Terrell Phillips, D.O.
401 SW 80th St, Bldg. D, Ste. 200
Oklahoma City, Oklahoma 73139
405-601-4227

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

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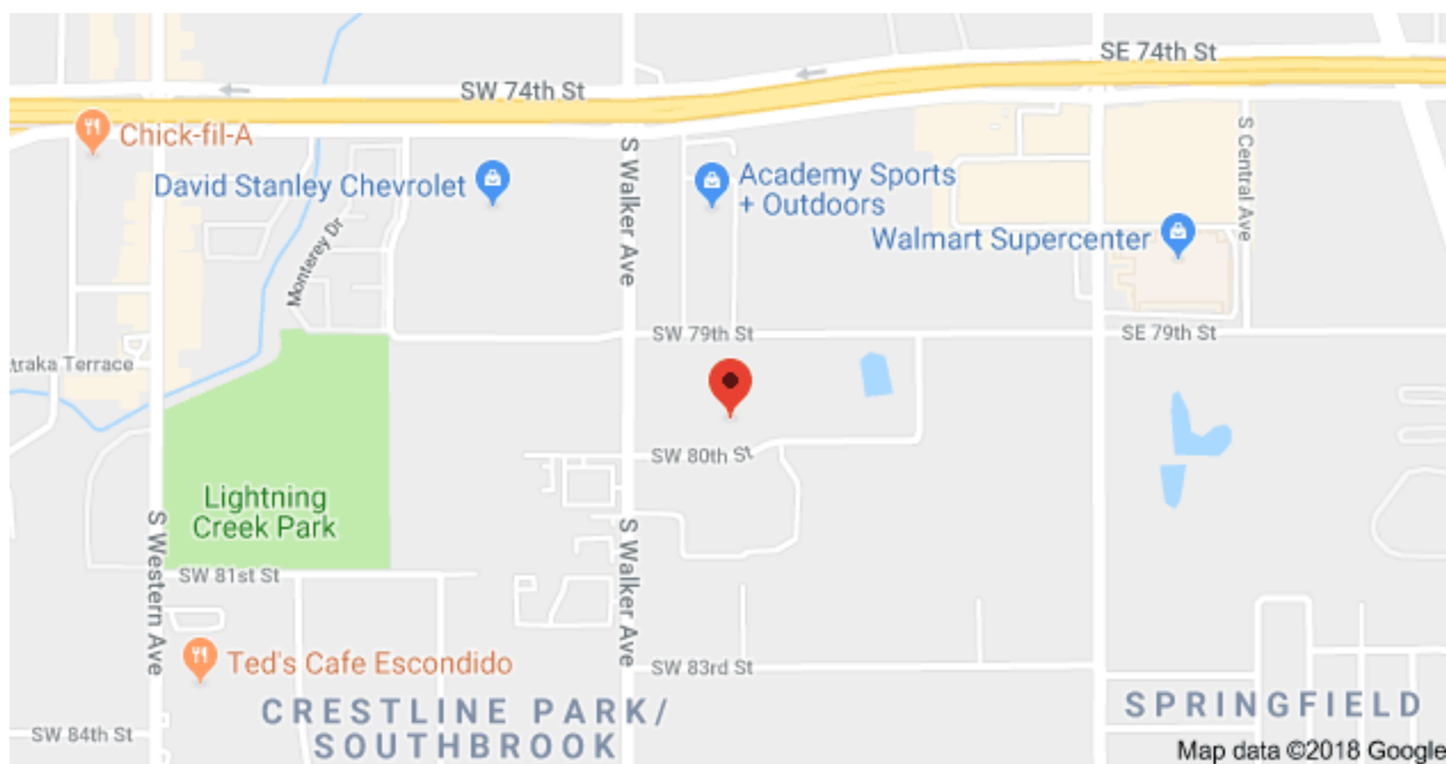
401 SW 80th St, Bldg. D, Ste. 200
Oklahoma City, Ok 73139
405-601-4227

We are located .5 miles south of 1-240 & Walker. Take I-240 to S Walker. Continue South on Walker for 0.5 miles to SW 80th St. Turn east onto SW 80th street. Clinic is a 2- story building located on the north side of SW 80th St and across the street from OCOM Surgery Center.

Parking lot is open to the public. Take elevator to 2nd floor, suite 200. Please check in at desk 30 minutes before your scheduled appointment.

Drive Safe! Remember not to text and drive!



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

Pt Documents, DEMO, Oct 2019 *Entered by:*_______

DATE:

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:** _________________

DATE:

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: _________

________________________________Date: _________

Date

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: ____

DATE:

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: ______________

DATE:

Pharmacy Name: ____ **Phone:** ___________________**Location:**_____________________________________

Medication/Supplement	Dosage	Frequency	Route	Physician	Date

MEDICATION LIST (write in medications or attach list)

DATE:

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

DATE:

Patient Goals

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

(Misc, PT GOALS, Oct 2019)