Patient Information

Patient Name: ____
Last First Middle
Mailing Address (incl. city & zip): ____

Permanent Address (incl. city & zip): ____

Daytime Phone: ________________________ Ext.______________Evening Phone: ____________________

Date of Birth: ________________ SSN: _____________________________ Marital Status:______________

Current Employer: ____ Occupation: ______________________

(If workers' comp, indicate employer where accident occurred)
Employer Address: ____

Date of Injury/Accident/Illness: __________________________

Closest friend or relative not living with you: ____

Address: ____

Daytime Phone: ________________________Ext: ________Evening Phone: __________________________

Insurance Information

Primary Insurance Company: ____

Subscriber's Relationship to Patient: SELF SPOUSE PARENT OTHER

Spouse Name:____
Last First Middle
Spouse's Employer: ____ Telephone # __________________

Spouse SSN: _________________________________Spouse Date of Birth: ______________________________

Secondary Insurance Company: ____

Third Insurance, if applicable: ____

Referral Information
(Please tell us how you were referred to our practice)

☐ Referring Physician_____________________________☐ Health Plan Provider List ________________________

☐ Other Source_____________________________________ (W/C Adjuster, Case Manager, Website, Friend etc.)

Please read the following authorization. Initial and sign below for our files.

__________ I understand that any appointment changes must be made at least 24 hours in advance or a fee may be accrued.

Signature____ Date_____________________________
***** Please present this form and all insurance ID cards to the receptionist at this time. *****

I, the undersigned, do hereby agree and give my consent for ***TAMPA PAIN RELIEF CENTERS*** to furnish medical care and treatment to myself, ____ considered necessary and proper in diagnosing or treating my/his/her physical and mental condition.

Patient/Guardian/Responsible Party_______________________________ Date ________________________

TAMPA PAIN RELIEF CENTERS

Patient Name ____ **Date of Birth** ________________ **Age** __________

Gender: ***(Please circle)*** Male / Female   Race: ***(Please circle)*** White / Black / Hispanic / Asian / Other ______

Who referred you to us? ________________________ Who is your Primary Care Provider? ________________________

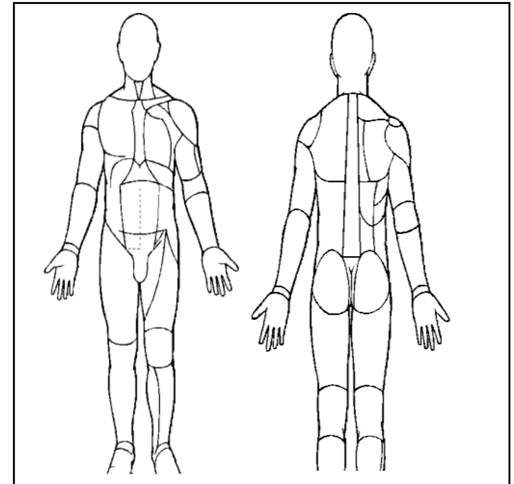
Is your visit related to an injury? YES/NO   If Yes, specify: AUTO   Work Comp   OTHER

Have you been to any previous pain management? Yes or No (***circle one***)
Name of Physician(s) ____

WORK STATUS: ____ Regular Duty _____ Light Duty Restrictions _____________________________________
___ Off Work – Last worked: ________________
___ Disabled – Since: __________________ By (Doctor's Name): ____
___ Retired – Since: (MM)_________ (DD)___________ (YYYY_____________

Location of Pain: ____

In the diagram below, please shade the areas of your pain



(***Circle your answer***)
Pain Scale: From 0 – 10 what is your pain level today?

(NO PAIN) **0 1 2 3 4 5 6 7 8 9 10** (WORST PAIN)

What is your range of pain in the past month?

(NO PAIN) **0 1 2 3 4 5 6 7 8 9 10** (WORST PAIN)

What treatments have you had for your pain? Check all that apply.

__ Physical Therapy   __ Favorable Results   __ Poor Results

__ Acupuncture   __ Favorable Results   __ Poor Results

__ Chiropractor   __ Favorable Results   __ Poor Results

__ Trigger Point Injections   __ Favorable Results   __ Poor Results

__ TENS Unit   __ Favorable Results   __ Poor Results

__ Nerve Blocks   __ Favorable Results   __ Poor Results

Type of Nerve Block __________________________________

___Back or Neck Surgery Type_________________________________ When ___________________

___Spinal Cord Stimulator Type_________________________________ Date implanted __________

___Morphine Pump   Type ________________________________ Date implanted __________

___Other: ____

Allergies: ______________________ ______________________ ______________________

______________________ ______________________ ______________________ ______________________

Patient History: (check each that apply)

Tobacco:	___ do not smoke	___ smoke	___ pack(s) per day
Alcohol:	___ do not drink	___ drink	# of drinks per ____ day ____ week
Social History:	___ Married	___ Single	___ Divorced
Lives With:	___ Spouse	___ Children	___ Other ____Alone

___Blind	___Glasses	___Contacts	___Hard of Hearing	___Deaf	___HIV+
___Hearing Aids	___Cancer	___Thyroid Disease	___Gallbladder Disease	___Birth Defects	

Under each Category, please check any symptoms that apply:

Cardiovascular	**Gastrointestinal**	**Neurological**	**Musculoskeletal**	**Psychiatric**
___Hypertension High)	__Chronic Diarrhea	__Migraines	__Arthritis	___Depression
___Hypotension (Low)	__Chronic Constipation	__Frequent Headaches	__Osteoarthritis	___Anxiety Disorder
___Anemia	__Incontinence	__Epilepsy	__Rheumatoid	___Bipolar
___Heart Disease	__Ulcers	__Sleeping Disorders	__Low Back Syndrome	___Alcoholism
___Stroke	__Hepatitis	__Restless Leg	__Cane	___Drug Addiction
___Swelling of Feet	__Ulcers	Syndrome	__Walker	___Suicide Attempt
___Chest Pain	__Liver Disease	__Other:__________	__Wheelchair	___Schizophrenia
___Shortness of Breath	__Diabetes		__Prosthesis	___Other:________
___Rheumatic Fever	__Gout __Other:__________		__ Other: _________	

Genitourinary:	**Respiratory:**
___ Urinary Incontinence	___ Asthma
___Kidney Disease	___ COPD
___Other:__________	____Chronic Cough
	____O2 Therapy

Medications you are presently taking: **Include Over the Counter & prescription drugs**.
Pain Medications, Muscle Relaxants, Sleep Aid, Anti-anxiety, and Antidepressants.

Medications — Dose — Frequency (use back of paper if needed)

____
____
____

All Others (including Over-the-Counter)
Medications

____
____

SURGERIES — DATE (month/year)

____
____
____

FAMILY HISTORY

Relation — Current State of Health & History of Problems

Mother ____
Father ____
Siblings ____

PHYSICIAN/PATIENT INFORMED CONSENT AND AGREEMENT FOR LONG-TERM OPIOID/NARCOTIC THERAPY FOR TREATMENT OF CHRONIC PAIN FORM

Patient Name: ____ **Date of Birth:** _________________

You have agreed to receive opioid/narcotic therapy for the treatment of chronic pain. You understand that these drugs are very useful, but have potential for misuse and are therefore closely controlled by local, state, and federal governments. The goal of this treatment is to: (a) reduce your pain; and (b) improve your level of function in performing your activities of daily living.

- Alternative therapies and medications have been explained and offered to you. You have chosen opioid/narcotic therapy as one component of treatment.

The use of cigarettes demonstrates a dependence of nicotine. This complicates opioid therapy. If you are a smoker, you have agreed to a smoking cessation program.

You must be aware of the potential side effects and risks of these medications. They are explained below. If you have any questions or concerns during the course of your treatment, you should contact your physician.

SIDE EFFECTS

Side effects are normal physical reactions to medications. Common side effects of opioid/narcotics include mood changes, drowsiness, dizziness, constipation, nausea, and confusion. Many of these side effects will resolve over days or weeks. Constipation often persists and may require additional medication. If other side effects persist, different opioid may be tried or they may be discontinued.

You should NOT:

a. Operate a vehicle or machinery if the medication makes you drowsy;
b. Consume ANY alcohol while taking opioids /narcotics; or
c. Take any other non-prescribed sedative medication while taking opioids/narcotics.

The effects of alcohol and sedatives are additive with those of opioids/narcotics. If you take these substances in combination with opioids/narcotics, a dangerous situation could result, such as coma, organ damage, or even death.

Driving while taking opioids for chronic pain is considered medically acceptable as long as you do not have side effects such as sedation or altered mental status. The side effects usually do not occur while taking opioids/narcotics chronically. However, it is **possible** that you could be considered DUI if stopped by law enforcement while driving.

Opioids have also been known to cause decreased sexual function and libido. This is due to their effects on suppression of certain hormones such as testosterone and DHEA which can cause these side effects. Your hormone levels can be monitored during your treatment.

Constipation is a well-known side effect of opioid therapy and can usually be treated with stool softeners or gentle laxatives. Constipation is a side effect that usually does not go away and requires treatment.

PATIENT'S INITIALS: _____

TAMPA PAIN RELIEF CENTERS

RISKS

Dependence

Physical dependence is an expected side effect of long-term opioid/narcotic therapy. This means that if you take opioids/narcotics continuously, and then stop them abruptly, you will experience a withdrawal syndrome. This syndrome often includes sweating, diarrhea, irritability, sleeplessness, runny nose, tearing, muscle and bone aching, gooseflesh, and dilated pupils. Withdrawal can be life-threatening. To prevent these symptoms, the opioids/narcotics should be taken regularly or, if discontinued, reduced gradually under the supervision of your physician.

Tolerance

Tolerance to the pain-relieving effect of opioids/narcotics is possible with continued use. This means that more medication is required to achieve the same level of pain control experienced when the opioid/narcotic therapy was initiated. When tolerance does occur, sometimes it requires tapering or discontinuation of the opioid/narcotic. Sometimes tolerance can be treated by substituting a different opioid/narcotic. When initiated, doses of medication must be adjusted to achieve a therapeutic, pain relieving effect; upward adjustments during this period are not viewed as tolerance.

Increased Pain (Hyperalgesia)

The long-term effects of opioids/narcotics on the body's own pain-fighting systems are unknown. Some evidence suggests that opioids/narcotics may interfere with the pain modulation, resulting in an **increased** sensitivity to pain. Sometimes individuals who have been on long-term opioids/narcotics, but who continue to have pain, actually note decreased pain after several weeks off of the medications.

Addiction

Addition is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing the development and manifestations. It is characterized by behaviors that include one or more of the following:

- Impaired control over drug use;
- Compulsive use;
- Continued use despite harm; and/or
- Craving

Most patients with chronic pain who use long-term opioids/narcotics are able to take medications on a scheduled basis as prescribed, do not seek other drugs when their pain is controlled, and experience improvement in their quality of life as the result of opioid therapy. Therefore, they are **NOT** addicted. **Physical dependence** is **NOT** the same as addiction.

Risk to Unborn Children

Children born to women who are taking opioids/narcotics on a regular basis will likely be physically dependent at birth. Women of childbearing age should maintain safe and effective birth control while on opioid/narcotic therapy. Should you become pregnant, immediately contact your physician and the medication will be tapered and stopped.

PATIENT'S INITIALS: _____

Long-Term Side Effects

The long-term effect of opioid/narcotic therapy is not fully known. Most long-term effects have been listed above. If you have additional questions regarding the potential long-term effects of opioid/narcotic therapy, please speak with your physician.

PRESCRIPTIONS AND USE OF OPIOID/NARCOTIC MEDICATIONS

Your medication will be prescribed by your physician for control of pain. Based on your individual needs, you will be provided with enough medication on a monthly basis, two-month basis, or three-month basis. New injuries or pain problems will require reevaluation. Prescriptions for opioids/narcotics will **not** be "called in" to the pharmacy.

You agree that you must be seen by your physician at the interval directed by your physician, at a minimum of every three months, during the course of your therapy.

You agree and understand that increasing your dose without the close supervision of your physician could lead to drug overdose, causing severe sedation, respiratory depression, and/or death.

You agree and understand that opioid/narcotic medication is strictly prescribed for you, and your opioid/narcotic medication should **NEVER** be given to others.

You agree to fill opioid/narcotic prescriptions at one pharmacy.

You agree to secure your opioid/narcotic medications in safe, locked source to prevent loss or theft. You are responsible for any loss or theft.

You agree that lost, stolen, or destroyed prescriptions or drugs **will not** be replaced, and may result in discontinuation of treatment.

You agree to obtain opioid/narcotic medication from one prescribing physician or that physician's substitute if your prescribing physician is not available and your prescribing physician has authorized his or her substitute to provide treatment.

You agree to submit to an initial examination and evaluation, to routine examination and evaluation on a monthly basis or regular basis (but no less than every three months), and to examination and evaluation at the direction of your physician.

You agree to submit to blood and/or urine testing to monitor the levels of medication or other drugs and any organ side effects. **You also agree** that other doctors and law enforcement may be notified of the results.

You agree NOT to call the physician for refills or replacement medications during evening hours or on weekends/holidays. Medication refill and/or replacement requests will be addressed during regular business hours only.

You understand and agree that if you lose your medication or run out early due to overuse, you may experience and go through withdrawal from opioids/narcotics. **You further understand and agree that you are solely responsible for your own medication.**

You agree to bring all prescription medications in their bottles or containers to the office during regularly scheduled visits.

PATIENT'S INITIALS: _____

You agree to provide a list from your pharmacy detailing all medications received from that pharmacy and to provide updated lists as requested by your physician.

For patients taking methadone: Methadone has significant interactions with many other medications. Some of these medications may reduce your body's ability to metabolize methadone, thus **INCREASING** the methadone in your body, which could be dangerous. Therefore, you **MUST** notify this office of **ALL** medications prescribed for **ANY** condition while taking methadone.

OPIOID/NARCOTIC THERAPY MAY BE DISCONTINUED IF YOU:

- Develop progressive tolerance which cannot be managed by changing medications;
- Experience unacceptable side effects which cannot be controlled;
- Experience diminishing function or poor pain control;
- Develop signs of addiction;
- Abuse any other controlled substance (this may be determined by random blood/urine testing);
- Obtain and or use street drugs (this may be determined by random blood/urine testing);
- Increase your medications without the consent of your physician;
- Either refuse to stop or resume smoking;
- Obtain opiates/narcotics from other physicians or sources;
- Fill prescriptions at other pharmacies without explanation;
- Sell, give away, or lose medications;
- Fail to submit to routine examination and evaluation on a monthly basis or regular basis (but no less than once every three months), or as directed by your physician;
- Fail to bring your prescription medications to your regularly scheduled visits;
- Fail to submit to blood/urine testing as directed;
- Call for refills during evenings, weekends or holidays; or
- Violate any of the terms of this agreement.

By signing below, I acknowledge and agree that: (i) I have read and fully understand the Physician/Patient Informed Consent and Agreement for long-term opioid/narcotic therapy for the treatment of chronic pain, (ii) I have been given the opportunity to ask questions about the proposed treatment (including no treatment), potential risks, complications, side effects, and benefits; (iii) I knowingly accept and agree to assume the risks of the proposed treatment as presented; and (iv) I agree to abide by the terms of this agreement.

Patient Signature: ____________________________ **Date** __________

Print Name: ____________________________

Witness Signature _____________________________ **Date** __________

Print Name: _____________________________

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing TAMPA PAIN RELIEF CENTERS as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for her treatment and care.
- We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
- Patients are responsible for the payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.
- Patients may incur, and are responsible for the payment of additional charges at the discretion of ____________. These charges may include (but are not limited to):
    - Charge for returned checks.
    - Charge for missed appointments without 24 hours advance notice
    - Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or prescriptions.
    - Charge for the copying and distribution of patient medical records.
    - Charge for extensive forms completion.
    - Any costs associated with collection of patient balances.

