

Pain Care Specialists of the Palm Beaches

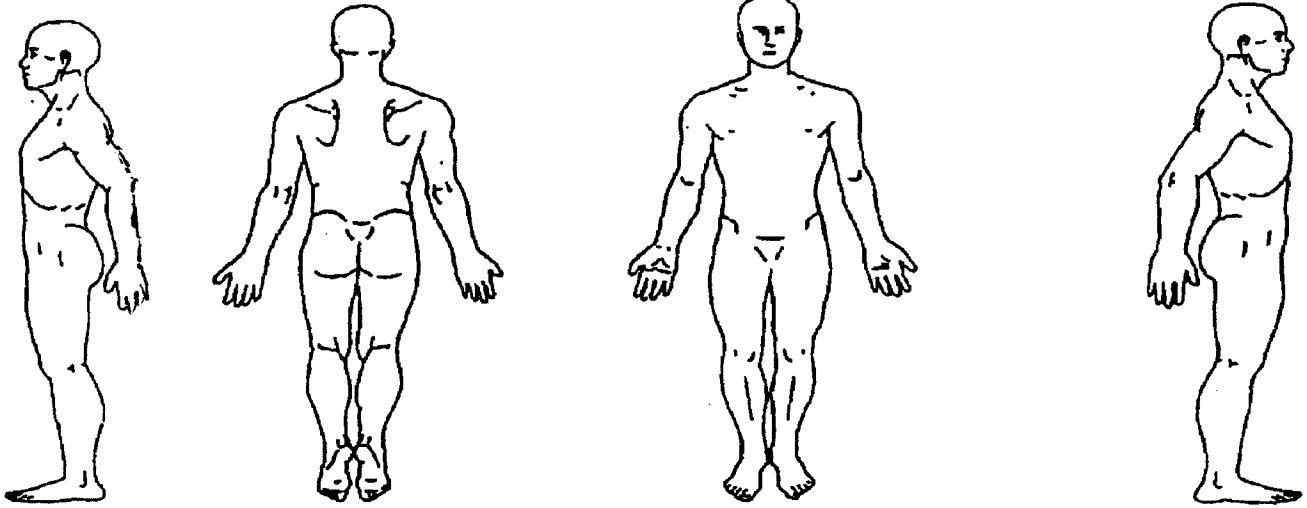
New Patient Evaluation

Today's Date _____

Name _____ Age _____ Sex _____ Height _____ Weight _____

Main reason for today's visit _____

LOCATION OF PAIN: (Please complete by marking your painful areas on the diagram below)



When did your pain start? _____

How did your pain start? _____

Is there any previous history of similar pain? _____



Severity of pain: (circle answer)

Rate your pain now: No pain 0 1 2 3 4 5 6 7 8 9 10 Worst imaginable

Rate your pain with daily activities: No pain 0 1 2 3 4 5 6 7 8 9 10 Worst imaginable

Describe frequency of pain: Constant Intermittent Occasional

Describe severity of pain: Mild Moderate Severe

Characteristics of pain: Aching Throbbing Cramping Sharp Stabbing Shooting
Tender Burning Other _____

What makes your pain worse? _____

What makes your pain better? _____

Describe past treatments for your pain: _____

Current Medications

Medication	Dose	Medication	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: _____

Surgical History: _____

Social History:

Marital Status: single married separated widowed **Use of Illicit Drugs:** never rarely moderate daily

Use of Alcohol: never rarely moderate daily **Smoking:** current packs/day ____ never quit

Currently Working: Yes No **Occupation:** _____

Family Medical History: _____

Review of Systems: Do you have a history of any of the following conditions? (circle all that apply)

<u>Constitutional:</u>	Weight Loss or Gain	Fever	Insomnia	Fatigue		
<u>Eyes:</u>	Blurring of vision	Double vision	Glaucoma	Injury or surgery	Need for Glasses	
<u>Ears, Nose, Throat:</u>	Sinusitis	Hearing loss	Ringing in ears	Dizziness	Sores	Swelling
<u>Cardiovascular:</u>	Heart attack	Chest pain	High blood pressure	Palpitations	Leg swelling	
<u>Respiratory:</u>	Shortness of breath	Asthma	Cough	Spitting up blood	Wheezing	
<u>Gastrointestinal:</u>	Loss of appetite	Nausea or vomiting	Blood in stool	Change in bowel habits	Pain	
<u>Genitourinary:</u>	Difficult urination	Frequent or painful urination	Incontinence	Infections	Irregular menses	
<u>Musculoskeletal:</u>	Spasm	Joint pain or stiffness	Weakness	Injury or surgery	Swelling	
<u>Skin/Breast:</u>	Ulcers	Rashes	Breast discharge	Breast lumps		
<u>Neurological:</u>	Stroke or TIA	Headaches	Dizziness	Seizures	Loss of balance	
<u>Psychological:</u>	Depression	Suicidal ideation	Psychiatric hospitalization	Insomnia		
<u>Endocrine:</u>	Diabetes	Thyroid problem	Excessive thirst	Excessive urination		
<u>Hematologic/Lymphatic:</u>	Abnormal bleeding	Abnormal bruising	DVT	Phlebitis	Enlarged lymph nodes	
<u>Infection:</u>	Hepatitis	HIV/AIDS	TB			

Females – Is there any possibility that you are currently be pregnant? Yes ____ No ____

Current Doctors:

Primary Care: _____ Chiropractor: _____

Physical Therapy/Rehab: _____ Surgeon: _____

Attorney: _____

Patient Signature: _____ Date: _____

Pain Care Specialists of the Palm Beaches

125 W. Indiantown Rd, Ste 103

Jupiter, FL 33458

Tel: 561-748-7644

Fax: 561-748-7645

CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent to Pain Care Specialists and all health care providers furnishing care within the practice to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Please be advised that our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by contacting our Privacy Officer at 561-748-7644.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the above address. You may deliver your revocation by any means you choose but it will be effective only when we actually receive the revocation. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Sign: _____ Date: _____

Print name of patient: _____

If you are signing as the patient's representative:

Print your name: _____

Describe your authority: _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

Dated: _____

Patient or Patient's Representative: _____

Print Patient's Name: _____

If signed by Representative, state name of Representative: _____

Representative: _____

Relationship to Patient: _____