NEW PATIENT INFORMATION

☐ Bedford
☐ Lewisville
☐ Benbrook
☐ Justin
☐ Boyd

Even though we at Comprehensive Pain Institute (CPI) are committed to compassionate care, we must exercise proper due diligence when prescribing opioid analgesics for chronic pain. Prescription drug abuse has reached epidemic proportions in our society. Therefore, our clinic policy is that an appropriate workup must be completed prior to the dispensing of an opioid prescription. This workup will include review of previous pharmacy/clinic records, evaluation by diagnostic and laboratory tests, and acceptable completion of a urine drug screen yielding expected results. Common examples of opioid analgesics include hydrocodone, morphine, oxycodone, fentanyl, Opana, and methadone.

- Please bring your driver's license and insurance cards along with your completed new patient paperwork to your scheduled appointment. Payment for services are expected at the time of service (co-pays, co-insurance, private pay). We accept cash and credit cards (Visa, American Express, MasterCard, and Discover).
- **If you have been instructed to obtain imaging reports and/or films by our staff, please bring them to your appointment. Our office requires these as part of your consultation.** ***If we do not have your films at the time of your appointment, you may be rescheduled.***
- NO CHILDREN are allowed in the clinic. Many of our patients are in wheelchairs and walkers and we see too many people to have children in the clinic. You will not be seen if you bring your children.
- If English is your second language, in order to provide you with the best health care service, please make arrangements for someone to accompany you to your visit who can translate. We want you to fully understand your diagnosis and prognosis and to answer any questions you may have.

Your Appointment is: _____

****If you have not filled out or completed the New Patient Packet, please arrive 30 minutes prior to your appointment.**

We wish to make your visit as comfortable as possible, so please do not hesitate to contact us if you have any questions or concerns.

NAME:_____ Date of Birth:_____ DATE:_____

Is this your legal name? ☐Yes ☐No

If no, LEGAL NAME: _____ FORMER NAME(S)? _____

_____ _____

NEW PATIENT INTAKE

Patient's Age _____ Gender: M ☐ F ☐

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

SSN: _____ DRIVER'S LICENSE #: _____

MARITAL STATUS: ☐ Married ☐ Widowed ☐ Single ☐ Divorced

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino PREFERRED LANGUAGE: _____

RACE: ☐Native American ☐Asian ☐Black/African-American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Other

RELIGION: _____ EDUCATION: _____

E-MAIL: _____☐@yahoo.com ☐@gmail.com ☐@hotmail.com

PREFERRED METHOD OF COMMUNICATION: ☐Home phone ☐Cell phone ☐Work Phone ☐E-mail

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

OTHER PHYSICIANS: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

EMERGENCY PHONE: _____ PHONE TYPE: _____

RESPONSIBLE PARTY INFORMATION

NAME: _____ DATE OF BIRTH:_____

ADDRESS:_____

RELATIONSHIP: _____ PHONE: _____ SSN: _____

EMPLOYER: _____ EMPLOYER PHONE:_____

NAME:_____ Date of Birth:_____ DATE:_____

INSURANCE or ATTORNEY INFORMATION

INSURANCE COMPANY: _____ **(Provide card to front desk)**

INSURED'S NAME:_____ DATE OF BIRTH:_____

INSURED'S SSN: _____ RELATIONSHIP TO PATIENT ☐Self ☐Spouse ☐Dependent

ATTORNEY NAME: _____ ATTORNEY PHONE: _____

ATTORNEY ADDRESS: _____

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 Comprehensive Pain Institute or insurance company to release any information required to process my claims.

