West Coast Anesthesiology Associates
Mauna M. Radahd, M.D.
Morgan Callahan, M.D. Jason C. Tse, D.O. Andrea Cordova-Ogg, M.D.

Dear Patient:

You have been scheduled for a consultation at the Pain Medicine Group to see Dr. _____ .

Please complete the enclosed paperwork as detailed as possible at your convenience. Though extensive, we have found that complete information better assists us in your treatment and saves you time at your first appointment. We ask that you bring the completed paperwork, insurance cards with your identification and your medical records, including any x-rays and/or MRI reports. You may have the records sent directly to us prior to your appointment. If all required information is not available at the time of your appointment, you may have to reschedule.

For the courtesy of other patients, please arrive on time or call us if you are unable to make your scheduled appointment. We will not be able to guarantee your appointment time if you are late.

Please be aware that all co-pays, co-insurance, and/or deductibles are due at the time of your appointment.

If you have any questions, feel free to call us toll free at 1-877-456-PAIN.

(7246)

Thank you,
Pain Medicine Group Staff

Date and Time:

Location:

2621 Cattlemen Road, Suite 202
Sarasota, FL 34232
(941) 365-5672
Fax: (941) 365-5854

1255 City View Center
Oviedo, FL 32765
(407) 332-1300
Fax: (407) 332-4409

Pain Medicine Group

On this questionnaire are groups of statements; please read each group carefully then pick out the one statement in each group which best describes the way you have been feeling the past week, including today. Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad or unhappy I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I Feel I have failed more than the average person
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be being punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am worse than anyone else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself but would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
    1 I cry more than I used to.
    2 I cry all the time.
    3 I used to be able to cry, but now I can't even though I want to.

11. 0 I am no more irritated than I ever am.
    1 I get annoyed or irritated more easily than I used to.
    2 I feel irritated all the time.
    3 I don't get irritated at all by things that used to bother me.

12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost interest in other people.
    3 I have lost all my interest in other people.

13. 0 I make decisions about as well as I ever did.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decisions than before.
    3 I can't make decisions any more.

14. 0 I don't feel I look any worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel that there are changes in my appearance that may look unattractive.
    3 I believe that I am ugly.

15. 0 I can work about as well as before.
    1 It takes an extra effort to get started at doing something.
    2 I have to push myself very hard to do anything.
    3 I can't do any work at all.

16. 0 I can't sleep as well as usual.
    1 I don't sleep as well as I used to.
    2 I wake up 1-2 hours earlier than I used to and find it hard to get back to sleep.
    3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
    1 I get tired more easily than I used to.
    2 I get tired from doing almost anything.
    3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
    1 My appetite is not as good as it used to be.
    2 My appetite is much worse now.
    3 I have no appetite at all any more.

19. 0 I have not lost much weight, if any, lately.
    1 I have lost more than 5 lbs. on purpose.
    2 I have lost more than 10 lbs. By eating less? (yes) (no)
    3 I have lost more than 15 lbs.

20. 0 I am no more worried about my health than usual.
    1 I am worried about my physical problems and it is hard to think of anything else.
    2 I am very worried about my physical problems and it is hard to think of anything else.
    3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
    1 I am less interested in sex than I used to be.
    2 I am much less interested in sex now.
    3 I have lost interest in sex completely.

McGill Pain Questionaire

Circle the words which best describes your pain. Leave out any work group that is not suitable. Use only a single word in each appropriate group-the one that best applies. You do not have to choose a word in every group.

1	2	3	4
1) Flickering	1) Dumping	1) Pricking	1) Sharp
2) Quivering	2) Flashing	2) Boring	2) Cutting
3) Pulsing	3) Shooting	3) Drilling	3) Lacerating
4) Throbbing		4) Stabbing	
5) Bearing		5) Lancinating	
6) Pounding			

5	6	7	8
1) Pinching	1) Tugging	1) Hot	1) Tingling
2) Pressing	2) Pulling	2) Burning	2) Itchy
3) Gnawing	3) Wrenching	3) Scalding	3) Smarting
4) Cramping		4) Searing	4) Stinging
5) Crushing			

9	10	11	12
1) Dull	1) Tender	1) Tiring	1) Sickening
2) Sore	2) Taut	2) Exhausting	2) Suffocating
3) Hurting	3) Rasping		
4) Aching	4) Splitting		
5) Heavy			

13	14	15	16
1) Fearful	1) Punishing	1) Wretched	1) Annoying
2) Frightful	2) Grueling	2) Blinding	2) Troublesome
3) Terrifying	3) Cruel		3) Miserable
	4) Vicious		4) Intense
	5) Killing		5) Unbearable

17	18	19	20
1) Spreading	1) Tight	1) Cool	1) Nagging
2) Radiating	2) Numb	2) Cold	2) Nauseating
3) Penetrating	3) Drawing	3) Freezing	3) Agonizing
4) Piercing	4) Squeezing		4) Dreadful
	5) Tearing		5) Torturing

