CLEARWATER PAIN MANAGEMENT

430 Morton Plant Street, Suite 210
Clearwater, FL 33756
P: 727-446-4506 F: 727-446-4695

7800 66th Street North, Suite 202
Pinellas Park, FL 33781
P: 727-431-7737 F: 727-431-3718

Edward Chen, M.D. Demetrios Kaiafas, M.D Anil Ladhani, M.D.
Michael Hux, P.A. Alphonso Fontaine, P.A, DHSc

Date: ____________________

Name: ______________________________ Sex: M / F Date of Birth: ________________

Referring Physician: __________________ Primary Care Physician: __________________

Allergies: ________________________ Your Occupation: __________ Retired / Unemployed / Student

1.) Where is your pain located?

____

2.) Have you been involved in any Motor Vehicle Accident(s) within the past 12 months?

____

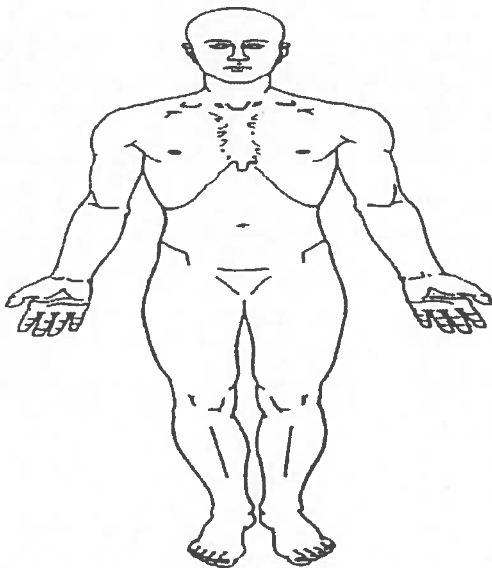
3.) When and how did your pain begin?

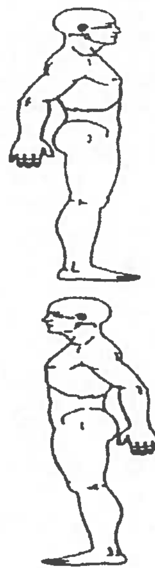
____

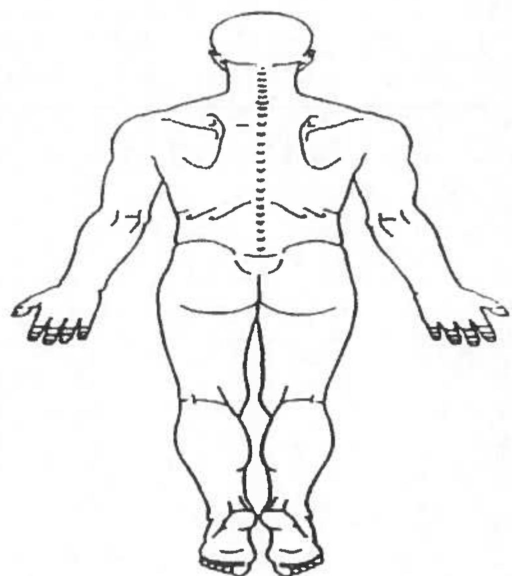
4.) Does your pain radiate anywhere? If yes, where?

____

5.) Please mark the area(s) in the diagrams below where you are having pain:







Is the pain (circle one) Constant / Several Times a day / Intermittent / Occasionally / Less than daily

6.) **On a scale from 0-10, with 0 being no pain and 10 being the worst pain imaginable, what number describes your most recent pain: At its best: ______ At its worst: ______ Right at this moment:_____**

7.) **When is your pain worse (circle one)? Morning / Afternoon / Evening / No Usual Pattern / All the time**

8.) **How has the pain intensity changed since it began? Better / Worse / No Change**

9.) **Circle all the items that describe your pain: Aching / Burning / Cramping / Dull / Electric Shock / Sharp / Shooting / Stabbing / Throbbing / Other ____________________________________**

10.) **Circle what makes your pain worse: Standing / Sitting / Walking / Movement / Lying Down / Using Bathroom / Bending Forward / Arching Backward / Coughing / Other_______________________**

