PATIENT INFORMATION

2717 Commercial Center Blvd STE E200
Katy, TX 77494

PLEASE PRINT CLEARLY!

Please circle or fill in all blanks that apply to you. DO NOT SKIP ANY QUESTIONS! If you need help ask one of our staff members to assist you. If the question does not apply to you, please write **N/A or Not Applicable**.

Date___/____/ _____ Date of Birth__/___ /____ Age _____

First _____Middle Initial_____Last_____Maiden_____

Address _____ City _____ State___Zip Code_____

Telephone ( ) _____ Sex M__F__ Race_____ SSN#____-_____-_____

Employer _____Work Number ( ) _____

Emergency Contact _____ Relationship _____

Telephone ( )_____ Work Number ( ) _____

Address _____ City _____ State _____

How did you hear about our clinic?_____

PHYSICAL ASSESSMENT INFORMATION

Where is your pain? Please circle all that apply.

Neck **Shoulder-**Right/ Left **Arm-**Right/ Left **Hand-**Right/ Left **Back-**Upper/ Lower/ Mid
Hip-Right/ Left **Leg-**Right/ Left **Knee-**Right/ Left **Ankle-**Right/Left **Foot-**Right/ Left

All Current Medications _____

List all Pain Management Clinics/MD that treated you in last 6 months with location (go on the back if necessary)

_____

Please list why you left all Pain Management Clinics/MD_____

Please list any other pain concerns _____

What was the cause of your pain? _____

How long ago did your pain begin? _____

Have you been diagnosed and/or treated for this condition? **Y N** If yes, where? _____
What type of treatment? **Physical Therapy Chiropractic Home Exercise Program Acupuncture Medications**

What medications have you taken in the past? _____

Where did you get your medications? **Family Doctor Emergency Room Specialist Other**_____
Are you allergic to any medications? **Y N** If yes, what medicines? _____

Have you ever used drugs other than those prescribed? Y N If yes, what drugs?_____

Are you currently or have you ever been addicted to illicit drugs? **Y N** If yes, what drugs? _____

Have you had any of the following tests? **X-Ray MRI CT EMG Other** _____

Where? _____ When? _____

Please circle the words that apply to your pain today. **Aching Burning Stabbing Throbbing Shooting Pinching Pulsing**

What makes your pain worse? **Sitting Standing Lifting Bending Squatting Walking Laying Twisting Driving**

What makes your pain better? **Hot Bath Massage Heat Walking Standing Exercise Stretching Sitting Laying**

Does the pain affect your sleep? **Y N** How many hours do you sleep? **1-3 4-6 7-10**

Do you (have)? **Trouble falling asleep Wake up frequently Daytime drowsiness**

Do you have any of the following? Please circle all that apply. If the question does not apply to you, please write **N/A or Not Applicable**.

Nervousness	**Poor concentration**	**Fidgety**	**Sweaty Palms**
Anemia	**Diabetes**	**Anxiety**	**Depression**
Arthritis	**Asthma**	**Angina**	**COPD**
CHF	**Dizziness**	**Epilepsy**	**Fatigue**
Heart Murmur	**Heart Attack**	**Palpitations**	**Short of Breath**
Stroke	**TIA**	**Thyroid**	**Ulcer**
ED	**High Cholesterol**	**Hypertension**	**Kidney Disease**
Liver Disease	**Menstrual Dysfunction**	**Headache**	**Gout**

Other _____

Have you ever been in the hospital? **Y N** If Yes, where? _____When? _____

Have you ever had surgery? **Y N**

If yes, what part of your body was operated on and what date? _____

Do you smoke? **Y N** If yes, How Much? _____ Packs per day If yes, How Long? _____

Do you drink alcohol? **Y N** If yes, How Much? **Occasional Social Moderate Heavy**

Does your immediate family have any of the following? Please circle all that apply. If the question does not apply to you, please write **N/A or Not Applicable**.

