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PRIDE

Conquering Pain thru Function

THE ORIGINATOR OF
FUNCTIONAL RESTORATION FOR
COMPLEX MUSCULOSKELETAL DISORDERS

GETTING TO KNOW YOU

We'd like to help you get the most out of your first visit with your doctor. Your time with your doctor is valuable and we have a few suggestions to help you make the most of your visit. During this first appointment, you will be asked to provide a brief medical history and discuss any current health concerns you may have related to your injury.

To begin with, we ask that you complete the New Patient Information Packet that is included with this welcome kit. Please make sure you:

- Complete all Forms
- Sign all of the notices

If you have questions or would like assistance in completing any of these forms, please call the number on the brochure.

Talk about your medications. It's very important that you tell your doctor about all the medications you use including prescriptions, homeopathic and over the counter remedies. It is also important to let them know about any adverse or allergic reactions you have ever had to common medications.

Don't be afraid to ask questions. Your doctor or nurse is a valuable resource for health information and advice. If you are concerned about any information you receive, please talk to your nurse about it.

Thank you!

5701 Maple Ave., Ste. 100
Dallas, Texas 75235

(214) 351-6600
Fax (214) 351-6453

Facility Location

PRIDE is located at the Northwest corner of Inwood and Maple in Dallas.

From North of Dallas: Take I–35 south and exit Inwood. Take a left on Inwood to Maple and take a left on Maple.

From South of Dallas: Take I–35 north and exit Inwood. Take a right on Inwood to Maple and take a left on Maple.

From East of Dallas: Take I–30 to I-35 north and exit Inwood. Take a right on Inwood to Maple and take a left on Maple.

From West of Dallas: Take I–30 to I-35 north and exit Inwood and turn right on Inwood or take 183 and merge to I-35 south and exit Inwood. Take a left on Inwood to Maple and take a right on Maple

5701 Maple Ave. Ste. 100 ♦ Dallas, TX 75235
214-351-6600 ♦ www.pridedallas.com

Please give 24 hours notice of cancellation to avoid a service charge

Thank you!

H=_____ W=_____
P=_____ R=_____

PATIENT ASSESSMENT FORM
Rev. Date 01/10/17

PATIENT'S NAME: _____
Last First Middle

Age:_____ **Gender:** F M

Race: Caucasian African-Amer. Hispanic Asian Other:_____

Birthdate:_____ **Social Security #:_____**

Address:_____ **Home Phone#:_____**
Number & Street City/State/Zip Area Code Number

Cell Phone#:_____ **Email:_____** **Work Phone#:_____**

Name of Spouse:_____ **Emergency Contact#:_____**

Insurance Type (circle all that apply):
Work Comp (State:____) Work Comp (Federal) Group Health Medicare TX DARS

Group #:_____ **Policy#**:_____

***Medicare #:_____** **TX DARS Counselor:_____**
*Note: This facility does not accept assignment

Who is your treating physician? _____

Who referred you to us?_____

What are your worst painful (or problem) body parts (in order)?

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

7) _____ 8) _____ 9) _____

Weakness? Arm: R L Leg: R L
Numbness? Arm: R L Leg: R L

I lose control of my…Urine...how often? _____Stool…how often?_____

Which injured joint buckles, gives way or pops?_____

Does your painful area have (circle all applicable):
Unusual tenderness Swelling Temperature change Color change Hair loss Dry skin Thinner skin

When pain began (mo/yr)**?**_____ **Injury Date** (if any)…(mo/yr)?_____ **Pain Cause**: Injury Illness

If injured, how?: Lifting MVA Fall Repeat Moves
Other:_____

Mechanism of Injury: _____

Injury Type: Sprain/Strain Fracture/Dislocation Concussion Chest Abdomen Hernia Amputation

If not injured, when did pain become constant (mo/yr)?_____
When did it become disabling from work or home activities (mo/yr)?_____

Current or most recent employer:_____ **JobTitle:**_____

Address:_____ **Business Telephone#**:_____
Number/Street City/State/Zip Code Area Code Telephone

Started Job (Mo/Yr)**:**_____ **Yrs. with emp**:_____
Date you last worked full duty (mo/yr)?_____**light duty, full time** (mo/yr)?_____**Part-time** (mo/yr)?_____

If you stopped working for reasons other than your painful condition, why did you stop?_____
_____

Total time worked since pain onset (mo/yr**)?**_____ **# of jobs since pain onset?**_____
Job titles since pain onset?_____

Other activities since pain began?: Disabled Homemaker Volunteer School/Training
Total time in this position (mo/yr)?_____

What income do you receive now? $_____/wk **What income did you receive before the pain began?** $_____/wk

Please circle all current sources of income (circle all applicable**):**
Regular salary Work Comp Temp. Benefits Work Comp Perm. (Settlement) Benefits Short/Long Term Disability Spouse Second Job Child Support/Alimony Social Security (SSDI/SSI) Other Government Support Other Family Support
Explain:_____

Litigation filed OR legal representation (circle and explain**):** Work Comp 3rd Party Claim (MVA) 3rd Party Claim (Other negligence) Malpractice Wrongful Termination Fraud
Other:_____

Attorney Name(s):_____**Firm name:**_____
Phone#:_____

Which body part(s) involved in your pain has been hurt before?

Injury Date (mo/yr)	Body part(s)	# of Surgeries?	Work Lost Time (mo)
1.			
2.			
3.			
4.			

Did any of these injuries happen on the job? Y N
Which ones?_____

If your current job when your pain began is NOT available, why? (circle applicable):
Terminated Only Full Duty Available FMLA Business Closed
Other:_____

Total years employed since first job? _____yrs. **# years in your longest job?**_____yrs.
Job Title:_____

What other skills do you have? (circle all applicable):
Machine Trade Manufacturing Agricultural Clerical/Sales Service Transportation Energy (Oil/Gas)
Assembly Warehouse/Construction Medical
Other:_____

Years in school?: _____yrs. Degree: H.S. Diploma GED Associate BA/BS MA/MS
Other:_____

Country of Origin: _____ **If not US, Years in US:** _____

Have you had surgery related to <u>your current illness, injury or painful condition</u>?

	Date (mo/yr)	Operation Name	Doctor
1.			
2.			
3.			
4.			
5.			

Have you had therapeutic injections since <u>this</u> pain? Y N **Did they improve your pain** Y N

	Date (mo/yr)	Injection (Type/Location)	Doctor
1.			
2.			
3.			
4.			

What diagnostic tests do you remember having done to each injured body part?

<u>Test</u>	**<u>Body part(s)</u>**	**<u>Date</u>**	**<u>Results (if you know)</u>**
X-Ray			
CT Scan			
MRI			
Myelogram: Neck Back			
EMG/Nerve Conduction	Arms: R or L	Legs: R or L	
Discogram			
Bone Scan			
Blood Tests			

Have you seen other consultant doctors? Y N

Date	Doctor's Name	Specialty	Opinion
1.			
2.			
3.			

Has your doctor recommended surgery for you at this time? Y N
What type?_____

How do you feel about surgery at this time? (Circle applicable)
Don't need it Scared of Complications Want it but doctors don't agree

What non-operative treatment have you had for this pain problem? (circle all applicable)
Manipulation Hot/cold TENS Stretch/strengthen Aqua therapy Speech/Hearing
Cognitive Work conditioning Work hardening Counseling/biofeedback Pain clinic
Other:_____

Daily therapy_____ Therapy 3x/week_____ Therapy 2x/week_____ Therapy 1x/week _____

Are you allergic to any medication? Y N
If yes, list medication(s)
_____

What medication are you currently taking, including OTC medication (Refer to Medication History list)?

Name	Reason taking	Dose	# per day	Since when
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

What medications have you tried that failed?
_____
_____

Has any doctor determined you to be at *Maximum Medical Improvement* (MMI) or given you an impairment rating? Y N
If yes: Who?_____ Rating_____ Mo/Yr_____
If yes: Who?_____ Rating_____ Mo/Yr_____

Pain level with medication (10 is worst possible pain) _____ 0-10

What activities make the pain worse? (Circle applicable)**:**
Lifting Pushing/Pulling Reaching Bending Forward/Backward Coughing/Sneezing Standing
Sitting Climbing Squatting Kneeling During Exercise All Activities

What reduces your pain? (Circle applicable)
Lying down Manipulation Ice Heat Physical therapy Sitting Standing Walking
Medications Nothing
Other:_____

Have any of these problems caused stress for you since the pain began? (Circle all applicable):
None Finances Family relations Work Physical ability Family role Weight gain (____lbs)
Interest in sex Hobbies Lost social contacts

continue below **PROAR Testing** (for nurse use only)

What are your goals? (Circle all applicable):
None Reduce pain Return to Work Retrain for other jobs Reduce Medication Prepare for surgery
Avoid surgery Feel less stress and frustration School for new career
Learn techniques for pain control Be able to participate in family/recreational activities

