Texas Spine Clinic™

SCRAMBLER THERAPY

NERVE PAIN — NEW PATIENT INTAKE FORM

Patient Name: _____

Date: _____

1 · PATIENT INFORMATION

Full Name	Date of Birth
Address	Age
City / State / ZIP	Sex ○ Male ○ Female
Home Phone	Cell Phone
Email Address	Marital Status S / M / D / W
Employer	Occupation
Insurance Company	Policy Holder Name
Policy Holder DOB	Policy Holder Employer
Emergency Contact Name	Emergency Contact Phone
Preferred Language	Family Physician / Referring Physician
Preferred Pharmacy Name	Pharmacy Phone Number

Race / Ethnicity: ○ Hispanic / Latino ○ Non-Hispanic / Latino ○ Decline to State

2 · NERVE PAIN HISTORY

1. What is the primary cause or diagnosis of your nerve pain? (Check all that apply)

- □ Diabetic peripheral neuropathy
- □ Chemotherapy-induced neuropathy (CIPN)
- □ Postherpetic neuralgia (shingles)
- □ Complex regional pain syndrome (CRPS)
- □ Lumbar radiculopathy (sciatica)
- □ Cervical radiculopathy
- □ Post-surgical nerve pain
- □ Phantom limb pain
- □ Small fiber neuropathy
- □ Idiopathic peripheral neuropathy
- □ Failed back surgery syndrome
- □ Unknown / undiagnosed nerve pain

Other / specify diagnosis: _____

2. How long have you been experiencing nerve pain?

○ Less than 3 months ○ 3–6 months ○ 6–12 months ○ 1–3 years ○ More than 3 years

3. Where is your pain located? (Check all that apply)

- □ Feet / toes
- □ Lower legs
- □ Thighs
- □ Buttocks / groin
- □ Hands / fingers
- □ Forearms
- □ Upper arms / shoulders
- □ Chest / torso
- □ Lower back
- □ Upper back / neck
- □ Face / head
- □ Widespread / full body

4. Have you seen a neurologist or pain specialist for this condition?

If yes, physician name:

5. Date of last neurology / pain management visit: _____

3 · CHIEF COMPLAINT — SYMPTOM DETAIL

DESCRIBE YOUR NERVE PAIN — CHECK ALL THAT APPLY:

- ☐ Burning sensation
- ☐ Electric shock / shooting pain
- ☐ Stabbing or piercing pain
- ☐ Aching or throbbing pain
- ☐ Pins and needles
- ☐ Numbness / loss of sensation
- ☐ Hypersensitivity to touch (allodynia)
- ☐ Extreme sensitivity to temperature
- ☐ Muscle weakness
- ☐ Balance or coordination problems
- ☐ Pain worse at night
- ☐ Pain with light touch / clothing

Additional symptoms: _____

Current pain severity — rate your pain today (0 = no pain, 10 = worst imaginable): 0 1 2 3 4 5 6 7 8 9 10
Pain at its WORST in the past week (0–10): 0 1 2 3 4 5 6 7 8 9 10
Pain at its BEST in the past week (0–10): 0 1 2 3 4 5 6 7 8 9 10

Frequency: ○ Occasional (0–25%) ○ Intermittent (25–50%) ○ Frequent (50–75%) ○ Constant (75–100%)

What makes pain worse? _____ What makes pain better? _____

Does nerve pain significantly interfere with your daily activities, work, or sleep? ☐ Yes ☐ No

Have you been told your nerve pain is neuropathic in nature by a physician? ☐ Yes ☐ No

4 · PREVIOUS TREATMENTS FOR NERVE PAIN

MEDICATIONS TRIED — CHECK ALL THAT APPLY:

- ☐ Gabapentin (Neurontin)
- ☐ Pregabalin (Lyrica)
- ☐ Duloxetine (Cymbalta)
- ☐ Amitriptyline / nortriptyline
- ☐ Opioids (e.g., oxycodone, morphine)
- ☐ Tramadol
- ☐ Lidocaine patch / cream
- ☐ Capsaicin cream / patch
- ☐ NSAIDs (ibuprofen / naproxen)
- ☐ Baclofen / muscle relaxants
- ☐ Ketamine infusion
- ☐ Other (specify below)

PROCEDURES OR THERAPIES TRIED — CHECK ALL THAT APPLY:

- ☐ Physical therapy
- ☐ Occupational therapy
- ☐ TENS unit
- ☐ Acupuncture
- ☐ Nerve block injection
- ☐ Spinal cord stimulator trial / implant
- ☐ Epidural steroid injection
- ☐ Sympathetic nerve block
- ☐ Scrambler Therapy (prior treatment)
- ☐ Plasma exchange
- ☐ IV immunoglobulin (IVIG)
- ☐ Other (specify below)

Results of prior treatments / any complications: _____

5 · SCRAMBLER THERAPY ELIGIBILITY — SAFETY SCREENING

Scrambler Therapy uses small surface electrodes to deliver synthetic "non-pain" signals to the nervous system. It is non-invasive and does not involve needles, injections, or implants. Certain conditions and devices may make you ineligible for treatment. Please answer every question below honestly — your answers will be reviewed by your provider.

