Comprehensive Pain Center

Terrell Phillips, D.O.
Brian Blick, M.D.
David Sharrah, M.D.

Welcome to Comprehensive Pain Center. We look forward to serving you and assisting you with pain needs. Allow two hours for your appointment. If you were given any medication to take before your appointment, please do not take until after you see Dr. Phillips. If you are intending on the taking the medication before any procedures, please bring someone to drive you home.

Please bring the following with you:

1. Your Driver's License
2. Completed Attached Paperwork (Use only black ink and write clearly)

If you are unable to keep your scheduled appointment, please contact our office 24-48 hours in advance to avoid any additional charges.

PLEASE DO NOT TAKE ANY SEDATIVE MEDICATION BEFORE ARRIVING TO OUR OFFICE. BRING THE MEDICATION WITH YOU AND WE WILL ADVISE YOU WHEN YOU MAY TAKE IT.

We look forward to meeting you!

Thank you,

Comprehensive Pain Center Staff

Comprehensive Pain Center
Terrell Phillips, D.O.
Brian Blick, M.D.
David Sharrah, M.D.

PATIENT INFORMATION:

Legal Name: _____ Date of Birth: _____ Age: _____

SS#: _____ Marital Status: _____ Male or Female

Address: _____

City: _____ State: _____ Zip Code: _____

Email address: _____

Emergency Contact: _____ **Relationship:** _____ **Phone Number:** _____

Home Phone: _____ Cell Phone: _____

Preferred number for voice mail communication: _____

Clinic may leave voicemails regarding : ___ All Info ____Appointment Reminders ____Lab Results
___ Prescription Information ___ General info ___ **I do not want voicemails left**

Currently Employed: YES or NO Are you disabled: YES or NO

Employer: _____ Address: _____ Phone: _____

Occupation: _____ Level of Education: _____

Circle any applicable:

Race: American Indian/Alaska Native Black/African American Asian White
Native Hawaiian/Pacific Islander Other Race: _____

Ethnicity: Hispanic/Latino Neither Hispanic nor Latino Other Ethnicity: _____ Decline to Specify

Primary Language: English Spanish Other: _____

Primary Care Physician: _____ **Referring Physician:** _____

Primary Pharmacy: _____ Phone number: _____

Location of Pharmacy: _____ City: _____

Primary Insurance: _____ Effective Date: _____

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

Relationship: _____

Employer: _____ Member ID: _____ Group# _____

Employer Address: _____

Secondary Insurance: _____ Effective Date: _____

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

Relationship: _____

Employer: _____ Member ID: _____ Group# _____

Employer Address: _____

PLEASE GIVE INSURANCE CARD(S) TO RECEPTIONIST TO COPY – Bring insurance card and ID to every visit.

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.

X_____ **Date** _____

Signature

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CHIEF COMPLAINT(S): _____

ON a scale from 0 (no pain) to 10 (excruciating), how do you rate your pain?

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

Describe your pain: (Circle all that apply & write site of pain)
Burning Throbbing Shooting Dull Numb Spasm Tingling Stabbing

SITE: _____ SITE: _____ SITE: _____

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 hours)? _____

What time of day is your pain the worst? (Circle pain time frame that applies)

Morning (before getting out of bed) Mid-morning (after the start of activities)

Noon Mid-after Night Middle of Night Pain is Constant

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

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

IS THIS A WORKERS' COMPENSATION INJURY? YES ____ NO ____

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

Employer: _____ Are you currently working? YES NO

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

Primary Goals of treatment: _____Return to Work? _____Become more active? _____Improve quality of life?

