



The Pain and Stress Management Center
Rey Ximenes, MD
3701 Bee Cave Road, Suite 104
Austin, TX 78746
512 306 1515

Dear New Patient,

Welcome to the Pain and Stress Management Center (PSMC). Attached please find our New Patient forms. Please do your best to fill out this requested information completely and accurately. If you cannot fill this out completely, please call or come by our office and our staff will be happy to assist you. The thoroughness and completeness of this information is very important and improves our ability to help you.

We also ask that patients arrive on time for appointments. Please find out where our office is located before your first appointment and, if necessary, make any transportation arrangements.

Please be aware of the following policies concerning your first appointment with our physician.

- 1) Please completely fill out and return the attached paperwork to our staff at your earliest opportunity in order to schedule your first appointment.

There are several options available to return completed paperwork to our office ~ fax, email, mail or personal delivery:

Address: Pain and Stress Management Center
3701 Bee Cave Road, Suite 104
Austin, TX 78746

Fax: (512) 306-8425

Email: newpatient@tpsmc.com (Please call 306-1515 to verify receipt of paperwork.)

- 2) Once our staff receives your completed paperwork, you will be contacted within 48-hours to schedule your initial appointment. If you do not receive a call from a staff member within this time period, please do not hesitate to contact us to schedule your appointment. Please be advised that we do not schedule New Patient appointments without completed paperwork.
- 3) Please arrive 15 minutes before your first scheduled appointment.
- 4) **Please bring originals** of completed paperwork (if not mailed). A copy can be made for you if desired.
- 5) If you need to reschedule or cancel your appointment, please call our staff at your earliest opportunity. Twenty-four(24)-hour notice is a reasonable request if you need to cancel or reschedule your initial consultation. If we do not receive 24-hour cancellation notice or if you miss your appointment, PSMC reserves the right to bill you up to fifty percent of the consultation fee.

Acknowledgement: I have read and understand the above information.

Patient (Responsible Party) Signature: _____

Print Patient Name: _____ Date: _____

Print Responsible Party (Guarantor) Name: _____

Relationship of Patient to Guarantor: _____

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Reason for Appointment (Chief Complaint): _____

How did you hear about Dr. Ximenes? Friend/Family _____ Doctor _____ WWW _____
Other _____ Yellow Pages _____ Insurance _____

RESPONSIBLE PARTY (GUARANTOR)

If Patient is NOT responsible party, Guarantor MUST SIGN spaces under Payment Policy and Assignment and Release.

Please initial if responsible party is Patient and skip to next section. _____

Last Name: _____ First Name: _____ MI: _____
Address: _____ Apt/Suite: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work/Other Phone: _____
Okay to Leave Message? (Indicate Yes or No) Home _____ Cell _____ Work _____
Email: _____ Gender: Female Male Relationship to Patient: _____
Social Security No: _____ Date of Birth: _____ Driver's License: _____
Employer Name: _____
Employer Address: _____
City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Is Patient Covered by Insurance? Yes No *Please bring insurance card to appointments.*

Is Patient a Medicare Beneficiary? Yes No *If no, skip next question.*

If patient a Medicare Beneficiary, has Patient (and/or Guarantor) been advised of Opt-Out Status? Yes No
(An Opt-Out Agreement will be provided to Medicare Beneficiaries and must be signed prior to any treatment.)

Is Patient a Medicaid Beneficiary? Yes No *If no, skip next question.*

If patient has Medicaid, has Patient been advised PSMC does not accept Medicaid? Yes No

Primary Insurance Carrier: _____

Is a referral required? Yes No *If yes, please contact Primary Care Physician for referral.*

Primary Insured (Subscriber) Name: _____ Social Security No: _____

Birthdate: _____ Gender: Female Male Relationship to Patient: _____

Subscriber (ID) #: _____ Group #: _____

Insurance Phone # (Providers): _____ Group/Employer Name: _____

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INSURANCE INFORMATION

Does Patient have Secondary Insurance? Yes No *If no, skip to next section..*
Secondary/Other Insurance Carrier: _____
Secondary Insured (Subscriber) Name: _____ Social Security No: _____
Birthdate: _____ Gender: Female Male Relationship to Patient: _____
Subscriber (ID) #: _____ Group #: _____
Insurance Phone # (Providers): _____ Group/Employer Name: _____

PHARMACY INFORMATION

Pharmacy Name: _____
Address: _____ Suite: _____
City: _____ State: _____ Zip: _____
Pharmacy Phone: _____ Fax Number: _____

Medication Allergies? Yes No If yes, please list in following space:

Other Allergies? Yes No If yes, please list in following space:

PAYMENT POLICY

You are financially responsible for all charges, whether or not reimbursable by your insurance. Insurance claims are filed as a courtesy to the Patient (and/or Guarantor). If your insurance carrier denies or otherwise does not pay your claim, in whole or in part, you agree to remit the entire balance immediately upon notice/request.

