

To help us understand your problem, please complete **ALL Questions** on **ALL** of the attached forms.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Age: \_\_\_\_ Date : \_\_\_\_\_

Who referred you to us? \_\_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_

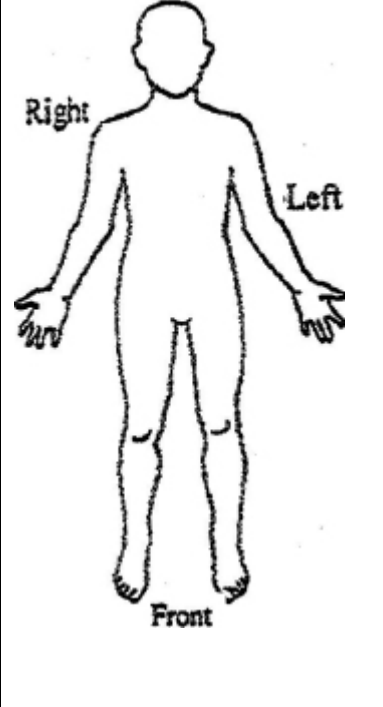
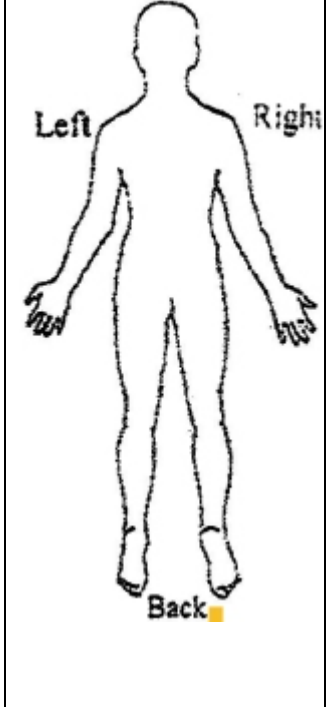
Which part of your body hurts the most? \_\_\_\_\_

How long have you had this pain? \_\_\_\_\_

*On a scale of 0 to 10, "0" being no pain and "10" being the worst pain imaginable, circle the number that describes your level of pain:*

No Pain = 0 1 2 3 4 5 6 7 8 9 **10** = Worst pain imaginable.

Shade in areas below where you have pain and check ALL the words that describe your pain.

	<ul style="list-style-type: none"><li><input type="checkbox"/> Aching Pain</li><li><input type="checkbox"/> Soreness</li><li><input type="checkbox"/> Shooting Pain</li><li><input type="checkbox"/> Cramping</li><li><input type="checkbox"/> Tingling</li><li><input type="checkbox"/> Radiating</li><li><input type="checkbox"/> Hotness</li><li><input type="checkbox"/> Tightness</li><li><input type="checkbox"/> Dullness</li><li><input type="checkbox"/> Constant Pain</li></ul>	<ul style="list-style-type: none"><li><input type="checkbox"/> Stinging Pain</li><li><input type="checkbox"/> Unbearable</li><li><input type="checkbox"/> Burning Pain</li><li><input type="checkbox"/> Stabbing Pain</li><li><input type="checkbox"/> Numbness</li><li><input type="checkbox"/> Excruciating</li><li><input type="checkbox"/> Coldness</li><li><input type="checkbox"/> Heaviness</li><li><input type="checkbox"/> Sharpness</li><li><input type="checkbox"/> Brief Pain</li></ul>	
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Pain caused from: Accident – Yes or No; Illness – Yes or No; Unknown Cause- Yes or No

If accident or illness, explain and give dates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## First Visit is Only a Consultation

Medications may not be prescribed at this visit.

It is strictly up to the Doctor and the office.

No Refunds after consulting with the Doctor.

Fee:

\$47 fax/copying per third party Firm's request.

(legal, personal injury law firms, social security law firms, disability, etc...)

You will be seen by appointment time, Thank you for arriving early.

I read and fully agree with the office policy.

Please Sign: \_\_\_\_\_ Date: \_\_\_\_\_

# Office Policies

## Rules and Policy of The Office:

1. You should not arrive 15 minutes early for your appointment.
2. Sign in 15 minutes late, may jeopardize your appointment.
3. Call **24 hours in advance** of your scheduled appointment to cancel if needed. Under 24 hour notice, you will be charged a **\$25.00 cancellation fee**, which must be paid **in addition** to your normal office visit fee, before you will be seen by the doctor.

All future appointments will be cancelled until the fee is paid.

You must call between the hours of 9:00 am and 4:30 pm M – F and **speak to our staff.**

This is enforced for the consideration of all other patients who are currently in the waiting list and improvement of our total patient care.

4. Cell phones in the office or waiting room disrupts our doctor.
5. No loitering or waiting in the parking lot.
6. Food or drink may contaminate our healthcare facility
7. You are in a healthcare and smoke free environment.
8. Your Primary Care Physician approves insurance and medical accessories.. If you are here, you are on a Medical Maintenance Program only. At the current time, we do not accept insurance.
9. Sorry, we cannot refund after professional service is provided.

These rules and policy copy will be kept in your chart.

I agree to follow these rules and policy.

Please Sign: \_\_\_\_\_ Date: \_\_\_\_\_

## AUTHORIZATION FOR USE DISCLOSURE OF HEALTH INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle

**Authorization for Use/Disclosure of Information:** I voluntarily authorize and direct my health care provider (Please insert name of provider) \_\_\_\_\_ to use or disclose my health information during the term of this Authorization to the recipient that I have identified below.

**Recipient:** Name of person or class of persons to whom my health care provider may disclose my health information: **The Pain Mgmt Corp.** Address/ where health information should be delivered: **6251 Park Blv # 1, Pinellas Park, FL 33781** Fax **888/373-4538**  
Phone: 727 548-1111

**Purpose:** I understand that the specific purpose of this Authorization is the release of medical records. (Note "at the request of the patient" is sufficient if the patient is initiating this Authorization).

**Information to be disclosed:** This authorization permits the above provider to disclose the following medical records: All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.\*

**Term:** This Authorization will remain in effect: Until Provider fulfills this request and recipient receives.

**Redisclosure:** I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

**Refusal to sign/right to revoke:** I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

**Revocation:** I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

**Questions:** I may contact the USC Privacy Officer for answers to my questions about the privacy of my health information at 3500 Figueroa, Ste 105, Los Angeles, CA 90089-8007, or by phone at (213) 740-8258.

\*Note: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris Short Act.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If individual is unable to sign this Authorization, please complete the information below:

Guardian/Representative: \_\_\_\_\_ Legal Relationship \_\_\_\_\_ Date: \_\_\_\_\_

New Health Care Consumer Questionnaire

Patient (Last) Name \_\_\_\_\_ First \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Date: \_\_\_\_\_

*In order to best serve your medical needs, we ask that you complete the following questionnaire as completely as possible. The Health Care Consumer (HCC) – Health Care Provider (HCP) relationship is a privileged relationship built on trust and honesty. By completing and signing this form, you acknowledge that you understand that any intentionally false information may seriously and adversely affect your health.*

Patient's Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender:  Male \_\_\_  Female \_\_\_

If the person completing this form is NOT the patient, please write your name, your relationship to the patient and why you are completing the form for this patient.

{Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Reason(completing form) \_\_\_\_\_ }

Reason for Visit: \_\_\_\_\_

Patient's Personal Contact Information (Address and Phone)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip \_\_\_\_\_

Patient's Email for contact: \_\_\_\_\_ @ \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact (Address and Phone)

Name: \_\_\_\_\_ Phone \_\_\_\_\_ Address \_\_\_\_\_

Insurance Information (Insurance Company, Policy Number, Contact Number)

Name: \_\_\_\_\_ Contact # \_\_\_\_\_

Policy # \_\_\_\_\_ Fax (if known) \_\_\_\_\_

Additional, or Secondary Insurance Company

Name: \_\_\_\_\_ Contact # \_\_\_\_\_

Policy # \_\_\_\_\_ Fax (if known) \_\_\_\_\_

Have you completed a Living Will or designated Durable Power of Attorney for Health care?  Yes  No

Do you have any religious or cultural beliefs that may impact your health care?  Yes  No

If yes, please describe \_\_\_\_\_

You Do  You Do Not understand English well. The language you prefer \_\_\_\_\_

Level of education completed

< 6<sup>th</sup> grade  6<sup>th</sup> – 8<sup>th</sup> grade  9<sup>th</sup> grade  12<sup>th</sup> grade  1-4 yrs college  >4 yr college

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New Health Care Consumer Questionnaire (continued 1)

Names and Phone Numbers for Health care Providers (HCPs) from whom you are currently receiving care (or have seen within the past 12 months) AND ANY Health Care Providers from whom you are obtaining prescriptions.

