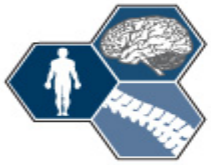


Irfan Lalani, MD, PA

Interventional Pain, Neurodiagnostics and Rehabilitation

New Patient Form

Pain Management

Methodist Sugar Land Hospital
Medical Office Building 3
16605 S.W. Freeway, Suite 320
Sugar Land, TX 77479
Ph: (281) 265-0225 Fax (281) 265-2219

Patient Information

First Name: _____ Middle Name/Initial: _____

Last Name: _____ DOB: _____ Gender: □ Female □ Male

Street Address: _____ City: _____ State:_____ Zip:_____

SSN#: _____ Home Phone#:_____ Cell Phone #:_____

Work Phone #:_____ Alternate Phone #:_____

Primary Insurance Information

Insurance Company Name:_____

Policy/Member #:_____ Group/Account #:_____ SSN#:_____

Claims Address:_____ City:_____ State:_____ Zip:_____

Phone Number #:_____ (Located on the card)

Subscriber's Full Name:_____ Subscriber's DOB:_____

Relationship to the Subscriber:_____

Secondary Insurance Information

Insurance Company Name:_____

Policy/Member #:_____ Group/Account #:_____ SSN#:_____

Claims Address:_____ City:_____ State:_____ Zip:_____

Phone Number #:_____ (Located on the card)

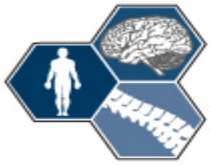
Subscriber's Full Name:_____ Subscriber's DOB:_____

Relationship to the Subscriber:_____

Pharmacy Information

Name:_____ Phone#:_____ Fax:_____

Address:_____ City:_____ State:_____ Zip:_____



Irfan Lalani, MD, PA

Interventional Pain, Neurodiagnostics and Rehabilitation

Emergency Contact (Not living with you)

Contact Name:_____ Relationship:_____

Home Phone #:_____ Cell Phone #:_____ Alternate Phone #:_____

Doctors

Do you have a Primary Care Doctor: □ Yes □ No If yes, Primary Care Doctor Name:_____

If No, would you like us to refer you to a Primary Care Doctor: □ Yes □ No

How did you find out about us? □ Referred by Doctor _____

□ Internet _____ _ □ Friend _____ □ Magazine _____

□ Methodist Spine Center □ Hospital ER _____ □ Other _____

Patient History

Principal Reason for seeing Dr. Lalani:_____

How long have you had this problem:_____

Any Other Neurological Issues:_____

Social History

Status: □ Married □ Single □ Divorced □ Separated □ Widowed

Occupation Status: □ Employed Full Time □ Employed Part Time □ Disabled □ Retired

Employer/Company Name:_____ Occupation/Job Title: _____

Employer Address:_____ City:_____ State:_____ Zip:_____

Student: □ Yes □ No Name of Institution:_____

Tobacco Smoker: □ Yes Current Smoker □ No, Former Smoker □ No, Non-Smoker

Do you drink alcohol? □ Yes : How much? _____ □ No, Never

Have you ever used illicit drugs: □ Yes □ No Have you used illicit drugs within the past year: □ Yes □ No

History of Addiction: □ Yes □ No

Irfan Lalani, MD, PA
Interventional Pain, Neurodiagnostics and Rehabilitation

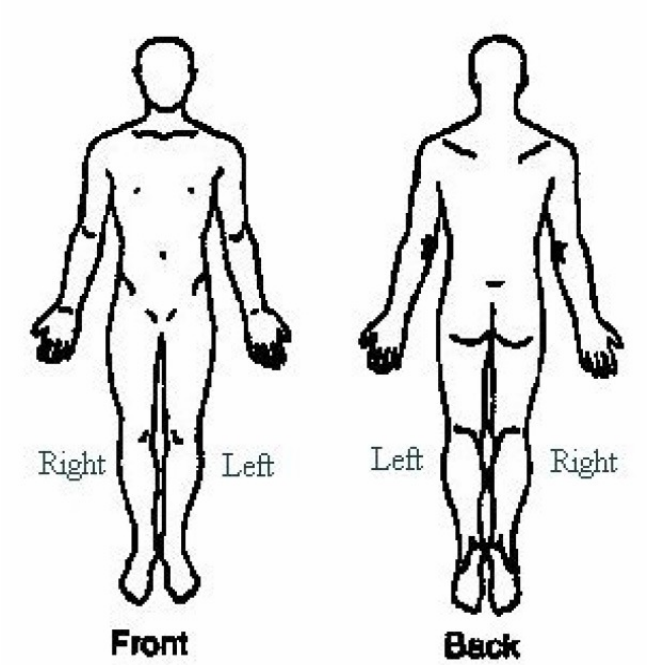
Please list ALL CURRENT medications:

MEDICATION NAME	DOSAGE
EXAMPLE: **IBUPROPHEN**	***EXAMPLE:*** **200mg three times a day**

Irfan Lalani, MD, PA
Interventional Pain, Neurodiagnostics and Rehabilitation

Pain Level

Please shade the areas where you experience pain. Mark the worst spot with an "X"



Pain Free	Easy to Ignore	Tolerable but annoying	Distracting but still can function pretty well	Interferes with strenuous activity such as climbing ladders, running lifting heavy objects, sports	Prevents activities that require mild effort, such as driving, shopping, climbing stairs, cooking	Trouble doing even simple daily activity (using bathroom, dressing bathing eating, etc.)	Need help from others with daily activity. Need help getting to bathroom, bathing, etc.	Pain prevents movement. Crying. Can not take care of self.	Screaming, vomiting, sweating	Passed out due to pain.
0	1	2	3	4	5	6	7	8	9	10

Using the scale above please enter the number that best describes your pain.