Patient Name:_____ Date:_____

Physician: _____

West Coast Anesthesiology Associates
Mauna M. Radahd, M.D.
Morgan Callahan, M.D. Jason C. Tse, D.O. Andrea Cordova-Ogg, M.D.
Assignment of Benefits and Lifetime Authorization for Release of Information

I, _____, hereby authorize West Coast Anesthesiology, and/or any of its affiliates to submit claims to my insurance company/companies. I authorize my insurance company/companies to make payment directly to WCAA and/or its affiliates. I also authorize WCAA to release any medical or other information which may be required for claim processing. I permit a copy of this authorization to be used in place of the original.

I understand in the event my insurance company/companies refuses to accept assignment of benefits, all correspondences and payments may be sent directly to me. I agree when such payments are received by me, I will endorse the insurance check "Pay to the order of WCAA" immediately. I agree to forward any and all correspondences received from insurance company/companies within 5 days of receipt.

I understand that I am responsible for payment of all charges and fees to West Coast Anesthesiology Associates and/or its affiliates, including my deductible, coinsurance, co-pays and any amount not covered by my insurance. I understand in the event my insurance company refuses to pay for medical services, I will assume full responsibility for payment.

I agree to notify WCAA and/or its affiliates of any changes to my insurance coverage or change my insurance company. The undersigned further agrees that whether he/she signs as agent or patient, he/she individually obligates himself/herself to pay the account in full excluding the amount paid directly to WCAA and/or its affiliates, by the insurance company/companies. It is your responsibility to verify your coverage amounts and understand your financial obligations before medical services rendered. WCAA and/or its affiliates, reserve the right to asses a fee for No Show appointments or cancellations made without 24-hour notice.

Affiliates of WCAA include, but not limited to the following:

Mauna M. Radahd, MD	West Coast Anesthesiology Associates, Inc	Pain Medicine Group
Morgan Callahan, MD	Jonathan Morris, CRNA	Rebecca Nelson, ARNP
Andrea Cordova-Ogg, MD	Susan Dupree, CRNA	Tracy Topjun, ARNP
Jason C. Tse, DO	Minerva Betancourt, CRNA	

_____ _____

Patients Signature Date

(If patient unable to sign and/or minor, please state relationship) _____

_____ _____

Witness Date

Mauna M. Radahd, M.D.

Morgan Callahan, M.D. Jason C. Tse, D.O. Andrea Cordova-Ogg, M.D.

HIPAA PRIVACY POLICY ACKNOWLEDGEMENT

I acknowledge that I have received my Health Information Privacy Policy Notice as required by the HIPAA Act of 1996. Further, I understand that I may call Pain Medicine Group at any time and request to speak to the Privacy Officer regarding any aspects of my Protected Health Information (PHI). I understand that Pain Medicine Group may use or disclose my PHI to others only for the treatment, payment or healthcare operations. I understand I have the right to receive copies of my PHI, with certain exceptions, including but not limited to PHI received by our office originating from other practices or physicians.

_____ _____

Print Name Date

_____

Patient Signature

I give my permission to release my PHI to the following individuals and I understand that Pain Medicine Group will release my PHI only to covered entities as detailed in the policy notice and to the following individuals:
(Please Circle and Print Name of Person(s)

My Spouse: _____

My Child(ren): _____

My Parent(s): _____

Other (Please Specify):

_____

_____ _____

Patient Signature Date

PAIN MEDICINE GROUP

Mauna M. Radahd, M.D.

Morgan Callahan, M.D. Jason C. Tse, D.O. Andrea Cordova-Ogg, M.D.

Patient Record of Disclosure

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by means such as sending correspondence to an address other than home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone:
__OK to leave message with detailed information
__Leave message with call back number only
__OK to fax to this number_____

Written Communications:
__OK to mail home address
__OK to mail work/office

Work Telephone:
__OK to leave message with detailed information
__Leave message with call back number only

Other:
__OK to email to this address:
_____

_____ _____
Signature Date

_____ _____
Print Name Birth Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

Uses and Disclosures for LifeTime Health Center may be permitted without prior consent in an emergency.

Healthcare entities must keep records of PHI disclosures. Information provided below will constitute this record. Please list who we may disclose information to such as appointment times, lab results or medication information.

Disclose information to:	Address or Phone #:	Disclose this information:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION

Pursuant to 45 CFR 164.508

To: Pain Medicine Group / Mauna Radahd, MD / Jason Tse, DO / Morgan Callahan, MD / Andrea Cordova-Ogg, MD

☐ 2621 Cattlemen Rd, Suite 202
Sarasota, FL 34232
Phone: (941) 365-5672
Fax: (941) 365-5854

☐ 1255 City View Center
Oviedo, FL 32765
Phone: (407) 332-1400
Fax: (407) 332-4409

Patient Name: _____ DOB: _____

I hereby request and authorize the disclosure of all protected information for the purpose of review and evaluation. I request the Pain Medicine Group to obtain full and complete protected medical information including the following:

( ) All medical records, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient, emergency room, progress notes, nurses notes, clinic records, treatment plans, discharge summaries, test results, questionnaires/history, correspondence and records received by other medical providers including psychiatric records, radiology records including MRI, CT Scans, EMG and laboratory results.