Patient/Guardian Signature _____ Date _____

PAST MEDICAL HISTORY

Please indicate if you have suffered from any of the following medical conditions. ***Also note the year these occurred.***

_____AIDS or HIV
_____Arthritis
_____Asthma
_____Cancer
_____Chronic skin disease
_____Depression
_____Diabetes
_____Emphysema
_____Fibromyalgia
_____Gallbladder
_____Gonorrhea
_____Gout
_____Headaches/migraine
_____Heart disease/attack
_____Heart failure
_____Heart murmur
_____Hepatitis
_____Herpes infection
_____High blood pressure
_____Hormone problems
_____Insomnia
_____Irregular heart beat
_____Jaundice
_____Kidney disease
_____Kidney Stones
_____Liver disease
_____Lupus
_____Menopause
_____Multiple sclerosis
_____Nervous breakdown
_____Other blood abnormality
_____Other venereal disease
_____Panic attacks
_____Peptic ulcer disease
_____Peripheral vascular disease
_____Pneumonia
_____Prostate enlargement
_____Rheumatic heart
_____Schizophrenia/bipolar
_____Seizures/convulsions
_____Shingles
_____Stroke
_____Syphilis
_____Thyroid
_____Tuberculosis
_____Urinary infection
Other: _____
_____
_____
_____

NAME:_____ Date of Birth:_____ DATE:_____

PAST SURGICAL HISTORY

_____Date/Year_____ _____Date/Year_____

_____Date/Year_____ _____Date/Year_____

_____Date/Year_____ _____Date/Year_____

FAMILY HISTORY

List any disease, illness, or ailments in your IMMEDIATE FAMILY. (i.e. mother-breast cancer, father - diabetic, grandfather - heart disease)

_____

_____

SOCIAL HISTORY

Occupation: _____

Do you smoke? ☐Yes ☐No Packs/day?_____ How many years?_____

Drink alcohol? ☐Yes ☐No How much?_____

Use any other drugs (marijuana, cocaine, etc.)? ☐Yes ☐No If yes, what?_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Live Alone? ☐Yes ☐No If no, who do you live with? _____

ALLERGIES _____

PHARMACY Name:_____Location:_____

CURRENT MEDICATIONS **include dosage and frequency for each

Medication	Dosage	Frequency

NAME:_____ Date of Birth:_____ DATE:_____

REVIEW OF SYSTEMS

In the past few months, have you had any of the following symptoms or difficulties? If you have any difficulty that needs further explanation please indicate such and explain in additional notes section.

General	**YES**	**NO**
Loss of appetite	☐	☐
Fever or chills	☐	☐
Eyes	☐	☐
Blurred vision	☐	☐
Loss of vision	☐	☐
Head/ear/nose/throat	☐	☐
Hoarseness	☐	☐
Trouble swallowing	☐	☐
Cardiovascular	☐	☐
Chest pain	☐	☐
Leg swelling	☐	☐
Varicose veins	☐	☐

Respiratory	**YES**	**NO**
Shortness of breath	☐	☐
Wheezing	☐	☐

Gastrointestinal	**YES**	**NO**
Nausea and vomiting	☐	☐
Ulcers	☐	☐
Blood in stool	☐	☐
Change in bowel habits	☐	☐
Kidney/bladder/urine	☐	☐
Painful urination	☐	☐
Frequent urination	☐	☐

Musculoskeletal	**YES**	**NO**
Significant pain/stiffness	☐	☐
Skin	☐	☐
Rash	☐	☐
Frequent rashes	☐	☐

Neurological	**YES**	**NO**
Tremor	☐	☐
Seizures	☐	☐
Stroke	☐	☐

Psychiatric	**YES**	**NO**
Mental Illness	☐	☐
Suicide Attempt	☐	☐
Depression	☐	☐
Drug/Alcohol addiction	☐	☐
Difficulty with sexual activities	☐	☐

Endocrine	**YES**	**NO**
Thyroid disease	☐	☐

Hematological/Lymphatic		
Easy bruising	☐	☐

Immunologic		
Enlarged/swollen lymph glands	☐	☐

Mark all that apply:	**YES**	**NO**
Recent weight loss	☐	☐
Low energy/fatigue	☐	☐
Double Vision	☐	☐
Eye pain	☐	☐
Hearing loss	☐	☐
Ear pain	☐	☐
Palpitations	☐	☐
Orthopnea	☐	☐
Chronic cough	☐	☐
Heartburn	☐	☐
Constipation	☐	☐
Hemorrhoids	☐	☐
Blood in urine	☐	☐
Change in urinary pattern	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Tingling	☐	☐
Suicidal Thoughts	☐	☐
Trouble sleeping (insomnia)	☐	☐
Heat/cold tolerance	☐	☐
Easy bleeding	☐	☐

