

**Personal Information**

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F

Occupation: \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Work Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Marital Status:  S  M  D  W Spouse's Name: \_\_\_\_\_ # of Children: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

**Insurance Information**

Primary Insurance Company: \_\_\_\_\_ I am the policy holder: (circle one) Yes - No

Secondary Insurance Company: \_\_\_\_\_ I am the policy holder: (circle one) Yes - No

**If yes, skip the Policy Holder Information Section and provide a copy of the current insurance card to Pain Management Center of Houston, Rehabilitation Spine Associates, or The Houston Spine & Rehabilitation Centers. If no, please complete Policy Holder Information Section below and provide current insurance card to Pain Management Center of Houston, Rehabilitation Spine Associates, or The Houston Spine & Rehabilitation Centers.**

**POLICY HOLDER INFORMATION - If other than self**

Relationship to patient: (circle one) Parent - Spouse - Self (if secondary insurance)

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ M.I. \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: Home: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Cell: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Work: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Employers Name: \_\_\_\_\_ Phone #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Contact: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Please provide a copy of your drivers license and insurance card. If this is an HMO, please provide a referral form from primary care doctor. Thank you.**

**Authorization & Assignment**

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the medical facility. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of services rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16 percent. I understand it is my responsibility to consult with my Primary Care Physician in order to rule out the possibility of an underlining medical condition not related to my musculoskeletal condition, and or symptoms presented.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian's Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_

## NEW PATIENT HISTORY

Welcome to our practice. Please help us by completing this questionnaire.

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Who may we thank for referring you to? \_\_\_\_\_ Phone No: \_\_\_\_\_

### WHAT BROUGHT YOU TO US ? PLEASE CHECK ALL THAT APPLY:

\_\_\_\_\_ ANKLE PAIN

\_\_\_\_\_ FIBROMYALGIA

\_\_\_\_\_ FOOT PAIN

\_\_\_\_\_ HAND / WRIST PAIN

\_\_\_\_\_ HIP PAIN

\_\_\_\_\_ INJURY - LOWER LIMB

\_\_\_\_\_ INJURY - UPPER LIMB

\_\_\_\_\_ JOINT PAIN / TENDERNESS

\_\_\_\_\_ KNEE - CHRONIC PAIN

\_\_\_\_\_ MUSCLE TENDERNESS / STIFFNESS

\_\_\_\_\_ SHOULDER PAIN

\_\_\_\_\_ OTHER: \_\_\_\_\_

SPINE: \_\_\_\_\_ CERVICAL, \_\_\_\_\_ THORACIC, \_\_\_\_\_ LUMBAR, \_\_\_\_\_ GENERAL

LOCATION OF PAIN: \_\_\_\_\_ SEVERITY 0-10 SCALE: \_\_\_\_\_

### ALLERGIES: PLEASE CHECK ALL THAT APPLY:

\_\_\_\_\_ NONE

\_\_\_\_\_ CODEINE

\_\_\_\_\_ ADHESIVE TAPE

\_\_\_\_\_ EGGS

\_\_\_\_\_ DAIRY PRODUCTS

\_\_\_\_\_ ENVIRONMENTAL (Pollen, dust, etc)

\_\_\_\_\_ IODINE

\_\_\_\_\_ LATEX

\_\_\_\_\_ NOVACAINE

\_\_\_\_\_ PENICILLIN

\_\_\_\_\_ SULFA DRUGS

\_\_\_\_\_ TETRACYCLINE

\_\_\_\_\_ XYLOCAINE

\_\_\_\_\_ OTHER: \_\_\_\_\_

IF ALLERGIES ARE KNOWN LIST WHAT MEDICATION OR PRODUCT AND WHAT SYMPTOMS / REACTIONS YOU EXPERIENCED.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**FAMILY HISTORY. PLEASE CHECK ALL THAT APPLY AND SPECIFY WHAT FAMILY MEMBER**

- |  |  |
|--|--|
| <input type="checkbox"/> ALCOHOLISM          | <input type="checkbox"/> ALZHEIMER'S DISEASE |
| <input type="checkbox"/> ANESTHESIA PROBLEMS | <input type="checkbox"/> ARTHRITIS           |
| <input type="checkbox"/> BLEEDING DISORDERS  | <input type="checkbox"/> CANCER              |
| <input type="checkbox"/> CHRONIC BACK PAIN   | <input type="checkbox"/> DEPRESSION          |
| <input type="checkbox"/> DIABETES            | <input type="checkbox"/> HEART PROBLEMS      |
| <input type="checkbox"/> HYPERTENSION        | <input type="checkbox"/> KIDNEY DISEASE      |
| <input type="checkbox"/> OSTEOPOROSIS        | <input type="checkbox"/> STROKE              |
| <input type="checkbox"/> THYROID DISEASE     |  |

**LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING WITH DOSAGES AND FREQUENCY.**

- |          |           |
|----------|-----------|
| 1. _____ | 2. _____  |
| 3. _____ | 4. _____  |
| 5. _____ | 6. _____  |
| 7. _____ | 8. _____  |
| 9. _____ | 10. _____ |

**SOCIAL HISTORY. PLEASE CHECK ALL THAT APPLY:**

- |   |  |
|---|--|
| <input type="checkbox"/> ALCOHOL USE: HOW OFTEN _____   | <input type="checkbox"/> CAFFEINE USE _____        |
| <input type="checkbox"/> ALTERNATIVE MEDICINE USE _____ | <input type="checkbox"/> DISABILITY _____          |
| <input type="checkbox"/> DIFFICULTY DRIVING _____       | <input type="checkbox"/> GOOD SUPPORT SYSTEM _____ |
| <input type="checkbox"/> FINANCIAL DIFFICULTY _____     |  |
| <input type="checkbox"/> RECREATIONAL DRUG USE _____    |  |

**EMPLOYMENT STATUS:** \_\_\_\_\_ **OCCUPATION:** \_\_\_\_\_

**HEALTH STATUS:**  POOR  FAIR  GOOD  VERY GOOD  EXCELLENT

**DO YOU PARTICIPATE IN LEISURE ACTIVITIES?** \_\_\_\_\_

**SEXUAL HISTORY:**

- |  |  |
|--|--|
| <input type="checkbox"/> SEXUALLY ACTIVE AT SOME POINT | <input type="checkbox"/> USES CONTRACEPTION  |
| <input type="checkbox"/> NORMAL LIBIDO                 | <input type="checkbox"/> NOW SEXUALLY ACTIVE |
| <input type="checkbox"/> INCREASED LIBIDO              | <input type="checkbox"/> DECREASED LIBIDO    |

**SLEEP HABITS**

- |  |  |
|--|--|
| <input type="checkbox"/> LESS THAN 6 HOURS A NIGHT | <input type="checkbox"/> 7 - 9 HOURS A NIGHT |
| <input type="checkbox"/> MORE THAN 9 HOURS A NIGHT | <input type="checkbox"/> POOR SLEEP          |

**TOBACCO USE:**

- |                               |  |                                       |
|-------------------------------|--|---------------------------------------|
| <input type="checkbox"/> NONE | <input type="checkbox"/> CHEWING TOBACCO | <input type="checkbox"/> CIGAR        |
| <input type="checkbox"/> PIPE | <input type="checkbox"/> PREVIOUS SMOKER | <input type="checkbox"/> NEVER SMOKED |
- CIGARETTE PACKS PER DAY? \_\_\_\_\_ How old were you when you started smoking? \_\_\_\_\_

**PAST MEDICAL HISTORY. PLEASE CHECK ALL THAT APPLY:**

- |   |  |
|---|--|
| <input type="checkbox"/> ALCOHOLISM               | <input type="checkbox"/> ANGINA                      |
| <input type="checkbox"/> ANKYLOSING SPONDYLOSIS   | <input type="checkbox"/> ASTHMA                      |
| <input type="checkbox"/> BACK INJURY / PAIN       | <input type="checkbox"/> BLOOD TRANSFUSION           |
| <input type="checkbox"/> BOWEL PROBLEMS           | <input type="checkbox"/> CANCER: Location_____       |
| <input type="checkbox"/> COAGULOPATHY             | <input type="checkbox"/> C.O.P.D.                    |
| <input type="checkbox"/> DEPRESSION               | <input type="checkbox"/> DIABETES                    |
| <input type="checkbox"/> FIBROMYALGIA             | <input type="checkbox"/> HEMOPHILLA                  |
| <input type="checkbox"/> HYPERTENSION             | <input type="checkbox"/> JOINT SPRAIN: Location_____ |
| <input type="checkbox"/> MUSCULOSKELETAL PROBLEMS | <input type="checkbox"/> NECK PAIN                   |
| <input type="checkbox"/> OSTEOPOROSIS             | <input type="checkbox"/> PACEMAKER                   |
| <input type="checkbox"/> PHLEBITIS                | <input type="checkbox"/> SHOULDER DISLOCATIONS       |
| <input type="checkbox"/> SLEEP APNEA              | <input type="checkbox"/> STOMACH PROBLEMS            |
| <input type="checkbox"/> STROKE                   | <input type="checkbox"/> SYNCOPE / FAINTING SPELLS   |
| <input type="checkbox"/> THYROID DISORDER         | <input type="checkbox"/> TUBERCULOSIS                |
| <input type="checkbox"/> OTHER_____               |  |

