

Thank you for using the Tool Kit. You may either fax or email the forms to us prior to your visit, or simply bring them with you at the time of your visit.

ROYSE CITY MEDICAL AND SURGICAL CLINIC
TRI-COUNTY PAIN MANAGEMENT CENTRE

Dr. Ron Jones, FAAFP, DAAPM, ACOFP

Misty Hornsby-Odom CFNP

200 Arch St. Royse City, Tx. 75189 Tele 972.636.9577 Fax 972.636.7048

[Email: info@roysecitymedical.com](mailto:info@roysecitymedical.com)

NEW PATIENT WORKSHEET AND PROBLEM LIST

Patient Name: _____ ID/BD: _____ Age: _____

Date: _____ Occupation: _____

FAMILY HISTORY: Circle the condition and the family member who has had the condition

Heart Disease	Mother	Father	Grandparents	Siblings
High Blood Pressure	Mother	Father	Grandparents	Siblings
Stroke	Mother	Father	Grandparents	Siblings
Cancer	Mother	Father	Grandparents	Siblings
Diabetes	Mother	Father	Grandparents	Siblings
Epilepsy	Mother	Father	Grandparents	Siblings
Bleeding Disorder	Mother	Father	Grandparents	Siblings
Kidney Disease	Mother	Father	Grandparents	Siblings
Thyroid Disease	Mother	Father	Grandparents	Siblings
Mental Illness	Mother	Father	Grandparents	Siblings

Hospitalizations or Surgery:

Reason	Date

Medical History (check):

Headache	Lactose Intolerance	Depression	Shortness of Breath
Gallbladder Disease	Gout	Heart Problems	Prostate Disease
Blood Pressure Problems	Cancer	Bowel Problems	Skin Rashes
Chest Pain	Incontinence	Rheumatic Fever	Dizziness/Fainting
Sexual/Menstrual Prob.	Mumps	Circulatory Problems	Venereal Disease
Allergies/Hay Fever	Measles	Venereal Disease	Frequent Infections
Asthma	Rubella	Hepatitis	Bronchitis
Emphysema	Polio	Anemia	Pneumonia
Tobacco Use (smoking)	Diphtheria	Arthritis	Ulcer
Drug Use or Abuse	Tetanus	Ulcers	Osteoporosis
Alcohol Use or Abuse	Diabetes		

Medication Allergies/Reactions:

Medication	Reaction



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I _____ by signing this form, am requesting and consenting to medical evaluation, diagnostic and therapeutic procedures to be performed by Dr. Ron Jones and/or Misty Hornsby-Odom, CFNP and/or members of his staff under their direct supervision. I understand that the following list cannot be all inclusive, and I am encouraged to question any procedures I do not fully understand.

- Medical Evaluation
- Physical Therapy
- Drug Prescription or Injection
- Conventional Radiographs and/or Fluoroscopy
- Trigger Point Injections
- Joint Injections
- 3D and M Mode Echocardiography with Doppler
- Audiometry and Automated Tympanography
- Bioelectric Medicine
- Cardiac Color Flow Doppler
- Cardiac Stress Testing
- Lab and Immunoassay
- Direct Flexible Fiberoptic Laryngoscopy
- Direct Flexible Fiberoptic Rhinoscopy
- Electrocardiography
- Facet Injection
- Fluoroscopic Joint Injection
- Hyaluronate Knee Injection
- Joint Injection with and without Fluoroscopic Guidance
- Needle Electromyography (EMG) and Nerve Conduction Velocity (NCV)
- Nerve Blocks (Somatic, Sensory, Peripheral, Paraspinal, Intercostal)
- Pain Management Diagnosis, Management, Second Opinion\\Peripheral Vascular Doppler
- Physical Therapy
- Psychological Testing (Pain Oriented with MMPI and/or MBMD)
- Pulmonary Function Testing with DLCO Studies
- Radiography and Fluoroscopy
- Trigger Point Injection

I will be informed of the nature and purpose of the treatment, the alternative treatment modalities, the projected duration of treatment, and the common side effects from drugs prescribed or injected. I understand that drugs used and prescribed by this facility are assumed to be FDA approved (unless I am specifically informed differently) and that this facility prescribes these drugs in "good faith" assuming that since the drugs have met and passed FDA approval, then all known side effects and/or potential hazards have been exposed. I fully

understand that ANY drug has the potential for unknown and unexposed side effects and the potential to cause harm regardless of FDA approval. I understand that Dr. Jones nor Misty Hornsby-Odom have the ability to predict side effects or potential hazards of any drugs above those which have been reported via FDA trials. I understand that if I feel that I am uninformed that I am encouraged to question Dr. Jones, Misty Hornsby-Odom and/or their staff regarding the above.

I may at any time refuse treatment and withdraw my consent to the performance of any procedure or treatment. Should I revoke this consent, I will be requested o sign a form of acknowledgment.

I recognize that no guarantees have been or can be made regarding the likelihood of success or the outcome of any evaluation, treatment, test, procedure, or therapy performed by Dr. Jones, Misty Hornsby-Odom, or their staff.

Pursuant to federal and state guidelines concerning my right to confidentiality, my response below indicates my wishes concerning release of medical history, exam, lab tests, treatment, reports, psychological test reports, psychiatric evaluation reports, social history, drug and alcohol **use** information. I realize that this release of such information may be used by other physicians and/or hospitals to aid in the development of a diagnosis and treatment, as well as in the coordination of medical, psychological and social rehabilitation. I understand that this authorization may be revoked at any time by my written statement or amended by a request for release with my signature.

CHECK APPLICABLE CIRCLES BELOW:

- I do consent to **release** of medical information
- I do not consent to **release** of medical information
- You may **release** any medical information to my spouse

A notice concerning complaints and equal opportunity is posted on the wall in the reception area.

By my signature below, I am verifying that I have read and understand to my satisfaction all of the above and certify that I have had the opportunity to discuss the contents with a member of the staff at this facility.

Patient

Date

Parent or Guardian

Witness