(October – March Only)

Influenza Injection (flu)	**YES or NO**	**Date:** _____	**Where:** _____
Pneumovax Vaccination (Age 65)	**YES or NO**	**Date:** _____	**Where:** _____
Prevnar 13 (Age 50)	**YES or NO**	**Date:** _____	**Where:** _____
Zoster (Shingles – Age 60)	**YES or NO**	**Date:** _____	**Where:** _____

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Past Medical History			DATE
abnormal liver functions tests	0 Yes	0 No	_____
AIDS/HIV	0 Yes	0 No	_____
alcohol abuse	0 Yes	0 No	_____
anemia	0 Yes	0 No	_____
angina	0 Yes	0 No	_____
anxiety	0 Yes	0 No	_____
asthma	0 Yes	0 No	_____
atrial fibrillation	0 Yes	0 No	_____
bipolar disorder	0 Yes	0 No	_____
bleeding issues	0 Yes	0 No	_____
bowel disorder	0 Yes	0 No	_____
cardiac arrhythmia	0 Yes	0 No	_____
cirrhosis	0 Yes	0 No	_____
coronary artery disease	0 Yes	0 No	_____
crohn's disease	0 Yes	0 No	_____
depression	0 Yes	0 No	_____
diabetes, type I	0 Yes	0 No	_____
diabetes, type II	0 Yes	0 No	_____
drug abuse	0 Yes	0 No	_____
emphysema	0 Yes	0 No	_____
epilepsy	0 Yes	0 No	_____
fibromyalgia	0 Yes	0 No	_____
gastric ulcer	0 Yes	0 No	_____
gout	0 Yes	0 No	_____
graves disease	0 Yes	0 No	_____
heart attack	0 Yes	0 No	_____
hepatitis B	0 Yes	0 No	_____
hepatitis C	0 Yes	0 No	_____
hypertension	0 Yes	0 No	_____
insomnia	0 Yes	0 No	_____
kidney failure	0 Yes	0 No	_____
lupus	0 Yes	0 No	_____
Lyme disease	0 Yes	0 No	_____
migraines/headaches	0 Yes	0 No	_____
multiple sclerosis	0 Yes	0 No	_____
osteoarthritis	0 Yes	0 No	_____
pacemaker/defibrillator	0 Yes	0 No	_____
psoriatic arthritis	0 Yes	0 No	_____
rheumatoid arthritis	0 Yes	0 No	_____
seizures	0 Yes	0 No	_____
schizophrenia	0 Yes	0 No	_____
sleep apnea	0 Yes	0 No	_____
stroke	0 Yes	0 No	_____

Surgical History			DATE
Appendix removed	0 Yes	0 No	_____
Ankle surgery	0 Yes	0 No	_____
Bladder surgery	0 Yes	0 No	_____
Bowel surgery	0 Yes	0 No	_____
Breast biopsy	0 Yes	0 No	_____
Carpal tunnel release	0 Yes	0 No	_____
Cervical fusion	0 Yes	0 No	_____
Coronary artery bypass	0 Yes	0 No	_____
Gallbladder removal	0 Yes	0 No	_____
Gastric bypass	0 Yes	0 No	_____
Heart bypass	0 Yes	0 No	_____
Hip replacement, left	0 Yes	0 No	_____
Hip replacement, right	0 Yes	0 No	_____
Hysterectomy	0 Yes	0 No	_____
Knee arthroscopy, left	0 Yes	0 No	_____
Knee arthroscopy, right	0 Yes	0 No	_____
Knee replacement, left	0 Yes	0 No	_____
Knee replacement, right	0 Yes	0 No	_____
Lumbar fusion	0 Yes	0 No	_____
Lumbar laminectomy	0 Yes	0 No	_____
Mastectomy	0 Yes	0 N0	_____
Surgery of fractured bone	0 Yes	0 No	_____
Pacemaker	0 Yes	0 No	_____
Partial thyroidectomy	0 Yes	0 No	_____
Shoulder arthroscopy	0 Yes	0 No	_____
Spine surgery	0 Yes	0 No	_____
Tonsillectomy	0 Yes	0 No	_____

Other History:

_____Date: _____

_____Date: _____

_____Date: _____

_____Date: _____

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Spine surgery	0 Yes	0 No	_____
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Other History:

_____Date: _____

_____Date: _____

_____Date: _____

_____Date: _____

_____Date: _____

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Review of Systems

Cardiovascular

chest pain	0 Yes	0 No
difficulty lying flat	0 Yes	0 No
fluid accumulation (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
Bipolar	0 Yes	0 No
Women Only		
Breast lump	0 Yes	0 No
Heavy bleeding (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

Family History

Mother: _____

Father: _____

Brother: _____

Sister: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Other: _____

(New Patient Packet, PAST MED HISTORY, Oct 2019)

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Allergies/Treatments/MRI/CT

Allergy: _____ **Reaction:** _____

Allergy: _____ **Reaction:** _____

Allergy: _____ **Reaction:** _____

Allergy: _____ **Reaction:** _____

Allergy: _____ **Reaction:** _____

Epidural Steroid Inj. **Nerve Block** **Facet Block** **Stimulator** **Other:** _____

Date: _____ Physician: _____ Facility: _____

Date: _____ Physician: _____ Facility: _____

Date: _____ Physician: _____ Facility: _____

Physical Therapy:

Date: _____ Treatment Type: _____ Facility: _____

Date: _____ Treatment Type: _____ Facility: _____

MRI:

Body Part: _____ Date: _____ Facility: _____

Body Part: _____ Date: _____ Facility: _____

Body Part: _____ Date: _____ Facility: _____

CT SCAN:

Body Part: _____ Date: _____ Facility: _____

Body Part: _____ Date: _____ Facility: _____

Body Part: _____ Date: _____ Facility: _____

Other Testing: _____ Date: _____ Facility: _____

_____ Date: _____ Facility: _____

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Pharmacy Name: _____ Phone: _____ Location: _____

Medication/Supplement	Dosage	Frequency	Route	Physician	Date

MEDICATION LIST (write in medications or attach list)

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Tobacco/Alcohol

TOBACCO

____Current Smoker ____Former Smoker ____ Non-Smoker

____ Uses in other forms (Chew, Snuff, Vape)

How often do you smoke? ____Everyday ____Some Days

How many cigarettes do you smoke daily? ___5 or less ___6-10 ___11-20 ___21-30 ___31 or more

How soon after you wake up do you use tobacco? ___5 Mins ___6-30 Mins ___31-60 Mins ___60 Mins

Are you interested in quitting? ___Yes ___No ___Thinking about it

ALCOHOL

Did you have a drink containing alcohol in the past year? ____NO ____YES

If yes, how often did you have a drink containing alcohol in the past year?

____Never ____Monthly or Less ____2-4 times monthly ____2-3 times weekly ____4 or more times weekly

If yes, how often did you have alcohol on a typical day in the past year?

___1-2 drinks ___3-4 drinks ___5-6 drinks ____7-9 drinks ____10 or more drinks

If yes, how often did you have 6 or more drinks on one occasion in the past year?

___Never ___Monthly ___Less than monthly ___Weekly ___Daily or almost daily

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Patient personal goals

What are some specific tasks (housework, yard work, shopping, care for children), hobbies, sports or any activities that you would like to start doing again or more of while receiving pain management?

1._____

2._____

3._____

When would you like to be able to accomplish these goals? 2-4 months **4-6** months **1** year

Work (please circle one)

Would you like to return to **normal work duty** or **light work duty**?

When would you want to accomplish this goal by? _____

Improve sleep

How many hours are you currently sleeping? _____ Goal sleep? _____

If you take medication to help you sleep please list:

1. _____

2. _____

3. _____

Increase physical activity

What are some ways you would like to increase your physical activity?

1. _____

2. _____

3. _____

Decrease Pain

Do you use any non-medication treatments (ice, heat, etc)?