Other: a)_____

b)_____

Persons you live with: None Spouse Fiancée Friends

#Children____ **Age**: Youngest____ Oldest_____
Are you: Married Single Divorced Since when (mo/yr)?:_____

Do you smoke? Y N **How much per day?_____**

Do you drink alcoholic beverages? Y N **How much per day?_____**

What is the heaviest thing you lifted this week? _____

Please indicate the activities that you are no longer able to do as a result of your pain. (Circle applicable):
Dressing Exercise Yard work Walking Shopping Sitting work Driving Housework
All Activities

How many hours out of 24 do you spend reclining (including sleep)?_____

Have you been in the hospital with other medical problems? Y N Number of times_____
Please describe:_____

Any surgeries (unrelated to current problem)?

Date (mo/yr) Surgery (Type and Body Part)

1._____

2._____

3._____

4._____

Please check any type of the following medical problems that you have been taking medications for:

_____ Allergies	_____Heart Murmurs	_____Diabetes
_____ Loss of hearing	_____Angina	_____Thyroid Disorders
_____ Vision problems, glaucoma	_____Heart Failure	_____Anemia
_____ Respiratory Disorders (Ie. Asthma, COPD, etc.)	_____High Cholesterol	_____Eczema
_____ Kidney Disease	_____High Blood Pressure	_____Cancer
_____ Prostatitis	_____Arthritis/Rheumatism	_____Sleep Apnea
_____ Colitis	_____Loss of consciousness	_____V.D.
_____ Hepatitis/Jaundice, liver problems	_____Frequent headaches/migraines	_____HIV
_____ Pancreatitis	_____Concussion/Head Injury	_____Arthritis
_____ Stomach disorders, ulcers, vomiting blood	_____Convulsions/Seizures	_____Other
_____ Heart Attack	_____Stroke	

List medications used to control the above medical problems:

_____

Do you wear a medical alert bracelet? (Diabetes, Seizures, DNR, other) Y N
If yes to the above, specify what type and explain:

_____

_____

Please fill in your family history.

Relation	Age	Age at Death	Name of Diseases
Mother			
Father			
Brother(s)			
Sister(s)			
Grandmothers			
Grandfathers			

Do you currently have any problems in the following areas? Please Check.

General: Fever, weight loss, weight gain, unusually tired, etc.	**Yes**	**No**	Explain:
Ears, Nose, Throat: Hard of hearing, stuffy nose, ear pain, buzzing ears, cough, dry mouth, etc.			
Cardiovascular: High blood pressure, low blood pressure, racing pulse, chest pain, etc.			
Respiratory: Congestion, wheezing, short of breath, cough, asthma, COPD, etc.			
Gastrointestinal: Stomach upset, diarrhea, constipation, hernia, ulcers, pain/cramps, acid reflux, etc.			
Genital, Kidney, Bladder: Painful urination, frequent urination, burning sensation, impotence, incontinence, infection, etc.			
Muscle, Bones, Joints: Muscle pain/cramps, joint pain swelling, stiffness, etc.			
Skin: Itching, rash, infection, ulcer, tumor/growths, warts, excessive dryness, etc.			
Neurological: Numbness, weakness, headaches, paralysis, seizures, tremors, tingling, etc.			
Mood: Depression, anxiety, mood swings, insomnia, psychosis, disorientation, etc.			
Endocrine: Diabetes, thyroid problems, fatigue, hair loss, hot/cold intolerance, etc.			
Blood/Lymph: Anemia, blood disorders, prolonged bleeding, frequent nose bleeds, bruise easily, high cholesterol			
Allergic/Immunologic: Recurrent infections, hay fever, food allergies, drug sensitivity, hives, redness, itching, etc.			

Your Signature: _____ Date: _____

CURRENT MEDICATION HISTORY

Please complete the following information about ALL mediations you are currently taking.

