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Welcome to Therapeutic Pain Management Medical Clinic (TPM)

Introduction: Your physician has referred you to be evaluated and possibly receive treatment, by one of our physicians. Our physicians are board certified anesthesiologists, who specialize in the treatment of pain by performing various injections, or by performing specialized procedures such as implanting morphine pumps or stimulator devices. We are no longer accepting new patients only for medication management with opioid type pain medications. We do not perform disability evaluations. TPM has its own x-ray machine (fluoroscopy unit) and most of the procedures may be performed in the clinic itself.

Hours of Operation: The clinic's hours are from 8 AM to 4:30 PM Monday - Thursday. On Fridays, the clinic closes at 12 PM. The Clinic is closed during lunch hours from 12 Noon to 1 PM. **We do not see "walk-in" patients or patients without appointments.**

Initial Visit: Your initial consultation visit takes about 1 hour and is usually an evaluation only. After the physician has completed your examination, he will give you his recommendations, answer questions, and talk about a plan of care. Please fill out the enclosed questionnaire before you arrive for your appointment, as the physician cannot adequately evaluate you without it. In addition, if you have had any recent x-rays or MRI scans, or CAT Scan reports, please bring them with you. **YOU MUST MAKE THE COMPLETED QUESTIONNAIRE AVAIALABLE TO US FOR US TO INPUT YOUR INFORMATION IN OUR ELECTRONIC MEDICAL RECORDS AT LEAST 5 WORKING DAYS PRIOR TO YOUR SCHEDULED APPOINTMENT. IF WE DO NOT RECEIVE THIS IN TIME, WE CAN NOT CONFIRM YOUR APPOINTMENT.**

Treatment: If treatment at our clinic is recommended and you decide to proceed, our secretary will set up an appointment after obtaining authorization from your insurance company, if necessary. The office will give you written literature about the recommended procedure, as well as answer any questions. Procedures may be scheduled at the office, or at Mercy Outpatient Surgery Center depending upon day, date and your insurance company requirements.

Prescriptions: The TPM physician will not take over prescribing your current medications without consulting your referring physician, but additional medications may be ordered for you by the TPM physicians. We are no longer accepting new patients only for medication management with opioid type pain medications and we are no longer prescribing medications such as Ambien, Lunesta, Xanax, Valium, Ativan or other benzodiazepines. Please be sure to list all your current medications, so that we do not duplicate something that you may already be taking. Patients receiving narcotic medications will have to sign a "Narcotic Contract" with this clinic.

Prescription Refills: Please call your pharmacy and have them fax us a refill request to refill your medication. Do not call the clinic to request refills. Allow 72 hours (3 days) for refills, not including weekends and holidays.

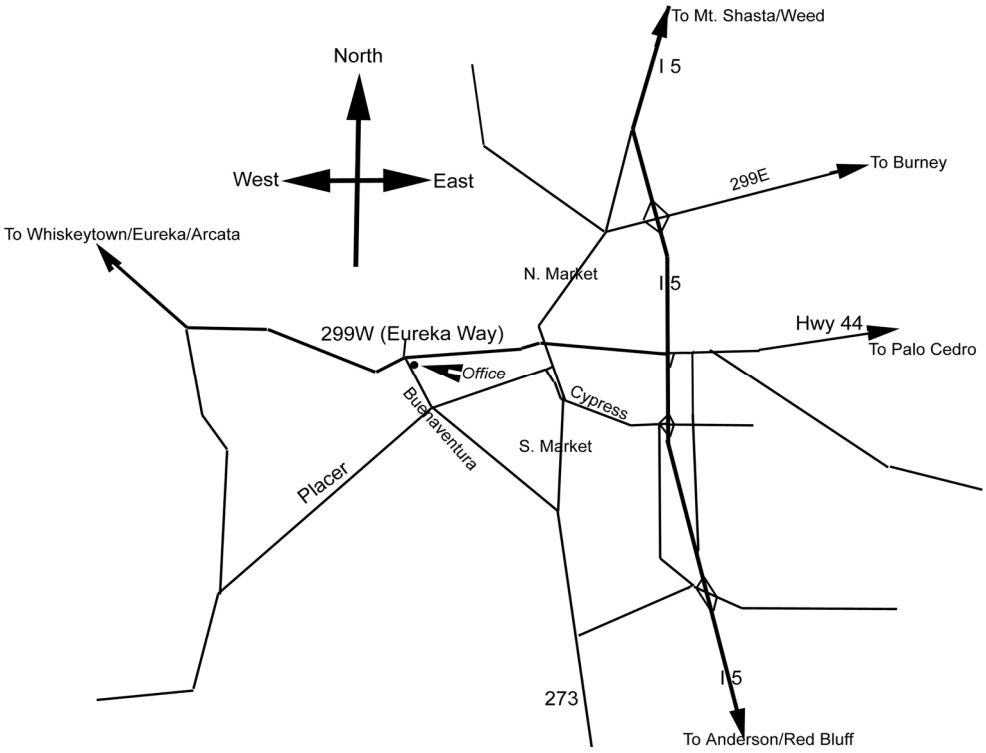
Appointment: If you need to cancel your appointment, 24 hours' notice is required. **Failure to give us adequate notice will result in a charge of $ 50 for "no show".**