Additional Notes:_____

_____

_____

NAME:_____ Date of Birth:_____ DATE:_____

PAIN EVALUATION

Is there an ongoing lawsuit related to your visit today? ☐Yes ☐No

Are you currently under workers' compensation? ☐Yes ☐No

Location of your pain: _____

When did pain start? _____

What happened and when? (Car accident, fall, nothing, etc.)_____

_____

_____

On a scale of 0 to 10 (0 = no pain at all and 10 = severe pain), how bad is your pain today?_____

Over the course of 30 days what was your average pain score?_____

What aggravates your pain? _____

_____

What makes your pain better?_____

_____

What medications have you tried to treat this pain (including over the counter drugs)? Note whether the medications helpful or not helpful._____

_____

How has this pain affected your physical function, quality of life, and ability to participate in activities (including activities required for daily living and self-care)? _____

_____

_____

NAME:_____ Date of Birth:_____ DATE:_____

What treatments have you tried in the past? Please indicate when you had the treatment and whether it helped.

Treatment	Tried	When (year)	Helped
Chiropractor	☐Yes ☐No	_____	☐Yes ☐No
Traction	☐Yes ☐No	_____	☐Yes ☐No
Braces	☐Yes ☐No	_____	☐Yes ☐No
Nerve block	☐Yes ☐No	_____	☐Yes ☐No
Physical therapy	☐Yes ☐No	_____	☐Yes ☐No
Hypnosis	☐Yes ☐No	_____	☐Yes ☐No
Acupuncture	☐Yes ☐No	_____	☐Yes ☐No
Biofeedback	☐Yes ☐No	_____	☐Yes ☐No
Ice/heat packs	☐Yes ☐No	_____	☐Yes ☐No
Opioids	☐Yes ☐No	_____	☐Yes ☐No
Massage	☐Yes ☐No	_____	☐Yes ☐No
Religious counseling	☐Yes ☐No	_____	☐Yes ☐No
Psychological counseling	☐Yes ☐No	_____	☐Yes ☐No
TENS/electrical stimulation	☐Yes ☐No	_____	☐Yes ☐No
Pain medication	☐Yes ☐No	_____	☐Yes ☐No
Surgery	☐Yes ☐No	_____	☐Yes ☐No

Which treatment above has helped you the most? _____

_____

_____

If you have had surgery for pain, please note what kind of surgery, how many, when and if it helped.