Anxiety	**Depression**	**Stroke**	**TIA**
Hypertension	**Diabetes**	**Osteoporosis**	**Osteopenia**
Thyroid Disease	**Kidney Disease**	**Glaucoma**	**High Cholesterol**
Heart Disease	**Bleeding Disorder**	**Liver Disease**	**Other** _____

PRINTED NAME _____ DATE _____

PATIENT SIGNATURE _____

WITNESS _____MD/MA/PA/NP_____

STRESS QUESTIONNAIRE

2717 Commercial Center Blvd STE E200
Katy, TX 77494

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

Directions: The following is a list of symptoms of anxiety that people sometimes have. Write the number in the space to the right of each statement that best describes how much that symptom or problem has bothered you during the past week.

0	**NOT AT ALL**	**2**	**MODERATE**
1	**SOMEWHAT**	**3**	**A LOT**

CATEGORY 1. ANXIOUS FEELINGS

1. Anxiety, Nervousness, Worry or Fear. _____
2. Feeling That Surroundings Are Strange, Unreal or Foggy. _____
3. Sudden, Unexpected Pain Spells. _____
4. Apprehension or a Sense of Impending Doom. _____
5. Feeling Tense, Stressed, "Uptight" or on Edge. _____
6. Inability to Handle Activities of Daily Living _____

CATEGORY 2. ANXIOUS THOUGHTS

7. Difficulty Concentrating _____
8. Racing Thoughts or Having Your Mind Jump from One Thing to the Next. _____
9. Feeling That You Are on the Verge of Losing Control. _____
10. Fears of Physical Illness or Heart Attack or Death. _____
11. Concerns about Looking Foolish or Inadequate In Front of Others. _____
12. Fears of Being Alone, Isolated or Abandoned. _____

CATEGORY 3. PHYSICAL REACTIONS

13. Feeling Like You Might Faint or Pass Out. _____
14. Hyperventilating/ Breathing Too Fast. _____
15. Change in Vision (Black Spots of Narrowing of Visual Field). _____
16. Problems Going to Sleep or Staying Asleep. _____
17. Difficulty breathing. _____
18. Racing heartbeat. _____

TOTAL _____

PRINTED NAME: _____ DATE: _____

PATIENT SIGNATURE: _____

REFERRAL: _____ PRACTITIONER: _____ MD/PA/NP

RECOMMENDED TREATMENT: MEDICATION MANAGEMENT NON-MEDICATION MANAGEMENT

TREATMENT CONSENT FORM

2717 Commercial Center Blvd STE E200
Katy, TX 77494

1. I hereby give consent for medical treatment for myself.
2. I have revealed all information concerning my previous healthcare needs, current medications and treatment received in the past for my condition.
3. I understand there are risks associated with the use of controlled substances including but not limited to increased tolerance, addiction, impaired thought processing, abuse, somnolence, and more. Benefits of the medications include reduction of pain, anxiety, muscle spasms, increased rest or sleep, and more. Special issues include caution or cessation of driving, operating heavy machinery, carrying a weapon and more while taking medications.
4. I agree to comply with treatment and participate actively.
5. I agree to use **only one pharmacy** when filling prescriptions for controlled substances and to get controlled substances from **only one physician**.
6. I have not nor will I participate in "doctor shopping".
7. I agree not to purchase other controlled substances through the Internet.
8. I agree to urine/ serum screens, and or pill counts, if requested.
9. I agree to designate a family member or friend for office accountability. I agree to report emergency room and outpatient visits within 48 hours of discharge.
10. I agree to report history of detoxification treatment.
11. I agree to handle and store controlled substances and other drugs safely.
12. I agree to policies on refills, renewals and consequences if I violate or do not comply with this or any other document associated with my treatment as described in the Patient Agreement.
13. I will not hold QUALITY PAIN CONSULTANTS, its affiliates, owners, independent contractors or employees, responsible for any injury to myself or others associated with my abuse, misuse, increased tolerance, addiction, compliance, or illicit drug use.
14. I understand any further testing or treatment modalities (including drug screening) required **will be** an additional expense and agree to be bound by it.
15. I agree that payment is due at time of service and that fees and or treatment may vary.
16. I acknowledge that I have read, understand and accept this document as well as all policies and procedures of this office.

