

17270 Red Oak Drive, Suite 200  
Houston, Texas 77090  
281-440-6960



18220 SH 249, Suite 200  
Houston, Texas 77070  
832-912-7804

Thank you for taking time to complete the enclosed packet. The information we obtain about you and your medical history prior to scheduling an appointment will enable the doctor to focus on your present physical condition and medical needs.

Please take a moment to look over this check list and be sure all of these items are completed and returned to our address listed below:

- ( ) List of Healthcare Providers
  - ( ) Pain Management Program Questionnaire
  - ( ) Records from most recent providers seen within the last three (3) months
- (NOTE: ANY RECORDS SUBMITTED WILL NOT BE RETURNED)**

Again, thank you for your time and cooperation in completing these forms and returning them prior to scheduling your pain management appointment.

Once the above information has been received and reviewed, our office will contact you regarding the status of your acceptance or denial to the Pain Management Program.

Sincerely,  
KSF Orthopaedic Center, P.A.  
Pain Management Program

FORWARD ABOVE INFORMATION TO:

**FAX # 281-880-1551 or EMAIL: [painprogram@ksfortho.com](mailto:painprogram@ksfortho.com)**

MAIL TO: KSF Orthopaedic Center, P.A.  
17270 Red Oak Drive, Suite 200  
Houston, Texas 77090

**\*\*\*\*\* ATTN: PAIN MANAGEMENT PROGRAM \*\*\*\*\***

NOTE: Be sure to put **\*\*PAIN MANAGEMENT PROGRAM\*\*** on the envelope to ensure proper delivery to the correct department and expedite appointment request.

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

### PAIN MANAGEMENT QUESTIONNAIRE

For what body part are you being seen? \_\_\_\_\_

Is this a work related injury? YES NO

Was this result of an accident? YES NO

If yes, what is the date of the accident? \_\_\_\_\_

If no, when did symptoms first start? \_\_\_\_\_

Have you had previous surgery for this issue? YES NO

If yes, provide date and name of surgery \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What other therapies and/or treatments have you had for this issue?

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

NSAIDs: Yes No

Physical Therapy: Yes No

Cortisone Injection: Yes No

Epidural Steroid Injection: Yes No

Pain Management Yes No

If yes, Name & phone # of physician:

\_\_\_\_\_

What pain medications are you currently taking? (provide separate sheet with additional medications)

Medication Name \_\_\_\_\_ Dose & Sig \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The information provided above is true and correct.

\_\_\_\_\_  
Signature of Patient or Patient's Legally Authorized Representative

\_\_\_\_\_  
Date

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Please list all healthcare providers that you have seen in the past three (3) months.

<b>Name/Specialty</b>	
<b>Address</b>	
<b>City, State, Zip</b>	
<b>Phone # (if known)</b>	
<b>Approximate time frame</b>	

<b>Name/Specialty</b>	
<b>Address</b>	
<b>City, State, Zip</b>	
<b>Phone # (if known)</b>	
<b>Approximate time frame</b>	

<b>Name/Specialty</b>	
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<b>Approximate time frame</b>	

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<b>Approximate time frame</b>	