_____

_____

_____

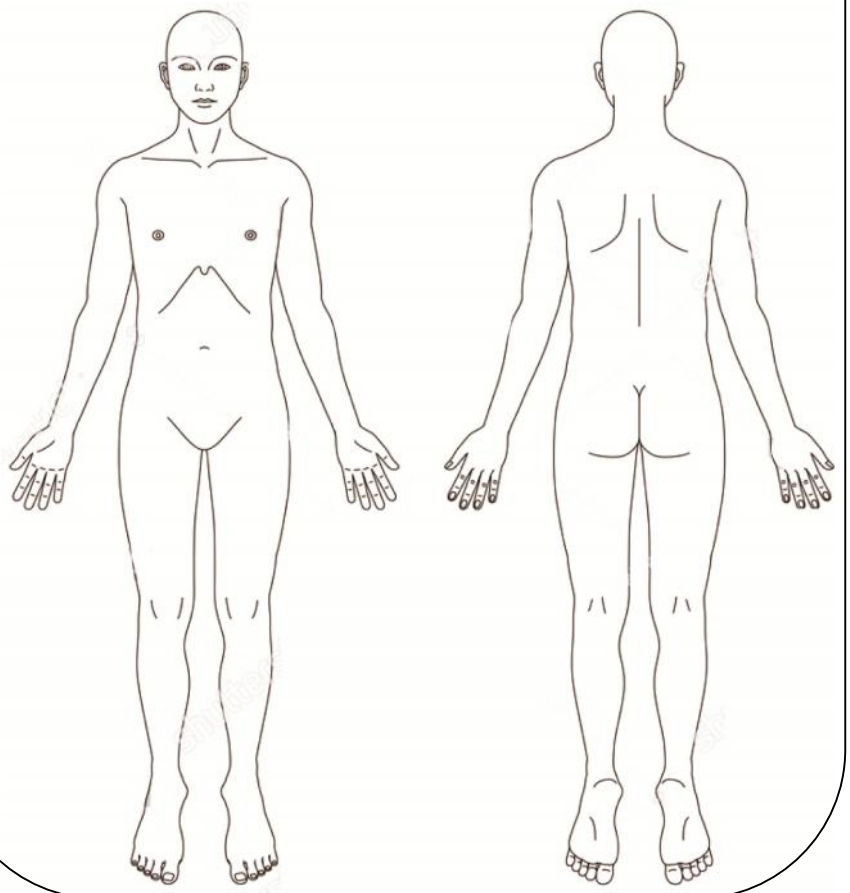
Have you tried any interventional pain modalities such as epidural or facet injections, nerve blocks, or ablations, or spinal cord stimulation? If so, please indicate the type of procedure, where and when it was done, and your response: _____

_____

NAME:_____ Date of Birth:_____ DATE:_____

Use the appropriate symbol and mark the area(s) on the diagrams below where you feel each of the sensations on your body:

Numbness	- - - - - - - - - -	Stabbing	ϕ ϕ ϕ ϕ ϕ ϕ ϕ
Pins & needles	o o o o o o o o	Constant	c c c c c c c c c
Burning	^ ^ ^ ^ ^ ^ ^ ^	Intermittent	i i i i i i i i i i i i i
Aching	X X X X X X X X	Deep	d d d d d d d d
		Superficial	s s s s s s s s s s



Pain Scale

Rate your pain on the line scale below and mark where your pain is right now.

Pain as bad as it can be.

No pain at all.

How long can you be comfortable until pain increases?

Sitting	0 min	1-30 min	31-60 min	1 hour
Standing	0 min	1-30 min	31-60 min	1 hour
Resting or reclining	0 min	1-30 min	31-60 min	1 hour

How much time do you spend each day?

Sitting	Less than 2 hours	2-5 hours	5-8 hours	8-12 hours	12 hours
Standing/walking	Less than 2 hours	2-5 hours	5-8 hours	8-12 hours	12 hours

NAME:_____ Date of Birth:_____ DATE:_____

SSN (last 4): XXX-XX-_____

COMM QUESTIONNAIRE

Please answer each question as it relates to the LAST 30 DAYS only. Answer as honestly as possible, there are no right or wrong answers. If you are unsure how to answer, please give the best answer you can.

0 = never 1 = seldom 2 = sometimes 3 = often 4 = very often

How often have you had trouble with thinking clearly or had memory problems?	0	1	2	3	4
How often do people complain that you are not completing necessary tasks?	0	1	2	3	4
How often have you had to go to someone other than your physician to get sufficient relief from medications (i.e. another doctor, ER, friend, etc.)	0	1	2	3	4
How much of your time was spent thinking about opioid med? (Having enough, taking them, dosing schedule, etc.)?	0	1	2	3	4
How often have you had trouble controlling your anger? (Screaming, road rage, etc.)?	0	1	2	3	4
How often have you taken your medications differently from how they are prescribed?	0	1	2	3	4
How often have you needed to take pain medications belonging to someone else?	0	1	2	3	4
How often have you seriously thought about hurting yourself?	0	1	2	3	4
How often have you been worried about how you are handling your medications?	0	1	2	3	4
How often have others been worried about how you are handling your medications?	0	1	2	3	4
How often have you been in an argument?	0	1	2	3	4
How often have you had to visit the emergency room?	0	1	2	3	4
How often have you had to make an emergency phone call or show up at the clinic without an appointment?	0	1	2	3	4
How often have you gotten angry with people?	0	1	2	3	4
How often have you had to take more medication than prescribed?	0	1	2	3	4
How often have you borrowed pain medication from someone else?	0	1	2	3	4
How often have you used your pain medication for symptoms other than for pain (i.e. help with sleep, improve mood, or relieve stress)	0	1	2	3	4

