



**Matt McCarty MD**  
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Name \_\_\_\_\_ Referring Physician \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

**A. CHIEF COMPLAINT (Reason for Visit)** \_\_\_\_\_

1. Please rate your **Present** Pain Level (0 = no pain 10 =worst pain)

1  2  3  4  5  6  7  8  9  10

2. Please rate your **Average** Pain level (0 = no pain 10 = worst pain)

1  2  3  4  5  6  7  8  9  10

3. Please rate your ability to Perform activities of daily living: such as hygiene, household chores, transportation etc.  
(0 = not able 10 = very able)

1  2  3  4  5  6  7  8  9  10

4. What is the exact location of your pain? \_\_\_\_\_

5. When did you first have this pain? \_\_\_\_\_

6. Please describe your pain. (Circle all that apply)

- |            |             |               |
|------------|-------------|---------------|
| * Sharp    | * Numbness  | * Constant    |
| * Dull     | * Tingling  | * Cramping    |
| * Aching   | * Radiating | * Burning     |
| * Pressure | * Stabbing  | * Other _____ |

7. How often do you have this pain? \_\_\_\_\_

8. What makes your pain worse? \_\_\_\_\_

9. Previous diagnoses for this pain? \_\_\_\_\_

10. Previous treatment for this pain? \_\_\_\_\_

11. Do you have numbness, tingling or weakness in the arms or legs? \_\_\_\_\_

12. Have you had any changes in bowel or bladder function? \_\_\_\_\_

**B. PAST MEDICAL HISTORY** (please check all that apply):

<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Vascular Problems	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Low Thyroid	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	Lupus	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	Other: _____			<input type="checkbox"/>	Osteoarthritis (regular)		

**C. PAST SURGICAL HISTORY:**

Surgery	Details	Date & Hospital
Back Surgery		
Breast		
Gall Bladder		
Hernia Repair		
Hysterectomy/Ovaries		
Tonsillectomy		
Stomach/Ulcer		
Other		

Hospitalizations other than surgery (include dates & hospitals) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

All current physicians \_\_\_\_\_

\_\_\_\_\_

**D. CURRENT MEDICATIONS** (Include over the counter & herbal products):

Name	Dose & Frequency	Condition Being Treated	Duration

**E. ALLERGIES TO MEDICATION** (List all medications & reactions): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**F. SOCIAL HISTORY:**

\*Tobacco Use: No / Yes (Circle) Packs per Day \_\_\_\_\_ # of Years \_\_\_\_\_  
\*Alcohol Use: No / Yes (Circle) Drinks per Week \_\_\_\_\_ # of Years \_\_\_\_\_  
\*Recreational Drug Use: No / Yes (Circle) Drugs Used \_\_\_\_\_  
\*Diet: (Circle) Vegetarian Lactose-Free Caffeine-Free Diabetic Regular Other \_\_\_\_\_  
\*Marital Status: (Circle) Married Single Divorced Widow/Widower  
\*Occupation: \_\_\_\_\_

**G. FAMILY HISTORY (Include age of family member):**

History	Father	Mother	Brother/Sister	Other Relatives
Cancer				
Diabetes				
Heart Disease				
Hypertension				
Other				

**H. RADIOLOGY:**

Have you had an X-ray or MRI? \_\_\_\_\_  
When? \_\_\_\_\_ Where? \_\_\_\_\_

**I. PRIOR PAIN MANAGEMENT HISTORY:**

Have you been treated for pain management before? Y N

**J. WORK STATUS:**

Are you currently working? Y N If not, when did you stop?  
Who took you off work? \_\_\_\_\_  
What are your current work restrictions, if any? \_\_\_\_\_

**K. PSYCHOLOGICAL TREATMENT:**

Have you ever had psychiatric, psychological, or social work treatments/evaluations for any diagnosis/problem, including your current pain? Y N

- a. If yes, for what diagnosis or problem were you treated? \_\_\_\_\_
- b. When were you treated? \_\_\_\_\_
- c. Therapist's name? \_\_\_\_\_

Have you considered suicide? Y N Date: \_\_\_\_\_  
Have you ever attempted suicide? Y N Date: \_\_\_\_\_

## L. REVIEW OF SYSTEMS:

### General

Y N Weight Gain  
Y N Weight Loss  
Y N Dry Mouth  
Y N Fatigue  
Y N Fever

### Skin

Y N Itching  
Y N New Lesions  
Y N Rash

### HEENT

Y N Blurred Vision  
Y N Headache  
Y N Nasal Congestion  
Y N Sinus Pain  
Y N Sore Throat

### Neck

Y N Neck Pain  
Y N Neck Stiffness

### Respiratory/Lung

Y N Cough  
Y N Snoring  
Y N Wheezing

### Cardiovascular

Y N Chest Pain  
Y N Palpitations  
Y N Shortness of Breath

### Gastrointestinal

Y N Abdominal Pain  
Y N Bloody Stool  
Y N Constipation  
Y N Diarrhea  
Y N Nausea  
Y N Vomiting

### Genitourinary

Y N Flank Pain  
Y N Frequency

### Genitourinary (Cont.)

Y N Painful Urination  
Y N Urgency

### Male (Only)

Y N Impotence  
Y N Testicular Pain

### Musculoskeletal

Y N Leg Cramps  
Y N Back Pain  
Y N Calf Pain  
Y N Decreased ROM  
Y N Joint Pain  
Y N Joint Redness  
Y N Joint Stiffness  
Y N Joint Swelling  
Y N Muscle Atrophy  
Y N Muscle Cramps  
Y N Muscle Pain  
Y N Muscle Weakness  
Y N Swelling of Extremities

