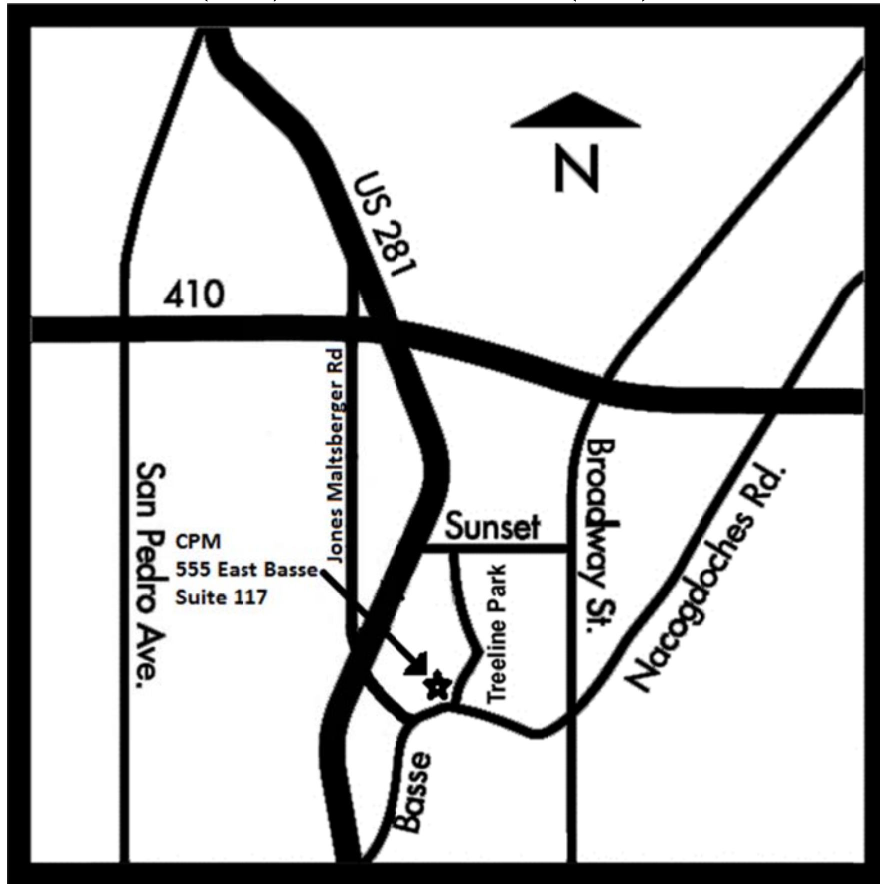
Consultants in Pain Medicine, P.A.

Stephanie S. Jones, M.D.

WWW.CIPM.COM

Phone (210) 546-1430 Fax (210) 546-1439



555 E Basse Suite 117; San Antonio, Texas 78209

Located in the Village on the Green shopping center at the corner of East Basse and Treeline Park.

Coming South on US 281:
Exit at Sunset (after Airport Exit) and follow road to stop light on Sunset. Take a left on Sunset and go under the freeway. Go to stop light and take a right onto Treeline Park. Continue for .7 miles. Turn Right into the Village on the Green shopping center.

Coming North on US 281:
Exit at E. Basse and turn right on to Basse. Go to Treeline Park and take a left. Turn Left into the Village on the Green shopping center.

Coming west on Loop 410 (heading west):
Exit on Broadway and take a left on Broadway (under 410). Come to East Basse and take a right. Turn Right onto Treeline Park. Turn Left into the Village on the Green shopping center.

Coming east on Loop 410 (heading east):
Exit at (21B Airport Blvd exit). Turn right on US 281 access road. Come to stop light at Sunset. . Take a left on Sunset and go under the freeway. Go to stop light and take a right onto Treeline Park. Continue for .7 miles. Turn Right into the Village on the Green shopping center.

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DATE:_________________

Dear Mr./Mrs./Ms.___________________________,

You have been referred to **Stephanie Jones, M.D.**, with Consultants in Pain Medicine by your physician. Please complete the enclosed information regarding your pain on the patient intake form provided for you. You must bring the questionnaire completed to the office on

____________, ________________ at ________ a.m./p.m. at our **555 E Basse Suite 117** location.
(*arrival time*) (*see map attached*)

ATTACHED WITH THE PACKET YOU MUST HAND CARRY ANY MRIs, X-RAY OR CT FILMS. IF THE FORMS ARE NOT COMPLETELY FILLED OUT AND YOU DO NOT HAVE YOUR FILMS YOUR APPOINTMENT MAY BE RESCHEDULED.

Please be aware that you are liable for any applicable co-pays at office and facility visits. Please follow up with your insurance company to be prepared for the cost that may possibly be incurred. Please bring your insurance card to your appointment. If you do not understand the questions and require assistance arrive 30/45 minutes prior to your office appointment and please call our office.

* If you are scheduled for an **injection** at the surgery center please arrive at least 1 hour prior to your procedure. **You must bring a driver**. You should not eat or drink for 6-8 hours prior to your procedure except for essential medications which can be taken with a **sip** of water only.

***Please notify our office if you are taking any Blood Thinners so we can arrange your lab work to be done prior to your procedure. Also, if you are on a blood thinner for cardiac reasons, especially an artificial heart valve, you must discuss stopping it with your primary care physician or cardiologist first. If you are placed on Lovenox, it must be stopped 12 hrs. prior to your procedure.**

We appreciate your cooperation and if you have any questions or require further assistance, please feel free to contact our office.

Thank you,

Ruth the Scheduler

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While under the care of **Stephanie Jones M.D.**, she may recommend you undergo certain procedures to maintain your pain. In that time certain medications cannot be taken. Please look over the medications below and **CIRCLE** the medication(s) that you are currently taking and return to our office signed. This will help us remind you on how to prepare for your procedure. **Please remember to continue to take all blood pressure, diabetes medication, and any other medications that you take on a regular basis that do not contain blood thinning agents**. If there is a medication you have a question about, please do not hesitate to call.

****DO NOT DISCONTINUE ANY MEDICATION IF YOU ARE SCHEDULED FOR A REGULAR OFFICE VISIT.****

*****PLEASE CHECK WITH YOUR PRIMARY CARE PHYSICIAN PRIOR TO DISCONTINUING ANY PRESCRIBED ANTICOAGULANTS.*****

The following medications must be **STOPPED SEVEN DAYS PRIOR** to your procedure, otherwise you will be rescheduled.

Aggrenox/Dipyridamole/ Persantine	Garlic Supplemennt	Tirofiban	Ginger
More than 1 Aspirin /day	Dalteparin/Fragmin	Vitamin E	Ginseng
Normiflo/Aredparin	Halfprin (Aspirin)	Empirin (Aspirin)	Ginko

BE SURE TO NOTIFY YOUR PRIMARY CARE PHYSICIAN PRIOR TO STOPPING PRESCRIPTION MEDICATIONS.

The following must be **STOPPED AT LEAST FOUR DAYS PRIOR** to your procedure, otherwise you will be rescheduled.

Coumadin/Warfarin	Plavix/Clopidogrel	Ticlid/Ticlopidine

The following must be **STOPPED AT LEAST 24 HOURS PRIOR** to your procedure, otherwise you will be rescheduled.

Lovenox/Enoxaparin

The following medication may be taken until the day of your procedure:

No more than 1 aspirin per day, Tylenol, non-steroidal anti inflammatory drugs (i.e., motrin, advil, aleve, naprosyn, mobic…)

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I hereby authorize Consultants in Pain Medicine, Inc., to take my photograph for inclusion in my medical chart retained by the clinic. I understand this photograph is solely for the purpose of identification and familiarization by the office staff and the clinic physician(s).

____
Patient Signature

Please fill out and sign the following release form so we can obtain copies of any medical records that may be needed in order to assess your condition more thoroughly.

Date:__________________

I, _________________________ hereby authorize the release of my medical records to Consultants in Pain Medicine.

