

GREATER HOUSTON PAIN CONSULTANTS
Ronald Parris, M.D.

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Mailing:

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Houston:

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Houston, TX 77027

Welcome!

We are please you have chosen Greater Houston Pain Consultants for your care. Dr. Parris will be personally performing your treatment. We understand how traumatic and isolating chronic pain can be. Finding the right treatment plan is a step that brings you closer to relief. Our multidisciplinary team will help you feel better, improve your functionality and help you live a more satisfying life. We certainly want your appointments to be informative and productive.

In order to accommodate you, we ask that you complete these forms in their ENTIRETY.

What to expect at your first visit:

Your visit will consist of a thorough history and physical examination. You will be seen by the physician. The initial evaluation may take up to an hour from start to finish, but this time is important for an assessment and treatment plan to be formulated. Due to the length of this examination, and various other factors such as insurance authorizations, please do not expect medications or injections during your first visit. Out of fairness to all our patients we ask that you try to arrive 15 minutes early for your visit, and please call at least 24 hours in advance if you must cancel. If you are more than 15 minutes late for your appointment it may need to be rescheduled. In addition, appointments canceled less than 24 hours in advance will be considered a no-show. You will be billed \$50.00 and after 3 no-shows you will not be rescheduled.

Please bring the following to your first appointment:

- Completed forms
- Insurance card and one form of photo ID
- All relevant past medical records including MRI, CT scans, bone scans and/or EMG reports (you need to bring the written reports and films if available)
- Worker's compensation / auto insurance phone number, adjuster's name and mailing address
- Referral or prescription slip, if required by your insurance
- Physical/occupational/aquatic therapy discharge summaries
- Co-Pay, if required by insurance

Please be aware that Dr. Parris has ownership interest in Texas Compounding Pharmacy. Dr. Parris believes these interests allow him greater influence over the care his patients receive. If you have any questions or concerns, please feel free to discuss them with him or the office manager.

Greater Houston Pain Consultants are committed to success and safety. Thank you for taking the time to provide this information this information that is important for the level of care we can provide. Your answers will help us individualize your treatment and optimize your success and safety.

Sincerely,

Ronald Parris, MD
ABA Diplomate in Anesthesiology

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

NOTICE OF PRIVACY POLICY

The following is the privacy policy (“Privacy Policy”) of **Greater Houston Pain Consultants** (“Covered Entity”) as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity’s legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include:

(a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. *Examples of instances in which we are required to disclose your personal health information include:* (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures:* to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health

information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, *except for* (a) psychotherapy notes, (b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services (“DHHS”). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to **Greater Houston Pain Consultants, 2411 Fountain View #200, Houston, TX 77057, or via FAX (713) 458-4630, Attention: Medical Records.**

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *We are not required to provide accountings of disclosures for the following purposes:* (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to **Greater Houston Pain Consultants, 2411 Fountain View #200, Houston, TX 77057, or via FAX (713) 458-4630, Attention: Medical Records.**

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy officer, **Marie Walton, CMPE** at GHPCHIPAA@choosenopain.com, **iMed Group, 2411 Fountain View #200, Houston, TX 77057**. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or

changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to **Greater Houston Pain Consultants, 2411 Fountain View #200, Houston, TX 77057** or at the following website address: www.choosenopain.com. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our privacy officer at the address, telephone number, or e-mail address listed above.

Greater Houston Pain Consultants

NEW PATIENT REGISTRATION

Date: _____

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ M.I.: _____
DATE OF BIRTH: _____ MARITAL STATUS: []Single []Married []Divorced []widowed
SEX: []Male []Female SOCIAL SECURITY#: _____ DL LICENSE#: _____
US CITIZEN: []Yes []No If no, country of citizenship: _____ RACE: _____
ADDRESS: _____ HOME PHONE: _____
CITY: _____ STATE: _____ ZIP: _____ CELL PHONE: _____
EMPLOYER: _____ WORK PHONE: _____
WORK ADDRESS: _____ FULL-TIME PART-TIME STUDENT
CITY: _____ STATE: _____ ZIP: _____ OCCUPATION: _____
PHARMACY: _____ PHONE#: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ PHONE: _____
ADDRESS: _____ RELATIONSHIP TO PT: _____