ABSOLUTE CONTRAINDICATIONS — DO YOU HAVE ANY OF THE FOLLOWING?

Question	Yes	No
Do you have a cardiac pacemaker or implantable defibrillator (ICD)?	○	○
Do you have a spinal cord stimulator (SCS) currently implanted?	○	○
Do you have an intrathecal (spinal) drug pump?	○	○
Do you have any aneurysm clips or vena cava clips?	○	○
Do you have any skull plates or metallic implants in the skull or brain?	○	○
Do you have spinal hardware (rods, screws, cages, plates) in the area to be treated?	○	○
Are you pregnant or possibly pregnant?	○	○
Have you been diagnosed with psychosis or uncontrolled severe mental illness?	○	○

MEDICATIONS THAT MAY REDUCE SCRAMBLER THERAPY EFFECTIVENESS:

The following medications may reduce the effectiveness of Scrambler Therapy. Your provider will discuss options with you.

Are you currently taking this medication?	Yes	No
Anticonvulsants for pain (gabapentin, pregabalin, carbamazepine, etc.)	○	○
Ketamine (any form — infusion, nasal, oral)	○	○

6 · PAST MEDICAL HISTORY

CURRENT CONDITIONS — CHECK ALL THAT APPLY:

- □ Type 1 or Type 2 Diabetes
- □ Peripheral vascular disease
- □ Heart disease / arrhythmia
- □ DVT / blood clots
- □ Active cancer (specify below)
- □ Prior chemotherapy / radiation
- □ Autoimmune disease
- □ HIV / AIDS
- □ Kidney disease
- □ Liver disease
- □ Depression / anxiety
- □ Coagulation disorder

Cancer type / chemotherapy agents received:

Previous injuries / surgeries related to nerve pain:

Allergies (medications, adhesives, latex, etc.):

CURRENT MEDICATIONS:

Medication Name	Dose / Frequency	Medication Name	Dose / Frequency

PREVIOUS SURGERIES:

Procedure / Surgery	Year	Procedure / Surgery	Year

6B · FAMILY & SOCIAL HISTORY

Associated health problems in family members (neuropathy, diabetes, cancer, heart disease, autoimmune disease, etc.):

SOCIAL HISTORY:

Cigarettes / tobacco: □ Yes □ No

Alcohol: □ Yes □ No
If yes, how much per week:

Exercise regularly: □ Yes □ No
If yes, type / frequency:

7 · REVIEW OF SYSTEMS

Check any symptoms you are currently experiencing. Check "None of the above" if no symptoms in that category.

Cardiovascular
- □ Chest pain
- □ Palpitations
- □ Edema
- □ SOB on exertion
- □ None of the above

Constitutional
- □ Fatigue
- □ Weight loss / gain
- □ Fever
- □ Loss of appetite
- □ None of the above

Endocrine / Metabolic
- □ Uncontrolled diabetes
- □ Thyroid disorder
- □ Cold / heat intolerance
- □ Excessive thirst
- □ None of the above

Gastrointestinal
- □ Nausea / vomiting
- □ Constipation
- □ Diarrhea
- □ Loss of appetite
- □ None of the above

Genitourinary
- □ Bladder incontinence
- □ Frequency / urgency
- □ Blood in urine
- □ Sexual dysfunction
- □ None of the above

Hematologic
- □ Easy bruising / bleeding
- □ Blood clots
- □ Lymphedema
- □ Blood transfusion
- □ None of the above

Musculoskeletal
- □ Muscle weakness
- □ Joint pain
- □ Cramps / spasms
- □ Muscle wasting
- □ None of the above

Psychiatric
- □ Depression
- □ Anxiety
- □ Sleep disturbance
- □ Suicidal thoughts
- □ None of the above

8 · AUTHORIZATION & SIGNATURE

I have read and answered all questions truthfully to the best of my knowledge. I understand that my provider will review my safety screening responses before initiating Scrambler Therapy. I authorize Texas Spine Clinic to perform necessary evaluations and treatment in accordance with Texas statutes and laws.

