ENID PAIN & SPINE
Dr. Chad Owens, D.O.
427 East Cherokee Avenue • Enid, OK 73701
(580)234-PAIN (7246) • Fax (580)233-2223
www.enidpain.com

Appointment Date & Time:

Please mail or fax back

**Patient Consent to Treat and Demographic Information**

Today's Date: _____ Patient's Name: _____
Last, First, Middle Initial

Date Of Birth: _____ Sex: M / F Social Security #:_____

Home Address: _____ City: _____State/Zip: _____

Home Phone #:_____ Cell #:_____ Email:_____

Preferred Language: _____ Ethnicity: (Circle One) Hispanic or Not Hispanic

Race :( Circle One) American Indian – Asian – African American – Pacific Islander – Caucasian

Primary Care Physician: _____ Marital Status: _____

Employer: _____Phone #:_____ Fulltime: ____ Part-time:_____ Retired: _____

Employer Address: _____ Student: Yes ___ No ___ If Yes, Fulltime: ____ Part-time: ___

Emergency Contact: _____ Relationship:_____

Contact Address: _____ City, State, Zip: _____

Contact Phone #: _____ Alternate #:_____

Responsible Party: _____ Male: ___ Female: ___ Date Of Birth: _____
Last, First, Middle Initial

Social Security #: _____Phone #: _____ Relationship to Patient: _____

Primary Insurance: _____ Subscriber's Name: _____

Date of Birth: _____ Relationship: _____ SS# Of Subscriber: _____

Secondary Insurance: _____ Subscribers Name: _____

What Pharmacy Do You Use: _____

**CONSENT TO TREAT:** I consent to the provision of health care services at Enid Pain & Spine. I acknowledge that no guarantee has been made to me as to the results that may be obtained from this care. If the health care services I am requesting require multiple visits, I consent to all necessary routine treatment ordered by my health care provider during each visit. I understand if special procedures are recommended, my health care provider will discuss this with me and my additional consent will be required.

_____ DATE: _____
Signature of Patient

_____ DATE: _____
Authorized Signature

RELATIONSHIP: _____
Parent, Guardian, POA

| Patient Name: | Date: |
|---|---|


**Directions:**

ENID PAIN & SPINE

**427 East Cherokee Avenue • Enid, OK 73701**
**Next to Saint Mary's Hospital in the Medical Arts Building**

Patient Name: | Date:

REFERRING PHYSICIAN: _____
Name Number Fax

PRIMARY CARE PROVIDER: _____
Name Number Fax

CARDIOLOGIST: _____ ❑ None
Name Number Fax

SPINAL SURGEON: _____ ❑ None
Name Number Fax

NEPHROLOGIST: _____ ❑ None
Name Number Fax

Check One: ❑ Psychiatrist ❑ Neurologist ❑ Oncologist ❑ Rheumatologist ❑ Orthopedic Surgeon

_____
Name Number Fax

OTHER PHYSICIANS you have seen specifically for this pain problem: _____

## Medical History

In order to develop your individualized plan of treatment, gathering detailed information about your past medical history, past psychological history, family, and social history are very important. Please answer the following questions openly and specifically. Please use back of form is more space is needed.

Weight: _____ Height: _____

Please check any major illnesses that may apply.

| | | | |
|---|---|---|---|
| ❑ High Blood Pressure | ❑ Vascular Problems | ❑ Epilepsy | ❑ Osteoarthritis (regular/common arthritis) |
| ❑ Diabetes | ❑Heart Disease | ❑ Tuberculosis | ❑ Hepatitis |
| ❑ Lupus | ❑ Asthma | ❑ Stroke | ❑ Rheumatoid arthritis |
| ❑ Shingles | ❑ HIV/AIDS | ❑Emphysema | ❑ Kidney problems |
| ❑ Thyroid Problems | ❑ Cancer | ❑ Other: _____ | |

## Surgical History

Please list prior surgeries or procedures below.

| Date | Surgery /Procedure | Physician |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Patient Name: | Date:

## Family Medical History

Please list any family members (such as mother, father, brother, etc) that may have or are currently suffering from any medical or psychiatric conditions such as: diabetes, hypertension, heart disease, cancer, stroke, chronic pain, depression, bipolar disorder, etc.

