

INTEGRATIVE PAIN SERVICES, P.A.

MARK S. WHITE, D.O.

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FINANCIAL POLICIES – PLEASE READ CAREFULLY

Your appointment will be made *after* we have received the completed packet *and* any referral or authorization required by your insurance company. Please arrive 15 minutes prior to your appointment time.

CANCELLATION POLICY

If you need to cancel, please do so 24 hours (one business day) in advance of your scheduled appointment time. This office reserves the right to charge a \$50 fee for missing an appointment or canceling with less than one business day’s notice. The purpose of this fee is to encourage our patients to take their appointments as seriously as we do. That time is reserved for you. If your appointment is not kept, other patients who may need same day visits or earlier appointments are obliged to wait longer than necessary.

NON-SUFFICIENT FUNDS FEE

There is a \$25 fee for checks returned to our office for insufficient funds, closed account, etc. The \$25 fee and the amount of the check must be paid with cash, cashier’s check, credit card or money order. If three checks are returned, we will no longer accept checks as a payment method. As of 3-1-07, we will be using Telecheck for electronic check deposits whenever possible to avoid returned checks.

PAYMENT POLICY

All payments are due at the time of service. This includes co-payments, deductibles, and any portion of your bill that is not covered by your health insurance carrier. Past due balances must be paid before additional services are provided unless payment arrangements have been made prior to your visit. If you need to make “payments” for services, our office utilizes Care Credit for this purpose. Please ask for an application. We will assist you in applying.

FINANCIAL RESPONSIBILITY AGREEMENT

I understand that the information given by my insurance company is “not a guarantee of payment”. I understand that my insurance company may deny payment for certain procedures or treatments. These procedures and treatments may not be covered benefits or the insurance company may later decide that they were “not reasonable”, “not medically necessary”, or “experimental and investigational”. If my insurance company denies payment on a procedure or treatment provided by Integrative Pain Services, P.A., I agree to be personally responsible for payment in full of all services rendered.

Patient/Guardian Signature

Date

Printed Name

Patient Information Sheet

Please answer all questions completely. This information is necessary for us to properly identify you & handle all your insurance matters.

Patient Last Name: _____ First Name: _____ MI: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Maiden Name: _____ DOB: _____ SSN: _____

Marital Status: S ___ M ___ D ___ W ___ DL# _____ State: _____

Sex: F ___ M ___ Race _____ Ethnicity: Hispanic / Non-Hispanic / Withheld (circle one)

Email Address: _____ Preferred Language: _____

Employer: _____

Employer Address: _____

In case of emergency please notify:

Name: _____ Phone: _____ Relationship: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Insurance Information

Please complete ALL of the insurance information below, even if you have given us a copy of your insurance card. All co-payments are to be paid PRIOR to seeing the physician.

Primary Insurance: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Name of Insured: _____ DOB: _____ SSN: _____

Relationship to patient: Self ___ Spouse ___ Child ___ Other ___

Policy Holder's Employer: _____ Retired: Yes ___ No ___

Policy ID#: _____ Group#: _____ Plan: _____

Secondary Insurance: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Name of Insured: _____ DOB: _____ SSN: _____

Relationship to patient: Self ___ Spouse ___ Child ___ Other ___

Policy Holder's Employer: _____ Retired: Yes ___ No ___

Policy ID#: _____ Group#: _____ Plan: _____

PLEASE READ CAREFULLY BEFORE SIGNING

I hereby authorize payment of medical benefits from my insurance companies to be paid directly to Integrative Pain Services, P.A. or Mark S. White, DO. I also authorize the release of medical information necessary to secure payment from my insurance carrier or other third party. I understand that I am fully responsible for all charges accumulated while under the care of the physician, regardless of insurance, and that full payment is due at the time of service unless I have made PRIOR arrangements.