Responsible Party Signature: _____ Print Name: _____
Patient Name: _____ Relationship to Patient: _____ Date: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above identified insurance company(ies), and I assign directly to Rey Ximenes, MD, Lone Star Anesthesiology, PA, dba The Pain and Stress Management Center, insurance benefits, if any, otherwise payable to me for services rendered. I have read and understand the above payment policy and hereby consent to and authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions.

Responsible Party Signature: _____ Print Name: _____
Patient Name: _____ Relationship to Patient: _____ Date: _____



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Today's Date _____

Patient Name _____ Date of Birth _____

Circle: Male / Female Telephone: Home _____ Cell/Work: _____

Home Address _____

Employer: _____

Age _____ L or R handed (circle one) Referred by _____

Please tell us about yourself and your problem so we can better understand. Please do your best to fill this out completely. Be honest. Your answers are confidential. I realize this is a lot to do but it will help save time during your first office visit and allow us to better help you deal with this problem.

What pain problem are you having? When or how did it begin? _____

What do you think is the problem? _____



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Patient Name _____ **Date of Birth** _____

What other doctors have you seen about this? When was that? What was done? (Procedures, exams, meds, etc.)

Doctor Name	Month/Year Seen	What was done?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please tell me in your own words where your pain is. _____

Circle any words below that describe your pain. Feel free to use your own words in the blank.

- | | | | |
|------------|----------|-------------|--------------|
| Aching | Sharp | Penetrating | Throbbing |
| Tender | Nagging | Shooting | Burning |
| Numb | Stabbing | Exhausting | Miserable |
| Gnawing | Tiring | Unbearable | Intermittent |
| Continuous | Sore | Deep | Dull |



Patient Name _____ **Date of Birth** _____

Circle the number that best describes your pain:

0 = No Pain

10 = Worst Pain Imaginable

At it's worst in the last month:

0 1 2 3 4 5 6 7 8 9 10

At it's least in the last month:

0 1 2 3 4 5 6 7 8 9 10

On average during the last month:

0 1 2 3 4 5 6 7 8 9 10

Right now:

0 1 2 3 4 5 6 7 8 9 10

What do you do to make your pain better? (For example: Heat, Cold, Rest, Medicine)

What seems to make it worse? (For example: Walking, Standing, Lifting, Sitting, Bending)

For the things that are being done or those that have been done, please tell me how they are working or how they have worked. On the scale of ten below, circle the number to signify the amount of relief you have had on average. Please put a check next to the ones you are currently receiving.

Treatment/Medication	No Relief = 0	Complete Relief = 10	Currently Receiving
_____	0 1 2 3 4 5 6 7 8 9 10		_____
_____	0 1 2 3 4 5 6 7 8 9 10		_____
_____	0 1 2 3 4 5 6 7 8 9 10		_____
_____	0 1 2 3 4 5 6 7 8 9 10		_____
_____	0 1 2 3 4 5 6 7 8 9 10		_____



Patient Name _____ Date of Birth _____

Please tell me how this pain problem is affecting your life or interfering with your function. Circle the number that best fits.

0 = Does not interfere with

10 = Completely interferes with

General Activity	0	1	2	3	4	5	6	7	8	9	10
Mood	0	1	2	3	4	5	6	7	8	9	10
Walking Ability	0	1	2	3	4	5	6	7	8	9	10
Work Routine	0	1	2	3	4	5	6	7	8	9	10
Relationships	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10
Concentration	0	1	2	3	4	5	6	7	8	9	10
Appetite	0	1	2	3	4	5	6	7	8	9	10

If medicines and/or treatments could decrease your pain, what level would it have to be at for you to function?

0 = No Pain

10 = Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

Major (ICD-10) Depression Inventory ©

The following questions ask about how you have been feeling over the last two weeks. Please refer to the legend and circle the number which is closest to describing how you feel.

