Patient Information Form

Name_____Age_____Height_____Weight_____

A. Information about pain

1. What is your major problem?_____

_____

_____

2. When and how did your pain start?_____

_____

_____

3. What event led to your present problem? (Circle):
Accident Disease Operation Injury Cancer Other_____

4. How often does your pain occur on average day? (Hrs/Day)_____

5. Do you have pain free intervals? Yes No / If yes, how long do they last?(Hrs/Day)_____

6. What factors aggravate your pain? (Circle):
Heat Walking Lying Down Sex Cold Running Anxiety Massage Coughing
Standing Alcohol Straining Sitting Caffeinated Drinks

7. What helps your pain? _____

_____

8. Which is a comfortable position for you? _____

_____

9. Does light touch/rubbing produce unpleasant sensations in any area? Yes No

If yes, state area _____

10. How has your pain progressed in severity since it began?_____

_____

11. Circle the number that best describes your pain at its worst on an average day.

No Pain→ | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | ←Worst pain

12. Circle the number that best describes your pain right now.

No Pain→ | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | ←Worst pain

13. Describe your pain in your own words_____

_____

14. How does your pain interfere with your activities.

(1=Continually, 2= Several times a day, 3=once a day, 4=several times a week, 5=several times a month)

ACTIVITIES	GRADE
WORK	
FAMILY LIFE	
CHORES	
PLAY/RECREATION	
EXERCISE	

15. Please check the boxes that describe our pain in words and severity.

Type of Pain	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Hot-				
Aching				
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				

16. What doctors have you seen? When did you see them? What did they do?

Doctor's Name	Month/Year seen	What was done?

17. What tests and studies have been done?

TESTS & STUDIES DONE	MONTH/YR DONE	RESULTS
X-rays		
CAT Scan		
MRI		
EMG		
Nerve Conduction Studies		
Myelogram		
Thermogram		

18. Previous treatment for plan.

MODALITIES	Y	N	EFFECTIVENESS
Blocks			
TENS			
Physiotherapy			
Biofeedback			
Counseling			
Pain Management			
Surgery			

19. What pain treatments or medications are you receiving now, or have received?

Treatment or Medication	No Relief/ Relief/ Complete	Check if receiving now
	0 1 2 3 4 5 6 7 8 9 10	
	0 1 2 3 4 5 6 7 8 9 10	
	0 1 2 3 4 5 6 7 8 9 10	

20. Drug Allergies: _____

_____

_____

Describe reaction: _____

_____

21. Past Surgeries with Dates: _____

_____

_____

_____

22. Medical History:

Past	Present		Past	Present	
O	O	Chest pain/pressure/tightening	O	O	Digestive Problems
O	O	Hypertension	O	O	Kidney disease
O	O	Heart attack	O	O	Shortness of breath
O	O	Stroke	O	O	Frequent Urinary Infections
O	O	Headaches	O	O	Skin Disorders
O	O	Glaucoma	O	O	Hepatitis
O	O	Difficulty Hearing	O	O	COPD/Asthma
O	O	Memory Loss	O	O	Allergies or Eczema
O	O	Bleeding Disorder	O	O	Depression
O	O	Asthma	O	O	Seizures
O	O	Dizzy Spells	O	O	Ulcers
O	O	Cancer	O	O	Arthritis
O	O	Diabetes	O	O	Blood in Stool
O	O	Cataracts	O	O	Other:_____

