



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# _____

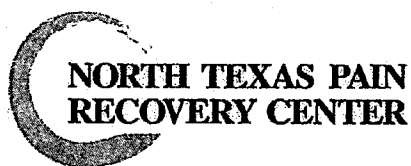
GROUP # _____

ADJUSTOR: _____ PHONE: _____

CLAIM #: _____

ATTORNEY: _____ PHONE: _____

ANY OTHER SIGNIFICANT INFORMATION WE SHOULD KNOW? _____



PAIN MANAGEMENT
WORK HARDENING
PHYSICAL THERAPY
PSYCHOLOGICAL SERVICES

VISUAL ANALOG PAIN SCALE

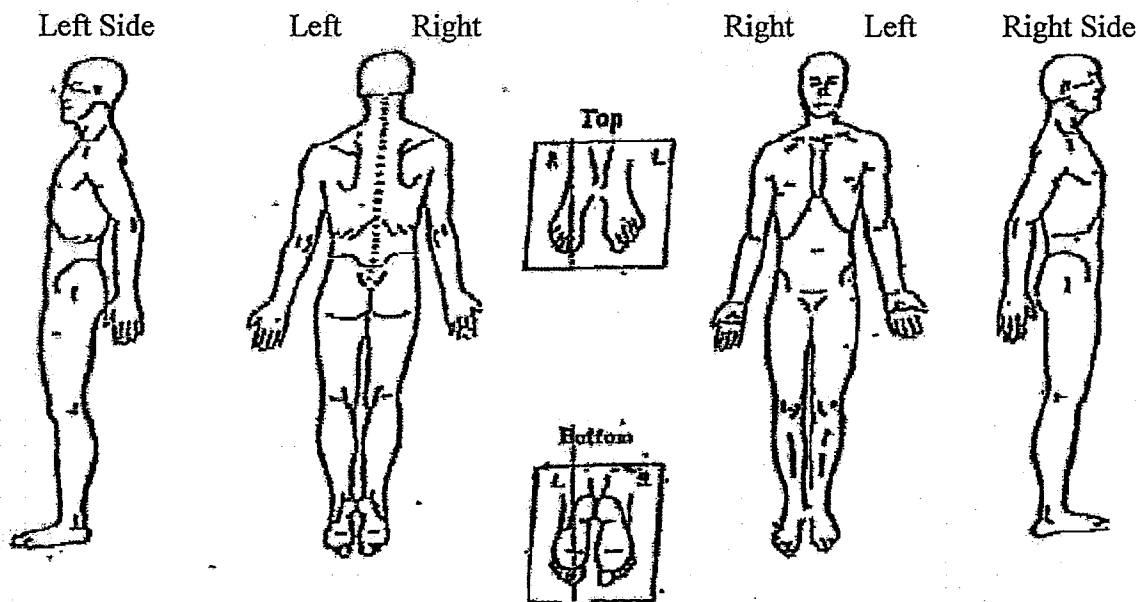
Name: _____ Date: _____

I do not have any pain _____ I have mild pain _____ I have moderate pain _____ I have severe pain _____ My pain could not be worse

None 1 2 3 4 5 6 7 8 9 10 Severe

Mark on the chart below the places you hurt, with the following key:

D = Dull X = Sharp B = Burning T = Tingling N = Numbness



6702 W Poly Webb, Arlington, Texas 76016 Phone 817-478-0095 Fax 817-478-7628



North Texas Pain Recovery Center

Pain Management Work Hardening

The Program Accreditations:

Rehabilitation Accreditation Commission (CARF) American Academy of Pain Management (AAPM)

Name: _____

Date: _____

Instructions: Please check the *one* appropriate response for each of the 10 selections below.

Please answer according to how you feel *this* week.

Section 1 -Pain Intensity

- ☐ I can tolerate the pain I have without having to use pain killers.
- ☐ The pain is bad but I manage without taking pain killers.
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ Pain killers give little relief from pain.
- ☐ Pain killers have no effect on pain and I do not use them.

Section 2 –Personal Care (washing, dressing, etc)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help everyday in most aspects of self care.
- ☐ I do not get dressed. I was with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift weights without extra pain.
- ☐ I can lift heavy but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on the table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are positioned contently.
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

Section 4- Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5- Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me sitting more than 1/2 hour.
- ☐ Pain prevents me sitting more than 10 minutes.
- ☐ Pain prevents me sitting at all.