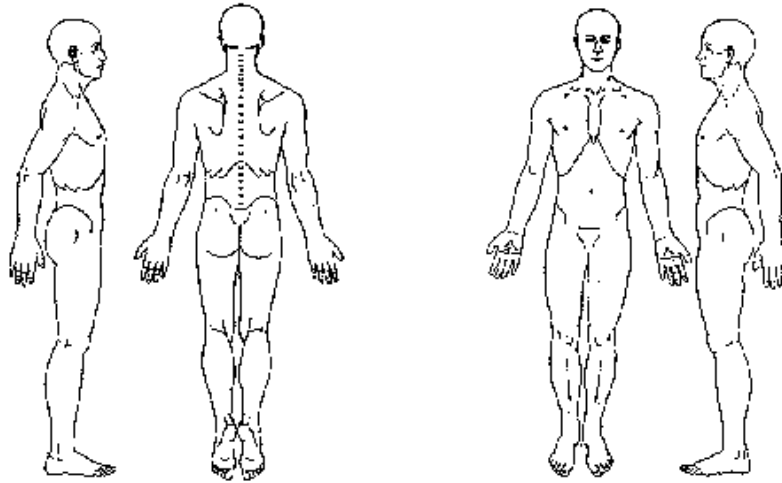
Patient or Legal Guardian's Signature

Date

PAIN QUESTIONNAIRE

Date: _____ Name: _____
First
Middle
Last

Please **shade** the area(s) where you feel pain on the diagram below. Place an **X** on the areas that hurt the most.



What is your chief complaint? Check the main reason you are coming to the pain clinic:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Lower Extremity Pain | <input type="checkbox"/> Pelvic Pain |
| <input type="checkbox"/> Upper Extremity Pain | <input type="checkbox"/> Abdominal Wall Pain | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Abdominal Pain | |
| <input type="checkbox"/> Chest Wall Pain | <input type="checkbox"/> Groin Pain | |

What side is your pain mainly on?

- Left side
 Right side
 Both sides
 In the middle

Does your pain radiate anywhere?

- Yes
 No
- Where? _____

How would you describe the character or quality of your pain? (check all that apply)

- | | | |
|------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Gnawing | <input type="checkbox"/> Splitting |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Hot-Burning | <input type="checkbox"/> Tiring-Exhausting |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Aching | <input type="checkbox"/> Sickening |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Heavy | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Tender | <input type="checkbox"/> Punishing-Cruel |

Please rate the severity of your pain:

- | | | |
|----------------------------------|--|---------------------------------------|
| <input type="checkbox"/> No Pain | <input type="checkbox"/> Discomforting | <input type="checkbox"/> Horrible |
| <input type="checkbox"/> Mild | <input type="checkbox"/> Distressing | <input type="checkbox"/> Excruciating |

On a scale of 0 to 10 (please see below for description of ratings):

What is your lowest level of pain? (Circle #) 0 1 2 3 4 5 6 7 8 9 10

What is your average level of pain? (Circle #) 0 1 2 3 4 5 6 7 8 9 10

What is your highest level of pain? (Circle #) 0 1 2 3 4 5 6 7 8 9 10

0 – Pain free

1 – Very minor annoyance, occasional minor twinges. No medication needed.

2 – Minor annoyance, occasional strong twinges. No medication needed.

3 – Annoying enough to be distracting. Occasional mild pain medications take care of it (i.e. Tylenol, aspirin, ibuprofen).

4 – Can be ignored if you are really involved in work, but still distracting. Mild pain meds provide 3-4 hours of complete relief.

5 – Cannot be ignored for more than 30 minutes. Mild pain medications provide 3-4 hours of moderate relief.

6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities. Stronger pain medications reduce pain for 3-4 hours (i.e. Codeine, narcotics).

7 – Difficult to concentrate and interferes with sleep, but you can still function with effort. Stronger pain medications are only partially effective.

8 – Physical activity is severely limited. It takes effort to read and converse. Nausea and dizziness set in as factors of pain.

9 – Unable to speak, crying out or moaning uncontrollably – near delirium.

10 – Unconscious, pain causes you to pass out.

When did you first notice the pain? (Please fill in the blank with the approximate number of days, weeks, etc.)

_____ days ago

_____ months ago

_____ weeks ago

_____ years ago

Under what circumstances did your pain begin? (Check one box.)

Accident at work

Accident at home

Following surgery

No apparent reason

At work (not accident)

Motor vehicle accident

Following illness

Other _____

When is your pain the worst?

In the morning

At the end of the day

Various times during the day

Later in the day

At night

Other

What makes your pain worse? (Check all that apply)

Bending or stooping

Prolonged sitting

Lying down

Twisting

Coughing or straining

Prolonged standing

Weight bearing

Walking

Driving

Lifting

Physical activity

Walking Up Stairs

Which of the following have been adversely affected by your painful condition?

Activities of daily living

Normal lifestyle

Sleep

Work activities

Please check the aids or **devices** that you usually use:

Cane

Crutches

Walker

Wheelchair

If you have tried any of the treatments below please check each box that applies.

For any of the treatments that you checked Did it help or not?

<input type="checkbox"/> Epidural Steroid Injections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Facet Injections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Joint Injections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Radiofrequency Nerve Destruction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Trigger Point Injections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Nerve blocks (injections)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> TENS (electrical stimulation)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Manipulation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Heat therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Bed rest	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Traction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Massage therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Psychotherapy/psychiatric care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Hypnosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Exercise	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Does your pain medication

- Relieve all or most all of your pain?
 Relieve about 50% of your pain?
 Relieve only a slight amount of pain?
 Relieve about 75% of your pain?
 Relieve about 25% of your pain?

For how long do you get relief after taking your pain medication? _____ hours

Do you get side effects from your pain medication? Yes No

If yes, what are the side effects?

- Nausea Dizziness Abdominal pain
 Constipation Confusion Dry mouth
 Drowsiness Heartburn Other _____

Do these side effects limit your use of pain medications? Yes No

Have you received treatment in the past by other pain management physicians? Yes ___ No ___ If so, who:

Have you received treatment for pain in the past by any other specialist physicians? Yes ___ No ___ If so, who:

Review of Systems: (Please mark if you have **EVER** experienced any of the following conditions – if you have not experienced any of the conditions within a specific category, please write N/A)

Constitutional (general health):

- Weakness Fever Significant nutritional History of chronic fatigue
 Development problems General malaise problems syndrome
 Fatigue

Eyes:

- Double image Eye pain Eye inflammation Visual loss
 Blurred vision Color blindness Eye trauma Blindness in one side

Ears, Nose, Mouth, and Throat:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Discharge of the ear | <input type="checkbox"/> Discharge of nose | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Lesions in mouth |
| <input type="checkbox"/> Acquired deafness | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Soreness of mouth | <input type="checkbox"/> Laryngitis |
| <input type="checkbox"/> Deafness from birth | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Soreness of tongue | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Mastoiditis | <input type="checkbox"/> Obstruction of nose | <input type="checkbox"/> Taste abnormality | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Frequent cold | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Cavities | <input type="checkbox"/> ENT malignancy |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Ear operations | <input type="checkbox"/> Dental infection | <input type="checkbox"/> Voice changes |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Runny nose | <input type="checkbox"/> Gum disease | |

Chest (breast):

- | | | |
|--|--|--|
| <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> Breast injury | <input type="checkbox"/> Breast mass |
| <input type="checkbox"/> Poor breast development | <input type="checkbox"/> Unequal breast size | <input type="checkbox"/> (Male) breast enlargement |
| <input type="checkbox"/> Fibrocystic disease | <input type="checkbox"/> Breast pain | <input type="checkbox"/> Breast cancer in family |

Respiratory:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Allergen exposure | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> History of pneumonia | <input type="checkbox"/> Pain of chest wall | <input type="checkbox"/> COPD |
| <input type="checkbox"/> History of bronchitis | <input type="checkbox"/> Irritant exposure | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Family history of COPD |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Tobacco use | <input type="checkbox"/> Family history lung cancer |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Short of breath lying down | <input type="checkbox"/> Tuberculosis exposure | |