NAME:_____ Date of Birth:_____ DATE:_____

PATIENT HEALTH QUESTIONNAIRE- 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 +_____+_____+ _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**

CPI
COMPREHENSIVE
PAIN INSTITUTE

PATIENT CONSENT AND AUTHORIZATION

☐ Bedford
☐ Lewisville
☐ Benbrook
☐ Justin
☐ Boyd

CONSENT TO TREAT

I, _____ (Patient name) give permission for Comprehensive Pain Institute to give me medical treatment and I allow Comprehensive Pain Institute to file for insurance benefits to pay for the care that I receive.

I understand that: ***(Please initial each)***

_____Comprehensive Pain Institute will have to send my medical records information to my insurance company.

_____I must pay my share of the costs.

_____I must pay for the cost of the services if my insurance does not pain or I do not have insurance.

_____I understand that I have the right to refuse any procedure or treatment.

_____I have the right to discuss all medical treatments with my provider.

Patient Signature: _____ Date: _____

Parent or Guardian Name (PRINTED): _____

Parent or Guardian Signature: _____

PATIENT CONSENT (PHI)

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO CARRY OUT TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS AND ANTI-DISCRIMINATION POLICY.

_____ hereby states that by signing this Consent, I acknowledge and agree as follows:

1) The Practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent and has encouraged me to read the Privacy Novice prior to signing this Consent and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3) I understand that, and consent to the following appointment reminders that will be used by the Practice: (a) a postcard mailed to me at the address provided by me; and (b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone; (c) text message to my mobile phone.

4) The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5) I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees with a requested restriction, then the restriction is binding on the Practice.

6) I understands that this consent is valid for seven years. I further understand that I have the right to revoke this Consent in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7) I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8) I understand that if I do not sign this Consent evidencing my consent to uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

ANTI-DISCRIMINATION POLICY

Initials_____ Discrimination or harassment against any member of Comprehensive Pain Institute (i.e. physicians, nurse practitioners, office staff, or patients) because of age, ancestry, color, disability as defined by Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, gender, gender identity and/or expression, marital or parental status, national origin, pregnancy, race, religion, sexual orientation, veteran's status, or any other categories protected by federal or state law is prohibited and will not be tolerated, nor will any person for those reasons be excluded from the participation in or denied the benefits of any program or activity within Comprehensive Pain Institute.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (PRINTED) Signature of Individual

_____ _____

Signature of Legal Representative (Attorney-in-Fact, guardian, or parent if a minor) Relationship

Date Signed: _____

Witness: _____ Title:_____

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's notice of privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of patient or representative

_____

Date

_____

Witness (CPI Employee) Title of Witness

List any person(s) you wish to have access to your medical information, including portal access:

NAME: _____ RELATIONSHIP:_____

NAME: _____ RELATIONSHIP:_____

NAME: _____ RELATIONSHIP:_____

FINANCIAL POLICY AGREEMENT

As part of our ongoing commitment to treating our patients with complete courtesy, dignity, and respect, we regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions regarding these policies, please discuss them with our billing specialists prior to treatment.

INSURANCE AND PATIENT RESPONSIBILITY

Initials_____ Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable copays, co-insurance payments, and deductibles for the insurance companies with whom we are contracted. CPI accepts cash, in-state personal checks, Visa, MasterCard, Discover, and American Express. There is a $30.00 service charge for returned checks.

