neurotexas®
Brain & Spinal Surgery

Initial Visit History *Please use black ink only*

Name: _____ Date: _____

DOB: _____

What is the purpose of your visit today?

_____

_____

Where is your problem located?

☐ Head ☐ Neck ☐ Middle Back ☐ Lower Back ☐ Other: _____

If you have numbness, where is it located?

Leg: ☐ Left ☐ Right ☐ Both ☐ Above Knee ☐ Below Knee

Arm: ☐ Left ☐ Right ☐ Both ☐ Above Elbow ☐ Below Elbow

How long have you had this problem?

☐ _____Days ☐ _____Weeks ☐ _____Months ☐ _____Years

Does the pain radiate anywhere? ☐ **No** ☐ **Yes, where?**

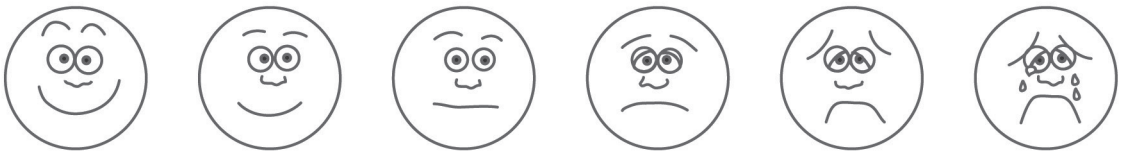
Leg: ☐ Left ☐ Right ☐ Both ☐ Above Knee ☐ Below Knee

Arm: ☐ Left ☐ Right ☐ Both ☐ Above Elbow ☐ Below Elbow

On a scale of 1-10, how bad is your pain?

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5 6 7 8 9 10



No Pain Mild Moderate Severe Very Severe Worst Possible

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Name: _____

When do your symptoms occur/worsen? (Check all that apply)

☐ Bending or stooping ☐ Coughing or straining ☐ Driving ☐ Prolonged sitting
☐ Prolonged standing ☐ Walking up stairs ☐ Lying flat ☐ Weight bearing
☐ Physical activity ☐ Twisting ☐ Walking ☐ Lifting ☐ Constantly ☐ At rest
☐ Other _____

Under what circumstances did your symptoms begin? (Check one box)

☐ Accident at work ☐ At work (not accident) ☐ Accident at home ☐ Motor vehicle accident
☐ Following surgery ☐ Following illness ☐ No apparent reason ☐ Other _____

If accident (auto or work related injury), in what state were you when it occurred?

_____ Date of occurrence? _____

When is your pain the worst?

☐ When you wake up ☐ Later in the morning, after breakfast ☐ Various times during the day
☐ At the end of the day ☐ At night ☐ Does the pain wake you up?
☐ Other _____

Does anything, other than medication, relieve your pain? _____

Describe your pain? (Check all that apply)

☐ Throbbing ☐ Shooting ☐ Stabbing ☐ Sharp ☐ Cramping ☐ Burning ☐ Aching

Do you have any associated symptoms? (Check all that apply)

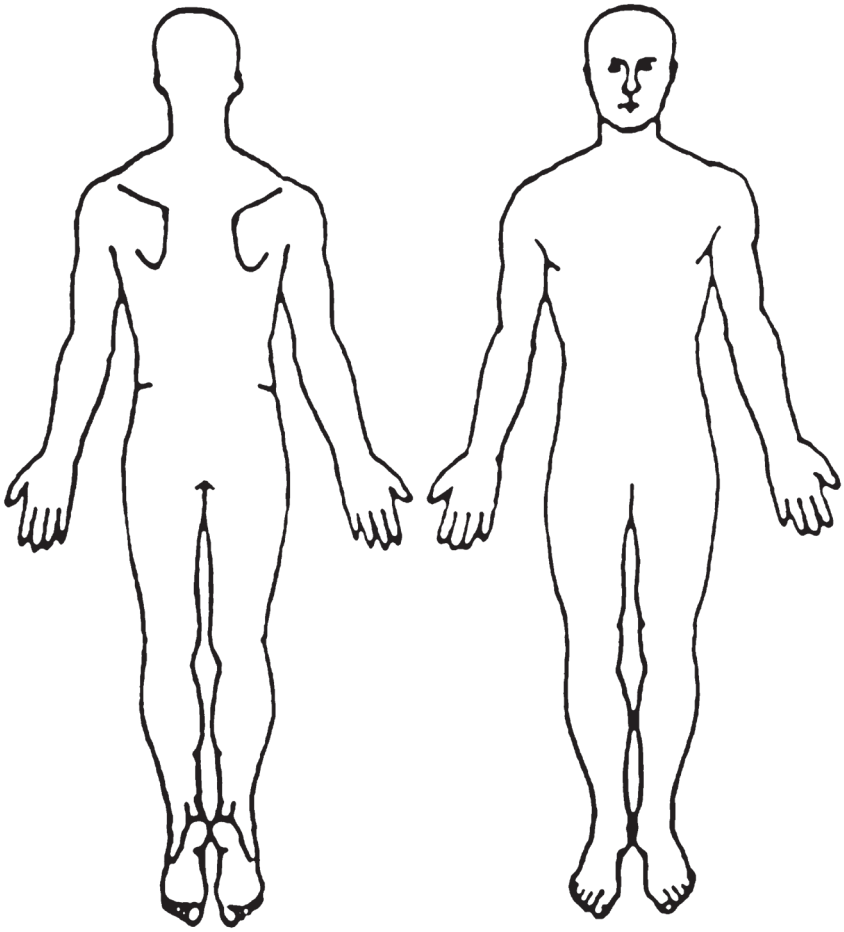
☐ Heavy ☐ Numbness ☐ Tingling ☐ Weakness ☐ Headache ☐ Dizziness ☐ Nausea
☐ Vomiting ☐ Fatigue ☐ Balance problems
☐ Bowel or bladder problems ☐ Other _____

Have you had difficulty with? (Check all that apply)

☐ Handwriting ☐ Grip strength ☐ Dropping items ☐ Buttoning your shirt
☐ Opening jars ☐ Picking up coins ☐ Getting out of a chair ☐ Getting up out of bed
☐ Pain with flexion/bending forward ☐ Pain with extension/bending backwards

Name: _____

Place an X on the areas where you are experiencing your symptoms.