GUARANTOR (Responsible Party) INFORMATION

(Complete only if different from patient)

LAST NAME: _____ FIRST NAME: _____ M.I.: _____
ADDRESS: _____ HOME PHONE: _____
CITY: _____ STATE: _____ ZIP: _____ CELL PHONE: _____
EMPLOYER: _____ WORK PHONE: _____
WORK ADDRESS: _____ FULL-TIME PART-TIME STUDENT
CITY: _____ STATE: _____ ZIP: _____ OCCUPATION: _____
DATE OF BIRTH: _____ RELATIONSHIP TO PT: [] PARENT/GUARDIAN [] SPOUSE
SEX: []Male []Female SOCIAL SECURITY#: _____ DL LICENSE#: _____

PRIMARY INSURANCE INFORMATION

INSURANCE: _____ PHONE: _____
CLAIMS ADDRESS: _____ EFFECTIVE: _____
INSURED NAME: _____ DOB: _____
POLICY/SSN#: _____ RELATIONSHIP TO PT: _____
GROUP#: _____ GROUP NAME: _____

SECONDARY INSURANCE INFORMATION

INSURANCE: _____ PHONE: _____
CLAIMS ADDRESS: _____ EFFECTIVE: _____
INSURED NAME: _____ DOB: _____
POLICY/SSN#: _____ RELATIONSHIP TO PT: _____
GROUP#: _____ GROUP NAME: _____

REFERRAL INFORMATION

Please tell us how you heard about our practice: []Internet []Magazine []Radio []Other: _____

If you were preferred by a physician, please provide the following information: NAME OF DOCTOR: _____

PHONE#: _____ ADDRESS: _____

This medical practice works with the patients to minimize difficulty in the payment of fees for service. Upon leaving from your appointment, you will be asked to pay those minimal unmet deductible amounts and co-insurance amounts which your insurance company authorizes to be collected. Please insure that the primary and secondary information is correct. Authorization to Release information: The undersigned hereby authorizes GHPC to release all information pertaining to the patient's treatment to his/her insurance company or companies and to any other physician or healthcare provider to whom the undersigned may be referred.

Assignment of Benefits: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plan to: Greater Houston Pain Consultants. Financial Responsibility: I understand that I am financially responsible for all services received, regardless of my insurance coverage.

(Patient/parent/Guardian Signature)

(Date)

(Guarantor/Responsible Party Signature)

(Date)

Patient Name: _____

Date: _____

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How often have you felt a need for higher doses of medication to treat your pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. How often have you felt impatient with your doctors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. How often have you felt that things are just too overwhelming that you can't handle them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. How often is there tension in the home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. How often have you counted pain pills to see how many are remaining?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. How often have you been concerned that people will judge you for taking pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. How often do you feel bored?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. How often have you taken more pain medication than you were supposed to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. How often have you worried about being left alone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. How often have you felt a craving for medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. How often have others expressed concern over your use of medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. How often have any of your close friends had a problem with alcohol or drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. How often have others told you that you had a bad temper?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. How often have you felt consumed by the need to get pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. How often have you run out of pain medication early?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. How often have others kept you from getting what you deserve?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. How often, in your lifetime, have you had legal problems or been arrested?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. How often have you attended an AA or NA meeting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. How often have you been in an argument that was so out of control that someone got hurt?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. How often have you been sexually abused?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. How often have others suggested that you have a drug or alcohol problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. How often have you had to borrow pain medications from your family or friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. How often have you been treated for an alcohol or drug problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please include any additional information you wish about the above answers. Thank you.

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GREATER HOUSTON PAIN CONSULTANTS
CONTROLLED SUBSTANCES REFILL POLICY

Every patient that is prescribed a Controlled Substance must present to the Clinic for a 30-day follow-up appointment.

As per this clinic's policy, telephone refill requests for controlled substances will not be accepted and prescriptions will not be refilled without a physician visit.