If any major accidents, list what type and what year:\_\_\_\_\_

**PAST SURGICAL HISTORY. PLEASE CHECK ALL THAT APPLY:**

- |   |   |
|---|---|
| <input type="checkbox"/> ABDOMINAL SURGERY          | <input type="checkbox"/> AMPUTATION                     |
| <input type="checkbox"/> ARTIFICIAL JOINT           | <input type="checkbox"/> BACK SURGERY                   |
| <input type="checkbox"/> CERVICAL FUSION            | <input type="checkbox"/> FRACTURE REPAIR                |
| <input type="checkbox"/> LAMINECTOMY                | <input type="checkbox"/> MEDICAL SPINE PROCEDURE        |
| <input type="checkbox"/> NECK SURGERY               | <input type="checkbox"/> PACEMAKER IMPLANT              |
| <input type="checkbox"/> POST OP PROLONGED BLEEDING | <input type="checkbox"/> REMOVAL OF ABDOMINAL ADHESIONS |
| <input type="checkbox"/> ANESTHETIC COMPLICATIONS   |   |

If any major accidents, list what type and what year:\_\_\_\_\_

**REVIEW OF SYSTEMS. PLEASE CHECK ALL THAT APPLY:**

- |   |  |
|---|--|
| <input type="checkbox"/> ALERGIC SYMPTOMS   | <input type="checkbox"/> ANGINA                      |
| <input type="checkbox"/> BREATHING DIFFICULTIES   | <input type="checkbox"/> ASTHMA                      |
| <input type="checkbox"/> ENDOCRINE-RELATED SYMPTOMS   | <input type="checkbox"/> BLOOD TRANSFUSION           |
| <input type="checkbox"/> JOINT / MUSCULOSKELETAL PROBLEMS                                     | <input type="checkbox"/> CANCER: Location_____       |
| <input type="checkbox"/> SKIN RELATED PROBLEMS  | <input type="checkbox"/> C.O.P.D.                    |
| <input type="checkbox"/> EAR, NOSE, THROAT, MOUTH PROBLEMS                                    | <input type="checkbox"/> DIABETES                    |
| <input type="checkbox"/> BALANCE PROBLEMS   | <input type="checkbox"/> HEMOPHILLA                  |
| <input type="checkbox"/> FATIGUE  | <input type="checkbox"/> JOINT SPRAIN: Location_____ |
| <input type="checkbox"/> LIGHT HEADEDNESS   | <input type="checkbox"/> NECK PAIN                   |
| <input type="checkbox"/> NUMBNESS   | <input type="checkbox"/> PACEMAKER                   |
| <input type="checkbox"/> PSYCHIATRIC PROBLEMS   | <input type="checkbox"/> SHOULDER DISLOCATIONS       |
| <input type="checkbox"/> WEAKNESS   | <input type="checkbox"/> STOMACH PROBLEMS            |
| <input type="checkbox"/> G.I. PROBLEMS - HEARTBURN, ACID REFLUX, CONSTIPATION, DIARRHEA, ETC. |  |
| <input type="checkbox"/> CONSTITUTIONS SYMPTOMS - FEVER, HEADACHE, NAUSEA, DIZZINESS, ETC.    |  |
| <input type="checkbox"/> OTHER SYMPTOMS: _____  |  |

**THANK YOU VERY MUCH.**

# PRIVACY NOTICE

REHABILITATION  
SPINE ASSOCIATES

THE HOUSTON SPINE &  
REHABILITATION CENTERS

PAIN MANAGEMENT  
CENTER OF HOUSTON

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## NOTICE OF PRIVACY PRACTICES

*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.*

Pain Management Center of Houston, Rehabilitation Spine Associates, or The Houston Spine & Rehabilitation Centers use health information about you for treatment to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of Greater Houston Therapeutics.

### How we may use or disclose your health information

**For Treatment:** We may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider such as a physician, therapist, nurse or other person providing health services to you will be recorded in your record related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond.

**For Payment:** We may use and disclose health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

**For Health Care Operations:** We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- Evaluate the performance of our staff;
- Assess the quality of care and outcomes in your case and similar cases;
- Learn how to improve our facilities and services;
- Determine how to continually improve the quality and effectiveness of the health care we provide.

**Appointments:** We may use your information to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

**Required by Law:** We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence;
- To assist law enforcement officials in their law enforcement duties.

**Public Health:** Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities. Health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

**Government Functions:** Your health information may be disclosed for specialized government functions such as protection of public official or reporting to various branches of the armed services.

**Workers' Compensation:** Your health information may be used or disclosed in order to comply with laws and regulation related to Workers' Compensation.

**Other uses:** Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent our facility has taken in reliance on such.

**Your Health Information Rights:** You have the right to:

- Request a restriction on certain uses and disclosures of your information provided by 45 C.F.R. § 164.522; however, our facility is not required to agree to a requested restriction;
- Obtain a paper copy of the notice of information practices upon request;
- Inspect and obtain a copy of your health record as provided for in 45 C.F.R. § 164.524;
- Request that your health record be amended as provided in 45 C.F.R. § 164.526;
- Request communications of your health information by alternative means or at alternative locations;
- Receive an accounting of disclosures made of your health information as provided by 45 C.F.R. § 164.528.

**Concerns / Complaints:** You may complain to our facility and / or to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a concern. To register a concern with our facility, please contact the Administrator to complete and return a Patient Concern Form to our facility.

**Our Obligations:** Our facility is required by law to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- Accommodate reasonable request you may make to communicate health information by alternative means or at alternative locations.

This office reserves the right to change information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made publicly available and posted at the facility.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY  
PRACTICES OF:**

**REHABILITATION  
SPINE ASSOCIATES**

**THE HOUSTON SPINE &  
REHABILITATION CENTERS**

**PAIN MANAGEMENT  
CENTER OF HOUSTON**

By signing this document, I acknowledge that I have received a copy of Pain Management Center of Houston's, Rehabilitation Spine Associate's, or The Houston Spine & Rehabilitation Center's Notice of Privacy Practices. I also acknowledge that I have been informed of Dr. Moore's partial ownership interest in University General Hospital; Mainstay Specialty Care; Humble Surgical Hospital. At any time you may change to have your procedure performed at another facility.

\_\_\_\_\_  
Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**Pain Management Center of Houston, P.A.  
The Houston Spine & Rehabilitation Centers  
Rehabilitation Spine Associates  
(use only)**

Date acknowledgement received: \_\_\_\_\_

-OR-

Reason acknowledgement was not obtained:

\_\_\_\_\_  
\_\_\_\_\_

# Pain Disability Index

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Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

For each of the 7 categories listed, please circle the number on the scale that describes the level of disability you typically experience. **A score of 0 means no disability at all, and a score of 10 signifies that all of these types of activities have been totally disrupted or prevented by your pain.**

Respond to each category by indicating the *overall* impact of pain in your life, not just when the pain is at its worst.

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## Family/Home Responsibility (such as house cleaning or errands):

No disability 

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

 Total disability

## Recreation (such as sports, exercise, and other similar leisure time activities):

No disability 

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

 Total disability

## Social Activity (such as going to parties, dining out, and other social functions):

No disability 

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

 Total disability

## Occupation (all activities related to one's job, including nonpaying jobs):

No disability 

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

 Total disability

## Sexual Behavior

No disability 

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

 Total disability

## Self-Care (such as bathing and dressing):

No disability 

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

 Total disability

## Life-Support Activity (eating, sleeping, and breathing):

No disability 

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

 Total disability

**Overall Disability Score** (out of a possible 70): \_\_\_\_\_

## **Patient Agreement**

### **TO: PATIENTS OF THE HOUSTON SPINE AND REHAB CENTERS, REHABILITATION SPINE ASSOCIATES, AND PAIN MANAGEMENT CENTER OF HOUSTON**

The Houston Spine and Rehabilitation Centers, Rehabilitation Spine Associates, and Pain Management Center of Houston specialize in the treatment of the spine and associated pain. We perform various treatments consisting of passive modalities, therapeutic interventions and spinal manipulation. The goal of our services is to reduce and/or eliminate your pain, however, as with any chiropractic and/or physical medicine services there are risks associated with the services we provide.

As your healthcare provider, we feel that it is crucial that you understand these risks. By informing you of these risks we are striving to more actively involve you in our case as well as further assist you in making well-informed decisions regarding your treatment options.

#### **PASSIVE MODALITIES**

Passive modalities consist of the following treatments: hot packs, cold packs, ultrasound electrical stimulation, massage, traction, paraffin, whirlpool, and iontophoresis.

The primary risk associated with passive modalities is skin irritation due to exposure to heat, cold or agents used in the application of modalities, i.e. lotions, pads, paraffin and/or iontophoresis (lidocaine/hydrocortisone). If you have experienced skin sensitivity to heat, cold temperatures, and/or lotions or similar products in the past or are aware of any skin allergies, please inform our staff prior to treatment so proper precautions can be made prior to initiating treatment.

#### **THERAPEUTIC INTERVENTIONS**

Therapeutic interventions consist of the following types of treatments: stretching, flexibility exercises, strengthening exercises, joint mobilizations and myofascial release.

Therapeutic interventions are generally quite safe though there are risks associated with each of these procedures. The primary risk is potential aggravation of your current condition and/or underlying condition. As with any physical activity and/or exercise there is also the risk of injury. Though this risk is minimal as you are under the direct supervision of experienced clinical staff, it may still exist.

Some responses to therapeutic interventions are muscle soreness, muscle fatigue, increased discomfort, overall tiredness and/or joint stiffness and/or pain. It is important that you inform your treating staff member of any of these responses following your treatment and more importantly it is crucial that you continue to attend your appointments as scheduled so your condition can be documented and your symptoms effectively managed.

#### **SPINAL MANIPULATION**

Spinal Manipulation consists of adjustments that seek to restore normal function to the spine and other joints. Typically, this involves applying a specific, highly controlled treatment directly to a joint or muscle. This treatment often reduces or eliminates both local and referred pain, allows muscle spasms to relax, and may even release the irritation from the nervous system, which may result in other health benefits.

As with any healthcare service there are potential reactions and risks, however as with any healthcare intervention, it is hoped that the expected benefits of spinal manipulation exceed the expected risks. These are unavoidable risks of spinal manipulation which, though rare, can occur.

#### **DISK HERNIATION**

The occurrence of disk herniation during spinal manipulation is highly unlikely. In fact, average disks withstand an average of 23 degrees of rotation and degenerated disks an average of 14 degrees of rotation before failure occurs. Furthermore, given the fact that during manipulation posterior facet joints limit rotation to a maximum of 2-3 degrees, this joint would have to fracture to allow any further rotation to occur.

#### **CAUDA EQUINA SYNDROME**

It is estimated that the rate of occurrence of the cauda equine syndrome as a complication of lumbar spinal manipulation is about one case per 100 million manipulations. It is probably higher in patients with a herniated nucleus pulposus, and lower in patients without this anatomic abnormality.

#### **VERTEBROBASILAR ARTERY COMPROMISE**

Serious complication of cervical spine manipulation are also rare (none having been reported in any of the clinical trials), but appear to be more common and severe than complication of lumbar manipulation. The most serious complication of the cervical spine manipulation is related to compromise of the vertebralbasilar artery, leading to stroke or death. The risk is higher for manipulation involving rotation plus extension of the cervical spine than for other types of manipulation, and those persons who have suffered manipulation-related vertebralbasilar artery compromise due to atherosclerotic disease. The best estimate of the incidence of vertebralbasilar artery compromise related to cervical spine manipulation is that it occurs one in 1 million manipulations (Hurwitz, 1996; McGregor, 1995).

#### **PATIENT UNDERSTANDING AND ACCEPTANCE OF RISKS ASSOCIATED WITH TREATMENT**

As your doctor it is our responsibility to inform you of the potential risks and benefits of your treatment, but we also want to assure you that we strive to minimize these risks by providing thorough clinical examination and by performing diagnostics as clinically indicated. Furthermore, we continually review medical literature pertaining to current trends within our profession as well as throughout the entire medical community to ensure the safest and most effective care.

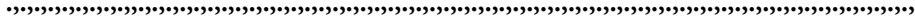
I have reviewed the information provided regarding the benefits and risks of treatment provided at The Houston Spine and Rehabilitation Centers, Rehabilitation Spine Associates, and Pain Management Center of Houston. I have been given the opportunity to discuss my questions and/or concerns and by signing below I acknowledge that I understand and accept the risks associated with my treatment.

**Patient Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Guardian's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_



**MEDICATION CONTRACT**

I, \_\_\_\_\_, understand that this contract is between me and Pain Management Center of Houston. It is designed to inform me fully of the manner in which my medications, especially narcotics, will be provided. It also outlines the criteria by which the Clinic team will determine whether or not to continue to prescribe my medications.