5 = All of the Time

2 = Less than half of the Time

4 = Most of the Time

1 = Some of the Time

3 = More than half of the Time

0 = At No Time

How much of the time...

1.	Have you felt in low spirits or sad?	5	4	3	2	1	0
2.	Have you lost interest in your daily activities?	5	4	3	2	1	0
3.	Have you felt lacking in energy and strength?	5	4	3	2	1	0
4.	Have you felt less self-confident?	5	4	3	2	1	0
5.	Have you had a bad conscience or feelings of guilt?	5	4	3	2	1	0



Patient Name _____ Date of Birth _____

5 = All of the Time **2 = Less than half of the Time**
4 = Most of the Time **1 = Some of the Time**
3 = More than half of the Time **0 = At No Time**

How much of the time...							
6.	Have you felt that life wasn't worth living?	5	4	3	2	1	0
7.	Have you had difficulty in concentrating? e.g. when reading the newspaper or watching TV?	5	4	3	2	1	0
8a.	Have you felt very restless?	5	4	3	2	1	0
8b.	Have you felt subdued?	5	4	3	2	1	0
9.	Have you had trouble sleeping at night?	5	4	3	2	1	0
10a.	Have you suffered from reduced appetite?	5	4	3	2	1	0
10b.	Have you suffered from increased appetite?	5	4	3	2	1	0

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Past Medical History

Please tell me about your Medical History (such as Heart Disease, Stroke, Cancer, Arthritis, Diabetes, Hypertension, Depression etc.)



Patient Name _____ **Date of Birth** _____

Past Surgical History

Please tell me about any surgeries you have had, in particular those associated with your pain problem.

Family History

Please list medical problems that family members might have that run in the family. (Heart Disease, Heart Attack, Stroke, Cancer, Diabetes, Back Pain, Alcoholism, Chemical Dependency, etc.)

Mother _____

Grandmother _____

Grandfather _____

Father _____

Grandmother _____

Grandfather _____

Sibling (include age and gender) _____

Sibling (include age and gender) _____

Sibling (include age and gender) _____

Sibling (include age and gender) _____

Child (include age and gender) _____

Child (include age and gender) _____

Child (include age and gender) _____

Child (include age and gender) _____



Patient Name _____ **Date of Birth** _____

Women only

How many times have you been pregnant? G _____
How many were full term? F _____
How many were premature? P _____
How many were abortions or miscarriages? A _____
How many are living? L _____

Work History

Job	Years there	Why did you leave?
-----	-------------	--------------------

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you married or single or divorced? _____

Who do you live with? _____

How far did you go in school? _____

How does this pain problem affect you in your home life? _____

How does this pain problem affect you at work? _____



Patient Name _____ **Date of Birth** _____

How does this pain problem affect your relationships? _____

Has this pain problem affected your income? _____

Are you involved in any litigation, lawsuits or legal matters? Please explain. _____

Do you smoke cigarettes or use tobacco in any form? Yes / No

If so, how much and for how long? _____ Pack/day for _____ Years

Do you drink any alcohol? Yes / No

What is your average amount per day or week or month? _____

Does it help your pain problem or make it worse? _____

Do you use any illegal drugs, street drugs or recreational drugs? Yes / No

If so, what type and how often? _____

Does it help your pain problem or make it worse? _____



Patient Name _____ **Date of Birth** _____

Do you drink coffee or tea? If so, how much per day? _____

Do you drink soft drinks? If so, how much per day? _____

Do you exercise? If so, what do you do and how often? How long? _____

Allergies

Please tell me about any allergies you may have to drugs/foods and what happened when you got them.
(Rash, Swelling, Shortness of Breath, Blood Pressure Problems etc.)

Drug Intolerances

Are you intolerant of any medications because of side effects? Please list them and what they do to you.
(Nausea, Vomiting, Constipation, Dry Mouth etc.)

List Current Medications:



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Patient Name _____ **Date of Birth** _____

List any Vitamins or Supplements/Herbs:

Are there any other medical problems/symptoms that you might have that you have not yet listed that you feel might be relevant to this pain problem?

General _____

Head _____

Eyes _____

Ears _____

Nose _____

Lungs _____

Heart/Circulatory System _____

Gastrointestinal _____

Genitourinary _____

Liver _____

Muscle/Bone _____

Neurological _____