

**GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, P.A.**  
**DIVISION OF PAIN MEDICINE**

**Administration Office**  
118 S. Oregon Ave.  
Tampa, FL 33606

Tel 813.253.2273  
Fax 813.253.2279

**PLEASE PRINT CLEARLY**

Today's Date \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_ Phone \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Gender:  Male  Female

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_ Other \_\_\_\_\_

May we leave detailed messages at the above listed numbers?  Yes  No

***In Case of an Emergency please contact:***

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

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**Primary Ins. Co** \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_

**2<sup>nd</sup> Ins. Co** \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_

**Auto Related Injury?**

**Auto Accident Carrier** \_\_\_\_\_

Claim # \_\_\_\_\_ Adjuster Name & Phone # \_\_\_\_\_

Date of Accident \_\_\_\_\_ State of Accident \_\_\_\_\_

**Workers' Compensation Related Injury?**

**Workers' Comp. Ins. Carrier** \_\_\_\_\_

Claim # \_\_\_\_\_ Adjuster Name & Phone # \_\_\_\_\_

Date of Injury \_\_\_\_\_

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**Primary Care Physician** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Pharmacy Name** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Pharmacy Location** \_\_\_\_\_

**For Office Use Only:**

**System Updated:** Yes No N/A      **Employee Initials:** \_\_\_\_\_ **Date :** \_\_\_\_\_

## PATIENT QUESTIONNAIRE (SPINE)

**INSTRUCTIONS:** Please complete the following questionnaire before you see the doctor. Circle the answers that best describe your situation. You may select more than one answer per question. Write additional information in the margins. This information will help your doctor to more accurately understand your condition(s) and develop an appropriate plan of treatment. A copy of this form will be included in your medical record. Thank you!

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Whom May We Thank For Referring You? \_\_\_\_\_ Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: M / F Dominant Hand: R / L / A

Occupation: \_\_\_\_\_ Place of employment: \_\_\_\_\_

What are you being seen for?

- A. Neck pain
- B. Upper back pain
- C. Lower back pain
- D. R / L / B Arm(s) pain
- E. R / L / B Leg(s) pain
- F. Other: \_\_\_\_\_

Do you have any weakness?

- A. Weakness
- B. Numbness
- C. Tingling
- D. If so, where?

Describe: \_\_\_\_\_

If more than one of the above is chosen, which is the most problematic? \_\_\_\_\_

Which term best describes your neck/back pain?

- A. Sharp
- B. Stabbing
- C. Burning
- D. Like electricity
- E. Dull ache
- F. Pins and needles
- G. Throbbing

Which term best describes your arm/leg pain?

- A. Sharp
- B. Stabbing
- C. Burning
- D. Like electricity
- E. Dull ache
- F. Pins and needles
- G. Throbbing

When did the problem(s) first start or when did the injury occur? \_\_\_\_\_

Explain in your own words how the pain started of the injury occurred:

\_\_\_\_\_

Did the problem start as a result of:

- A. Normal daily activity
- B. Motor vehicle accident
- C. Sports or recreation
- D. Fall
- E. Job related

Have you seen a doctor in the past for this condition? Yes / No

If yes, who and when? \_\_\_\_\_

What treatments have you already received for this condition?

- A. Medications(List) \_\_\_\_\_
- B. Physical therapy (how many weeks)? \_\_\_\_\_
- C. Epidural injections: How many injections? \_\_\_\_\_ When was the last one? \_\_\_\_\_
- D. Other: \_\_\_\_\_

Since the pain/condition began it:

- A. Has improved
- B. Has worsened
- C. Has stayed the same
- D. Comes and goes (fluctuates)

What time of the day is the pain most intense?

- A. On arising in the morning
- B. During the daytime
- C. At the end of the day before bedtime
- D. During the night

What aggravates the pain?

- A. Walking
- B. Standing
- C. Sitting
- D. Lying down
- E. Bending
- F. Activity in general
- G. Nothing in particular
- H. Other:\_\_\_\_\_

What makes the pain better?

- A. Walking
- B. Standing
- C. Sitting
- D. Lying down
- E. Resting
- F. Nothing in particular
- G. Other:\_\_\_\_\_

Does the pain awaken you from sleep?

- A. Never
- B. Occasionally
- C. Frequently

Does the pain keep you from sleeping?

- A. Never
- B. Occasionally
- C. Frequently

Do you have any difficulty walking due to this condition?