How are we different than most other pain clinics? New patients are ALWAYS evaluated by an MD and not by a PA or NP, and it is "more than a hand-shake". Our focus is on improving your quality of life and functionality rather than just pushing pills or needles only. We tend to practice "evidence based medicine". Our MDs are available to answer any questions you may have before, during and after the procedure.

Contact Information: Telephone: 24-7-PAIN (247-7246), Fax: 245-0849,

Email: mail@Tpmclinic.com **Web Site**: http://www.tpmclinic.com

Pre- registered patient portal web site: https://health.eclinicalworks.com/TPM



Directions from North: (Mt. Shasta, Burney)

- Take I5 south
- Take 299West (Eureka – Weaverville) Exit
- Continue west on 299W (also called Eureka Way) through downtown Redding
- Drive about 2 miles; at Traffic Signal make a LEFT on Buenaventura Blvd.
- The Office Building is 200 Feet on LEFT (Behind Sunset Market Place)
- Office is on the First Floor, Suite 100 – Side of the building
- 1335 Buenaventura Blvd., Suite 100

Directions from South: (Anderson, Red Bluff, Corning)

- Take I5 North
- Take 299 West (Eureka – Weaverville) Exit # 678
- Continue west on 299W (also called Eureka Way) through downtown Redding
- Drive about 2 miles; at Traffic Signal make a LEFT on Buenaventura Blvd.
- The Office Building is 200 Feet on LEFT (Behind Sunset Market Place/Top's Market)
- Office is on the First Floor, Suite 100 – Side of the building
- 1335 Buenaventura Blvd., Suite 100

Directions from East: (Shingletown, Susanville)

- Take 44 West towards Redding
- Continue west on 299W (also called Eureka Way) through downtown Redding
- Drive about 2 miles; at Traffic Signal make a LEFT on Buenaventura Blvd.
- The Office Building is 200 Feet on LEFT (Behind Sunset Market Place/Top's Market)
- Office is on the First Floor, Suite 100 – Side of the building
- 1335 Buenaventura Blvd., Suite 100

Therapeutic Pain Management Medical Clinic

New Patient Pain Questionnaire

Last Name	First Name	Middle Initial
_____	_____	_____

Gender: ☐ Male ☐ Female **Date of Birth:** _____

Social Security Number: _____

Address: _____
Street Address

_____
City, State, Zip

Tel: ( ) _____-_____ **Cell:** ( ) _____-_____

Work: ( ) _____-_____ **E-mail:**_____@_____

Referring Doctor: _____

Regular Medical Doctor: _____

YOU MUST MAKE THE COMPLETED QUESTIONNAIRE AVAIALABLE TO US FOR US TO INPUT YOUR INFORMATION IN OUR ELECTRONIC MEDICAL REORDS AT LEAST 5 WORKING DAYS PRIOR TO YOUR SCHEDULED APPOINTMENT. IF WE DO NOT RECEIVE THIS IN TIME, WE CAN NOT CONFIRM YOUR APPOINTMENT. YOU MAY MAIL, FAX, EMAIL or BRING IT IN.

