NORTH TEXAS PAIN
RECOVERY CENTER

PATIENT INFORMATION

DATE:_____

PATIENT NAME:_____ AGE:_____ BIRTHDAY:_____

ADDRESS:_____ CITY:_____ STATE:___ ZIP:_____

HOME PHONE NUMBER: (___)_____ WORK: (____)_____

SOCIAL SECURITY #:_____ DRIVER'S LICENSE #:_____

OCCUPATION:_____ EMPLOYER:_____

MARITAL STATUS:_____ EMAIL:_____

SPOUSE'S NAME:_____ AGE:___ WORK NUMBER: _____

CHILDREN:_____ AGES:_____

NEAREST RELATIVE NOT LIVING WITH YOU:_____ RELATIONSHIP:_____

ADDRESS:_____ PHONE NUMBER:_____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:_____

_____

ALLERGIES: _____

TREATING PHYSICIAN:_____ PHONE:_____

PHYSICIAN'S ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

DIAGNOSIS:_____

DATE OF INJURY:_____ REFERRING DOCTOR:_____

INSURANCE INFORMATION: (circle one) Workers' Comp Private LOP Other

INSURANCE COMPANY: _____ PHONE: _____

ADDRESS: _____

NAME OF INSURED: _____ INSURED DOB: _____

INSURED SS# _____ ID# _____

GROUP #_____

ADJUSTOR: _____ PHONE: _____

CLAIM #: _____

ATTORNEY: _____ PHONE: _____

ANY OTHER SIGNIFICANT INFORMATION WE SHOULD KNOW? _____

NORTH TEXAS PAIN RECOVERY CENTER

PAIN MANAGEMENT
WORK HARDENING
PHYSICAL THERAPY
PSYCHOLOGICAL SERVICES

6702 W. Poly Webb Rd. Arlington TX 76016 Phone: (817) 478-0095 Fax (817) 478-7628

Medical History

Name:_____ Age: _____ Height: _____ Weight: _____

Please complete entire form.

Yes	No	If yes, please explain
☐	☐	Heart attack, angina, irregular heartbeat _____
☐	☐	Mitral Valve prolapsed/ rheumatic fever _____
		Last time an EKG done_____Where? _____
☐	☐	Do you have sleep apnea or use a CPAP _____
☐	☐	High Blood Pressure _____
☐	☐	Epilepsy, Seizures, Fainting Spells _____
☐	☐	Paralysis or Stroke _____
☐	☐	Diabetes _____
☐	☐	Thyroid Problems _____
☐	☐	Asthma, Bronchitis, Emphysema _____
☐	☐	Do you Smoke? _____PPD _____Years
		Last chest X-Ray Date_____ Where? _____
☐	☐	Hepatitis, Jaundice _____
☐	☐	Alcohol Consumption How much? _____
☐	☐	Reflux, Heartburn _____
☐	☐	Kidney or Bladder Problems _____
☐	☐	Neck or Back Trouble _____
☐	☐	Arthritis _____
☐	☐	Bleeding tendency or Clotting Problems _____
☐	☐	Could you possibly be pregnant? LMP _____
☐	☐	Any other Medical Problems not listed? _____
☐	☐	Are you taking any medications, Rx diet pills, herbs, vitamins? _____
☐	☐	Are you allergic to any medications, fish, eggs, soy products, latex, iodine contrast (Ex: IVP Dye)
		Please List _____
☐	☐	Previous Surgeries _____
☐	☐	Problems with Anesthesia _____
☐	☐	Family History Problems not listed _____
☐	☐	Dentures, Partial Plates, Caps, Crowns, Bridges, Braces _____
☐	☐	Blood tests done in the last month? Where? _____
☐	☐	Do you have any body piercing (s) Where _____

Check all that apply:

Quality: Sharp___ Constant___ Aching___ Intermittent___ Pressure/Tightness___

Sensation: Normal___ Decreased___

Specific Location and Level of Pain

_____

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain

I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law.

_____ _____

Signature Date

North Texas Pain Recovery Center

Authorization Form

This form, when completed and signed by you, authorizes your doctor to release protected information from your clinical record to North Texas Pain Recovery Center.

I authorize _____ to release all of my medical records pertaining to my current illness to North Texas Pain Recovery Center.

This information should only be released to:

North Texas Pain Recovery Center
6702 W. Poly Webb Road
Arlington, TX 76016

I am requesting the abovementioned doctor (clinic) release this information to aid in the treatment of my illness.

This authorization shall remain in effect for 90 days.

I have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that your doctor has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and under the insurer has a legal right to contest a claim.

I understand that my doctor generally may not condition medical or psychological services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

North Texas Pain Recovery Center

Authorization Form

This form when completed and signed by you, authorizes us to release protected information from your clinical record to the person you designate.

