PAIN INSTITUTE OF TAMPA BAY

Patient ______________________________________ DOB ______/______/______

TELL US ABOUT YOU (please print)

First ____________________________________ MI _____ Last ____

Address 1 ____

Address 2 ______________________________ CITY ____________________ ST _____ ZIP _____ COUNTRY ______

E-mail ____ ☐ Opt out of providing E-mail Address

Language Preference _________________________ SSN _______ - ________ - ________ DOB _____/_____/_____

Driver's License # ____ ST ________________________

Phone 1 ___________________________ CELL HOME BUSINESS

Phone 2 ___________________________ CELL HOME BUSINESS

Appointment Reminder Preferred Contact Method PHONE TEXT EMAIL

Gender	Race	Status
M F	☐ BLACK/AFRICAN AMERICAN ☐ WHITE ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ ASIAN ☐ DECLINE ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐ HISPANIC	☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ LEGALLY SEPARATED

Employment ☐ EMPLOYED ☐ DISABLED ☐ RETIRED ☐ PART-TIME Employer ________________________________

Student Status ☐ FULL-TIME ☐ PART-TIME ☐ NOT A STUDENT School ________________________________

Emergency Contact Name ____

Relationship ____ Phone ________________________

Primary Care Physician _______________________________ Phone ________________________

Did a Physician Refer you to us? YES NO Physician Name _____________________________________

How did you hear about us? ____

HEALTH INSURANCE (enter N/A if not applicable)

Insurance Company Name ____

Policy Type ___________________________________ Member Number ___________________

Group Number _______________________ Group Name ____________________________________

Effective from Date _____/_____/_____ Effective To Date _____/_____/_____

Secondary Insurance if applicable

Insurance Company Name ____

Policy Type ___________________________________ Member Number ___________________

Group Number _______________________ Group Name ____________________________________

Effective from Date _____/_____/_____ Effective To Date _____/_____/_____

PAIN INSTITUTE OF TAMPA BAY

Patient ____ DOB ______/______/______

Information required by law. Complete only if the Primary Policy holder is NOT the patient.

Relationship to Primary Insured ☐ SELF ☐ SPOUSE ☐ CHILD ☐ MOTHER ☐ FATHER ☐ OTHER _________________

Primary Insured Name ____

Address 1 ____

Address 2 _______________________________________ CITY ______________________ ST __________ ZIP __________

Phone 1 _________________________ CELL HOME BUSINESS DOB ______/______/______ Gender M F

Current Bain Complete Wellness Patient? YES NO

MEDICARE ONLY – Additional Questions

If Medicare, are you currently receiving Home Health Services? YES NO If YES, Name of Agency? ____________________

If YES, what type of Home Health Services are you receiving? ______________________ Last Date of Service ________________

Are you currently a patient at a Skilled Nursing Facility? YES NO If YES, Name of facility? ______________________

If Medicare, have you received PT, OT, or Speech services since the first of the year? YES NO

- If YES, do you know if you have exceeded your Medicare Therapy Cap amount? YES NO
- Are you aware of any partial amount used since the first of the year? $ __________.
- If YES, please bring in any billing information from your previous therapy, or contact your previous provider for the information. Please bring the Medicare benefit summary you receive from Medicare.

TELL US WHY YOU ARE HERE (please print)

What is the primary reason for your visit? ____

Where is the pain located? ____

Does the pain go anywhere from there? ____

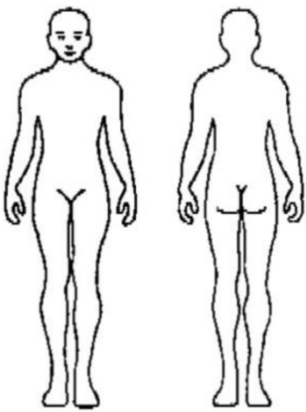
Did the pain start suddenly or gradually and get worse? ____

Does anything make the pain better? (e.g., ice, heat, medications, rest, etc.) ________________________________

Does anything make the pain worse? (e.g., moving, standing, sitting, etc.) __________________________________

What does the pain feel like? (e.g., sharp, numb, tingly, achy, etc.) _______________________________________

How long have you had the pain? ____



Is your pain? ☐ OCCASIONAL ☐ INTERMITTENT ☐ FREQUENT ☐ CONSTANT

On a scale of 0-10, please rate your pain/symptom today?

None = 0 1 2 3 4 5 6 7 8 9 10 = Worst Possible

Mark an X on the picture where you have pain.

PAIN INSTITUTE OF TAMPA BAY

Patient ____ DOB ______/______/______

PAST MEDICAL HISTORY (please circle all that apply)

DIAGNOSES

Denial of any significant medical history	Hematologic disorder	Anemia	Coronary artery disease (heart attack)	STD
Headache	Abdominal pain	Anxiety	Cancer	Chest pain
Cataract	Glaucoma	Hearing loss	Edema	Heart disease
Congestive heart failure	Hypertension	DVT of lower extremity	Emphysema	Esophageal reflux
Pneumonia	Asthma	Chronic obstructive pulmonary disease	Diverticulitis of colon	Irritable bowel syndrome
Gastric ulcer	Colitis	Polyps of colon	Hepatitis	Chronic liver disease
Hemorrhoids	Cholelithiasis (gallstones)	Cholecystitis (gall bladder disorder)	Hyperlipidemia	Obesity
Chronic kidney disease	Nephrolithiasis	Urinary tract infection	Polycystic ovarian syndrome	Psoriasis
Thyroid disorder	Osteoporosis	Diabetes mellitus	Migraine	TIA
Arthritis	Gout	SLE	Sleep apnea	Tuberculosis
CVA	Dementia	Depression	Colon cancer	Breast cancer

Other ____

SURGICAL

Please notate the year of the surgery next to the type.

Tonsillectomy	Heart surgery	Varicose vein ligation	Mastectomy	Splenectomy
Appendectomy	Hemorrhoidectomy	Cholecystectomy	Hernia repair	Vasectomy
Hysterectomy	Cesarean section	Prostatectomy	Back surgery	Hip surgery
Knee surgery	Fusions	Laminectomy	Hernia	

Other ____

RECENT EVENTS

Recent staphylococcal infection	Recent streptococcal infection	Recent upper respiratory infection	Recurrent urinary tract infections

Other ____

PAIN INSTITUTE OF TAMPA BAY

Patient ______________________________________ DOB ______/______/______

REPORTED MEDICAL HISTORY

Recent hospitalizations? Please list ____

____

Recent emergency room visits? ____

Recent psychiatric treatment? ____

SLEEP HISTORY

How many hours of sleep do you get on an average night? __________

What time do you go to sleep? ________________________ What time do you wake up? ________________________

Do you have difficulty falling asleep? YES NO Do you snore? YES NO

How do you sleep? ☐ BACK ☐ FRONT ☐ SIDE

PSYCHOLOGY HISTORY

Have you ever had psychiatric or psychological counseling? YES NO

Do you currently have emotional or psychological problems that concern you? YES NO

SOCIAL HISTORY (please circle all that apply)

BEHAVIORAL HISTORY

CAFFEINE USAGE YES NO If YES, how much per day? ____

TOBACCO USAGE

Current every day smoker Current some day smoker Packs per day?__________ Previous history of smoking Never smoked

ALCOHOL USAGE YES NO If YES, drinks per week? ____

Beer consumption	Wine consumption	Drinking in moderation -2 drinks/day or less
Recent increases in alcohol consumption	Recent decrease in alcohol consumption	Stopped drinking alcohol
Previous attempts to decrease alcohol consumption		Recovering alcoholic

PAIN INSTITUTE OF TAMPA BAY

Patient ____ DOB ______/______/______

SOCIAL HISTORY continued (please circle all that apply)

DRUG USAGE YES NO If YES, Please circle all that apply.

Barbiturates	Marijuana	Heroin
Amphetamines	Cocaine	

EXERCISE YES NO If YES, how often per week? _____________ How long per work out? _________

SEXUALLY ACTIVE YES NO

Other ____

FAMILY HISTORY

Please check all items that apply to your family members.

FAMILY MEMBER	Not in Good Health	Deceased	Diabetes mellitus	Cancer*	Chronic kidney disease	Heart disease	Systemic HTN	Obesity	Hyperlipidemia	Osteoporosis
FATHER										
MOTHER										
BROTHER(S)										
SISTER(S)										
DAUGHTER(S)										
SON(S)										

Type of Cancer * ____

Other ____

____

____

PAIN INSTITUTE OF TAMPA BAY

Patient ____ DOB ______/______/______

MEDICATIONS/SUPPLEMENTS CURRENTLY ON OR HAVE PREVIOUSLY USED

If you have a current list of medications, please allow the front desk staff to make a copy rather than fill out the list below.

Date Started	Medication Supplement Name	Dose Given	Frequency of Use (e.g., 2x per day)	Time (AM or PM)

Do you use any Medical Equipment (e.g., cane, brace, wheelchair, etc.) ____

PAIN INSTITUTE OF TAMPA BAY

Patient ____ DOB ______/______/______

ALLERGIES

FOOD	ENVIRONMENTAL (e.g., pollen, dust)	MEDICINE	OTHER

____ **Date ______/______/______**

Patient Signature

Intake Completed By ____ **Date ______/______/______**

Implementation Date:	**Revision Date:**