Terrell Phillips, D.O.
401 SW 80th St, Bldg. D, Ste. 200
Oklahoma City, Ok. 73139
Phone: 405-601-4227
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Website - http://okcomppain.com
Email – rileyw@okcomppain.com

We are pleased to inform you that **Comprehensive Pain Center has accepted you as a pain management referral patient**. We look forward to meeting you and assisting with your pain management needs.

Included with this letter is the necessary NEW PATIENT PACKET. The next step in this process is for you to complete the paperwork and mail, fax or hand deliver to our clinic. Please understand, we will not be able to schedule your appointment until we receive this paperwork back completed in our office. Once the completed paperwork is received by our Medical Scheduler, you will be contacted, by the phone number listed on your paperwork, to verify information and schedule your first appointment. Please do not send your personal healthcare information through an unsecure method.

_____NEW PATIENT PACKET- Complete paperwork and send back to office. The Medical Scheduler will contact you, with number on paperwork, to schedule an appointment once paperwork is received. **Please direct all questions to rileyw@okcomppain.com**

Bring to scheduled appointment
Additional paperwork and disclosures will need to be completed once arriving to the appointment. Please be prepared to arrive 30 minutes prior to appointment and allow 1 -2 hours for the appointment. If you are unable to speak English or write – you will need to bring someone to assist you (they must be over 18 years of age).

_____Referred for NEW PATIENT INJECTION – **EXCLUDE ITEMS #4**

_____Referred for NEW PATIENT APPOINTMENT FOR MEDICATIONS – **BRING ITEMS 1-5**

_____Referred for CONSULTATION APPOINTMENT – **BRING ITEMS 1-5**

1. Your Driver's License
2. Your Current Insurance Card(s)
3. Your Co-Pay (must be paid before seeing the Physician or Advanced Practitioner).
4. Bring all **prescription medication** bottles with you. (exclude if injection only patient)
5. Bring current MRI, X-RAY or CT Scans (Paper reports only)

(Clinic directions on back of page)

Comprehensive Pain Center
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!

DATE:

PATIENT INFORMATION:

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

SS#: _____ Marital Status: _____ Male or Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Phone number preferred for voice mail communication: _____ I prefer to OPT OUT _____

Clinic may communicate (Circle) All Info, Appointment Reminders, Lab Results, Prescription Information, and General Health Info

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

Employer: _____ Address: _____

Occupation: _____ Level of Education: _____

Email Address: _____

Emergency Contact: _____ Phone Number: _____

Race: (please circle one)

American Indian/Alaska Native Black/African American White Asian

Native Hawaiian/Pacific Islander Other Race: _____

Ethnicity: Hispanic/Latino Other Ethnicity: _____

Primary Language: English Spanish Other: _____

Primary Care Physician: _____ Referring Physician: _____

Primary Pharmacy: _____ Phone number: _____

Address: _____ City: _____State: _____ Zip code: _____

Primary Insurance: _____ Effective Date: _____

Name of Insured: _____ Date of Birth: _____ Relationship: _____

Employer: _____ Member ID: _____Group #: _____

Employer Address: _____

Secondary Insurance: _____ Effective Date: _____

Name of Insured: _____ Date of Birth: _____ 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: _____

Comprehensive Pain Center
Terrell R. Phillips, D.O.

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: _____.**

)

Comprehensive Pain Center
Terrell R. Phillips, D.O.

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: _____

(Med Hist, New, 2/11/19)

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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:

_____

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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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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 Park: _____Date: _____ Facility: _____

Body Park: _____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:

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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** _____/1