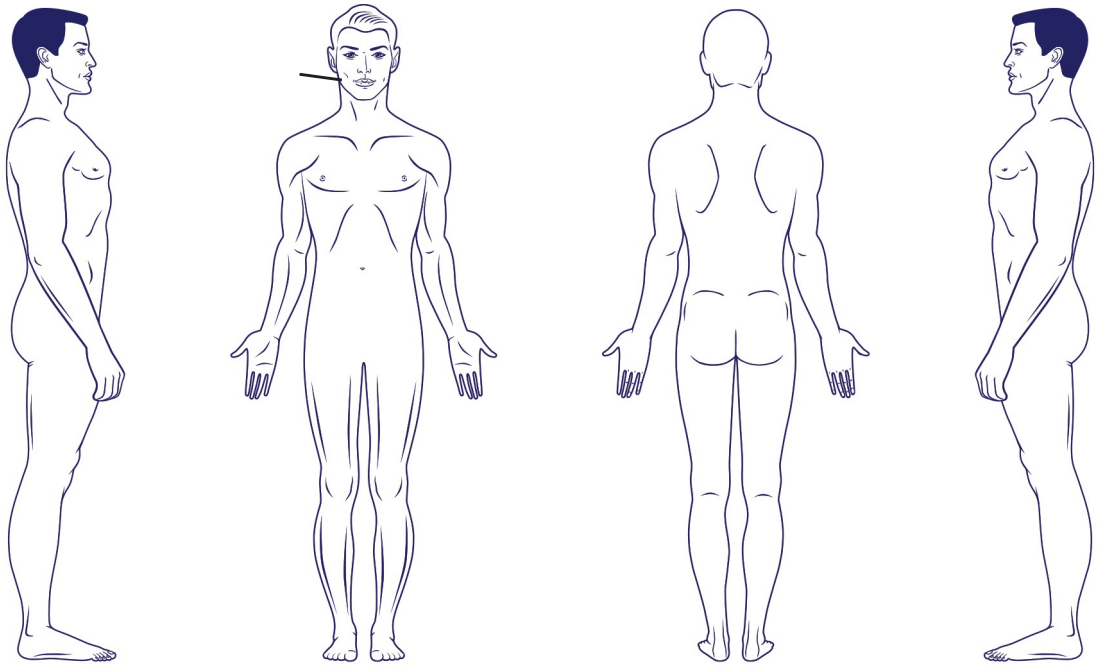
SPINE & JOINT
PAIN SPECIALISTS
WM. ALEC TISDALL, MD AND ASSOCIATES

WESTOVER HILLS • STONE OAK • SCHERTZ
(210) 541-0700 • Fax: (210) 541-6868
PainSanAntonio.com

Patient Name: _____

MARK ON THE PICTURE WHERE YOU ARE HAVING PAIN

ALSO MARK (X) FOR NUMBNESS, (T) FOR TINGLING, (B) FOR BURNING



DURATION OF PAIN:

❑ 1-4 weeks ❑ 1-3 months ❑ 3-6 months ❑ Less than 1 year ❑ More than 1 year ❑ Many years

Was this the result of a work accident? ❑ Y ❑ N

HOW OFTEN DOES THE PAIN OCCUR?

❑ Continuously ❑ Constantly (76-100% of the day) ❑ Frequently (51-75% of the day) ❑ Occasional (26-50%of the day)
❑ Intermittently (0-25% of the day) ❑ Less than daily ❑ Monthly

SELECT ONE OR MORE ITEMS BELOW TO DESCRIBE THE NATURE OF YOUR PAIN:

❑ Throbbing ❑ Shooting ❑ Sharp ❑ Cramping ❑ Hot/Burning ❑ Aching ❑ Stabbing ❑ Tingling ❑ Numbing ❑ Dull-ache

HOW DO THE FOLLOWING FACTORS AFFECT YOUR PAIN?

	Worse	Better	No Effect
Standing	❑	❑	❑
Walking	❑	❑	❑
Sneezing	❑	❑	❑
Coughing	❑	❑	❑
Weather	❑	❑	❑
Lifting	❑	❑	❑
Lying Down	❑	❑	❑
Sitting	❑	❑	❑

Pain Treament Goals:

A. I would like my pain ❑ **Improved** ❑ **Maintained**

B. I would like to be able to ❑ **Increase/Improve my daily activities**

Current Pain Score _____ **(0-10, 10 being the worst pain)**

Best Pain Score _____ **w/pain medication?** ❑ **Y** ❑ **N**

Worst Pain Score _____ **w/pain medication?** ❑ **Y** ❑ **N**

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CHECK THE TREATMENTS YOU HAVE HAD FOR PAIN:

❑ Acupuncture ❑ Physical Therapy ❑ Trigger Points ❑ Massage ❑ Exercise ❑ TENS Unit
❑ Chiropractor ❑ Brace ❑ Surgery ❑ Facet Blocks ❑ Radiofrequency neurotomy
❑ Epidural ❑ Nerve Blocks ❑ Biofeedback ❑ Other _____

