Name _____ **Date** _____

Who referred you to us? _____ **Allergies** _____

Location of pain _____ **Age:** _____

How long have you had this pain? _____ Caused from an: ☐ Auto Accident? ☐ Work Accident/Injury? ☐ Unknown

On a scale of 0 to 10, "0" being no pain and "10: being the worst pain imaginable, circle the number that best describes your level of pain:

No pain= 0 1 2 3 4 5 6 7 8 9 10 = Worst pain imaginable

Shade in areas below where you have pain and check *ALL* the words that best describe your pain:

☐ Aching ☐ Pinching

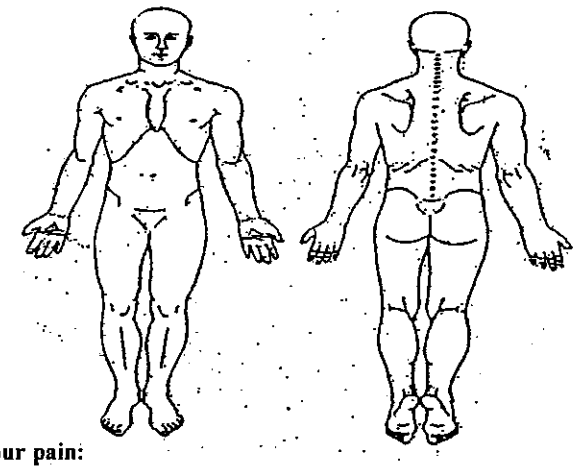
☐ Burning ☐ Coldness

☐ Cramping ☐ Sharp

☐ Dull ☐ Shooting **R**

☐ Throbbing ☐ Tingling

☐ Numbness



R

Is your pain ☐ constant or ☐ intermittent?

Please indicate below all factors that increase or decrease your pain:

Factors	Increase	Decrease	**Factors**	Increase	Decrease
Weather Changes			Walking		
Heat			Sitting		
Cold			Lying down		
Physical activity			Rising from sitting		

Please indicate which diagnostic test(s) you have had for this pain:

☐ MRI ☐ CT Scan ☐ X-Ray ☐ EMG/NCS ☐ Bone Scan ☐ Discogram

Please circle any of the following treatments you have had for this pain:

Approximate Date	**(Improved Pain?)**	**YES**	**NO**	**SOME**
Pain Management/Pain medications				
Epidurals, Nerve Blocks, Steroid Injections				
Physical Therapy				
Massage Therapy				
Tens Unit				
Acupuncture				
Chiropractor				
Other				

Please list any other physicians you have seen for your pain: _____

Please list all medications you take (including OTC): _____

_____

_____

Do you take a bloodthinner? ☐Yes ☐ No Name: _____

Please list any surgeries with approximate dates: _____

_____

_____

Previous Medical History: _____

_____

_____

Please check any of the following that you have or have had:

Constitutional	Eyes	HEENT	Cardiovascular	Respiratory	GI/GU	Neurological
☐ Chills	☐ Double Vision	☐ Hearing loss	☐ Palpatations	☐ Asthma	☐ Loss of appetite	☐ Stroke
☐ Fatigue	☐ Blurred Vision	☐Ringing in ears	☐ Chest pain	☐ Cough	☐Nausea/Vomiting	☐ TIA
☐ Weight gain	☐ Glasses	☐ Mouth sores	☐ Heart attack	☐ Wheezing	☐ Bloody Stools	☐ Seizures
☐ Weight loss	☐ Contact lenses	☐ Voice changes	☐ Angina	☐ Shortness of	☐ Constipation	☐ Headache
		☐ Hearing aids	☐ High blood	breath	☐ Incontinence	☐ Shingles
			pressure			☐ Dizziness

Psychological	Musculoskeletal	Integumentary	Endocrine	Hematologic	Infection
☐ Memory loss	☐Joint Pain/Stiffness	☐ Skin rashes	☐ Diabetes	☐ Bleeding tendencies	☐ Hepatitis
☐ Depression	☐ Weakness	☐ Skin ulcers	☐ Thyroid problems	☐ Bruising	☐ HIV/AIDS
☐ Insomnia	☐ Injury		☐ Excessive thirst	☐ DVT	☐ Other
☐ Anxiety	☐ Swelling		☐ Excessive urination	☐ Blood clots	
☐ Nervousness	☐ Spasm			☐ Phlebitis/Cellulitis	
				☐ Transfusion	

Have you, or are you currently experiencing any loss of balance or frequent falls? ☐ Yes ☐ No

Do you use a ☐ Cane ☐ Walker ☐ Wheelchair

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widow

Do you use tobacco? ☐ Yes ☐ No If yes, check one ☐ Cigarettes #/packs a day _____ ☐ Chewing tobacco ☐ Cigars

Do you drink alcohol? ☐ Yes ☐ No ☐ social ☐ daily ☐ weekly ☐ monthly

Family History: Describe current health, age, cause of death, illness, diabetes, cancer, hypertension,etc.

	Age	(Living?) Yes	No	Major Illnesses or Cause of Death
Father				
Mother				
Sibling				
Sibling				

Florida Pain Center
of Naples

J.M. Campoamor, M.D. • James J. Worden, M.D.

American Board of Anesthesiology, Certification in Pain Management
Board Certified American Board of Pain Medicine

PATIENT INFORMATION

PATIENT NAME: _____ DATE: _____

BIRTH DATE: ____/____/____ SEX: M____ F____ MARITAL STATUS: M___ S___ D___ W___

SSN#: _____ DL#: _____

LOCAL ADDRESS: _____

LOCAL PHONE: _____ CELL PHONE: _____ ALT #: _____

NORTHERN ADDRESS: _____ PH #: _____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ PHONE: _____

SPOUSE/GUARDIAN NAME: _____ PHONE: _____ DOB: _____

EMERGENCY CONTACT: _____ PHONE: _____

REFERRING PHYSICAIN: _____ PRIMARY: _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY: _____ ID#: _____ GRP#: _____

POLICY HOLDER (IF DIFFERENT FROM ABOVE): _____ DOB: _____

RELATIONSHIP TO PATIENT: _____ SSN #: _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY: _____ ID# _____ GRP# _____

POLICY HOLDER (IF DIFFERENT FROM ABOVE): _____ DOB: _____

RELATIONSHIP TO PATIENT: _____ SSN #: _____

IS THIS VISIT RELATED TO ___WORMANS COMPENSATION, ___ACCIDENT, OR ___MOTOR VEHICLE CLAIM? __Y __N

NAME OF COMPANY: _____ DATE OF INJURY: _____ CLAIM #: _____

PRESCRIPTION PLAN

INS COMPANY: _____ ID #: _____ GRP #: _____

ASSIGNMENT OF BENEFITS: I authorize the release of any medical records necessary to process any claims I may incur and assign Florida Pain Center of Naples (aka First Anesthesia Associates), all benefits otherwise payable to me for any services rendered to me. I agree that I am financially responsible for any non-covered services, deductibles or co-payments.

SIGNATURE: _____ DATE: _____

NOTICE OF PRIVACY PRACTICE

I have received a copy of Florida Pain Center of Naples Privacy Policy. I have had the opportunity to have any questions answered regarding the privacy practices of the office.

SIGNATURE: _____ DATE: _____

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