CRPS and Neuropathic Pain Center of America

CRPS and Neuropathic Pain Center of America

CONFIDENTIAL PATIENT MEDICAL HISTORY

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| | | | | | |
|---|---|---|---|---|---|
| Name: | | Date Of Birth/Age: | | | |
| Email Address: | | Mobile phone number: | | | |
| Address: | | City: | | | |
| State: | | Zip: | | Country: | |
| Primary Language: | | Male<br>Male<br>Female<br>Female | | | |

Primary Care Physician:

| | | | |
|---|---|---|---|
| If Under 18 years of age and accompanied by parent(s): | | | |
| Mother: | | Father: | |

| | |
|---|---|
| Marital Status: | Single<br>Single<br>Widowed<br>Widowed<br>Divorced<br>Divorced<br>Separated<br>Separated<br>Married<br>Married |
| Employment Status: | Employed<br>Employed<br>Retired<br>Retired<br>Unemployed<br>Unemployed<br>Student<br>Student<br>Disabled<br>Disabled |

| | |
|---|---|
| Patient Occupation: | |
| Employer: | |
| Disability: | Completely disabled/Date:<br>Completely disabled/Date:<br>Partially Disabled<br>Partially Disabled<br>Not Disabled<br>Not Disabled |
| Emergency Contact Person & phone number: | |
| Relationship: | Spouse<br>Spouse<br>Parent<br>Parent<br>Other<br>Other<br>Guardian<br>Guardian<br>Friend<br>Friend |
| Driver License Number: | |

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|---|---|
| How did you hear about us? | Advertisement<br>Advertisement<br>Internet<br>Internet<br>Former Patient<br>Former Patient<br>Social Media<br>Social Media<br>Facebook<br>Facebook |

I, the undersigned certify that I (or my dependent) have insurance coverage and that I am responsible for filing with my insurance for reimbursement. It is not the responsibility of CRPS and Neuropathic Pain Center of America to collect payment from your insurance company. Payment is REQUIRED at the time of service. Your signature below indicates that you are financially responsible for all charges incurred during your visit. You are responsible for all amounts.

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| Signature of Patient or Legal Guardian: | Date: |

**REQUIRED PAPERWORK AND FILMS**

By signing below, you the patient acknowledge that you have read, understand, and agree to the policies and procedures of outpatient treatment as defined in the.

Regarding your upcoming appointment with Dovie McVean MS, PA-C. You will need the following: 1. Completed new patient paperwork 2. Driver's license or photo ID 3. Films for any prior imaging related to the body part we will be seeing you for (X-rays, MRI's, CT Scans, discograms, myelograms, etc.) and associated reports. Even if the referring doctor's office is to send these films and tests, we ask that you request your own copy to bring to the appointment to avoid rescheduling your appointment. 4. Operative reports for any prior procedures related to the body part we will be seeing you for (EMG/NCV, Epidural Steroid injections, Facet Joint injections, Rhizotomy, etc.). Our Hurst office is located at 729 W. Bedford-Euless Rd. Ste 206. Hurst. TX 76053. Please call for directions. You can reach us by calling 817-714-7710. If you need to cancel your appointment, please give us 24 hour notice or you could be charged $100.

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| Signature of Patient or Legal Guardian: | Date: |

**PAIN MANAGEMENT AGREEMENT**

Your signature on this agreement means that you will follow all the terms below. It also is an understanding that you are to follow the plan of care and will not receive Opioid prescriptions from Dr. Robert Myles MD or Dovie McVean MS, PA-C office.

I understand that I am currently under the care of another doctor for my pain management, or I will be referred to another doctor for my pain management. It is my responsibility to make appointments with my pain management doctor. I will not come to the Dr. Robert Myles MD or Dovie McVean MS, PA-C office or request by phone, prescription refills or new prescriptions from Dr. Robert Myles MD or Dovie McVean MS, PA-C. This includes and is not limited to pain medication or other controlled substances. If I am unable to keep the appointments, decide to change pain management doctors or am terminated from my pain management doctor, I will not contact Dr. Dr. Robert Myles MD or Dovie McVean MS, PA-C during this interim for refills or new prescriptions. I assume full responsibility for re-establishing pain management care. I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by all physicians involved in my care.