23. Social History

Marital Status: Married Divorced Widowed Single

Children: How many? _____ **Education:** High School Some College Degree

24. Do you smoke? O Yes O No O Cigarettes O Pipe O Cigars

Number of years you have smoked? _____ How many per day?_____

25. Do you regularly drink alcohol? O Yes O No How many per day?_____

26. History of drug abuse? O Yes O No (Marijuana, cocaine, IV, other?)

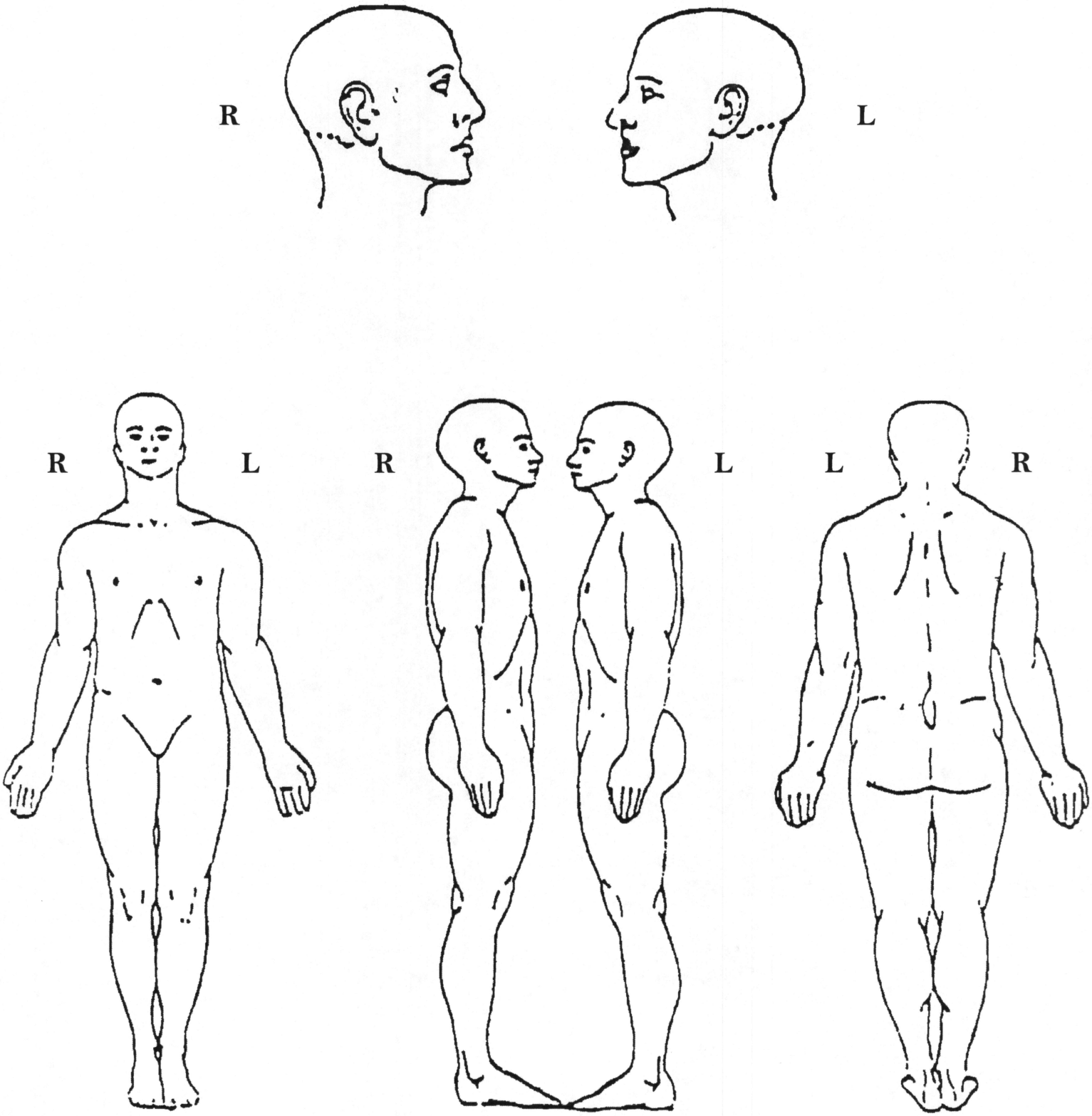
27. Family History	**Father**	**Mother**	**Siblings**	**Children**
High Blood Pressure	O	O	O	O
Epilepsy	O	O	O	O
Cancer	O	O	O	O
Eczema/Psoriasis	O	O	O	O
Heart Attack	O	O	O	O
Diabetes	O	O	O	O
Asthma	O	O	O	O
Hay Fever	O	O	O	O
Thyroid Disorder	O	O	O	O

28. List all current medications (include birth control pills and hormones)

Medication	Dosage	How it is taken	Prescribing Dr.Name	Dr.'s Phone Number
For Example Aspirin	81mg	1 every day	Dr.James Howdy	281-234-5678

29. Location:

PLEASE SHADE IN, ON THE DRAWING BELOW, WHERE YOU FEEL PAIN.



TEXAS PAIN MANAGEMENT
9323 PINECROFT DRIVE #100
THE WOODLANDS TX 77380

Professional fees are due at the time the services are rendered. It is the patient's responsibility to pay co-pay and/or deductible at the time of service. Any balance due after insurance, or should insurance not pay for any reason, it is the patient's responsibility. Delinquent accounts (over 30 days) are subject to interest of 1 1/2 % per month. Any fees related to collection of delinquent accounts will be borne by the patient.

Signature_____**Date**_____

NOTE: WE DO NOT ACCEPT CHECKS, DISCOVER, OR AMEX

WE ONLY ACCEPT VISA, MASTERCARD, CASH, MONEY ORDERS, AND CASHIER'S CHECK.