By signing this document the patient agrees to this policy and understands that any violation may result in dismissal from this clinic.

I have read, understand and agree with the above.

Patient Signature

Date

Please print patient name

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

3rd Edition: Developed by the Texas Pain Society, April2008 (www.texaspain.org)

NAME OF PATIENT: _____ DATE: _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word “physician” is defined to include not only my physician but also my physician’s authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS “OFF-LABEL” PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

GREATER HOUSTON PAIN CONSULTANTS

For female patients only:

To the best of my knowledge **I am NOT pregnant.**

If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.

If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus / baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

GREATER HOUSTON PAIN CONSULTANTS

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called ‘narcotics, painkillers’, and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued.**
- I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician.**
- I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will **not allow or assist in the misuse/diversion of my medication; nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible.** Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. **If either are lost or stolen, they may NOT BE REPLACED.**
- Refill(s) **will not be ordered before the scheduled refill date.** However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s).** I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- I agree to **submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

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- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.
- I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

I certify and agree to the following:

- 1) I am **not currently using illegal drugs or abusing prescription medication(s)** and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.
- 2) I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)
- 3) **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.
- 4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

Patient Signature

Physician Signature (or Appropriately Authorized Assistant)

Name and contact information for pharmacy

Authorization to Obtain Release of Information

Patient Last Name	First Name	MI
Date of Birth	S.S.# (optional)	
I hereby authorize: _____ (Name of Physician, Hospital, etc.)		
To release my health information to: <u>Greater Houston Pain Consultants</u> Ronald Parris, M.D.		
Address: 3100 Timmons Lane, Suite 540		
City: Houston	State: TX.	Zip: 77027
I hereby authorize the use of disclosure of protected health information as described below:		
Description of information being disclosed for the following date(s) of service:		
<input type="checkbox"/> Complete health record <input type="checkbox"/> Abstract / Pertinent Information <input type="checkbox"/> Consultation Reports <input type="checkbox"/> History/physical exam <input type="checkbox"/> HIV / AIDS Information <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Progress Note <input type="checkbox"/> Drug / Alcohol Treatment Information <input type="checkbox"/> Emergency Dept. Records <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Discharge summary <input type="checkbox"/> Other: _____		
Purpose of the Disclosure: <input type="checkbox"/> Medical Care <input type="checkbox"/> Legal <input type="checkbox"/> Insurance <input type="checkbox"/> Other		
Expiration: If the health information to be disclosed contains HIV/AIDS or drug and alcohol abuse treatment records, this authorization expires within 60 days. Otherwise, you may select either of the following expiration events.		
<input type="checkbox"/> 1 year from the date in which I, or my legal representative signs this authorization <input type="checkbox"/> Upon the happening of the following event: _____ (Example: "Upon release of the above records")		
I understand that:		
1. I may revoke this authorization at any time by providing written notice to the Director of Medical Records at the address of the facility in which I received my medical care. 2. My revocation will not have any affect on any actions taken by the organization before they received the revocation and is not effective if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim under my insurance policy. 3. The organization will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this authorization. 4. I have the right to inspect of copy the health information to be used or disclosed pursuant to this authorization.		
Signatures: I have read the above and authorize the disclosure of the protected health information as stated.		
Signature of Patient (or Patient's Representative)		Date:
Print Name of Patient (of Patient's Representative)		Date:
If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:		
<input type="checkbox"/> Power of Attorney <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Surrogate Decision-Maker <input type="checkbox"/> Executor or Personal Representative <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____		

Return to:
 Greater Houston Pain Consultants
 3100 Timmons Ln., Ste. 540
 Houston, TX 77027

Phone: 713-621-3900
Fax: 713-621-3908

**GREATER HOUSTON PAIN CONSULTANTS
ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE**

Patient Name: _____

Date: _____

By signing this form you acknowledge that Greater Houston Pain Consultants has provided you access to a copy of its HIPAA Privacy Notice, which explains how your health information will be handled in various situations. By law, we are required to have you sign this form on or about your first visit with us.

