Central Texas Spine Institute, LLP

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

Neal H. Blauzvern, D.O.
6818 Austin Center Blvd., Ste. 200
Austin, Texas 78731
(512) 795-9482

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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 <u>30</u> 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.**

MEDICAL AND INSURANCE AUTHORIZATIONS

NAME ____
(Last) (First) (MI)

ADDRESS ____

____

MEDICAL AUTHORIZATION

I hereby authorize and permit Central Texas Spine Institute, LLP (Neal H. Blauzvern, D.O.) to furnish my family physician and all other physicians involved in my care with any and all records or information concerning me with respect to consultation and treatment methods while a patient under their care.

Signed ________________________________ Date ______________________

Witness _______________________________

STATEMENT TO PERMIT PAYMENT OF INSURANCE BENEFITS TO CENTRAL TEXAS SPINE INSTITUTE, LLP

I authorize release of any information needed to act on this request. I request the payment of authorized benefits be made in my behalf and I assign payment directly to Central Texas Spine Institute, LLP. I understand that I am responsible for any remaining insurance deductibles and co-insurance. If, for any reason, the insurance company fails to pay the claim in a timely manner, I will be responsible for the entire amount.

Signed ________________________________ Date ______________________

Witness _______________________________

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? ____

Name ___________________________________

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

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? ____
____
____
____
____
____

Name ___________________________________

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.

- ❑ Allergist/Immunologist
- ❑ Cardiologist
- ❑ Dermatologist
- ❑ Ear, Nose or Throat (Otorhinolaryngolgist)
- ❑ Endocrinologist (Glandular Disorders)
- ❑ General Practice or Family Practice
- ❑ Ophthalmologist (Eyes)
- ❑ Orthopedist (Bone, Joints and Muscles)
- ❑ Pediatrician (Children)
- ❑ Plastic Surgeon
- ❑ Radiologist
- ❑ Surgeon (General)

Name ___________________________________

- ❑ Internal Medicine (Internist)
- ❑ Neurologist (Nervous System)
- ❑ Obstetrician/Gynecologist
- ❑ Neurosurgeon
- ❑ Acupuncturist
- ❑ Faith Healer
- ❑ Physical Therapy
- ❑ Psychologist
- ❑ Osteopath
- ❑ 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

Name ____________________________________

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.

Pain Medications	Dose	Frequency	Date Started

Name ____________________________________

40. Please list **ALL** the medications that you have tried previously for the pain.

Pain Medications	Dose	Frequency	Date Started	Date Stopped

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.

Location	Treatments	Dates	Response

44. Have you ever used a TENS unit? If so, what was your response?

Dates Used	Response

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

Treatment	Physician	Response

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

	Dates	Location (Physician)	Response
Biofeedback			
Hypnosis			
Relaxation Training			
Counseling			

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

____

____

Name ___________________________________

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.

Date	Operation

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 (No Pain) 10 (Worst Pain Imaginable)

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

____

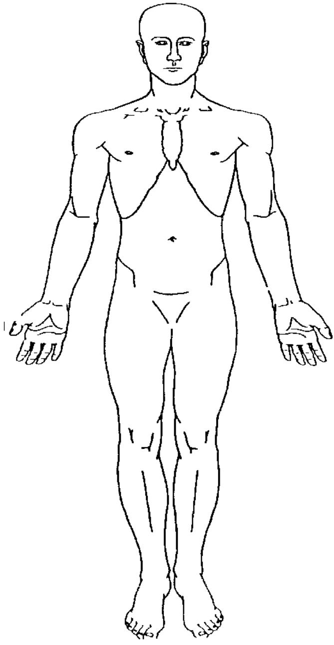
____

____

____

Name ___________________________________

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.



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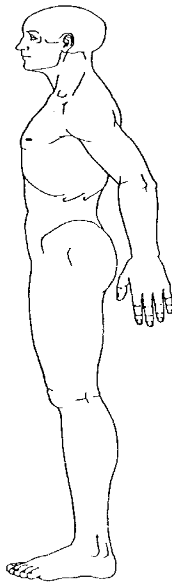

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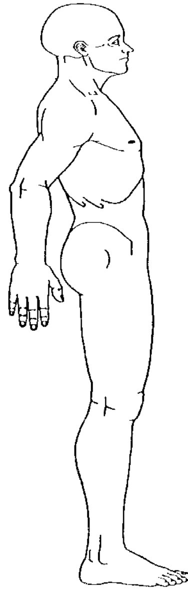

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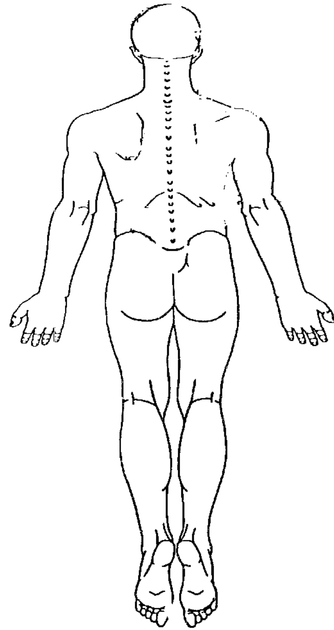

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MISSED APPOINTMENT CHARGE

THERE WILL BE A $50.00 N0-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