

Central Texas Spine Institute, LLP

An Association of Independent Medical Practices
Specializing in Spinal Disorders and Pain Management

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Dear Patient:

The attached includes an information sheet, a form authorizing direct billing to the insurance company, a Pain Clinic questionnaire, and a form authorizing us to relay medical findings to your referring physician. ***It is very important that all of the forms are filled out completely at home before you come in for your appointment.*** If there are any questions regarding these forms please call our office and ask for assistance. This information is strictly confidential and will not be released to anyone without your permission.

Sincerely,

James M. Gdula
Business Manager

attachments

Appointment Date _____

Time _____

*** PLEASE ARRIVE AT THE OFFICE 30 MINUTES BEFORE YOUR APPOINTMENT WITH ALL FORMS COMPLETED. OTHERWISE, THE DOCTOR WILL NOT BE ABLE TO PROPERLY EVALUATE YOU, AND YOUR APPOINTMENT WILL HAVE TO BE RESCHEDULED.**

PAIN EVALUATION QUESTIONNAIRE

Date _____

1. Name _____
Last First Middle

2. Address _____
No. Street City State Zip Code

3. Date of Birth _____
Month/Day/Year

4. Current Marital Status: Single Married Separated Divorced Widowed

5. Number of Children _____ Ages of Children _____

6. If you are married, what is your spouse's occupation (be specific): _____

THE FOLLOWING QUESTIONS RELATE TO YOUR EMPLOYMENT. Please answer all questions that apply to you.

7. Are you presently employed? Full Time Part Time Housewife/Homemaker
 Unemployed If unemployed, how long? _____

8. What is, or was, your specific occupation? Briefly describe what you do or what you did on your job.

9. If you are unemployed or employed part time, is this due to your present pain condition?

Yes No

10. How long have you been working for your present employer? _____ years
If unemployed, retired, disabled, etc., how long did you work for your last employer? _____ years

11. Do you enjoy your work?

All the time Most of the time Some of the time Rarely or not at all

IF YOUR PRESENT PAIN CONDITION WAS CAUSED BY YOUR JOB OR OCCURRED WHILE ON THE JOB OR WAS DUE TO AN ACCIDENT, PLEASE ANSWER THE FOLLOWING:

12. Have you ever received compensation for your injury/illness? Yes No Still waiting

13. If you have received compensation, do you feel that it has been satisfactory? Yes No

14. Are you now, or have you ever, been involved in a lawsuit regarding your pain? Yes No
If yes, who are your attorneys? _____

15. Have you attempted to return to work? Yes No
If yes, did you attempt to work? Full Time Part Time

16. Compared to your abilities (including housewife) before your present condition, how do you see your present job abilities?

- Can do as much as before Can do somewhat less than before
 Can do much less than before Cannot do job at all

17. Comparing how you were **BEFORE** you had your pain problem with your **PRESENT** condition, please answer the questions below:

SOCIAL ACTIVITIES

Desire for social activities: Remains the same as before Somewhat less than before
 Very much less than before No desire for such activities

Ability for social activities: Remains the same as before Somewhat less than before
 Very much less than before No ability for such activities

RECREATIONAL ACTIVITIES

Desire for such activities: Remains the same as before Somewhat less than before
 Very much less than before No desire for such activities

Ability for recreational activities: Remains the same as before Somewhat less than before
 Very much less than before No longer have the ability

18. Are you frequently confined to bed because of poor health? Yes No

19. What do **YOU** think is the cause of your pain? _____

20. Since your pain condition began, which of the following people have you consulted for treatment and pain relief? Please also list the health care provider's name that you consulted.