- A. No
- B. Yes, can walk unlimited distances
- C. Yes, can walk less than a mile
- D. Yes, can walk only 1-2 blocks
- E. Yes, can walk less than 1 block
- F. Yes, non ambulatory (can not walk)
- G. Other:\_\_\_\_\_

Have you had any problems with bowel, bladder or sexual functions since this condition began?

- A. No
- B. Yes, explain:\_\_\_\_\_

Have you had a previous back or neck problem?

- A. No
- B. Yes, explain:\_\_\_\_\_

Do you exercise regularly?

- A. No
- B. Yes, explain:\_\_\_\_\_

## PAST MEDICAL HISTORY

Do you have a history of any of these medical conditions? None\_\_\_\_\_

If YES, please circle all that apply.

- |  |                                   |
|--|-----------------------------------|
| A. High blood pressure                         | M. Ulcers                         |
| B. Diabetes Mellitus                           | N. Liver Disease                  |
| C. High Cholesterol                            | O. Hepatitis, Type:_____          |
| D. Coronary Artery Disease (Chest Pain/Angina) | P. Kidney Disease                 |
| E. Heart Disease (Congestive Heart Failure)    | Q. Seizure Disorder               |
| F. Past Heart Attack                           | R. Cancer/Tumor                   |
| G. Peripheral Vascular Disease                 | What Type:_____                   |
| H. Lung Disease (COPD/Emphysema)               | S. Tuberculosis                   |
| I. Asthma                                      | T. Osteoarthritis (wear and Tear) |
| J. Thyroid Disorder                            | U. Rheumatoid Arthritis           |
| K. Immune Disorder                             | V. Mental Disorders:_____         |
| L. Overweight                                  | W. Other:_____                    |

## PAST SURGICAL HISTORY

Have you had any surgeries?

- A. No
- B. Yes, list below

<u>Date</u>	<u>Procedure</u>

## MEDICATIONS

- A. None
- B. Yes, list below

<u>Name</u>	<u>Dose</u>	<u>For which condition?</u>

## ALLERGIES

Do you have any allergies to Medications?

- A. No known allergies
- B. Yes, list: \_\_\_\_\_

## SOCIAL HISTORY

Marital Status: \_\_\_\_\_ single \_\_\_\_\_ married \_\_\_\_\_ divorced \_\_\_\_\_ widowed

How many children do you have? \_\_\_\_\_

Who do you live with? \_\_\_\_\_

What is the highest level of education that you have completed?

\_\_\_\_\_ Some high school \_\_\_\_\_ High school \_\_\_\_\_ Trade school \_\_\_\_\_ College

How much alcohol do you consume?

- A. None
- B. Social drinker
- C. Drink daily
- D. Recovering alcoholic

Do you smoke?

- A. No, I have never smoked.
- B. Yes, I am currently a smoker
  - \_\_\_\_\_ # packs daily
  - \_\_\_\_\_ # packs yearly
- C. I quit smoking
  - \_\_\_\_\_ years ago and smoked
  - \_\_\_\_\_ packs daily for \_\_\_\_\_ yrs.

Do you currently use recreational drugs? No / Yes, list \_\_\_\_\_

## FAMILY HISTORY

Do you have a family history of any of these diseases? (Circle all that are appropriate)

- |                           |                         |
|---------------------------|-------------------------|
| A. None                   | G. Stroke               |
| B. Back and Neck Problems | H. Asthma               |
| C. Cancer                 | I. Osteoarthritis       |
| D. Diabetes               | J. Rheumatoid Arthritis |
| E. Heart Disease          | K. Bleeding Disorders   |
| F. Hypertension           | L. Others: _____        |

## REVIEW OF SYSTEMS

Have you recently experienced any of the following?

Weight gain	yes	no	Shortness of Breath	yes	no
Weight loss	yes	no	Coughing/Wheezing	yes	no
Fever/Chills	yes	no	Chest pain	yes	no
Dizziness	yes	no	Palpations	yes	no
Night sweats	yes	no	Frequent urination	yes	no
Difficulty seeing	yes	no	Difficulty with urination	yes	no
Double vision	yes	no	Swelling in the legs	yes	no
Difficulty hearing	yes	no	Muscle weakness/Cramps	yes	no
Nose bleeds	yes	no	Joint pain/Stiffness	yes	no
Nausea/Vomiting	yes	no	Difficulty sleeping	yes	no
Change in bowel habits	yes	no	Anxiety	yes	no
Blood in stool	yes	no	Depression	yes	no
Heartburn	yes	no	Confusion/Memory Loss	yes	no