Patient Authorizations

- By my signature below, I hereby authorize_________________ and the physicians, staff, and hospitals associated with ________________ to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate in my care.
- I understand that I must check one or more of the following types of health information to indicate that I authorize that information type to be released to the necessary insurance companies, third party payers, and/or other physicians and/or healthcare entities required to participate in my care. By checking one or more of the following boxes, the health information I authorize to be released may include any of the following:
    - □ Diagnosis, evaluation, and/or treatment for alcohol and/or drug abuse.
    - □ Records of HTLV-III or HIV testing (AIDS test) result, diagnosis, and/or treatment.
    - □ Psychiatric and/or psychological records, or evaluation and/or treatment for mental, physical, and/or emotional illness, including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluations.
- By my signature below, I hereby authorize assignment of financial benefits directly to ______________ and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize ______________ personnel to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to ***TAMPA PAIN RELIEF CENTERS***. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Information Privacy: *TAMPA PAIN RELIEF CENTER* will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, and have copies available for distribution. The undersigned acknowledges receipt of this information.

*Patient/Guardian/Responsible Party*______________________________ *Date* _______________________

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made due to policy termination, you will be responsible for the amount of money refunded to your insurance company. We reserve the right to assess a finance charge of 18% annually for balances carried over an extended period of time.

Benefits and eligibility are verified prior to your visit as a courtesy and as a result, we are not responsible for incorrect information provided by your insurance company as it relates to copay or benefit plan limitations. Your policy must be in effect at the time of service and subject to individual plan limitations and exclusions as mandated by your plan. An authorization is not a guarantee of payment.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to ***TAMPA PAIN RELIEF CENTER***.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

I UNDERSTAND MY RESPONSIBILTY FOR THE PAYMENT OF MY ACCOUNT.

*Patient/Guardian/Responsible Party*______________________________ *Date*_________________________

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

____ ___________________________________

Signature of Patient or Guardian Date

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

____ ___________________________________

Signature of Patient or Guardian Date

Pain Disability Index Sheet

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (i.e. yard work) and errands or favors for other family members (i.e. driving the children to school).

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (i.e. taking a shower, driving, getting dressed, etc.)

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Life-Supporting Activities: This category refers to basic life supporting behaviors such as eating, sleeping, and breathing.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Signature ________________________ **Print Name** ________________________

Date __________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: ____ **DOB: _____/_____/_________**

I authorize the release of my health information records to **Tampa Pain Relief Centers** to enable a comprehensive review of my medical care. I authorize the following physician offices, clinics, hospitals, other health care providers, pharmacies and legal offices to provide copies of my health information to:

TAMPA PAIN RELIEF CENTERS, INC.
3488 E Lake Road Suite 403
Palm Harbor, FL 34685
OFFICE: 813-872-4492 FAX: 813-475-7739

(List of all facilities, clinics, and offices from which information will be requested)
PHYSICIAN OFFICES (please list all physicians you have seen in the past two years)

Physician's Name	Address	Phone Number	Fax Number
1.			
2.			
3.			
4.			

PHARMACY (please provide an updated list of all pharmacies that you have used in the past two years)

Pharmacy Name	Address	Phone Number	Fax Number
1.			
2.			
3.			
4.			

HOSPITAL AND OTHER FACILITIES (for surgeries/procedures, MRI/CT SCANS and any LAB and X-RAY reports)

Facility Name	Address	Phone Number	Fax Number
1.			
2.			
3.			
4.			

Restrictions:
__________ There are NO restrictions on the information that can be released.
__________ The following information CAN NOT be released:
____

DURATION:
This authorization shall be effective immediately. I understand this authorization to release medical records will become invalid when I am no longer a patient of Tampa Pain Relief Center. I understand I have the right to revoke this authorization, at any time by sending written notification to the privacy/compliance office at the above listed address.

____ ________________________
Signature of Patient Date

(PLEASE PRINT) Name of patient or personal representative: ________________________________

(PLEASE PRINT) If personal representative, describe authority: ______________________________

*****THIS RELEASE FORM MUST BE FILLED OUT IN ITS ENTIRETY TO BE VALID*****

TAMPA PAIN RELIEF CENTERS

Medical History

Your Name:_______________________________ Date of Birth: ________________________

Today's Date:_______________________________ Height:__________Weight:__________lbs

Pain Location

You will have a pain diagram to describe more details on the following page

Where is your worst area of pain located?____

Does this pain radiate? If so, where? ____

Please list any additional areas of pain:____

Onset of Symptoms

Approximately when did this pain begin? ____________________________________

What caused your initial pain episode? ____________________________________

____

☐ How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began, how has it changed? ☐ Decreased ☐ Increased ☐ Unchanged

☐ Personal Injury (legal term describing injury sustained by negligence of another)

☐ Motor Vehicle Accident:________________________Claim Open______Claim Closed________

☐ Work Related Injury (Worker's Compensation)__________Claim Open______Claim Closed________

☐ Other:____

Pain Description

Check all the following that describe of your pain:

☐ Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp

☐ Cramping ☐ Numbness ☐ Spasming ☐ Throbbing

☐ Dull ☐ Shock---like ☐ Squeezing ☐ Tiring/Exhausting

☐ Tingling/Pins and Needles ☐ Other:____

What word best describes the frequency of your pain? ☐ Constant ☐ Intermittent

When is your pain at its worst? ☐ Mornings ☐ During the day ☐ Evenings ☐ Middle of the night

