University Pain Medicine

Robert Florio, MD. PA.
Diplomate American Board of Pain Medicine
Diplomate American Board of Physical Medicine and Rehabilitation

Welcome to University Pain Medicine,

The enclosed paperwork must be completed prior to your scheduled appointment. Please complete before arriving to our office. If the paperwork is not completed upon arrival at your scheduled time, we may be forced to reschedule to another day.

Patients must call 24 hours in advance to cancel or reschedule appointments. If a patient fails to call within the 24 hours or does not show up for an appointment, a $25.00 Fee will be charged to the patient.

Please bring with you:

1. Past Doctor Information
2. Any imaging reports that you have (x-ray, MRI, etc.)
3. Valid Florida ID
4. Medical Insurance Card (if applicable)
5. Completed paperwork enclosed

Thank you,

University Pain Medicine

8451 Shade Avenue, Suite 210 Sarasota, FL 34243
Phone: (941) 355-0496 Fax: (941) 355-0323
www.UniversityPainMedicine.com

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COMPREHENSIVE PAIN QUESTIONNAIRE

PATIENT ID _____

DATE:_____ Social Security Number: _____

Full Name: _____

Address: _____ Zip: _____

Home Phone ( ) _____ Work Phone ( ) _____

Cell Phone ( ) _____ Sex: Male ( ) Female ( )

Age: _____ Date of Birth: _____

Occupation: _____

Is your condition work related? Yes _____ No _____

Does your case involve workers' comp? Yes _____ No _____

Are you receiving disability income? Yes _____ No _____

Ongoing lawsuit involving your case? Yes _____ No _____

We should send reports to:

Physician: _____ Tel: _____

Address: _____

_____

Physician: _____ Tel: _____

Address: _____

_____

Lawyer: _____ Tel: _____

Address: _____

_____

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Allergies to Medications:

_____

_____

_____

Any other allergies (include foods, iodine, etc.):

_____

_____

_____

Medicines that you are currently tacking: (include non prescription) Note: please bring in bottles of pain pills to your visit.

Name of Medication	Dose	Frequency

Do you take Blood Thinners such as Coumadin, Pradaxa, Aspirin, Ibuprofin, Arixtra?
Yes ( ) No ( )
Please list pain medications that have been tried already:

Name of Medication	Dose	Reason for Stopping/Side Effects

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Chief Complaint: List main pain or medical issue(s) you need help with:

_____

_____

_____

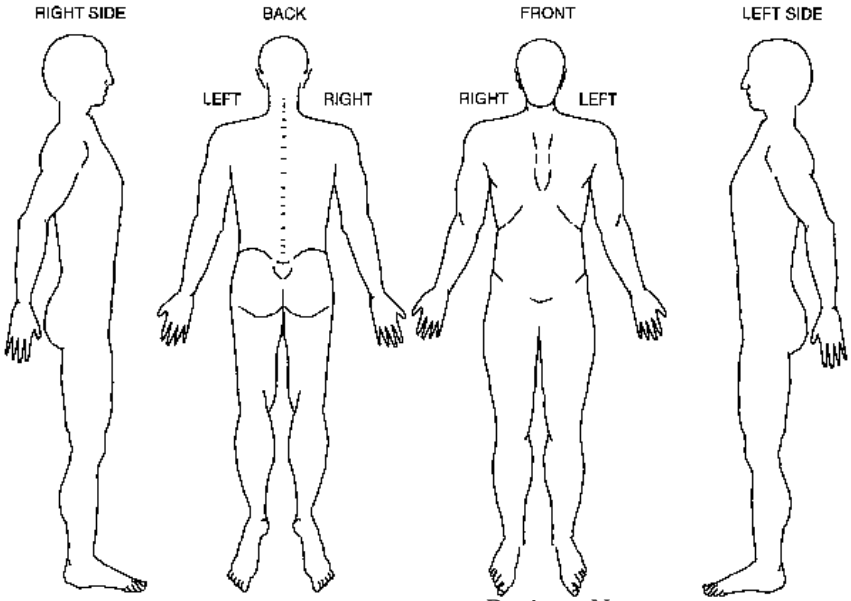
HPI: How did your pain First Begin?