Condition: _____ Specific family member _____

Condition: _____ Specific family member _____

Condition: _____ Specific family member _____

## Habits

Do you smoke? ❑ Yes, currently ❑ Yes, in the past ❑ No, never

If yes, how many packs do you smoke per day? ❑ 0-1/2 ❑ 1/2-1 ❑ 1-2 ❑ More than 2

How long have you smoked? Years: _____ Months: _____

Do you use alcohol? ❑ Yes ❑ No If yes, how many drinks do your consume?

I consume _____ drinks every day. I consume _____drinks every week. I consume _____ drinks every month.

Do you use recreational drugs? ❑ Yes, currently ❑ Yes, in the past ❑ No, never

Have you ever misused, abused, or been addicted to prescription medications?

❑ Yes, currently ❑ Yes, in the past ❑ No, never

Have you ever been treated for addiction? ❑ Yes ❑ No Have you ever been treated for alcoholism? ❑ Yes ❑ No

Have you ever had psychiatric, psychological or social work treatments/evaluations for any diagnosis/problem, including your current pain? ❑ Yes ❑ No

If yes, for what diagnosis or problem were you treated? _____

When were you treated? _____ Therapist's name: _____

Have you considered suicide ❑ Yes ❑ No Date: _____

## Employment

Are you on disability: ❑ Yes ❑ No If yes, why: _____

Occupation: _____ Employment status: _____

What are your current work restrictions, if any? _____

If you are unemployed, employed part-time, or have work restrictions, is this due to your present pain conditions? ❑ Yes ❑ No

If employed, how many hours do you work each week?

❑ Less than 10 ❑ 11-20 ❑ 20-30 ❑ 30-40 ❑ More than 40

## Education & Family Life

Please list your highest education level completed: _____

**Marital Status:** ❑ Single and never married ❑ Married ❑ Divorced ❑ Widowed

❑ I have (#) ___ children. Ages: _____ Significant other's name: _____

My pain is the result of an: ❑ accident ❑ illness ❑ I do not know what caused my pain

What is the date of the accident: _____ Type of accident: ❑ Auto ❑ Work Injury ❑ Other _____

Please describe illness or accident: _____

_____

If this is a work injury, Employer: _____ Do you have an open workman's comp claim? ❑ Yes ❑ No

Case Manager: _____ Phone: _____

If accident, is there litigation involved ❑ Yes ❑ No Please explain: _____

_____

Attorney Name: _____ Phone: _____ Fax: _____

Patient Name: | Date:

You have been referred to Enid Pain & Spine. Our goal is to help you improve your level of function and reduce your level of pain. We specialize in both evaluation and management of many types of pain disorders.

In order to develop an effective plan of treatment, we need to obtain detailed information about you and your health. Please take time to complete the following questionnaire. In addition, we will ask to scan your insurance card(s) and state issued identification when finished with this form.

