WELCOME TO FLORIDA PAIN MANAGEMENT PHYSICIANS.COM

Please bring your completed form to your local office

To submit forms by email: office@floridapainmanagmentphysicians.com

Fax: 727-849-0926 or Mail: P.O. Box 1209, New Port Richey, Fl 34656-1209

To help us understand your problem, please complete ALL of the pages.

Section A: Background

Name _____ Age_____ Date _____

Who referred you to us? _____Height: _____Weight:_____

Which part(s) of your body hurt the most? _____

_____

How long have you had this pain? _____

Is this pain caused from: Accident –Yes or No? _____

Illness: Yes or No? _____

Unknown Cause: Yes or No? _____

If accident or illness please explain and give dates:

_____

Family Physician Name and Tel._____

List other Physicians you have seen for your pain:

Name	Specialty	Recommendation	Appt. Dates

Section B: Pain Scale

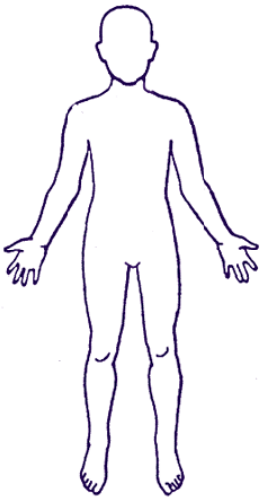
On a scale of 0 to 10, "0" being no pain and "10" being the worst pain imaginable, **CIRCLE or BOLD** the number that describes your level of pain:

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

Section C: Body Diagrams- Front

Shade/"X" in areas below where you have pain and **CIRCLE or BOLD** all of the words that best describe your pain:

Front:



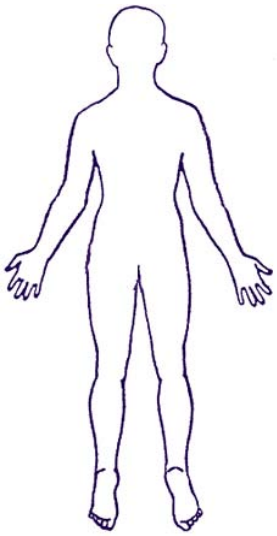
Right **Left**

Aching	Stinging
Soreness	Unbearable
Shooting	Burning
Cramping	Stabbing
Tingling	Numbness
Radiating	Excruciating
Hotness	Coldness
Tightness	Heaviness
Dullness	Sharpness
Constant	Brief

Section C: Body Diagrams- Back

Shade/"X" in areas below where you have pain and **CIRCLE or BOLD** all of the words that best describe your pain:

Back:



Left **Right**

Aching	Stinging
Soreness	Unbearable
Shooting	Burning
Cramping	Stabbing
Tingling	Numbness
Radiating	Excruciating
Hotness	Coldness
Tightness	Heaviness
Dullness	Sharpness
Constant	Brief

Section D: Activities, Treatments and Diagnostic Tests

Please **INDICATE** the factors or activities that increase or decrease your pain:

	Increase	Decrease	No Effect		Increase	Decrease	No Effect
Weather Change				Pressure			
Heat				Sexual Activity			
Cold				Bowel movement			
Physical Activity				Bright light/noise			
Posture				Sneeze, cough			
Walking				Lying down			
Sitting				Other			

Please **DETAIL and CHECK** any of the following treatments you have had for this pain problem and improvements or not:

		Improved Pain?	
	Approximate Date/ Details	Yes	No
Pain Clinic			
Nerve Blocks, Epidurals			
Tens Unit			
Physical Therapy			
Acupuncture			
Chiropractor			
Psychiatrist/Psychologist			
Massage Therapy			
Other			

Please **INDICATE** which diagnostic procedures (tests) you have had for **THIS** pain problem:

	Body Part	Approximate Date	Facility Performed
MRI Scan			
CT Myelogram			
X-Ray			
EMG/NCS			
Discogram			
Bone Scan			

