_\_

27. Date of last physical exam or office visit. \_\_\_\_\_

28. Have you had counselling for any reason? \_\_\_\_\_

29. Since your pain started have you had any of the following?

dizziness _____	ringing in the ear _____	weight loss _____
vomiting _____	blurred vision _____	weight gain/how much? _____
nausea _____	loss of appetite _____	change in sex pattern _____
diarrhea _____	urinary problems _____	tire easily _____
weakness _____	change in skin color _____	excessive dry skin _____
sweating _____	change in menstrual cycle _____	change in temperature _____
constipation _____	pain to light touch _____	change in nail growth _____
change in sleep pattern _____	how many hours do you sleep? _____	

30. Do you have or have you had any of the following medical problems?

CONDITION

WHEN FOUND

Glaucoma/Cataracts \_\_\_\_\_

Asthma \_\_\_\_\_

Pneumonia \_\_\_\_\_

Emphysema \_\_\_\_\_

Sinus/allergies \_\_\_\_\_

Thyroid \_\_\_\_\_

Diabetes \_\_\_\_\_

Liver \_\_\_\_\_

hepatitis \_\_\_\_\_

cirrhosis \_\_\_\_\_

Kidney \_\_\_\_\_

stones \_\_\_\_\_

failure/dialysis \_\_\_\_\_

infections \_\_\_\_\_

13. PLEASE MARK MORE OR LESS. Do any of the following change your pain?

heat _____	cold / ice _____	standing _____	sitting _____
walking _____	staying busy _____	moving around _____	lying down _____
lifting _____	pushing _____	tension _____	bending _____
pain pills _____	alcohol _____	dampness _____	other _____

14. Using the pain scale below, answer the following questions?

no pain	mild	discomforting	distressing	horrible	limits to bedrest excruciating
0	1	2	3	4	5

Which number describes your pain most of the time? \_\_\_\_\_  
Which number describes your pain at its worst? \_\_\_\_\_  
Which number describes your pain at its least? \_\_\_\_\_

15. What do you think is causing the pain? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. Have you found it necessary to seek legal advice or counsel for this problem? no \_\_\_\_\_ yes \_\_\_\_\_  
If yes, attorney's name \_\_\_\_\_

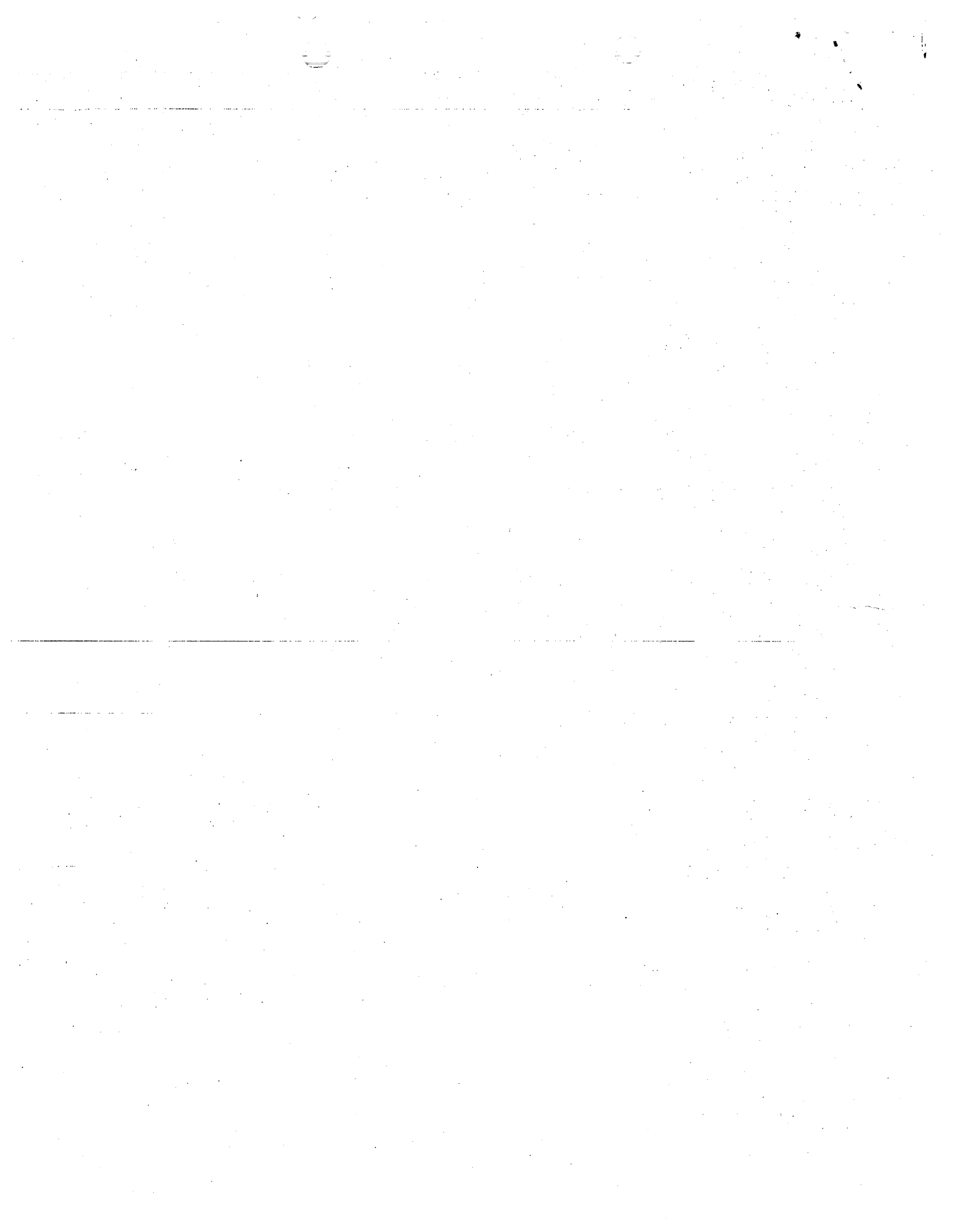
17. Have you been to emergency rooms for treatment of your pain? \_\_\_\_\_  
If yes, how often? \_\_\_\_\_

