NewTampa interventional pain & sports medicine
2014 Ashley Oaks Cir. Wesley Chapel FL 33544
Phone 813-999-3030 / Fax 813-333-0453

Today's Date _____ **Social Security #** _____-_____-_____

Patient Name _____**DOB** _____ **Gender:** ☐ **Male** ☐ **Female**

Address_____

City _____ **State** _____**Zip**_____

Home Phone # _____ **Cell #** _____ **E-mail:** _____
May we leave detailed messages at the above listed numbers? ☐ **Yes** ☐ **No**

Race : ☐ **Caucasian** ☐ **Black** ☐ **American Indian** ☐ **Asian** ☐ **Greek** ☐ **Hispanic** ☐ **Other** _____
Ethnicity: ☐ **American** ☐ **Cuban** ☐ **Asian** ☐ **Indian** ☐ **Bosnian** ☐ **African American** ☐ **Other** _____
Language Spoken: ☐ **English** ☐ **Spanish** ☐ **French** ☐ **Italian** ☐ **Portuguese** ☐ **Chinese** ☐ **Japanese** ☐ **Other** _____

In Case of an Emergency please contact:

Name _____ **Relationship** _____ **Phone #** _____

Primary Ins. Co _____ **Policy #** _____ **Group #** _____

Policy Holder _____ **Relationship** _____ **DOB** _____

2nd Ins. Co _____ **Policy #** _____ **Group #** _____

Policy Holder _____ **Relationship** _____ **DOB** _____

☐ **Auto Related Injury? Yes**_____ **No** _____

Auto Accident Carrier _____

Claim # _____ **Adjuster Name & Phone #** _____

Date of Accident _____**State of Accident** _____

Workers' Compensation Related Injury?

Workers' Comp. Ins. Carrier _____

Claim # _____ **Adjuster Name & Phone #** _____

Date of Injury _____ **State of Injury** _____

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Primary Care Physician _____**Phone** _____

Pharmacy Name_____**Phone** _____

Pharmacy Location_____

Preferred Laboratory by your Insurance Company: _____

INSTRUCTIONS: ***Please complete the following questionnaire before you see the doctor. Circle the answers that best describe your situation. You may select more than one answer per question. This information will help your doctor to more accurately understand your condition(s) and develop an appropriate plan of treatment. A copy of this form will be included in your medical record.***

PATIENT NAME: _____ **DATE:** _____

OCCUPATION: _____**EMPLOYER:** _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

1. **CHIEF COMPLAINT:**
   WHAT IS THE REASON FOR YOUR VISIT TODAY:_____

2. **AGE OF PATIENT:** _____ ☐ **MALE** ☐ **FEMALE**

3. **WHAT ARE YOU BEING SEEN FOR?**
   - **A. HEADACHE**
   - **B. NECK PAIN**
   - **C. UPPER BACK PAIN**
   - **D. LOWER BACK PAIN**
   - **E. ARM PAIN**
   - **F. LEG PAIN**
   - **G. OTHER:** _____

   DO YOU HAVE ANY:
   - **A. WEAKNESS**
   - **B. NUMBNESS**
   - **C. TINGLING**

   IF SO, WHERE? _____

   IF MORE THAN ONE OF THE ABOVE IS CHOSEN, WHICH IS THE MOST PROBLEMATIC? _____

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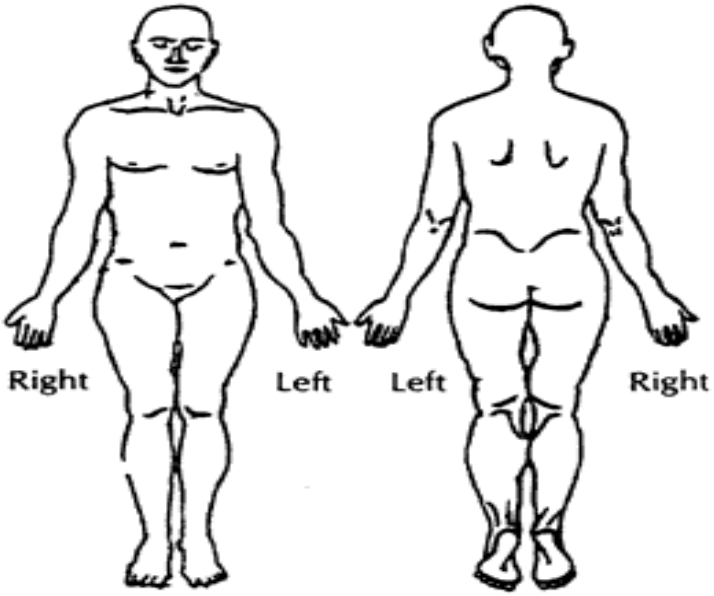
MARK THE LOCATION(S) OF YOUR PAIN ON THE FIGURE(S) BELOW:

FOR SYMPTOMS OF PAIN FILL THE AFFECTED AREAS WITH THE FOLLOWING PATTERN: XXXXXXXX
FOR SYMPTOMS OF NUMBNESS/TINGLING FILL THE AFFECTED AREAS WITH: OOOOOO



PHYSICIAN NOTES:

4. **WHICH TERM BEST DESCRIBES YOUR PAIN? CHARACTER/ Quality of pain: (Please check one box per line that describes your pain in words and severity)**

Sharp	☐ **none**	☐ **mild**	☐ **moderate**	☐ **severe**
Stabbing	☐ **none**	☐ **mild**	☐ **moderate**	☐ **severe**
Burning/ Hot	☐ **none**	☐ **mild**	☐ **moderate**	☐ **severe**
Shooting	☐ **none**	☐ **mild**	☐ **moderate**	☐ **severe**
Aching	☐ **none**	☐ **mild**	☐ **moderate**	☐ **severe**

5. **RATE YOUR PAIN INTENSITY BY CIRCLING THE NUMBER THAT BEST DESCRIBES YOUR PAIN *RIGHT NOW:***
NO PAIN 0 1 2 3 4 5 6 7 8 9 10 INTOLERABLE

6. **WHEN DID THE PROBLEM(S) FIRST START OR WHEN DID THE INJURY OCCUR? _____**

7. **DID THE PROBLEM START AS A RESULT OF:**
   - **A. NORMAL DAILY ACTIVITY**
   - **B. MOTOR VEHICLE ACCIDENT**
   - **C. SPORTS OR RECREATION**
   - **D. FALL**
   - **E. JOB RELATED**
   - **F. CANCER**
   - **G. ILLNESS**
   - **H. OTHER: _____**

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8. **HAVE YOU SEEN A DOCTOR IN THE PAST MONTH FOR THIS CONDITION? YES NO**
   IF YES, WHO/WHEN _____

9. **HAVE YOU BEEN SEEN BY A PAIN MANAGEMENT DOCTOR BEFORE? YES NO**
   IF YES, WHO/WHEN _____

10. **WHAT TREATMENT(S) HAVE YOU ALREADY RECEIVED FOR THIS CONDITION? *(CIRCLE ALL THAT APPLY)***
    - **A. MEDICATIONS (LIST IN TABLE BELOW)**
    - **B. PHYSICAL THERAPY: HOW MANY WEEKS? _____ WAS IT EFFECTIVE? YES NO**
    - **C. STEROID/CORTISONE/EPIDURAL INJECTIONS? (LIST IN TABLE ON NEXT PAGE)**
    - **D. CHIROPRACTIC CARE: DR. _____ WAS IT EFFECTIVE? YES NO**
    - **E. TENS UNIT: PRESCRIBED BY: _____ WAS IT EFFECTIVE? YES NO**
    - **F. SURGERY TYPE: _____ WHEN? _____ DOCTOR? _____**
      TYPE: _____ WHEN? _____ DOCTOR? _____
      TYPE: _____ WHEN? _____ DOCTOR? _____

11. **INJURY HISTORY (IF YOU HAVE NOT HAD ANY TYPE OF INJURY, CHECK BOX AND SKIP TO #12.) ☐**
    - **A. HAVE YOU HAD ANY AUTO INJURIES? YES NO IF YES, WHEN? _____**
      AUTO CASE IS: OPEN CLOSED
    - **B. HAVE YOU EVER HAD ANY SPORTS INJURIES? YES NO IF YES, WHEN? _____**
    - **C. HAVE YOU EVER BROKEN ANY BONES? YES NO IF YES, WHEN? _____WHAT BONE? _____**
    - **D. HAVE YOU EVER HAD A WORKER'S COMPENSATION CLAIM? YES NO**
      WORK COMP CASE IS: (CIRCLE ALL THAT APPLY): CURRENT PAST OPEN CLOSED SETTLED
    - **E. HAVE YOU EVER BEEN DISABLED? YES NO**
      ARE YOU CURRENTLY DISABLED? YES NO IF YES, WHAT TYPE? SSD SSI

12. **SINCE THE PAIN/CONDITION BEGAN, IT:**
    - **A. HAS IMPROVED**
    - **B. HAS WORSENED**
    - **C. HAS REMAINED THE SAME**
    - **D. COMES & GOES (FLUCTUATES)**

    WHAT TIME OF DAY IS THE PAIN MOST INTENSE?
    - **A. WHEN GETTING UP IN THE MORNING**
    - **B. DURING THE DAYTIME**
    - **C. AT THE END OF THE DAY BEFORE BEDTIME**
    - **D. DURING THE NIGHT**

13. **WHAT AGGRAVATES THE PAIN?**
    - **A. WALKING**
    - **B. STANDING**
    - **C. SITTING**
    - **D. LYING DOWN**
    - **E. BENDING**
    - **F. ACTIVITY IN GENERAL**
    - **H. COUGING**
    - **I. TEMPERATURE**
    - **OTHER: _____**

    WHAT MAKES THE PAIN BETTER?
    - **A. WALKING**
    - **B. STANDING**
    - **C. SITTING**
    - **D. LYING DOWN**
    - **E. RESTING**
    - **F. MEDICATION**

14. **DOES THE PAIN AWAKEN YOU FROM SLEEP?**
    A. NEVER B. OCCASIONALLY C. FREQUENTLY

15. **DO YOU HAVE ANY DIFFICULTY WALKING DUE TO THIS CONDITION?**
    A. YES B. NO
    B.

16. **HAVE YOU HAD ANY PROBLEMS WITH BOWEL, BLADDER, OR SEXUAL FUNCTIONS SINCE THIS CONDITION BEGAN?**

NewTampa interventional pain & sports medicine
2014 Ashley Oaks Cir. Wesley Chapel FL 33544
Phone 813-999-3030 / Fax 813-333-0453

A. NO **B. YES, EXPLAIN:** _____

17. HAVE YOU HAD A PREVIOUS PAIN PROBLEM/CONDITION?

A. NO **B. YES, EXPLAIN:**_____

REVIEW OF SYSTEMS: HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING? (MARK YES OR NO FOR EACH

GENERAL	EYE, EAR, NOSE, THROAT	CARDIOVASCULAR	GASTROINTESTINAL	GENITO-URINARY
Y N	Y N	Y N	Y N	Y N
☐ ☐ FEVERS	☐ ☐ EYE PROBLEMS	☐ ☐ CHEST PAIN	☐ ☐ CONSTIPATION	☐ ☐ BLOOD IN URINE
☐ ☐ CHILLS	☐ ☐ DOUBLE VISIONS	☐ ☐ HIGH BLOOD PRESSURE	☐ ☐ BLOATING	☐ ☐ FREQUENT URINATION
☐ ☐ NIGHT SWEATS	☐ ☐ HAY FEVER	☐ ☐ RAPID HEARTBEAT	☐ ☐ DIARRHEA	☐ ☐ INCONTINENCE
☐ ☐ MALAISE	☐ ☐ LOSS OF HEARING	☐ ☐ SWELLING OF ANKLES	☐ ☐ RECTAL BLEEDING	☐ ☐ PAINFUL URINATION
☐ ☐ DIZZINESS	☐ ☐ SNORING	☐ ☐ POOR EXERCISE ABILITY	☐ ☐ STOMACH BLEEDING	SKIN
☐ ☐ WEIGHT GAIN	☐ ☐ SINUS PROBLEMS		☐ ☐ STOMACH PAIN	☐ ☐ CANCER
☐ ☐ WEIGHT LOSS	☐ ☐ EARACHE		☐ ☐ NAUSEA/VOMITING	☐ ☐ DISEASE
☐ ☐ LOSS OF SLEEP			☐ ☐ HEARTBURN	

MUSCLE/BONE/JOINTS	NEUROLOGICAL	HEMATOLOGICAL	PSYCHIATRIC	RESPIRATORY
Y N	Y N	Y N	Y N	Y N
☐ ☐ MUSCLE SPASM(S)	☐ ☐ NERVE DAMAGE	☐ ☐ BLOOD DISORDER	☐ ☐ FEELING SAD/UNHAPPY	☐ ☐ PERSISTENT COUGH
☐ ☐ NECK PAIN	☐ ☐ SEIZURES (ACTIVE)	☐ ☐ BLEEDING PROBLEMS	☐ ☐ SUICIDAL IDEATION	☐ ☐ COUGHING BLOOD
☐ ☐ ARM PAIN	☐ ☐ NUMBNESS/TINGLING	☐ ☐ BLEEDING GUMS	☐ ☐ ADDICTION	☐ ☐ CHRONIC BRONCHITIS
☐ ☐ BACK PAIN	☐ ☐ LIGHTHEADEDNESS	DO YOU TAKE:	☐ ☐ NERVOUSNESS	☐ ☐ SLEEP APNEA
☐ ☐ LEG PAIN	☐ ☐ MUSCLE WEAKNESS	☐ ☐ COUMADIN	ENDOCRINE	☐ ☐ USE OXYGEN
☐ ☐ JOINT PAIN	☐ ☐ POOR CONCENTRATION	☐ ☐ LOVENOX	☐ ☐ SEVERE THIRST	☐ ☐ USE CPAP
☐ ☐ PELVIC PAIN	CANCER	☐ ☐ PLAVIX	☐ ☐ SEVERE FATIGUE	☐ ☐ SHORTNESS OF BREATH
	☐ ☐ PROSTATE/COLON	☐ ☐ HEPARIN	☐ ☐ TAKE CORTISONE	ALLERGY/IMMUNOLOGY
	☐ ☐ BREAST	☐ ☐ AGGRENOX	☐ ☐ ROUGH SKIN/ELBOWS	☐ ☐ SHELLFISH ALLERGY
	☐ ☐ LUNG	☐ ☐ PRADAXA	☐ ☐ DECREASED SEX DRIVE	☐ ☐ ENVIRONMENTAL ALLERGIES
	☐ ☐ OTHER _____	☐ ☐ OTHER _____	☐ ☐ LOSS OF SEXUAL PERFORMANCE	☐ ☐ HIV

18. PAST SURGICAL HISTORY HAVE YOU HAD ANY SURGERIES? (INCLUDE PRIOR PAIN INECTIONS)

A. NONE **B. IF YES *(LIST BELOW)***

DATE	SURGERY	PHYSICIAN

NewTampa interventional pain & sports medicine
2014 Ashley Oaks Cir. Wesley Chapel FL 33544
Phone 813-999-3030 / Fax 813-333-0453

19. PAST MEDICAL HISTORY

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING MEDICAL CONDITIONS? *(CIRCLE ALL THAT APPLY)*

A. NONE
B. THYROID DISORDER
C. OVERWEIGHT
D. LUNG DISEASE (COPD / EMPHYSEMA)
E. ASTHMA/TUBERCULOSIS
F. CORONARY ARTERY DISEASE (CHEST PAIN/ANGINA)
G. PRIOR HEART ATTACK if yes WHEN? _____
H. HIGH BLOOD PRESSURE / HYPERTENSION
I. HEART DISEASE (CONGESTIVE HEART FAILURE)
J. HIGH CHOLESTEROL
K. PERIPHERAL VASCULAR DISEASE
L. STOMACH ULCERS
M. DIABETES MELLITUS
N. HEPATITIS, TYPE: _____
O. LIVER DISEASE
P. KIDNEY DISEASE
Q. IMMUNE DISORDER
R. SEIZURE DISORDER
S. MULTIPLE SCLEROSIS/ OR OTHER BRAIN DISEASE
T. STROKE / CVA
U. OSTEOARTHRITIS/ OSTEOPOROSIS
V. RHEUMATOID ARTHRITIS
W. ENDOMETRIOSIS/ OR PELVIC PAIN
X. DEPRESSION/ ANXIETY DISORDER
Y. MENTAL DISORDER(S)/ _____
Z. CANCER/TUMOR, TYPE: _____
*** LIST ALL OTHER: _____

ALLERGIES

20. ARE YOU ALLERGIC TO ANY MEDICATIONS: ____ A. NO KNOWN ALLERGIES ____B. YES *(LIST BELOW)*

MEDICATION	REACTION (I.E. RASH, ETC)

CURRENT MEDICATIONS

21. ARE YOU CURRENTLY TAKING ANY MEDICATIONS: __A. NONE __B. IF YES *(LIST ALL BELOW)*

MEDICATION	DOSAGE/FREQUENCY	PRESCRIBING PHYSICIAN	FOR WHICH CONDITION?

SOCIAL HISTORY

22. PLEASE ANSWER THE FOLLOWING ABOUT YOURSELF:

A. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED
B. WHO DO YOU LIVE WITH? _____
C. YOUR HIGHEST LEVEL OF EDUCATION: ☐ SOME HIGH SCHOOL ☐ HIGH SCHOOL ☐ TRADE SCHOOL ☐ COLLEGE
D. DO YOU CURRENTLY WORK? ☐ NO ☐ YES: OCCUPATION _____ EMPLOYER: _____

E. HOW MUCH ALCOHOL DO YOU CONSUME: ☐ NONE ☐ SOCIAL DRINKER ☐ DRINK DAILY ☐ RECOVERING ALCOHOLIC
F. DO YOU SMOKE? ☐ NO ☐ YES, I CURRENTLY SMOKE: _____# OF PACKS DAILY ☐ I QUIT SMOKING ___YRS AGO
Have you been counseled about smoking cessation: ☐ NO ☐ YES
G. DO YOU HAVE A HISTORY OF USE/ABUSE OF ILLICIT DRUGS? ☐ NO ☐ YES: LIST: _____
H. Have you ever taken a pill from a family member or from a friend? ☐ NO ☐ YES

NewTampa interventional pain & sports medicine
2014 Ashley Oaks Cir. Wesley Chapel FL 33544
Phone 813-999-3030 / Fax 813-333-0453

FAMILY HISTORY

23. DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING? (*CIRCLE ALL THAT APPLY)*

A. NONE	E. HEART DISEASE	I. OSTEOARTHRITIS
B. BACK/NECK PROBLEMS	F. HYPERTENSION	J. RHEUMATOID ARTHRITIS
C. CANCER	G. STROKE	K. BLEEDING DISORDERS
D. DIABETES	H. ASTHMA	L. LIST ALL OTHER: _____

24. Health Maintenance:

Last physical examination: _____ Last blood work: _____ Last EKG (heart check up): _____
Last Mammogram: _____ Last Dental check up: _____ Last vision examination: _____
Last colorectal cancer screen: _____ Last colonoscopy: _____ Last Bone density test: _____
Last influenza vaccination: _____ Last pneumococcal vaccination: _____ last TB test: _____

25. PLEASE LIST THE NAMES OF ALL OF YOUR CURRENT PHYSICIANS:

PHYSICIAN	SPECIALTY

CERTIFICATION

- **TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM MY DOCTOR IF I, OR MY MINOR CHILD, EVER HAVE A CHANGE IN HEALTH INFORMATION.**
- **I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL AND AGREE TO PAY ALL CHARGES FOR SERVICES AND ITEMS PROVIDED TO ME.**
- **I PERMIT A COPY OF THIS TO BE USED IN PLACE OF THE ORIGINAL.**

_____ _____
SIGNATURE OF BENEFICIARY, GUARDIAN, OR PERSONAL REPRESENTATIVE **DATE**

_____ _____
PLEASE PRINT NAME OF PATIENT, PARENT, OR GUARDIAN **RELATIONSHIP**

NewTampa interventional pain & sports medicine
2014 Ashley Oaks Cir. Wesley Chapel FL 33544
Phone 813-999-3030 / Fax 813-333-0453

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with:

_____ (Name of Insurance Company)

And assign directly to ***NEW TAMPA INTERVENTIONAL PAIN & SPORTS MEDICINE, INC.*** all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I authorize the use of my signature on all insurance correspondence and submissions. I permit a copy of this to be used in place of the original.

The above named physician may use my health care information and may disclose such information to the above-named insurance Company/Companies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for such services. This consent will end when my current treatment plan is completed or in one year from the date signed below.

_____ _____

Signature of Beneficiary, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent or Guardian Relationship

NOTICE OF PRIVACY PRACTICES

NewTampa interventional pain & sports medicine
2014 Ashley Oaks Cir. Wesley Chapel FL 33544
Phone 813-999-3030 / Fax 813-333-0453

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive from our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you.

2. OUR LEGAL DUTY

Law Requires Us To:

1. **Keep your medical information private**
2. **Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.**
3. **Follow the terms of the current notice.**

We Have The Right To:

1. **Change out privacy practices and terms of this notice, provided changes are permitted by law.**
2. **Changes that are made will affect all medical information, including previously received information.**

If any changes are made, the new notice will be available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following are ways that we will be using and disclosing your medical information

FOR TREATMENT: We may share medical information about you to doctors, nurses, technicians, medical students, or other people taking care of you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. When billing your insurance company, the information on, or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use your medical information for our health care operations. This might include: quality improvement, training programs, evaluating the performance of employees etc.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. **Look at, or get copies of your medical information. You must make your request in writing. You may obtain this form from our office's front desk.**
2. **Receive a list of all the times we have shared your medical information for purposes other than treatment, payment and health care operations.**
3. **Request that we place additional restrictions on our use or disclosure of your medical information.**
4. **Revoke your authorization to share your medical information at any time by notifying our office in writing, and the authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.**
5. If you have any questions about this notice, or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit request involving any of your rights in Section 4 of this notice by writing to the following address:

NEW TAMPA INTERVENTIONAL PAIN AND SPORTS MEDICINE
2014 Ashley Oaks Circle Wesley Chapel, FL 33544

PRIVACY PRACTICES ACKNOWLEDGMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ DOB: _____ Date: _____

PATIENT RECORD OF DISCLOSURE

NewTampa interventional pain & sports medicine
2014 Ashley Oaks Cir. Wesley Chapel FL 33544
Phone 813-999-3030 / Fax 813-333-0453

Patient Name: _____DOB: _____Date: _____

In general, the HIPAA privacy act gives individuals the right to request a restriction on uses and disclosures of Personal Health Information (PMI). The individual is also provided the right to request confidential communication.

I wish to be contacted in the following manner… (**Please check all that apply)**

☐ Home Phone # _____ ☐ Work Phone # _____ ☐ Cell Phone # _____

___ Ok to leave detailed messages ___ Ok to leave detailed messages ___ Ok to leave detailed messages

Please send all written communication to the following address: _____

Please choose one of the following options:

☐ **Option 1:** Information about my treatment at New Tampa Interventional Pain & Sports Medicine may be released to the Following individuals**:** ***This includes prescription pick-ups****

Name & Relationship: _____ Phone # _____

Name & Relationship: _____ Phone # _____

Name & Relationship: _____ Phone # _____

_____ _____ _____
Signature of Patient/Legal Guardian Date Relationship to Patient

Option 2: ***I DO NOT want my medical information released to anyone***

_____ _____ _____
Signature of Patient/Legal Guardian Date Relationship to Patient

_____ _____
Witness Date

I understand that this health information may include HIV related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form I am specifically authorizing the release of information relating to:

Substance Abuse (including alcohol/drug abuse)
HIV related information (including AIDS-related testing)
Mental Health
☐ Psychotherapy Notes
☐

The confidentiality of this record is required under Chapter 899 of the Connecticut General Studies, as well as Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

* **I understand that this form will expired in one year from my last date of service visit. A photocopy of this form will be considered as valid as the original.**

Patient Opioid Agreement

NewTampa interventional pain & sports medicine
2014 Ashley Oaks Cir. Wesley Chapel FL 33544
Phone 813-999-3030 / Fax 813-333-0453

This is an agreement between _____ (print patient name) and ***New Tampa Interventional Pain & Sports Medicine*** concerning the use of Opioid medications for the treatment of chronic pain. The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

Please read each statement carefully and initial next to each to indicate your agreement.

Patient Initials	Statement
	1. I understand that Opioid medications are strong medications for pain relief and I have been informed of the risks and side effects involved with taking them.
	2. I understand that opioid medications could cause physical dependence. If I suddenly stop or decrease the medication, I could experience withdrawal symptoms that may occur within 24-48 hours of the last dose. Therefore, it is my responsibility to make sure I do not run out of my medications on weekends or holidays. ****Prescriptions will not be refilled without an appointment****
	3. I understand that if I am pregnant or become pregnant while taking Opioid medications, my child would be physically dependent on the opioids, and withdrawal can be life-threatening for my baby.
	4. I understand that if the medication causes drowsiness, sedation, or dizziness, I should not drive a motor vehicle or operate heavy machinery that could put my life or someone else's life in danger.
	5. I understand that it is my responsibility to notify the physician of any/all side effects I am experiencing from the medication(s).
	6. I agree to take this medication ***only as prescribed*** by my physician, and that I will not change the amount or frequency of the medication without discussing it with the prescribing physician.
	7. I agree that my opioid medication(s) will be prescribed by only ***New Tampa Interventional Pain & Sports medicine*** 8. I agree not to take any pain medications prescribed by any other physician without first discussing it with **NTPM**. I give permission to **NTPM** to verify that I am not seeing other physicians for Opioid medication.
	9. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.
	10. I agree not to sell, lend, or in any way give my medication to any other person.
	11. I agree not to drink alcohol or take mood altering drugs while I am taking Opioid medication. I agree to submit a urine specimen at any time that my doctor requests, and give my permission for it to be tested for alcohol and/or drugs.
	12. I agree that I will attend all of my required follow-up visits with the doctor to monitor this medication, and I understand that failure to do so will result in discontinuation of this treatment.
	13. I will not go the emergency room for pain management for my chronic condition for which NTIP&SP treating me. **** This agreement does not restrict me from going to the emergency room for new acute pain of any nature. I shall report to New Tampa Interventional Pain & Sports Medicine within one week of such an ER visit.****
	14. I understand that pain medications are only one aspect of my pain treatment plan. I also agree to follow other modalities of treatment as recommended by my physician. Failure to follow the treatment plan may indicate that I no longer respect the treatment suggestions of New Tampa Interventional Pain & Sports Medicine, and may result in my discharge from the practice.

This agreement shall remain in effect until either party withdraws from it in writing, or until I violate the agreement.

_____ _____ _____ _____

Patient Signature **Date** **Physician Signature** **Date**

Patient Name: _____Date: _____/_____/_____

Ordering Physician Name: Jose M. De La Torre, MD

NewTampa interventional pain & sports medicine
2014 Ashley Oaks Cir. Wesley Chapel FL 33544
Phone 813-999-3030 / Fax 813-333-0453

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 rights or wrong answers.

SCORE	Initials of Tech	SOAPP®-R	Never	Seldom	Sometimes	Often	Very Often
			0	1	2	3	4
		1. How often do you have mood swings?	o	o	o	o	o
		2. How often have you felt a need for higher doses of medication to treat your pain?	o	o	o	o	o
		3. How often have you felt impatient with your doctors?	o	o	o	o	o
		4. How often have you felt that things are just too overwhelming that you can't handle them?	o	o	o	o	o
		5. How often is there tension in your home?	o	o	o	o	o
		6. How often have you counted pain pills to see how many are remaining?	o	o	o	o	o
		7. How often have you been concerned that people will judge you for taking pain medication?	o	o	o	o	o
		8. How often do you feel bored?	o	o	o	o	o
		9. How often have you taken more pain medication than you were supposed to?	o	o	o	o	o
		10. How often have you worried about being left alone?	o	o	o	o	o
		11. How often have you felt a craving for medication?	o	o	o	o	o
		12. How often have others expressed concern over your use of medication?	o	o	o	o	o
		13. How often have any of your close friends had a problem with alcohol or drugs?	o	o	o	o	o
		14. How often have others told you that you had a bad temper?	o	o	o	o	o
		15. How often have you felt consumed by the need to get pain medication?	o	o	o	o	o
		16. How often have you run out of pain medication early?	o	o	o	o	o
		17. How often have others kept you from getting what you deserve?	o	o	o	o	o
		18. How often, in your lifetime, have you had legal problems or been arrested?	o	o	o	o	o
		19. How often have you attended an AA or NA meeting?	o	o	o	o	o
		20. How often have you been in an argument that was so out of control that someone got hurt?	o	o	o	o	o
		21. How often have you been sexually abused?	o	o	o	o	o
		22. How often have others suggested that you have a drug or alcohol problem?	o	o	o	o	o
		23. How often have you had to borrow pain medications from your family or friends?	o	o	o	o	o
		24. How often have you been treated for an alcohol or drug problem?	o	o	o	o	o
		Has any relative had a problem with: (Please circle Y/N for each question Below) - Alcohol? Y/N - Addiction? Y/N - Mental Illness? Y/N					

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

RELEASE HEALTHCARE INFORMATION

NewTampa interventional pain & sports medicine
2014 Ashley Oaks Cir. Wesley Chapel FL 33544
Phone 813-999-3030 / Fax 813-333-0453

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: NEW TAMPA INTERVENTIONAL PAIN & SPORTS MEDICINE – DR. JOSE DE LA TORRE

Address: 2014 ASHLEY OAKS CIRCLE

City: WESLEY CHAPEL State: FL Zip Code: 33544

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

PATIENT QUESTIONNAIRE

NewTampa interventional pain & sports medicine
2014 Ashley Oaks Cir. Wesley Chapel FL 33544
Phone 813-999-3030 / Fax 813-333-0453

NAME: _____ **DATE:** _____

Surgery Procedure: _____

Age: _____ Height: _____ Weight: _____

Latex Sensitivity: **Yes**_____ **No**_____ (Have you ever reacted after exposure to Band-Aids, tape, bandages, elastic, spandex, avocados, bananas, tropical fruit, kiwi, rubber products, surgical gloves, balloons?)

Allergies: _____

Current Medications: _____

_____

If Blood Thinner (instructions to stop/continue?) _____

Previous Surgeries: _____

Previous Hospitalizations: _____

*****Below: (Please circle any that apply or indicate N/A (Not Applicable)*****

Medical History Review: ***(CIRCLE ALL THAT APPLY)***

Central Nervous System/Skeletal:
Stroke/TIA Seizure MS Cerebral Palsey

Cardiovascular: ***(CIRCLE ALL THAT APPLY)***
Hypertension **Chest Pains/Angina Heart Attack CHF** Heart Murmur Pacemaker AICD, Cardiac Cath or Stent

When was your last cardiac doctor visit? _____

Respiratory: ***(CIRCLE ALL THAT APPLY)***
Asthma Emphysema/COPD Bronchitis recent cold/flu

Gastrointestinal: ***(CIRCLE ALL THAT APPLY)***
PUD Hiatal Hernia Reflux (Heartburn)

Hematologic: ***(CIRCLE ALL THAT APPLY)***
Anemia Bleeding Tendency

Miscellaneous: ***(CIRCLE ALL THAT APPLY)***
Diabetes Liver Disease **Kidney Disease** Pregnant Glaucoma HIV TB MRSA

Social History: ***(CIRCLE ALL THAT APPLY)***
How much Alcohol you consume: None_____ Social Drinker _____ Daily Drinker _____ Recovery Alcoholic _____
Do you Smoke: No ___ Yes ___, I currently Smoke: ___ # of Packs Daily ____ I quit smoking _____ years ago
Do you have a history of use/Abuse of Illicit drugs: Yes ____ No ____ List: _____

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Have you or any of your family members had any problems with anesthesia?

Yes _____ **No** _____ **if yes, please explain:** _____

_____

Information Obtained from: **Patient, Spouse, Parent, or Other**

Patient Name: _____

Patient Signature: _____ Date: _____

Nurse Name: _____

Nurse's Signature: _____ Date: _____

Complete and Review by: _____ Date: _____