CLEARWATER PAIN MANAGEMENT

430 Morton Plant Street, Suite 210
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?

_____

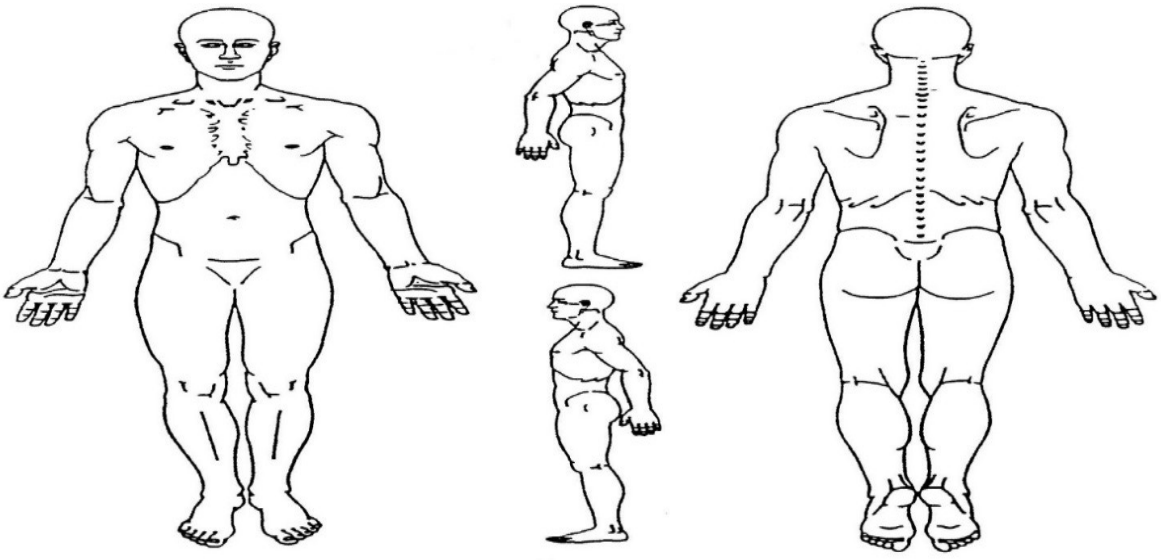
3.) When and how did your pain begin?

_____

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)
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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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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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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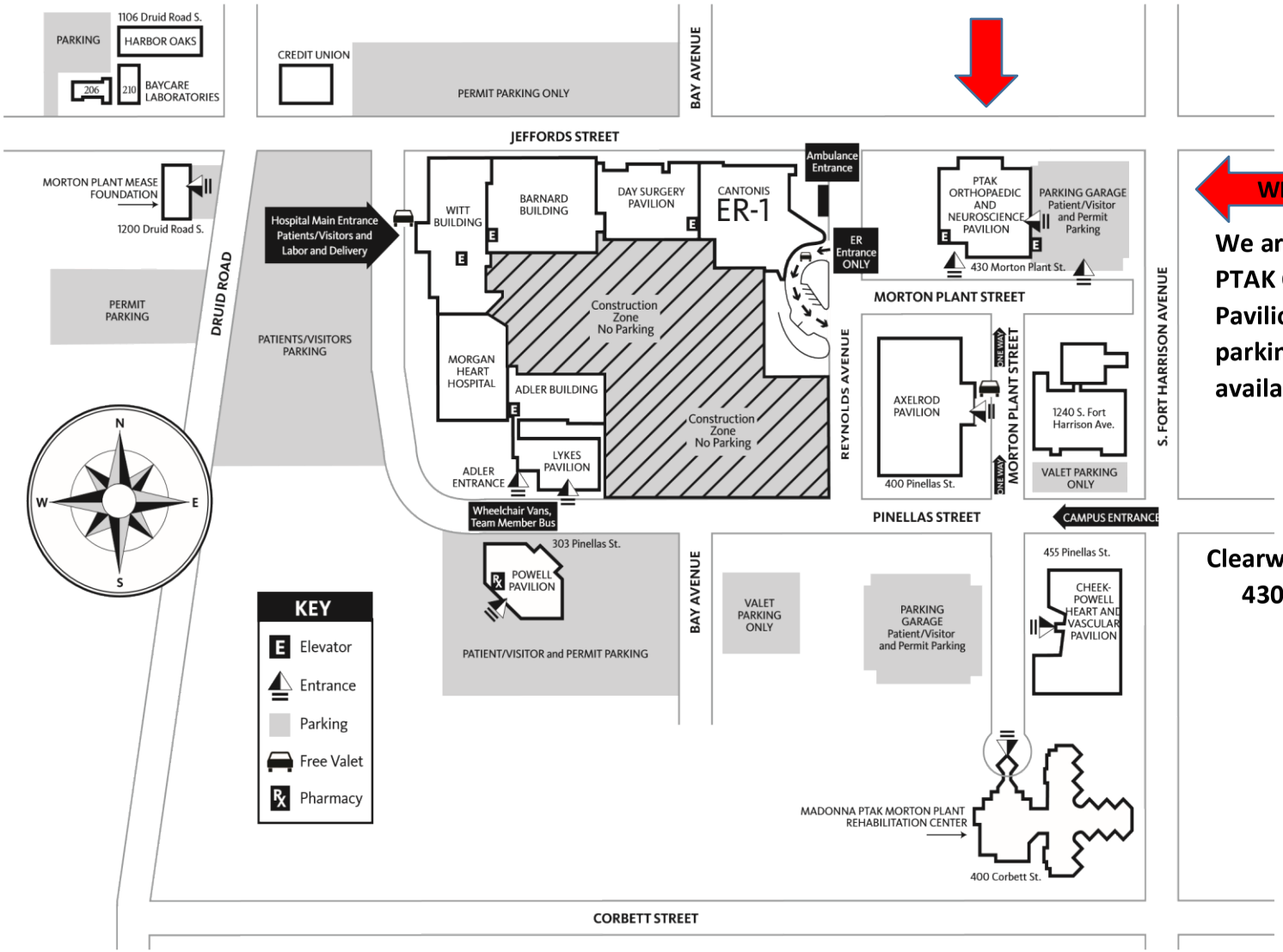

WE ARE HERE

We are located on the 2nd Floor of the PTAK Orthopaedic and Neuroscience Pavilion. Please park in the attached parking garage. Building access is available on the ground and 3rd floors.

Clearwater Pain Management Associates
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