Associated Symptoms:

☐ Limb Weakness

☐ Bladder Incontinence

☐ Bladder Retention

☐ Bowel Incontinence

☐ Bowel Retention

☐ Other:

TAMPA PAIN RELIEF CENTERS

Mark the effect of each of the following on your pain

	Increases my pain	Decreases my pain	No change in my pain
Bending Backward	☐	☐	☐
Bending Forward	☐	☐	☐
Changes in the Weather	☐	☐	☐
Climbing Stairs	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Driving	☐	☐	☐
Lifting Objects	☐	☐	☐
Lying on Your Back	☐	☐	☐
Lying on Your Stomach	☐	☐	☐
Rising from a Sitting Position	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐

Other activities: ____

In the past three months have you developed any new:

☐ Balance Problems

☐ Difficulty Walking ☐ Fevers ☐ Nausea

☐ Numbness/Tingling – Where?____________________ ☐ Weakness – Where? ________________________

☐ I HAVE NOT RECENTLY DEVELOPED ANY OF THE ABOVE CONDITIONS.

Other Doctors Consulted

Mark the following physicians or specialists you have consulted ***for treatment of your current pain problem(s)***. *(ONLY FOR PAIN RELIEF. NOT FOR OTHER PROBLEMS)*

☐ Family Physician
☐ Internist
☐ Emergency Physician
☐ Dentist
☐ Psychiatrist/ Psychologist: _______________

☐ ENT Physician
☐ Gastroenterologist
☐ Neurologist
☐ Endocrinologist
☐ Ophthalmologist

☐ Chiropractor
☐ Podiatrist
☐ Acupuncturist
☐ Physical Therapist: ________________
When?__________
Sessions:_______

☐ Orthopedic Surgeon:____________________
☐ Neurosurgeon:______________
☐ Rheumatologist:_____________
☐ Pain Physician(s):____________
____

TAMPA PAIN RELIEF CENTERS

Diagnostic Tests and Imaging

Mark tests you have had that are related to your current pain complaints:

- ☐ MRI of the________________ Date:________ Facility: ________
- ☐ X-ray of the ________________ Date: ________ Facility: ________
- ☐ CT scan of the________________ Date:________ Facility: ________
- ☐ EMG/NCV study of the________________ Date:________ Facility: ________
- ☐ Other diagnostic testing: ________________
- ☐ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

Interventional Pain Treatment History

Mark all the following interventional pain treatments you have undergone prior to today's visit:

- ☐ Trigger Point Injection – Where?________________Helped?________
- ☐ Joint Injection – Joint(s):________________Helped?________
- ☐ Epidural Steroid Injection – (circle all levels that apply) Cervical / Thoracic / Lumbar Helped?________
- ☐ Medial Branch Blocks or Facet Injections – (circle all levels that apply) Cervical / Thoracic / Lumbar________ Helped?________
- ☐ Nerve Blocks – Area/Nerve(s) Helped?________________
- ☐ Radiofrequency Ablation (circle all levels that apply) Cervical / Thoracic / Lumbar________ Helped?________
- ☐ Spinal Cord Stimulator – (circle one) Trial Only / Permanent Implant:________________
- ☐ Intrathecal (Opiate) Pump:________________
- ☐ Vertebroplasty / Kyphoplasty – Level(s)________________
- ☐ Other:________________

Please mark all of the following treatments you have used for pain relief

	Helped pain	Worsened pain	No change
Acupuncture	☐	☐	☐
Biofeedback	☐	☐	☐
Brace Support	☐	☐	☐
Chiropractic Treatment	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Injection Therapy	☐	☐	☐
Massage Therapy	☐	☐	☐
Medications	☐	☐	☐
Physical Therapy	☐	☐	☐
TENS Unit	☐	☐	☐
Traction	☐	☐	☐

TAMPA PAIN RELIEF CENTERS

Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? ☐ Yes ☐No

If so, have you ever had any adverse reaction to anesthesia? ☐ Yes ☐No

From what type of anesthesia did you react adversely to? Please check all that apply.

☐ Local anesthesia ☐ Epidural ☐ General anesthesia ☐ IV Sedation

Please explain: ______________________________

Do you have a family history of adverse reactions to anesthesia? If so, to which of the following?

☐ Local anesthesia ☐ Epidural ☐ General anesthesia ☐ IV Sedation

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Abdominal Surgery

☐ Gallbladder removal ______________________

☐ Appendectomy ______________________

☐ Other ______________________

Female Surgeries

☐ Caesarean section ______________________

☐ Hysterectomy ______________________

☐ Laparoscopy ______________________

☐ Ovarian ______________________

☐ Other ______________________

Heart Surgery

☐ Valve replacement ______________________

☐ Aneurysm repair ______________________

☐ Stent placement ______________________

☐ Other ______________________

Joint Surgery

☐ Shoulder ______________________

☐ Hip ______________________

☐ Knee ______________________

Spine / Back Surgery

☐ Discectomy (levels)______________________

☐ Laminectomy ______________________

☐ Spinal fusion (levels) ______________________

Other Common Surgeries

☐ Hemorrhoid surgery ______________________

☐ Hernia repair ______________________

☐ Thyroidectomy ______________________

☐ Tonsillectomy ______________________

☐ Vascular surgery ______________________

Please list any other surgeries and dates (attach an additional sheet if necessary)

☐ I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE.