I authorize North Texas Pain Recovery Center to release (provide description of the information that you want disclosed. Your description should be as specific and detailed as possible).

All Medical Records

This information should only be released to (name and address of person to whom the information is to be released).

Dr.

I am requesting NTPRC to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose).

At Patient Request

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).

Until Resended.

I have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that your doctor has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and under the insurer has a legal right to contest a claim.

I understand that my doctor generally may not condition medical or psychological services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient _____ Date _____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

NORTH TEXAS PAIN RECOVERY CENTER'S
INFORMED CONSENT FOR ASSESSMENT & TREATMENT

I understand that I was referred to North Texas Pain Recovery Center (NTPRC) in order to receive one or more of the services offered by NTPRC. The type and extent of service to be received will be determined by the type of referral received from my treating physician, NTPRC's initial assessment and a thorough discussion with me. The goal of the initial assessment is to determine the best course of treatment for me.

Section 1 – Confidentiality

I understand that all the information shared with the clinicians at NTPRC is confidential and no information will be released without my consent (with the exception of the limits listed below). Consent to release information is given through written authorizations. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

1. When there is a risk of imminent danger to myself the clinician is ethically bound to take the necessary steps to prevent such danger;
2. When there is suspicion that a child or an elder is being sexually or physically abused or is at risk of such abuse the clinician is legally required to inform the authorities;
3. When a valid court order is issued for medical records the clinician and NTPRC are bound by law to comply with such request;
4. If your treatment is covered by workers' compensation insurance the clinician is required to send in treatment notes with my medical bills and must keep my treating/referring doctor informed of my progress;
5. Some of the treatments (ex: the chronic pain or work hardening programs) at NTPRC are interdisciplinary in

Section 2 – Interns & Post-Doctoral Fellows

I understand that a range of health care professionals, some of whom are in training, provide NTRPC services. All interns or post-doctoral fellows are supervised by licensed staff. I will be informed if my clinician is an intern or post-doctoral fellow and will be informed who is supervising them.

Section 3 – Functional Capacity Evaluation or Physical Therapy Evaluation

If my assessment involves a Functional Capacity Evaluation or a Physical Therapy Evaluation I understand these assessments determine my safe maximum physical ability. They may include tests of strength, flexibility, cardiovascular fitness, static posturing, repetitive movements and material handling ability. All tests will be thoroughly explained to be before I perform them.

I understand there are risks of injury during these assessments. I may experience an increase in my pain, an aggravation of my existing injury or a new injury. These tests are considered safe and acceptable if I do not permit pain to increase throughout testing. Therefore it is important that I to do the following:

1. Report any pain increase immediately;
2. Stop any test if I experience an increase in pain;
3. I do not perform any test that I do not feel able to perform.

All tests are voluntary and you may refuse any test if you feel you are not capable of performing the task.

There are indicators which determine if I am cooperating to determine my best ability level. I understand that any indication that I am not giving my best effort will be reported along with my results of this evaluation. My evaluator will then report my estimated functional ability based on any available information.

If I am undergoing a Functional Capacity Evaluation or a Physical Therapy Evaluation I agree to the following:

1. I understand the above information and agree to participate in the FCE or PT evaluation to the best of my ability;
2. I certify that I have been advised of my right to request any reasonable accommodation needed because of my disability;
3. I further agree to hold NTPRC harmless if I do incur an injury during this examination;
4. I also understand that I am authorizing NTPRC to release the results of this examination to the referring physician or entity;
5. I also specifically relieve NTPRC of any liability that could results from the use of these results in making any decisions regarding my present or prospective medical care or employment.

Section 4 – Medical Consultative Evaluation & Treatment

If I have to see a physician during my evaluation or treatment, I understand that this physician is not an employee of NTPRC and is independent professtonal who is contracted to provide medical consultation to NTPRC's patient. As such whatever medication that is prescribed by him/her or medical procedures he/she recommends constitutes an independent contract between me and the physician.

