

**WF
PM**

WEST FLORIDA PAIN MANAGEMENT, P.A.

Diagnostic & Interventional Pain Medicine

Gerald Trimble, M.D.

Susan Samlaska, M.D.

Amended 07/24/07

Name: _____ Age: _____ Date: _____

I. Patient Data

Family physician: _____

Who referred you to West Florida Pain Management? _____

II. Medical History

Have you ever, or do you now have, any of the following conditions?

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Bleeding / bruise easily | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Irregular heart rhythm | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Epilepsy / Seizures |
| <input type="checkbox"/> Stomach / Intestinal Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cigarette use |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Liver disease / Hepatitis | | |

List any Surgeries you have had:

Type of Surgery	Date	Type of Surgery	Date

List all Medications you are currently using and how often you use them. Please indicate below:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Medication Allergies:

List any tests you have had:

Tests	Date & Place done	Results	Tests	Date & Place done	Results
X-rays			CAT SCAN		
MRI			EMG		

PLEASE NOTE!

We do not perform disability ratings at this practice. Should you need this service performed, we will refer you to the appropriate physician.

III. Social History

What is your occupation? _____ What duties do you perform? _____
 When did you last work? _____ Part or Full time? _____
 Years of Education _____ Married Yes No How long? _____ # of children _____ Ages _____

IV. SYSTEMS REVIEW

<u>General:</u>	Comments	<u>HEENT:</u>	Comments
Recent chills and / or fever	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Head-headaches	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Recent night sweats	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Dizziness	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Weight gain	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Eyes- glasses	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Weakness	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Episodic blindness	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Weight Loss	<input type="checkbox"/> Y <input type="checkbox"/> N _____	glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N _____
<u>Skin:</u>		cataracts	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Sores	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Ears- hearing problems	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Rash	<input type="checkbox"/> Y <input type="checkbox"/> N _____	infection	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Change in body hair	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Nose – bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Skin Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N _____	allergies	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Warts or moles removed	<input type="checkbox"/> Y <input type="checkbox"/> N _____	sinusitis	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Nodes: any change in glands	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Mouth – hoarseness	<input type="checkbox"/> Y <input type="checkbox"/> N _____
		pain when chewing	<input type="checkbox"/> Y <input type="checkbox"/> N _____
		ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N _____
		Dentures	<input type="checkbox"/> Y <input type="checkbox"/> N _____

<u>Respiratory (lungs):</u>	Comments	<u>Gastrointestinal:</u>	Comments
Shortness of breath	<input type="checkbox"/> Y <input type="checkbox"/> N _____	poor appetite	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Chronic cough	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Painful swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Pleurisy- pain on breathing	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Difficult swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Cough up blood	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Food intolerance	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Indigestion / heartburn	<input type="checkbox"/> Y <input type="checkbox"/> N _____
<u>Cardiovascular:</u>		Change of bowel habits	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Have you ever been examined for heart disease	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Inability to retain stool	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Heart attack	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Gas / bloating	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Angina	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Abdominal pain	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Chest pain	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Bleeding hemorrhoids	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Rapid heartbeats	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Blood in stool	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Smothering at night	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Black stools	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Discomfort in legs			
when walking	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Nausea or vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Painfully cold hands	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Blood clot	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Constipation	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Describe your exercise program	_____	Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N _____

<u>Genitourinary:</u>	Comments	<u>Musculoskeletal (cont):</u>	Comments
Do you get up at night to urinate?	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Back pain	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Bladder, kidney infection	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Total joint replacement	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Difficult urination	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<u>Neurologic:</u>	
Blood in urine	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Memory problems	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Kidney stone	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Fainting or blackouts	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Inability to retain urine	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Depression	<input type="checkbox"/> Y <input type="checkbox"/> N _____
<u>Musculoskeletal:</u>		Anxiety	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Bursitis, tendonitis	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Arthritis, rheumatism	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Paralysis	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Sciatica	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Tremor	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Neck pain	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Difficulty walking	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Leg pain on exertion	<input type="checkbox"/> Y <input type="checkbox"/> N _____	Frequent falls	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Leg pain at night	<input type="checkbox"/> Y <input type="checkbox"/> N _____		

Family History / Blood relatives Please list any diseases you are aware of.