Current Medications

Are you currently taking any blood-thinners or anticoagulants? ☐ Yes ☐ No

If Yes, which ones? ☐ Plavix ☐ Coumadin ☐Lovenox ☐ Pradaxa ☐ Aspirin

Other? ______________________________

TAMPA PAIN RELIEF CENTERS

Please list *all* medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency

Allergies

Do you have any known drug allergies? ☐Yes ☐No

If so, please list all medications you are allergic to.

Medication Name	Allergic Reaction Type

Topical Allergies: ☐ Iodine ☐ Latex ☐ Tape

Are you allergic to shellfish? ☐ Yes ☐ No

Family History

Mark all appropriate diagnoses as they pertain to your biological *MOTHER AND FATHER* only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother													
Father													

Other medical problems: ____________________

☐ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY. ☐ I AM ADOPTED (No Medical History Available).

TAMPA PAIN RELIEF CENTERS

Social History

Are you or can you be pregnant? ☐ Not Applicable ☐ Yes ☐No

Number of Children:______________________ Number of Children Living at Home: ___________________

Highest level of education obtained: ☐ Grammar school ☐ High School ☐ College ☐ Post-graduate

Alcohol Use: ☐ Daily Limited Use ☐ History of Alcoholism ☐ Current Alcoholism
☐ Never Drinks Alcohol ☐ Drinks Alcohol Socially

Tobacco Use: ☐ Current Tobacco User ☐ Former Tobacco User ☐ Has Never Used Tobacco

Illegal Drug Use: ☐ Denies Any Illegal Drug Use ☐ Currently Using Illegal Drugs
☐ Currently Uses Marijuana ☐ Currently Using Someone Else's Prescription Medications
☐ Formerly Used Illegal Drugs (not currently using)

Have you ever had abuse/dependence problems with narcotic or prescription medications? ☐ Yes ☐No

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical
☐ Cancer – Type _____________
☐ Diabetes – Type ___________
☐ HIV / AIDS

Head/Eyes/Ears/Nose/Throat
☐ Headaches
☐ Migraines
☐ Head Injury
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Glaucoma

Cardiovascular / Hematologic
☐ Anemia
☐ Heart Attack
☐ High Blood Pressure
☐ High Cholesterol
☐ Mitral Valve Prolapse
☐ Murmur
☐ Phlebitis
☐ Poor Circulation
☐ Stroke
☐ Coronary Artery Disease

Respiratory
☐Asthma
☐ Bronchitis
☐ Emphysema / COPD
☐ Pneumonia
☐ Tuberculosis
☐ Valley Fever

Gastrointestinal
☐ Bowel Incontinence
☐ GERD (Acid Reflux)
☐ Gastrointestinal Bleeding
☐ Constipation

Musculoskeletal
☐ Amputation
☐ Bursitis
☐ Carpal Tunnel Syndrome
☐ Chronic Low Back Pain
☐ Chronic Neck Pain
☐ Chronic Joint Pain
☐ Fibromyalgia
☐ Joint Injury
☐ Osteoarthritis
☐ Osteoporosis
☐ Phantom Limb Pain
☐ Rheumatoid arthritis
☐ Tennis Elbow
☐ Vertebral Compression Fracture

Genitourinary/Nephrology
☐ Bladder Infection(s)
☐ Dialysis
☐ Kidney Infection(s)
☐ Kidney Stones
☐ Urinary Incontinence

Hepatic
☐ Hepatitis A (active / inactive / unsure)
☐ Hepatitis B (active / inactive / unsure)
☐ Hepatitis C (active / inactive / unsure)

Neuropsychological
☐ Alcohol Abuse
☐ Alzheimer Disease
☐ Bipolar Disorder
☐ Depression
☐ Epilepsy
☐ Prescription Drug Abuse
☐ Multiple Sclerosis
☐ Paralysis
☐ Peripheral Neuropathy
☐ Schizophrenia
☐ Seizures
☐ Reflex Sympathetic Dystrophy/CRPS
☐ **Other Diagnosed Conditions**
____

TAMPA PAIN RELIEF CENTERS

Review of Systems

Mark the following symptoms that you currently suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History (page 9).*

Constitutional:
- ☐ Chills
- ☐ Difficulty Sleeping
- ☐ Easy Bruising
- ☐ Excessive Sweating
- ☐ Excessive Thirst
- ☐ Fatigue
- ☐ Fevers
- ☐ Insomnia
- ☐ Low Sex Drive
- ☐ Night Sweats
- ☐ Tremors
- ☐ Unexplained Weight Gain
- ☐ Unexplained Weight Loss
- ☐ Weakness

Eyes:
- ☐ Recent Visual Changes

Ears/Nose/Throat/Neck:
- ☐ Dental Problems
- ☐ Earaches
- ☐ Hearing Problems
- ☐ Nosebleeds
- ☐ Recurrent Sore Throats
- ☐ Ringing in the Ears
- ☐ Sinus Problems

Cardiovascular:
- ☐ Bleeding Disorder
- ☐ Chest Pain
- ☐ Deep Vein Thrombosis
- ☐ Fainting
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Lightheadedness
- ☐ Shortness of Breath During Sleep
- ☐ Swelling in the Feet