\_\_\_\_\_ Contact # \_\_\_\_\_  
 \_\_\_\_\_ Contact # \_\_\_\_\_

Please list all the medications you are taking. Include over the counter medications, herbs & Vitamins

Medication Name	Dose	Last taken	Medication Name	Dose	Last Taken
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please list and describe allergic reactions you have had to food, medications, or insect stings.

Check If you are allergic to : \_\_ Shellfish \_\_\_\_\_ IV Constrast Dye \_\_\_\_\_ Penicillins \_\_\_\_\_

Please list Food, Medication or Insect Allergies	Reaction
_____	_____
_____	_____

Please list your occupations. Include the length of time you performed in that role, and describe your work responsibilities in that occupation. (Include military experience).

Occupation	Start Date	Stop Date	Responsibilities
_____	_____	_____	_____
_____	_____	_____	_____

Patient's signature \_\_\_\_\_ or Representative's signature: \_\_\_\_\_

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New Health Care Consumer Questionnaire (Continued 2)

Have you ever been exposed to known cancer causing agents or inhalation hazards?  Yes  No

Examples: asbestos, paints, aniline, dyes, chemicals, silica, etc...

If yes, please list types of exposure, time period exposed, and health problems experienced at time of exposure

Chemical agent	Start Date	Stop Date	Health problems resulting from exposure
_____	_____	_____	_____
_____	_____	_____	_____

Please describe your hobbies;

Travel destinations	OUTSIDE the United States	Dates spent at this destination
_____	_____	_____
_____	_____	_____

Travel destinations	INSIDE the United States	Dates spent at this destination
_____	_____	_____
_____	_____	_____

Do you exercise?  Yes  No If Yes, describe how long and how often you exercise on average each week

In the past 12 months, have you fallen?  Yes  No If yes, how many times? \_\_\_\_\_

If yes, have you ever broken bones, or sustained an injury, as a result of falling?  Yes  No

Do you have a history of smoking?  Yes  No If yes, \_\_\_\_\_ # packs per day X  for # years

Have you ever chewed tobacco?  Yes  No

Have you ever smoked pipes/ cigars?  Yes  No If yes, how many cigars or bowls  per day or wk.

Have you quit? If so, when.  Yes  No \_\_\_\_\_

Have you considered quitting?  Yes  No If yes, have you set a date to quit?  Yes  No

Have you tried quitting?  Yes  No If yes, what is the longest time period you quit smoking? \_\_\_\_\_

Do you have a history of alcohol use?  Yes  No If yes, specify \_\_\_\_\_ # drinks per  Day  Wk

1 "drink" is equal to 12 oz. can of beer; 1.5 oz. liquor (80 proof) or 5 oz. wine

Have you ever experienced a blackout or loss of consciousness due to alcohol intake?  Yes  No

Have you ever needed to drink to prevent yourself from shaking, sweating, and becoming irritable?  Yes  No

Have you ever been arrested or ticketed for DUI (Driving Under the Influence)?  Yes  No

Have you been involved in any motor vehicle accidents in the past 12 months?  Yes  No

Do you use drugs for recreational purposes?  Yes  No

If yes, check all that apply  Amphetamines  Cocaine  Marijuana  Heroin  Inhalants  LSD

Method of delivery you chose  Ingestion  Injection  Inhalation

Patient's signature \_\_\_\_\_ or Representative's signature: \_\_\_\_\_

New Health Care Consumer Questionnaire (Continued 3)