Name:	**Date of Birth:**
Allergies:	

Start Date	**Medication Name**	**Dose**	**Frequency**	**Prescribing Practitioner**	**Reason for Medication**	**End Date**

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MEDICATION HISTORY
(Please circle any medications you have *ever* taken)

Patient Name:_____ Date:_____

STIMULANTS
Ritalin, Concerta (methylphenidate)
Cylert (pemoline)
Dexedrine, Adderall (dextroamphetamine)
Provigil (modafanil)
Fastin/Adipex (phentermine)
Ephedra/Ephedrine
Daytrana
Strattera (atomoxetine)
Vyvanse

ANTIDEPRESSANTS
Viibryd
Trimipramine
Pristiq
Savella
Cymbalta (duloxetine)
Anafranil (clomipramine)
Asendin (amoxapine)
Celexa (citalopram)
Desyrel (trazodone)
Effexor (venlafaxine)
Elavil (amitriptyline)
Lexapro (escitalopram)
Ludiomil (maprotiline)
Luvox (fluvoxamine)
Nardil (phenelzine)/Marplan
Norpramin (desipramine)
Pamelor (nortriptyline)
Paxil (paroxetine)
Prozac (fluoxetine)
Parnate (tranylcypromine)
Remeron (mirtazapine)
Serzone (nefazodone)
Sinequan (doxepin)
Tofranil (imipramine)
Wellbutrin (bupropion)
Zoloft (sertaline)
Lithobid/Eskalith/Lithonate (lithium)
EMSAM/Eldepryl (selegiline)/DLPA
St.John's Wort
Inositol / Omega 3 Fatty Acids/SAM-E
Vivactil (protriptyline)

ANTI-NAUSEANTS
Vistaril, Atarax (hydroxyzine)
Zofran (ondansetron)/Kytril
Tigan (trimethobenzamide)
Phenergan (promethazine)
Marinol (dronabinol)
Compazine (prochlorperazine)
Reglan (metoclopramide)
Emetrol

ANTI-ANXIETY
Ativan (lorazepam)
Klonopin (clonazapam)
Librium (chlordiazepoxide)/Librax
Serax (oxazepam)
Valium (diazepam)
Xanax (alprazolam)
Tranxene (chlorazepate)
Buspar (buspirone)
Valerian
Kava
Phenobarbital
Meprobamate

MUSCLE RELAXERS
Dantrolene
Flexeril (cyclobenzaprine)
Lioresal (baclofen)
Norflex (orphenadrine)
Norgesic
(corphenadrine/caffeine/aspirin)
Parafon Forte/Lorzone (chlorzoxazone)
Robaxin (methocarbamol)
Skelaxin (metaxalone)
Soma (carisoprodol)
Zanaflex (tizanidine)
Botox

CENTRAL NERVOUS SYSTEM
Artane (trihexyphenidyl)
Cogentin (benztropine)
Eldepryl, Deprenyl (selegiline)
Symmetrel (amantidine)
Parlodel (bromocryptine)
Permax (pergolide)
Sinemet (levodopa/carbidopa)
Mirapex (pramipexole)
Requip (ropinerole)
Mysoline
Inderal (propranolol)
Tenormin (atenolol)
Visken (pindolol)
Dostinex
Prazosin
Terazosin
Dibenzyline

HYPNOTICS
Ambien/Intermezzo (zolpidem)
Dalmane (flurazepam)
Doral (quazepam)
Halcion (triazolam)
Noctec, Somnote (chloral hydrate)
Prosom (estazolam)
Restoril (temazepam)
Seconal (secobarbital)
Sonata (zaleplon)
Melatonin
Xyrem (GHB)
Lunesta (eszopiclone)
Rozerem (ramelteon)

NEUROLEPTICS
Abilify(aripiprazole)
Geodon (ziprasidone)
Risperdal (risperidone)
Seroquel (quetiapine)
Zyprexa (olanzapine)
Clozaril
Haldol (haloperidol)
Loxitane (loxapine)
Mellaril (thioridazine)
Moban (molindone)
Navane (thiothixene)
Stelazine (trifluoperazine)
Thorazine (chlorpromazine)
Trilafon (perphenazine)
Thorazine (chlorpromazine)
Methotrimprazine
Symbyax/ (Zyprexa-Prozac)
Invega (palloperidone)
Limbitrol
Saphris
Latuda
Fanapt

TOPICAL
EMLA Cream (lidocaine prilocaine)
Lidoderm (lidocaine patch)
Zonalon Cream (doxepin)
Capsaicin lotion
Ketamine gel/cream
Biofreeze
Salicylate/Menthol
Volran gel / Flector patch
Ketprofen gel
Clonidine gel
Gabapentin gel
Morphine gel
Amitriptyline gel
Qutenza