PRINTED NAME _____ DATE _____

PATIENT SIGNATURE _____

WITNESS _____ MD/MA/PA/NP_____

CONTROLLED SUBSTANCE CONTRACT

2717 Commercial Center Blvd STE E200
Katy, TX 77494

As a condition of receiving regular doses of narcotics from my doctor, I agree to the following:

1. I will take my medication as prescribed by my doctor. I will not take more than prescribed. I will not allow other individuals to take my medication. I will not take narcotics prescribed by other doctors.
2. I will avoid alcohol and all illegal drugs while I am taking narcotics.
3. If I feel tired or mentally foggy, I will not operate a vehicle and/ or heavy machinery or serve in any capacity related to public safety.
4. I will submit urine or blood specimen for testing of narcotics and other drugs whenever my doctor requests. My doctor may ask that a clinic staff member observe me as I produce the urine specimen.
5. I will allow my doctor to receive information from any health care provider or pharmacist about the use or possible misuse of alcohol and other drugs. This permission shall expire only upon my written cancellation of this agreement.
6. I will allow my doctor to contact my family and friends to help monitor my condition. If my doctor recommends, I will see a specialist to help determine whether I am developing an addiction. I will allow the pain clinic to send a copy of this agreement to my other doctors or to the pharmacy where I obtained my prescription.
7. I understand that my doctor will not be available to prescribe medication during evenings and weekends. It is my responsibility to call my doctor at least three business days in advance of running out of medication. Under no circumstances will allowances be made for lost or stolen prescriptions or drugs.
8. I will not obtain pain medications from any other doctors outside of this clinic. In the event of an emergency, I will alert the emergency room doctor of my special arrangement (Treatment Consent Form). The doctor should provide me with enough medication to last until I can be seen in the clinic.
9. I will keep all clinic appointments and if I must reschedule I will notify the clinic prior to my schedule time.
10. If asked, I will bring all of my unused pain medication to each clinic visit.
11. I will have all medications filled at the pharmacy agreed upon by me and my doctor.
12. If I do not follow the above contract, I understand that my doctor will gradually reduce or discontinue my narcotics or refer me to an addiction specialist.
13. **I understand that Narcotic Therapy will be stopped if**:
    a. My doctor feels the medication is harming me, is not providing adequate pain control or is not improving my activity or functioning.
    b. I sell, abuse, or misuse my medication.
    c. I develop significant side effects.
    d. I obtain pain medication from other sources or repeatedly request increased dosages or early refills.

PRINTED NAME _____ DATE _____

PATIENT SIGNATURE _____

WITNESS _____ MD/MA/PA/NP _____

WARNINGS / SIDE EFFECTS

2717 Commercial Center Blvd STE E200
Katy, TX 77494

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

The medications prescribed to you may have side effects. Please notify Quality Pain Consultants if any of the following symptoms persist or become bothersome. Seek immediate medical attention at your nearest emergency room or call 911 if necessary. If treated due to complications caused by your medications please notify Quality Pain Consultants of the situation.

- Lightheadedness
- Dizziness
- Sedation or Unusual Sleepiness or Drowsiness
- Nausea/ Vomiting
- Constipation
- Clumsiness
- Rash
- Itchiness
- Dry Mouth
- Depression
- Diarrhea
- Confusion
- Insomnia
- Dizziness on standing up from sitting or sitting up from laying down
- Sensation of a “spinning room”
- Ataxia (Lack of muscle coordination)
- Gas
- Indigestion
- Tremor
- Fever
- Death

PRINTED NAME _____ DATE _____

PATIENT SIGNATURE _____

WITNESS _____ MD/MA/PA/NP_____

PATIENT AGREEMENT

2717 Commercial Center Blvd STE E200
Katy, TX 77494

As the patient I understand:

1. If I do not follow the instructions included in this document, the medications I have been prescribed may be gradually reduced over a thirty-day period until it is safe to stop the medications and then termination, I may be put on a probationary period or may be discharged from the practice.
2. My medical records are a required part of treatment and further evaluation and or testing may be required. Failure to bring medical records on a timely basis is grounds for disciplinary action as aforementioned.
3. Occasionally I may be tested by urine and/or blood for illicit and or prescribed medications, and if the testing is positive for drugs and/ or medications other than those prescribed or if not positive for the medications I am prescribed, I may be required to complete a rehabilitation program, counseling, and may be terminated as a patient.
4. Communication with the medical practitioner concerning any issues with the medication, anxiety, or pain relief is a requirement.
5. Offering, supplying, and or selling my prescribed medication to another medical facility except in an emergency is prohibited.
6. Requesting, receiving, or soliciting pain or anxiety medications from another medical facility except in an emergency is strictly prohibited.
7. My medications are to be kept in a safe place and will not be replaced if lost or stolen on a monthly basis. They will be replaced on a weekly basis until my regularly scheduled appointment providing there is adequate documentation or reasonable explanation of the loss.
8. Refills of prescribed medications can be completed only in the office, in person.
9. Taking my medications at a rate greater than prescribed is unacceptable.
10. There are other methods of pain management including physical therapy, chiropractic, exercise programs, counseling, rehabilitation, and more. These services if necessary may be implemented in my treatment plan and/or available to me at such time as I may request them.
11. This document and any other documents in my chart may be requested by Federal, State, or City law enforcement agencies subject to investigation of misuse, sale, or delivery of a controlled substance and I fully agree to provide cooperation as may be requested. I have read, understand, completed, and signed or initialed the, Patient Agreement, Treatment Consent Form, Notice of Privacy Practices, Patient Assessment Forms and the Pain Scale Assessment Forms.
12. I agree to utilize one pharmacy of my choice.
13. I will not take my medications in any other fashion than that for which it was prescribed including quantity.
14. I will not drink alcohol or use other sedating drugs without consulting my doctor.
15. I understand that sudden cessation of my medications may result in a syndrome of physiological withdrawal and or seizure activity. I will not discontinue my medication without consulting my provider.
16. My pain is legitimate, I am not feigning pain to acquire medications or treatment either as a would be diverter or as an agent of any investigative or law enforcement agency.
17. I am aware of the effects of my medication and will take all precautions necessary while operating a motor vehicle or any type of machinery.
18. I have been informed of my treatment plan and all of my questions and concerns regarding such treatment plan and my documents I have completed or signed have been answered to my satisfaction.

PRINTED NAME _____ DATE _____

PATIENT SIGNATURE _____

WITNESS _____ MD/MA/PA/NP _____

MEDICAL RECORDS AGREEMENT

2717 Commercial Center Blvd STE E200
Katy, TX 77494

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

As the patient I understand **ALL** of the following:
My radiology reports are **required** for my first visit if I am under 30 years of age, or by my second office visit if I am 30 years of age or older.
**** Receipt and verification of record does not guarantee its acceptance, as relevancy will have to be determined by clinician.**
Patients failing to bring their radiology reports for their second visit can be seen but will be given only a 2 weeks supply of their pain management medications, with instructions on how to taper their medications to avoid possible withdrawal effects, and an order for a XRAY/MRI/CT. **If said patient brings in a copy of a valid radiology report showing pathology consistent with disease which could necessitate treatment with chronic pain medications within 2 weeks of their last visit to QUALITY PAIN CONSULTANTS, they will be given the rest of their medication for said month.**

My medical records are a **required** part of any treatment plan involving controlled substances and that additional evaluation and or testing may be required. Failure to bring medical records is grounds for immediate discharge from the practice. Lab work will be performed on your first visit to ensure your safety. Lab work will be repeated every 3 months to continue to monitor your liver function amongst other things. If your lab work comes back abnormal, it will be repeated upon your next visit and you will be responsible for payment of these services.

