CLEARWATER PAIN MANAGEMENT
A DIVISION OF PAINCARE FLORIDA

401 Corbett Street, Suite 330
Clearwater, FL 33756
P: 727-446-4506 F: 727-446-4695

Edward Chen, M.D. Demetrios Kaiafas, M.D
Michael Hux, P.A. Alphonso Fontaine, P.A, DHSc

Date: _____

Name:_____**Sex: M / F Date of Birth:** _____

Referring Physician:_____**Primary Care Physician:**_____

Allergies:_____**Your Occupation:**_____Retired / Unemployed / Student

1.) Where is your pain located?

_____

2.) Have you ever been involved in any Motor Vehicle Accident(s) or Slip and Fall(s)? If so, when?

_____

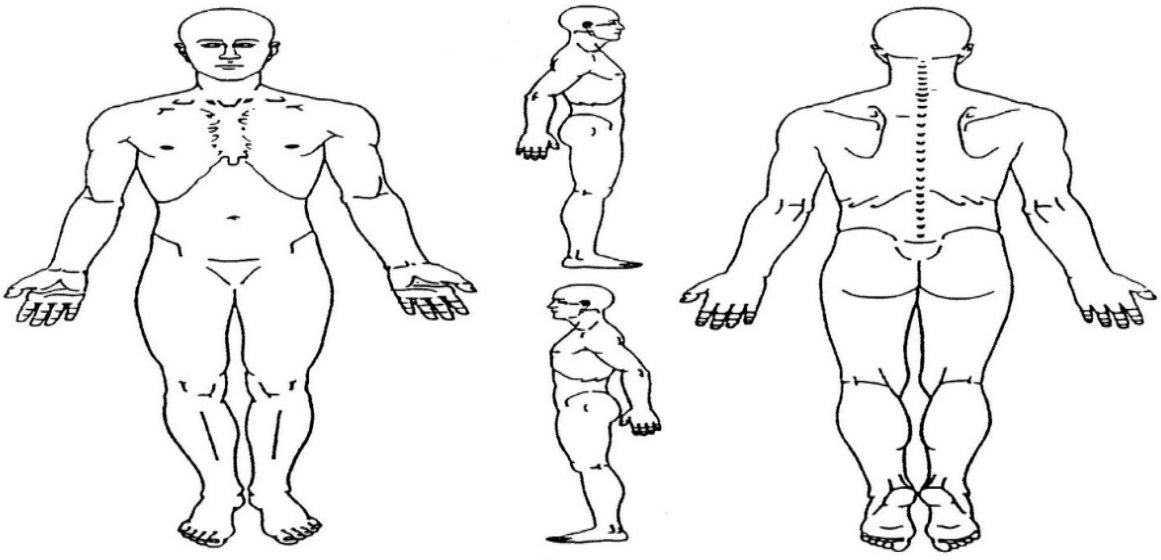
3.) When and how did your pain begin?

_____

4.) Does your pain radiate anywhere? If yes, where?

_____

5.) Please mark the area(s) in the diagrams below where you are having pain:



Is the pain (circle one) Constant / Several Times a day / Intermittent / Occasionally / Less than daily

6.) On a scale from 0-10, with 0 being no pain and 10 being the worst pain imaginable, what number describes your most recent pain: At its best:_____**At its worst:**_____**Right at this moment:**_____

7.) When is your pain worse (circle one)? Morning / Afternoon / Evening / No Usual Pattern / All the time

8.) How has the pain intensity changed since it began? Better / Worse / No Change

9.) Circle all the items that describe your pain: Aching / Burning / Cramping / Dull / Electric Shock / Sharp / Shooting / Stabbing / Throbbing / Other _____

10.) Circle what makes your pain worse: Standing / Sitting / Walking / Movement / Lying Down / Using Bathroom / Bending Forward / Arching Backward / Coughing / Other_____

11.) Circle what makes your pain better: Standing / Sitting / Walking / Movement / Lying Down / Using Bathroom / Bending Forward / Arching Backward / Coughing / Other_____

12.) Please list what diagnostic tests you have had done:

Test	Area(s) Tested	Date(s)	Facility
X-Ray			
CT Scan			
MRI			
Bone Scan	N/A		
EMG	N/A		
Myelogram			
Other			

13.) Do you have any of the following symptoms associated with your pain?
___Numbness/Tingling If yes, where? _____
___Weakness If yes, where? _____
___Bowel/Bladder Incontinence When did it start? _____

14.) Have you seen any other physicians for this pain? Y / N

What is/are the name(s) of the physician(s) you have seen regarding this pain?

Specialty	Physician Name	Approximate Date Seen
Neurosurgeon:		
Orthopedics:		
Pain:		
Psychiatrist/Psychologist:		
Other:		

15.) Please circle all procedures or modalities you have tried to manage or treat your pain with:

	Did It Help?		Did It Help?
Acupuncture		**Massage**	
Biofeedback		**Meditation**	
Chiropractor		**Nerve Blocks**	
Epidural		**Physical Therapy**	
Facet Block		**Psychotherapy**	
Ice/Heat		**Surgery**	
Medications		**TENS**	

16.) Are you seeking workers compensation as result of your pain? Yes / No

17.) Are you seeking social security benefits/disability as a result of your pain? Yes / No