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

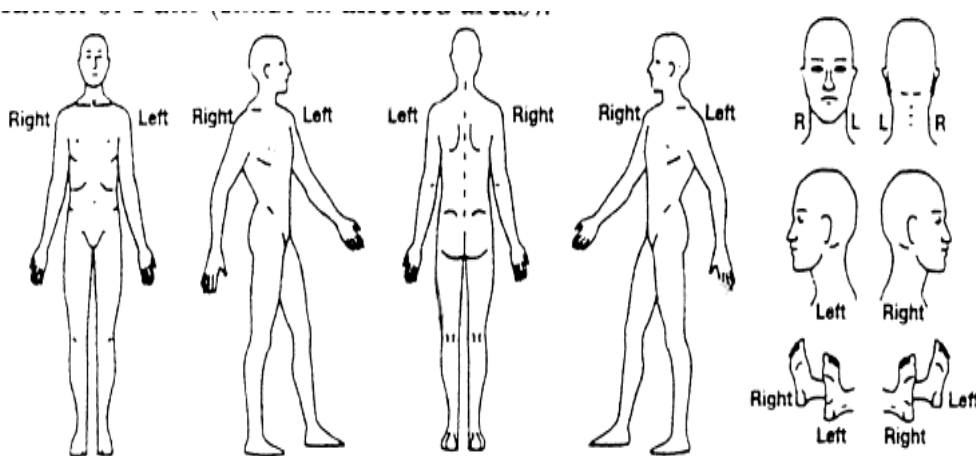
## PAIN ASSESSMENT

### Instructions:

Mark the location of your pain on the figure below.

For symptoms of pain, fill in the affected areas with the following pattern: XXXXXX

For symptoms of numbness and/or tingling, fill in the affected areas with: 000000



(-----)  
 0% (No Pain) 100% (Worst Possible Pain)

PAIN LINE: Draw a perpendicular line across line above to indicate your typical level of daily pain.



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.

**1. OUR PLEDGE REGARDING MEDICAL INFORMATION**

We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive from our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you.

**2. OUR LEGAL DUTY**

Law Requires Us To:

- 1. Keep your medical information private
- 2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
- 3. Follow the terms of the current notice.

We Have The Right To:

- 1. Change out privacy practices and terms of this notice, provided changes are permitted by law.
- 2. Changes that are made will effect all medical information, including previously received information.

If any changes are made, the new notice will be available upon request.

**3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

The following are ways that we will be using and disclosing your medical information

**FOR TREATMENT:** We may share medical information about you to doctors, nurses, technicians, medical students, or other people taking care of you.

**FOR PAYMENT:** We may use and disclose your medical information for payment purposes. When billing your insurance company, the information on, or accompanying the bill may include your medical information.

**FOR HEALTH CARE OPERATIONS:** We may use your medical information for our health care operations. This might include: quality improvement, training programs, evaluating the performance of employees etc.

**4. YOUR INDIVIDUAL RIGHTS**

You Have a Right to:

- 1. Look at, or get copies of your medical information. You must make your request in writing. You may obtain this form from our office's front desk.
- 2. Receive a list of all the times we have shared your medical information for purposes other than treatment, payment and health care operations.
- 3. Request that we place additional restrictions on our use or disclosure of your medical information.
- 4. Revoke your authorization to share your medical information at any time by notifying our office in writing, and the authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

If you have any questions about this notice, or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit request involving any of your rights in Section 4 of this notice by writing to the following address:

**Gulf-to-Bay Integrative Pain Medicine**  
**118 S. Oregon Avenue**  
**Tampa, FL 33606**                      **813-253-2273 (phone)**                      **813-253-2279 (fax)**

**PRIVACY PRACTICES ACKNOWLEDGMENT**

**ACKNOWLEDGEMENT STATEMENT**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

**PATIENT RECORD OF DISCLOSURE**

In general, the HIPAA privacy act gives individuals the right to request a restriction on uses and disclosures of Personal Health Information (PHI). The individual is also provided the right to request confidential communication.