Please bring a copy of your insurance card or information to be copied at your first visit. The billing services for the TPM physicians are performed by EMMI, which has an office in Redding. Tel # (530) 241-0410. As a courtesy to our patients, they will bill Primary and Secondary insurances. Any deductible or co-pay required by your insurance plan is due at the time of your visit.

Please note that a 24 Hour notice is required if you decide to cancel the appointment. This office reserves a right to bill you $ 50 if you cancel your appointment without notifying us in advance. Please be courteous – don't be a "no-show".

Dr. Dhruva, Dr. Hansen
Board Certified in Anesthesiology

Therapeutic Pain Management Medical Clinic
1335 Buenaventura Blvd, Suite 100
Redding, CA 96001-0160
Tel: (530) 24-7-P-A-I-N ; (530) 247-7246 **Fax**: (530) 245-0849
Email: mail @TPMClinic.com; www.TPMclinic.com

Reason for this visit? Example:" *Pain in my low back, mostly right side" or "I have pain in my arms"*

Answer*:* _____

Please list ALL medications you are CURRENTLY taking:

Name	**Pill strength**	**Amount at a time**	**How often?**
e.g: Advil	*200 mgs*	*2 to 3 tablets*	*3 times a day*
e.g: Norco	*10/325*	*1 tablet*	*every 6 hours*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please check the medications you have taken IN THE PAST for any reason:

☐ Norco/Vicodin/Lortab	☐ Percocet/Percodan	☐ Ultram/Tramadol	☐ Codeine
☐ Darvocet	☐ Nucynta	☐ OxyContin	☐ Kadian/Embeda
☐ MS Contin	☐ Avinza	☐ Fentanyl Patch	☐ Dilaudid
☐ Advil/Motrin/Ibuprofen	☐ Naprosyn	☐ Aleve	☐ Celebrex
☐ Neurontin/Gabapentin	☐ Lyrica	☐ Cymbalta	☐ Elavil
☐ Trazodone	☐ Nortriptyline	☐ Effexor	☐ Wellbutrin
☐ Prozac	☐ Paxil	☐ Lexapro	☐ Celexa
☐ Remeron	☐ Zoloft	☐ Flector Patch	☐ Lidoderm
☐ Tylenol	☐ BenGay	☐ Aspercream	☐ Capsasin
☐ Flexeril	☐ SOMA	☐ Baclofen	☐ Zanaflex
☐ ParafonForte	☐ Robaxin	☐ Skelexin	☐ Valium
☐ Klonopin	☐ Xanax	☐ Ativan	☐ Ambien
☐ Lunesta	☐ Sonata	☐ Rozerem	☐ Restoril
☐ Provigil	☐ Nuvigil	☐ Retalin	☐ Adderall
☐ Exalgo	☐ Voltaren Gel	☐ Opana	☐ Methadone
☐ Butrans	☐ Suboxone	☐ Subutex	☐ Gralise

Others: _____

Please tell us if you are or if you have in the past suffered from any of these conditions:

☐ High Blood pressure	☐ Angina	☐ Heart Attack	☐ Stroke
☐ Diabetes	☐ Thyroid Problems	☐ Overweight	☐ Cancer
☐ Seizures/Epilepsy	☐ Depression	☐ Asthma	☐ Ulcers
☐ Hepatitis/Jaundice	☐ Kidney Problems	☐ Major accident	☐ _____

Please list medication and substance allergies and the reaction you had? ☐ None

Medication/Substance	**Reaction**
e.g.: Penicillin	*Throat swells*
_____	_____
_____	_____
_____	_____
_____	_____

Please tell what surgeries you had so far for any conditions:

Year	**Type of surgery**
Example: 1986	*Appendix removed*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please tell about your close relatives:

Father ☐ Alive ☐ Passed away. Major Health Problems: _____

Mother ☐ Alive ☐ Passed away. Major Health Problems: _____

Brother #1 ☐ Alive ☐ Passed away. Major Health Problems: _____

Brother #2 ☐ Alive ☐ Passed away. Major Health Problems: _____

Brother #3 ☐ Alive ☐ Passed away. Major Health Problems: _____

Sister #1 ☐ Alive ☐ Passed away. Major Health Problems: _____

Sister #2 ☐ Alive ☐ Passed away. Major Health Problems: _____

Sister #3 ☐ Alive ☐ Passed away. Major Health Problems: _____

I have _____ **brother(s)** and _____ **sister(s).** I have _____ **son(s)** and _____ **daughter(s).**

