Advanced Pain and Spine Institute of Florida

New Patient Demographic Form

First Name:_____ Last Name: _____

Date of Birth: _____ Sex: _____Preferred Pronouns: _____

Home address: _____

Home Phone: _____Cell Phone: _____

Work Phone: _____ Email Address: _____

Social Security No.: _____

Emergency Contact:_____ Relation: _____

Emergency Phone: _____

Primary Insurance: _____

Primary Policy ID: _____ Group #: _____

Subscriber: _____ Relation: _____

Secondary Insurance: _____

Secondary Policy ID: _____ Group #: _____

Subscriber: _____ Relation: _____

Preferred Pharmacy:_____

Pharmacy Address: _____

Pharmacy Phone: _____

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Please list ALL active treating physicians e.g. Primary Care, Neurologist, Neurosurgeon, Orthopedist, Physiatrist, Sports Medicine, Cardiologists

Doctor's Name: _____ Specialty: _____

Address/Phone/Fax:_____

Doctor's Name: _____ Specialty: _____

Address/Phone/Fax:_____

Doctor's Name: _____ Specialty: _____

Address/Phone/Fax:_____

Doctor's Name: _____ Specialty: _____

Address/Phone/Fax:_____

Doctor's Name: _____ Specialty: _____

Address/Phone/Fax:_____

Doctor's Name: _____ Specialty: _____

Address/Phone/Fax:_____

Doctor's Name: _____ Specialty: _____

Address/Phone/Fax:_____

Doctor's Name: _____ Specialty: _____

Address/Phone/Fax:_____

Doctor's Name: _____ Specialty: _____

Address/Phone/Fax:_____

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1. Reason for visit (where does it hurt?) _____

_____

2. When did the pain start?

_____

3. How did it start? [ ] Injury [ ] Motor Vehicle Accident [ ] Work Injury [ ] Fall [ ] Unknown

4. Have you been treated for these symptoms before? [ ] Yes [ ] No

5. If yes, when? _____ Diagnosis: _____

6. Did you fully recover? [ ] Yes [ ] No

7. Describe the pain (Check all that apply)

Quality	Worse with:	Improves with:	Associated symptoms
[ ] Sharp	[ ] Sitting	[ ] Sitting	[ ] Numbness/tingling
[ ] Aching	[ ] Standing	[ ] Standing	[ ] Weakness in hands/feet
[ ] Burning	[ ] Lying down	[ ] Lying down	[ ] Loss of bladder or bowel control
[ ] Shooting	[ ] Up/down Stairs	[ ] Rest	[ ] Unintended weight loss
[ ] Electric	[ ] Walking	[ ] Walking	[ ] Fever/night sweats

Previous Pain Procedures

Please list your previous pain procedures including **epidural steroid injections, nerve blocks, ablations, joint/ bursa injections, stimulators**. Please include dates, effectiveness

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Previous Therapies

Please list and explain previous and current treatments for your pain including dates, frequency, effectiveness

Treatment	Dates	Location (body)	Effectiveness
Physical Therapy			
Occupational Therapy			
Acupuncture			
Massage			
TENS unit			
Psychologist/ Psychiatrist			
Biofeedback			
Meditation			
Water Therapy			
Other			

Previous Medications

Are you currently on or have previously been on any of the following medications?

Medication	Effective				
Neurontin (Gabapentin)	YES	NO	Elavil (Amitriptyline)	YES	NO
Lyrica (Pregabalin)	YES	NO	Pamelor (Nortriptyline)	YES	NO
Robaxin (Methocarbamol)	YES	NO	Effexor (Venlafaxine)	YES	NO
Skelaxin (Metaxalone)	YES	NO	Cymbalta (Duloxetine)	YES	NO
Baclofen	YES	NO	Milnacipran (Savella)	YES	NO
Flexeril (Cyclobenzaprine)	YES	NO	Topamax (Topiramate)	YES	NO
Soma (Carisoprodol)	YES	NO	Motrin/Advil (Ibuprofen)	YES	NO
Zanaflex (Tizanidine)	YES	NO	Mobic (Meloxicam	YES	NO
Tylenol (Acetaminophen)	YES	NO	Toreador (Ketorolac)	YES	NO
Ultram (Tramadol)	YES	NO	Naprosyn/Aleve (Naproxen)	YES	NO
Nucynta (Tapentadol)	YES	NO	Morphine IR	YES	NO
Percocet (oxycodone-acetaminophen)	YES	NO	Lortab (hydrocodone-acetaminophen)	YES	NO
Dilaudid (Hydromorphone)	YES	NO	Roxicodone (oxycodone)	YES	NO
Oxycontin (oxycodone ER)	YES	NO	MS Contin (morphine ER)	YES	NO
Tylenol #3 codeine	YES	NO	Opana (Oxymorphone)	YES	NO
Methadone	YES	NO			
Subutex (Buprenorphine)	YES	NO	Suboxone (buprenorphine - naloxone)	YES	NO