How much would you use \_\_\_\_\_

How long did you use drugs \_\_\_\_\_

Have you quit?  Yes  No If so, when \_\_\_\_\_

Have you ever taken drugs to prevent shaking, sweating and becoming irritable?  Yes  No

Have you ever had a problem with addiction to prescription pain medication or benzodiazepines?  Yes  No

Have you EVER been diagnosed with sexually transmitted disease (like syphilis, gonorrhea, or HIV) or were you exposed to a sexually transmitted disease during childbirth?  Yes  No

Do you have any tattoos or body piercings?  Yes  No

Have you received any transfusions of blood or blood products?  Yes  No

Can you perform your own hygiene, dressing, cooking and shopping needs independently?  Yes  No

Do you feel safe in your relationship?  Yes  No

Have you ever been in a relationship where you were threatened, hurt or afraid?  Yes  No

Have you ever had the following exams?

Cardiac Stress Test  Yes  No \_\_\_\_\_

ECHO  Yes  No \_\_\_\_\_

Chest X-Ray  Yes  No \_\_\_\_\_

CT "CAT" Scan of chest  Yes  No \_\_\_\_\_

Pulmonary function test  Yes  No \_\_\_\_\_

EEG  Yes  No \_\_\_\_\_

Bone density test  Yes  No \_\_\_\_\_

Have you had any of the following vaccinations? Check all that apply, and specify when last received.

Yes  No Tetanus \_\_\_\_\_

Yes  No BCG \_\_\_\_\_

Yes  No Varicella \_\_\_\_\_

Yes  No HPV (Gardasil) \_\_\_\_\_

Patient's signature: \_\_\_\_\_ or Representative's signature: \_\_\_\_\_

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New Health Care Consumer Questionnaire (Continued 4)

Past Medical History Please check all that apply

Adrenal Dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Irregular Heart Rhythm	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alzheimer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kyphosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Amyotrophic Lateral Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anorexia or Bullimia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Failure, or Dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Malignancy if yes, describe below	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arteriovenous Malforamtions (AVMs)	<input type="checkbox"/> Yes	<input type="checkbox"/> No		n/a	n/a
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		n/a	n/a
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mania	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Autoimmune Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscular Dystrophy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bipolar Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Myocardial Infarction (heart attack)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Narcolepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Obstructive Sleep Apnea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cerebrovascular Accident (Stroke)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Organ Transplant If yes, describe	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy if yes, state when	<input type="checkbox"/> Yes	<input type="checkbox"/> No		n/a	n/a
	N/a	n/a	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Claudication	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pancreatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clotting Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Periodic Limb Movement Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Peripheral Artery Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coronary Artery Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Personality Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
COPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pituitary Dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cystic Fibrosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polycystic Ovarian Syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pulmonary Artery Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pulmonary Fibrosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dialysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Therapy If yes, explain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eclampsia or Pre-eclampsia	<input type="checkbox"/> Yes	<input type="checkbox"/> No		n/a	n/a
Endocarditis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Recurrent infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Endometriosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Restless leg syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No
End stage renal disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sarcoidosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Erectile Dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Schizophrenia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Esophageal Dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scleroderma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scoliosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gallstones	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizure disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gastritis or Gastric Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sickle Cell	<input type="checkbox"/> Yes	<input type="checkbox"/> No
GERD (reflux problems)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sjogren	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Disorders (Psoriasis, Acne)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart or Valve Defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thalassemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hemochromatosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thrombocytopenia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hemorrhoids	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thrombophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Transfusions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HIV or AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, have you been treated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hyperthyroidism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Urinary retention or urgency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypotension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vasculitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypothyroidism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Visual defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inflammatory Bowel Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vocal cord dysfunction/paralysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Patient's signature: \_\_\_\_\_ or Representative's Signature: \_\_\_\_\_

New Health Care Consumer Questionnaire (Continued 5)