Cardiovascular:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Abdominal fluid build-up | <input type="checkbox"/> Cyanosis | <input type="checkbox"/> Heart disease in family | <input type="checkbox"/> Syncope |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Air hunger | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Dizzy when standing |
| <input type="checkbox"/> Intermittent pain in legs | <input type="checkbox"/> Ankle edema | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Cold extremities | <input type="checkbox"/> Significant cardiac history | <input type="checkbox"/> Rhythm disturbance | <input type="checkbox"/> Use of heart medication |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Vascular disease | <input type="checkbox"/> Risk for heart disease | |

Gastrointestinal:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Belching | <input type="checkbox"/> Gastrointestinal disease |
| <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Weight changes | <input type="checkbox"/> Gastrointestinal surgery |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Nausea | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Use of alcohol |
| <input type="checkbox"/> Flatulence | <input type="checkbox"/> Abnormal stools | <input type="checkbox"/> Heartburn | <input type="checkbox"/> GI cancer in family |

Genitourinary:

Female –

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> UTI symptoms | <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Unusual menstruation |
| <input type="checkbox"/> Pelvic pain | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Kidney pain or colic | |
| <input type="checkbox"/> Abnormal urination | <input type="checkbox"/> Vaginal infections | <input type="checkbox"/> Bladder incontinence | |

Male –

- | | | |
|---|---|---|
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> UTI symptoms | <input type="checkbox"/> Bladder incontinence |
| <input type="checkbox"/> Abnormal urination | <input type="checkbox"/> Kidney pain or colic | |

Musculoskeletal:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Posture abnormalities | <input type="checkbox"/> Swelling | <input type="checkbox"/> Fractures | <input type="checkbox"/> Abnormal joints |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Wasting or atrophy | <input type="checkbox"/> Kidney pain | |
| <input type="checkbox"/> Abnormal muscles | <input type="checkbox"/> Night cramps | <input type="checkbox"/> Migratory pain | |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Recent trauma or injury | <input type="checkbox"/> Muscular weakness | |

Integumentary:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Skin eruptions | <input type="checkbox"/> Excessive hair growth | <input type="checkbox"/> Nail ridging | <input type="checkbox"/> Nail pitting |
| <input type="checkbox"/> Color change of the skin | <input type="checkbox"/> Premature graying | <input type="checkbox"/> Infection of the nails | <input type="checkbox"/> Significant skin disorders |
| <input type="checkbox"/> Skin pigmentation changes | <input type="checkbox"/> Diffuse thinning of the hair | <input type="checkbox"/> Psoriasis nail distortion | <input type="checkbox"/> Skin lesions |
| <input type="checkbox"/> Abnormal hair texture | <input type="checkbox"/> Abnormal sweating | <input type="checkbox"/> Abnormal nail color | <input type="checkbox"/> Ingrown nails |
| <input type="checkbox"/> Patchy baldness on scalp | <input type="checkbox"/> Fungal infection - nails | <input type="checkbox"/> Unusual hair distribution | <input type="checkbox"/> Brittle nails |
| <input type="checkbox"/> Hot areas of the skin | <input type="checkbox"/> Itching of the skin | <input type="checkbox"/> Unusual nail configuration | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Abnormal hair loss | <input type="checkbox"/> Abnormal hair color | <input type="checkbox"/> Male pattern baldness | |

Neurological:

- Disturbance in hearing
- Convulsions or seizures
- Gait disturbance
- Visual disturbance
- Tingling or numbness
- Headaches
- Syncope
- Dizziness
- Speech difficulties
- Difficulty swallowing

Psychiatric:

- Adjustment problems
- Anxiety problems
- Depression symptoms
- Grandiose ideas
- Take psych. medications
- Hallucinations or delusions
- Psychiatric disorder
- Family psychiatric disorder
- Poor personal relationship