If I see a phystcian at NTPRC, I understand and agree to the following:

1. NTPRC's physician may collect a medical history from me;
2. NTPRC's physician may conduct a physical exam on me related to my injury.
3. I understand the above information and agree to receive such treatment from NTPRC's physician as he/she and I deem appropriate and medically necessary;
4. I understand that (a) most medication(s) have side effects, (b) some medication(s) may lead to physical dependence and/or addiction, and (c) medication(s) may be harmful if taken in a manner or dosage that differs from the way they are prescribed;
5. I understand and agree that I will obtain an adequate explanation of any risks, side effects and manner of administration (of medication(s)) prior to taking the medication(s));
6. I agree to undergo such medical tests as my physician may deem necessary, including random or unannounced tests, to determine the effectiveness of the prescribed medication(s) and whether or not they are being taken as ordered;
7. I understand that if I am found to be taking unauthorized substances or not taking my prescribed medication in a manner that it was prescribed, my physician may at his/her discretion (a) discontinue prescribing the medication, (b) require drug screening, and/or (c) discharge me from his/her care;
8. I understand that noncompliance with this medication agreement may also lead to discharge from my treatment program at NTPRC and documentation of this reason for discharge in my medical records.
9. I further understand that when medication is lost, stolen, etc., the physician has sole discretion whether or not he/she write another prescription to replace the misplaced or stole medication.
10. I understand that misuse/diversion of my medication(s) is against the law; I will not give or sell it to anyone else;
11. I understand and agree that any treatment, whether at NTPRC's facility or another facility, rendered by NTPRC's physician is a contract between me and that physician. I furthermore agree to hold NTRPC harmless for any complications, harm, medical, or psychological problems that may arise from this treatment.

Section 5 – Behavioral Health Assessment

If I am participating in a behavior health assessment it will be conducted to assess the impact of my medical condition on my emotional condition, relationships and overall functional abilities. The behavioral health assessment consists of an interview with a clinician and completion of several paper and pencil assessment instruments. I have the right to obtain the results of this evaluation and/or to schedule an appointment with the examining clinician to have him/her explain the results to me.

If I am at NTPRC for a Behavioral Health Assessment, I understand and agree to the following:

1. An interview with the clinician;
2. Complete the paper and pencil assessment instruments;
3. I agree that the results of the behavioral health assessment can be shared with the physician/entity that referred me.

Section 6 – Pre-Surgical Psychological Evaluation

A pre-surgical psychological evaluation is usually ordered by a surgeon to determine whether psychological factors will impede or assist your recovery from surgery. Sometimes the results of this evaluation will suggest that you will need counseling or another form or treatment prior to surgery. Or the results may suggest you could benefit from post-surgical counseling. Finally the results may suggest you will not need pre or post surgical psychological services. A pre-surgical psychological evaluation will consist of an interview with a psychologist and completing various paper and pencil psychological tests. I have the right to obtain the results of this evaluation and/or schedule an appointment with the examining psychologist to have him/her explain the results to me.

If I am at NTPRC for a Pre-Surgical Psychological Evaluation, I understand and agree to the following:

1. An interview with a psychologist;
2. Complete the paper and pencil psychological tests;
3. I agree that the results of the pre-surgical psychological evaluation can be shared with the physician that referred me.

Section 7 – Physical Therapy

Physical therapy is usually ordered by a physician to increase my strength, endurance and/or range of motion. Physical therapy will be under the direction of a licensed physical therapist. My physician or physical therapist may also recommend aquatic or pool therapy. My physical therapist will explain to me the nature and purposes of the procedures. The physical therapist will also inform me of the expected benefits and possible complications or discomfort which may result from my physical therapy. I understand that initially I may experience an increase in my pain. Although not likely I understand physical therapy may aggravate my existing injury or cause a new injury. In addition, the physical therapist will explain to me the risks of receiving no treatment.

If I am at NTPRC for physical therapy, I understand and agree to the following:

1. I understand the above information and agree to participate in the activities prescribed to me by my physical therapist and physician;
2. I understand that it will be necessary for me to practice some exercises and activities at home;
3. I further agree to hold NTPRC harmless if I do incur an injury during my physical therapy;
4. I also understand that I am authorizing NTPRC to keep my referring physician apprised of my progress in physical therapy;
5. I have given my physical therapist an accurate medical history;

6. If I participate in aquatic or pool therapy I agree that I have no rashes, open sores, infections, communicable disease and am not running a temperature;
7. If I participate in aquatic or pool therapy I will eat and drink liquids at least 1 to 1 ½ hours prior to getting into the pool. Due to heat in the pool it is easy to get dehydrated. If you have a headache, make sure you drink more water prior to exercising.

Section 8 – Counseling

If I am at NTPRC for counseling, I understand and agree to the following:

1. I understand that while counseling may provide significant benefits, it may also elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories.

Section 9 – Misc.

LATE CANCELLATION/NO-SHOWS: I understand that my clinician has set aside an adequate amount of time for my treatment. If I cannot make my appointment I will contact NTPRC as soon as possible and notify them of my intent to cancel or reschedule. I ALSO UNDERSTAND THAT IF I NO SHOW OR CANCEL MY APPOINTMENT WITH LESS THAN 24 HOURS NOTICE I CAN BE CHARGED FOR THE MISSED SESSION. NOTE: INSURANCE COMPANIES (INCLUDING WORKERS' COMPSENATION INSURANCE COMPANIES) WILL NOT PAY FOR MISSED APPOINTMENTS. THEY ARE THE PATIENT'S RESPONSIBILITY.