______________________________ __________________________
Patient Signature Date

______________________________ __________________________
Witness: Date

Information Form DATE:________________

Name:________________________________ Date of Birth:____________________ Age:_______

Employer:________________________________ Occupation:______________________________

Do you work now? Yes No Part Time What does your work involve?______________________

____

____

Name of Doctor who referred you?_________________________ List of other Doctors you have seen for this pain problem:____

____

Names of other Doctors you see for other medical reasons:________________________________

____

How long have you had your pain? ____

Give details of injury or circumstances causing your pain:_______________________________

____

____

____

Were you injured on the job? Yes No Is there an attorney involved? Yes No

How and when were you treated for this problem?____________________________________

____

____

____

Have you had surgery for this problem? Yes No

If yes, give:	Date	Hospital	Name of surgeon
	_______________	_____________________________	___________________________
	_______________	_____________________________	___________________________
	_______________	_____________________________	___________________________

Tests performed: X-Rays MRI CT Scan EMG Bone Scan Discogram Other Tests

Where & When:____

What is your pain status now? Worse Better Same Has it changed?____________ How?_______

____

____

____

What other treatments have you received? (i.e., bedrest, physical, therapy, hypnosis, chiropractic manipulation, acupuncture, injections) Please list details:

Treatment:____

Where:____

When: ____

MEDICATIONS

Please list medications to which you are ALLERGIC, and the type of reaction to each (i.e. rash, upset stomach, etc…..): ____

____

Please list medications you have previously taken **for pain**:

MEDICATION	HELPFUL?	REASON FOR STOPPING USE

Please list medications you are CURRENTLY TAKING FOR PAIN:

MEDICATION	DOSAGE	TIMES/DAY	HELPFUL?	DOCTOR

Please list other medications you are CURRENTLY TAKING (include vitamins, etc.):

MEDICATION	HELPFUL?	DOCTOR

Please circle on a scale of 0 to 10 (0 is no pain……10 is the worst imaginable)

AT ITS BEST 0 1 2 3 4 5 6 7 8 9 10

MOST OF THE TIME 0 1 2 3 4 5 6 7 8 9 10

AT ITS WORST 0 1 2 3 4 5 6 7 8 9 10

For the following descriptions, place a SINGLE number for each word that describes you pain:

NONE = 0 MILD = 1 MODERATE = 2 SEVERE = 3

THROBBING	______	HEAVY	______
SHOOTING	______	TENDER	______
STABBING	______	SPLITTING	______
SHARP	______	TIRING/EXHAUSTING	______
CRAMPING	______	SICKENING	______
GNAWING	______	FEARFUL	______
HOT/BURNING	______	PUNISHING/CRUEL	______

Married? Yes No

How many children do you have?____________

Level of Education?_______________

What type of work do you do?____

Have you lost or gained weight in the last six months? Yes No

How many pounds? Lost___________lbs. Gained___________lbs.

Do you: Drink alcoholic beverages? Yes (Amt) ___________ No Smoke? Yes (Amt)__________ No

Have you ever been treated for addiction to alcohol or any other substance? Yes No

Do you currently take any illegal drugs or have you taken any narcotics in a non-prescribed manner? Yes No

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FAMILY HISTORY (Circle all that apply TO YOUR BLOOD RELATIVES)

Asthma	Genetic Disorders	Kidney Problems
Arthritis	Headaches	Lung Problems
Cancer	Heart Problems	Seizures
Diabetes	High Blood Pressure	Tuberculosis

Other:____

Please circle any of the following that APPLY TO YOU

Anxiety	Constipation	GI Bleed	Heart Problems	Kidney Problems	Tuberculosis
Arthritis	Depression	Glaucoma	HIV	Lung Problems	
Asthma	Diabetes	Hepatitis	High Blood Pressure	Stomach Ulcer	
Cancer	Genetic Disorder	Headaches	Impotence	Seizures	

Other:____

Please list previous surgeries:

DATE	PROCEDURE	SURGEON	HOSPITAL