Endocrine:

- Diabetic symptoms
- Change hand or feet size
- Diabetes family history
- Obesity
- Abnormal skin pigments
- Abnormal sex develop.
- Sterility
- Thyroid disease
- Unusual weakness
- Weight change
- Abnormal growth
- Abnormal hair distribution
- Abnormal head size
- Abnormal body proportion

Hematologic / Lymphatic:

- Abnormal bleeding
- Lymphatic cancer
- Hemophilia in family
- Lymph node problems
- Anemia

Allergic and Immunology:

- Allergic conjunctivitis
- Asthma
- Allergic skin diseases
- Tuberculin tests
- Excess nasal spray use
- Family history of allergy
- Migraine headaches
- Triggered by allergies
- Allergy treatment

Past Surgical History:

Please place a check by any of the following **surgeries** if you have had them:

- Dental/oral surgery.
- PE tube insertions.
- Tonsillectomy.
- Thyroidectomy.
- Carotid endarterectomy.
- Coronary angioplasty.
- Coronary artery bypass graft.
- Lysis of abdominal adhesions.
- Exploratory laparotomy.
- Gall bladder surgery.
- Appendectomy.
- Hemorrhoidectomy.
- Bladder cystoscopy.
- Bladder Repair.
- C-Section.
- Tubal Ligation.
- D & C.
- Hysterectomy.
- Ovarian Cystectomy.
- Breast biopsy.
- Mastectomy.
- Inguinal hernia repair
- Hydrocelectomy.
- Vasectomy.
- TURP (prostate surgery).
- Skin cancer removal.
- Hip pinning.
- Hip replacement right or left
- Knee arthroscopy right or left
- Knee replacement right or left
- Surgical fracture repair.
- Lumbar laminectomy (back surgery).
- Lumbar laminectomy with fusion.
- Cervical laminectomy (neck surgery)
- Cervical fusion

Please list any other surgeries you have had:

Past Medical History:

Please check any of the following **conditions** you have now or have had in the past:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Varicose veins/Phlebitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis A, B or C (Circle) | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pyelonephritis | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Angina pectoris | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Anorexia or bulimia |
| <input type="checkbox"/> High cholesterol. | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Preadolescent sexual abuse |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Sexually transmit. diseases | <input type="checkbox"/> Alcoholism, active |
| <input type="checkbox"/> HIV or AIDS (circle) | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Alcoholism, in recovery |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Benign Prostate Swelling | <input type="checkbox"/> Drug addiction, active |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Drug addiction, in recovery |
| <input type="checkbox"/> Vision impairment | <input type="checkbox"/> Arrhythmias | <input type="checkbox"/> Menstrual disorder | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ovarian cyst | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Fibrocystic breast disease | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Peptic ulcer disease | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Bipolar disorder |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Alzheimer's disease |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Constipation | <input type="checkbox"/> Arthritis, nonspecific | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Fractures | <input type="checkbox"/> ADHD or OCD |

Have you ever received a blood transfusion? Yes No

Family History:

Please place a check by any diseases your relatives have had. If you are adopted and don't know your history, check here _____.

	FATHER	MOTHER	GRAND-PARENTS	SIBLINGS	CHILDREN
Age					
Good Health?					
Unknown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deceased: age at death?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease, Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strokes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Illegal drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History:

What is your **marital status** now?

- Married Never married Divorced/separated Widowed
Number of children (if applicable)? _____

What is your level of education?

- High school – GED High school – no degree College – no degree
 High school – graduate College – graduate College – post graduate

Do you drink **alcohol** (beer, wine, or liquor)?

- Not at all Occasional social drink About 1 to 3 drinks per day Four or more drinks per day

Do you now use, or have you ever used illegal drugs?

- Never used IV drugs _____ still use _____ quit (when) Marijuana _____ still use _____ quit (when) In recovery _____ how long?