Please specify by checking the appropriate answer below if we may leave health-related information (e.g. lab/radiology results, billing issues or other doctor-patient communications) with/on:

- Home Answering Machine No Yes Number: _____
- Work Voicemail No Yes Number: _____
- Personal/Work Email No Yes Email: _____
- Cell Phone: No Yes Number: _____
- Relative or Other Person living with you No Yes Name: _____

Please note that if the above section is not completed you are allowing us to contact you using any one of these methods.

Greater Houston Pain Consultants has provided me with a copy of its Privacy Notice. I acknowledge that I have read, understand and agree to the above.

I have read the Privacy Notice and DO NOT AGREE to its provisions.

Patient/Guardian Signature

Date

FOR PRACTICE STAFF TO COMPLETE IF ACKNOWLEDGEMENT FORM IS NOT SIGNED:

1. Does the patient have a copy of the Privacy Notice? No Yes
2. Please explain why the Patient/Guardian was unable to sign an acknowledgement form and your efforts in trying to obtain the Patient/Guardian signature: _____

Employee's Initials Date

PATIENT EDUCATION

NEW PATIENT QUESTIONNAIRE

Date: _____

Patient Name: _____

STAFF USE ONLY

Temp: _____ Pulse: _____ Resp: _____ BP: _____ WT: _____

Ambulatory: Yes No Assistive Devices: _____

Referring Physician: _____

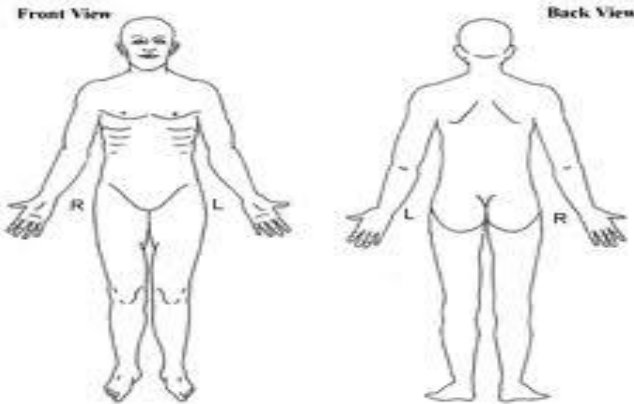
TO BE COMPLETED BY PATIENT

Chief Complaint: _____

Duration of Symptoms: _____

Brief Pain Inventory

On the diagram, mark the areas where you feel pain. Put an X on the area that hurts:



PAIN SCALE:

0 1 2 3 4 5 6 7 8 9 10

None

Worst

Over the last week, rate:

Worst Pain:..... 0 1 2 3 4 5 6 7 8 9 10

Least Pain:..... 0 1 2 3 4 5 6 7 8 9 10

Usually:..... 0 1 2 3 4 5 6 7 8 9 10

Right Now:..... 0 1 2 3 4 5 6 7 8 9 10

Acceptable Level:..... 0 1 2 3 4 5 6 7 8 9 10

Please describe your pain:

- Throbbing
 Shooting
 Stabbing
 Sharp
 Cramping
 Gnawing
 Hot-burning
 Aching
 Heavy
Tender
 Splitting
 Tiring-Exhausting
 Sickening
 Fearful
 Punishing-Cruel

What makes the pain better? (check box)

- Heat
 Cold
 Walking
 Sitting
 Standing
 Massage
 Resting in Bed
 Medications
Other _____

What makes the pain worse? (check box)

- Heat
 Cold
 Walking
 Sitting
 Standing
 Activity
 Coughing
 Vomiting
 Having a BM
Being Still
 Lying Down
 Other: _____

Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

	<u>Does Not Interfere</u>					<u>Completely Interferes</u>					
General Activity	0	1	2	3	4	5	6	7	8	9	10
Normal Work	0	1	2	3	4	5	6	7	8	9	10
<i>(includes both work outside the home and housework)</i>											
Mood	0	1	2	3	4	5	6	7	8	9	10
Relationships	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10

Treatment History

What other medications and treatments have you tried for your pain?

