Dr. Terrell R. Phillips, D.O.

You have an appointment with Dr. Terrell R. Phillips, D.O. for Pain Management.

Please bring the following with you:

1) Your Driver's License

2) Your Insurance Card or Cards

3) Your Co-Pay or Deductible, if not met - this must be paid before seeing the Physician. If you are unsure of the amount please contact your Insurance Company. (**Credit/Debit card payments must be a minimum of $10.00 , No Exceptions**)

4) Fill out all paperwork that was mailed to you (PLEASE USE BLACK INK ONLY) and bring it with you on the day of your appointment. **Fill Out All Forms Completely**!

5) Must bring **ALL of Your Medication Bottles** with you.

6) Bring your MRI, X-RAY or CT SCAN paper **Reports** with you on your first visit (films are not necessary).

ADDRESS: **Dr. Terrell Phillips, D.O.**
401 S.W. 80th, Building D, Suite 200
Oklahoma City, Ok 73139

We are located off I-240 and S. Walker. Follow I-240 around and exit on S. Walker. Go South on Walker, turn East onto S.W. 80th. Our office is on the North side of S.W. 80th across from OCOM Surgical Center. If you have any problems locating us please feel free to call our office at 405-601-4227.

If you are unable to keep your appointment please call us at 405-601-4227.
We look forward to meeting with you and taking care of you.

Dr. Phillips' Office

Please note: Our office opens the doors at 7:30 a.m. and they are locked from 12:00 to 12:30 for lunch.

Comprehensive Pain Center
Terrell Phillips, D.O.

401 SW 80th Street, Suite 200
Oklahoma City, OK 73139
405-601-4227 • Fax 405-601-4237

PATIENT INFORMATION:

Legal Name:_____Address:_____

City: _____ State:_____ Zip Code: _____ MALE or FEMALE

SS#: _____ Date of Birth: _____ Age:_____ Marital Status:_____

Home Phone:_____ Cell:_____ Work:_____

Employer:_____ Address:_____

Email address: _____

Race: (please circle one)

American Indian/Alaska Native Black/African American White Hispanic Asian
Native Hawaiian/Pacific Islander Unreported/Refused to report Other Race

Ethnicity: (please circle one)

Hispanic/Latino Non-Hispanic/Latino Unreported/Refused to Report Race and Identity

Primary Language: (please circle one)

English Spanish Other

PERSON RESPONSIBLE FOR BILL: (If minor, parent or guardian information)

Name: _____ Date of Birth: _____ SS#: _____

Relationship to Patient: _____ Address: _____

Home Phone: _____ Cell: _____ Work: _____

Employer: _____ Address: _____

INSURANCE INFORMATION:

Name of Insured: _____ Date of Birth: _____ SS#: _____

Relationship to Patient: _____ Employer: _____

Name of Insurance Company: _____ Address: _____

Group #: _____Policy ID#: _____

PLEASE GIVE INSURANCE CARD(S) TO RECEPTIONIST FOR COPYING Authorization: My signature indicates that I have read above and grant authorization of treatment and I am responsible for payment of fees. I also authorize the release of any medical information requested by my insurance carrier and authorize payment of medical benefits to physician.

_____ _____

DATE PATIENT OR LEGAL GUARDIAN SIGNATURE

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NAME: _____ DATE: _____

DOB: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

REFERRING PHYSICIAN: _____

CHIEF COMPLAINT(S): _____

ON a scale from 0 (no pain) to 10 (excruciating) rate your pain:

At its WORST: _____ At its LEAST: _____ At its USUAL: _____ TODAY: _____

Describe your pain: Sharp, dull, burning, shooting.

Site: _____ Referral pattern: (legs, arms) _____

When did your pain start: _____

What makes your pain worse: _____

What makes your pain better: _____

How many hours in a day are you in enough pain requiring medication (1-24) _____

What time of day is your pain the worst: _____

IS THIS INJURY RELATED TO A MOTOR VEHICLE ACCIDENT? YES_____ NO _____

IF YES, Date of Accident: _____ Date Pain Began: _____

IS THIS A WORKERS' COMP INJURY? YES _____ NO _____

If Yes, date of injury: _____ Date Pain Began: _____ Employer: _____

Occupation: _____ Are you currently working? YES NO

If no, last day worked: _____ Current Restrictions: _____

List all previous Workers' Comp Injuries: _____

Previous Treatment:

Surgeries: _____

Medical: _____

Any Nerve Blocks, Epidural Blocks: Yes No _____

Physical Therapy or other treatment: _____

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NAME: _____ DOB: _____

PLEASE CIRCLE ONE

Past Medical History:		Surgical History:	
abnormal liver functions tests	0 Yes 0 No	appendix removed	0 Yes 0 No
AIDS/HIV	0 Yes 0 No	ankle surgery	0 Yes 0 No
alcohol abuse	0 Yes 0 No	bladder surgery	0 Yes 0 No
anemia	0 Yes 0 No	bowel surgery	0 Yes 0 No
angina	0 Yes 0 No	breast biopsy	0 Yes 0 No
anxiety	0 Yes 0 No	carpal tunnel release	0 Yes 0 No
arthritis/osteoarthritis	0 Yes 0 No	cervical fusion	0 Yes 0 No
arthritis/rheumatoid	0 Yes 0 No	coronary artery bypass graft	0 Yes 0 No
asthma	0 Yes 0 No	gallbladder removed	0 Yes 0 No
atrial fibrillation	0 Yes 0 No	gastric bypass	0 Yes 0 No
autoimmune disorder	0 Yes 0 No	heart bypass	0 Yes 0 No
bipolar disorder	0 Yes 0 No	hip replacement, left	0 Yes 0 No
bleeding problems	0 Yes 0 No	hip replacement, right	0 Yes 0 No
bowel disorder	0 Yes 0 No	hysterectomy	0 Yes 0 No
cardiac arrhythmia	0 Yes 0 No	knee arthroscopy, left	0 Yes 0 No
cirrhosis	0 Yes 0 No	knee arthroscopy, right	0 Yes 0 No
coronary artery disease	0 Yes 0 No	knee replacement, left	0 Yes 0 No
Crohn's disease	0 Yes 0 No	knee replacement, right	0 Yes 0 No
depression	0 Yes 0 No	lumbar fusion	0 Yes 0 No
diabetes, type I	0 Yes 0 No	lumbar laminectomy	0 Yes 0 No
diabetes, type II	0 Yes 0 No	mastectomy	0 Yes 0 No
drug abuse	0 Yes 0 No	open reduction, internal fixation (ORIF)	0 Yes 0 No
emphysema	0 Yes 0 No	pacemaker, cardiac	0 Yes 0 No
epilepsy	0 Yes 0 No	partial thyroidectomy	0 Yes 0 No
gastric ulcer	0 Yes 0 No	shoulder arthroscopy	0 Yes 0 No
gout	0 Yes 0 No	spine surgery	0 Yes 0 No
heart attack	0 Yes 0 No	tonsillectomy	0 Yes 0 No
hepatitis B	0 Yes 0 No		
hepatitis C	0 Yes 0 No		
hypertension	0 Yes 0 No		
kidney failure	0 Yes 0 No		
lupus	0 Yes 0 No		
migraine headaches	0 Yes 0 No		
pacemaker	0 Yes 0 No		
schizophrenia	0 Yes 0 No		
seizures	0 Yes 0 No		
sleep apnea	0 Yes 0 No		
stroke	0 Yes 0 No		

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NAME: _____ DOB: _____

PLEASE CIRCLE ONE

Review of Systems:

Caridovascular

chest pain	0 Yes	0 No
difficulty lying flat	0 Yes	0 No
fluid accumulation in the legs	0 Yes	0 No
irregular heartbeat	0 Yes	0 No
palpitations	0 Yes	0 No
shortness of breath	0 Yes	0 No

Gastrointestinal

blood in stool	0 Yes	0 No
constipation	0 Yes	0 No
diarrhea	0 Yes	0 No
change in bowel habits	0 Yes	0 No

Neurologic

balance difficulty	0 Yes	0 No
difficulty speaking	0 Yes	0 No
dizziness	0 Yes	0 No
fainting	0 Yes	0 No
gait abnormality	0 Yes	0 No
loss of strength	0 Yes	0 No
paralysis	0 Yes	0 No
seizures	0 Yes	0 No

Respiratory

shortness of breath	0 Yes	0 No
wheezing	0 Yes	0 No

Peripheral Vascular

absent pulses in feet	0 Yes	0 No
absent pulses in hands	0 Yes	0 No
blanching of skin	0 Yes	0 No
cold extremities	0 Yes	0 No
ulceration of feet	0 Yes	0 No

Musculoskeletal

joint stiffness	0 Yes	0 No
leg cramps	0 Yes	0 No
pain in shoulder(s)	0 Yes	0 No
sciatica	0 Yes	0 No
swollen joints	0 Yes	0 No
trauma to ankle(s)	0 Yes	0 No
trauma to arm(s)	0 Yes	0 No
trauma to hip(s)	0 Yes	0 No
trauma to knee(s)	0 Yes	0 No
weakness	0 Yes	0 No

Psychiatric

anxiety	0 Yes	0 No
depressed mood	0 Yes	0 No
difficulty sleeping	0 Yes	0 No
suicidal thoughts	0 Yes	0 No

Women Only

breast lump	0 Yes	0 No
heavy bleeding during menses	0 Yes	0 No
painful intercourse	0 Yes	0 No

Genitourinary

blood in urine	0 Yes	0 No
difficulty urinating	0 Yes	0 No

Men Only

hernia	0 Yes	0 No
hard testicle	0 Yes	0 No
difficulty initiating stream	0 Yes	0 No

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NAME: _____ DOB: _____

Recent Hospitalization(s):

_____

_____

Social History:

Do you smoke: Yes No _____ Packs per Day

Drink Alcohol: (Circle One) Occasionally Frequently Daily

History of alcohol or drug abuse: Yes No _____

Marital Status: _____ Number in Household: _____

Level of Education: _____ Occupation: _____

Employer: _____ Currently Working: _____

Are you Disabled? Yes No Permanent Restrictions _____

_____ _____% of Disability

Goals:

_____ Return to Work? _____ Become More Active? _____ Improve Quality of Life? _____ Other?

ALLERGIES:

_____

Medication: List ALL medications, strength and quantity:

_____

_____

_____

_____

_____

Mention any Blood Thinner: _____

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NAME: _____ DOB: _____

Check any Test performed for evaluation of pain:

_____ Lumbar MRI Location: _____ Date_____

_____ Cervical MRI Location: _____ Date _____

_____ CT Scan Location: _____ Date _____

_____ Myelogram Location: _____ Date _____

_____ X-Rays Location: _____ Date _____

_____ Bone Scan Location: _____ Date _____

_____ EMG Location: _____ Date _____

_____ Discogram Location: _____ Date _____

Family History:

Father Illnesses: _____

Mother Illnesses: _____

Siblings Illnesses: _____

Family Members with an Alcohol or Drug Addiction: _____

_____

Primary Care Physician and Phone Number: _____

_____

Other Treating Physicians, Phone Number and Conditions:_____

_____

_____

_____

_____

_____