Comments: _____

Please tell us tell us about yourself, family, employment and habits:

I am: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Decline to state
I live with: ☐ Spouse/Partner ☐ Kids ☐ Parents ☐ Alone ☐ Friends ☐ Pet(s)
I am: ☐ Retired ☐ Disabled ☐ Working FT ☐ Working PT ☐ Unemployed

If working, I am employed as: _____

Education: ☐ School ☐ GED ☐ College ☐ Post-Grad. ☐ Trade School
Exercise: ☐ None ☐ Walk ☐ Go to gym ☐ Yoga/Stretch ☐ Swim
Alcohol use: ☐ Don't drink ☐ Social ☐ Heavy: _____per day
In the past year, I have used: ☐Marijuana ☐ Meth/Speed ☐ Cocaine ☐ Heroin ☐ None
I had problems with: ☐ Alcohol abuse ☐ Drug abuse ☐ Prescription drug abuse ☐ None
Smoker?: ☐ Daily ☐ Yes, but not every day ☐ Past Smoker ☐ Never smoked ☐ Decline to state
If ever smoked: Age started smoking _____ Yrs. **Type of material**: ☐ Cigarettes ☐ Cigar ☐ Pipe
Packs per day _____ **Tried to quit?** ☐ Yes ☐ No **If yes, age quit smoking** _____ Yrs
Planning to quit? ☐ Yes ☐ No
Modalities to help quit smoking: ☐ Hypnosis ☐ Support Group ☐Nicotine Patch
☐ Nicotine gum ☐ Prescription Medication (*Chantix, Zyban* etc) ☐ Self determination

Comments: _____

Within the past year, have you suffered from the following?

Constitutional: ☐ Fever ☐ Appetite loss ☐ Weight gain ☐ Weight loss
Dermatology: ☐ Rash ☐ Dry skin ☐ Skin Infections
Ophthalmic: ☐ Poor vision ☐ Blurred vision ☐ Double vision ☐ Bright lights bother
ENT: ☐ Trouble swallowing ☐ Cold ☐ Cough
ENT: ☐ Hearing loss ☐ Ringing in ears ☐ Sore throat
Respiratory: ☐ Shortness of breath ☐ Wheezing ☐ Pneumonia
Cardiology: ☐ Chest pain ☐ Dizziness ☐ Palpitations ☐ Leg swelling
GI: ☐ Stomach pain☐ Blood in stools ☐ Constipation ☐ Diarrhea
GI: ☐ Difficulty swallowing ☐ Heartburn ☐ Nausea/Vomiting
Musc/Skeletal: ☐ Weakness ☐ Joint pain ☐ Joint stiffness ☐ Joint swelling
Musc/Skeletal: ☐ Leg cramps ☐ Muscle spasms
Neurology: ☐ Headaches ☐ Can't sleep ☐ Memory loss ☐ Seizures
Neurology: ☐ Tingling/Numbness ☐ Tremors ☐ Weakness in limbs
Hematology: ☐ Abnormal bleeding ☐ Easy bruising ☐ Enlarged nodes

Psychology:	☐ Anxiety	☐ Depression	☐ High stress level	☐ Anger
Females:	☐ Weak bladder		☐ Post-Menopausal	☐ Diminished libido
Males:	☐ Difficulty- urination		☐ Difficulty- erections	☐ Diminished libido
Endocrine:	☐ Excessive sweating		☐ Easy Fatigue	☐ Thyroid problems
Allergy:	☐ Itchy or red eyes		☐ Runny nose	☐ Skin itch/scratch

Comments: _____

My Height: _____ Feet _____ Inch **My Weight:** _____ Lbs.

I am: ☐ Right handed ☐ Left handed ☐ Ambidextrous

Details about your pain:

My pain stated after…….

