Pain Relief Centers
Return to Wellness
6640 – 78th Avenue North, Suite A, Pinellas Park, Florida 33781
Ph # (727) 518-8660 Fax # (727) 518-8662

PATIENT HISTORY FORM

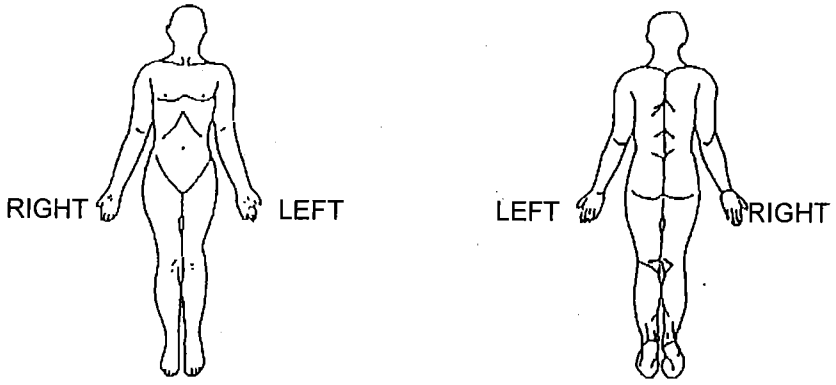
To help us understand your problem, please complete **ALL QUESTIONS** on **ALL** the attached forms prior to your visit.
If these forms are not completed before your appointment, you will be rescheduled to allow you time for completion.

Name _____ Age _____ Date _____

Who referred you to us? _____

How long have you had this pain? _____

Please shade in the areas on the diagrams where your present pain is located.



Please circle appropriate words that best describe your pain.

ACHING	TINGLING	SURPERFICIAL	CONSTANT
BURNING	HOTNESS	TIGHT	INTERMITTENT
CRAMPING	COLDNESS	HEAVY	ANNOYING
NUMBING	SORENESS	INTENSE	SEVERE
STINGING	SHARP	BRIEF	UNBEARABLE
STABBING	DULL	TRANSIENT	EXCRUCIATING
SHOOTING	DEEP	THROBBING	SPASMS

If "0" represents no pain and "10" represents the **WORST** pain you have ever had, circle the number that best describes the average pain you have had over the past seven days.

0 1 2 3 4 5 6 7 8 9 10

Circle Yes or No
Pain caused from: Accident – Yes or No Illness – Yes or No Unknown cause – Yes or No

If accident or illness explain and give dates:

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Please indicate if the following **increases**, **decreases** or causes **no change** in your **pain.**

	Increase	Decrease	No Change		Increase	Decrease	No Change
Liquor	☐	☐	☐	Lying down	☐	☐	☐
Stimulant	☐	☐	☐	Sitting	☐	☐	☐
Eating	☐	☐	☐	Standing	☐	☐	☐
Heat	☐	☐	☐	Distraction (TV etc)	☐	☐	☐
Cold	☐	☐	☐	Urination	☐	☐	☐
Damp	☐	☐	☐	Bowel Movement	☐	☐	☐
Weather Changes	☐	☐	☐	Tension	☐	☐	☐
Physical Activity	☐	☐	☐	Bright Lights	☐	☐	☐
Massage	☐	☐	☐	Loud Noises			☐
Pressure	☐	☐	☐	Fatique	☐	☐	☐
Mōvement	☐	☐	☐	Sneezing	☐	☐	☐
Sleep/Rest	☐	☐	☐	Coughing	☐	☐	☐

COMMENTS: _____

Please **check** (√) any of the following treatments you have had for this pain problem.

	Approximate Date/Details	Improved Pain? Yes	No
__ Pain Clinic	_____	☐	☐
__ Nerve Blocks, Epidurals	_____	☐	☐
__Tens Unit	_____	☐	☐
__ Physical Therapy	_____	☐	☐
__ Acupuncture	_____	☐	☐
__ Chiropractor	_____	☐	☐
__ Psychiatrist, Psychologist	_____	☐	☐
__ Hypnosis, Biofeedback	_____	☐	☐
__ Other	_____	☐	☐

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Please **check** (√) any 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	_____	_____	_____

Please list **other physicians** you have seen for your pain:

Name	Recommendation	Specialty	Appt Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family Physician (Name and Phone) _____

