SAMUEL J. ALIANELL MD
3275 College Park Dr.
The Woodlands, Tx 77384
Ph: 936.321.0214 Fax: 936.271.0219

Private Insurance- Patient Profile

Samuel J. Alianell, MD
Appt Date & Time: _____
Reason for visit: _____

Referring Physician: _____
Primary Physician: _____
Referral on file: ( ) Yes ( ) No

Patient Information

Name: _____ DOB: _____ Age: _____

Address: _____ SS#: _____

City, St, Zip: _____ Sex: ( ) M ( ) F

Home Phone: _____ Employer: _____

Cell Phone: _____ Work Phone: _____

Email address: _____

Primary Insurance

Insurance Company: _____

Address: _____

City, St, Zip: _____

Phone: _____

ID# _____

Group# _____

Policy Holder: ( ) same as patient
Name: _____
Address: _____
City, St, Zip: _____
SS#: _____
DOB: _____
Employer: _____
Phone: _____

Secondary Insurance

Insurance Company: _____

Address: _____

City, St, Zip: _____

Phone: _____

ID# _____

Group# _____

Policy Holder: ( ) same as patient
Name: _____
Address: _____
City, St, Zip: _____
SS#: _____
DOB: _____
Employer: _____
Phone: _____

I authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

Patient Signature: _____ Date: _____

WOODLANDS PHYSICAL MEDICINE
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Patient name:_____ SS#_____
Insurance company:_____

Release of information: I hereby authorize Samuel Alianell MD PA to release any or all information acquired in the course of my examination and/or treatment that may be required to process claims for payment. I also authorize the release of information to another doctor or health care facility to which the patient may be transferred or referred.

Medicare Patients Certification: I certify that the MEDICARE information given by me is correct. As this office does accept assignment with Medicare, this information will be used for the purpose of processing my Medicare claims for payment. I understand, due to government regulations, that if Medicare coverage is available to me, I must inform my physician. I also understand, if in addition to Medicare, I am covered under an EMPLOYER GROUP HEALTH INSURANCE, LIABILITY, NO-FAULT WORKER'S COMPENSATION, or any other insurance which may be responsible for payment, I must inform this office.

I have read and understand the above statement regarding MEDICARE coverage.

_____ MEDICARE is my Primary coverage. _____ This is NOT a Work Related condition.

_____ MEDICARE is my Secondary coverage. _____ This IS a Work Related condition.

_____ I do not have MEDICARE/HMO.

_____ I do not have MEDICAID/HMO.

ASSIGNMENT OF BENEFITS: I hereby authorize payment to Dr. Samuel Alianell of the surgical and/or medical benefits, if any, otherwise payable to me for services I have received.

FINANCIAL OBLIGATION: The undersigned hereby unconditionally guarantees full and prompt payment of all charges incurred as a result of services rendered to me during the course of my medical treatment.

FINANCIAL DISCLOSURE: Dr. Alianell is an owner/shareholder in Chronic Pain Recovery Center Holdings LLC.

_____ _____
Signature of Insured/Guardian Date Witness Date

SAMUEL J. ALIANELL MD
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INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

3Rd Edition: Developed by the Texas Pain Society, April2008 (www.texaspain.org)

NAME OF PATIENT: _____ DATE: _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

For female patients only:

To the best of my knowledge **I am NOT pregnant.**

If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.

If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus / baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:
That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued**.
- I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician**.
- I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will **not allow or assist in the misuse/diversion of my medication**; **nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money**. If either are lost or stolen, they may NOT BE REPLACED.**
- Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s)**. I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- I **agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.
- I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.
- I will not consume **alcohol** while I am taking pain medication.

I certify and agree to the following:

1) I am **not currently using illegal drugs or abusing prescription medication**(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

2) I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

3) **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

_____

Patient Signature

_____

Physician Signature (or Appropriately Authorized Assistant)

_____

_____

Name and contact information for pharmacy

SAMUEL J. ALIANELL MD
3275 College Park Dr.
The Woodlands, Tx 77384
Ph: 936.321.0214 Fax: 936.271.0219

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in this authorization.

Your Rights: a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF DR SAMUEL ALIANELL'S NOTICE OF PRIVACY PRACTICES.

_____

Print Name

_____

Signature

_____

Date:

SAMUEL J. ALIANELL MD
3275 College Park Dr.
The Woodlands, Tx 77384
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PATIENT INFORMATION

We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Policy that we require you to read and sign prior to any treatment.