	Yes	No	Worse					No Change					Much Better													
Physical Therapy/Occupational Therapy			-5	-4	-3	-2	-1	0	1	2	3	4	5													
Injections/Nerve Blocks			-5	-4	-3	-2	-1	0	1	2	3	4	5													
Psychological Therapies			-5	-4	-3	-2	-1	0	1	2	3	4	5													
Medications			-5	-4	-3	-2	-1	0	1	2	3	4	5													
Other			-5	-4	-3	-2	-1	0	1	2	3	4	5													

Please list all pain medications:

Current: _____

Medications you have tried: _____

Have you had a pain procedure in the past?	Did you have any side effects from your procedure?
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please check one of the following	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please check one of the following
<input type="checkbox"/> Epidural Steroid Injection	<input type="checkbox"/> Bleeding/Hematoma
<input type="checkbox"/> Facet Injection	<input type="checkbox"/> Infection
<input type="checkbox"/> Intercostal nerve blocks/Paravertebral blocks	<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Sacroiliac joint injection	<input type="checkbox"/> Headache
<input type="checkbox"/> Radiofrequency ablation	<input type="checkbox"/> Punctured lung/Pneumothorax
<input type="checkbox"/> Celiac/Scpachnic plexus block	<input type="checkbox"/> New onset Weakness
<input type="checkbox"/> Vertebroplasty/Kyphoplasty	<input type="checkbox"/> New onset Numbness
<input type="checkbox"/> Spinal cord stimulator	<input type="checkbox"/> Increased Pain
<input type="checkbox"/> Intrathecal catheter	<input type="checkbox"/> Bowel and Bladder function changes
<input type="checkbox"/> Other: (please specify)	<input type="checkbox"/> Other: (please specify)
	After block, was your pain: <input type="checkbox"/> Better <input type="checkbox"/> Same <input type="checkbox"/> Worse

Personal Functional Goals

What is your personal functional goal with regard to the following activities:

CURRENT	FUTURE
Work – Check all that apply	Work-Check all that apply
<input type="checkbox"/> full-time work	<input type="checkbox"/> full-time work
<input type="checkbox"/> part-time work	<input type="checkbox"/> part-time work
<input type="checkbox"/> not work	<input type="checkbox"/> not work
<input type="checkbox"/> disability	<input type="checkbox"/> disability
<input type="checkbox"/> other: (please specify)	<input type="checkbox"/> other: (please specify)
Daily activities check all that apply	Daily activities check all that apply
<input type="checkbox"/> Able to perform all activities	<input type="checkbox"/> Able to perform all activities
<input type="checkbox"/> Perform some instrumental daily activities (shopping, groceries, housework)	<input type="checkbox"/> Perform some instrumental daily activities (shopping, groceries, housework)
<input type="checkbox"/> Limited basic daily activities (personal hygiene, dressing, moving around the house)	<input type="checkbox"/> Limited basic daily activities (personal hygiene, dressing, moving around the house)
<input type="checkbox"/> Need assistance with basic activities, Bedbound	<input type="checkbox"/> Need assistance with basic activities, Bedbound
<input type="checkbox"/> Other (please specify):	<input type="checkbox"/> Other (please specify):

How would you rate your current goal achievement for the following activities?

	Not Met											Completely Met										
Work	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Recreation	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Daily Activities	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10

Quality of live

	Worst											Best										
How would you rate your overall quality of life?	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Satisfaction with overall pain management	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10

Medical History and FSH Components

Do you have any allergies? Yes No If yes, please specify: _____

Are you taking any medications to include blood thinners: Yes No

If yes, please specify: _____

Past Medical History: Have you been diagnosed with any of the following conditions? (check all that apply)

Heart: Hypertension, Coronary Artery Disease, History of Heart Attack, Peripheral Vascular Disease

Lungs: COPD/Emphysema, Pulmonary Hypertension

Kidneys: Renal insufficiency

GI: GERD/Reflux disorder, Gastric Ulcer, Diverticulosis/Diverticulitis, Colitis

Endocrine: Diabetes, Hypothyroidism

Psychiatric: Depression, Anxiety, Psychotic Disorders

Other: (please specify) _____

Past Surgical History: (please be sure to describe any spine procedures)