IMAGING STUDIES/TESTS DONE:

❑ MRI ❑ CT Scan ❑ X-rays ❑ EMG/NCV Results of Test _____

PAST MEDICAL HISTORY (Circle all that apply)

Constitutional
Obesity Weight Loss Weight Gain Cancer

Musculoskeletal
Arthritis Fibromyalgia Muscle spasms

Neurological
Headache Seizures Migraines Stroke

Psychiatric
Depression Substance Abuse Anxiety
Bipolar Schizophrenia

Cardiovascular
Angina Heart Attack Heart Stent
Pacemaker High Blood Pressure (Hypertension)

Respiratory
Asthma Emphysema Chronic Bronchitis
Lung Cancer Obstructive Sleep Apnea COPD

Gastrointestinal
Reflux HepatitisUlcer
Irritable Bowel Syndrome Heartburn
Cirrhosis Diverticulitis Colon Cancer

Genitourinary
Impotence Kidney Stones Incontinence

Endocrine Hematologic Allergy/Immunologic
Diabetes Hypothyroidism Hyperthyroidism
HIV Hyperlipidemia (Elevated Cholesterol)
Leukemia Lymphoma Multiple Myeloma

Rheumatologic
Lupus Sjogrens Scleroderma
Polymyalgia Rheumatica Rheumatoid Arthritis.

REVIEW OF SYSTEMS (Circle all that apply)

Constitutional
Chills Fever Fatigue

Musculoskeletal
Numbness Weakness

Neurological
Confusion Dizziness Light Sensitivity
Loss of Consciousness

Psychiatric
Difficulty Sleeping

Cardiovascular
Chest Pain Palpitations

Respiratory
Cough Shortness of Breath

Gastrointestinal
Diarrhea Constipation Abdominal Pain
Bloating Nausea Vomiting

Genitourinary
Decreased Libido Urinary Frequency

Endocrine Hematologic Allergy/Immunologic
Easy Bruising Ringing In Ears

Surgical History (Check all that apply)

❑ Appendectomy ❑ Tonsillectomy/Adenoids ❑ Gallbladder Surgery ❑ Coronary Bypass ❑ Hernia Repair ❑ Tubal Ligation
❑ Mastectomy ❑ Hysterectomy ❑ Breast Biopsy ❑ Prostate ❑ Vasectomy ❑ Knee Replacement
❑ Hip Replacement ❑ Knee Surgery ❑ Shoulder Surgery ❑ Cataracts ❑ Colon ❑ Liver Surgery

Lumbar Spinal Surgery/ Back Surgery: _____
Cervical Spinal Surgery/ Neck Surgery: _____
Other: _____

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Patient Name: _____

WOMEN: Are you pregnant? ❑ YES ❑ NO ❑ NOT SURE PATIENT'S INITIALS ___

SOCIAL HISTORY:

Do you smoke/vape? ❑ YES ❑ NO How much per day? _____ How many years? _____

Do you drink alcohol? ❑ YES ❑ NO How much per day? _____ How many years? _____

Do you use illicit drugs? ❑ YES ❑ NO How much per day? _____ How many years? _____

FAMILY HISTORY:

CONDITIONS	DIABETES	HEART	ANXIETY	KIDNEY	CANCER	DEPRESSION	BACK	OTHER
MOTHER	❑	❑	❑	❑	❑	❑	❑	❑
FATHER	❑	❑	❑	❑	❑	❑	❑	❑
BROTHER(S)	❑	❑	❑	❑	❑	❑	❑	❑
SISTER(S)	❑	❑	❑	❑	❑	❑	❑	❑

ALLERGIES:

❑ Latex ❑ IV Contrast ❑ Betadine/Iodine ❑ Shellfish/Seafood

DRUG ALLERGIES:

1. _____
2. _____
3. _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

Medication	Dose	Prescribing Physician	Medication	Dose	Prescribing Physician
1.			9.		
2.			10.		
3.			11.		
4.			12.		
5.			13.		
6.			14.		
7.			15.		
8.			16.		

Are you taking any medications that are blood-thinners? ❑ Y _____ Prescriber ❑ N

Are you taking any medications that are prescription pain relievers? _____

Past pain medications tried: _____

_____

_____

I ACKNOWLEDGE THAT I HAVE COMPLETED THIS QUESTIONNAIRE ACCURATELY AND TO THE BEST OF MY KNOWLEDGE

_____ _____

Patient or Legal Guardian Signature **Date**

DATE: _____ Name: _____

Date of Birth: ____/____/_____

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

 The SOAPP®-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.

PainEDU.org
IMPROVING PAIN TREATMENT THROUGH EDUCATION

TELEMEDICINE INFORMED CONSENT

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting Spine & Joint Pain Specialists at 210-541-0700.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____ _____

Patient/Parent/Guardian Printed Name Patient/Parent/Guardian Signature

_____ _____

Witness Signature Date