REGARDING INSURANCE

We will gladly bill your insurance company directly if you have provided us with all the necessary information to do so. Your contract for health insurance is between you and your insurance company. We are not a party to the contract. The services that you receive, and the bill is an agreement between you and Dr. Samuel Alianell MD PA. It is ultimately your responsibility to see that your bill is paid in full. Agreements between insurance companies vary greatly and it is your responsibility to pay in a timely manner. If your insurance company does not pay Dr. Samuel Alianell MD PA, it will be your responsibility to contact them. A statement will be sent by mail of the balance due on your account. We will look to you for payment, not the insurance carrier, unless you are covered by worker's compensation.

X_____

REGARDING INSURANCE WHERE WE ARE A PARTICIPATING PROVIDER

All copayments and deductibles are due ***prior*** to treatment. We cannot bill you for your copayment of deductible as your insurance contract requires us to collect it at the time of service. In the event that your coverage changes to a plan where we are not the participating provider, refer to the paragraph above.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under certain medical insurances.

X_____

PAYMENT FOR SERVICES

Payment is due in full at the time of service for those without insurance coverage. All payment arrangements must be made in advance with the Office Manager. If we bill your insurance and reimbursement is 100% denied, we will bill you our self pay rates. On occasion, certain procedures may not be reimbursed by your insurance company. If it is expected that insurance will not cover, payment is due at the time of service.

X_____

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BILLING OFFICE PHONE NUMBER

Dale Billing Resources: (281) 419-9669

FEES

- **REWRITING OF PRESCRIPTIONS**
  If an insurance company limits you to a list of certain drugs or facilities, please tell us. Bring the listing of approved drugs with you to every office visit with Dr. Alianell. Rewriting prescriptions after you leave the office to suit your insurance plan is $14.
- **PRESCRIPTION REFILLS**
  We want to provide the best and most accurate healthcare possible. Medication is prescribed in person, and in writing, at your appointment. I f you pick-up a prescription without an appointment, there is a $14 charge (determined by treatment guidelines).
- **PRIOR AUTHORIZATIONS**
  If your insurance company requires a Prior Authorization, there is a $20 charge. This is a service not included in your office visit. The charge is $14 if you provide the form to be completed (obtained from your insurance company).
  ALL FEES MUST BE PAID BEFORE WE WORK ON ANY PRIOR AUTHORIZATION.
- **CHECK RETURNS**
  A fee of $35 will be charged for each check returned for insufficient funds.
- **MEDICAL RECORDS RELEASES**
  Please allow 30 days for your records request to be processed. We require your *written* authorization before releasing records to anyone other than your referring doctor or to your insurance company. Our fee for producing medical records at your request is:
  - $25 for the first 25 pages
  - $0.50 for additional page

  These records can be picked up by the patient.
  This fee must be received before records will be released.
- **FORMS (DISABILIT FMLA, INSURANCE)**
  There is a fee of $30 per form.
- **URINE DRUG TESTING**
  A fee of $5 will be charged to any patient that is self-pay. Insured patients if you undergo urine toxicology testing, your insurance will be billed accordingly. In addition, many of our lab results are also sent to an in-network confirmatory lab for additional information on the quantitative results of the specimen.

X_____

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PHONE CALLS

Office hours are Monday through Friday, 8 AM to 5 PM. We are not open on evenings or weekends. It is the policy of this office that phone calls are returned within 24 hours from the time the message is received, although every effort is made to return call the same day. However, phone messages received after 3:30PM will not be returned until the following business day. After business hours, non-emergency calls *will* be subject to a $50.00 charge. These charges are not covered by most insurance plans.

X_____

NO SHOW & LATE CANCELLATION

If you are unable to keep your appointment, please call the office 24 hours in advance. If less than 24 hours' notice is received, a charge of $50 will be incurred. The intent of the fee is to ensure access to Dr. Alianell for patients who need care. This appointment was set aside for you and when you no show or cancel with less than 24 hours' notice, another patient who is in pain cannot receive the care they need. With 24 hours' notice, we are often able to fit a patient in who might otherwise have to wait.

X_____

Thank you for choosing Dr. Samuel Alianell! We welcome you and look forward to a long relationship together.

I acknowledge that I have read and agree to the information on these pages.