What is your marital status? Single Married Divorced Partner Widowed

Do you live with anyone: Yes No If yes, who? _____

Do you have a caregiver: Yes No If yes, who? _____

Do you work? Yes No If yes, what is your occupation: _____

Have you ever used drugs recreationally: Yes No

If yes, check all that apply: marijuana cocaine crack heroin ecstasy PCP LSD
Methamphetamines Other: _____

Prescription drugs: Vicodin/Lortab Oxycodone (oxycontin, roxy's) Xanax Soma Other: _____

If so, when was the last time you used? _____

Do you drink caffeinated drinks? Yes No 1 drink/day 2-3 drinks/day >4 drinks/day

Do you have a history of alcohol use? Yes No

Do you currently drink alcohol? Yes No

1. How many drinks a week on average? _____
2. How many drinks a day on average? _____

Do you have a history of smoking: Yes No

1. Have you quit? Yes No (If yes) When? _____
2. Number of Years smoking?: _____
3. How many packs per day?: _____

Bowel Patterns

Usual frequency: _____ Last BM: _____ Consistency: _____

Are you using any meds/supplements for constipation: Yes No If yes, please specify: _____

Review of Systems

Constitutional Symptoms	Neurological	Cardiovascular
<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Fever	<input type="checkbox"/> Headache	<input type="checkbox"/> Leg pain/swelling
<input type="checkbox"/> Chills	<input type="checkbox"/> Seizures	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Irregular heartbeat
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Weakness	<input type="checkbox"/> Fast heart beat
<input type="checkbox"/> Sleep problems	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Other:
<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Unbalanced walking	<input type="checkbox"/> No Complaints
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	Endocrine
<input type="checkbox"/> No Complaints	<input type="checkbox"/> No Complaints	<input type="checkbox"/> Hot flashes
Respiratory	Gastrointestinal/Nutrition	<input type="checkbox"/> Cod intolerance
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Short of breath	<input type="checkbox"/> Yellow skin/eyes	<input type="checkbox"/> Thyroid nodules
<input type="checkbox"/> Cough productive or not	<input type="checkbox"/> Problems swallowing	<input type="checkbox"/> Hypo/Hyperthyroidism
<input type="checkbox"/> Bloody sputum	<input type="checkbox"/> Cramping/Stomach pain	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Other:	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Other:
<input type="checkbox"/> No Complaints	<input type="checkbox"/> Black stool/blood in stool	<input type="checkbox"/> No Complaints
Genitourinary	<input type="checkbox"/> Change in appetite/diet	Head and Neck
<input type="checkbox"/> Burning	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Nose bleeds
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Constipation	<input type="checkbox"/> Swelling
<input type="checkbox"/> Frequency	<input type="checkbox"/> Other:	<input type="checkbox"/> Lumps
<input type="checkbox"/> Dribbling	<input type="checkbox"/> No Complaints	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Unable to control bladder	Breasts	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Other	<input type="checkbox"/> Changes	<input type="checkbox"/> Other:
<input type="checkbox"/> No Complaints	<input type="checkbox"/> Nipple discharge	<input type="checkbox"/> No Complaints
Hematologic	<input type="checkbox"/> Lumps	Skin
<input type="checkbox"/> Abnormal bleeding	<input type="checkbox"/> Date of last mammogram	<input type="checkbox"/> Abnormal color
<input type="checkbox"/> Swelling in groin/neck	<input type="checkbox"/> Other:	<input type="checkbox"/> Open sore
<input type="checkbox"/> Easy bruising	<input type="checkbox"/> No Complaints	<input type="checkbox"/> Rashes
<input type="checkbox"/> Other:	Musculoskeletal	<input type="checkbox"/> Other:
<input type="checkbox"/> No Complaints	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> No Complaints
Male Only	<input type="checkbox"/> Joint/back pain	Psychological
<input type="checkbox"/> Problems passing urine	<input type="checkbox"/> Falls	<input type="checkbox"/> Worried/Anxious
<input type="checkbox"/> Enlarged prostate	<input type="checkbox"/> Other:	<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Other:	<input type="checkbox"/> No Complaints	<input type="checkbox"/> Sad/depressed
<input type="checkbox"/> No Complaints		<input type="checkbox"/> Other:
Female Only		<input type="checkbox"/> No Complaints
<input type="checkbox"/> Unusual bleeding/discharge		
<input type="checkbox"/> Last Menstrual Period		
<input type="checkbox"/> Birth Control <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Other:		