On a **bad day** my pain is _____ On a **good day** my pain is _____ My pain **usually** is _____

Irfan Lalani, MD, PA

Interventional Pain, Neurodiagnostics and Rehabilitation

Describing the Pain

Please mark the following item that best describe your pain

□ Sharp	□ Dull	□ Suffering
□ Burning	□ Aching	□ Tiring
□ Shooting	□ Throbbing	□ Miserable
□ Stabbing	□ Tender	□ Fearful
□ Stinging	□ Cramping	□ Punishing
□ Numb	□ Pressure	□ Unbearable

Please mark the timing of you pain

□ Constant □ Comes and Goes

When is the pain:

Better	□ Morning	□ Afternoon	□ Night
Worse	□ Morning	□ Afternoon	□ Night

Please mark any factors that *reduce* or *help* your pain.

□ Sitting	□ Standing	□ Lying Down	□ Bending	□ Walking
□ Heat	□ Cold	□ Coughing	□ Rubbing Area	□ Lifting

□ Other (Please Describe) _____

Please mark any factors that *aggravate* or *worsen* your pain.

□ Sitting	□ Standing	□ Lying Down	□ Bending	□ Walking
□ Heat	□ Cold	□ Coughing	□ Rubbing Area	□ Lifting

□ Other (Please Describe) _____

Effectiveness of Pain Treatment

Please rate the effectiveness of pain treatments you have tried for your current condition.

Physical Therapy	□ Excellent	□ Good	□ Fair	□ Poor	□ N/A
Psychology/Therapy	□ Excellent	□ Good	□ Fair	□ Poor	□ N/A
Massage	□ Excellent	□ Good	□ Fair	□ Poor	□ N/A
Chiropractor	□ Excellent	□ Good	□ Fair	□ Poor	□ N/A
Injections	□ Excellent	□ Good	□ Fair	□ Poor	□ N/A

Irfan Lalani, MD, PA

Interventional Pain, Neurodiagnostics and Rehabilitation

Please rate the effectiveness of pain treatments you have tried for your condition.

Surgery □ Excellent □ Good □ Fair □ Poor □ N/A

Please specify the type of surgery: _____

Medications □ Excellent □ Good □ Fair □ Poor □ N/A

Please specify the medications used: _____

Other Treatments □ Excellent □ Good □ Fair □ Poor □ N/A

Please specify the treatment: _____

Medications used in the Past

Please mark all medications from the list that you have ever used:

□ Prozac	□ Lexapro	□ Celexa	□ Zoloft	□ Paxil	□ Effexor
□ Valium	□ Klonopin	□ Xanax	□ Ativan	□ Soma	□ Buspar
□ Ambien	□ Lunesta	□ Sonata	□ Restonl	□ Adderal	□ Ritalin
□ Vicodin	□ Lortab	□ Norco	□ Fioricet	□ Darvocet	□ Stadol
□ Tylox	□ Percocet	□ Oxycodone	□ OxyContin	□ Demerol	□ Morphine
□ Kadian	□ Avinza	□ MS Contin	□ Duragesic	□ Actiq	□ Methadone

Please check any of the following tests that you have had to diagnose your current problem.

□ CT Scan Facility Used: _____ Date of Scan: _____ Ordered by Dr. _____

□ MRI Scan Facility Used: _____ Date of Scan: _____ Ordered by Dr. _____

□ EMG Facility Used: _____ Date of Test: _____ Ordered by Dr. _____

Irfan Lalani, MD, PA
Interventional Pain, Neurodiagnostics and Rehabilitation

Patient Medical History

Please mark any conditions for which you have been treated:

□ High Blood Pressure	□ Diabetes	□ Cancer	□ Seizures
□ Heart Disease or Chest Pain	□ Stroke	□ Suicidal Thoughts	□ Arthritis
□ Lung Disease/Asthma/COPD	□ Migraine/Chronic headache	□ Hormone problems	□ Fibromyalgia
□ Kidney Disease	□ Depression/Anxiety	□ Sleep Apnea	□ HIV/AIDS
□ Liver Disease/Hepatitis/Cirrhosis	□ Alcoholism/Addiction	□ Stomach Ulcers	□ Other
□ High Cholesterol	□ Alzheimer's/Dementia	□ Psychiatric Condition	_____

Allergies/Intolerance

Please list all medications that you are allergic to and describe the reaction:

Medication	Reaction

Family History

Do you have a family history of any of these following conditions?