Initials_____ I understand that if I have insurance I am the responsible party and that having insurance does not guarantee payment of the services rendered to me. I authorize submission of my claim to the insurance company listed above. CPI bills participating insurance companies as a courtesy to our patients. Patients are expected to pay their deductible and/or co-insurance/copay at the time of service. ***You must present an insurance card at each visit. If you or your dependent(s) do not present a valid insurance card at the time of your visit, you will be responsible for the visit cost in full.***

PATIENT RESPONSIBILITY

Initials_____ I understand that some, or perhaps all of the services I receive may be non-covered or not considered reasonably necessary by my insurance company. In the event that my insurance company determines a service to be non-covered, I understand that I will be responsible for the service(s) performed. The physicians in the office will be unable to change their normal course of treatment due to non-covered services or limitations of my insurance benefits. Payment for non-covered services will be due at the time of service or upon receipt of a statement from CPI.

PAYMENT ARRANGEMENTS

Initials_____ I understand that patients with an outstanding balance of 30 days or more overdue must make payment arrangements prior to scheduling appointments. Payment plans must be set up by the patient in person and will automatically be deducted from the credit/debit card specified in that arrangement.

MINOR PATIENTS

Initials_____ Regardless of marital status, CPI will look to the adult accompanying the patient for payment due at the time of service is rendered to the minor patient. If a parent other than the one accompanying the patient to the office is legally responsible for the account, a copy of the court decree with need to be submitted to the office. Minors and dependents must present a valid insurance card at each visit if a claim is to be filed. In addition, minor cannot receive medical treatment without the signed consent of a parent or legal guardian.

CLAIMS SUBMISSION

Initials_____ I understand that CPI will submit my claims and assist me in any way they reasonably can to help get my claims paid. I understand that my insurance company may need me to supply certain information directly to them and it is my responsibility to comply with their requests.

NON-PAYMENT

Initials_____ I understand that statement balances must be paid within 30 days to avoid late payment penalty charges. If my account is over 90 days past due, I will receive a letter stating that I have 20 days to pay my account in full. Partial payments will not be accepted unless arranged in advance with a signed payment arrangement in place. I understand that if a balance remains unpaid, CPI may refer my account to a collection agency. Any collection agency fees, in addition to my unpaid balance, will be my responsibility.

MISSED APPOINTMENTS AND LATE CANCELLATIONS

Initials_____ I understand that if I am unable to make an appointment, I must call within 24 hours prior to your appointment time to reschedule. If I fail to notify CPI prior to missing my scheduled appointment, I understand that I will be charged a NO SHOW FEE of $25.00 for an office visit and $50 for a procedure. This must be paid prior to scheduling any future visit. Frequent missed appointments/no show, or chronic rescheduling may result in termination of physician/patient relationship and release from CPI.

Patient Signature or
Authorized Representative:_____

Printed Name of above: _____

Date: _____

PATIENT AUTHORIZATION FOR MEDICAL DISCLOSURE (BY TELEPHONE OR FAX)

Please fill out this form and give to the Front Desk.

The patient authorizes this clinic to disclose medical information regarding clinical care and diagnoses, including laboratory results and medical history to those listed below: (i.e. family physician, referring physician, family members, attorney, etc.)

Primary Care Physician_____

Telephone _____

Name_____

Telephone _____ Relationship _____

Name_____

Telephone _____ Relationship _____

Name_____

Telephone _____ Relationship _____

I hereby request and authorize CPI to release and send the following information:

☐ Complete Record

☐ Complete Hospital Records

☐ Records from _____ to _____ only.

☐ Records concerning the following conditions only: _____

_____

This consent is in effect until revoked in writing. Our office requires patient consent in writing for all information requests not related to billing requirements.

_____ _____

Name of Patient (PRINTED) **Date**

_____ _____

Signature of Patient or Legal Guardian **Relationship to Patient**

CPI
COMPREHENSIVE
PAIN INSTITUTE

OPIOID AGREEMENT
PAIN MANAGEMENT

☐ Bedford
☐ Lewisville
☐ Benbrook
☐ Justin
☐ Boyd

The purpose of this agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This is to help both you and your doctor comply with the law regarding controlled pharmaceuticals.