Pain medication, especially of a narcotic type, will be provided only after it is determined that reasonable alternatives for adequate pain control have been investigated / attempted.

I will agree to try other approaches or techniques as felt appropriate by the team that may assist me in taking the lowest effective dose possible.

My “pain medications” will be prescribed by one doctor and one doctor only, and filled at one pharmacy. Any attempt, successful or not, to obtain additional medications without the permission of the Medication Clinic may result in discontinuation of medication therapy.

Medications will be given at fixed intervals, usually every two or four weeks, and only if I keep my Clinic appointments.

I may at times, be requested to submit to a drug screen to confirm that I am taking only those medications prescribed.

Medications will be continued as long as (a) there is associated pain relief of at least 30% to 50%, (b) my functional activity is commensurate with what would be expected, given my physical condition, and is enhanced by taking the medication, and (c) there is no evidence of physical tolerance as suggested by the need for increasing medicine.

Evidence of hoarding or other mismanagement of my pain medication may result in discontinuation of Clinic services.

“Flare-ups” or exacerbations of my pain symptoms will be handled by other therapies, such as TENS, exercise, icing, heat, relaxation, or non-habit forming preparations. Only when it is determined that there is a physiological basis for the flare-up and additional medicine is required, a brief increase or “rescue dose” will be considered.

If it is determined that the situation may be out of control, I will agree to be hospitalized where medications and other therapies can be provided in a controlled fashion.

I understand that there are risks with medications that will be given to me including constipation, decreased appetite, confusion, loss of balance, breathing difficulty, physical dependence, psychological dependence and tolerance. I am willing to take these risks.

I have read and understand each of the above statements. I realize that the Medication Clinic will assume the responsibility of assisting me in my therapy as long as long as I comply with the above.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Spouse / Family member / Guardian

\_\_\_\_\_  
Witness

\_\_\_\_\_  
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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How often have you felt a need for higher doses of medication to treat your pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. How often have you felt impatient with your doctors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. How often have you felt that things are just too overwhelming that you can't handle them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. How often is there tension in the home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. How often have you counted pain pills to see how many are remaining?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. How often have you been concerned that people will judge you for taking pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. How often do you feel bored?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. How often have you taken more pain medication than you were supposed to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. How often have you worried about being left alone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. How often have you felt a craving for medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. How often have others expressed concern over your use of medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. How often have others told you that you had a bad temper?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. How often have you felt consumed by the need to get pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. How often have you run out of pain medication early?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. How often have others kept you from getting what you deserve?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. How often, in your lifetime, have you had legal problems or been arrested?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. How often have you attended an AA or NA meeting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. How often have you been in an argument that was so out of control that someone got hurt?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. How often have you been sexually abused?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. How often have others suggested that you have a drug or alcohol problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. How often have you had to borrow pain medications from you family and friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. How often have you been treated for an alcohol or drug problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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



## Patient Acknowledgement of Billing Practice

Patient: \_\_\_\_\_

Houston Spine and Rehabilitation has many facets to care for patients and their back care needs.

A patient may be treating with the professionals and clinicians in one or more of the facets of Houston Spine and Rehabilitation Center. The treating doctors, physical therapists, and clinicians include, but are not limited:

Dr. Mark Yezak D.C.  
Dr. Robert Alan Moore, Jr., M.D.  
Dr. Scott G. Neuburger B.S., D.C.  
Dr. Jason Schell D.C.  
Dr. Lynnette Orrick D.C.  
Dr. Joshua Akerman D.C.  
Dr. Kole Kopnick D.C.  
Alfred G. Vela, III M.P.T.

Due to the multiple disciplines utilized for patient care, Houston Spine and Rehabilitation Centers are under the direction of Medical Director, Dr. Robert Alan Moore, Jr., M.D.

All claims for patient care are submitted to insurance companies under the direction of our Medical Director, Dr. Robert Alan Moore, Jr., M.D. Dr. Robert Alan Moore is in-network on most major medical insurance plans and it will be his name which is seen on all explanation of benefits and correspondence from the insurance company.

During patient care, the benefit levels that will be utilized on insurance plans are the specialist and physical therapy benefits.

By signing this acknowledgement, the patient understands the billing practices for Houston Spine and Rehabilitation Center. If there are any questions, please ask Practice Administrator, Rebecca Sandefur.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date