☐ I don't know ☐ An injury ☐ After surgery ☐ Auto Accident

Comments: _____

My **WORST** Pain score: 0 1 2 3 4 5 6 7 8 9 10

My **LEAST** Pain score: 0 1 2 3 4 5 6 7 8 9 10

My **USUAL** Pain score: 0 1 2 3 4 5 6 7 8 9 10

My pain is…… (Select ONE ANSWER only)

☐ Always present, always the same intensity
☐ Always present, intensity varies
☐ Usually present—short periods without pain
☐ Often present—but have pain-free periods lasting for one to several hours

My pain is…… (Select ONE ANSWER only)

☐ Worse in the morning ☐ Worse in the evening ☐ Worse in the night
☐ Time of the day or night has NO association with my pain. ☐ 24-7

The type of pain I feel is…….

☐ Burning ☐ Aching ☐ Throbbing ☐ Shooting
☐ Electric Shock ☐ Sharp ☐ Tight ☐ Stabbing

I also have associated…….

☐ Numbness ☐ Coldness ☐ Tingling ☐ Pins/Needles
☐ Weakness ☐ Stiffness ☐ Spasms ☐ Sensitive to touch
☐ Increased sweating ☐ Color changes ☐ Bladder problems ☐ _____

My pain gets worse with…….

☐ Sitting ☐ Standing ☐ Walking ☐ Laying down
☐ Leaning forwards ☐ Arching backwards ☐ Coughing/Sneezing ☐ Straining

My pain gets better with……

☐ Medications ☐ Rest ☐ Heat ☐ Ice Pack ☐ Relaxing
☐ Exercises ☐ Laying down ☐ Medical Marijuana ☐ Alcohol ☐ _____

My pain is interfering with my…….

☐ My sleep ☐ My family life ☐ Relationship with my spouse/partner
☐ Work performance ☐ Friends/Co-workers ☐ Driving

Because of my pain, I have problems with…….

☐ Falling asleep ☐ Staying a sleep ☐ Wake up frequently
☐ Pain does not affect my sleep

My goals with pain control are…….

☐ Better quality of life ☐ Go back to work ☐ Travel, play sports, family time
☐ Avoid surgery ☐ Get off or reduce medications ☐ Able to sleep and rest better

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Answer <u>only</u> if you are suffering from neck pain:

My neck pain/shoulder pain/upper back pain is…….

☐ Worse looking up ☐ Worse looking down ☐ Both same ☐ No change up or down
☐ Looking right ☐ Looking left ☐ Both same ☐ No change right or left

Answer <u>only</u> if you are suffering from headaches:

My headaches are…….

☐ More on the right ☐ More on the left ☐ Both same
☐ More in the back of skull ☐ More in the front (behind eyes) ☐ More on the top of head

When having headaches…….

☐ Bright lights bother ☐ Loud noises bother ☐ No change with them

---

The treatments I have received so far includes……

☐ Medications ☐ Physical Therapy ☐ Surgery ☐ Chiropractic
☐ Injections ☐ Massage Therapy ☐ Psychotherapy ☐ Acupuncture

Comments: _____

I have seen the following for the problems I am having……..

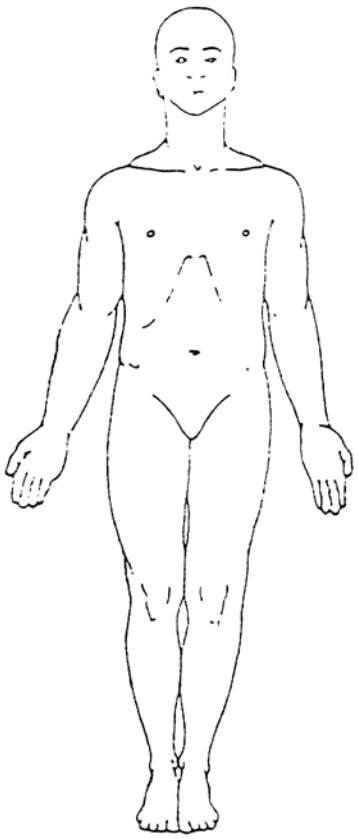
☐ Family MD ☐ Neuro-surgeon ☐ Spine/Ortho Surgeon ☐ Chiropractor
☐ Neurologist ☐ Psychologist/Psychiatrist ☐ Pain Clinic ☐ _____