Section 6-Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me standing for more than 1 hour.
- ☐ Pain prevents me standing for more than ½ hour.
- ☐ Pain prevents me standing for more than 10 minutes.
- ☐ Pain prevents me standing at all.

Section 7 – Sleeping

- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using tablets
- ☐ Even when I take tablets I have less than 6 hours sleep
- ☐ Even when I take tablets I have less than 4 hours sleep
- ☐ Even when I take tablets I have less than 2 hours sleep
- ☐ Paine prevents me from sleeping at all

Section 8 – Sex Life

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal and causes some extra pain
- ☐ My sex life is nearly normal is very painful
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9- Social life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (for ex. dancing)
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10- Traveling

- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I can I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to short, necessary, journeys of under 30 minutes
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Rev 7/17

Örebro Musculoskeletal Pain Questionnaire (ÖMPQ)

Linton and Boersma 2003¹

1. Name _____ Phone _____ Date _____
2. Date of Injury _____ Date of birth _____
3. Male ☐ Female ☐

These questions and statements apply if you have aches or pains, such as back, shoulder or neck pain. Please read and answer questions carefully. Do not take long to answer the questions, however it is important that you answer every question. There is **always** a response for your particular situation.

4. Where do you have pain? Place a check for all appropriate sites.

<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Arm	<input type="checkbox"/> Upper Back
<input type="checkbox"/> Lower Back	<input type="checkbox"/> Leg	<input type="checkbox"/> Other (state)	

2x
(max 10)

5. How many days of work have you missed because of pain during the past 18 months? check one.

<input type="checkbox"/> 0 days (1)	<input type="checkbox"/> 1-2 days (2)	<input type="checkbox"/> 3-7 days (3)	<input type="checkbox"/> 8-14 days (4)
<input type="checkbox"/> 15-30 days (5)	<input type="checkbox"/> 1 month (6)	<input type="checkbox"/> 2 months (7)	<input type="checkbox"/> 3-6 months (8)
<input type="checkbox"/> 6-12 months (9)	<input checked="" type="checkbox"/> over 1 year (10)		

6. How long have you had your current pain problem? Check one.

<input type="checkbox"/> 0-1 week (1)	<input type="checkbox"/> 1-2 weeks (2)	<input type="checkbox"/> 3-4 weeks (3)	<input type="checkbox"/> 4-5 weeks (4)
<input type="checkbox"/> 6-8 weeks (5)	<input type="checkbox"/> 9-11 weeks (6)	<input type="checkbox"/> 3-6 months (7)	<input type="checkbox"/> 6-9 months (8)
<input type="checkbox"/> 9-12 months (9)	<input type="checkbox"/> over 1 year (10)		

7. Is your work heavy or monotonous? Circle the best alternative.

0	1	2	3	4	5	6	7	8	9	10
Not at all					Extremely					

8. How would you rate the pain that you have had during the past week? Circle one.

0	1	2	3	4	5	6	7	8	9	10
No pain					Pain as bad as it could be					

9. In the past three months, on average, how bad was your pain on a 0-10 scale? Circle one.

0 1 2 3 4 5 6 7 8 9 10
No pain Pain as bad as it could be

10. How often would you say that you have experience pain episodes, on average, during the past three months? Circle one.

0 1 2 3 4 5 6 7 8 9 10
Never Always

11. Based on all things you do to cope, or deal with your pain, on an average day, how much are you able to decrease it? Circle the appropriate number. 10 - x

0 1 2 3 4 5 6 7 8 9 10
Can't decrease it at all Can decrease it completely

12. How tense or anxious have you felt in the past week? Circle one.

0 1 2 3 4 5 6 7 8 9 10
Absolutely clam and relaxed As tense and anxious as I've ever felt

13. How much have you been bothered by feeling depressed in the past week? Circle one.

0 1 2 3 4 5 6 7 8 9 10
Not at all Extremely

14. In your view, how large is the risk that your current pain may become persistent? Circle one.

0 1 2 3 4 5 6 7 8 9 10
No risk Very large risk

15. In your estimation, what are the chances that you will be able to work in six months? Circle one. 10 - x

0 1 2 3 4 5 6 7 8 9 10
No chance Very large chance

16. If you take into consideration your work routines, management, salary, promotion possibilities and work mates, how satisfied are you with your job? Circle one. 10 - x

0 1 2 3 4 5 6 7 8 9 10
Not satisfied at all Completely satisfied

Here are some of the things that other people have told us about their pain. For each statement, circle one number from 0 to 10 to say how much physical activities, such as bending, lifting, walking or driving, would affect your pain.