_____
Print Name

_____
Signature

_____
Date

WOODLANDS PHYSICAL MEDICINE
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SAMUEL J. ALIANELL MD

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General Medical History

Patient: _____ DOB:_____ Date: _____

Emergency contact name:_____

Relation:_____ **Phone number(s):**_____

Please give first and last name of the doctors below. If you don't know the first name, please try to give initial.

Primary Care Physician: _____

Referring Physician: _____

Onset of Symptoms

You are: R Handed L Handed Ambidextrous

Where are you having pain? _____

How long have you had this problem? _____

Is this a legal or third person liability case? No Yes Potential

If Yes, Date of Injury:_____

Work Comp Motor Vehicle Accident Where did you get hurt? Home / School / Work / Store / Car

How did you get hurt? _____

Since your pain began, how has it changed? ☐ Decreased ☐ Increased ☐ Stayed the same

Pain Description

Check all the following that describe your pain:

☐Aching ☐Hot/Burning ☐Shooting ☐Stabbing/Sharp ☐Cramping

☐Numbness ☐Spasms ☐Throbbing ☐Dull ☐Shock-like

☐Squeezing ☐Pin & Needles ☐Tingling

☐Constant dull/aching background pain with exacerbations as checked above

What word best describes the frequency of your pain? ☐ Constant ☐ Intermittent

When is your pain at its worst? ☐Mornings ☐During the day ☐ Evenings ☐Middle of night

☐ Progressively worsens throughout the day ☐ No Changes- always the same

Pain Description continued

I have: ☐Weakness (from pain) in my: ☐ R arm ☐ L arm ☐ R leg ☐ L leg

☐Specific weakness in my: ☐ R arm ☐ L arm ☐ R leg ☐ L leg

☐ Numbness of my: ☐ arms ☐ hands ☐ legs ☐ feet

☐ Tingling of my: ☐ arms ☐ hands ☐ legs ☐ feet

☐ Leg pain when I walk: ☐ less than a block ☐ 1-3 blocks ☐ >3 blocks

☐ this pain improves if I stand still

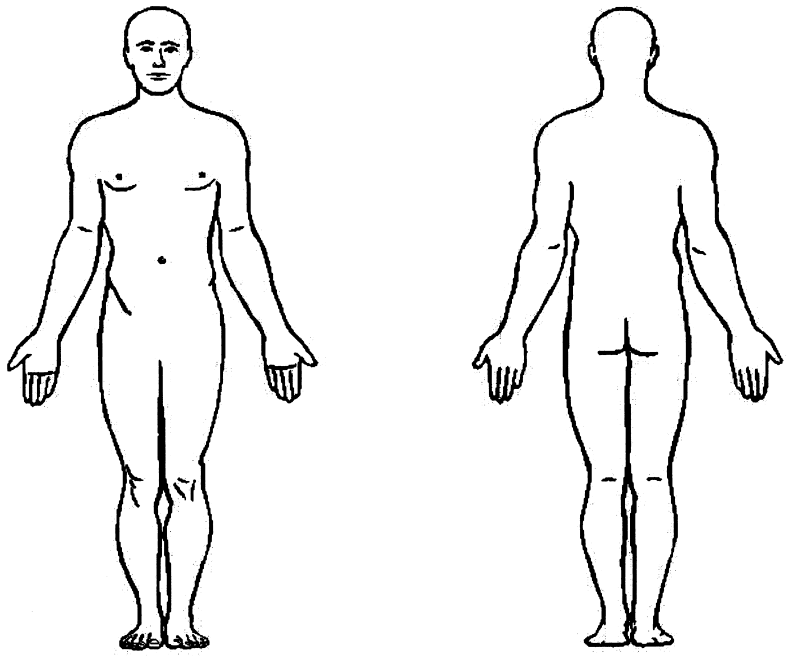
☐ this pain improves only if I sit or lean forward

☐ Bladder (urine) trouble ☐ Loss of urine (accidents) ☐ Can't empty

☐ Bowel trouble ☐ Loss of control (accidents) ☐ Constipation

☐ Pain worst at night

Use this diagram to indicate the location of your pain by marking the drawing with an x wherever you feel pain.



What Makes your Pain Worse? (Check all that apply)

☐Bending/ Stooping ☐Coughing/Sneezing ☐Driving ☐Lifting ☐ Lying Flat

☐Lying Sideways ☐Physical Activity ☐Sitting ☐Walking ☐Other

☐Going to Bathroom

What aspects of your life are affected by your pain? (Check all that apply)

☐Performing activities of daily living ☐Engaging in a normal lifestyle

☐Performing work-related activities ☐Achieving adequate sleep

What Makes your Pain Better? (Check all that apply)

☐Bed Rest ☐Reducing Activities ☐Bending forward ☐Bending backwards

☐Heat ☐Massage ☐Ice ☐Other

Past Medication Treatment: Which medication have you tried? (check all that apply)

	Did it help?	Y	N
☐Anti-inflammatories: _____		☐	☐
☐Muscle relaxants: _____		☐	☐
☐Opioids/Pain Pills: _____		☐	☐
☐Others _____		☐	☐

Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

☐MRI of the_____Date:_____ Facility:_____

☐X-ray of the_____Date:_____ Facility:_____

☐CT Scan of the_____Date:_____ Facility:_____

☐EMG/NCVof the_____Date:_____Facility:_____

☐Other testing of the_____Date:_____Facility:_____

☐I have not had any diagnostic tests performed for my current pain complaints.

Pain Treatment History

How do the following treatments impact you pain? **if you haven't tried it, leave it blank**

Treatment	No Relief	Temporary Relief	Excellent Relief	Dates: (ok to approximate)
Chiropractic				
Injections (describe)				
Physical Therapy				
Surgery Details:				
Traction				
Spinal Cord Stimulator				

Please describe any further details regarding previous pain treatments:

_____

_____

☐ I have not had any prior treatments for my current pain complaints.

What other specialists have you seen regarding your pain?_____

Allergies

Do you have any known drug allergies? ☐ YES ☐ NO If so, please list all medications, topical allergies or medical equipment you are allergic to and the reaction it caused:_____

Current Medications

Please list all medication you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency		Medication Name	Dose	Frequency

Past Surgical History

Please list any surgical procedures you have had done in the past, including the date, type, and any details.

Surgeries or Hospitalization	Year	Complications (if any)

☐ I have never had any surgical procedures.

Family History

Has anyone in your family had: Check all that apply

☐ Diabetes ☐ Heart Attack Female under 65 ☐ Cancer ☐ Bleeding Disorder

☐ Headaches ☐ Heart Attack Male under 55 ☐ Arthritis ☐ Osteoporosis

☐ Stroke ☐ Anesthesia problems ☐ High Blood Pressure

☐ Other medical problems:_____

☐ I have no significant family medical history

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐Widowed

Children: ☐ Yes ☐ No

Are you capable of becoming pregnant? ☐ Yes ☐ No *if so, are you currently pregnant?*

Do you live alone? ☐ Yes ☐ No *If no, who do you live with?* _____

Do you wear: ☐ Glasses ☐ Contacts

Social History continued

Occupation:_____

What kind of work? ☐ Physical ☐ Sedentary ☐ Retired ☐ Homemaker

☐Regular Duty ☐Light Duty ☐Off Work- since Date:_____Reason:_____

Alcohol Use: ☐ Daily Limited Use ☐ History of Alcoholism ☐ Never Drinks Alcohol

☐Drinks Alcohol Socially ☐ Drinks Alcohol Occasionally

Tobacco Use: ☐ Current Tobacco User ☐ Former Tobacco User ☐ Have never Used Tobacco

# of packs/day_____ for _____years

Illegal Drug Use: ☐ Yes ☐ No *if yes, what?*_____

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

*if yes, what?*_____

Exercise: ☐ daily ☐weekly ☐monthly ☐ rarely ☐never *What type?*_____

Past Medical History

Check all that apply:

☐Anemia	☐Diabetes Diabetic Foot	☐Hypothyroidism	☐Poor Circulation
☐Angina	☐Ulcer	☐Irregular Heart Beat	☐High Blood Pressure
☐Anxiety	☐Dialysis	☐Kidney Failure	☐Pulmonary Embolism
☐Asthma	☐Diverticulitis	☐Liver Problems	☐Reflux
☐Bleeding Disorder	☐Emphysema	☐LMP:	☐Rheumatoid
☐Blood Clot	☐GI Bleed	☐Lupus	☐Seizures
☐Cancer: Type/Status	☐Heart Attack	☐Migraines	☐Sleep Apnea
☐Chronic Back Pain	☐Hepatitis A, B, C	☐Neurological Disorder	☐Stroke
☐Congestive Heart Failure	Urinary Tract Infection	☐Numbness/Tingling	☐Ulcers
☐Depression	☐HIV	☐Other:	

_____

Current Medical Health

Overall level of physical health is:

☐Excellent ☐ Very Good ☐ Good ☐ Fair ☐Poor Immunizations up to date? ☐Yes ☐No

Have you ever had any complications from surgery? ☐ Yes ☐ No

Have you ever had any problems with anesthesia? ☐ Yes ☐ No

If yes, describe: _____

Review of Systems

Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.