**Review of Systems** In the last 6 months, have you experienced any of the following symptoms?

<b>Constitutional</b>			<b>Genitourinary</b>		
Weight Loss or Gain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood in your urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appetite changes (increased or decrease)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Menstrual changes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fatigue, profound and impairs daily function	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Urinating that is painful or difficult	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Erection problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Eyes</b>			<b>Musculoskeletal</b>		
Eye pain or drainage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Broken bones	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Visual changes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joint pain or swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dry, irritated eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle aches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>ENT/Mouth</b>			Muscle weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ear pain or drainage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Back pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent sinus infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Skin/Breasts</b>		
Hearing changes or loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Masses or lumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nosebleeds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nipple discharge	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rashes or nonhealing ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Respiratory</b>			<b>Neurologic</b>		
Blood in your sputum	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest tightness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Coughing or choking with swallowing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough lasts > 1month, productive or not	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Excessive daytime sleepiness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Extremely pain/ burning sensations	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hallucinations	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest pain with inhalation or coughing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Numbness or tingling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Cardiovascular</b>			Difficulty falling/staying asleep	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest pain or heaviness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Endocrinologic</b>		
Palpitations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hair loss		
Fainting or near fainting spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swelling of feet or legs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Increased thirst	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath lying flat in bed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heat or cold intolerance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Gastrointestinal</b>			<b>Heme/ Lymph</b>		
Abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding from gum or nose	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood in your stool	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Unexplained bruising	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Night sweats	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea or food intolerance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen, painful lymph nodes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heartburn or indigestion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Allergy / Immun</b>		
Vomiting or nausea lasting > 1 day	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Watery eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swallowing difficulty	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Runny nose	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Psych</b>			Food intolerance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety without clear explanation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent skin sores	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sadness lasting for days/weeks	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Hearing voices	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Thoughts of hurting yourself	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Thought of hurting others	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Fear of people, places or things	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Patient's signature: \_\_\_\_\_ or Representative's Signature: \_\_\_\_\_

New Health Care Consumer Questionnaire (Continued 6 END)

PLEASE list all surgical procedures you have had. Include surgeon and date of procedure.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family Medical History Please list all known medical problems in your immediate family.  
( specify M = Mother, F = Father, B = Brother, S= Sister, So = Son, D = Daughter, GM/GF = Grand M/F)

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional information that you feel may be helpful for your healthcare provider to know:

_____
_____
_____
_____
_____
_____

Health care provider notes:

_____
_____
_____
_____
_____
_____
_____
_____

Patient's signature: \_\_\_\_\_ or Representative's Signature: \_\_\_\_\_

Name : \_\_\_\_\_ Date: \_\_\_\_\_

## DRUG USE QUESTIONNAIRE (DAST – 20)

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 18 months.

Carefully read each statement and decide if your answer is “Yes” or “No”. Then, circle the appropriate response beside the question. In the statements, “drug abuse” refers to

- (1) the use of prescribed or over the counter drugs in excess of the directions and
- (2) any non-medical use of drugs.

The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilizers (e.g. valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin).

Please answer every question and/or the most right questions

These questions refer to the past 18 months

Circle your  
Responses

- |   | Yes | No |
|---|-----|----|
| 1 Have you used drugs other than those required for medical reasons?  | Yes | No |
| 2 Have you abused prescription drugs?   | Yes | No |
| 3 Do you abuse more than one drug at a time?  | Yes | No |
| 4 Can you get through the week without using drugs?   | Yes | No |
| 5 Are you always able to stop using drugs when you want to?   | Yes | No |
| 6 Have you had blackouts or “flashbacks” as a result of drug use?   | Yes | No |
| 7 Do you ever feel bad or guilty about your drug use?   | Yes | No |
| 8 Does your spouse (or parents) ever complain about your involvement with drugs?  | Yes | No |
| 9 Has drug abuse created problems between you and your spouse or your parents?  | Yes | No |
| 10 Have you lost friends because of your use of drugs?  | Yes | No |
| 11 Have you neglected your family because of your use of drugs?   | Yes | No |
| 12 Have you been in trouble at work (or school) because of drug abuse?  | Yes | No |
| 13 Have you lost your job because of drug abuse?  | Yes | No |
| 14 Have you gotten into fights when under the influence of drugs?   | Yes | No |
| 15 Have you engaged in illegal activities in order to obtain drugs?   | Yes | No |
| 16 Have you been arrested for possession of illegal drugs?  | Yes | No |
| 17 Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?                                 | Yes | No |
| 18 Have You had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc...)? | Yes | No |
| 19 Have you gone to anyone for help for drug problem?   | Yes | No |
| 20 Have you been involved in a treatment program specifically related to drug use?  | Yes | No |

Patient’s signature: \_\_\_\_\_ or Representative’s signature: \_\_\_\_\_

## Pain treatment Agreement

I understand that I have a right to comprehensive pain management. I understand that failure to follow any of these agreed statements might result in The Pain Mgmt Corp (the office) and /or physician not providing ongoing pain management care for me.