( ) Suddenly
( ) Gradually
( ) Lifting
( ) Twisting
( ) Fall
( ) Bending
( ) Injured at Work
( ) Pulling
( ) Auto Accident
( ) Sports
( ) Hit from Behind
( ) No Apparent Cause
( ) Other _____

Approximately when did this pain start? Date: _____/_____/_____

Where is your pain located?

_____



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Describe what the pain feels like: (circle all that apply)

Sharp	Dull	Gnawing
Burning	Aching	Cramping
Stabbing	Throbbing	Nauseating
Tearing	Pounding	Penetrating

Other descriptors: _____

Where does it spread to? _____

_____

Is your pain intermittent (off & on) or constant? _____

How long does pain last? Seconds ____ Minutes ____ Hours ____

How many hours per day do you have pain? _____

In the past, did you ever have similar pain? _____

If yes, Date: _____

What makes you pain Worse?

( ) During exercise	( ) After exercise	( ) Sitting	( ) Standing
( ) Walking	( ) Damp weather	( ) Stress	( ) Sex
( ) Bending forward	( ) Bending backward	( ) Morning	( ) Night
( ) Coughing	( ) Sneezing	( ) Fatigue	( ) Work
( ) Touching skin in area of pain		( ) Cold weather	

( ) Other _____

What makes your pain Less?

( ) Lying down	( ) Physical Therapy	( ) Sitting	( ) Standing
( ) Walking	( ) Alcohol	( ) Injections	( ) Aspirin
( ) Advil, Naproxen	( ) Exercise	( ) Massage	( ) Heat
( ) Ice	( ) Nothing		

( ) Pain Pills _____

( ) Other _____

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Pain Level: Please mark this line with the intensity of your pain using all the following letters:

L=Least amount of pain P=Present pain
M=Most of the time W=Worst it gets

No Pain Greatest Pain

I----------I----------I----------I----------I----------I----------I----------I----------I----------I----------I

0 1 2 3 4 5 6 7 8 9 10

Functionality History

What you can do now:

( ) Activities of daily living (bathing, grooming, dressing)
( ) Housework / chores
( ) Drive
( ) Walk 1 Block
( ) Work part-time
( ) Work full-time
( ) Exercise

Describe in your own words how you spend an average day:

_____

_____

Pain Treatments Tried: (please checkmark)	Did it help?
( ) Physical Therapy	( ) yes ( ) no
( ) TENS unit	( ) yes ( ) no
( ) Prior surgery to address pain	( ) yes ( ) no
( ) Previous pain management doctor	( ) yes ( ) no
( ) Previous pain medications	( ) yes ( ) no
Pain Procedures:	
( ) Trigger Point Injections	( ) yes ( ) no
( ) Epidural Injections	( ) yes ( ) no
( ) Nerve Blocks	( ) yes ( ) no
( ) Medications	( ) yes ( ) no
( ) Chiropractor	( ) yes ( ) no
( ) Psychology Counseling	( ) yes ( ) no
( ) Biofeedback / Relaxation Techniques	( ) yes ( ) no
( ) Group Therapies	( ) yes ( ) no
( ) Acupuncture	( ) yes ( ) no
( ) Other _____	( ) yes ( ) no

Patient Name _____5

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Have you had any tests for your problem?

X-Rays	( ) yes ( ) no	Date_____
CAT Scan	( ) yes ( )no	Date _____
MRI	( ) yes ( ) no	Date_____
EMG / Nerve Test	( ) yes ( )no	Date _____
Myelogram	( ) yes ( ) no	Date_____
Discogram	( ) yes ( )no	Date _____
Other _____		Date_____

PMH: Please circle any medical problems

Cancer _____		Liver Disease	Stomach Ulcers/Bleeding
Heart Disease / Prior Heart Attack		Hepatitis_____	Arthritis
High Blood Pressure		HIV/AIDS	Migraine
Lung Problems		Bleeding Disorder	Shingles
Asthma	Seizures	Hyperthyroid	Hypothyroid
COPD/Emphysema	Spine or Bone Fractures	Stroke	Diabetes

Other medical problems or hospitalizations (include dates, reason):

_____
_____
_____
_____

Past Surgeries

_____
_____
_____
_____

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FAMILY HISTORY

What diseases run in your family?

