# PAIN & STRESS CENTER

8650 Bandera Rd. #101, San Antonio, TX 78250

Phone (210) 614-7246 FAX (210) 614-4336 Email: info@painstresscenter.com


## New Patient Forms

Please complete the enclosed forms and return them to our office so that an appointment can be made for you. Returning the complete records will allow one of the nutritional consultants time to review them before the appointment.

Payment is required before consulting with the nutritional consultant. Please supply a Visa, Master Card or Discover along with the expiration date.

__MasterCard __VISA __Discover __AMEX **Name on Card** _____

**Card No:** _____ **Exp Date**: _____

The fees are as follows:

**Laura Boyd, C.N.C**.
Certified Nutritional Consultant
$70.00 – hour consult
$40.00 – 30-minute consult
$20.00 – 15-minute consult

**Linda M. Volpenhein, C.N.C.**
Certified Nutritional Consultant
$70.00 – hour consult
$40.00 – 30-minute consult
$20.00 – 15-minute consult

Dr. Billie J. Sahley consults with physician referrals and established patients. Her fee is $150.00 an hour. She is semi-retired and writes and does research and product development. Contact Linda for scheduling with Dr. Sahley. Additionally, Dr. Sahley will review and outline individualized programs for amino acid panels run by other physicians through MetaMetrix or Great Smokies Diagnostic Laboratory for $150.00.

Dr. Katherine M. Birkner is in the midst of an extended research project and has suspended any new patient appointments.

Please call our office in 3-4 working days after returning the paperwork and payment to schedule the phone consult.

If you have any questions, please feel free to contact us.

Thank You,

Linda Volpenhein
Office Manager

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ALL INFORMATION MUST BE PROPERLY FILLED OUT BEFORE CONSULTING WITH ONE OF THE NUTRITIONISTS. ***PLEASE PRINT LEGIBLY IN INK.***

PATIENT'S NAME DOB

STREET ADDRESS CITY/STATE/ ZIP CODE HOME PHONE #

PATIENT'S EMPLOYER ADDRESS CITY/STATE/ZIP BUSINESS PHONE#

SPOUSE'S NAME/PT. IF MINOR ADDRESS CITY/STATE/ZIP PHONE #

SPOUSE'S EMPLOYER OCCUPATION HOW LONG BUSINESS PHONE #

EMPLOYER'S STREET ADDRESS CITY/STATE/ZIP

NEAREST RELATIVE IF EMERGENCY ADDRESS PHONE #

WORKMAN'S COMP: YES/NO NAME OF CARRIER DATE OF INJURY

REFERRED BY:

FAMILY/ATTENDING PHYSICIAN ADDRESS PHONE #

INSURANCE COMPANY NAME POLICY # / GROUP # TX DRIVER'S LICENSE

I understand I am financially responsible to the Pain & Stress Mgmt. Clinic and its providers for services rendered to me or any member of my family. If you have any questions, we will, of course, assist you.

SIGNATURE OF RESPONSIBLE PARTY _____ DATE _____

I hereby consent to medical treatment and/or therapy at the Pain & Stress Mgmt. Clinic.
I certify that the information is correct. I authorize the Pain & Stress Mgmt. Clinic to obtain information about my financial situation to establish my eligibility for medical care and will inform the credit office if there is a change in my financial status or insurance coverage. I accept sole responsibility for the cost of medical care I receive at the Pain & Stress Mgmt. Clinic and agree to pay the full amount at the time services are rendered, in accordance with the financial policy of this institution.
I hereby give consent to the Pain & Stress Mgmt. Clinic to give the desired information from my medical records, including laboratory findings and diagnosis, to my insurance company herein specified. **Patient certification, authorization to release information and payment request:** I certify the information given me in applying for payment under Title XVII of the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment or authorized benefits be made on my behalf.

SIGNATURE OF RESPONSIBLE PARTY DATE

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**NAME** _____ **DATE** _____ **APPROX WEIGHT** _____

**MEDICATION TAKEN REGULARLY** **MEDICATION AS NEEDED**

**VITAMINS/AMINO ACIDS/HERBS TAKEN REGULARLY**

**KNOWN DRUG OR FOOD ALLERGIES**

**LIST ANY OPERATIONS YOU HAVE HAD ALONG WITH THE YEAR**

**IN YOUR OWN WORDS, PLEASE DESCRIBE THAT YOU FEEL IS YOUR MAJOR PROBLEM.**

***PLEASE use ink and print or write legibly.***

_____

_____

_____

_____

_____

_____

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**THIS INFORMATION IS CONFIDENTIAL. FOR DOCTOR'S USE ONLY.**

CHECK THE SYMPTOMS THAT YOU THINK WILL DESCRIBE THE WAY YOU FEEL NOW.

**PHYSICAL**

__ appetite change
__ headache
__ tension
__ fatigue
__ insomnia
__ weight change
__ colds
__ muscle aches
__ digestive upset
__ pounding heart
__ teeth grinding
__ rash
__ restlessness
__ foot tapping
__ finger drumming
__ increased alcohol, drug, tobacco use
__ numbness in limbs
__ poor circulation
__ cold feet or hands
__ rapid heartbeat
__ constipation
__ painful joints
__ back or neck pain
__ tender headedness
__ tingling lips/fingers
__ faintness
__ chest pain
__ sweating
__ chronic pain
__ fibromyalgia
__ post-surgical pain
__ TMJ
__ chemical sensitivities
__ food allergies

**EMOTIONAL/MENTAL**

__ anxiety
__ frustration
__ the "blues"
__ mood swings
__ bad temper
__ nightmares
__ crying spells
__ irritability
__ "no one cares"
__ depression
__ nervous laugh
__ worrying
__ easily discouraged
__ little joy
__ guilt
__ forgetfulness
__ mental dullness
__ poor concentration
__ low productivity
__ lethargy
__ whirling mind
__ no new ideas
__ boredom
__ spacing out
__ negative self talk
__ low self talk
__ fear of failure
__ feelings of low reality
__ trembling/shaking
__ loss of control
__ fear of choking
__ grief
__ panic attacks
__ anger
__ fear of death

**RELATIONAL**

__ isolation
__ intolerance
__ resentment
__ loneliness
__ lashing out
__ hiding
__ clamming up
__ lowered sex drive
__ nagging
__ fewer contacts w/ friends
__ lack of intimacy
__ using people
__ fear of people
__ fear of commitment

__ Have you lost anyone close this year:
__ from illness
__ separation

**SPIRITUAL**

__ emptiness
__ loss of meaning
__ doubt
__ martyrdom
__ looking for magic
__ loss of direction
__ needing to "prove oneself"
__ cynicism
__ apathy
__ turned away from church

Have you ever been diagnosed with post-traumatic stress disorder? ___ Yes ___ No When? _____

Do you use or have you used recreational drugs? _____

Do you consume alcohol ___ daily ___ weekly ___ for stress ____for pain?

Patient _____ Date: _____

## PAIN INTENSITY RATING

On the line below CIRCLE your AVERAGE PAIN over this last week.

No Pain — Worst Possible

0% 10 20 30 40 50 60 70 80 90 100%

## PAIN DRAWING

**WHERE IS YOUR PAIN NOW?**

Use appropriate symbols shown below to mark the areas on your body where you feel the described sensations. Include ALL areas affected by your pain and mark the type and area of pain if it radiates or spreads to other areas.

BURNING X | NUMBNESS O | PINS and NEEDLES = | STABBING / | ACHE ^