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4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or with your regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of time	None of the time
Cut down on the <u>amount of time</u> you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Accomplished less</u> than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were limited in the <u>kind</u> of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had <u>difficulty</u> performing the work or other activities (for example, it took extra effort)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. During the past 4 weeks, how much of the time have you had any of the following problems with your work or your regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of time	None of the time
Cut down on the <u>amount of time</u> you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>accomplished less</u> than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did work or activities less <u>carefully than usual</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all	Slightly	Moderately	Quite a bit	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. How much bodily pain have you had during the past 4 weeks?

None	Very Mild	Mild	Moderate	Severe	Very Severe
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Did you feel full of life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been very nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt downhearted and depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you feel worn out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been happy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. How true or false is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
I seem to get sick a little easier than other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am as healthy as anybody I know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I expect my health to get worse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My health is excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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AUDIT and DAST SBI**

AUDIT: Circle correct answer

1. How often do you have a drink containing alcohol?
(0) Never (1) Monthly (2) 2-4 times a month (3) 2-3 times a week (4) 4 or more times a week _____
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
(0) 1-2 (1) 3-4 (2) 5-6 (3) 7-9 (4) 10 or more _____
3. How often do you have six or more drinks on one occasion?
(0) Never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily _____
4. How often during the last year have you found that you were unable to stop drinking once you started?
(0) Never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily _____
5. How often during the last year have you failed to do what was normally expected of you because of drinking?
(0) Never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily _____
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
(0) Never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily _____
7. How often during the last year have you felt guilt or remorse after drinking?
(0) Never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily _____
8. How often during the last year have you been unable to remember what happened the night before because of drinking?
(0) Never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily _____
9. Have you or someone else been injured as a result of your drinking?
(0) No (2) Yes, but not in the last year (4) Yes, during the last year _____
10. Has a friend, relative, or doctor or other health worker been concerned about your drinking or suggested you cut down?
(0) No (2) Yes, but not in the last year (4) Yes, during the last year _____

TOTAL SCORE: _____

DAST: Check "Yes" or "No"

During the past year:

1. Have you used drugs other than those required for medical reasons? Yes No _____
2. Have you abused prescription drugs (taken more or more frequently than prescribed)? Yes No _____
3. Do you abuse more than one drug at a time? Yes No _____
4. Can you get through the week without using drugs? Yes No _____
5. Are you always able to stop using drugs when you want to? Yes No _____
6. Have you had "blackouts" or "flashbacks" as a result of drug use? Yes No _____
7. Do you feel bad or guilty about your drug use? Yes No _____
8. Does your spouse (or parents) ever complain about your involvement with drugs? Yes No _____
9. Has drug abuse created problems between you and your spouse (or parents)? Yes No _____
10. Have you lost friends because of your use of drugs? Yes No _____
11. Have you neglected your family because of your use of drugs? Yes No _____
12. Have you been in trouble at work (or school) because of your use of drugs? Yes No _____
13. Have you lost a job (or failed a class) because of drug abuse? Yes No _____
14. Have you gotten into fights when under the influence of drugs? Yes No _____
15. Have you engaged in illegal activities in order to obtain drugs? Yes No _____
16. Have you been arrested for possession of illegal drugs? Yes No _____
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? Yes No _____
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)? Yes No _____
19. Have you gone to anyone for help for a drug problem? Yes No _____
20. Have you been involved in a treatment program especially related to drug use? Yes No _____

TOTAL SCORE: _____