	Alive?	Age		Alive?	Age
Paternal grandfather	<input type="checkbox"/> Y <input type="checkbox"/> N	_____		Brothers	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Paternal grandmother	<input type="checkbox"/> Y <input type="checkbox"/> N	_____			<input type="checkbox"/> Y <input type="checkbox"/> N _____
Maternal grandfather	<input type="checkbox"/> Y <input type="checkbox"/> N	_____		Sisters	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Maternal grandmother	<input type="checkbox"/> Y <input type="checkbox"/> N	_____			<input type="checkbox"/> Y <input type="checkbox"/> N _____
Mother	<input type="checkbox"/> Y <input type="checkbox"/> N	_____		Aunt	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Father	<input type="checkbox"/> Y <input type="checkbox"/> N	_____		Uncle	<input type="checkbox"/> Y <input type="checkbox"/> N _____

V. Description of Pain and Influencing Factors

Location: Mark drawing showing approximate areas of pain

Patient rates the pain. Scale used 1-10 (10= worst pain)

Worst pain gets: _____

Best pain gets: _____

1. How long have you had this problem? _____

2. Please describe how your pain first began. (e.g. accident, illness, etc.): _____

3. Words that describe your pain (e.g. prick, ache, burn, throb, pull, sharp) : _____

4. What causes your pain to:

Increase? _____

Decrease? _____

Effects of pain (note-decreased function, decreased quality of life.):

Accompanying symptoms(e.g. nausea): _____

Sleep: _____

Appetite: _____

Physical activity: _____

Relationship with others (e.g. irritability): _____

Emotions (e.g. anger, suicidal, crying): _____

Concentration: _____

VI. Treatment

Treatment	Yes/No If Done	How Helpful Was This?
Nerve Blocks		
Surgery		
TENS unit		
Occupational therapy		
Physical therapy		
Biofeedback		
Psychological therapy		
Other		

VII. Litigation

In the past, have you ever been compensated for a work related injury or a motor vehicle accident? If so please give the date of injury and describe any injuries/ disabilities you were compensated for.

Date of Injury: _____

Description of Injury/ Disability: _____

If your pain is due to an accident, is litigation (legal suit) or an insurance settlement pending?
 Yes No If yes, describe the current status of the litigation or settlement: _____

If your pain is due to a work related injury what is you official work status as of today's date?

Is faith important to you in this illness?

Has faith been important to you at other times in your life?

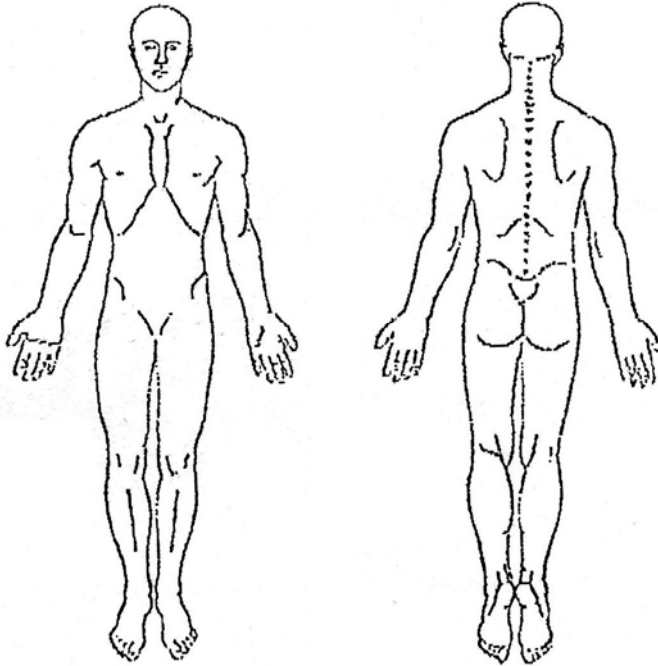
How have you coped in the past with difficult situations?