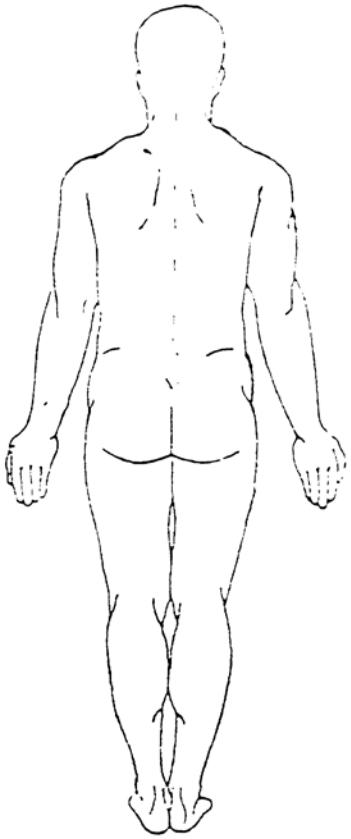
I have undergone these tests for the current problem……

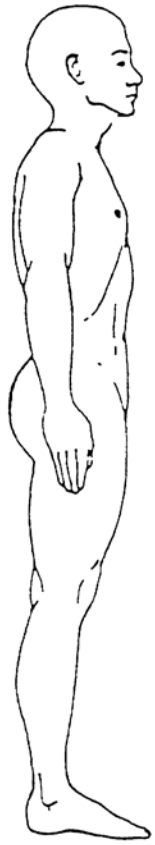
☐ X-Rays ☐ CAT Scan ☐ MRI Scan ☐ Myelogram
☐ Nerve Testing (EMG) ☐ Bone Scan ☐_____

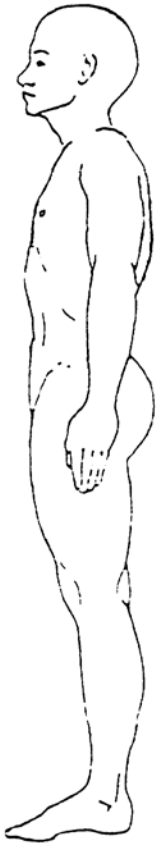
Comments: _____ **END**

Please mark the areas where you have pain:









Appointment Cancellations and "No Show" Policy

We expect that our patients will keep their appointments, which are setup with mutual agreement. There are always several patients, who would like to be treated sooner, but have to wait for their turn, as this clinic is very busy.

When a patient does not show up for his/her appointment or does not give adequate cancellation notice, that time slot is wasted, which could have been utilized to take care of other patients, especially for those who would like to get in sooner.

This clinic reserves a right to bill the patients a fee for not showing up or not giving adequate notice for a scheduled appointment.

The "No Show" fee is $ 20 for a follow-up visit;

The "No Show" fee is $ 50 for a procedure appointment or initial consultation.

Please note that your insurance company will NOT pay this amount and you will be personally responsible for the fee. We may NOT reschedule your appointment until this fee is paid. Certainly, we will use discretion while implementing this policy as we realize that true emergencies do occur.

If you are being treated under Worker's Compensation insurance, we are also required to notify your Work Comp Adjuster and it may affect your benefits.

I have read the above "Appointment Cancellations and "No Shows" Policy". I agree that TPM Medical Clinic reserves a right to bill me for not showing up at a scheduled appointment, or for not giving adequate notice of cancellation. I further agree that I may not be rescheduled if I do not pay the "No-Show" charge billed to me.

_____ _____

Signature **Date**

Authorization for collection, use, and release of Personal and Medical Confidential Information

HIPAA (Healthcare Insurance Portability and Accountability Act of 1996) restricts collection, use, and sharing of confidential medical and personal information. This information includes items such as Name, Age, Date of Birth, Tel Numbers, address, Social Security Number, Information about your health, work, employment, family, medication use, diagnostic data, health insurance, email address, digital facial photographs etc.

At Therapeutic Pain Management Medical Clinic (TPM), we use the information obtained from you, your referring physician and other related healthcare providers, insurance carriers, pharmacies, and diagnostic facilities for the purpose of:

- Scheduling for consultations and treatments at TPM and other healthcare facilities
- Evaluation and treatment
- Identifying a particular patient to locate him/her within waiting areas
- Discussing diagnosis and treatment plan with staff and other health providers at TPM
- Discussing diagnosis and treatment with your family members or guardian
- Referring you for further diagnostic studies (X-Ray, MRI, CAT Scan, Blood Work etc)
- Referral to other providers such as Consultants, Physical Therapists, Surgeons, Psychologists etc
- Calling in, Faxing, or confirming prescriptions to pharmacies
- Billing and collection firms' use
- Sending reports to your attorney, insurers, nurse case manager, W/C adjuster
- Dictation transcribing companies' use
- Sending information to other persons or firms where you have signed a valid "Release of Information"

The information is stored in paper charts and computers at TPM and is shared via Fax, E-Mail, Mail, Telephone, Internet, and personal communications. We share as minimum information as possible for an appropriate use. TPM does not to provide, or sell, or market the information to commercial firms for marketing reasons.

The HIPAA guidance clarifies that a health care provider may rely on his or her professional judgment in determining whether there is an emergency which would justify foregoing the consent requirement, as is permitted by the Privacy Standards.

I understand the purpose of collection, use and release of confidential information about me by TPM as listed above and I hereby authorize TPM to collect, use, and release such confidential information about me, as needed for my medical care and financial liability.

The information obtained or released by the clinic pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer protected.

This consent can be revoked at any time by giving a written notice, except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

This consent will remain in effect while I am a patient at TPM and for 180 days after my discharge from the TPM Clinic.

_____ _____

Signature **Date**

Consent for Release of Information

To give you the best possible care, Therapeutic Pain Management Medical Clinic (TPM) needs to be able to obtain records of your treatment by other physicians and hospitals as well as copies of laboratory and x-ray tests. This consent authorizes us to obtain that information. All information obtained is treated as confidential and will not be disclosed outside of TPM without your consent.

I hereby authorize physicians, hospitals, clinics, and laboratories that have treated me to release information from my health records to:

Therapeutic Pain Management Medical Clinic (TPM)
1335 Buenaventura Blvd., Suite 100
Redding, CA 96001-0160

(530) 247-7246 Tel
(530) 245-0849 FAX
mail@TPMclinic.com

Information to be released includes:

- Copies of History & Physical and Clinical Notes
- Copies of Laboratory and X-ray, and other diagnostic results
- Copies of Operative Reports and Discharge Summaries

This consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

This consent will remain in effect while I am a patient at TPM.

Attending physicians and facilities, including their employees and officers are released from legal responsibility or liability from the release of information to TPM.

_____ _____

Signature Date

_____ _____

PRINT Name Date of Birth

Medication Risks Acknowledgement

It is very important to us that you understand that we may be prescribing one or more of the following **medications*** to you. You may already be taking one or more of these; however we may increase or decrease the dosage of your medication(s) or discontinue at any time.

*All opioids or Narcotics (e.g. Vicodin, Lortab, Oxycontin, Percocet, Percodan, Codeine, Norco, Morphine, Dilaudid, Tramado, Fentanyl, Opana, Exalgo etc).
All Tricyclic-Antidepressants (e.g., Elavil, Triavil, Doxepin, etc).
All anti-seizure type medication (e.g., Neurontin, Lyrica, Cymbalta, Tegretol, etc).
All anti-depressants (e.g. Paxil, Prozac, Cymbalta, Effexor, Wellbutrin etc)
All sedatives-benzodiazepines (e.g., Valium, Klonopin, Ativan, etc).
All muscle relaxants (e.g., Flexeril, SOMA, Zanaflex, Baclofen, etc).
Other medications as deemed necessary.

☑ **Taking medications containing aspirin, acetaminophen, or ibuprofen or other anti-inflammatory medications with alcohol may impair your liver or other organs.**

☑ **These medications can cause impairment of mental and/or physical abilities necessary when driving or operating heavy equipment. These effects may be enhanced by use of alcohol and/or other Central Nervous System depressants. We advise you not to drive or operate heavy machinery while you are under the influence of sedating medications.**

☑ **Stopping some of the medications suddenly can cause serious health problems.**

Please consult your physician or pharmacist if you have any questions or need further information about the side effects and risks associated with the use of these medications.

I have read the above and understand the implications of using the above-mentioned medications:

_____ _____

Signature **Date**