OPIOIDS

Fioricet/ Fiorinal with codeine
Tylenol with codeine , #2, #3,#4
Soma compound with codeine
Duragesic Patch (fentanyl)
Actiq Lozenge (fentanyl)
Nucynta (tapentadol)
Lorcet,Lortab,Norco,Vicodin,Zydone,Xodol (hydrocodone/acetominophen)
Vicoprofen (hydrocodone/ibuprofen)
Opana (oxymorhone)
Exalgo, Dilaudid (hydromorphone)
Levo-Dromoran (levorphanol)
Demerol/Mepergan Fortis (meperidine)
Dolophine (Methadone)
Darvon/Darvocet (propoxyphene)
Avinza,MS-Contin,Oramorph,Kadian (morphine)
Oxycontin, OxyIR/Roxicodone (oxycodone)
Percocet/Tylox/Endocet (oxycodone/acetaminophen)
Percodan (oxycodone/aspirin)
Buprenex /Suboxone/Subutex /Butrans(buprenorphine)
Nubain (nalbuphine)
Stadol (butorphanol)
Talwin NX (pentazocine/naltrexone)
Delsym/Dexalone (dextromethorphan)

HEADACHE MEDICATIONS

Relpax (eletriptan)
Amerge (naratriptan)
Axert (almotriptan)
Maxalt (rizatriptan)
Imitrex tablet/injection/spray (sumatriptan)
Zomig (zolmitriptan)
Frova (frovatriptan)
Bellergal (ergotamine tartrate, belladonna alkaloids, Phenobarbital)
Cafergot, Wigraine (ergotamine tartrate, caffeine)/ Methergine
D. H. E. 45 (dihydroergotamine mesylate)
Migranal nasal spray (dihydroergotamine)
Midrin (isometheptene, acetaminophen, dichloralphenazone)
Petadolex (butterbur)
Periactin (cyproheptadine)
Sansert (methysergide)
Esgic, Fioiricet (butalbitol/acetominophen/caffeine)
Fiorinal (butalbital/aspirin/caffeine)
Nimotop (nimodipene)
Calan (verapamil)
Inderal (propranolol)/ Tenormin (atenolol)
Botox
Feverfew
Magnesium/Coenzyme Q10
Lidocaine drops

ADDICTION MEDICATIONS

Revia/Trexan (naltrexone)
Catapres (clonidine)
Antabuse (disulfuram)
Ibogaine
Methadone/LAAM
Suboxone/Subutex (buprenorphine)
Campral (acamprosate)
Chantix
Prometa

NON-OPIOID PAINKILLERS

Ultram/Ultracet (tramadol)
Tylenol (acetaminophen)
Advil, Motrin, Nuprin (ibuprofen)
Aleve, Anaprox, Naprelan, Naprosyn (naproxen)
Ansaid (flubiprofen)
Arthrotec (diclotenac/ misoprostol)
Aspirin (acetylsalicylic acid)
Voltaren (diclofenac)
Celebrex (celecoxib)
Clinoril (sulindac)
Daypro (oxaprozine)
Dolobid (diflunisal)
Feldene (piroxicam)
Indocin (indomethacin)
Lodine (etodolac)
Mobic (meloxicam)
Nalfon (fenoprofen)
Orudis, Oruvail (ketoprofen)
Relafen (nabumetone)
Trilisate (choline magnesium trisalicylate)
Toradol (ketorolac)
Vioxx (rofecoxib)
Bextra (valdecoxib)
MSM (methylsufonylmethane)
Chondroitin/Glucosamine
Enbrel/ /Remicade/Humira/Methotrexate
Prialt (ziconotide)
Intravenous Lidocaine/Ketamine
Nuedexta

COGNITIVE ENHANCERS

Hydergine (ergoloid mesylates)
Aricept (donepezil)
Exelon (rivastigmine)
Piracetam
Vinpocetine
Razadyne (galantamine)
Cognex (tacrine)
Ginko Biloba
Eldepryl/Deprenyl (selegiline)
DMAE/Choline/Phosphatadiylcholine
Namenda (memantine)
Vayacog

ANTICONVULSANTS/ NERVE PAIN

Mexitil (mexiletine)
Carbatrol, Tegretol (carbamazepine)
Depakote/ Depakene (valproic acid)
Dilantin (phenytoin)
Gabitril (tiagabine)
Klonopin (clonazepam)
Lamictal (lamotrigine)
Neurontin (gabapentin)
Lyrica (pregabalin)
Keppra (levetiracetam)
Topamax (topiramate)
Trileptal (oxcarbazepine)
Felbatol (felbamate)
Zonegran (zonisamide)
Ketamine
Tambocor (tocainamide)
Namenda (memantine)
Vimpat (lacosamide)