Do you have or have you ever had (please check):

Heart Disease
__High Blood Pressure
__ Low Blood Pressure
__Heart Murmur
__Mitral Valve Prolapse
__Chest Pain or Angina
__Irregular Rhythm
__Skipped Beats
__Heart Failure
__Heart Attack
__Pacemaker
__Easily Fatigued

Other
__Recent Weight Loss
__Recent Weight Gain
__Fever/ Chills
__Visual Change
__Hearing Change
__Snoring
__Use CPAP/BIPAP

Lung Disease
__Shortness of Breath
__Chronic Cough
__Emphysema
__Bronchitis
__T.B.
__Asthma
__O2 Dependent (Oxygen)
__ Sleep Apnea

Neurological Disease
__Epilepsy or Seizures
__Paralysis
__Dizziness
__Fainting
__Numbness
__Headache
__Concussion
__Muscle Disorder
__Stroke

Genitourinary
__Change in Bowel Control
__Change in Bladder Control
__Kidney

Gastrointestinal
__Heart Burn
__Bloody Stools
__Dark Stools
__Recent Vomit/Diarrhea
__Cirrhosis/Liver Disease
__Ulcer
__Hiatal Hernia
__Hepatitis Type ____

Immunological
__Lupus
__HIV +
__Other: _____

Muscle or Joint Disease
__Unusual Muscle Weakness
__Arthritis or Joint Disease
__Frequent Muscle Spasms
__Back Problems
__ Neck Problems

Hematologic
__Anemia
__Easy Bleeding
__Poor Blood Clotting
__Sickle Cell
__Other: _____

Metabolic
__Thyroid
__Diabetes
__Other: _____

Please list any other past or current medical problems not listed: _____

_____

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Please List any Surgeries

Surgery	Approximate Date

List any allergies to medications and your reaction

Medication	**Dosage**	**Times/Daily**

Have you ever taken or been given:	**YES**	**NO**	**When/Any Problems**
Anticoagulants (blood thinners-Coumadin, Heparin)	☐	☐	
Cortisone or Steroids	☐	☐	
Anesthetic (Given by a doctor or dentist)	☐	☐	

(Females please complete)

Date and result of last Mammogram_____ Breast Biopsy Yes ☐ No ☐ If yes, date and result_____

Could you be pregnant? Yes ☐ No ☐ Unsure ☐ Are you trying to become pregnant? Yes ☐ No ☐

History of Number of pregnancies _____ Comments: _____

Date of last Menstrual Period _____ History of irregular vaginal bleeding? Yes ☐ No ☐

(Males please complete)

Do you have difficulty Urinating? Yes ☐ No ☐ Date/result of last Chest xray_____

Date Last Rectal Prostate Exam ____ Normal? Yes ☐ No ☐ Last PSA(Prostate Blood Test)Date ____ Result ____

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Please answer the following questions:

Date/ result last colonoscopy Yes ☐ _____ Never ☐ Brain Scan (CT or MRI) Yes ☐ Date____Never ☐

Have you ever had a blood transfusion? Yes ☐ No ☐ Date_____

Have you been tested for HIV Virus? Yes ☐ No ☐ Date_____ Negative ☐ Positive☐

Cancer History

Have you ever had cancer? No ☐ Yes ☐ What Type?_____

Approximate date of discovery _____ Treating Physician_____

Currently receiving treatments? No ☐ Yes ☐ What type? _____

Last Staging _____ Is your treating physician aware of your current pain problems? Yes ☐ No ☐

Mental Health

Have you ever been treated for depression or any other mental health issue? Yes ☐ No ☐

Please explain _____

Treating Physician's Name _____Phone Number of Physician_____

Last Visit _____Frequency of Visits_____

Origin of Depression _____

Family History

Describe current health, age, cause of death, illness, diabetes, cancer, hypertension, etc.