17. Physical activity makes my pain worse.

0 1 2 3 4 5 6 7 8 9 10
Completely disagree Completely agree

18. An increase in pain is an indication that I should stop what I'm doing until the pain decreases.

0 1 2 3 4 5 6 7 8 9 10
Completely disagree Completely agree

19. I should not do my normal work with my present pain.

0 1 2 3 4 5 6 7 8 9 10
Completely disagree Completely agree

Here is a list of five activities. Circle the one number that best describes your current ability to participate in each of these activities.

20. I can do light work for an hour.

0	1	2	3	4	5	6	7	8	9	10
Can't do it because of pain problem						Can do it without pain being a problem				

21. I can walk for an hour.

0	1	2	3	4	5	6	7	8	9	10
Can't do it because of pain problem						Can do it without pain being a problem				

22. I can do ordinary household chores.

0	1	2	3	4	5	6	7	8	9	10
Can't do it because of pain problem						Can do it without pain being a problem				

23. I can do the weekly shopping.

0	1	2	3	4	5	6	7	8	9	10
Can't do it because of pain problem						Can do it without pain being a problem				

24. I can sleep at night.

0	1	2	3	4	5	6	7	8	9	10
Can't do it because of pain problem						Can do it without pain being a problem				



North Texas Pain Recovery Center's
Informed consent for assessment and 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 authorization. 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 a request.
4. If your treatment is covered by workers' compensation insurance the clinician is required to send 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.

Section 2- Functional Capacity Evaluation or Physical therapy Evaluation

If my assessment involves a Functional Capacity Evaluation (FCE) 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 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





NORTH TEXAS PAIN RECOVERY CENTER

PAIN MANAGEMENT WORK HARDENING

considered safe and acceptable if I do not permit to pain increase throughout testing. Therefore, it is important that I 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 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 an FCE 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 my 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 result from the use of these results in making any decisions regarding my present or prospective medical care or employment.

Section 4- 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 it is 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.





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*PAIN MANAGEMENT
WORK HARDENING*

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 informed 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 the 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 5- Late cancellations/no-shows:

Clients/customers are expected to arrive on time for their scheduled appointments. Late arrivals may result in a shortened appointment time to avoid inconveniencing other clients/customers.

If a client/customer arrives significantly late (beyond [grace period, e.g., 10 minutes]), the appointment may need to be rescheduled, and it will be treated as a "No-Show."

North Texas Pain Recovery Center is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. **Please call us at (817) 478-0095, 24 hours in advance prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 4:00 p.m. on Friday.** If prior notification is not given, you could be charged \$25 for the missed appointment.

Please sign below to consent to these terms.

Client Signature (Client's Parent/Guardian if under 18)

Date





**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	
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack, angina, irregular heartbeat	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve prolapsed/ rheumatic fever	_____
		Last time an EKG done _____ Where? _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have sleep apnea or use a CPAP	_____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	_____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy, Seizures, Fainting Spells	_____
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis or Stroke	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma, Bronchitis, Emphysema	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you Smoke? _____ PPD _____ Years	_____
		Last chest X-Ray Date _____ Where? _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, Jaundice	_____
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Consumption	How much? _____
<input type="checkbox"/>	<input type="checkbox"/>	Reflux, Heartburn	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney or Bladder Problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Neck or Back Trouble	_____
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendency or Clotting Problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Could you possibly be pregnant? LMP _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Any other Medical Problems not listed? _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking any medications, Rx diet pills, herbs, vitamins? _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to any medications, fish, eggs, soy products, latex, iodine contrast (Ex: IVP Dye)	_____
		Please List _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Previous Surgeries	_____
<input type="checkbox"/>	<input type="checkbox"/>	Problems with Anesthesia	_____
<input type="checkbox"/>	<input type="checkbox"/>	Family History Problems not listed	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dentures, Partial Plates, Caps, Crowns, Bridges, Braces _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Blood tests done in the last month? _____ Where? _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	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 _____