Are you hopeful that your pain can be managed or alleviated?

Signature: _____

Date: _____

WHERE IS THE PAIN YOU ARE SEEKING TREATMENT FOR LOCATED?



Any Changes? Good or bad

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Amended 7/24/07

Susan Samlaska, M.D.

Patient Name: _____

Date: _____

Patient DOB: _____

SSN: _____

**IN CONSIDERATION FOR YOUR CARING FOR ME,
I AGREE TO THE FOLLOWING:**

1. YOU ARE AUTHORIZED TO RELEASE ANY INFORMATION YOU DEEM APPROPRIATE CONCERNING MY PHYSICAL CONDITION TO ANY INSURANCE COMPANY, OR ADJUSTER IN ORDER TO PROCESS ANY CLAIM FOR REIMBURSEMENT OF CHARGES INCURRED BY ME.
2. YOU ARE AUTHORIZED TO RELEASE ANY INFORMATION YOU DEEM APPROPRIATE TO PROVIDE MEDICAL TREATMENT OR FOR HEALTH CARE OPERATIONS
3. I AUTHORIZE THE DIRECT PAYMENT TO **WEST FLORIDA PAIN MANAGEMENT, P.A.** ANY BENEFITS DUE ME FROM MY INSURANCE COMPANY AND/OR MEDICARE AND/OR FROM THE PROCEEDS OF ANY SETTLEMENT OF S CASE RESULTING FROM LEGAL ACTION. I FURTHER AUTHORIZE PAYMENT TO **WEST FLORIDA PAIN MANAGEMENT, P.A.** FOR YOUR SERVICES
4. I UNDERSTAND THAT HEALTH INSURANCE IS A CONTRACT BETWEEN MYSELF AND THE COMPANY. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT OF MY ACCOUNT WITH TO **WEST FLORIDA PAIN MANAGEMENT, P.A.** IN ITS ENTIRETY REGARDLESS OF INSURANCE PAYMENT OR ATTORNEY SETTLEMENT. THIS PROVISION DOES NOT APPLY SHOULD THE PATIENT BE COVERED BY AN APPROPRIATE AND VALID WORKER'S COMPENSATION CLAIM.
5. I AUTHORIZE THE HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE SAID INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION AND THE HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF TO **WEST FLORIDA PAIN MANAGEMENT, P.A.**, ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF ANY MEDICAL INSURANCE BENEFITS TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.
6. MY INITIALS INDICATE THAT I HAVE RECEIVED A COPY OF West Florida Pain Management, P.A.'S PRIVACY POLICY.