1. _____

2. _____

3. _____

What was your pain level in the past week (1-10)? Best _____/10 **Worst** _____/10

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OFFICE POLICIES:

1. Co-pays and office visit charges are due in full before you see the doctor. If you are unable to pay your co-pay we will reschedule your appointment. The only exception will be if you have spoken with the office manager prior to your appointment and made arrangements for payment. We accept cash, personal checks, Visa and MasterCard. If you should have a check returned from your bank for any reason, there will be a $25.00 charge in addition to the amount of the check which must be paid in cash or with a money order prior to your next visit. We will file claims with your insurance company for office visits and procedures, however, if your insurance does not pay within 90 days, you will be responsible for the bill. If it becomes necessary to send your account to an outside collection agency, their fees will be added to your balance.
2. If you need to cancel or reschedule your office visit please call 24 hours in advance. If you fail to cancel and do not keep your appointment you will be charged $25.00. **This will be due from you at your next visit and cannot be billed to your insurance**.
3. Please limit phone calls to the office to 1 call and 1 message, multiple calls only delay the process. Please allow 24 to 48 hours for a return call.
4. In regards to prescription refills please contact your pharmacy and they will fax us a request. There are NO prescription refills after hours or on weekends or holidays. NO EXCEPTIONS!
5. If you require a copy of your medical records, you will be required to sign a release form and allow two weeks for copying. There is a charge of $1.00 for the first page and $.50 for each additional page. We will not fax records to anyone other than another physician who requests them with a signed release form.
6. Your children are welcome in the office but must remain seated and quiet at all times. If they are disruptive or destructive you will asked to reschedule your appointment for a time when you will not have to bring them with you.
7. We only treat patients with Workers' Compensation injuries with prior authorization from the insurance carrier. You must also provide us with the correct billing information before your first appointment. If you do not give us correct information and your claims are denied, you will be responsible for the entire bill.

Print Name: _____ DOB: _____

Signature: _____ Date: _____

revised 07/15

301 SW 80th St.
Oklahoma City, OK 73139
Phone: (405) 601-4227
Fax: (405) 601-4237

1616 S. Kelly Ave.
Edmond, OK 73013
Phone: (405) 330-0015
Fax: (405) 340-8804

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PAIN PATIENT's BILL OF RIGHTS

The following Office Policy of Comprehensive Pain Center, regarding the Patient's Bill of Rights, particularly with respect to Pain Management. It is an expectation that compliance with the Patient's Bill or Rights can contribute to an effective program for the patient.

1. The patient has the right to considerate and respectful care.

2. The patient has the right to obtain from the credentialed practitioner complete and current information concerning the:

   a. Diagnosis;

   b. Proposed treatment; and

   c. Expected prognosis in terms that the patient may reasonably be expected to understand.

   d. When it is not advisable to give such information to the patient, the information should be made available to an appropriate person (medical proxy) on the patient's behalf.

3. The patient has the right to receive the necessary information for the medical decision-making and the granting of informed consent form the treating credentialed practitioner prior to the start of any procedure or treatment. This information shall include at the minimum: the expected procedure or treatment to be used, who will perform the procedure or treatment, what are the likely benefits from the procedure or treatment, what alternatives exist if any, what are the likely risks from the procedure of treatment, what may occur if no treatment is undertaken, and the length of probable duration of incapacitation if any is expected.

4. The patient has the right to refuse any and all treatment to the extent permitted by law, and to be informed of any medical consequences of this action.

5. The patient has the right to every consideration of privacy concerning the medical care provided except when there is an imminent risk to the individual or others, or when the practitioner is ordered by a court to breach confidentiality.

6. The patient has the right to be advised if the practitioner, agency, or facility propose to engage in any form of human experimentation affecting the care of the treatment provided. The patient has the right to refuse to participate in research projects or to withdraw continued consent to participate without repercussions.

7. The patient has the right to examine and receive an explanation of the bill for professional services rendered.

All pain management activities are to be provided with an overriding concern for the patient, and above all, the recognition of the patient's dignity as a human being.

_____ _____

Patient Signature Date

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