Respiratory:
- ☐ Cough
- ☐ Wheezing
- ☐ Pulmonary Embolism
- ☐ Shortness of Breath on Exertion/Effort
- ☐ Shortness of Breath at Rest

Gastrointestinal:
- ☐ Abdominal Cramps
- ☐ Acid Reflux
- ☐ Constipation
- ☐ Coffee Ground Appearance in Vomit
- ☐ Dark and Tarry Stools
- ☐ Diarrhea
- ☐ Hernia
- ☐ Vomiting

Musculoskeletal:
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Muscle Spasms
- ☐ Neck Pain

Genitourinary/Nephrology:
- ☐ Blood in Urine
- ☐ Decreased Urine Flow/Frequency/Volume
- ☐ Flank Pain
- ☐ Painful Urination

Neurological:
- ☐ Carpal Tunnel Syndrome
- ☐ Dizziness
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Instability When Walking
- ☐ Tremors
- ☐ Seizures

Psychiatric:
- ☐ Depressed Mood
- ☐ Feeling Anxious
- ☐ Stress Problems
- ☐ Suicidal Thoughts
- ☐ Suicidal Planning

TAMPA PAIN RELIEF CENTERS

Your completed intake paperwork helps our providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk if you have any questions or are unsure how to complete any section of this form.

Patient Information

Your Name: ____________________

Gender: ☐ Male ☐ Female Date of Birth:__________ Age:______

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other __________

Primary Language: ☐ English ☐ Spanish ☐ Other __________

Social Security Number:_____ - ____ - _____ Mother's Maiden Name: __________

Mailing Address:__________ City/State/Zip: __________

Physical address same as Mailing? ☐ Yes ☐ No If not, __________

Preferred Phone: (   ) ____ - ____ ☐ Home ☐ Mobile ☐ Work

Secondary Phone: (   ) ____ - ____ ☐ Home ☐ Mobile ☐ Work

Email: __________ Driver's License # /State: __________

Referral and Physician Relationships

Who is your primary care physician? __________

Were you referred by another physician? ☐ Yes ☐ No

If so, whom? __________

If not, how did you hear about us? ☐ TV ☐ Radio ☐ Insurance Company ☐ Family ☐ Friend ☐ PCP ☐ Website ☐ Facebook ☐ Other__________

Who is your surgeon?__________

Health Care Coverage

Mark the following sources of medical coverage that apply to you for this current pain complaint(s)

☐ Private Insurance ☐ State Medicaid ☐ **Worker's Compensation**
☐ Medicare ☐ Self-Pay ☐ **Automobile Insurance**

Preferred Pharmacy

Pharmacy Name:__________ Phone Number: __________

Street Address:__________ City/State/Zip: __________

TAMPA PAIN RELIEF CENTERS

Primary Insurance Plan

Payer (e.g. BC/BS):______________________________ Plan:______________________________

Group Number:______________________________ Policy/I.D. Number: ______________________

Insurance policy holder: ☐ Self ☐Spouse ☐ Child ☐ Other

Complete this box if you are *not* the policy holder for your primary insurance

Policy Holder Name: ______________________ Policy Holder Gender: ☐ Female ☐ Male

Street Address:______________________ Date of Birth: ______________________

City/State/Zip:______________________ Social Security Number: ______________________

Primary telephone number:______________________ Employer: ______________________

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS):______________________________ Plan:______________________________

Group Number:______________________________ Policy/I.D. Number: ______________________

Insurance policy holder: ☐ Self ☐Spouse ☐ Child ☐ Other

Complete this box if you are *not* the policy holder for your secondary insurance

Policy Holder Name: ______________________ Policy Holder Gender: ☐ Female ☐ Male

Street Address:______________________ Date of Birth: ______________________

City/State/Zip:______________________ Social Security Number: ______________________

Primary telephone number:______________________ Employer: ______________________

Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim

Workers Comp Company:______________________ Agent Name: ______________________

Phone number:______________________ Fax number: ______________________

Claim Number:______________________ Date of initial injury: ______________________

Emergency Contact

Name:______________________ Phone:__________________ Relationship: ______________