Patient Signature

Date

Guardian Signature (if applicable)

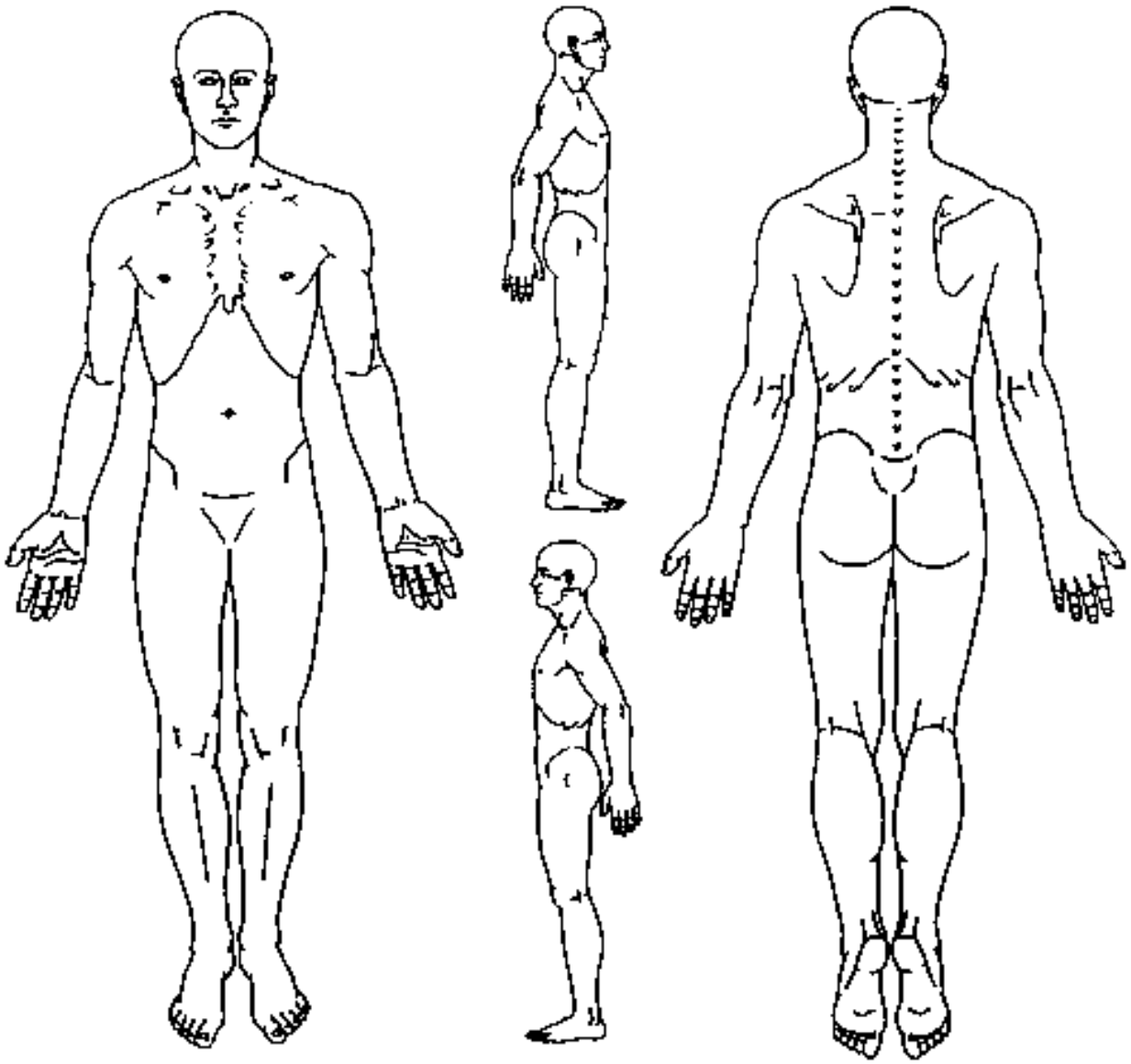
Date

THE REVISED OSWESTRY PAIN QUESTIONNAIRE

NAME _____ DATE _____

How long have you had back pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain, right now. Please complete both sides of this form.



A = ACHE	**B** = BURNING	**N** = NUMBNESS
P = PINS & NEEDLES	**S** = STABBING	**O** = OTHER

Patient Information:

Full Name: _____

Address: _____

Date of Birth: _____ Soc. Sec. # _____

Medical Records Release

Facility Information is Requested From

_____
_____
_____

Requesting Organization

Texas Spine Clinic
3212 NAPIER PARK
SAN ANTONIO, TX 78231

Date and Type of Information Requested

_____/_____/_____ _____

_____/_____/_____ _____

_____/_____/_____ _____

I, _____, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1.) I do hereby authorize Texas Spine Clinic to obtain and release the following types of medical information: MRI/CT/Radiograph reports, History/Physical examination reports, Progress reports, Surgical reports and/or any information that could be relevant to my medical condition.
2.) I have the right to revoke this authorization at any time by writing to the health care provider listed. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
3.) I understand that signing this authorization in voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be condition upon my authorization of this disclosure.
4.) Information disclosed under this authorization may be subject to redisclosure by the recipient.
5.) Date of authorization and expiration _____/_____/_____ thru _____/_____/_____

_____ _____

Patient Signature *Date*

New Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, the Texas Spine Clinic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that the Texas Spine Clinic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Texas Spine Clinic reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Texas Spine Clinic change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

Who may we share your information regarding ☐Medical information ☐ Billing/Payment information?

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including but not limited to disclosures via fax, email, telephone, and by mail.

I fully understand and accept / decline the terms of this consent.

_____ _____

Patient's Signature Date