II. Medical Illnesses (Circle all that apply)

Thyroid	**Lung(Asthma, Emphysema, COPD)**
Liver(Hepatitis(A/B/C), Cirrhosis)	**Heart(Angina, Heart Attack, Pacemaker, Defibrillator)**
Psychiatric(Depression, Anxiety, Suicidal)	**Stomach(Ulcer, GERD/Reflux)**
High Blood Pressure	**Kidney(Stones, Failure, Dialysis)**
High Cholesterol	**Neurologic(Stroke, Seizure, Neuropathy, MS, Migraine)**
Diabetes(Diet, Medication, Insulin)	**Arthritis(Rheumatoid, Fibromyalgia, Lupus)**
Cancer (Type?)	**Other (Please List)**

III. Prior Surgeries:

Type	Date	Type	Date

IV. Medications:

Medication Allergies: _____

Current *Non-Pain* Medications

Current *Pain* Medications

***Previous* Pain Medications**

Do you take any of the following?: Aspirin / Plavix / Aggrenox / Effient / Coumadin / Brilinta / Pletal / Ticlid / Eliquis / Jantoven / Pradaxa / Xarelto / Other Blood Thinners

V. Social History (circle all that apply)

Tobacco: Never / Former / Current **Type:** Snuff / Cigarettes / Cigar / Pipe **Use:** Light / Moderate / Heavy

Alcohol: Never / Former / Current **Usage:** Special Occasion Only / Socially / Moderately / Daily

Illegal Drugs: Never / Former / Current **Type:** Marijuana / Cocaine / Heroin / Ecstasy / Other

Have you ever been treated for alcohol or drug addiction? Yes / No. If Yes, date: _____

VI. Family History

	Relative		Relative
Cancer		**Hypertension**	
Diabetes		**Stroke**	
Heart Disease		**Alcohol/Drug Abuse**	

VII. Review of Systems:

General	Weight Gain/Loss, Fever	**GI**	Heartburn, Nausea, Constipation, Abdominal Pain
Skin	Rashes, Jaundice	**GU**	Blood in urine, Incontinence
Head/Eyes	Vision Changes	**M.S.**	Neck Pain, Back Pain, Joint Pain, Difficulty Walking
ENT	Ears Ringing, Sinusitis, Sore Throat, Snoring	**Neuro**	Seizures, Dizziness, Headache, Loss of Consciousness
RES	Chronic Cough, Shortness of Breath, Sleep Apnea	**PS**	Depression, Anxiety, Sleep Problems, Memory Loss
CV	Chest Pain, Palpitations, Ankle Swelling	**END**	Fatigue, Excessive Thirst, Hair Loss
HEM	Anemia, Easy Bruising/Bleeding	**Vasc**	Bruising, Excessive/Easy Bleeding, Itching, Hives

Patient Signature:_____ Date: _____

If this form was completed by someone other than the patient, please complete:
Name:_____
Relationship to Patient: _____
Sign:_____
Date: _____

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Please complete the following information and sign and date.

Patient Name:_____ Patient DOB: _____
Patient SSN:_____ Gender: M / F Marital Status: _____
Patient Home Phone Number: _____ Email:_____
Patient Primary Address: _____
Race: (White / Black / Asian / American Indian / Pacific Islander / Other)
Ethnicity: Hispanic / Non-Hispanic Language: _____
Pharmacy and Address:_____ Phone:_____
Emergency Contact:_____ Relationship: _____
Phone Number: _____ □ Allowed to make medical decisions

Insurance Information:

Primary Insurance: _____
Ins. Address: _____
ID#_____ Group#_____ Phone#_____
Primary Insurance Subscriber Name: _____
Primary Insurance Subscriber Relationship: _____
Secondary Insurance: _____
Ins. Address: _____
ID#_____ Group#_____ Phone#_____
Was this injury due to a car accident? Y / N
Auto Insurance Carrier:_____ Date of Accident:_____
Adjuster:_____ Phone #:_____ Claim #:_____
Was this an on the job injury? Y / N
Workers' Comp Carrier:_____ D.O.I.: _____
Employer:_____ Claim #: _____
Adjuster and/or Case Manager:_____ Phone #:_____

Responsible Party:

Name:_____ Relationship to Patient: _____
Address:_____ Phone Number: _____
SS#_____ DOB:_____ Employed By:_____

Signed:_____ **Date:** _____

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Opioid Risk Tool

Name:_____ DOB:_____ Date: _____

Please circle the numbers that apply to your situation in the correct column.

Has anyone in your immediate family had problems with the following:	**Female**	**Male**
Alcohol	1	3
Illegal Drugs	2	3
Rx drugs	4	4

Have you had any personal history of substance abuse?		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5

Do you suffer from any of the below psychological diseases?		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1

Age between 16-45 years	1	1
History of preadolescent sexual abuse	3	0

Scoring Totals		

If you have any questions or concerns, please discuss them with the MA when they call you back.

Thank you.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, ____/____/____, ____-____-____
Patient's Full Name Date of Birth Social Security Number

hereby authorize _____
Name and Address of Facility Releasing Records

to release medical, including HIV antibody testing, psychiatric/psychological, alcohol and/or drug abuse information contained in my records to:

Facility/Individual & Relationship: _____

Address: _____

Phone Number: _____ Fax Number: _____

For the purpose of: _____

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

This Authorization will expire in one year unless otherwise specified.

A copy of this authorization is as valid as the original.

_____ _____
Patient Signature **Date**

_____ _____ _____
Parent, Legal Guardian or Authorized Representative **Relationship to Patient** **Date**