- | | |
|--|---|
| <input type="checkbox"/> Allergist/Immunologist | <input type="checkbox"/> Ophthalmologist (Eyes) |
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Orthopedist (Bone, Joints and Muscles) |
| <input type="checkbox"/> Dermatologist | <input type="checkbox"/> Pediatrician (Children) |
| <input type="checkbox"/> Ear, Nose or Throat (Otorhinolaryngologist) | <input type="checkbox"/> Plastic Surgeon |
| <input type="checkbox"/> Endocrinologist (Glandular Disorders) | <input type="checkbox"/> Radiologist |
| <input type="checkbox"/> General Practice or Family Practice | <input type="checkbox"/> Surgeon (General) |
| <input type="checkbox"/> Internal Medicine (Internist) | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Neurologist (Nervous System) | <input type="checkbox"/> Osteopath |

- Obstetrician/Gynecologist
- Neurosurgeon
- Acupuncturist
- Faith Healer
- Physical Therapy

- Dentist
- Clergyman
- Chiropractor
- Hypnotist
- Pain Clinic (Specify) _____
- Other (Specify) _____

21. Have any doctors ever told you that your pain was imaginary or "all in your head"? Yes No

22. Under what circumstances did your pain begin:

- Accident at work
- Accident at home
- Other accident
- At work, but not an accident
- Following surgery
- Following illness
- Pain just began; can't relate it to anything
- Other reasons or circumstances

23. Please describe the circumstances you checked above. _____

24. When did you first experience the pain for which you are now seeking help? Date _____

25. In what part(s) of the body did the pain begin? (Name all parts) If it spread to other parts of the body, which parts?

26. The following words represent pain of increasing intensity. How would you describe your pain?

- Mild
- Uncomfortable
- Distressing - Fairly Severe
- Very Severe - Horrible
- Unbearable - Excruciating

27. Do you have trouble falling asleep because of pain?

- Never
- Sometimes
- Usually
- Always

28. Does pain wake you up while your are sleeping?

- Never
- Sometimes
- Usually
- Always

29. Do you take medicine to help you fall asleep?

- Never
- Sometimes
- Usually
- Always

30. If you take medicine for sleep, is the medicine prescribed or recommended by your doctor? Yes No
Decided to take yourself? Yes No

31. What is the name of the sleep medicine you take? _____

32. What do you do (activities) that will bring on the pain or make the pain worse?

33. About how long after beginning this activity does it take for the pain to begin or become worse?

34. What do you do to decrease the pain? (Massage, medicine, lying down, relaxation, etc.)

Describe exactly what brings relief: _____

35. How long does it take for these remedies to take effect? _____

36. How many times during the day do you usually have to lie down because of pain?

37. How many times during an average day do you have to stop what you are doing because of pain?

38. Do you have days when the pain is so bad that you spend the day in bed? Yes No

If yes, about how often does this happen? _____

39. Please list **ALL** medications you are **NOW** taking for pain.

<u>Pain Medications</u>	<u>Dose</u>	<u>Frequency</u>	<u>Date Started</u>
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40. Please list **ALL** the medications that you have tried previously for the pain.

<u>Pain Medications</u>	<u>Dose</u>	<u>Frequency</u>	<u>Date Started</u>	<u>Date Stopped</u>
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41. Please list **ALL** other medications you take currently. _____

42. Are you allergic to any medications? If so, please list them.

43. Please list all Physical Therapy treatments you have received.

<u>Location</u>	<u>Treatments</u>	<u>Dates</u>	<u>Response</u>
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44. Have you ever used a TENS unit? If so, what was your response?

<u>Dates Used</u>	<u>Response</u>

45. Have you ever had injections or nerve blocks for the pain? If so, what was the response?

<u>Treatment</u>	<u>Physician</u>	<u>Response</u>

46. Have you ever used any of the following techniques of pain control? If so, what was the response?

	<u>Dates</u>	<u>Location (Physician)</u>	<u>Response</u>
Biofeedback			
Hypnosis			
Relaxation Training			
Counseling			

47. Have you ever had any operations for the pain? If so, what were the results?

48. What type and how much exercise do you currently get on a daily basis?

49. If you are now unemployed and, if you had no pain problems, would you plan to go to work?

Yes No If yes: Full Time Part Time

50. Please list all previous operations below.

<u>Date</u>	<u>Operation</u>

51. Please list all significant past and current medical problems (i.e. Hypertension, Diabetes, Emphysema, Heart Disease, etc.) List current problems first, and then past problems in chronological order.

