PATIENT REGISTRATION

Contact Information

Patient Name:			Date:
Gender: ☐ M ☐ F	Date of Birth:	Social Security Number:	
Street Address:			
City:		State:	Zip:
Home:	Cell:		Fax:
Email:			
Employer:			Phone:
Emergency Contact:			Phone:
Closest Relative:			Phone:

Medical Information

Current Medications:			
Surgical History:			
Allergies:			
Primary Physician:			Phone:
Physician's Address:			
Physician's Fax:		Date of Last Physical:	
Pharmacy Name:			Phone:

Insurance Information

Company Name:	Plan Number:
Group Name:	Phone:

I affirm, by signing this Patient Registration Form, that Patient is a resident of the State of Florida and that all information I have given above is true and correct to the best of my knowledge.

Patient's Signature: _____

INTAKE HISTORY

1. Please list the previous medical professionals you have seen, including but not limited to physicians, chiropractors, and acupuncturists for the medical conditions you are experiencing today.

Physician's Name	Specialty	Last Visit	Treatments

2. Please indicate which diagnostic tests you have had to evaluate the medical conditions you are experiencing today.

	Date		Date		Date
Regular X-Ray		C.T, Scan		MRI	
Bone Scan		Arthrogram		Sleep Study	
Myelogram		EMG/NCV/SSEP		Other	

3. Please indicate which treatments you have had for the medical conditions you are experiencing today.

	Yes	No	Sessions	Number of Helpful?
Physical Therapy				
Electrical Stimulation				
Hot / Cold Packs				
Ultrasound				
Massage				
Manipulations				
Aquatics / Whirlpool				
Home Exercises				
Acupuncture				
Injections: Joint / Epidural				
Inplantable Devices				
Other:				
Other:				

4. ✶ **Star** the medications you have used at least once in the past.
   __ **Underline** the medications that have helped you medical conditions.
   ○ **Circle** the medications you currently use to treat you medical conditions.

Advil	Aspirin	Buprenex	Codeine	Darvocet	Demerol
Dilaudid	Duragesic	Elavil	FEldene	Fentanyl	Fioricet
Flexeril	Kadian	Klonopin	Lorcet	Lortabs	Methadone
Motrin	Naprosyn	Neurontin	Norflex	Oxycodone	Oxycontin
Paxil	Percocet	Percodan	Prosac	Relafen	Restoril
Skelaxin	Soma	Toradol	Tylenol	Tylenol #3	Tylox
Ultram	Valium	Vicodin	Voltaren	Xanax	Zoloft
Others:					

5. Are you currently experiencing any of these conditions?

	Yes	No	How Much?
Weight Loss in Last 6 Months			
Anxiety or Stress			
Problems with Sleep			
Fatigue			
Change in Bowel Movement			
Blood in Stool / Dark Stool			
Blood in Urine			
Nausea / Vomiting			
Chronic Cough			
Fevers / Night Sweats			
Urinary Tract Disorders / Infections			
Tuberculosis			
Morning Joint / Muscle Stiffness			
Joint Pain / Swelling			
Heart Murmur			
Rheumatic Fever			
Arterial Graft Surgery			
Chest Pain			
Palpitations			
Shortness of Breath			
Increased Thirst			
Fainting / Dizziness / Vertigo			
Double Vision			

Female Specific Conditions	Yes	No	Date
Hysterectomy			
Abnormal Vaginal Bleeding			
Last Menstrual Period			
Endometriosis			
Nipple Discharge			
History of Breast Biopsy			
Last Pelvic Exam			

Male Specific Conditions	Yes	No	Date
Prostatitis			
Difficulty in Urinating			
Rectal Test			
PSA Test			

6. Please answer the following questions regarding your personal history.

Occupation:					☐ Full ☐ Part Time
If retired or unemployed, what was your last occupation?					
Do you receive any disability benefits?	☐ Yes	☐ No			
Daily Physical Activities:	☐ None	☐ Light	☐ Mild	☐ Medium	☐ Heavy
Do You Use Tobacco?	☐ Yes ☐ No	Indicate Type and Quantity (daily):			
Do You Use Alcohol?	☐ Yes ☐ No	Indicate Type and Quantity (daily):			
Have you ever been treated for substance:					
Abuse	☐ Yes ☐ No	If so, when?			
Addiction	☐ Yes ☐ No	If so, when?			
Dependency	☐ Yes ☐ No	If so, when?			

7. Please answer the following questions regarding your family history.

Describe the current health, any major illness or cause of death of your family member.
Father:
Mother:
Siblings:

I affirm, by signing this Patient Registration Form, all information I have given above is true and correct to the best of my knowledge.

Patient's Signature: _____

PAIN ASSESSMENT

Please answer the following questions about any pain you experience.

Where is your pain?

Circle the word or words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable
Dull	Toothache Type	Radiating Elsewhere

Do you need support to help you walk? ☐ Yes ☐ No	If so, what kind?
Do you wear a brace of any kind? ☐ Yes ☐ No	If so, what kind and how long?
Do you feel your pain: ☐ Occasionally	☐ Continuously
What time of day is your pain the worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night	

Rate your pain by circling the number that best describes your pain in the last month.

NONE ⟵ ⟶ **BAD AS YOU CAN IMAGINE**

a) Pain at its worst last month	0	1	2	3	4	5	6	7	8	9	10
b) Pain at its best last month	0	1	2	3	4	5	6	7	8	9	10
c) Pain at its average last month	0	1	2	3	4	5	6	7	8	9	10
d) Pain right now	0	1	2	3	4	5	6	7	8	9	10

Initial Here _____

What position(s) / activities make the pain WORSE?

☐ Sitting	☐ Standing	☐ Bending	☐ Coughing	☐ Walking
☐ Bowel Movements	☐ Other (explain):			

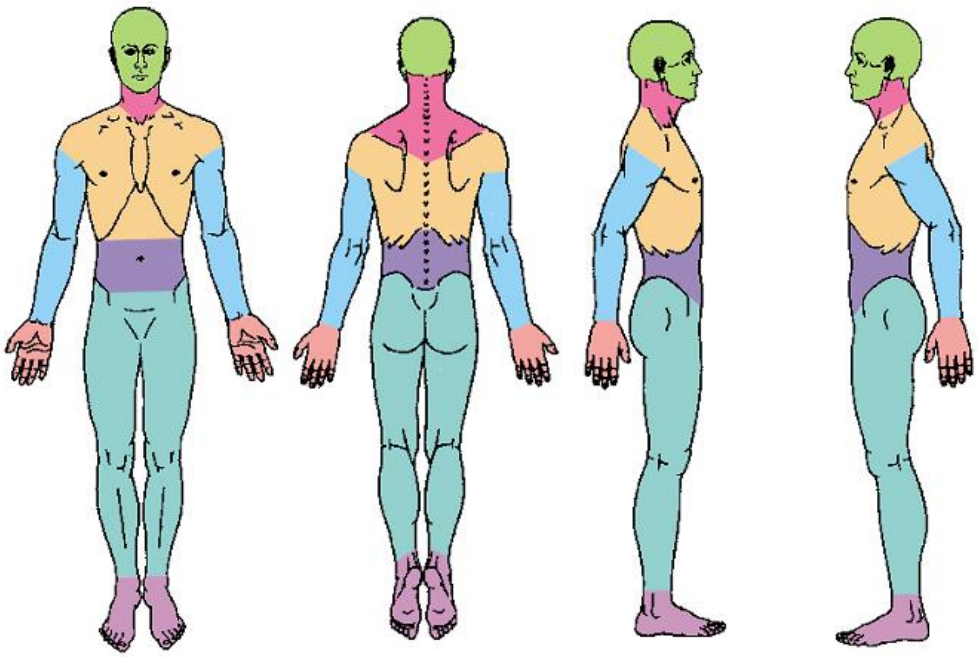
What position(s) / activities make the pain BETTER?

☐ Sitting	☐ Standing	☐ Bending	☐ Lying Down	☐ Walking
☐ Home Remedies	☐ Other (explain):			

Circle the ONE number that best describes how during the PAST WEEK pain has interfered with your:

	NONE										COMPLETELY
1) General Activity	0	1	2	3	4	5	6	7	8	9	10
2) Mood	0	1	2	3	4	5	6	7	8	9	10
3) Normal Work	0	1	2	3	4	5	6	7	8	9	10
4) Sleep	0	1	2	3	4	5	6	7	8	9	10
5) Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10
6) Ability to Concentrate	0	1	2	3	4	5	6	7	8	9	10
7) Relations with Other People	0	1	2	3	4	5	6	7	8	9	10
8) Stress / Anxiety	0	1	2	3	4	5	6	7	8	9	10

Please mark exactly where your pain is located.



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ANXIETY AND STRESS ASSESSMENT

Please answer the following questions about any anxiety or stress you experience.

1. When did you start having anxiety or stress?
2. What was the date of your last severe anxiety or stress experience?
3 How often do you experience anxiety or stress?
4. How long do you experience anxiety or stress?
5. Describe what appears to cause the anxiety or stress.
6. What makes it worse?
7. What makes it better?
8. In your own words, giving as many details as possible, describe what happens during your anxiety or stress experience, including what kind of thoughts you have and what this makes you do.
9. How does this affect your ability to function?

Initial Here _____

DRUG USE SCREENING

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in the home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in you lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from you family or friends?					
24. How often have you been treated for an alcohol or drug problem?					

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AUTHORIZATION FOR TREATMENT

I, the undersigned, a patient of Pain Care of Clearwater and/or a parent or guardian of a patient of Pain Care of Clearwater, hereby authorize the professional staff of Pain Care of Clearwater to administer treatment for the purpose of pain management and/or medication management for anxiety or sleep disturbance.

I have been informed of the nature and purpose of treatment, common side effects thereof, alternative treatment modalities, approximate length of care, and that consent to such treatment may be revoked, orally or in writing, at any time.

Pain Care of Clearwater is legally required to report incidences of communicable diseases to the Florida Department of Health. If, during the course of treatment, it is determined that you have acquired a communicable disease, this information will be reported to the Florida Department of Health. Such report will only be made to individuals and entities as required by law.

I have read and fully understand the foregoing Authorization for Treatment. No guarantee or assurance has been made to me as to the results that may be obtained as a result of such treatment.

Patient's Signature: _____

Dated the _____day of _____, 201___

MEDICAL MALPRACTICE INSURANCE

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. Alexis P Henderson, M.D. and Mohammad H. Gharavi, M.D. MEET THESE REQUIREMENTS AND HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

Patient's Signature: _____

Dated the _____day of _____, 201___

ACKNOWLEDGMENT, CONSENT AND DISCLOSURE

1. This Acknowledgment, Consent and Disclosure ("Acknowledgment"), made this the _____ day of _____, 201___, by _____ (print name), an individual with a medical condition desiring treatment ("Patient") at Pain Care of Clearwater, a medical office in the state of Florida, by the treating physician at Pain Care of Clearwater.

2. Goals of Medical Treatment. Treatment of Patient's medical conditions and improvements in Patient's quality of life are the goals of the medical treatment at Pain Care of Clearwater.

3. Medical Treatment. During the course of medical treatment, Physician may prescribe narcotic and other medications ("Medications") for the management of pain, anxiety, stress, anger, depression, sleep disturbances, operate reduction therapy, or other medical conditions as diagnosed and treated from time to time ("Treatment").

4. No Guarantees or Assurances Regarding Results from Treatment. No guarantees or assurances have been made, are being made, or will ever be made to Patient regarding specific results Patient may expect from obtaining Treatment. Patient with medical conditions relating to pain shall not expect complete pain relief. The proper use of Treatment for pain is not the total elimination of pain, but rather a significant reduction in pain so Patient will be better able to perform the many activities of Patient's daily life whether those activities are personal, professional, or social.

5. Adverse Reactions. Medications have the potential to produce side effects in Patient. These adverse reactions may be more significant in some individuals.

5.1. Medications may produce dose-related **RESPIRATORY DEPRESSION**, irregular breathing, or shortness of breath at high does or even at standard doses in individuals whose body may be more sensitive to Medications.

5.2. Medications may impair Patient's mental and/or physical abilities. Patient's mental and/or physical abilities are necessary and required for the performance of potentially hazardous tasks such as, but not limited to, **driving a car**, riding a bicycle, or operating machinery. Patient has the responsibility of following Physician's oral and written guidance related to the ingestion or other intake of Medications.

5.3. The most frequently observed adverse reactions of Medications include lightheadedness, dizziness, sedation, nausea and vomiting. These adverse effects may be alleviated if Patient lies down. Additional adverse reactions to Medications include: drowsiness, mental clouding, lethargy, and impairment of mental and physical performance, anxiety, fear, depression, restlessness, psychic dependence, mood changes, and constipation.

5.4. If there is any question of impairment of Patient's ability to safely perform any activity, Patient agrees Patient will **NOT** attempt to perform said activity **UNTIL** Patient's ability to perform said activity has been evaluated by Physician or Patient has not used medication for at least twenty-four (24) hours.

6. Patient's Responsibility and Adverse Reactions. Patient has the sole responsibility to report all incidences of significant adverse reactions from Medications or Treatment to Physician. Pain Care of Clearwater and Physician are available during its regular business hours, which are conspicuously posted. If Patient is experiencing significant adverse reactions from Medications, after business hours, Patient shall **IMMEDIATELY** contact the emergency department of Patient's local hospital.

7. Dependency, Tolerance, and Addiction. Medications may promote dependency in some people. Dependency and tolerance are normal physiological consequences of extended Treatment with Medications and are not the same as addiction.

7.1. Psychological dependence and physical dependence may develop upon continued use. While psychological dependence is unlikely to occur during short-term Treatment, some mild degree of physical dependence may develop after a few days use of Medications.

7.2. Tolerance is the condition in which increasingly large doses are required in order to produce the same degree of results, manifested initially by a shortened duration of effect, and subsequently by decreases in the intensity of the effect.

7.3. Addiction is a behavioral syndrome characterized by psychological dependence and aberrant, drug-related behaviors. Relying upon Medications to relieve medical conditions is not addiction. Pain Care of

Initial Here _____

Clearwater and Physician will not manage or treat Patient when Patient uses Medications for other than legitimate medical purposes.

8. Withdrawal Symptoms. Abrupt discontinuation of Medications may result in withdrawal symptoms. Withdrawal symptoms usually occur 24-48 hours after the last dose of Medications. Withdrawal symptoms may consist of yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot or cold flashes, 'goose flesh", abdominal cramps and diarrhea. Withdrawal symptoms may last a few days and may be life threatening to some individuals. Medications can be safely discontinued and withdrawal symptoms significantly minimized or eliminated with the slow tapering of Medications. Patient agrees not to discontinue Treatment or Medications without first procuring the consent of Physician.

9. Patient's Responsibilities Toward Medications. Patient understands violations of the following provisions in this section 9 may be violations of the specific laws and/or regulations of local, state, federal, or other governmental or regulatory bodies ("Laws") and may result in criminal prosecution of Patient. Patient further understands if Pain Care of Clearwater has evidence of Patient's violation of the following provisions, Pain Care of Clearwater may have a duty under the Laws to disclose the violations to the proper authorities.

9.1. Physician will prescribe all Medications. Patient will not attempt to acquire Medications from any third party without first disclosing to the third party, and to Physician, in writing, Medications currently prescribed by Physician ("Third Party Disclosure"). If Patient attempts to acquire Medications from any third party without first procuring and then disclosing the Third Party Disclosure, Patient will be discharged.

9.2. Patient does acknowledge and agree to ingest or otherwise consume Medications strictly as instructed by Physician. Patient will be discharged if this provision is violated.

9.2.1. Patient will not increase the instructed dosage of Medications without first procuring the consent of Physician. Over dosage of Medications may cause severe sedation, respiratory depression and possibly death. Patient will be discharged if this provision is violated.

9.2.2. Patient acknowledges and agrees Medications should be taken whole and are not to be broken, chewed, crushed or otherwise altered, unless directed by Physician or Medications will not work properly and may cause severe sedation, respiratory depression and possibly death. Patient will be discharged if this provision is violated.

9.3. Patient will not ingest or otherwise consume non-Physician prescribed medications, over-the-counter medications, alcohol, illegal drugs or other substances without first receiving the consent of Physician. The combination of drugs or alcohol may cause severe sedation, respiratory depression and possibly death. Patient will be discharged if this provision is violated.

9.4. Patient acknowledges and agrees not to share, sell, or trade Medications for any reason including but not limited to an exchange for money, goods and services or for charitable or humanitarian purposes. Patient will be discharged if this provision is violated.

9.5. Patient agrees to properly safeguard Medications from loss or theft and understands the consequences of Patient's failure to do so will result in Patient going without medication for a period of time until Patient's next regularly scheduled appointment.

9.5.1. Regularly scheduled appointments will be made no earlier than 21 days and no later than 30 days apart. These regularly scheduled appointments are required for the proper management of Medications.

9.5.2. Refills of Medications will not be made for any reason prior to Patient's next regularly scheduled appointment.

9.5.3. Continued loss of Medications may result in Patient being discharged.

9.6. Patient acknowledges and agrees if Pain Care of Clearwater receives any evidence of the hoarding of Medications, acquisition of medications from other sources, uncontrolled dose escalation, or other aberrant behavior, Patient will be discharged.

9.7. Patient acknowledges and agrees that consent to and compliance with random drug screening is a condition of Treatment. Continued Treatment of Patient is based on the successful passing of drug screening. If Patient fails the drug screening, Patient will be discharged or referred for further consultation at the sole discretion of Physician.

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10. Patient's Privileges, Rights of Privacy and Confidentiality.

10.1. Patient agrees to waive any applicable privilege, right of privacy or confidentiality with respect to the investigation of any possible misuse, sale, or other diversion of Medications.

10.2. Patient acknowledges and agrees the Laws may require Pain Care of Clearwater to report incidences of some communicable diseases to governmental agencies such as the Department of Health. Pain Care of Clearwater fully respects Patient's fundamental rights to privacy and will only disclose such information as is required under the Laws. Patient does agree to waive any rights or privileges Patient may have in this information and permit Pain Care of Clearwater to disclose the information as specifically required to comply.

10.3. Patient acknowledges and agrees the Laws require Patient to maintain Patient's primary residence within the State of Florida to receive Treatment from Pain Care of Clearwater. Patient agrees to notify Pain Care of Clearwater of each change of residence by the next appointment. Patient also agrees that Treatment will be terminated should the Patient move outside the State of Florida.

11. Patient's Comprehension of Acknowledgement and Responsibility to Inquire. Patient has read, understands, consents to and accepts this Acknowledgement and has the responsibility to inquire if Patient does not full comprehend every provision hereof.

By signing below, Patient acknowledges Patient has read, understands, authorizes, consents to, and accepts this Acknowledgement.

Dated this _____ day of _____, 201___

Patient's Printed Name: _____

Patient's Signature: _____

Witness: _____