Thank you,
Enid Pain & Spine

## Pain Description

When did your pain begin? _____

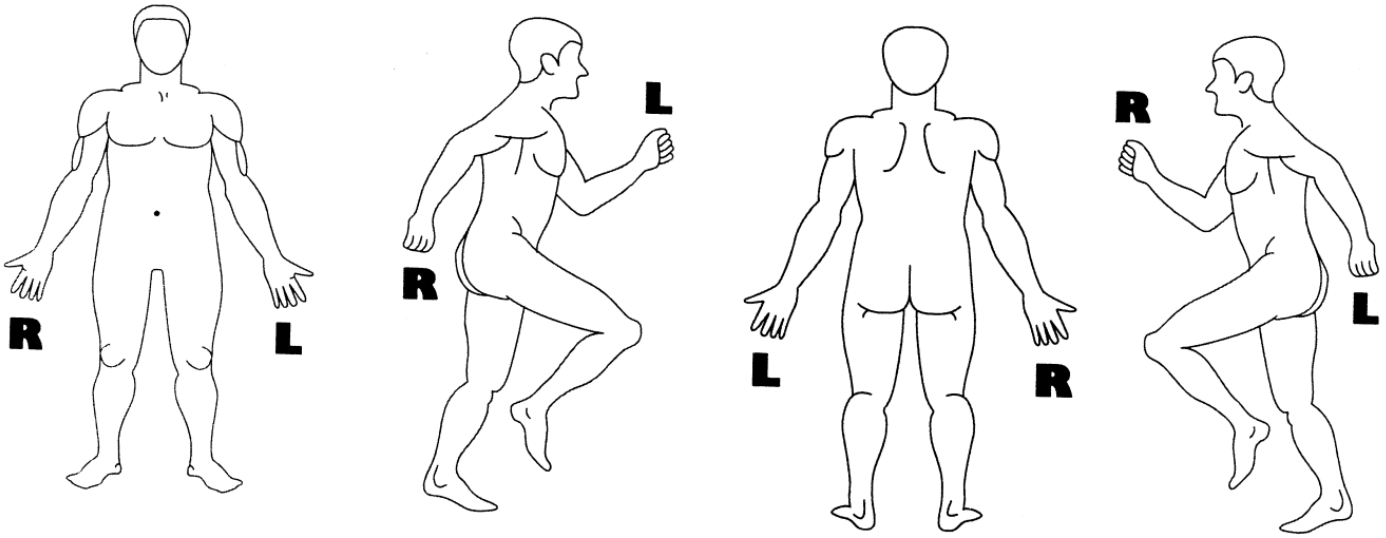
Where is your pain? _____

_____

Please check the words that best describe your pain.

❑ Aching ❑ Dull ❑ Constant ❑ Numbing ❑ Coldness ❑ Burning

❑ Sharp ❑ Stinging ❑ Stabbing ❑ Tingling ❑ Cramping ❑ Radiating




## Pain Scales

**(0 = No pain 10 = Worst pain)**

Please rate your present pain level.

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Please rate your worst pain level.

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Please rate your average pain level.

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Patient Name: | Date:

Please indicate if any of the following increases, decreases, or causes no change to your pain.

| Stimulus/ Treatment | Increase Pain | Decrease Pain | No Change | Stimulus/ Treatment | Increase Pain | Decrease Pain | No Change |
|---|---|---|---|---|---|---|---|
| Heat | ❑ | ❑ | ❑ | Standing | ❑ | ❑ | ❑ |
| Cold | ❑ | ❑ | ❑ | Sneezing/Coughing | ❑ | ❑ | ❑ |
| Weather Changes | ❑ | ❑ | ❑ | Physical Therapy | ❑ | ❑ | ❑ |
| Lying Down | ❑ | ❑ | ❑ | Massage Therapy | ❑ | ❑ | ❑ |
| Sleep | ❑ | ❑ | ❑ | Urination | ❑ | ❑ | ❑ |
| Physical Activity | ❑ | ❑ | ❑ | Bowel Movement | ❑ | ❑ | ❑ |
| Sexual Intercourse | ❑ | ❑ | ❑ | Tension | ❑ | ❑ | ❑ |
| Sitting | ❑ | ❑ | ❑ | Fatigue | ❑ | ❑ | ❑ |

## Functional Scales

**(0 = Not able 10 = Very able)**

Please rate your ability to cope with pain.

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Please rate your ability to perform activities of daily living such as hygiene, household chores, transportation, etc.

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Please rate your ability to function and interact well with family and friends.

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Please rate your ability to work in your usual occupation.

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

## Sleep Behavior

Do you have difficulty falling asleep? ❑ Yes ❑ No

Do you have difficulty remaining asleep? ❑ Yes ❑ No

Are you ever awakened by your pain? ❑ Yes ❑ No

How many hours do you sleep, on average, per night?

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ More than 10

Patient Name: | Date:

# Pain Treatment History

Please indicate which diagnostic procedures you have had and the approximate date/location where the test was performed.

| Diagnostic Procedure | Body Part/Area | Date | Location |
|---|---|---|---|
| Bone Scan/SPECT | | | |
| MRI Scan | | | |
| CT Scan | | | |
| Myelogram | | | |
| X-Ray | | | |
| EMG/Nerve Conduction Study | | | |
| Urine Drug Screen | | | |
| Lab work | | | |

Please indicate the amount of relief and date of the following treatments if applicable.

| Treatment | No Relief | Moderate Relief | Excellent Relief | Date |
|---|---|---|---|---|
| Surgery | ❑ | ❑ | ❑ | |
| Traction | ❑ | ❑ | ❑ | |
| Spine Injection | ❑ | ❑ | ❑ | |
| Physical Therapy | ❑ | ❑ | ❑ | |
| Chiropractic Care | ❑ | ❑ | ❑ | |
| Acupuncture | ❑ | ❑ | ❑ | |
| TENS Unit | ❑ | ❑ | ❑ | |
| Injections | ❑ | ❑ | ❑ | |

Do your pain medications provide relief? ❑ Yes ❑ No ❑ I do not take pain medications

If yes, how much relief do you receive?