52. On a scale of 0 to 10, please rate the severity of your pain with a number _____ and with an "X" on the line below.

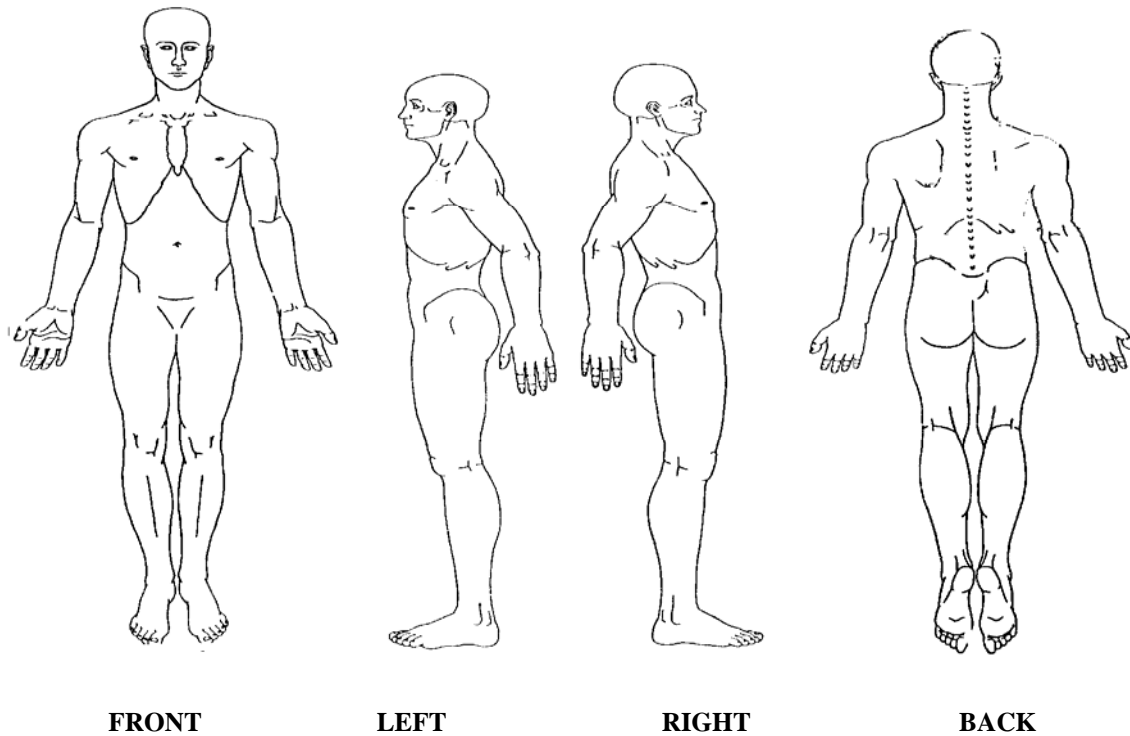
|_____|

0 10

(No Pain) (Worst Pain Imaginable)

53. In your own words, please describe what your pain feels like, where it is located, and where it goes.

54. Please mark with an 'X' on these diagrams exactly where your pain or problems are located. Also, use an arrow to show where the pain goes, if the pain radiates to another part of your body.



MISSED APPOINTMENT CHARGE

BEGINNING 12/1/98 THERE WILL BE A \$50.00 NO-SHOW CHARGE TO ALL PATIENTS WHO DO NOT GIVE 24 HOUR NOTICE OF CANCELLATION. THIS INCLUDES PATIENTS WHO ARE MORE THAN 15 MINUTES LATE.

INSURANCE COMPANIES DO NOT COVER THIS CHARGE. IF YOU DO NOT SHOW OR DO NOT CANCEL, THIS FEE WILL BE YOUR RESPONSIBILITY.

ANYONE WITH A NO-SHOW FEE MUST PAY ON OR BEFORE YOUR NEXT VISIT IN ORDER TO SEE THE DOCTOR

PLEASE HELP US AND HELP YOURSELF BY BEING ON TIME TO YOUR APPOINTMENT.

THANK YOU!

I have read the above and understand my responsibility.

Patient Signature

Date