I am aware that I **have not** provided the physician with my radiology records and or medical records.

Patient Signature _____ Date _____ **INITIAL VISIT**

I am aware that I **have** provided the physician with my radiology records and or medical records.

Patient Signature _____ Date _____ **INITIAL VISIT**

Radiology reports brought in by patient: ___YES, ___NO _____XRAY, _____MRI, _____CT
Medical records ___YES, ___NO

Witness _____ MD/MA/PA/NP _____

Patient Signature _____ Date _____ **SECOND VISIT**

Witness _____ MD/MA/PA/NP _____
Radiology reports brought in by patient: ___YES, ___NO _____XRAY, _____MRI, _____CT
Medical records ___YES, ___NO

NOTE: Receipt and verification of record does not guarantee its acceptance, as relevancy will have to be determined by clinician.
COMMENTS: _____
_____

PATIENT PRIVACY NOTICE

2717 Commercial Center Blvd STE E200
Katy, TX 77494

PATIENT NAME: DATE OF BIRTH: DATE:

We are providing this notice to inform you of the privacy Standards which will be applied to your medical records at our office which is now called your "Protected Health Information". We have been mandated by Federal Law to make you aware of your rights and our responsibilities regarding your medical records. You will need to sign a new consent for treatment and financial policy that will outline how you would like our office to handle privacy issues related to your Protected Health Information.

*** * * Please read and complete the following carefully * * ***

1. I hereby give consent to receive medical treatment from the physician(s) of this practice and/or their associations.

2. **For treatment.** We may use medical information about you to provide you with medical treatment or services.
Example: In treating you for a specific condition, we may have allergies that could influence which medications we prescribe for the treatment process.

3. **For Health Care Operations.** We may use and disclose medical information about you for your health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can be Made Without Your Consent or Authorization.

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health safety
- As required by military command authorities for their medical records
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- As required by the US Food and Drug Administration

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.

I understand that the authorized person(s) will be required to furnish proof of their identity when making an inquiry. I understand that this authorization will remain in force in its entirety until it is replaced by a new signed agreement by me.

I further agree to release this practice, its employees, or agents on its behalf from any and all liability resulting of my "Protected Health Information" to any individual herein authorized.

I understand and consent to the above authorization. □ Authorize myself **ONLY**.

Patient Signature _____ Date _____

1. _____ _____ N/A □ Initial: _____
Authorized Person Relationship

2. _____ _____ N/A □ Initial: _____
Authorized Person Relationship

Further Instructions: N/A □ Initial: _____

I do do not request a copy of my Patient Privacy Policy. Initial: _____

James A. Bodin, Jr. M.D.
Commercial Center Blvd STE E200
Katy, TX 77494

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name:_____ Date of Birth:_____ SS#:_____

TO: _____
_____
_____
_____

FROM: James A. Bodin, Jr. M.D.
Commercial Center Blvd STE E200
Katy, TX 77494
Phone: 832-913-5039
Fax: 832-913-5037

I request a copy or summary of the following medical records:

X-Rays MRI CT Scans Medication Allergies
Surgical Procedures Other_____

From (date) _____ To (date) _____

Purpose of Request Treatment or Consultation Request of Patient

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire ____days from the date of my signature.
If no time period is specified, it shall expire in 180 days from date of signature.
I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.
TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.
FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

Patient Signature:_____ Date:_____
Driver's License/ID #:_____

Witness: _____ Date:_____

J.Bodin 1-11

DRUG TESTING

2717 Commercial Center Blvd STE E200
Katy, TX 77494

DATE_____ /_____/_____

Drug Screening is required to be done randomly. If you test positive for illegal and or drugs you do not have a prescription for you will not be treated with controlled medications for your medical condition. Also, you may be discharged from this practice

Patient printed name and signature:_____

WITNESS MD/MA/PA/NP