_____

_____

Has anyone in your family experienced a similar condition as yours? Please specify details:

_____

_____

SOCIAL HISTORY

Do you currently smoke or use tobacco products? ( ) yes ( ) no
If yes, how many packs/day and years of smoking _____
If you formerly smoke, what year did you quit? _____
Do you ever drink alcohol? ( ) yes ( ) no
If yes, how many drinks/week do you average: _____
Ever had a problem related to alcohol? (ieDUI) ( ) yes ( ) no
Have you ever used an illicit substance or street drug? ( ) yes ( ) no
Have you ever misused prescription narcotics? ( ) yes ( ) no

Work Status: (please circle)

Full-time Part-time Unemployed Retired Disabled

Are you receiving disability income currently? ( ) yes ( ) no
Current occupation:_____
If not working, last day on job:_____
Previous jobs:

_____

_____

Marital Status? (please circle) Single Married Divorced Widowed
How many people in your household? _____
What is your highest level of education? Grade School Middle School High School

Associate Degree Undergraduate Graduate/Professional School

Patient Name _____7

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REVIEW OF SYSTEMS: Please circle all that *currently* apply to you.

CONSTITUTIONAL

Weakness	Fever	Unintentional Weight Loss
Fatigue	Chills	Weight Gain

EYES/EARS/NOSE/THROAT

Dry Eyes	Difficulty Hearing	Sore Throat
Double Vision	Ringing in Ears	Difficulty Swallowing
Loss of Vision	Ear Pain	Vertigo
Blurry Vision	Loss of Balance	Dizziness

RESPIRATORY

Dry Cough	Wheezing	Shortness of Breath
Coughing up Blood	Tuberculosis	Asthma

CARDIOVASCULAR

Chest Pain at Rest	Leg Swelling	Palpitations
Chest Pain with Activity	Prior Heart Attack	Irregular Heart Beat

GASTROINTESTINAL

Nausea	Diarrhea	Abdominal Pain
Vomiting	Constipation	Hernia
Unable to Control Bowel Movements		Black Tarry Stools

GENITOURINARY

Bladder Incontinence	Painful Urination	Blood in Urine
Bladder Retention/Unable to Urinate		Kidney Stones

Patient Name_____8

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MUSCULOSKELETAL

Joint Pain	Muscle Pain	Back Pain
Joint Stiffness	Muscle Cramps	Neck Pain

NEUROLOGICAL

Seizures	Numbness	Tremors
Memory Loss	Weakness on one side of the Body	Headaches

PSYCHOLOGICAL

Mood Changes	Anxiety	Difficulty Sleep
Depression	Serious Thoughts of Suicide	Mania

ENDOCRINE

Heat or Cold Intolerance	Excessive Thirst	Poor Appetite
Excessive Sweating at Rest	Thyroid Problems	Frequent Urination

HEMATOLOGIC

Easy Bruising	Abnormal Bleeding	Anemia

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Please answer the questions below as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Please include any additional information you wish about the above answers.

Please use the following scale:

0=Never 1=Seldom 2=Sometimes 3=Often 4=Very Often

How often do you have mood swings?	0 1 2 3 4
How often do you smoke a cigarette within an hour you wake up?	0 1 2 3 4
How often have any of your family members, including parents and Grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
How often have others suggested you have a problem with alcohol or drugs?	0 1 2 3 4
How often have you attended an AA or NA meeting?	0 1 2 3 4
How often have you taken medication other than the way it was prescribed?	0 1 2 3 4
How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
How often have your medications been lost or stolen?	0 1 2 3 4
How often have others expressed concern over your use of medication?	0 1 2 3 4
How often have you felt a craving for medication?	0 1 2 3 4
How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
How often have you used illegal drugs in the past five years?	0 1 2 3 4
How often in your lifetime have you had legal problems or been arrested?	0 1 2 3 4

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NARCOTIC AGREEMENT

Opioids (narcotics) are used for the treatment of moderate to severe pain. Our goal is to relieve distressing pain, with minimal drug side effects, with improved quality of life. It is our job to continually re-evaluate your pain experience and respond to unrelieved pain.