CO-PAYS/DEDUCTABLES: I understand that any insurance co-pays and deductibles must be paid at the time services are rendered. If this is a problem I will discuss it with my clinician or NTPR's office mauager.

EMERGENCIES: If I have a medical emergency I should call 911 for emergency care. I will call NTPRC after my condition is stabilized.

CONSENT FOR EVALUATION AND/OR TREATMENT: I am giving my consent to obtain an evaluation and/or treatment from NTPRC.

I understand and agree to this therapeutic contract in it's entirely and agree to all specific provision related to the type of treatment and/or evaluation I receive. I furthermore understand and agree that I have provided NTPRC an accurate medical history. I understand that I can ask for clarification of this agreement and any treatment I am about to receive or am receiving at any time.

_____ _____

Patient's Name Date

_____

Witness

NORTH TEXAS PAIN RECOVERY CENTER

PAIN MANAGEMENT
WORK HARDENING
PHYSICAL THERAPY
PSYCHOLOGICAL SERVICES

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plans to: **North Texas Pain Recovery Center.** I instruct and direct payment by check made out to:

North Texas Pain Recovery Center
6702 W. Poly Webb Road
Arlington, TX 76016

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make the check out to me and mail it as follows:

c/o North Texas Pain Recovery Center
6702 W. Poly Webb Road
Arlington, TX 76016

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the profession services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed by indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

_____ _____

Signature of Patient Date

_____

Witness

Please read each item in the list below. Indicate how much you have been bothered by each of this issues during the past month by circling the number in the corresponding space in the column next to each item.

	Not at all	Mildly, but it didn't bother me much	Moderately – it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding / racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot / cold sweats	0	1	2	3

North Texas Pain Recovery Center

Pain Management Work Hardening

Program Accreditations:

The Rehabilitation Accreditation Commission (CARF) American Academy of Pain management (AAPM)

Many of the following issues have been associated with individuals who experience persistent pain. To fully assess the impact of pain in your life please mark the highest number in each group that applies.

1.	0	I do not feel sad.
	1	I feel sad.
	2	I am sad all the time and I can't snap out of it.
	3	I am so sad and unhappy that I can't stand it.
2.	0	I am not particularly discourages about the future.
	1	I feel discouraged about the future.
	2	I feel I have nothing to look forward to.
	3	I feel the future is hopeless and that things cannot improve.
3.	0	I do not feel like a failure.
	1	I feel I have failed more than the average person.
	2	As I look back on my life, all I can see is a lot of failure.
	3	I feel I am a complete failure as a person.
4.	0	I get as much satisfaction out of things as I used to.
	1	I don't enjoy things the way I used to.
	2	I don't get real satisfaction out of anything anymore.
	3	I am dissatisfied or bored with everything.
5.	0	I don't feel particularly guilty.
	1	I feel guilty a good part of the time.
	2	I feel quite guilty most of the time.
	3	I feel guilty all of the time.
6.	0	I don't feel I am being punished.
	1	I feel I may be punished.
	2	I expect to be punished.
	3	I feel I am being punished.

7.
0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8.
0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weakness or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9.
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10.
0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11.
0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.
0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.
0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.
0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive
2 I feel there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15	0	I can work about as well as before.
	1	It takes an extra effort to get started at doing something.
	2	I have to push myself very hard to do anything.
	3	I can't do any work at all.
16.	0	I can sleep as well as usual.
	1	I don't sleep as well as I used to.
	2	I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
	3	I wake up several hours earlier than I used to and cannot get back to sleep.
17.	0	I don't get more tired than usual.
	1	I get tired more easily than I used to.
	2	I get tired from doing almost anything.
	3	I am too tired to do anything.
18.	0	My appetite is no worse than usual.
	1	My appetite is not as good as it used to be.
	2	My appetite is much worse now.
	3	I have no appetite at all anymore.
19.	0	I haven't lost much weight, if any, lately.
	1	I have lost more than five pounds.
	2	I have lost more than ten pounds.
	3	I have lost more than fifteen pounds.
20.	0	I am more worried about my health than usual.
	1	I am worried about physical problems like aches, pains, upset stomach, or constipation.
	2	I am very worried about physical problems and it's hard to think of much else.
	3	I am so worried about my physical problems that I cannot think of anything else.
21.	0	I have not noticed recent change in my interest in sex.
	1	I am less interested in sex that I used to be.
	2	I have almost no interest in sex.
	3	I have lost interest in sex completely.