Employment Status

☐ Employed ☐ Retired ☐ Unemployed ☐ Disabled

Employer: ______________________ Occupation: ______________________

TAMPA PAIN RELIEF CENTERS

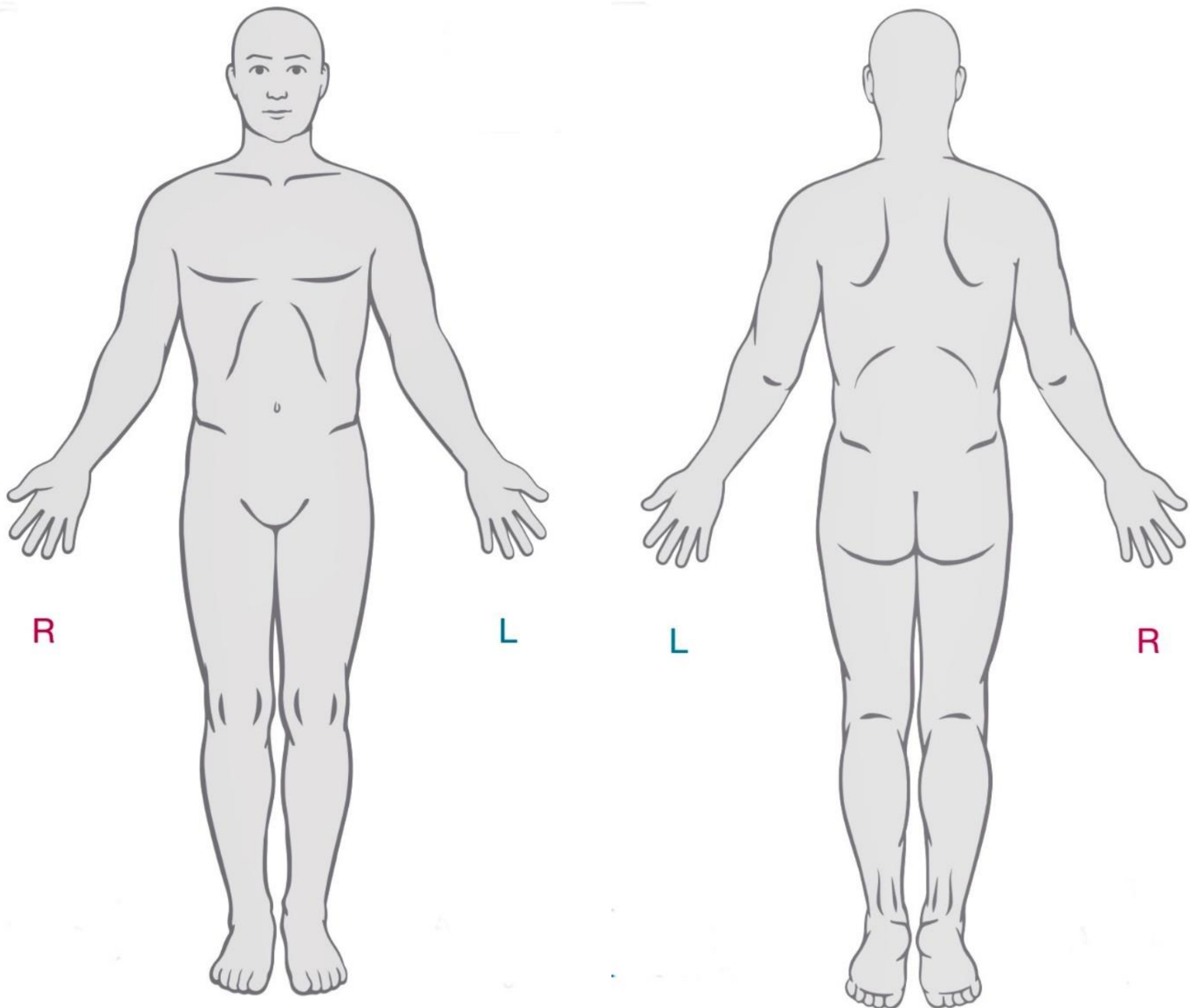
Miguel D. Attias, MD

NAME:_______________________ DATE OF BIRTH:__________________ DATE:_________________

1. Delineate the painful areas in the figure bellow
2. Add pain intensity scores (over a 10 scale) if you wish
3. Draw arrows where the pain radiates.
4. Use the following letters to describe your pain:

Ache = **A,** *Burning* = **B,** *Cramping* = **C,** *Dull* = **D,** Numbness = **N,** *Pins/Needles* = **P,** *Stabbing* = **S**

Throbbing = **T**, *Muscle spasm* = **M**



NOTES:

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Miguel D. Attias, MD

NAME:_________________________ DATE OF BIRTH:____________________ DATE:__________________

1. Delineate the painful areas in the figure bellow
2. Add pain intensity scores (over a 10 scale) if you wish
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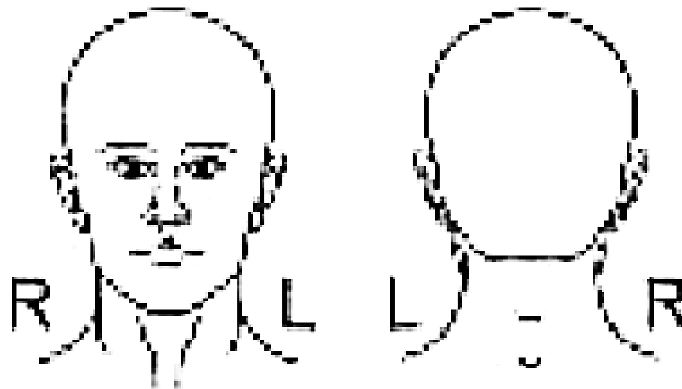

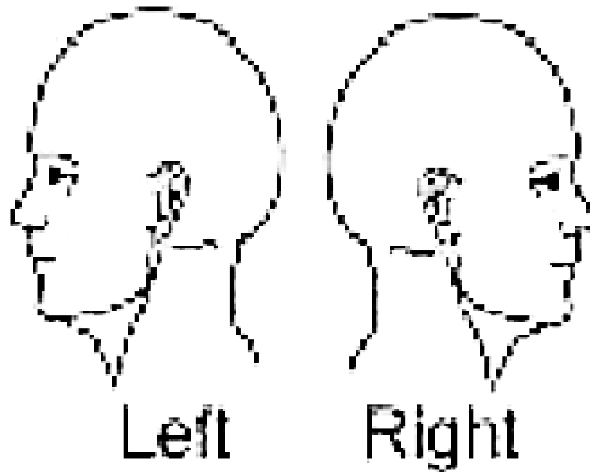

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