	Age	Alive	Deceased	Medical History or Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____

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Social History

Martial Status _____ Children's Ages _____

Smoker? Yes ☐ No ☐ If you quit, when? _____

How many cigarettes did you/do you smoke per day? _____ Number of years? _____

Number of caffeinated beverages a day? (average) _____

Alcohol Use? No ☐ Yes ☐ How much? _____ Do you have a history of alcoholism? Yes ☐ No ☐

History of street drug use? No ☐ Yes ☐ _____

Family history of drug or alcohol abuse? No ☐ Yes ☐ _____

Education History (Please check which apply)

☐ GED ☐ High School Diploma ☐ Technical Training ☐ Undergraduate ☐ Graduate Major:_____

Work History

Presently Working: Yes ☐ No ☐ Retired ☐ Hours per Week: _____

Current/ Previous Occupation: _____ Employer:_____

Do you have any current work restrictions? Yes ☐ No ☐ If yes, describe _____
_____

If you are not working due to your pain, when did you last work?_____

Have you been disabled by another physician? Yes ☐ No ☐ If so please explain _____
_____

Have you been placed at Maximum Medical Improvement (MMI)? Yes ☐ No ☐

If yes what percentage ? _____ Is there an attorney involved because of your pain condition? Yes ☐ No ☐

If yes, give name and phone number of attorney: _____

Is there a law suit or any other legal issues pending? Yes ☐ No ☐ Disability pending? Yes ☐ No ☐

Have you had any other previous work comp injuries or claims?

Please add any additional information that you think may be helpful to us.

_____
_____
_____

Signature of Patient: _____ Date: _____

PAIN RELIEF CENTERS

PATIENT INFORMATION

Name (please print):		Gender: M / F
SS#:	Date of Birth:	Marital Status:
Phone: ( )		Email:
Street Address:		
City, State, Zip:		
Emergency Contact (Name/Relationship):		
Street Address:		
City, State, Zip:		Phone: ( )
Person Responsible for Payment (Name/Relationship):		
Street Address:		
City, State, Zip:		Phone: ( )
Employer Name:		Occupation:
Employer Street Address:		
City, State, Zip:		Phone: ( )
Referring Physician:		Phone: ( )
Primary Care Physician:		Phone: ( )
Were you injured on the job (Workers Comp)? yes / no		Date of Injury:
Were you injured in an accident?	yes / no	Date of Accident:
Was an automobile involved?	yes / no	Are benefits exhausted? yes / no
Do you have an Attorney?	yes / no	Attorney Name:
Contact person:		Phone: ( )
Primary Insurance Company:		
Policy/Claim#:		Group #
Claims Address:		
Phone:		
Subscriber Name/Relationship:		
Secondary Insurance Company:		
Policy/Claim #:		Group #
Claims Address:		
Phone:		
Subscriber Name/Relationship:		

All co-pays and deductibles are due at the time of service. Insurance is filed as a courtesy only. Patients are ultimately responsible for any and all charges that insurance does not pay.
A 24-hour notice must be given for all cancelled appointments or you could be charged a fee.

Signature: _____ **Date:** _____

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STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed
The information covered by this authorization includes:

Patient's entire medical history, mental or physical condition, diagnosis, treatment including psychiatric drug or alcohol abuse treatment.

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:
Personnel employed by Pain Relief Centers

Persons to Whom Information May be Disclosed:
Please list anyone that the Pain Relief Centers will be able to release medical information to regarding your care:

_____
_____
_____

Expiration date of Authorization
This authorization is effective through___/___/___ unless revoked or terminated by the patient or the patient's personal representatives.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Pain Relief Centers. You should contact the Pain Relief Centers Compliance officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it was sent. The privacy of this information may not be protected under the federal privacy regulations.

Overall, by signing this form you are giving the Pain Relief Centers permission to release or receive your medical records to or from any physician office, hospital, attorney, or any persons name from above you approved us to disclose information to.

_____ ***Social Security #*** _____
Name of Patient (please print)

_____
Signature of Patient ***Date***

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

Office Use Only

_____
Signature of PRC employee confirming that this was explained to and signed by patient.

Pain Relief Centers

Dear Patient,

Our practice is now using an electronic prescribing system called "E-prescribing" to send your prescriptions directly to the pharmacy of your choice. When a prescription is sent by this method, the prescription is available directly to the pharmacy, and you will NOT be given a paper prescription for that medication. At this time, some types of medication may still require a paper prescription, and some pharmacies may not participate in this program.

Please help us make it easier for you to get your prescriptions by providing the information below.

Sincerely,

The Physicians and Staff of Pain Relief Centers

Patient Pharmacy Information

Patient Name: _____

Pharmacy Name: _____

PharmacyAddress:_____

_____

_____

Pharmacy Phone Number: _____