Which of the following have been adversely affected by your painful condition?

☐ Activities of daily living ☐ Normal lifestyle ☐ Work activities ☐ Sleep

☐ Excercise ☐ Sexual Activity

Please check the aids or devices that you use:

☐ Wheelchair ☐ Crutches ☐ Walker ☐ Cane **Use:** ☐ Recent ☐ Longterm

Do you exercise? ☐ Yes ☐ No ☐ Unable to due to pain

☐ Type _____

☐ Frequency _____

Name: _____

What treatments have you had for this condition in the last <u>two</u> years?

TREATMENTS		FACILITY NAME / DOCTOR
Physical Therapy	☐	
Pain Injections	☐	
Chiropractor	☐	
Anti-Inflammatories (Ibuprofen / Aspirin)	☐	
Prescription Painkillers	☐	
Oral Steroids (Medrol Dosepak)	☐	
Acupuncture	☐	

Does your pain medication:

☐ Relieve most of your pain? ☐ Relieve about 75% of your pain?

☐ Relieve about 50% of your pain ☐ Relieve about 25% of your pain

☐ Relieve only a slight amount of pain?

☐ How long does your relief last after taking your pain medication? _____ hrs

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Pain Management Medication Agreement

The vast majority of our patients use pain medications appropriately, but pain medications have a potential for misuse and are therefore closely controlled by local, state, and federal authorities. Tolerance with repeated use is a characteristic feature of these medications and is a potential limitation to their use in pain management. To prevent any misunderstanding between you and your doctor, we have developed the following rules.

I agree to accept responsibility to know whether there are any Controlled Substances in any medications that I take.

1. I agree to not ask multiple doctors for Controlled Substance medication prescriptions.
2. No prescriptions will be refilled early.
3. No prescription will be refilled if I lose or destroy any of my medication.
4. I will get all of my prescriptions filled at one pharmacy which is:

   Pharmacy: _____ Phone: _____
5. Prescription refills will require 48 business hours to process.
6. Refills **WILL NOT** be made on weekends, holidays, or after 4:00PM on business days. Please do not call the after-hours medical service for medication refills. These requests will not be addressed until the following business day.
7. NeuroTexas does not have the ability to manage long-term pain. Our office will prescribe appropriate medications post-surgery for up to 6 weeks post-operatively per physicians' orders. Any patient requiring medications for a longer duration will be referred to Pain Management for additional care.

_____ (Patient initials) I am currently under the care of a pain management physician and will not obtain controlled medications from NeuroTexas. _____
Pain Management Provider

I understand and agree to follow these patient rules for Pain Management while under the care of NeuroTexas. The NeuroTexas staff has answered any and all questions to my satisfaction. If I do not follow these rules completely, the clinic physicians and staff reserve the right to stop any further prescribing of these medications.

_____
Signature of Patient

_____
Printed Name of Patient

_____
Date

Baylor Scott & White HEALTH

neurotexas® Brain & Spinal Surgery

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BSWH)

I hereby authorize:

Individual/Organization Name		Telephone Number
Street Address	City, State, Zip	Fax Number

to disclose my individually identifiable health information as described below. I understand the following:

- This Authorization is voluntary and I may refuse to sign this document.
- My health care and the payment of my health care will not be affected if I do not sign this form.
- If the recipient of this information is not a covered entity under federal or state privacy law, the information may be subject to redisclosure by the recipient.
- I may revoke this authorization at any time by notifying the disclosing individual/organization listed above in writing. This revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.
- This authorization will expire in 180 days or at the date or event specified here: _____

Patient Name	Date of Birth	Acct #	MRN
Street	City	State	Zip
Telephone number	Email:		

The information will be released TO:

Individual/Organization Name: **Baylor Scott & White Health**			Telephone Number
Street Address	City	State	Zip
Fax number	Email		

Purpose: Continued Care

Record copy delivery: ☐ Fax to healthcare provider/facility ☐ Mail ☐ Email ☐ Other _____

Please release the following information for treatment dates: from _____ to _____

Include this information if applicable: _____ Alcohol/Drug _____ Genetics _____ HIV/AIDS _____ Mental Health
(PT INITIALS) (PT INITIALS) (PT INITIALS) (PT INITIALS)

☐ Summary Abstract only (clinic notes, history & physical, procedure reports, pathology, consultations, test results, discharge summary)

☐ Clinic Notes	☐ Consultations	☐ Laboratory	☐ Radiology Images (CD only)
☐ Emergency Department	☐ Discharge Summary	☐ Medication	☐ Radiology Reports
☐ Billing Record	☐ History & Physical	☐ Operative Reports	
☐ Complete Chart	☐ Immunization	☐ Progress Notes	

☐ Other: _____

By typing my name below, I certify that this information can be used for the purpose of processing my Authorization for Release of Information request. I consider this as my electronic signature for this request.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient or Legal Representative Relationship to Patient

_____
Representative's Authority to Act for Patient (attach supporting documentation)

Scan doc type: Authorization to Release Protected Health Information

BAYLOR SCOTT & WHITE HEALTH