I, _____, understand that compliance with the following guidelines is important to the continuation of pain treatment by University Pain Medicine.

No other pain medications are to be taken unless discussed first with a provider at University Pain Medicine. _____ initials

No increase in medication will be made without the approval of University Pain Medicine. _____ initials.

I will not request opioids or any other medicine from prescribers other than from University Pain Medicine. _____ initials

I will consent to random drug testing. _____ initials

I will keep my scheduled appointments and/or cancel, my appointment a minimum of 24 hours in advance to my scheduled appointment. _____ initials

I understand that the reduction in the intensity of my pain and the improvement in my quality of life are the goals of this program. _____ initials

I realize that all the medications have potential side effects and I will have the recommended laboratory studies required to keep the regimen as safe as possible. _____ initials

I realize that it is my responsibility to keep myself and others from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used any medication for at least four days. _____ initials

I will not use any illegal controlled substances, including marijuana, cocaine, etc. _____ initials

I will not share, sell, trade my medication for money, goods or services. _____ initials

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I understand and acknowledge that I will not consume any alcohol beverages while on narcotic medications. _____ initials

I understand that any need for medication adjustments or changes, will require scheduling an appointment in the office. _____ initials

I will not attempt to get my pain medication from any other health care provider without telling them that I am taking pain medication prescribed by the Doctor. I understand it is against the law to do so. If my primary care provider is willing to prescribe my medication, the Doctor will have to approve the arrangements to make sure there is no duplication. _____ initials

I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my prescribed medication for a period of time. _____ initials

I agree to use _____ pharmacy, located at _____, telephone number _____, for all my pain medication. If change pharmacies for any reason, I agree to notify the Doctor at the time I receive a prescription, and advise my new pharmacy of any prior pharmacy's address and telephone number. _____ initials

I agree to waive any applicable privilege or right of privacy of confidentiality with respect to the prescribing of my pain medication. I authorize the Doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the Florida Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize the Doctor to provide a copy of this agreement to the pharmacy. _____ initials

I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in me being without medication for a period of time. _____ initials

I understand that my pain treatment may be stopped if any of the following occur: _____ initials

- If the practitioner feels that opioids are not effective for my pain or my functional activity is not improved.
- I give, sell or misuse the drug
- I develop rapid tolerance or loss of effect from this treatment.
- I develop side effects that are significant in the view of the practitioners.
- I obtain opioids from sources other than University Pain Medicine
- If I miss three(3) scheduled appointments

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If we choose to discontinue your opioids, we will generally lower the dose slowly over several days. _____ initials

I understand that if I have any questions or concerns regarding my pain treatment that I will call University Pain Medicine. _____ initials

I am a legitimate patient seeking healthcare and not part of any ongoing investigation. _____ initials

Doctor and patient agree that this agreement is essential to the Doctor's ability to treat the patient's pain effectively and that failure of the patient to abide by the terms of this agreement may result in the withdrawal of all prescribed medication by the Doctor and the termination of the Doctor/patient relationship.

This agreement entered into on _____ day of _____

Patient Signature _____ Date _____

Physician's Signature _____ Date _____

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I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped, reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain, cramping, diarrhea, irritability, aches throughout my body and flu like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain, however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my Doctor to choose another form of treatment.

(Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone is normal.

(Females only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric Doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I have read this form or have it read to me. I understand all of it. I have had a chance to have all my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.

Patient Signature _____ Date _____

Witness to above _____

Approved by the AAPM Executive Committee on January 14, 1999

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Medication Refills

Dear patient,

Please acknowledge by your signature below, that our involvement in your healthcare is limited to the neuromuscular, musculoskeletal, and complex pain issues that you are being treated for in this office.

If you have problems with your routine medical care, please discuss this with your treating physician here at University Pain Medicine so that he/she may direct you toward the appropriate specialist.

At University Pain Medicine we try to accommodate as many of your individual needs as we possibly can. However, due to the enormous workload that this sometimes require, your assistance with scheduling and medication refills is necessary.

Medication Refills

Medications will be refilled in a timely manner as long as the pharmacy or patient calls us at least 72 hours BEFORE you run out of your medication. Weekend and after hour refills will not be filled on a routine basis under any circumstances.

