INTERVENTIONAL PAIN PHYSICIANS OF SOUTH FLORIDA

1500 N Dixie Highway, Suite 103
West Palm Beach, FL 33401
Tel 561 833-8893 Fax 561 833-8939

1111 SE 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.)

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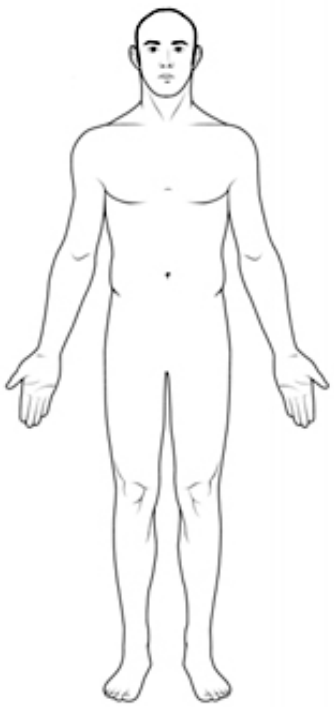
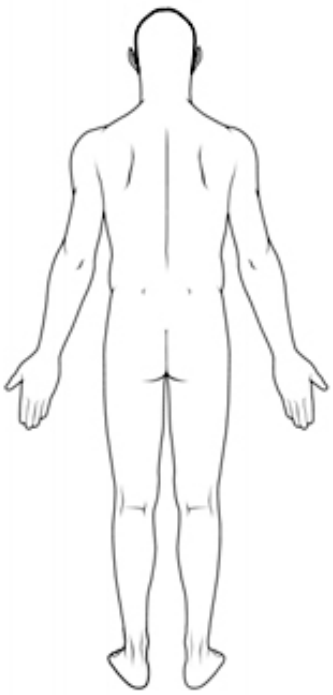
PAIN DIAGRAM – PLEASE MARK THE EXACT AREA OF PAIN ON THE PICTURE BELOW

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_____

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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** _____

INTERVENTIONAL PAIN PHYSICIANS OF SOUTH FLORIDA

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_____

INTERVENTIONAL PAIN PHYSICIANS OF SOUTH FLORIDA

SOAPP® Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestlyas possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
2. How often do you smoke a cigarette within an hour after you wake up?	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
4. How often have any of your close friends had a problem with alcohol or drugs?	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
5. How often have others suggested that you have a drug or alcohol problem?	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
6. How often have you attended an AA or NA meeting?	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
7. How often have you taken medication other than the way that it was prescribed?	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
8. How often have you been treated for an alcohol or drug problem?	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
9. How often have your medications been lost or stolen?	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
10. How often have others expressed concern over your use of medication?	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
11. How often have you felt a craving for medication?	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
12. How often have you been asked to give a urine screen for substance abuse?	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4
14. How often, in your lifetime, have you had legal problems or been arrested?	❒ 0	❒ 1	❒ 2	❒ 3	❒ 4

The SOAPP® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

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ANNUAL MIPS QUESTIONNAIRE GENERAL 2019

Patient Name: _____ Date: _____

1. Do you have little or no interest in doing things? ❒ No ❒ Yes,

   Please check one: ❒ Several Days ❒ More than half the days ❒ Everyday

2. Are you feeling down, depressed or hopeless? ❒ No ❒ Yes,

   Please check one: ❒ Several Days ❒ More than half the days ❒ Everyday

If you answered YES to question 1 or 2, then complete the following table. If you answered No to both question 1 and 2 then you DO NOT have to complete the table, skip to Immunizations below.

	Not at all (O)	**Several days (1)**	**More than half the days (2)**	**Everyday (3)**
3. Do you have trouble falling or staying asleep or sleeping too much?				
4. Do you feel tired or have little energy?				
5. Do you have poor appetite or overeating?				
6. Do you feel bad about yourself, feel like a failure, or feel you have let yourself or your family down?				
7. Do you have trouble concentrating on things, such as reading the newspaper or watching television?				
8. Do you move or speak so slowly that other people could have noticed? Or the opposite? Are you fidgety or restless and move around more than usual?				
9. Do you have thoughts that you would be better off dead and/or have thoughts of hurting yourself in some way?				

Have you fallen in the last 365 days? (Answer only if 65 years and older.)

❒ NO ❒ Yes: ❒ 1 fall with injury ❒ 2 or more falls with injury

❒ 1 fall without injury ❒ 2 or more falls without injury

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"NO-SHOW" NOTICE

Thank you for choosing our practice to assist you with your care. We appreciate your trust and are committed to providing you with high quality, compassionate care.

We value our patients and tailor their treatment plans according to their unique needs, in doing so; we allocate time for each appointment accordingly. We realize that circumstances may occur beyond your control that may not allow you to provide 24 notification. Failure of a patient to notify the office to cancel or change their appointment without 24-hour notice is considered a "No-Show". To help remind patients of their appointments we have implemented an automated reminder system. Please assure we have your correct and most up to date phone numbers or email address at all times throughout the course of your treatment to allow us to better serve you.

The "no show "appointments will be documented in the patient record.

Charges for "no-show" appointments are as follows:

- Office visit $50.00
- Procedure or surgical center visit $100.00

This letter will serve as notice about the office no show policy and fees.

I acknowledge that I have read and understand the policy.

_____

Print Name

_____ _____

Signature Date