

# **SOUTH FLORIDA INSTITUTE OF PAIN MANAGEMENT, LLC**

## **CONFIDENTIAL PATIENT CASE HISTORY**

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take the time and answer each question as completely as possible.

### **PATIENT INFORMATION\*\*\*\*\***

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_ MIDDLE INT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: ( ) \_\_\_\_\_ AGE: \_\_\_\_\_ BIRTH DATE: \_\_\_/\_\_\_/\_\_\_ SOC. SEC#: \_\_\_/\_\_\_/\_\_\_

EMAIL: \_\_\_\_\_ MARITAL STATUS: M / S / D / W # OF CHILDREN: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ WORK#: ( ) \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ SPOUSE'S EMPLOYER: \_\_\_\_\_ WORK#: \_\_\_\_\_

NAME OF PERSON WHO REFERRED YOU: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ PHONE#: \_\_\_\_\_

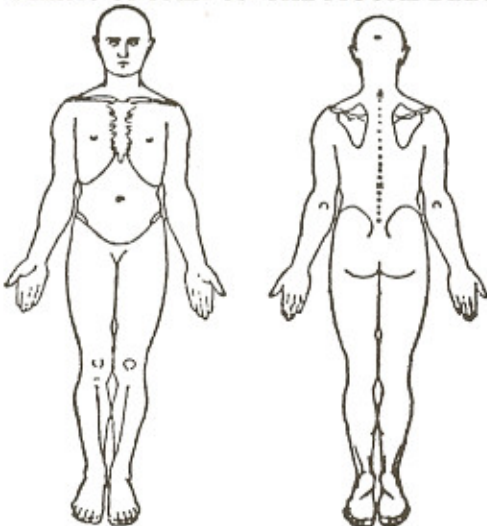
FAMILY DENTIST: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ PHONE#: \_\_\_\_\_

### **HEALTH INFORMATION\*\*\*\*\***

**WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?  
(PLEASE LIST IN ORDER OF IMPORTANCE WITH 1 BEING MOST IMPORTANT)**

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

PLEASE MARK YOUR CURRENT  
AREAS OF PAIN ON THE FIGURE BELOW



ARE YOU CURRENTLY OR HAVE YOU  
PREVIOUSLY SUFFERED FROM THE  
ANY OF THE FOLLOWING

CONDITION	CURRENTLY	PAST
ARTHRITIS		
ASTHMA		
BACKACHES		
DIABETES		
DIGESTIVE DISORDER		
DIZZINESS		
HEADACHES		
HEART CONDITION		
NECK PAIN		
NERVOUSNESS		
NEURITIS		
SINUS CONDITION		
OTHER		

# **SOUTH FLORIDA INSTITUTE OF PAIN MANAGEMENT, LLC**

HOW LONG HAVE YOU HAD THIS CONDITION(s)? \_\_\_\_\_

HAVE YOU HAD THIS CONDITION IN THE PAST? \_\_\_\_\_

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? YES  NO  CONSTANT  OTHER \_\_\_\_\_

IS THIS CONDITION INTERFERING WITH YOUR: WORK  SLEEP  DAILY ROUTINE  OTHER: \_\_\_\_\_

OTHER DOCTORS WHO TREATED THIS CONDITION: \_\_\_\_\_

LIST TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING FOR THIS CONDITION:

PHYSICIAN	SPECIALTY	TREATMENT DATES

**PAST MEDICAL HISTORY**\*\*\*\*\*

DATE OF LAST PHYSICAL EXAMINATION: \_\_\_\_\_

LIST SURGICAL OPERATON AND YEAR: \_\_\_\_\_

LIST ANY MEDICATIONS THAT HAVE CAUSED AN ALLERGIC REACTION: \_\_\_\_\_

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: \_\_\_\_\_

ARE YOU WEARING:  ORTHOTIC SUPPORTS  PACEMAKER  OTHER: \_\_\_\_\_

HAVE YOU EVER BEEN IN AN AUTOMOBILE ACCIDENT?  YES  NO WHEN: \_\_\_\_\_

DESCRIBE: \_\_\_\_\_

HAVE YOU HAD ANY OTHER PERSONAL INJURY OR ACCIDENT?  YES  NO WHEN: \_\_\_\_\_

DESCRIBE: \_\_\_\_\_

ARE YOU PREGNANT?  YES  NO  MAYBE LAST MENTRAL CYCLE: \_\_\_\_\_

**FAMILY HEALTH INFORMATION**\*\*\*\*\*

(MANY HEALTH PROBLEMS ARE THE RESULT OF HEREDITARY CONDITIONS; THIS INFORMATION ABOUT YOUR FAMILY MEMBERS WILL GIVE US A BETTER PICTURE OF YOUR TOTAL HEALTH)

RELATIVE	HEALTH PROBLEM / CAUSE OF DEATH
FATHER	
MOTHER	
BROTHER	
SISTER	
OTHER	

# **SOUTH FLORIDA INSTITUTE OF PAIN MANAGEMENT, LLC**

**PLEASE CHECK THE FOLLOWING CONDITIONS THAT APPLY TO YOUR MEDICAL HISTORY**

CONDITION	COMMENT
ALLEGIES	KIDNEY/URINARY DISORDERS
HAY FEVER	BLADDER INFECTIONS
FOOD ALLERGIES	BLOOD IN URINE
ALLERGIC TO	KIDNEY DISEASE
ARTHRITIS	SUGAR IN URINE
GOUT	URINARY TRACT INFECTIONS
OSTROARTHRITIS	OTHER
RHEUMATOID DISEASE	LIVER DISEASE
OTHER	CIRRHOSIS OF THE LIVER
ARTIFICIAL IMPLANTS	HEPATITIS A (INFECTIOUS)
HEART PACE MAKER	HEPATITIS B (SERUM)
HEART VALVE	OTHER
JOINT REPLACEMENT	LUNG/RESPIRATORY DISORDERS
OTHER	ASTHMA
BLOOD DISORDERS	CHRONIC COLDS
ANEMIA	EMPHYSEMA
BLEEDING EASILY	FREQUENT COUGH
HEMOPHILIA	LUNG CANCER
LEUKEMIA	SHORTNESS OF BREATH
SICK CELL ANEMIA	TUBERCULOSIS
OTHER	OTHER
ENDOCRINE DISORDERS	MUSCLE DISORDERS
DIABETES	MUSCULAR DYSTROPHY
HYPOGLYCEMIA	MUSCLE SHAKING (TREMORS)
PARATHYROID DISEASE	MUSCLE SPASMS OR CRAMPS
THYROID DISEASE	OTHER
OTHER	NERVE DISORDERS
EYE DISORDERS	CEREBRAL PALSY
GLAUCOMA	EPILEPSY
OCULAR HERPES	MULTIPLE SCLEROSIS
OTHER	PARKINSON'S DISEASE
HEART/CIRCULATORY DISORDERS	STROKE
ARTERIOSCLEROSIS	OTHER
CONGENITAL HEART DISORDER	STOMACH/INTESTINAL DISORDER
CORONARY ARTERY DISEASE	BLOATING
HEART MURMUR	COLITIS
HEART PALPITATIONS	CONSTIPATION
HIGH BLOOD PRESSURE	FREQUENT DIARRHEA
LOW BLOOD PRESSURE	FREQUENT GAS
POOR CIRCULATION	GALLBLADDER PROBLEMS
RHEUMATIC FEVER	HEARTBURN
OTHER	ULCERS
	OTHER

**PLEASE THINK...IS THERE ANY THING ELSE ABOUT YOU THAT YOU WOULD LIKE THE DOCTOR TO KNOW ABOUT YOU?** \_\_\_\_\_

# **SOUTH FLORIDA INSTITUTE OF PAIN MANAGEMENT, LLC**

## **ACCIDENT INFORMATION\*\*\*\*\***

**IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT, COMPLETE THIS SECTION**

DATE OF ACCIDENT: \_\_\_\_\_

BRIEFLY DESCRIBE THE ACCIDENT: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DESTINATION AFTER ACCIDENT / INJURY: \_\_\_\_\_

WERE YOU HOSPITALIZED:  YES  NO HOSPITAL NAME: \_\_\_\_\_

WERE X-RAYS TAKEN:  YES  NO IF YES, RESULTS: \_\_\_\_\_

HAS DOCTOR OR DENTIS EVER DIAGNOSED A TMJ DISORDER PRIOR TO THE ACCIDENT:  YES  NO

## **INSURANCE INFORMATION\*\*\*\*\***

AUTOMOBILE INSURANCE: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ CLAIM NUMBER: \_\_\_\_\_

NAME OF ADJUSTER: \_\_\_\_\_

HEALTH INSURANCE: \_\_\_\_\_

SUBSCRIBER NAME / NUMBER: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_

SECONDARY HEALTH INSURANCE: \_\_\_\_\_

SUBSCRIBER NAME / NUMBER: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_

IF YOU DO NOT HAVE YOUR OWN INSURANCE, DO YOU LIVE WITH ANY ONE THAT DOES:  YES  NO

NAME OF INSURED: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ CLAIM NUMBER: \_\_\_\_\_

NAME OF ADJUSTER: \_\_\_\_\_

## **ATTORNEY INFORMATION\*\*\*\*\***

NAME OF ATTORNEY: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ATTORNEY ADDRESS: \_\_\_\_\_

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for the treatment rendered to me regardless of insurance coverage.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that *South Florida Institute of Pain Management, LLC* will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to *South Florida Institute of Pain Management, LLC* will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

# **SOUTH FLORIDA INSTITUTE OF PAIN MANAGEMENT, LLC**

## **CONSENT TO TREAT**

I hereby authorize your practice and whomever you may designate to perform examination, physiotherapy, physical therapy and perform non-invasive diagnostic tests and, if any unforeseen condition arises in the course of the procedures calling for judgment, procedures in addition to or different from those non complicated. I further request and authorize this office to perform whatever your practice deems advisable. The nature and purpose of these procedures have risks involved and the possibility of complications has been fully explained to me. I acknowledge that no guarantee has been made to me as the result that may be obtained.

## **AUTHORIZATION FOR MEDICAL INFORMATION**

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-ray and physical findings diagnosis and prognosis. You are authorized to provide this information in accordance with the automobile personal injury protection law (Chapter 71-252F.S.).

## **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)**

Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the South Florida Institute of Pain Management, LLC provides you a copy of, or access to, our *Notice of Privacy Practices* which is printed on this clipboard.

I acknowledge that I have been presented the opportunity to read the South Florida Institute of Pain Management, LLC Notice of Privacy Practices.

## **ASSIGNMENT OF BENEFITS**

Assignment of benefits defined as the medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to SOUTH FLORIDA INSTITUTE OF PAIN MANAGEMENT, LLC any right and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by SOUTH FLORIDA INSTITUTE OF PAIN MANAGEMENT, LLC.

A photocopy of this document shall be sufficient.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that *South Florida Institute of Pain Management, LLC* will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to *South Florida Institute of Pain Management, LLC* will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

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PRINT NAME: \_\_\_\_\_