TEXAS PAIN MANAGEMENT
Vidyadhar S. Hede, M.D.

Name:_____ **Male:**_____ **Female:**_____
Address:_____**D.O.B.**_____
City:_____**Age:**_____
State:_____**Zip:**_____**Social Security #:**_____
Mailing Address (if different from above):_____
_____
Phone #: (_____**)**_____**Home:(**_____**)**_____
Name of spouse:_____**Spouse Ph.#:(**_____**)**_____
Referring Physician:_____**Ph#:(**_____**)**_____
Address:_____
Family Physician:_____**Ph#:(**_____**)**_____
Address:_____

Party Responsible for patient (if other than patient):

Name:_____**Relation to patient:**_____
Address:_____**Employer:**_____
_____ **SS# of policy holder**_____
Phone:(_____**)**_____**Work:(**_____**)**_____

INSURANCE INFORMATION: Please check appropriate circle(s) and complete.

- ○ **Medicare #:**_____
- ○ **Medicaid #:**_____
- ○ **Private Insurance:**_____
  - o **Policy #:**_____**Group:**_____
  - o **Policy holder's name:**_____**Ph:**_____
- ○ **Security Insurance:**_____
  - o **Policy #:**_____**Group:**_____
  - o **Policy holder's name:**_____**Ph:**_____

In case of an emergency, contact:
(Friend or family member who does not live with you)

Name:_____**Ph:(**_____**)**_____

TEXAS PAIN MANAGEMENT
Vidyadhar S. Hede, M.D.

AUTHORIZATION FORM

I authorize Texas Pain Management to release information regarding my:
(Check all that apply)

( ) **Appointments**
( ) **Prescriptions**
( ) **Bills**
( ) **Procedure Schedules**
( ) **Insurance Information**
( ) **Referring doctor's information**
( ) **Other:**_____

to the following person(s):

Name:_____
Relationship:_____**Ph:(**_____**)**_____
Name:_____
Relationship:_____**Ph:(**_____**)**_____
Name:_____
Relationship:_____**Ph:(**_____**)**_____

I understand that only the above mentioned people are allowed to discuss on my behalf regarding my care with Dr.Hede or his staff. (YES) (NO)

I authorize Texas Pain Management to leave detailed messages regarding my
(Check all that apply)

( ) **Appointments**
( ) **Prescriptions**
( ) **Bills**
( ) **Procedure Schedules**
( ) **Insurance Information**
( ) **Referring doctor's information**

on the following telephone #:_____

_____ _____
Patient Name **D.O.B.**

_____ _____
Patient Signature **Date**

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Texas Pain Management.

Texas Pain Management

Vidyadhar S. Hede, M.D., P.A.
9323 Pinecroft Drive
The Woodlands, TX 77380
Phone :(281) 296-0669 Fax :(281) 681-2344

AGREEMENT

Acknowledgement of review and consent for the following policies:

1) **Notice of Privacy Practices**

2) **Financial Policy**

3) **Medication Agreement**

I have reviewed these office policies. I understand that I am entitled to receive a copy of these documents.

_____ _____

Patient/ Representative Signature Date

_____

Patient/Representative Printed Name

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)				
Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "x" to indicate your answer)				
QUESTION	**NOT AT ALL**	**SEVERAL DAYS**	**MORE THAN HALF THE DAYS**	**NEARLY EVERY DAY**
	0	1	2	3
1) Little interest or pleasure in doing things				
2) Feeling down, depressed, or hopeless				
3) Trouble falling or staying asleep, or sleeping too much				
4) Feeling tired or having little energy				
5) Poor appetite or overeating				
6) Feeling bad about yourself- or that you are a failure or have let yourself or your family down				
7) Trouble concentrating on things, such as reading the newspaper or watching television				
8) Moving or speaking so slowly that other people could have noticed, or the opposite?- being so fidgety or restless that you have been moving around a lot more than usual				
9) Thoughts that you would be better off dead, or of hurting yourself in some way.				

MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Healthcare System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle)	Date of Birth

Information that will be Disclosed; Purpose of the Consent for Disclosure

I, _____[Patient Name], hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Healthcare System providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE].

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. **HOWEVER, IF YOU DO NOT SIGN [AND INITIAL] THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHIE.**

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Members of the MHiE are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the timeframe in which your Consent was active.

INDIVIDUAL'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include this Consent in the individual's records.

Official Use Only:

MHiE
Memorial Hermann
Information Exchange