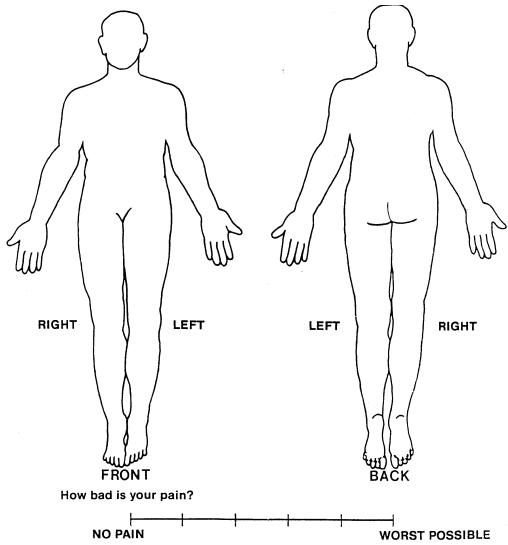




CAPITOL PAIN INSTITUTE

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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Confidential

Patient:
DOB:
Date: