PALM BEACH PAIN CONSULTANTS

1411 N Flagler Drive, Suite 4000
West Palm Beach, FL 33401
Tel 561 833-0882 Fax 561 833-0813

1111 S Federal Hwy, Suite 228
Stuart, FL 34994
Tel 772 286-8607 Fax 772-286-8701

NAME Last _____ First _____

Address _____ City _____ State_____ Zip _____

Home Phone _____ Cell _____ Email _____

AGE _____ DOB _____Social Security _____ Height _____ Weight _____

SEX □ Male □ Female Race_____ Ethnicity_____ Preferred Language_____

Emergency Contact Name/ Relationship_____ Phone _____

Referring Physician _____ Primary Physician _____

Pharmacy name/ phone number _____

WHEN DID YOUR PAIN BEGIN? _____ **WHAT CAUSED YOUR PAIN?** *Check all that apply*

□ Spontaneous (don't know) □ Injury (auto / work / other) Date of Injury _____ □ Following an illness _____

□ Cancer (type) _____ □ Due to Surgery _____

□ Other _____

DESCRIBE THE PAIN: *Check all that apply*

□ NUMBNESS □ ACHING □ SHARP □ BURNING □ THROBBING □ TINGLING □ DULL □ HEAVY □ SHOOTING SENSATION

□ OTHER (please describe) _____

RATE THE INTENSITY OF YOUR PAIN (0 representing NO pain, 10 representing WORST pain)

NOW _____ (0 to 10 scale) **MOST** _____ **(**0 to 10) **LEAST** _____ (0 to10)

WHEN DOES THE PAIN OCCUR? □ Constant □ Intermittent □ How Often _____

WHAT MAKES THE PAIN WORSE? □ Activity □ Bending □ Walking □ Cold □Heat □ Twisting

Other _____

WHAT MAKES THE PAIN BETTER? □ Activity □ Rest □ Heat □ Cold □ Anti-inflammatories □ Medicine

□ Other _____

WHERE IS THE PAIN LOCATED? _____Does it travel? **Y** □ **or N** □ WHERE _____

WHAT PAIN TREATMENTS HAVE YOU TRIED? *Check all that apply*

□ Surgery □ Biofeedback □ Massage □ Physical Therapy □ Chiropractor □ Epidurals □ Other Injections □ Acupuncture

□ Hypnosis □ Psychiatrist/ Psychologist □ Anti-inflammatory and Pain medications (please list) _____

MEDICATION ALLERGIES: _____

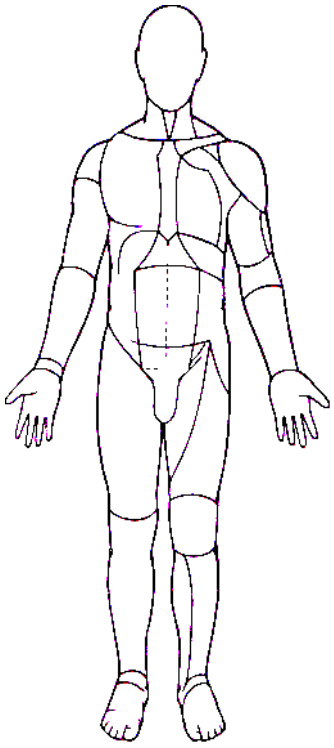
CURRENT MEDICATIONS or provide medication list

Medication Name	Dose	How Often	Route (oral, topical, Inj.)

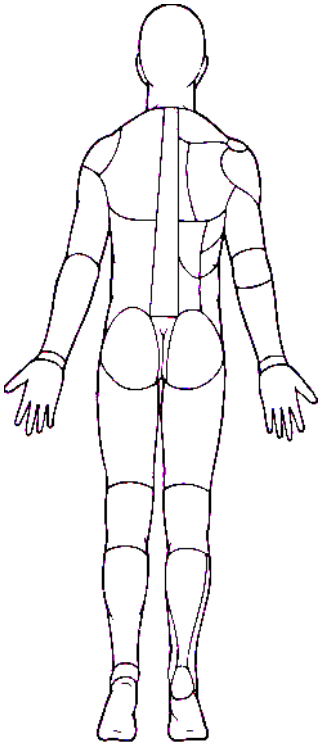
PALM BEACH PAIN CONSULTANTS

PAIN DIAGRAM – PLEASE MARK THE EXACT AREA OF PAIN ON THE PICTURE BELOW

FRONT



BACK



MEDICAL HISTORY *Check all that apply*

CONDITION/DISEASE	YES	NO	CONDITION/DISEASE	YES	NO
HEART PROBLEMS			**BRAIN/ SPINE**		
Chest Pain / Angina			Stroke/ TIA		
Heart Attack			Seizures / Epilepsy		
High Blood Pressure			**LUNGS**		
Mitral Valve Prolapse			Asthma / Bronchitis		
Pacemaker/ Defibrillator			Emphysema / TB		
Congestive Heart Failure			Sleep Apnea		
Coronary Bypass Surgery			**KIDNEY DISEASE**		
Arrhythmia			Dialysis		
LIVER DISEASE			Stones		
Hepatitis/ Jaundice			**ENDOCRINE**		
Cirrhosis			Diabetes		
BLOOD PROBLEM			Thyroid		
Bleeding Disorder			**OTHER**		
Sickle Cell			HIV or AIDS		
Anemia			Currently Pregnant		
MUSCLE/BONE			History of Cancer/Type of Cancer		
Arthritis			Previous Operations		
Back/ Neck Problems					

EXPLAIN ALL YES ANSWERS _____

_____

PALM BEACH PAIN CONSULTANTS

FAMILY HISTORY (Indicate ANY significant illnesses in your family)

_____

SOCIAL HISTORY

Marital Status _____ Occupation_____ Currently working? □ YES □ NO

Do you drink alcohol? □ NO □ YES Frequency/Quantity _____

Do you smoke? □ NO □ YES Frequency/ Quantity _____

Do you currently or have you ever used Illegal drugs? □ NO □ YES Explain _____

Have you ever / do you have an addiction problem with drugs or alcohol? □ NO □ YES

Explain _____

REVIEW OF SYSTEMS: *Check all that apply*

General: □ Weight Loss, □ change in appetite, □ fatigue, □ weakness

ENT: □ Visual changes, □ headaches

Endocrine: □ Cold intolerance, □ heat intolerance, □ excessive thirst, □ frequent urination

Respiratory: □ Shortness of breath, □ wheezing, □ other lung problems

Cardiac: □ Chest pain, □ heart attack, □ palpitations, □ irregular heartbeat, □ shortness of breath, □ edema

GI: □ Anorexia, □ nausea, □ vomiting, □ diarrhea, bloating, □ constipation, □ liver disease or jaundice, □ abdominal pain

GU: □ Incontinence, □ kidney stones, □ blood in urine, □ difficulty urinating

Musculoskeletal: □ Weakness of muscle, □ joint stiffness, □ muscle aches

Skin: □ Rash, □ itching, □ hives

Neurologic: □ Paralysis, □ Seizures, □ dizziness, □ tremors, □ balance problems, □ stroke, □ memory loss

Psychiatric: □ Anxiety, □ depression, □ difficulty sleeping

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INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR PAYMENT? □ PRIVATE INSURANCE □ Workers' Comp □ AUTO □ SELF PAY

Primary Insurance _____ID # _____ TEL # _____

Secondary Insurance _____ ID # _____ TEL # _____

Date of Onset Symptoms_____ DATE OF INJURY _____

Accident Related? YES / NO Work Related? YES / NO Motor Vehicle Related? YES / NO

How did the Injury Occur? _____

W/C & AUTO Claim #_____Company Name _____

Adjuster Name _____ TEL #_____ FAX # _____

Do you have an attorney? YES / NO Attorney _____TEL # _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID BY MY INSURANCE.

PATIENT SIGNATURE _____**DATE** _____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have reviewed the Notice of Privacy Practices for the company and its subsidiaries and affiliates. I understand that copies of the Notice of Privacy Practices are available on the company's website and paper copies are out and available in the office and that I can take one of these copies with me. The Notice of Privacy Practices is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including as it has been amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 and any implementing regulations.

Effective Date of Notice: September 23, 2013

Patient: _____ Date: _____
(print name)

Patient Signature:_____

or

Patient's Representative: _____ Date: _____

Relationship to Patient: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Reason_____

Date_____ Initials_____