❑ 10% ❑ 20% ❑ 30% ❑ 40% ❑ 50% ❑ 60% ❑ 70% ❑ 80% ❑ 90% ❑ 100%

Which pain medications have you tried? _____

_____

Do your pain medications improve your function? ❑ Yes ❑ No ❑ I do not take pain medications

If yes, how much improvement in function do you receive?

❑ 10% ❑ 20% ❑ 30% ❑ 40% ❑ 50% ❑ 60% ❑ 70% ❑ 80% ❑ 90% ❑ 100%

Please indicate any side effects caused by your pain medications.

❑ Nausea ❑ Vomiting ❑ Rash ❑ Constipation ❑ Upset Stomach ❑ Sedation

❑ Dizziness ❑ Acid Reflux ❑ Itching ❑ No side effects ❑ Other: _____

Patient Name: | Date:

## Allergy History

If you are allergic to any medications, please list the medication name and reaction you had below.

| Medication | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## Medications

Please list all medications that are currently prescribed to you.

| Name | Strength | Directions | Reason for Medication |
|---|---|---|---|
| | | | |
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Please check the appropriate box if you currently take any of the following medications.

❑ Yes ❑ No Coumadin

❑ Yes ❑ No Plavix

❑ Yes ❑ No Lovenox

❑ Other blood thinners: _____

Patient Name: | Date:

**Review of Systems**

Please mark any symptoms you have experienced in the **last month**.

If not marked, it is considered negative or non-pertinent.

**Constitutional**
- ☐ Appetite, excessive
- ☐ Appetite, poor
- ☐ Chills
- ☐ Fatigue
- ☐ Fevers
- ☐ Insomnia

**Head**
- ☐ Dizziness
- ☐ Grinding teeth
- ☐ Headache
- ☐ Jaw Pain or click
- ☐ Tooth Pain

**Eyes**
- ☐ Blurred Vision
- ☐ Floaters or Spots
- ☐ Vision Change
- ☐ Vision Loss

**ENT**
- ☐ Ear Pain
- ☐ Hearing Loss
- ☐ Ringing or Buzzing
- ☐ Nosebleed
- ☐ Sinus Pain
- ☐ Sinus Congestion
- ☐ Sinus Infection
- ☐ Change in Taste
- ☐ Dry Mouth
- ☐ Sore Throat
- ☐ Trouble swallowing

**Cardiovascular**
- ☐ Blood Clots
- ☐ Chest Pain
- ☐ Shortness of Breath with Activities
- ☐ Irregular Heartbeat
- ☐ Lightheaded
- ☐ Swelling Feet

**Respiratory**
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cough
- ☐ Frequent Colds
- ☐ Pneumonia
- ☐ Short of Breath
- ☐ Wheezing

**Gastrointestinal**
- ☐ Bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn/Reflux
- ☐ Indigestion
- ☐ Nausea
- ☐ Ulcer
- ☐ Vomiting
- ☐ Bloody or Dark Stools
- ☐ Loss of Bowel Control

**Musculoskeletal**
- ☐ Broken Bones
- ☐ Difficulty Standing
- ☐ Difficulty Sitting
- ☐ Difficulty Walking
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Morning Stiffness
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Numb Hands/Fingers
- ☐ Numb Feet/Toes

**Neuro/Psych**
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty Falling Asleep
- ☐ Difficulty Staying Asleep
- ☐ Fainting
- ☐ Head Injury
- ☐ Loss of Consciousness
- ☐ Loss of Sensation
- ☐ Tremor or Shakes
- ☐ Skin
- ☐ Dry
- ☐ Itchy
- ☐ Rashes

**Genitourinary**
- ☐ Urination that is:
- ☐ Bloody
- ☐ Burning
- ☐ Frequent
- ☐ Painful
- ☐ Kidney Stones
- ☐ Loss of Urinary Control
- ☐ Wake Up to Urinate

**Reproductive**
- ☐ Infertility
- ☐ Pain with Sex
- ☐ Erection Problems
- ☐ Pelvic Pain
- ☐ Painful Periods
- ☐ Hot Flashes
- ☐ ____# of Pregnancies
- ☐ ____# of Live Births
- ☐ ____Age Periods Began
- ☐ ____Age Menopause Began

**Immune/Endocrine**
- ☐ Anemia
- ☐ Easy Bruising
- ☐ Frequent Infections
- ☐ High / Low Blood Sugar
- ☐ Low Thyroid
- ☐ High Thyroid
- ☐ Hot Flashes
- ☐ Swollen Lymph Nodes
- ☐ Weight Gain or Loss