**American Pain Experts**
**6333 North Federal Highway suite 250**
**Fort Lauderdale FL, 33308**

**Date: _____ / _____ / _____**

**Name _____**
**Address_____**
**City_____ State _____ Zip Code_____**
**Home Phone _____ Cell _____Work Phone _____**
**Social Security # _____ D.O.B _____Age _____**
**Sex _____ Marital Status _____ # of Children_____**
**Name of Employer _____ Occupation _____**
**E-Mail Address _____Referred By _____**
**Emergency Contact _____ Phone #_____**

**How did you hear about our office? Please Circle Answer**

**Friend/Family_____ Internet Yellow book Self Referral**
**Referred Physician_____ Radio Yellow Pages Other_____**

**Insurance Information**

**Primary Carrier _____**
**Address _____**
**_____**
**Phone _____ Policy # _____ Group # _____**

**Secondary Insurance**

**Primary Carrier _____**
**Address _____**
**_____**
**Phone _____ Policy # _____ Group # _____**

**Patient Signature: Date:_____**
**_____**

**The following questions are designed to help your physician understand your current pain patterns and past treatment history. If you do not understand any of the following questions, please as for assistance.**

**Where is your main pain Located?_____ right side/left side?On a pain scale 0 1 2 3 4 5 6 7 8 9 10 (0= none, 10= worst)**
**Where does the pain radiate to? :_____**
**Is the pain Constant/ Intermentit?**
**Is the pain mild/moderate/severe?**
**Describe your pain:**
**Sharp/dull/throbbing/aching/burning/stabbing/cramping/tearing/other:_____**
**Is the pain constant chronic or acute interment it?**
**When did the pain start (Month/Year)?_____**
**How did the pain start?_____**
**How long have you had this pain?_____**
**Place of occurrence: Home/ Vacation/Work/Motor Vehicle accident/other?:_____**
**What have you done for the pain?_____**
**What makes the pain worse?_____**
**What makes the pain Better?_____**
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**Is there any other part of your body where you have pain? yes or no**
**Where is your second pain locate?_____ right side/left side?**
**On a pain scale 0 1 2 3 4 5 6 7 8 9 10 (0= none, 10= worse)**
**Where does the pain radiate to? :_____**
**Is the pain Constant/ Intermentit?**
**Is the pain mild/moderate/severe?**
**Describe your pain:**
**Sharp/dull/throbbing/aching/burning/stabbing/cramping/tearing/other:_____**
**Is the pain Constant chronic or acute interment it?**
**When did the pain start(Month/Year)?_____**
**How did the pain start?_____**
**How long have you had this pain?_____**
**Place of occurrence: Home/ Vacation/Work/other_____**
**What have you done for the pain?_____**
**What makes the pain worse?_____**
**What makes the pain better?_____**
**Are you currently experiencing any of the following: Depression, loss of energy, sleeping problems, anxiousness, loss of appetite, panic attacks, sudden weight loss**
**Other:_____**

**List of Medication:**

**Starting with Pain Medications:**

_____ _____ _____

_____ _____ _____

_____ _____ _____

**Medication Allergies:**_____

**Pharmacy name:**_____ **Telephone number:**_____

**Address:**_____

**Are you taking blood thinner: yes/no**

**What are you taking? Coumadin, Lovenox, Aspirin, Plavix, Ticlid, Heparin, Other**_____

**How long have you been taking the medication?**_____

**Which Doctor is monitoring this medication use?**_____
_____ **Phone number:**_____

**Are you In any antibiotic?**_____

## Past Medical History (Please circle all that apply to your Health)

**Cardiac:** Hypertension, Heart Attack, Chest Pain, Heart Failure, Pacemaker, Irregular Rhythm,Other_____

**Gastro-Intestinal:** Hernia, Ulcers, Gastritis, Pancreatitis GERD, IBS, Diverticulitis, Colitis, Hepatitis, Other_____

**Immune/Endocrine:** Diabetes, Tuberculosis, Cancer, Thyroid, Arthritis, Fibromyalgia, Rheumatologic, Other _____

**Respiratory:** COPD, Asthma, Chronic Cough or Lung Disease, Emphysema,

Other_____

**Neurological:** Headaches, Seizures, stroke/TIA, Head Injury, Epilepsy, Sleeping problems, Other_____

**ENT:** Eye Disorders, Ear Disorders, Nasal Disorders, Throat Disorders, Other_____

**Musculoskeletal**: Abnormal Muscle function, Loss of joint function, Spine/Joint Pain, Arthritic Pain,Joint Replacement, Generalized aches/ Pain, Other_____

**Hematological:** Bleeding disorder, Inability to control bleeding from cuts, Phlebitis/Blood Clots, Transfusion Immune Problems/ HIV/AIDs, Other_____

**Have you had any Surgery in the past? Yes/ No**

**if yes how many?_____**

**What kind?:**

**1)_____Date:_____**

**2)_____Date:_____**

**3)_____Date:_____**

**4)_____Date:_____**

**Injections: (Please Circle)**

**Have you had Injections done in the past? Yes/ No**

**If so what kind of Injections?**

**Trigger points Radio frequency Body Location: Cervical/ Lumbar/ Thoracic /Other_____**

**Joint/ Bursa Botox**

**Epidural**

**Facet**

**Did Injections Help? Yes/ No**

**Family History : (Please Complete)**

**Mother Alive or Deceased**

**age: Reason:**

**Father Alive or Deceased**

**age: Reason:**

**Do you have Kids? Yes/ No**

**How many?____ Ages:_____ _____ _____**

**Social History: (Please Circle)**

**Occupation:_____**

**Hobbies:_____**

**Do you have Disability Compensation? Yes/ No**

**Tobacco use:**

**Current how many cigarettes a day do you smoke?_____**

**Past Smoker how long ago did you quiet?_____**

**Never smoked**

**Recreational Drugs: Current, Past History, Never**

**Psychiatric History: Current/ Past Treating Physician:_____**

**Thank you for taking the time to fill this new patient Form out. This information will help us in offering you a more Comprehensive evaluation and treatment plan.**

# Acknowledgement of Receipt of Notice

## Apex Florida, LLC

**6333 North Federal Highway suite 250**
**Fort Lauderdale, FL 33308**

**I hereby acknowledge that I have received a copy of this practice's Notice of Privacy practice**

**Print name:_____ Telephone number:_____**
**Signature:_____ Date:_____**

**If not signed by the patient, please indicate:**

**Relationship(please circle):**

- **Parent or guardian of minor patient**
- **Guardian or conservator of an incompetent patient**
- **Beneficiary or personal representative of deceased patient**

**Name of Patient:_____**

**For office use only:**
**Signed form received by: _____ Date:_____**
**Acknowledgement refused:_____**
**Reason for refusal:_____**