PLEASE READ EACH OF THE ITEMS IN THIS AGREEMENT AND INITIAL IN THE SPACES PROVIDED

_____I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement. I understand that if I break this agreement, my doctor will stop prescribing pain control medications.

_____I am aware that the use of such medicine has certain risks associated with it including, but not limited to sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, decrease in respiration rate, physical dependence, tolerance to analgesia, addiction, and the possibility that the medicine will not provide complete pain relief.

_____I will tell my doctor about all other medicines and treatments that I am receiving. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might be slowed. Such activities include, but are not limited to using heavy equipment or a motor vehicle, working at unprotected heights or being responsible for another individual who is unable to care for themselves.

_____I am aware that addiction is deemed as the use of a medicine even it if causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor and counselor my complete and honest personal drug history and that of my family to the best of my knowledge.

_____In understand that physical dependence is a normal, expected result of using these medications for an extended period of time. I understand that physical dependence is not the same as addiction. I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has occurred and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

_____I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve the pain.

_____I will not use any illegal controlled substances, including marijuana, cocaine, etc. I will not share, sell, or trade my medication to anyone.

CPI
COMPREHENSIVE
PAIN INSTITUTE

OPIOID AGREEMENT
PAIN MANAGEMENT

_____**I will not attempt to obtain any controlled medications, including opioid pain medicines, controlled stimulants, or anti-anxiety medications from any other doctor.**

_____**I will safeguard my pain medication from loss or theft. Lost or stolen medications will not be replaced. I REALIZE THAT LOST, DISCARDED, OR STOLEN MEDICATION IS A BREACH OF THE MEDICATION AGREEMENT.**

_____I agree to bring discharge paperwork from all Emergency Room(ER) visits. I understand that ER visits are allowed for emergencies only. I agree to NOT fill any opioid pain medications, controlled stimulants, or anti-anxiety medications from the ER without consulting with my pain management provider first.

_____I agree that if my doctor feels that my blood pressure is too high or low, I will go to the nearest ER and my medications will not be resumed until my blood pressure has been stabilized.

_____I agree that refills of my prescriptions for pain medication will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings and/or weekends.

_____I agree to bring medication in original bottle if any changes are needed.

_____I understand that appropriate disposal of my medications will be a requirement to obtain any changes.

_____I agree to use one pharmacy for my controlled substance prescriptions:

_____
Pharmacy name and Location

_____I agree that I will submit to blood or urine testing as requested by my doctor to confirm my compliance with my program of pain control medications.

_____I agree that I will bring in my medications for a pill count when requested to do so by my doctor or representative.

_____I agree that I will use my medication at a rate no greater than the prescribed amount and that use of my medication at a greater rate will result in my being without medication for a period of time.

_____I understand the treatment of pain requires a multi-modality approach and that the best outcomes cannot be obtained solely on pain medications alone and I agree to participate entirely with the prescribed treatment plan as determined by my doctor, to include counseling (individual and group), physical therapy, topical creams/patches, and interventional procedures/injections.

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OPIOID AGREEMENT
PAIN MANAGEMENT

_____I understand that chronic pain impacts the quality of life and is most always accompanied by depression. I agree that in order for me to have the best quality of life, the areas that chronic pain impacts, both physical and mental, must be addressed. I understand and agree to participate with a counselor/therapist as my doctor determines is necessary.

_____I understand that my failure to cooperate with the treatment plan as established by my doctor and team will cause me to be in a breach of the agreement and I can be discharged from care.

MALES ONLY: _____I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my moods, stamina, and sexual desire, physical and sexual performance. I understand that my doctor may check my blood to determine if my testosterone level is normal.

FEMALES ONLY: _____If I plan to become pregnant or believe that I have become pregnant while taking the prescribed pain medication, I will immediately cal my obstetric doctor and this office to inform them. I am aware that, should I not carry a baby to delivery while taking these medications; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medications and there is always the possibility that my child will have a birth defect while I am taking an opioid.

