Texas Spine & Pain MD, PLLC
1055 Clarksville St # 165, Paris, TX 75460
Ph: +1(903) 401-5145; Fax: +1(903) 401-5146
Email: info@txspmd.org; Web: www.txspmd.org

New Patient Intake Form

Last Name: _____First Name: _____ Middle Init: _____

Preferred Name: _____ Sex: ☐M ☐F DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

May we leave a voice message to remind you about appointments on your home and/or cell phone number? ☐ Yes ☐ No

Email address: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐ Separated ☐Widowed

Primary Language: ☐ English ☐ Spanish ☐ Other

Race: ☐ African/American ☐ Caucasian ☐ Hispanic ☐ Other _____ Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino

Occupation: _____ Work Phone: _____

Address _____

Referring Physician: _____

Primary Care Physician: _____ Phone Number: _____

Pharmacy Name: _____Phone Number: _____

Do you take Blood Thinners? ☐ Yes ☐ No If so which one?

Emergency Contact Name: _____Relationship: _____

Home Phone: _____ Cell Phone: _____

INSURANCE

INFORMATION PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____

Policy #: _____

Group ID#: _____

Whose name is insurance in? ☐ Self ☐ Spouse ☐ Other ___

Insured Name: _____

DOB: _____ SSN: _____

Address: ☐ Same as above _____

_____

INFORMATION PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____

Policy #: _____

Group ID#: _____

Whose name is insurance in? ☐ Self ☐ Spouse ☐ Other ___

Insured Name: _____

DOB: _____ SSN: _____

Address: ☐ Same as above _____

_____

The above information is true to the best of my knowledge. I authorize Texas Spine & Pain MD, PLLC to furnish information to insurance carriers required to process my claims. I authorize my insurance benefits be paid directly to the physician. I understand fully that I am responsible for any amount not covered by the insurance, or any collection fees, or interest acquired.

_____ _____

Signature Printed Name

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Communication Form

I _____ give permission to Texas Spine & Pain MD, PLLC to share my health information with the following individuals who are involved in my care:

Name	Relationship	Contact Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature _____ Date: _____

Print Name _____ Date of Birth _____

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PRIMARY PAIN

Last Name _____ First Name _____ DOB _____

How did your pain Begin?

_____

_____

_____

Circle the words that describe your pain

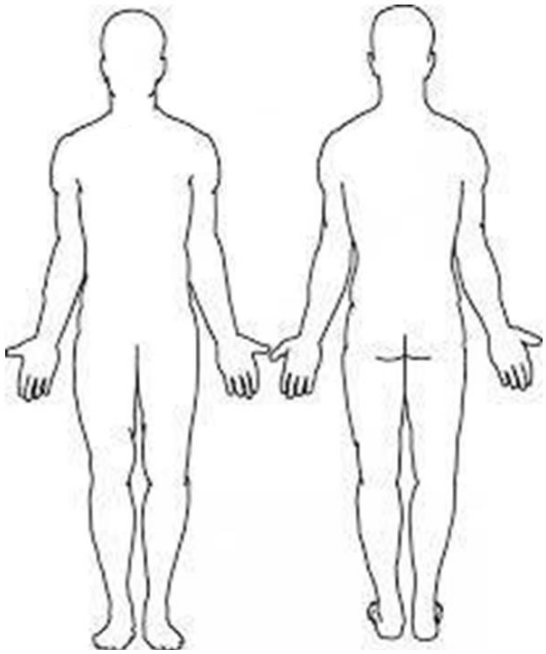
Burning	Aching	Sharp	Constant
Electric	Throbbing	Stabbing	Occasional
Prickling	Dull	Shooting	Frequent
Numbing	Cramping	Stinging	Rare
Other _____			

How would you rate your pain on a scale from 0-10 with 0 being no pain and 10 being the worst pain?

0 1 2 3 4 5 6 7 8 9 10

Please designate your pain location; mark W for worst pain

Front Back



What makes your pain better?

Lying down Sitting Standing Walking Exercising Medications Leaning Forward

Other _____

What makes your pain worse?

Lying down Sitting Standing Walking Exercising Bending Twisting

Other _____

Previous Treatments (Circle all that apply):

Physical therapy Surgery Medications

Injections TENS Acupuncture

Chiropractic Massage Other _____

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Previous Medications:

☐ Tylenol	☐ Oxycodone	☐ Methadone	☐ Morphine	☐ Dilaudid	☐ Celebrex
☐ NSAIDS	☐ Fentanyl	☐ Neurontin	☐ Tapentadol	☐ MS contin	☐ Butrans
☐ Oral Steroids	☐ Hydrocodone	☐ Cymbalta	☐ Lyrica	☐ Opana	☐ Belbuca
☐ Tramadol	☐ Oxycontin	☐ Percocet	☐ Mobic	☐ Topamax	☐ Nucynta

Others: _____

Past Medical History

List all Medical Problems:

_____

_____

_____

_____

List all surgeries and Pain procedures:

_____

_____

_____

_____

MEDICATIONS (Please list all medications or attach a list)

_____

_____

_____

_____

ALLERGIES: Please list all known drug allergies.

If you are unware of any drug Allergies check here ☐

_____

_____

_____

_____

Family History:

_____

_____

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Social History:

Married: ☐ YES ☐ NO

Children: ☐ YES ☐ NO If so, how many: _____

Do you drink any alcohol? ☐ YES ☐ NO If so, ☐ Heavily ☐ Daily ☐ Occasionally ☐ Socially ☐ Rarely

How much/often? _____

Have you ever smoked cigarettes or used tobacco? ☐ YES ☐ NO Do you currently ☐ YES ☐ NO

Packs per Day? Years of use? _____

Do you use illicit drugs? ☐ YES ☐ NO ☐ Heavily ☐ Daily ☐ Occasionally ☐ Raely

Drug name(s): _____

REVIEW OF SYSTEMS: (Please circle any symptoms you have experienced within the last month.)

General	Appetite change	Chills	Sweating	Fever	Fatigue	Weight change
Hent	Neck Pain	Neck Stiffness	Sinus Pressure	Sore Throat	Congestion	Ear Pain
Eyes	Vision Changes	Eye Pain	Eye Redness	Eye Discharge		
Respiratory	Apnea	Shortness of breath	Wheezing	Cough		
Cardiovascular	Chest pain	Swelling	Palpitations	Chest pressure		
Gastrointestinal	Diarrhea	Constipation	Nausea/Vomiting	Heartburn		
Endocrine	Thyroid Problems	Elevated Glucose	Sexual Difficulties			
Genitourinary	Incontinence	Hesitancy	Urgency			
Musculoskeletal	Arthralgia	Back Pain	Gait Disturbance	Joint Swelling	Myalgia	Fibromyalgia
Skin	Color Changes	Pain to light touch	Wounds	Rash		
Neurological	Headache	Dizziness	Numbness	Weakness	Confusion	Seizures
Hematologic	Anticoagulation	Bleeding disorder	HIV			
Psychiatric	Depression/anxiety	Substance abuse	Suicidal Thoughts			