PLEASE DOCUMENT DOSAGE/DURATION AND DATES USED, IF ABLE:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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Medical History

Do you have or have you been treated for any of the following conditions?

NEUROLOGIC

□ Y □ N Stroke
□ Y □ N Cerebral Aneurysm
□ Y □ N Seizure/Epilepsy
□ Y □ N Brain Tumor
□ Y □ N Neuropathy
□ Y □ N Paralysis
Other: _____

CARDIOVASCULAR

□ Y □ N High Blood Pressure
□ Y □ N Heart Attack
□ Y □ N Valvular Disorder
□ Y □ N Heart Failure
□ Y □ N Irregular Heart beat
□ Y □ N Pacemaker/Defibrillator
Other: _____

GASTROINTESTINAL

□ Y □ N Acid Reflux/GERD
□ Y □ N Stomach Ulcer
□ Y □ N Hiatal Hernia
□ Y □ N Crohn's Disease/Ulcerative Colitis
□ Y □ N Liver Disease/Cirrhosis

Other: _____

RESPIRATORY

□ Y □ N Asthma
□ Y □ N COPD/Emphysema
□ Y □ N Bronchitis
□ Y □ N Pulmonary Hypertension
□ Y □ N Sleep Apnea

Other: _____

OTHER

□ Y □ N Diabetes
□ Y □ N Liver Disease
□ Y □ N Kidney Disease/ESRD/Dialysis
□ Y □ N Bleeding Disorder
□ Y □ N Blood Clots
□ Y □ N Metabolic syndrome
□ Y □ N Hypo/Hyperthyroid
Other: _____

BONE/JOINT/MUSCLE

□ Y □ N Osteoarthritis
□ Y □ N Rheumatoid Arthritis
□ Y □ N Fibromyalgia
□ Y □ N Gout
□ Y □ N Vasculitis
□ Y □ N Lupus
□ Y □ N Myopathy

INFECTIOUS DISEASE

□ Y □ N Hepatitis A/B/C
□ Y □ N HIV/AIDS
Other: _____

Medical History

CANCER

Please list any history of cancer, treatments, surgeries, and dates:

_____

_____

_____

_____

SURGICAL HISTORY: - Please list all surgeries and dates

_____

_____

_____

_____

_____

FAMILY HISTORY (please list medical history of parents, siblings, children)

□ Y □ N Cancer: _____

□ Y □ N Diabetes: _____

□ Y □ N Heart Disease: _____

□ Y □ N Anxiety/Depression:_____

□ Y □ N Arthritis: _____

□ Y □ N Alcoholism/Addiction:_____

SOCIAL HISTORY

Marital Status: _____ Highest Level of Education: _____

Current/Previous Occupation: _____

Is your care today related to a disability claim, workman's comp, or litigation?

Explain: _____

Tobacco use □ Y □ N Explain: _____

Alcohol use: □ Y □ N □ Heavy Use □ Abuse (past or present)

Explain: _____ _____

Opioid Dependence or Addiction: _____

Cocaine: □ Y □ N _____ Amphetamine: □ Y □ N _____

Heroin: □ Y □ N _____ Marijuana □ Y □ N _____

Intravenous Drug Use □ Y □ N _____

ALLERGIES:

Please list all medication/latex/adhesive allergies:_____

_____

Current Medication List

Medication	Dose	Times/Day	Route