_____I agree to follow guidelines that have been explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This agreement is entered on this date: _____

_____ _____

Patient Name Patient Signature

Witnessed by: _____ Title:_____

SLEEP HISTORY AND EXAMINATION FORM

☐ Bedford
☐ Lewisville
☐ Benbrook
☐ Justin
☐ Boyd

Your physician requests that you complete this Sleep History Form which evaluates the need for you to have a user-friendly home sleep test. The home sleep test will determine if you have a sleep disorder. Sleep disorders negatively affect your well-being, especially your cardiovascular health. Sleep disorders can be treated effectively.

Date:_____ Name:_____ Date of Birth:_____ Age:_____

Phone:_____Home Address:_____

Physician Name:_____ Height_____ Weight____lbs. BMI_____

1) Have you ever been given a CPAP device? ☐Yes ☐No (Date_____)
2) Are you comfortable with your CPAP and satisfied with its use? ☐Yes ☐No
3) How many hours do you sleep on average per night? ☐Less than 4 hrs. ☐More than 4 hours

Epworth Sleepiness Scale

How likely are you to doze off while doing the following activities? Please use the following scale:

0 = never 1 = slight 2 = moderate 3 = high

1)	Being a passenger in a motor vehicle for 1 hour or more?	0 1 2 3 4
2)	Sitting and talking to someone.	0 1 2 3 4
3)	Sitting and reading.	0 1 2 3 4
4)	Watching TV.	0 1 2 3 4
5)	Sitting inactive in a public place.	0 1 2 3 4
6)	Lying down to rest in the afternoon.	0 1 2 3 4
7)	Sitting quietly after lunch without alcohol.	0 1 2 3 4
8)	In a car, while stopped for a few minutes in traffic.	0 1 2 3 4

Part I

1)	Have you been told that you snore or grind your teeth at night?	☐Yes ☐No
2)	Do you wake unrefreshed, tired, feeling sleepy most of the time or need to nap?	☐Yes ☐No
3)	Does your family have a history of premature death in sleep?	☐Yes ☐No
4)	Do you have diabetes?	☐Yes ☐No
5)	Have you ever been told you have coronary artery disease?	☐Yes ☐No
6)	Do you have high blood pressure?	☐Yes ☐No
7)	Have you ever experienced irregular heart rhythms?	☐Yes ☐No
8)	Do you have heart disease?	☐Yes ☐No
9)	Do you have lung disease?	☐Yes ☐No
10)	Do you suffer from depression?	☐Yes ☐No
11)	Do you take sleep medication?	☐Yes ☐No

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12) Do you experience morning headaches? ☐Yes ☐No
13) Do you take sleep medication? ☐Yes ☐No
14) Do you suffer from restless leg syndrome? ☐Yes ☐No
15) Do you suffer from insomnia? ☐Yes ☐No
16) Do you suffer from narcolepsy? ☐Yes ☐No

PART II

1) Have you ever been diagnosed with sleep apnea? ☐Yes ☐No
2) Do you wake from sleep with chest pain or shortness of breath? ☐Yes ☐No
3) Has anyone said that you seem to stop breathing while sleeping? ☐Yes ☐No
4) Is your neck size larger than 15”(female) or 16.5”(male)? ☐Yes ☐No
5) Have you ever had a stroke? ☐Yes ☐No
6) Have you ever been told you have congestive heart failure? ☐Yes ☐No
7) Do you have or did you even have atrial fibrillation? ☐Yes ☐No
8) Do you wake up from sleep choking or gasping for air? ☐Yes ☐No
9) Do you wake or bother bed partner with legs kicking or moving? ☐Yes ☐No
10) Do you sleep walk, talk, or act out dreams? ☐Yes ☐No

Actual Neck Size

Patient Signature: _____ Date:_____

If patient presents with positive screening or sleep apnea a home sleep study will be ordered. ☐

Physician Signature: _____ Date:_____

Mallampati Score: _____ ☐Teeth marks on tongue ☐Overbite or recessive chin