**I wish to be contacted in the following manner... (Please check all that apply)**

Home Phone # \_\_\_\_\_  Work Phone # \_\_\_\_\_  Cell Phone \_\_\_\_\_

\_\_\_\_\_ Ok to leave detailed messages      \_\_\_\_\_ Ok to leave detailed messages      \_\_\_\_\_ Ok to leave detailed messages

Please send all written communication to the following address:

**Please choose one of the following options:**

**Option 1** Information about my treatment at Gulf-to-Bay Integrative Pain Medicine may be released to the following individuals:      \*\*\*This includes prescription pick-ups\*\*\*

Name & Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

Name & Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

Name & Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

**Option 2** \*\*\*I DO NOT want my medical information released to anyone\*\*\*

\_\_\_\_\_  
Signature of Patient/Legal Guardian to Patient      Date      Relationship

\_\_\_\_\_  
Witness      Date

I understand that this health information may include HIV related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form I am specifically authorizing the release of information relating to:

- Substance Abuse (including alcohol/drug abuse)
- Mental Health
- Psychotherapy Notes
- HIV related information (including AIDS-related testing)

The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes, as well as Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

**\* I understand that this form will expire in one year from my last date of service visit.  
A photocopy of this form will be considered as valid as the original.**

Signature of Patient/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_



**Patient Opioid Agreement**

This is an agreement between \_\_\_\_\_ (print patient name) and ***Gulf-to-Bay Pain Management*** concerning the use of opioid medications for the treatment of chronic pain.

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

***Please read each statement carefully and initial next to each to indicate your agreement.***

Patient Initials	Statement
	1. I understand that Opioid medications are strong medications for pain relief and I have been informed of the risks and side effects involved with taking them.
	2. I understand that opioid medications could cause physical dependence. If I suddenly stop or decrease the medication, I could experience withdrawal symptoms that may occur within 24-48 hours of the last dose. Therefore, it is my responsibility to make sure I do not run out of my medications on weekends or holidays.

<b>*Prescriptions will not be refilled without an appointment*</b>	
	3. I understand that if I am pregnant or become pregnant while taking opioid medications, my child would be physically dependent on the opioids, and withdrawal can be life-threatening for my baby.
	4. I understand that if the medication causes drowsiness, sedation, or dizziness, I should not drive a motor vehicle or operate heavy machinery that could put my life or someone else's life in danger.
	5. I understand that it is my responsibility to notify the physician of any/all side effects I am experiencing from the medication(s).
	6. I agree to take this medication <b>only as prescribed</b> by my physician, and that I will not change the amount or frequency of the medication without discussing it with the prescribing physician.
	7. I agree that my opioid medication(s) will be prescribed by only <b>Gulf-to-Bay Pain Management</b> , and I agree to fill my prescriptions at only one pharmacy. (** We understand that in rare instances, your designated pharmacy may experience a medication shortage. In that instance, please <u>notify us</u> & we will obtain approval from the physician to use your second pharmacy of choice**) 8. I agree not to take any pain medications prescribed by any other physician without first discussing it with Gulf-to-Bay. I give permission to Gulf-to-Bay to verify that I am not seeing other physicians for opioid medication.
	9. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.
	10. I agree not to sell, lend, or in any way give my medication to any other person.
	11. I agree not to drink alcohol or take mood altering drugs while I am taking opioid medication. I agree to submit a urine specimen at any time that my doctor requests, and give my permission for it to be tested for alcohol and/or drugs.
	12. I agree that I will attend all of my required follow-up visits with the doctor to monitor this medication, and I understand that failure to do so will result in discontinuation of this treatment.
	13. I will not go the emergency room for pain management for my chronic condition for which Gulf-to-Bay is treating me. <b>* This agreement does not restrict me from going to the emergency room for new acute pain of any nature. I shall report to Gulf-to-Bay within one week of such an ER visit.*</b>
	14. I understand that pain medications are only one aspect of my pain treatment plan. I also agree to follow other modalities of treatment as recommended by my physician. Failure to follow the treatment plan may indicate that I no longer respect the treatment suggestions of Gulf-to-Bay, and may result in my discharge from the care of Gulf-to-Bay Pain Management.

**The Pharmacy at which I will fill all of my Controlled Substance prescriptions is:**

Name of Pharmacy : \_\_\_\_\_ Pharmacy phone # \_\_\_\_\_

2<sup>nd</sup> Pharmacy of Choice\*: \_\_\_\_\_ Pharmacy Phone# \_\_\_\_\_

( Only to be used in the event of a medication shortage at your primary pharmacy)

***This agreement shall remain in effect until either party withdraws from it in writing, or until I violate the agreement.***

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date