Have you ever abused or been addicted to prescription drugs?

- Never abused or addicted In recovery _____ how long? Currently addicted

Do you use **tobacco**? If yes, for how long? _____ years.

- Never Smoke _____ cigars per day Chews _____ pouches per week
 Smoke _____ cigarettes per day Smoke _____ pipefull(s) per day Dips _____ cans per week
Do you live in a house with a smoker? Yes No

What is your current occupation?

- | | |
|---|---|
| <input type="checkbox"/> Professional specialty (e.g., teacher, nurse) | <input type="checkbox"/> Machine operator, assembler, or inspector (e.g., factory-worker) |
| <input type="checkbox"/> Executive, administrative, or managerial | <input type="checkbox"/> Transportation or material moving occupation (bus or truck driver) |
| <input type="checkbox"/> Technician or related support | <input type="checkbox"/> Handler, equipment cleaner, helper, or laborer |
| <input type="checkbox"/> Sales-related | <input type="checkbox"/> Military |
| <input type="checkbox"/> Administrative or support occupation, including clerical | <input type="checkbox"/> Student |
| <input type="checkbox"/> Private household service | <input type="checkbox"/> Homemaker |
| <input type="checkbox"/> Protective service occupation (e.g., police, fire) | <input type="checkbox"/> Vocational rehabilitation or job training |
| <input type="checkbox"/> Service occupation, except protective or household | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Farming, forestry, or fishing-related | <input type="checkbox"/> Disabled |
| <input type="checkbox"/> Precision production, craft, or repair-related | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Construction relate | |

Specifically, what do you do at work? _____

Are you employed now?

- Yes – Full-time Yes – Part-time No – But not because of pain
 Yes – Full-time with restrictions Yes – Part-time with restrictions No – Unable to work or unemployed because of pain
 Yes – Full-time, but on sick leave Yes – Part-time, but on sick leave

Place of employment (if employed): _____

Has your job changed because of your painful condition? Yes No

If your job has changed as a result of your pain, what was your former occupation? _____

Since your pain began, has your income changed?

- No – It has stayed the same Yes – It has decreased moderately
 Yes – It has increased Yes – It has decreased greatly
 Yes – It has decreased slightly

Have you sued because of your pain in the past? Yes No

Are you suing now or do you plan to sue in the future because of your pain? Yes No

If so, for what? Check all that apply:

- Lost wages Payment for pain and suffering
 Payment of medical bills Other (describe): _____

**Integrative Pain Services, P. A.
Mark S. White, D.O.**

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

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, Mark S. White, DO to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent to administer or prescribe the 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).

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 have been informed that the drug therapy that my physician may prescribe for me may involve using a drug that the Federal Food and Drug Administration may not have been asked by the manufacturer to review for safety for effectiveness for my condition. Current medical literature shows that such “off label” use may be beneficial to some patients and I understand that recommended dosages for treating chronic pain are often exceeded in order to balance the benefit and risk to the patient.

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), 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

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
TO Integrative Pain Services, P.A./Mark S. White, D.O.

Patient Name _____

Date of Birth _____ SS # _____ (optional)

I authorize:

Name/Facility: _____

Address: _____

Phone: _____ Fax _____

To disclose health information TO:

Name: **Integrative Pain Services, P.A./ Mark S. White, D.O.**

Address: 4807 Spicewood Springs Rd., Bldg. 1, Ste. 1235, Austin, TX 78759

Phone: (512) 795-9977

Fax: (512) 418-8445

Please release the following records:

1. **Office visits and procedure/surgery notes from the last 6 months of seeing patient.**
2. **Drug agreement now in effect**
3. **Medication records**
4. **MRI/CT/Lab reports**
5. **Other** _____

For the purpose of: Informing Dr. White of the patient's previous and/or current healthcare so that he may contribute to that care with Interventional Pain Management.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

Signature of Patient or Legal Representative

Date _____

Relationship to Patient (If Legal Representative)

Witness if Legal Representative