I, \_\_\_\_\_, voluntary agree to undergo pain management. My diagnosis is:

\_\_\_\_\_.  
I agree to use the prescribed medicine for managing pain only and no other use permitted or recommended.

I understand that The Pain Mgmt Corp. believes in the following Pain Patients Bill of Rights.”

### **You have the right to:**

- Have your pain prevented or controlled adequately.
- Have your pain and medication history taken.
- Have your pain questions answered.
- Know what medication, treatment or anesthesia will be given.
- Know the risks, benefits and side effects of treatment.
- Know what alternative pain treatments may be available to you.
- Ask for changes in treatments if your pain persists.
- Receive compassionate and sympathetic care.
- Receive pain medication on a timely basis.
- Refuse treatment without prejudice from your provider/physician.
- Include your family in decision-making

### **Termination Clauses**

- A. The provider/physician may terminate this agreement at any time if he/she has cause to believe that I am not complying with the terms of this agreement, or to believe that I have made a misrepresentation or false statement concerning my pain or my compliance with the terms of this agreement.
- B. I understand that I may terminate this agreement at any time.

If the agreement is terminated, I will not be a patient of the physician and/or at The Pain Mgmt Corp. and would strongly consider treatment for chemical dependency if clinically indicated.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

[www.PainManagementDoctorsTampa.com](http://www.PainManagementDoctorsTampa.com)

**Patient consent form for opioid use**

I, \_\_\_\_\_, agree to the following conditions regarding opioid use.

1. I understand that I have a chronic pain problem that requires the prescription of an opioid pain medication for pain relief and to improve my functional ability. I am aware that the risks include, but are not limited to: drug dependency, addiction, respiratory depression, cardiovascular depression, liver and/or kidney damage, death... The physician has discussed the risks, benefits, and alternatives of medications with me prior to treatment.
2. I will obtain prescriptions for opioid and other controlled medication(s) from only one physician, i.e. **The Pain Mgmt Corp**, as long as my treating Physician believes that it is appropriate to use opioid therapy.
3. I will have my prescriptions filled at only one pharmacy and will notify my treating physician of the name of the pharmacy.
4. I will take the medication(s) only as prescribed and will notify my physician if I do not. If necessary, I agree to **random urine** and blood tests to assess my compliance.
5. I understand that the eventual goal is to taper off the narcotic medication(s) as tolerated. I agree to meet regularly with my physician to assess my progress.
6. **Random urine drug tests** may be performed to monitor prescribed pain medication.
7. Lost, stolen, or misplaced opioids controlled substance **WILL NOT BE REPLACED**. Refills will not be given early for any reason. **PRESCRIPTIONS WILL ONLY BE GIVEN DURING REGULAR OFFICE HOURS AND WILL NOT BE GIVEN OR REFILLED BY THE PHYSICIAN DURING WEEKENDS OR EVENINGS.** If the prescription or the medication(s) are lost or stolen, a police report will be required.
8. A psychological evaluation regarding addiction and drug dependency may be necessary at any time the treating physician sees fit.
9. If I deviate from the above guidelines or if the medication loses its effectiveness in increasing my functional ability, I understand that the physician may taper off or discontinue the narcotic.
10. Patient gives **The Pain Mgmt Corp.** permission to contact other physicians and pharmacies to confirm compliance.
11. I am not currently using any illegal street drug(s) and will not do so while being treated at this facility. Failure to comply with this rule could be cause for my immediate termination from this treatment.

My signature at the bottom indicates my understanding and agreement with the above guidelines.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Or Patient's Representative's signature: \_\_\_\_\_ Date: \_\_\_\_\_