□ High Blood Pressure	□ Diabetes	□ Cancer	□ Seizures
□ Heart Disease or Chest Pain	□ Stroke	□ Suicidal Thoughts	□ Arthritis
□ Lung Disease/Asthma/COPD	□ Migraine/Chronic headache	□ Hormone problems	□ Fibromyalgia
□ Kidney Disease	□ Depression/Anxiety	□ Sleep Apnea	□ HIV/AIDS
□ Liver Disease/Hepatitis/Cirrhosis	□ Alcoholism/Addiction	□ Stomach Ulcers	□ Other
□ High Cholesterol	□ Alzheimer's/Dementia	□ Psychiatric Condition	_____

Review of Symptoms

Please mark the symptoms that you have experienced in the last 6 months:

□ Loss of appetite	□ Double vision	□ Depression	□ Incontinence	□ Hearing loss	□ Anxiety
□ Chest pain	□ Joint pain	□ Constipation	□ Poor balance/falls	□ Easy bleeding/bruising	□ Weight gain
□ Shortness of breath	□ Itching	□ Rash	□ Shaking/tremors	□ Repeated infections	□ Weight loss

Irfan Lalani, MD, PA

Interventional Pain, Neurodiagnostics and Rehabilitation

Consent Form:

Treatment Authorization: I authorize Irfan Lalani, MD PA to examine, diagnose and treat me. I authorize and give Irfan Lalani, MD PA consent to submit specimens of blood, urine, tissue, etc. to the laboratory (ies) of choice for analysis and study and to include diagnosis for submission for payment to the insurance carrier for the named patient.

Authorization for Release of Information: I hereby authorize Irfan Lalani, MD PA to release any information necessary to my insurance company, including governmental health care insurer, such as Medicare and Medicaid or other health care practitioners involved in the care of the named patient. I understand that I am giving this authorization only in the care of a subpoena or for the release of information necessary for the provision of continuity of care to determine insurance benefits and the payment of any claims, and/or for all health plan procedures related to the evaluation of the quality and cost efficiency of care. I also authorize the release of all my medical records, including but not limited to, imaging, labs, office notes, Rx history and other medical information relevant to my care.

Responsible Party Agreement: I do hereby acknowledge that I am the guarantor of this account and agree to pay for services rendered including supplies or pharmaceuticals that are provided to me in my treatment. If any charges are submitted to my insurance carrier by either Irfan Lalani, MD PA or by a provider of healthcare services, products, or equipment which are ordered by my physician for the care of the named patient and there services are not covered medical services. I agree to pay for any balance deemed applicable according to my insurance and that I agree to make payment for these amounts at the time of service. If I am not covered by any insurance carrier, I agree to pay for services rendered at the time of service.

Acknowledgement of Review of Notice of Privacy Practices: I have reviewed this Office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

I, _____, have read and agree to the consent form above by proof of my signature below.

_____ _____

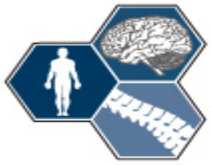
Signature of Patient or Legal Representative Date

Nurse Section

Vitals Signs

Current Weight: _____ BP: _____

Height: _____ HR: _____



Irfan Lalani, MD, PA
Interventional Pain, Neurodiagnostics and Rehabilitation

Methodist Sugar Land Hospital
Medical Office Building 3
16605 Southwest Freeway Suite #320
Sugar Land, TX 77479
Phone: (281) 265-0225
Fax: (281) 265-2219

Medical Records Request Form

Authorization For Disclosure of Health Information

This is a request for medical records for the following patient:

Patient Name: _____

Patient Address: _____

Patient DOB: _____

Patient SSN: _____

Information to be disclosed:

□ ALL MEDICAL RECORDS ON FILE
□ All Laboratory Tests
□ All Imaging and Radiology
□ All History and Physicals
□ All Progress Notes
□ All Current Medications
□ All EMG Tests
□ Other _____

Information to be disclosed to:

Irfan Lalani, MD, PA
Neurology and Pain Medicine
16605 Southwest Freeway Suite #320
Sugar Land, TX 77479
Phone: (281) 265-0225
Fax: (281) 265-2219

I, _____, do hereby authorize the release of all my medical records to Dr. Irfan Lalani and staff.

_____ _____
Signature of Patient or Qualified representative Date

Neurological Examination

MOTOR	Del	Bicep	Tricep	WF	WE	FF	FE	IP	QUAD	HAM	TA	GASTROC
Right												
Left												

REFLEXES	Bicep	Tricep	Brachiorad	Knee	Ankle	Babinski	Clonus
Right							
Left							

MMSE:	

	R	L
Hoffman's	□	□
Spurling Sign	□	□
Lumbar Facet Loading	□	□
Cervical Facet Loading	□	□
FABER	□	□
SLRT	□	□
Romberg	□	□

SENSATION:	Vibration decreased/normal in both feet. Pinprick decreased/normal in both feet

COORDINATION:	Finger to nose R □ L □
	Heel to Shin R □ L □

GAIT:	Base Normal □ Wide □
	Steady/unsteady

NOTES:	