Section E: Past or Current Medical Problems, Medications and Surgeries

Please **CIRCLE or BOLD** past or current medical problems:

Heart Disease	Lung Disease	Diabetes	Stroke	Herpes (Shingles)
Hypertension	Kidney Problems	Liver Disease	Seizures	HIV/AIDS
Migraines	Thyroid Disease	Depression/Anxiety	GERD /Ulcer	Hepatitis
Open Wound	Current Infection	Other		

Have you ever had cancer? Yes or No _____ If yes, which type(s)? _____

Are you currently receiving treatment? Yes No If yes, type(s) of treatment? _____

Do you have or have you ever had please **CIRCLE or BOLD**:

Cardiovascular	**Respiratory**	**Genitourinary**	**Muscle/Joint Disease**	**Neurological**
Chest Pain	Wheezing	Blood in Urine	Frequent Muscle Spasm	Epilepsy or Seizures
Leg Swelling	Chronic Cough	Bladder Control Change	Arthritis/Joint Dis.	Weakness
Palpitations	Shortness of Breath	Bowel Control Change	Redness in Joints	Dizziness
	Sputum Production		Swelling of Joints	Fainting
			Neck or Back Problems	Numbness
				Headaches

Endocrine	**Gastrointestinal**	**Hematologic**	**Psychiatric**	**Constitutional**
Frequent Urination	Nausea	Easy Bleeding	Depression	Hearing Change
Change In Appetite	Diarrhea	Poor Blood Clotting	Anxiety	Fever/Chills
Heat or Cold Tolerance	Rectal Bleeding	Bleeding Disorder	Stress	Visual Change
Sweating	Heart Burn		Psychiatric Care	Recent Weight Loss
	Constipation			Recent Weight Gain

Please LIST ALL medications you are currently taking:

1._____2._____

3._____4._____

5._____ 6._____

7._____ 8._____

Do you have any allergies to medication or food? Yes No

Please **LIST** your ALLERGIES to food and/or medication and the REACTION(S) below:

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Please **CHECKMARK** if you have ever taken or been given:

	Yes	No	Adverse Reaction Details
Anticoagulants			
Blood-Thinners			
Coumadin			
Plavix			
Pletel			
Cortisone			
Steroids			

Section F: Family and Social History

Please **DESCRIBE** your family history with Age, Cause of Death, and Diseases (Ex.: Cancer, Hypertension, et cetera)

	Age	Living/Deceased	Cause of Death and/or Current Diseases
Mother			
Father			
Sibling			
Sibling			
Grandparent			

Grandparent			
Aunt/Uncle			
Aunt/Uncle			

Please **DESCRIBE and CIRCLE or BOLD** your social information:

What is your marital status: Married Divorced Single

Do you currently work? Yes No What is/was your occupation: _____

Are you a Smoker? Yes No If no, when did you quit? _____ How many cigarettes did you/do you smoke per day? _____ How many years have or did you smoke(d)? _____

Do you use Alcohol? Yes No If yes, how much? _____

Do you have a history of street drug use? Yes No If yes, what type? _____

Do you have a history of alcoholism? Yes No

Do you have a family history of drug or alcohol abuse? Yes No

Is there any possibility that you are pregnant? Yes No

Have you been tested for the HIV Virus? Yes No Date _____ Positive Negative

Have you ever been treated for depression or any other mental health issue? Yes No
Please explain _____ Treating Physician's Name _____ Phone Number _____ Last Visit _____
Frequency of Visits _____ Origin of Depression _____
_____

Thank you for filling out this Client Questionnaire. Please include the following contact info below:

Name _____

Address_____

Email_____ Tel._____

Other Tel. # _____ Fax_____

2215 Nebraska Ave., Suite 3C,

Fort Pierce, Florida 34950

Office Tel: 772-464-0800

5539 Marine Pkwy., Ste. #9
New Port Richey, Florida 34652
Office Tel: 727-849-5502