11.) **Circle what makes your pain better: Standing / Sitting / Walking / Movement / Lying Down / Using Bathroom / Bending Forward / Arching Backward / Coughing / Other_______________________**

12.) **Please list what diagnostic tests you have done:**

Test	**Area(s) Tested**	**Date(s)**
X-Ray		
CT Scan		
MRI		
Bone Scan	N/A	
EMG	N/A	
Myelogram		
Other		

13.) **Do you have any of the following symptoms associated with your pain?**

___Numbness/Tingling If yes, where? ____

___Weakness If yes, where? ____

___Bowel/Bladder Incontinence When did it start? ______________________________

14.) **Have you seen any other physicians for this pain?** Y / N

What is/are the name(s) of the physician(s) you have seen regarding this pain?

Specialty	**Physician Name**	**Approximate Date Seen**
Neurosurgeon:		
Orthopedics:		
Pain:		
Psychiatrist/Psychologist:		
Other:		

15.) Please circle all procedures or modalities you have tried to manage or treat your pain with:

	Did It Help?		Did It Help?
Acupuncture		Massage	
Biofeedback		Meditation	
Chiropractor		Nerve Blocks	
Epidural		Physical Therapy	
Facet Block		Psychotherapy	
Ice/Heat		Surgery	
Medications		TENS	

16.) Are you involved in any litigation or lawsuit regarding your pain? Yes / No

If yes, please list your law firm's contact information:

Law Firm: ______________________ Telephone: ______________ Fax: ______________

Address: ____

Attorney Representing Your Case: ______________________________

Contact Person: ____

17.) Are you seeking workers compensation as result of your pain? Yes / No

18.) Are you seeking social security benefits/disability as a result of your pain? Yes / No

II. Medical Illnesses (Circle all that apply)

Thyroid	Lung(Asthma, Emphysema, COPD)
Liver(Hepatitis(A/B/C), Cirrhosis)	Heart(Angina, Heart Attack, Pacemaker, Defibrillator)
Psychiatric(Depression, Anxiety, Suicidal)	Stomach(Ulcer, GERD/Reflux)
High Blood Pressure	Kidney(Stones, Failure, Dialysis)
High Cholesterol	Neurologic(Stroke, Seizure, Neuropathy, MS, Migraine)
Diabetes(Diet, Medication, Insulin)	Arthritis(Rheumatoid, Fibromyalgia, Lupus)
Cancer (Type?)	Back/Neck Pain
Other(Please List)	

III. Prior Surgeries:

Type	Date	Type	Date

IV. Medications:

Medication Allergies: ____

Current *Non-Pain* Medications

Current *Pain* Medications

***Previous* Pain Medications**

Do you take any of the following?: Aspirin / Plavix / Aggrenox / Effient / Coumadin / Brilinta / Pletal / Ticlid / Eliquis / Jantoven / Pradaxa / Xarelto

V. Social History (circle all that apply)

Tobacco: Never / Former / Current **Type:** Snuff / Cigarettes / Cigar / Pipe **Use:** Light / Moderate / Heavy

Alcohol: Never / Former / Current **Usage:** Special Occasion Only / Socially / Moderately / Daily

Illegal Drugs: Never / Former / Current **Type:** Marijuana / Cocaine / Heroin / Ecstasy / Other

Have you ever been treated for alcohol or drug addiction? Yes / No. If Yes, date: ____________________

VI. Family History

	Relative		Relative
Cancer		**Hypertension**	
Diabetes		**Stroke**	
Heart Disease		**Alcohol/Drug Abuse**	

VII. Review of Systems:

General	Weight Gain/Loss, Fatigue	**GI**	Heartburn, Nausea, Constipation
Skin	Bruising, Rashes	**GU**	Blood in urine, painful urination
Head/Eyes	Headache/Blurry Vision	**M.S.**	Joint Pain, Arthritis, Back Pain, Neck Pain
ENT	Ears Ringing, Sinusitis, Sore Throat	**Neuro**	Stroke, Seizures, Weakness
RES	Chronic Cough, Shortness of Breath	**PS**	Depression, Anxiety, Sleep Problems
CV	Chest Pain, Palpitations	**END**	Thyroid Problems, Diabetes
HEM	Anemia, Easy bruising/bleeding	**Vasc**	Leg Cramps, Aneurysms

Patient Signature: ________________________________ **Date:** __________________

If this form was completed by someone other than the patient, please complete:
Name: ____
Relationship to Patient: ____________________________________
Sign: ____
Date: ____

Clearwater Pain Management COVID 19 Screening Questions

PATIENTS MUST WEAR MASK FOR OFFICE ENTRY

PATIENT NAME: ______________________________ DATE: ____________________

In The last 2 weeks, have you had any of the following symptoms?

1. Have recently felt feverish or had temperature greater than 100.4 F Y N
2. Do you have a cough (not related to chronic lung disease or allergies) Y N
3. Do you have Shortness of Breath/Difficulty Breathing Y N
4. Have you been in close contact with someone who has been ill with COVID -19 Y N
5. Do you have chills or repeated shaking with Chills? Y N
6. Have you had Muscle Pain? Y N
7. Have you had Headaches? Y N
8. Have you had recent loss of taste or smell? Y N
9. Have you had a Sore Throat? Y N
10. Do you have Congestion or runny nose Y N
11. Do you have Nausea or vomiting? Y N
12. Have you had diarrhea? Y N

Comments: ____

____

CLEARWATER PAIN MANAGEMENT

430 Morton Plant Street, Suite 210
Clearwater, FL 33756
P: 727-446-4506 F: 727-446-4695

7800 66th Street North, Suite 202
Pinellas Park, FL 33781
P: 727-431-7737 F: 727-431-3718

Edward Chen, M.D. Demetrios Kaiafas, M.D. Anil Ladhani, M.D.
Michael Hux, P.A. Alphonso Fontaine, P.A., DHSc

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 honestly as 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? 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 (marijuana, cocaine, etc.) in the past 5 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

Please include any additional information you wish about the above answers. *Thank you.*

CLEARWATER PAIN MANAGEMENT

430 Morton Plant Street, Suite 210
Clearwater, FL 33756
P: 727-446-4506 F: 727-446-4695

7800 66th Street North, Suite 202
Pinellas Park, FL 33781
P: 727-431-7737 F: 727-431-3718

Edward Chen, M.D. Demetrios Kaiafas, M.D. Anil Ladhani, M.D.
Michael Hux, P.A. Alphonso Fontaine, P.A., DHSc

Opioid Risk Tool

Name: ______________________ DOB: __________ Date: __________

Please circle all that applies in the appropriate column.

Family history of substance abuse	**Female**	**Male**
Alcohol	1	3
Illegal Drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Age between 16-45 years	1	1
History of preadolescent sexual abuse	3	0
Scoring Totals		

If you have any questions or concerns, please discuss them with the MA when they call you back.

Thank you.

CLEARWATER PAIN MANAGEMENT

430 Morton Plant Street, Suite 210
Clearwater, FL 33756
P: 727-446-4506 F: 727-446-4695

7800 66th Street North, Suite 202
Pinellas Park, FL 33781
P: 727-431-7737 F: 727-431-3718

Edward Chen, M.D. Demetrios Kaiafas, M.D. Anil Ladhani, M.D.
Michael Hux, P.A. Alphonso Fontaine, P.A., DHSc

Please complete the following information and sign and date.

Patient Name: ______________________________ Patient DOB: __________________________

Patient SSN: ______________________ Gender: M / F Marital Status: _______________________

Patient Home Phone Number: ____________________ Email: __________________________

Patient Primary Address: ____

Race: (White / Black / Asian / American Indian / Pacific Islander / Other)

Ethnicity: Hispanic / Non-Hispanic Language: ______________________________

Pharmacy and Address: ____________________________Phone:_________________________

Emergency Contact: _________________________ Relationship: _________________________

Phone Number: __________________________ ☐ Allowed to make medical decisions

Insurance Information:

Primary Insurance: ____

Ins. Address: ____

ID#_________________ Group#______________ Phone#______________________

Primary Insurance Subscriber Name: ____

Primary Insurance Subscriber Relationship: ____

Secondary Insurance: ____

Ins. Address: ____

ID#_________________ Group#______________ Phone#______________________

Was this injury due to a car accident? Y / N

Auto Insurance Carrier:______________________________ Date of Accident:_______________

Adjuster: _____________________ Phone #:_________________ Claim #:_________________

Was this an on the job injury? Y / N

Workers' Comp Carrier: _________________________________ D.O.I.: ___________________

Employer: _____________________________ Claim #:______________________________

Adjuster and/or Case Manager:________________________________ Phone #:_____________

Responsible Party:

Name: ______________________________ Relationship to Patient: _______________________

Address: ____ Phone Number: _______________

SS#_______________ DOB: ______________ Employed By: ____________________________

PLEASE PROVIDE YOUR INSURANCE CARD AND DRIVERS LICENSE SO WE CAN MAKE A COPY FOR YOUR FILE.

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES: I hereby authorize Clearwater Pain Management Associates to release any information in the course of my examination and treatment for insurance purposes, including, but not limited to, Medicare, Medicaid, and private insurance carriers.

AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment directly to Clearwater Pain Management Associates of all appropriate payments. This authorization includes, but is not limited to Medicare (HCFA 1500, Blocks 12 and/or 13), Medicaid, and other governmental and private insurance coverage.

AUTHORIZATION OF PAYMNT TO CLEARWATER PAIN MANAGEMENT ASSOCIATES: I hereby agree to be fully responsible for any amounts remaining unpaid 60 days after the date of the service.

ACCEPTANCE OF PERSONAL RESPONSIBILITY: I fully understand, and agree, that if the service(s) provided to me by Clearwater Pain Management are not covered by my insurance company (including but not limited to Medicare, Medicaid, and other insurance), that I will be personally responsible for the payment of all charges. Although Clearwater Pain Management will attempt to ascertain whether the services are covered, Clearwater Pain Management Pain Management cannot be responsible for final determination of coverage- this is between me and the insurance company.

AS A COURTESY TO OUR PATIENTS: Clearwater Pain Management Associates will contact the insurance for which we cannot be responsible for lapses in coverage, incorrect information we receive from you or your physician, or failure of the insurance company to provide authorization. You will ultimately be responsible for payment of your bill if your insurance company refuses to pay or pays incorrectly.

AUTHORIZATION TO DOWNLOAD MEDICATION HISTORY: I authorize Clearwater Pain Management Associates to download my medication history and Rx benefits into my account from an Rx clearinghouse.

NO-SHOW FEE: There will be a $25.00 fee charges to any patient who does not cancel their appointment at least 24 hours prior to their scheduled appointment time. The charge will be assessed to you prior to your next visit of prescription refill. This will not be sent to your insurance company. It is the patient's responsibility.

Signed: ____________________________________ **Date:** ___________________________

ANNUAL QUESTIONNAIRE

Patient Name: ______________________________ DOB: ______________ Date: ______________

Immunizations:

Have you had a Pneumonia Vaccination? ☐ Yes ☐ No If yes, when: ______________________

Have you had a Flu Vaccination? ☐ Yes ☐ No If yes, when: ______________________

Have you fallen in the past year (If 65 or older please answer)? ☐ Yes ☐ No

If yes, please complete:

☐ I fell with injury ☐ 2 or more falls with injury
☐ I fell without injury ☐ 2 or more falls without injury

Do you have little interest and/or pleasure in doing things? ☐ Yes ☐ No

If YES, please check one: ☐ Several Days ☐ More than half the days ☐ Everyday

Are you feeling down, depressed or hopeless? ☐ Yes ☐ No

If YES, please check one: ☐ Several Days ☐ More than half the days ☐ Everyday

If you answered NO to the last TWO questions, YOU ARE DONE WITH THIS QUESTIONNAIRE. DO NOT CONTINUE.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several Days 1	More than half the days 2	Everyday 3
Do you have trouble falling or staying asleep or sleeping too much?				
Do you feel tired or having little energy?				
Do you have poor appetite or overeating?				
Do you feel bad about yourself, or that you are a failure, or have let yourself or your family down?				
Do you have trouble concentrating on things, such as reading the newspaper or watching television?				
Do you move or speak so slowly that other people could have noticed? Or the opposite? Being so fidgety or restless that you have been moving around a lot more than usual?				
Do you have thoughts that you would be better off dead and/or of hurting yourself in some way?				