### Neurologic

Y N Dizziness  
Y N Paresthesias  
Y N Unusual Sensation  
Y N Weakness

### Psychiatric

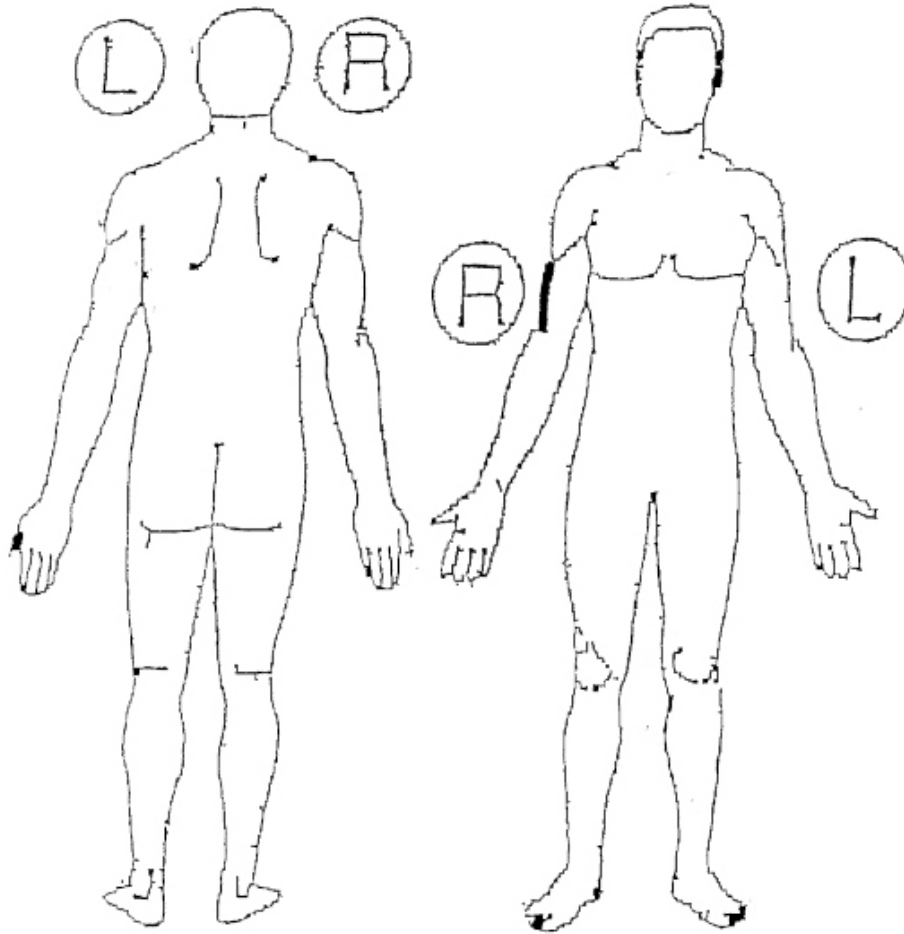
Y N Anxiety  
Y N Depression  
Y N Mood Changes  
Y N Insomnia  
Y N Suicidal Ideation  
Y N Suicidal Planning  
Y N Previous Suicide Attempts

### Endocrine

Y N Cold Intolerance  
Y N Heat Intolerance  
Y N Libido Change  
Y N Thyroid Problems

# PAIN DIAGRAM

Please shade the areas on the diagrams where your pain is located.



Additional Comments: \_\_\_\_\_

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## ACKNOWLEDGEMENT/CONSENT

\_\_\_\_ (initial) **RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, (print patient name) \_\_\_\_\_, have read a copy of Balcones Pain Consultants Notice of Privacy Practices. (This document is available in our waiting room or balconespain.com).

\_\_\_\_ (initial) **CANCELLATION POLICY**

If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. Balcones Pain Consultants reserves the right to charge the patient a **\$50.00 fee if the patient does not cancel an office visit and a \$100 fee if the patient does not cancel an injection/procedure** without the adequate notification.

\_\_\_\_ (initial) **RELEASE OF MEDICAL INFORMATION**

I **do/do not** (circle one) authorize Balcones Pain Consultants and its designated representatives to release medical information to my spouse, parent, or guardian.

\_\_\_\_ (initial) **CONTACT PERMISSION**

In the event that Balcones Pain Consultants needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to:

*Check all that apply:*

- Leave a message on an answering machine.
- Speak with spouse/significant other. (please list name) \_\_\_\_\_
- Speak with other family members. (please list names) \_\_\_\_\_

\_\_\_\_ (initial) **CONSENT TO TREATMENT**

I consent to the performance of those diagnostic procedures, examinations, and rendering of treatment by the medical provider and their designated medical office staff as it deemed necessary in the medical provider's judgment.

\_\_\_\_ (initial) **AUTHORIZATION/ASSIGNMENT/FIANCIAL RESPONSIBILITY**

I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and that I am responsible for obtaining any referrals required by my insurance carrier. I request that my medical insurance carrier make any payment directly to Balcones Pain Consultants for services rendered to me. As a courtesy, my charges will be filed with my insurance carrier; however, I will be billed if the claim is denied or is not paid in a timely manner. **Should my account become a collection problem, additional charges may be incurred. Any co-payments/co-insurance amount, plus any deductible is due when services are rendered.** There is a **\$30.00 service fee on all returned checks in addition to the amount of the check.** If this happens checks must be redeemed with certified funds (credit card or cash) at or before the next visit.

\_\_\_\_ (initial) This is notification that Dr. Matthew McCarty has a partial ownership interest in Stonegate Surgery Center and Austin Surgical Hospital and Dr. McCarty will receive remuneration for patients treated at those entities.

***My signature below indicates that I have read and am in agreement with all statements that I have initialed above.***

\_\_\_\_\_  
Signature of Patient (or guardian)

\_\_\_\_\_  
Date