18. Our goals are to relieve or reduce pain to a level you can tolerate so that you can resume a normal routine. What types of activities would you like to resume that your pain has not allowed you to do?

Childcare _____	Cooking _____	Yardwork _____
Sleep well _____	Walking _____	Work at job _____
Housework _____	Crafts _____	Church/volunteer _____
Sports _____	Driving _____	Travel _____
Visiting _____	Shopping _____	Sex _____
Other _____		

19. Are there goals you would like the Pain Management Clinic to help you accomplish?

Weight reduction \_\_\_\_\_  
Decrease use of pain medication \_\_\_\_\_  
Decrease or stop smoking \_\_\_\_\_  
Increase endurance for activity \_\_\_\_\_  
Get back to work at previous job? \_\_\_\_\_  
Get a new job \_\_\_\_\_  
Other - specify \_\_\_\_\_





34. Place of employment \_\_\_\_\_  
How long have you worked at the company? \_\_\_\_\_  
What do you do? \_\_\_\_\_

35. How long have you been in your present job? \_\_\_\_\_

36. Did you return to work after the injury or after treatment at any time? \_\_\_\_\_

37. When did you last work? \_\_\_\_\_

38. Are you presently working: full time \_\_\_\_\_ part time \_\_\_\_\_ how many hours \_\_\_\_\_  
Not working due to: medical leave \_\_\_\_\_ disabled \_\_\_\_\_  
personal choice \_\_\_\_\_ retired \_\_\_\_\_

39. Are you currently receiving financial assistance? yes \_\_\_\_\_ no \_\_\_\_\_  
Do you plan to apply for financial assistance? yes \_\_\_\_\_ no \_\_\_\_\_

If yes to either of the above, please check type of assistance.  
Social Security \_\_\_\_\_ Disability \_\_\_\_\_ Medicare \_\_\_\_\_  
Workmen's Compensation \_\_\_\_\_  
AFDC \_\_\_\_\_ Medicaid \_\_\_\_\_  
SSI Supplementary social income \_\_\_\_\_  
Other \_\_\_\_\_

40. Do you smoke? \_\_\_\_\_ How much do you smoke? \_\_\_\_\_  
If you have stopped, how long ago? \_\_\_\_\_  
How many years did you or have you smoked? \_\_\_\_\_

41. a. How much alcohol do you use in a week?  
Beer \_\_\_\_\_ Wine \_\_\_\_\_ Liquor \_\_\_\_\_  
b. If none, when did you stop? \_\_\_\_\_

42. Have you ever borrowed pills from your family or friends for pain relief?  
Name of medicine \_\_\_\_\_

43. Do you or does anyone in your family use recreational drugs, IV drugs or have a history of alcoholism? \_\_\_\_\_

44. Marital status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_  
How many years? \_\_\_\_\_

45. Names and ages of all children  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

46. Who lives with you now? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

47. What was the highest grade you completed in school? \_\_\_\_\_

48. Does anyone in your family use alcohol? \_\_\_\_\_

49. Does anyone in your family use your drugs? \_\_\_\_\_

50. Distance from your home to the Pain Management Clinic. \_\_\_\_\_