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| Signature of Patient or Legal Guardian: | Date: |

## PRIVACY INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Name: | | Date Of Birth/Age: | | | |
| Email Address: | | Mobile phone number: | | | |
| Address: | | City: | | | |
| State: | | Zip: | | Country: | |

- Please list the names of family members or other persons, if any, who we may inform about your general medical condition and you diagnoses:

- 

- Please list the names and phone numbers of family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

- 

- Please print the address of where you would like your correspondence from our office to be sent if other than your home.

- 

- NO

NO
YES
YES

- Please print the telephone number, if any, where you want to receive calls about your appointments, lab or other health care information if other than your home number:

- 

- YES

YES
NO
NO

- 
- 

| | |
|---|---|
| Signature of Patient or Legal Guardian: | Date: |

## PAST MEDICAL HISTORY

Please complete the following information as accurately as possible. All information is confidential.
How did the injury occur and when did it start? Use a separate piece of paper if needed. Location of Pain:

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Location of Pain:

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Pain Drawing: (Allodynia: areas of very sensitive skin, you feel pain from light touch, pressure from clothing, water, breeze)

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| X= Allodynia |
| X= Allodynia |
| N=Numbness |
| N=Numbness |
| S=Stabbing |
| S=Stabbing |
| P=Pain |
| P=Pain |
| P=Pins & Needles |
| P=Pins & Needles |
| B= Burning |
| B= Burning |
| A= Ache |
| A= Ache |

How long have you been in pain? _____
How would you describe your pain?

- Aching Throbbing Shooting Stabbing Gnawing Sharp Tender

- Burning Exhausting Dull Knife-like Spasms Other

When dose your pain occur?

Constantly Occasionally With Activity Daily Weekly Monthly

Since the pain began, the pain has:

Increased Decreased Has not Changed

Does the pain wake you up at night?

Yes No

What makes your pain better?

Lying down Sitting Standing Walking Movement/Exercise

Inactivity Nothing Other:_____

What makes your pain worse?

Walking Sitting Standing Lifting Typing Writing

Reaching Twisting Riding in a car Other:_____

Overall: On a Scale 0-10, how would you rate your pain on the Average?

Previous Treatments (Check all that tried):

Psychologist Exercise Acupuncture TENS Unit Physical Therapy

Ice/Heat Pack Massage Brace Traction Epidurals

Nerve Block Pool therapy Spinal Cord Stimulator Bio-Feedback

Trigger point injections Facet joint injections Rhizotomy

Other: _____

Does this pain Interfere with your interpersonal relationships?

Yes No

Gardasil HPV Vaccine: If you have had the HPV Vaccine, have chronic pain and have been diagnosised with CRPS. Did the CRPS present before or after the vaccine?

Have you used any of the following?

**NSAIDS:** aspirin, Motrin, diclofenac, Advil, ibuprofen, naproxen

**Sleep Aids:** Ambien, Restoril, Benadryl

**Neuropathic Pain Meds:** **Neurontin, Gabapentin, Pregabalin, Lyrica, Tegretol,** Dilantin, baclofen, Ultram, prazocin

**Antidepressants:** Elavil, Amitriptyline, Prozac, Effexor, Zoloft, Deseryl, Paxil, Parmetor

**Narcotics:** Vicodin, Tylenol 3, Codeine, Percocet, Percodan, MS contin, Oxycontin, Demerol, Morphine, Methadone, Dilaudid

**Relaxants:** Flexeril, Valium, Xanax, Ativan, Skelaxin

Anti-inflammatory Oral Steroids Topamax Ketamine Lamotrigine Trileptal Medical Marijuana or Recreational Last Used?_____

Alcohol If yes, how much?_____ How Long?_____

Smoke Yes No Did you ever smoke?_____ Last Smoked?_____ How Much?_____

How many years?_____

Allergies:

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Current Medications with dose and how often(attach to additional paperwork if needed):

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Past Surgical history or Past Injury and dates:

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| **ATTENTION: Cannot do treatment if you've had the following surgeries aneurysm clips (Non-Ferromagnetic clips/plates are ok), vena cava clips, skull plate, spinal cord stimulator, pain pump, pacemaker, automatic defibrillator** |