All controlled medications will be refilled at your scheduled follow-up appointment. If you are unable to fill a prescription for any reason you must return to the clinic to consider an appropriate substitute in a timely manner (no longer than one week). Lost or stolen medication will not be replaced.

Appointments

Once you begin your participation here we are sure you will understand that your appointment time is valuable to you and us. Please be sure to give at least 24 hour notice when you cannot keep your appointment.

Patient Signature _____ Date _____

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Notice of Privacy Practices Acknowledgement

I understand that, under the **Health Insurance Portability and Accountability Act of 1996 "HIPPA"**, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved on that treatment directly and indirectly.

Obtain payment from third party payers

Conduct normal healthcare operations such as quality assessments and physician certificates

I have received, read and understand the **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address provided to obtain a current copy the **Notice of Privacy Practices**.

I understand that may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care options. I also understand you are not required to agree to my requested restrictions, but if you so agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason:

_____

_____

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Authorization to Release Medical Records

Date: _____

I _____ hereby authorize University Pain Medicine and/or its authorized representatives to release the following:

_____

I request that this information be forwarded to:

( ) myself ( ) other

Name: _____

Address: _____

Phone: ( ) _____

Patient Signature _____

Print Name: _____

Patient Date of Birth: _____

Witness Signature: _____ Date: _____

Please Note: There is a charge of:

(This charge needs to be paid when or before records are released)

( ) $25 copy of medical records less than 5 pages

( ) $50 more than 5 pages or extensive search

( ) $100 One page dictated report (additional pages $100 each)

Please make checks payable to: University Pain Medicine

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STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

The doctors and staff of University Pain Medicine appreciate the confidence you have shown in choosing them to provide for your health care needs. We are committed to providing you with the best possible medical care. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our services. You are ultimately responsible for payment of services and care received under the care of University Pain Medicine.

PAYMENTS

Payment Policy

Full payment is expected at the time of service. *If for some reason full payment cannot be made at the time of service, please speak with the practice administrator prior to your office visit to determine if a reasonable payment arrangement can be established.*

Returned Checks Policy

There is a $25.00 service charge on all returned checks. After receiving a returned check, University Pain Medicine, will only accept cash, money order or credit card.

Cancellation/No Show Policy

While understanding there may be times when you miss an appointment due to emergencies or obligations, University Pain medicine requires at least 24 hours notice on all cancelled appointments. Our office charges a fee of $25.00 for appointments not cancelled or rescheduled 24 hours in advance.

Cancellation/no show fees must be paid prior to your next appointment.

Form Completion Policy

There is a fee of $10.00 for all completed forms. Multiple forms may be assessed a different fee. This fee is due upon pick up.

If you fail to meet financial obligations agreed upon in this financial policy or other payment arrangements made with University Pain Medicine, your outstanding balance will be sent to a collection agency and the complete balance will have to be paid before receiving any further treatment. Your future status with this office will be considered at that time and may lead to being discharged from University Pain Medicine.

If you have any questions, please contact our practice administrator.

I have read and understand University Pain Medicine Patient Financial Responsibility. I agree to assign insurance benefits to University Pain Medicine, whenever necessary. I authorize University Pain Medicine to release information to a collection agency or attorney. In the event of nonpayment or default, I am responsible for all costs and reasonable collection and/or attorney fees. University Pain Medicine reserves the right to change or amend this statement at any time and at its discretion.

_____
Signature of Patient/Responsible Party Printed Name of Signer

_____ _____ _____
Print Name of Patient Date of Birth Today's Date

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I _____ hereby request that my medical records on file with:

_____

be sent to:

University Pain Medicine
8451 Shade Avenue, Suite 210
Sarasota, FL 34243
Ph. 941-355-0496 Fax. 941-355-0323

Please forward:

( ) Office Visits

( ) Initial History and Physical

( ) MRI Reports

( ) Lab Reports

( ) Correspondence

( ) Insurance Information

Patient Name: _____

Patient Signature: _____ Date: _____

Patient DOB: _____ Patient SS: _____ - _____ - _____

Note: If someone other than the patient will be picking up the records, a written note from the patient is required. The note must include the date and patient's signature. Attach note to this form prior to sending the records.