General Health: ☐Fever/Chills ☐Fatigue ☐Sleep Problems

Eyes: ☐Blurry vision ☐Double vision

Ears/Nose/Throat: ☐Decreased hearing ☐Sore throat ☐Ears ringing ☐Sinus Problems

Cardiovascular: ☐Chest pain ☐Fainting ☐ Irregular Heartbeat ☐ Swelling in feet

Respiratory: ☐Shortness of breath ☐Cough ☐Wheezing

Gastrointestinal: ☐Heartburn/Constipation ☐Nausea/Vomiting/Diarrhea ☐Rectal Bleeding

Genitourinary: ☐Pain on urination ☐Incontinence ☐Increased frequency

Musculoskeletal: ☐Joint Swelling ☐Joint Stiffness ☐Muscle Spasms ☐ Joint Pain

Dermatological: ☐Rash ☐Itching

Neurological: ☐Numbness/Tingling ☐Loss of balance ☐History of Seizures

Psychological: ☐Anxiety ☐Depression

Endocrine: ☐Weight change ☐Thirsty all the time

Allergy/Immunology: ☐Hives ☐Hay fever

Hematology: ☐Easy bruising ☐Bleeding ☐Edema ☐Enlarged lymph nodes

NAME:_____ DATE:_____

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	o	o	o	o	o
2. How often have you felt a need for higher doses of medication to treat your pain?	o	o	o	o	o
3. How often have you felt impatient with your doctors?	o	o	o	o	o
4. How often have you felt that things are just too overwhelming that you can't handle them?	o	o	o	o	o
5. How often is there tension in the home?	o	o	o	o	o
6. How often have you counted pain pills to see how many are remaining?	o	o	o	o	o
7. How often have you been concerned that people will judge you for taking pain medication?	o	o	o	o	o
8. How often do you feel bored?	o	o	o	o	o
9. How often have you taken more pain medication than you were supposed to?	o	o	o	o	o
10. How often have you worried about being left alone?	o	o	o	o	o
11. How often have you felt a craving for medication?	o	o	o	o	o
12. How often have others expressed concern over your use of medication?	o	o	o	o	o

 The SOAPP®-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

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	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.

PainEDU.org

SAMUEL J. ALIANELL MD

3275 College Park Dr.

The Woodlands, Tx 77384

Ph: 936.321.0214 Fax: 936.271.0219

AUTHORIZATION TO RELEASE INFORMATION

PATIENT INFORMATION

Patient name:	Date of birth:	
Street Address:		
City:	State:	Zip:
Day Phone:	Evening Phone:	

HEALTH INFORMATION RELEASED FROM:

□*Doctor, Clinic, or Hospital:*		□***Samuel Alianell, MD PA*** 3117 College Park Dr St 210 The Woodlands, TX 77384 Phone: (936) 321-0214 Fax: (936) 271-0219
Phone:		
Fax:		
Address:		

HEALTH INFORMATION RELEASED TO:

□*Doctor, Clinic, or Hospital:*		□***Samuel Alianell, MD PA*** 3117 College Park Dr St 210 The Woodlands, TX 77384 Phone: (936) 321-0214 Fax: (936) 271-0219
Phone:		
Fax:		
Address:		

INFORMATION TO BE RELEASED

□Complete Medical Records	□Billing Records	□X-Ray/MRI Reports
□History & Physical	□Progress Notes	□Lab Reports
□Mental Health	□HIV Related	□Operative Reports
□Other:		

ACKNOWLEGEMENT

Dr. Samuel Alianell is hereby released from legal responsibility or liability for the release of the records to the extent indicated and authorized herein. I also understand that I may revoke this authorization at any time and that in any event this authorization will automatically expire as described below.

I authorize the release of my medical information as specified above. This authorization will expire **ONE YEAR** from the date of my signature or as otherwise specified by the date,
event, or condition as follows.

_____ _____

Signature of Patient, Parent/ Guardian *Date*