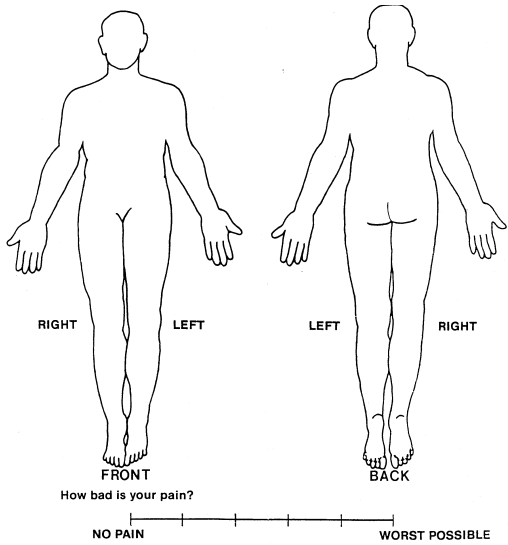




# CAPITOL PAIN INSTITUTE

S.MATTHEW SCHOCKET, M.D.  
RAIMY AMASHA, M.D.  
ANJULI DESAI, M.D.  
SAMEER SHARMA, M.D.



### Review of symptoms:

- Constitutional:  Fatigue  Insomnia  Fever/chills
- Weight loss/gain  Night sweats
- Psychological:  Depression  Anxiety
- Neurological:  Dizziness  Weakness
- Numb/tingling
- Muscular:  Spasms  Tightness  Joint pain
- CV:  Chest pain  Palpitations
- Respiratory:  Cough  Shortness of breath
- GI:  Heartburn  Nausea/vomiting
- Diarrhea  Constipation
- GU:  Incontinence (bowel or bladder)

### Past Medical and Social History:

Have you been diagnosed with any new problems by another doctor?  Yes  No  
If yes, please list any new diagnosis: \_\_\_\_\_

Have you been prescribed any new medications by another doctor?  Yes  No  
If yes, please list new medications: \_\_\_\_\_

Have you had any lab work, x-rays, or other studies (since last visit?)  Yes  No

Area of Pain #1: \_\_\_\_\_

Area of Pain #2: \_\_\_\_\_

Average pain score in this area (0-10): \_\_\_\_\_

Average pain score in this area (0-10): \_\_\_\_\_

What does the pain feel like? \_\_\_\_\_

What does the pain feel like? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it better? \_\_\_\_\_

Worse? \_\_\_\_\_

Worse? \_\_\_\_\_

Since your last visit is the pain better, worse, or the same (circle one?)

Since your last visit is the pain better, worse, or the same (circle one?)

Capitol Pain Institute  
Established Patient Visit  
Confidential

Patient:  
DOB:  
Date:



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Long Acting Opioid (OxyContin, MSER/MS Contin/Kadian, Opana ER, Fentanyl patch, Methadone, Embeda, Avinza)

On average, how long does the pain relief last? \_\_\_\_\_  
On average, what is your pain score (0-10) before taking the medication? \_\_\_\_\_  
On average, what is your pain score (0-10) after taking the medication? \_\_\_\_\_

Short Acting Opioid (Hydrocodone/Norco/Vicodin/Lortab, Oxycodone/Percocet, Morphine IR, Dilaudid/Hydromorphone, Opana, Nucynta, Suboxone)

On average, how soon do you start to feel relief after taking the medication? \_\_\_\_\_  
On average, how long does the pain relief last? \_\_\_\_\_  
On average, what is your pain score (0-10) before taking the medication? \_\_\_\_\_  
On average, what is your pain score (0-10) after taking the medication? \_\_\_\_\_

Do the medications help improve your activity level? \_\_\_\_\_  
Do the medications improve your quality of life? \_\_\_\_\_

Are you having any of the following side effects?  Other \_\_\_\_\_

Nausea  Constipation  Itching  Fatigue  Drowsiness

## **PLEASE BE SURE TO READ THE FOLLOWING:**

**Taking more medication than you are prescribed or combining your prescription medications with other prescription medications, alcohol, or illicit drugs can be very dangerous and result in significant side effects including, but not limited to severe respiratory depression and possible even death. If your prescribed medications are not effectively controlling your pain, please call the office for instructions. Do not take more medications than prescribed without the permission of this office.**

**Urine drug screening of patients receiving pain medications is mandated by Texas Law. Pursuant to Chapter 107, Subchapter B, Section 107.052 (2) of the Texas occupations Code, you may be requested to provide a urine sample for the purposes of drug screening. The results of these screens are entirely confidential and cannot be released without your written consent. If you believe that this is inappropriate, please contact your state Representative or state Senator.**

I attest and certify that all of the following statements are true and factual:  
**PLEASE INITIAL EACH ITEM ON THE LINE PROVIDED AND SIGN AT THE BOTTOM**

\_\_\_\_\_ I have used all medications prescribed to me exactly as prescribed.  
\_\_\_\_\_ All of the answers provided on this form are true and factual.  
\_\_\_\_\_ I have accurately reported all side-effects to my physician.  
\_\_\_\_\_ I have not sold, diverted, or otherwise transferred my medication(s) to anyone, including safeguarding my medications from theft.  
\_\_\_\_\_ I have not received, accepted, or taken any other opioid medications from any source, including prescriptions from other physicians.  
\_\_\_\_\_ I have not received, accepted, taken, or otherwise used any illicit drugs pursuant to my opioid agreement.

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Patient:  
DOB:  
Date: