PAIN MANAGEMENT PHYSICIANS of South Florida

8880 Royal Palm Blvd., Suite 103, Coral Springs, FL 33065 | (954) 975-8233 | F: (954) 974-2335 | records@pmpsf.com | PMPSF.com

Initial Consultation Form

Please answer each question as completely as possible. This information helps us understand your pain, prior treatment and health history.

Date: _____ Email: _____

Last name: _____ First name: _____

Date of birth: _____ Age: _____

Height: _____ Weight: _____

Referring physician: _____

Other physicians seen for this problem: _____

Medication allergies or adverse reactions: _____

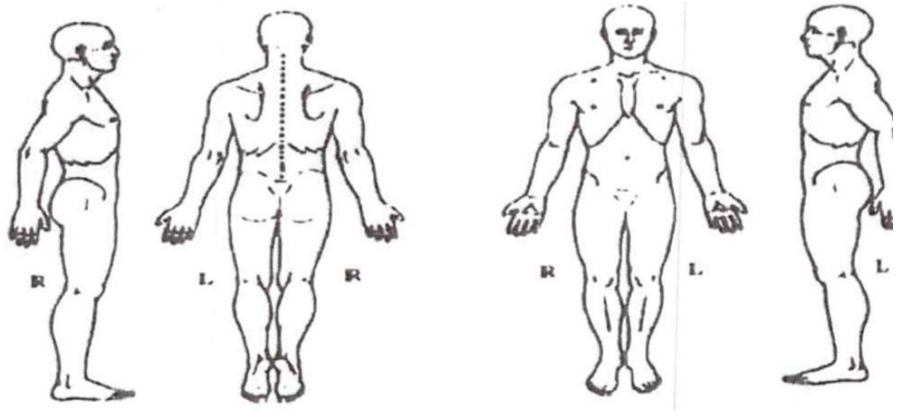
Other allergies: _____

How long have you had this pain: _____

Pain today from 0 no pain to 10 worst pain: _____

Pain location

Shade or mark the figures to show where your pain is located:



Words that describe your pain

☐ Aching ☐ Burning ☐ Cramping ☐ Dull ☐ Numbness ☐ Radiating ☐ Sharp ☐ Shooting ☐ Soreness ☐ Stabbing ☐ Tightness ☐ Tingling ☐ Other: _____

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OF SOUTH FLORIDA

Pain Symptoms and Prior Treatment

Lower back or leg pain

☐ Yes ☐ No Tingling or pins and needles in the legs

☐ Yes ☐ No Numbness in the legs

☐ Yes ☐ No Weakness in the legs

☐ Yes ☐ No Pain worsened by sneezing

☐ Yes ☐ No Pain worsened by coughing

Activity that aggravates the pain most: _____

Neck or arm pain

☐ Yes ☐ No Tingling or pins and needles in the arms

☐ Yes ☐ No Numbness in the arms

☐ Yes ☐ No Weakness in the arms

☐ Yes ☐ No Pain worsened by sneezing

☐ Yes ☐ No Pain worsened by coughing

Movement or position that increases the pain most: _____

Prior treatment

☐ Yes ☐ No Physical therapy

☐ Yes ☐ No Chiropractic treatment

☐ Yes ☐ No Acupuncture

☐ Yes ☐ No Pain-related injections

☐ Yes ☐ No Oral steroids such as prednisone

Anti-inflammatory medications tried: _____

Nerve-pain or antidepressant medications tried: _____

Other treatment: _____

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Diagnostic Studies and Medical History

Previous studies

☐ Yes ☐ No MRI Date: _____ ☐ Report attached Results: _____

☐ Yes ☐ No X-ray Date: _____ ☐ Report attached Results: _____

☐ Yes ☐ No CT scan Date: _____ ☐ Report attached Results: _____

☐ Yes ☐ No EMG or nerve-conduction study Date: _____ ☐ Report attached Results: _____

General and neurologic history

☐ Yes ☐ No Unintentional weight loss

☐ Yes ☐ No Chills or fever

☐ Yes ☐ No Bowel retention

☐ Yes ☐ No Bladder retention or incontinence

☐ Yes ☐ No Dizziness

☐ Yes ☐ No Headaches or migraines

☐ Yes ☐ No Seizure

☐ Yes ☐ No Stroke or TIA

Heart and lung history

☐ Yes ☐ No High blood pressure

☐ Yes ☐ No Heart attack

☐ Yes ☐ No Chest pain

☐ Yes ☐ No Heart stent

☐ Yes ☐ No Open-heart or valve surgery

☐ Yes ☐ No Heart failure

☐ Yes ☐ No Pacemaker

☐ Yes ☐ No Asthma

☐ Yes ☐ No Emphysema

☐ Yes ☐ No Sleep apnea

☐ Yes ☐ No Current wheezing

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Additional Medical History

☐ Yes ☐ No Blood thinner use

☐ Yes ☐ No Hepatitis or liver disease

☐ Yes ☐ No Reflux, heartburn or ulcer

☐ Yes ☐ No Rectal bleeding

☐ Yes ☐ No Kidney stones

☐ Yes ☐ No Kidney-function problems

☐ Yes ☐ No Burning with urination

☐ Yes ☐ No Dialysis

☐ Yes ☐ No Diabetes

☐ Yes ☐ No Insulin use

☐ Yes ☐ No Low thyroid function

☐ Yes ☐ No Easy bruising

☐ Yes ☐ No Cancer

☐ Yes ☐ No Rheumatology care

☐ Yes ☐ No Depression

☐ Yes ☐ No Anxiety

☐ Yes ☐ No Hospitalization for depression or anxiety

☐ Yes ☐ No Skin cancer

☐ Yes ☐ No Psoriasis or other chronic skin condition

Surgical and anesthesia history

Past surgeries: _____

_____

_____

Patient or family history of anesthesia problems:

_____

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Medications Social History and Goals

Current medications and supplements

1. Medication: _____ Dose: _____ Frequency: _____
2. Medication: _____ Dose: _____ Frequency: _____
3. Medication: _____ Dose: _____ Frequency: _____
4. Medication: _____ Dose: _____ Frequency: _____
5. Medication: _____ Dose: _____ Frequency: _____

Social history

☐ Yes ☐ No Currently working
☐ Yes ☐ No Retired
☐ Yes ☐ No Receiving disability benefits
☐ Yes ☐ No Married
☐ Yes ☐ No Divorced
☐ Yes ☐ No Widowed
☐ Yes ☐ No Smoke or use tobacco
☐ Yes ☐ No Drink alcohol

Employer: _____ Hours worked per day: _____

Number of children: _____ Tobacco amount: _____

Alcoholic drinks per week: _____

Activities and interests: _____

What would you like to do if your pain were reduced:

_____

Family history

☐ Noncontributory to the pain condition

Other relevant family history: _____

I certify that the information provided is complete and accurate to the best of my knowledge.

Patient or representative name: _____

Signature: _____ Date: _____

Assisting staff: _____ Date: _____

Physician review: _____ Date: _____

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Patient Information and Communication Preferences

Today's date: _____

Patient name: _____

Date of birth: _____

Age: _____

Permanent address: _____

City State ZIP: _____

Primary phone: _____

Secondary phone: _____

Marital status: _____

Emergency contact: _____

Emergency phone: _____

Employer: _____

Employer phone: _____

Preferred pharmacy: _____

Pharmacy phone: _____

Pharmacy city: _____

Communication preferences

Please check each method the practice may use for scheduling and return-call messages. Do not include detailed medical information unless you have separately authorized it.

☐ Home or mobile telephone, including voicemail or a message asking me to return the call.

☐ Workplace telephone, including a message asking me to return the call.

I understand that surgeons, anesthesiologists, facilities, laboratories or pathologists may bill separately for their services.

Patient or representative name: _____

Signature: _____ Date: _____

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PAIN MANAGEMENT PHYSICIANS

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Authorization for Release of Medical Records

Patient name: _____ Date of birth: _____

Address: _____ City State ZIP: _____

Telephone: _____

I authorize the person or organization identified below to release the records described in this authorization to Pain Management Physicians of South Florida.

Records requested from: _____

Address: _____

Telephone and fax: _____

Information requested

☐ All medical records ☐ Progress notes ☐ Operative reports ☐ Laboratory results ☐ Imaging and diagnostic reports ☐ Other: _____

Recipient

Pain Management Physicians of South Florida
8880 Royal Palm Blvd., Suite 103
Coral Springs, FL 33065
Phone 954-975-8233 | Fax 954-974-2335

This authorization expires one year after signature unless a different date or event is written here: _____. I may revoke it in writing, except to the extent already acted upon. Information disclosed may be redisclosed by the recipient and may no longer be protected by HIPAA.

Patient or representative name: _____

Signature: _____ Date: _____

IMPORTANT TREATMENT INFORMATION

We strongly encourage non-opioid treatment alternatives whenever clinically appropriate. This agreement is included in case an opioid prescription becomes necessary during the course of treatment.

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OF SOUTH FLORIDA

Controlled Substance Treatment Agreement

This agreement supports the safe use of controlled substances for chronic nonmalignant pain. It does not guarantee that a controlled substance will be prescribed. Treatment decisions remain based on clinical judgment, applicable law and the patient's individualized treatment plan.

- I will take medication only as prescribed and will not change the dose, frequency or route without approval.
- Controlled substances for my chronic pain will be prescribed by one designated prescriber unless that prescriber authorizes and documents an exception. I will promptly report controlled substances received in an emergency or from another clinician.
- Prescriptions and refills will be issued only at the number and frequency directed by the prescriber. I will request renewals during regular office hours and allow at least two business days. Early refills and replacement of lost, stolen or damaged medication are not guaranteed.
- I will use one pharmacy whenever reasonably possible and will tell the practice if that pharmacy changes.
- I will not share, sell, trade or divert medication, use another person's medication, use illegal substances, or combine prescribed medication with alcohol, sedatives or other substances contrary to medical advice.
- I will store medication securely, keep it away from children and others, and use an authorized take-back or other recommended disposal method.
- I agree to clinically appropriate monitoring, which may include Florida Prescription Drug Monitoring Program review, urine or blood testing, medication reconciliation and pill counts.
- I will attend follow-up visits and communicate honestly about pain, function, side effects, other medications and substance use. Controlled substances can cause sedation, impaired driving, constipation, tolerance, physical dependence, addiction, respiratory depression, overdose and death. Abrupt discontinuation may cause withdrawal.
- Therapy may be reduced, changed or discontinued for lack of benefit, unacceptable risk or side effects, unsafe combinations, diversion, false information, missed monitoring, repeated nonadherence or violation of this agreement. The practice will address clinically appropriate tapering and continuity of care when required.

I have had the opportunity to ask questions and agree to follow this agreement.

Patient or representative name: _____

Signature: _____ Date: _____

Prescriber signature: _____ Date: _____

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PAIN MANAGEMENT PHYSICIANS
OF SOUTH FLORIDA

Notice of Privacy Practices

Effective date _____

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. This notice applies to Pain Management Physicians of South Florida and its workforce.

Your rights

- Get an electronic or paper copy of your medical record.
- Ask us to correct information you believe is incorrect or incomplete.
- Ask us to contact you in a specific way or at a different address.
- Ask us to limit certain uses or disclosures.
- Get a list of certain disclosures we have made.
- Get a paper copy of this notice.
- Choose someone legally authorized to act for you.
- File a complaint if you believe your privacy rights were violated.

Your choices

You may tell us your preferences about sharing information with family, friends or others involved in your care, and about disaster-relief communications. If you cannot tell us your preference, we may share information when we believe it is in your best interest or when needed to lessen a serious and imminent threat.

We will not use or share your information for marketing, sale of your information, or most uses of psychotherapy notes without your written permission. We may contact you about fundraising only if applicable, and you may tell us not to contact you again.

How we typically use or share information

- Treat you and coordinate your care with other health professionals.
- Run our practice, improve care and contact you when necessary.
- Bill for services and obtain payment from health plans or other entities.

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Notice of Privacy Practices Continued

Other uses and disclosures permitted or required by law

- Public health and safety activities; legally permitted research; and compliance with federal or state law.
- Organ or tissue donation; medical examiners, coroners or funeral directors.
- Workers' compensation, health oversight, law enforcement and special government functions when legally permitted.
- Court or administrative orders, subpoenas and legal proceedings when applicable legal requirements are met.

Substance use disorder records

To the extent we maintain records protected by 42 CFR Part 2, we will not use or disclose them in proceedings against you without your written consent or the court order and subpoena required by law. We will provide all additional protections required for Part 2 records.

More protective laws

When Florida or another applicable law provides greater protection for sensitive information, we will follow the more protective law.

Our responsibilities

- We are required by law to maintain the privacy and security of protected health information.
- We will notify you promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in the notice currently in effect and give you a copy.
- We will not use or share information other than as described here unless you authorize us in writing. You may revoke an authorization in writing, except to the extent already acted upon.

Complaints

You may complain to our Privacy Officer or to the U.S. Department of Health and Human Services Office for Civil Rights at 1-877-696-6775 or hhs.gov/hipaa/filing-a-complaint. We will not retaliate against you.

We may change this notice. The current notice will be available upon request, in our office and on our website.

Privacy Officer or title: _____ Phone: _____

Email: _____ Website: _____

Acknowledgment of Receipt

I acknowledge that I received or was offered this Notice of Privacy Practices. My signature confirms receipt only and does not authorize uses or disclosures beyond those permitted by law.

Patient or representative: _____ Signature: _____ Date: _____

If not obtained: ☐ Declined ☐ Emergency ☐ Other: _____ Staff initials: _____

PAIN MANAGEMENT PHYSICIANS
OF SOUTH FLORIDA

Urine Drug Testing Notice

Urine drug testing may be ordered when clinically appropriate as part of monitoring medication safety, treatment adherence and the individualized treatment plan. Testing decisions are made by the treating clinician based on the patient's care and applicable requirements.

Insurance coverage varies. If urine testing is not covered by your insurance, but is necessary by practice guidelines, you may be responsible for a fee of $25. Please ask our staff if you have questions about coverage or charges. *If you receive a bill that is confusing, please contact us before paying, so we can help verify whether this needs attention.*

By signing below, I acknowledge that I have read and understand this notice.

Patient or representative name: _____

Signature: _____ Date: _____

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OF SOUTH FLORIDA

Authorization to Discuss Medical Information

I authorize Pain Management Physicians of South Florida to discuss the information selected below with the person or people identified on this form.

☐ Appointment dates and times ☐ Diagnosis ☐ Imaging results ☐ Medications
☐ Laboratory results ☐ Summary of medical record ☐ Care plan ☐ Other: _____

Sensitive information authorized: ☐ Mental health ☐ HIV-related information ☐ Alcohol or substance-use information

Patient name: _____ Date of birth: _____

Authorized recipient one

Name: _____ Relationship: _____

Address: _____ Phone: _____

Authorized recipient two

Name: _____ Relationship: _____

Address: _____ Phone: _____

Expiration: ☐ No expiration date ☐ Expires on this date or event: _____

- I may inspect or copy the information to be used or disclosed.
- I may revoke this authorization in writing, except to the extent already acted upon.
- Information disclosed to the recipient may be redisclosed and may no longer be protected by HIPAA.
- I may refuse to sign, and the practice generally will not condition treatment or payment on this authorization.

Patient or representative name: _____

Signature: _____ Date: _____

Relationship to patient if signed by representative: _____

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PAIN MANAGEMENT PHYSICIANS

OF SOUTH FLORIDA

Appointment Cancellation and No Show Policy

We understand that plans change. Please give us at least 24 hours' notice if you need to cancel or reschedule an appointment. Advance notice allows us to offer the appointment time to another patient who needs care.

No shows and fees

- An appointment missed without notice will be recorded as a no-show.
- After two no-show incidents, the practice may assess a $50 no-show fee.
- After three no-show incidents within a 12-month period, the practice may initiate dismissal from the practice, consistent with applicable notice and continuity-of-care requirements.
- An advanced procedure scheduled at a surgical center or other separate facility may be subject to a $100 cancellation or no-show fee because the appointment requires additional coordination with the facility.

Practice discretion

We recognize that emergencies and unavoidable circumstances occur. The ultimate handling of repeated cancellations, consecutive no-shows, fees and possible dismissal is at the discretion of the practice and Office Manager after considering the circumstances.

Please contact the Office Manager at 954-975-8233 with questions. By signing below, I acknowledge that I have read and understand this policy.

Patient or representative name: _____

Signature: _____ Date: _____

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PAIN MANAGEMENT PHYSICIANS
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Nonopioid Alternatives for Pain Management

Talk with your health care provider about a safe and effective treatment plan. Benefits, risks and insurance coverage vary by patient and treatment.

Approach	Examples and considerations
Medication	Acetaminophen; anti-inflammatory medicines such as ibuprofen or naproxen; selected nerve-pain medicines; certain antidepressants; and topical medicines. Risks vary and may include liver injury, stomach or kidney problems, bleeding, sedation, dizziness or skin irritation.
Procedures	Targeted injections, nerve blocks, spinal cord stimulation and drug-delivery systems may help selected patients. Benefits and risks depend on the procedure and individual health conditions.
Anesthesia	Multimodal or nonopioid anesthesia may reduce opioid exposure for some procedures. Discuss options with the surgeon and anesthesia professional.
Cold and heat	Cold may reduce pain and swelling after some injuries; heat may reduce stiffness or muscle pain. Incorrect use can injure skin or worsen swelling.
Movement	Walking, individualized exercise, yoga or tai chi may improve movement and function when medically appropriate.
Complementary care	Acupuncture, chiropractic care, osteopathic manipulation, massage or TENS may help selected patients. Results and risks vary.
Rehabilitation	Physical therapy may improve strength, movement and function. Occupational therapy may make daily activities safer and easier.
Behavioral health	Cognitive behavioral therapy, counseling and treatment of depression, anxiety or substance-use disorders can support pain management and function.

I have reviewed this information and had an opportunity to ask questions.

Patient or representative name: _____

Signature: _____ Date: _____

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ATTENTION:

The following Oswestry Disability Index questionnaire is *optional*.

Your insurance carrier may require a completed functional assessment to authorize certain advanced procedures during the course of your care.

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OF SOUTH FLORIDA

Optional Oswestry Disability Questionnaire

Please answer every section and mark only one response in each section. If a section does not apply to you, ask a member of our staff for guidance.

Patient name: _____ Date: _____

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Oswestry Disability Index (ODI) version 2.1b

This questionnaire is designed to give us information as to how your back (or leg) trouble affects your ability to manage in everyday life.
Please answer every section. Mark one box only in each section that most closely describes you today.

Section 1 - Pain intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 - Personal care (washing, dressing, etc.)

- ☐ I can look after myself normally without causing additional pain.
- ☐ I can look after myself normally but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of my personal care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 - Lifting

- ☐ I can lift heavy weights without additional pain.
- ☐ I can lift heavy weights but it gives me additional pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than a quarter of a mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can only walk using a cane or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than half an hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

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Section 6 - Standing

- ☐ I can stand as long as I want without additional pain.
- ☐ I can stand as long as I want but it gives me additional pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than half an hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 - Sleeping

- ☐ My sleep is never interrupted by pain.
- ☐ My sleep is occasionally interrupted by pain.
- ☐ Because of pain I have less than 6 hours sleep.
- ☐ Because of pain I have less than 4 hours sleep.
- ☐ Because of pain I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 - Sex life (if applicable)

- ☐ My sex life is normal and causes no additional pain.
- ☐ My sex life is normal but causes some additional pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly non existent because of pain.
- ☐ Pain prevents me from having any sex life at all.

Section 9 - Social life

- ☐ My social life is normal and causes me no additional pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to home.
- ☐ I have no social life because of pain.

Section 10 - Traveling

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives me additional pain.
- ☐ Pain is bad but I am able to manage trips over two hours.
- ☐ Pain restricts me to trips of less than one hour.
- ☐ Pain restricts me to short necessary trips of under 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

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