Past Medical Problems/ Illnesses? (Check all that apply)

NO KNOW MEDICAL PROBLEMS OR ILLNESSESS

ATTENTION: Cannot do treatment if you have had the following past medical history epilepsy, heart attack or myocardial infraction within the last six months, severe heart arrhythmias, brain damage from trauma (neuropathic pain can be treated)

| | Y | N | | Y | N |
|---|---|---|---|---|---|
| CRPS/RSD | | | Vulvodynia | | |
| Sciatica | | | Diabetes | | |
| Failed Back Surgery | | | High Blood Pressure | | |
| Failed neck Surgery | | | Angina (Chest pain) | | |
| Phantom Limb Pain | | | Sickle Cell | | |
| Trigeminal Neuralgia | | | Heart disease | | |
| Diabetes Peripheral Neuropathy | | | High Cholesterol | | |
| Chemotherapy Peripheral Neuropathy | | | Lupus | | |
| Brachial Plexus Neuropathy | | | Lyme disease | | |
| Post Herpetic Neuropathy | | | Rheumatoid arthritis | | |

| | | | | | |
|---|---|---|---|---|---|
| TMJ | | | Emphysema | | |
| Fibromyalgia | | | Ulcerative colitis | | |
| Pudendal Neuropathy | | | Crohn disease | | |
| Oncologist Pain Resistant to Drug Treatment | | | Cancer | | |
| MS | | | Blood clots in legs | | |
| Depression | | | Stomach ulcers | | |
| Anxiety | | | Hepatitis | | |
| Asthma | | | **Epilepsy** | | |
| Thyroid Disease | | | Jaundice | | |
| AIDS/HIV | | | Stroke | | |
| Kidney disease | | | Tuberculosis | | |
| Bipolar Disorder | | | Glaucoma | | |

Other:_____

FAMILY HISTORY:

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REVIEW OF SYSTEMS

| **Constitutional Symptoms** | | Y | N |
|---|---|---|---|
| | Fever | | |
| | Chills | | |
| | Headache | | |
| **Eyes** | | | |
| | Blurred Vision | | |
| | Double Vision | | |
| | Pain | | |
| **Neurological** | | | |
| | Tremors | | |
| | Dizzy Spells | | |
| **Endocrine** | | | |
| | Excessive Thirst | | |
| | Too Hot or Cold | | |
| | Tired/sluggish | | |
| **Gastrointestinal** | | | |

| | | | |
|---|---|---|---|
| | Abdominal Pain | | |
| | Nausea/vomiting | | |
| | Indigestion/Heartburn | | |
| | Ulcer | | |
| **Cardiovascular** | | | |
| | Chest Pain | | |
| | Varicose Veins | | |
| **Skin** | | | |
| | Skin rash | | |
| | Boils | | |
| | Persistent Rash | | |
| **Musculoskeletal** | | | |
| | Joint Pain | | |
| | Neck Pain | | |
| | Back Pain | | |
| **ENT** | | | |
| | Ear Infection | | |
| | Sore Throat | | |
| | Sinus Problems | | |
| **Genitourinary** | | | |
| | Urine Retention | | |
| | Painful Urination | | |
| | Urinary Frequency | | |
| **Respiratory** | | | |
| | Wheezing | | |
| | Frequent Cough | | |
| | Shortness of Breath | | |
| | Chronic cough | | |
| **Hepatologic/Lymphatic** | | | |
| | Swollen Glands | | |
| | Blood Clot | | |
| | Anemia | | |
| | Sickle cell | | |
| **Cancer** | | | |
| | Chemotherapy | | |
| | Radiation | | |

ADDITIONAL COMMENTS:

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By my signature below, I attest that the above information is true and accurate:

I herby acknowledge, by my signature below, I am authorizing Dr. Robert Myles MD and Dovie McVean MS, PA-C, CRPS and Neuropathic Pain Center of America, or their specified agent(s), to preform diagnostic and therapeutic procedures they may deem medically necessary to adequately evaluate and treat my condition.

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| Signature of Patient or Legal Guardian: | Date: |