_____initials

Date: _____

X _____
Signature of Patient or Legally Responsible Person

X _____
Witness

Patient Name: _____
Patient DOB: _____

Date: _____
SSN: _____

This agreement is between myself, _____, and WEST FLORIDA PAIN MANAGEMENT, P.A.. It is designed to inform me fully of the manner in which my medication, *especially narcotics*, will be provided. It also outlines the criteria by which the Program Team will determine whether or not to continue to prescribe medication.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbituate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as a consideration for, and a condition of, the willingness of the physician whose name appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. Pain medications, *especially of a narcotic type*, will be provided only after it is determined that all reasonable alternatives for adequate pain control have been investigated or attempted.
2. I will agree to try other approaches or techniques as felt appropriate by the team that may assist me in taking the lowest effective dose possible.
3. My "pain medication" will be prescribed by only the doctor whose name appears below and filled at **one** pharmacy. Should the need arise to change pharmacies our office must be informed. The pharmacy you have selected is: _____ Phone: _____ Any attempt, successful or not, to obtain additional medication without the permission of the Pain Management Program may result in discontinuation of medication therapy.
4. Medications will be given in fixed intervals, usually every two to four weeks, and only if I keep my appointments.
5. I may at times be requested to submit to a drug test to confirm that I am taking only those medications prescribed.
6. Medications will be continued as long as:
 - a. There is associated pain relief of at least 30% to 50%;
 - b. My functional activity is about what would be expected, given my physical limitations, and;
 - c. There is not evidence of addiction as suggested by the need for increasing medicine.
7. Evidence of hoarding or other mismanagement of my pain medication may result in discontinuation of services.
8. Exacerbations or "flare-ups" of my pain will be handled by other therapies, such as tens, exercise, ice, heat, relaxation, or non-habit forming medications. Only when it is determined that there is a physiological basis for the "flare-up", and additional medicine required, will a brief increase be considered.
9. If it is determined that the situation may be out of control, I will agree to be hospitalized where medications and other therapies can be provided in a controlled fashion.

10. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
11. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
12. You may not share, sell or otherwise permit others to have access to these medications.
13. These drugs should not be stopped abruptly, as an abstinence syndrome (withdrawal) will likely develop.

I HAVE READ AND UNDERSTAND EACH OF THE ABOVE POLICIES. I REALIZE THAT THE PAIN MANAGEMENT PROGRAM WILL ASSUME THE RESPONSIBILITY OF ASSISTING ME IN MY THERAPY AS LONG AS I COMPLY WITH ALL OF THE ABOVE POLICIES.

Date: _____

X _____
Signature of Patient or Legally Responsible Person

X _____
Witness

Dr. Gerald E. Trimble, M.D.
Susan Samlaska, M.D.
Treating Physician

**ATTENTION
PATIENTS OF WEST FLORIDA
PAIN MANAGEMENT**

**EFFECTIVE APRIL 1, 2004
WEST FLORIDA PAIN MANAGEMENT
WILL CHARGE:**

\$10.00

**TO THE PATIENTS WHO WISH THEIR PRESCRIPTIONS
TO BE CALLED IN.**

**THIS CHANGE IN POLICY IS DUE TO INCREASED
REQUESTS FOR THIS SERVICE.
WE ENCOURAGE YOU TO MAKE SURE YOU GET YOUR
PRESCRIPTIONS AT YOUR REGULARLY
SCHEDULED OFFICE VISITS.**

**Remember there are some medications, which due to DEA regulations,
Where prescriptions cannot be called in.**

Signed

Date

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Susan Samlaska, M.D. Amended 7/24/07

Please bear in mind that scheduled appointments are important to the total treatment plan. If you must cancel an appointment, please do so 48 hours prior to your scheduled appointment so another patient can fill that time slot.

Failure to contact our office within 24 hours before your scheduled appointment will result in a \$50.00 to you that will not be covered by your insurance. If the scheduled appointment is for an injection there may be an additional charge.

Failure to contact our office within 24 hours before your scheduled brief follow-up will result in a \$20.00 charge that will not be covered by your insurance.

Date: _____

Signature of patient or guarantor

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Modified 7/24/07

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MEDICAL RECORDS RELEASE

Patient Name: _____ Date: _____

Patient DOB: _____ SSN: _____

__ I hereby authorize release of my medical records and/or x-rays for services rendered to me by **West Florida Pain Management, P.A.**

Please mail my records to:

__ I authorize that you discuss my medical information with:

Name _____ Relationship if any: _____

__ I request that my records from _____

_____ be sent to **West Florida Pain Management, P.A.** at the address at the bottom of the page.

I realize that there will be a reasonable fee for copying medical record as set forth in the Florida Administrative Code Chapter 64B8-10.003. Records can be sent to a requesting physician at no charge.

X _____
Patient/Guardian Signature

X _____
Print Name

X _____
Witness