( )I understand the information to be released/disclosed may include information relating to AID, HIV, and alcohol and drug abuse. I authorize the release/disclosure of this type of information.
This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions have been considered and waived.

I understand the following:

a. I have the right to revoke authorization in writing at any time, except to the extent information has been released in response to the authorization.
b. The information released in response to the authorization may be re-disclosed to other parties.

Authorized Representative: ( ) Parent ( ) Surviving Spouse ( ) Legal Guardian/Administrator/Executor*
*If Legal Guardian, Administrator, or Executor, legal proof of this status must accompany this authorization.

_____ _____
Signature or patient or authorized representative Date signed

_____ _____
Name and Relationship of legal authorized representative Date signed

In the event these records are being requested other than for the use of the patient or attending physician, a charge of $1.00 per page will be assessed in accordance with Florida State Statute 395.3025.

Patient Name:		Date:
Phone:	Work:	Cell:
Address:		
City:	State:	Zip:
DOB:	SS#:	Sex : Male ( ) Female ( )

- Caucasian (White) ☐
- Hispanic ☐
- Black/African American ☐
- Pacifice Islander ☐
- Asian ☐
- Native American ☐
- Other _____ ☐

Email:

PCP/Referring Dr. Information:

Referred by:

Primary Insurance:

Address:

City: State: Zip: Phone:

ID#: Group#: Claim#: DOI:

Adjuster: NCM: Other Info:

Secondary Insurance:

Address: City: State: Zip:

ID#: Group#: Phone:

Pharmacy: Phone:

****Please note you may use only one pharmacy.

Address: City: State: Zip:

Current Medications: Please list any and ALL medications you are currently taking. Use a separate sheet if needed.

Name:	Prescribed By	Dosage and Frequency	Effectiveness
Name: _____	_____	_____	_____
Name: _____	_____	_____	_____
Name: _____	_____	_____	_____
Name: _____	_____	_____	_____
Name: _____	_____	_____	_____

Allergies: _____

I confirm the above information is the most current and accurate. I understand I am responsible to notify the office of any changes to include by not limited to my medications, insurance information, address, phone number, etc.

Patient Signature: _____ Date: _____

Additional Notes: _____

Name: _____ Date: _____

Greatest Area of Concern/Pain: _____

What Caused your current pain?_____

When did your pain start: _____

Localization of Pain:

- ☐ Facial Pain
- ☐ Neck Pain
- ☐ Lower Back Pain
- ☐ Thoracic/Mid Back Pain
- ☐ Abdominal Pain
- ☐ Groin Pain
- ☐ Muscle Aches
- ☐ Skin Pain
- ☐ Leg Pain
- ☐ Joint Pain in Knee
- ☐ Pain in Hands and Feet
- ☐ Hip Pain
- ☐ Shoulder Pain
- ☐ Headache
- ☐ Other_____

Pain Level (0-10)

Current Pain Level: _____

Timing of Pain

- ☐ Constant
- ☐ Frequent
- ☐ Occasional

Pain Quality

- ☐ Burning
- ☐ Throbbing
- ☐ Dull, Aching
- ☐ Shooting
- ☐ Sharp
- ☐ Cramping
- ☐ Pressure Like
- ☐ Lightening Like
- ☐ Electric Like
- ☐ Cutting
- ☐ Numbness
- ☐ Tingling

Activities Avoided due to Pain

- ☐ Work
- ☐ Yard Work
- ☐ Recreation
- ☐ Exercise
- ☐ Housework
- ☐ Socializing
- ☐ Sexual Activity
- ☐ Driving
- ☐ Self Care
- ☐ Other _____

Pain Modifiers

Standing	☐ Relieves	☐ Worsens	☐ No Change
Sitting	☐ Relieves	☐ Worsens	☐ No Change
Walking	☐ Relieves	☐ Worsens	☐ No Change
Exercise	☐ Relieves	☐ Worsens	☐ No Change
Medication	☐ Relieves	☐ Worsens	☐ No Change
Relaxation	☐ Relieves	☐ Worsens	☐ No Change
Coughing/Sneezing	☐ Relieves	☐ Worsens	☐ No Change
Lying Down	☐ Relieves	☐ Worsens	☐ No Change
Other_____	☐ Relieves	☐ Worsens	☐ No Change

Name: _____ Date: _____

Previous Physician Seen for your Pain:
Name: _____ Phone #: _____
Name: _____ Phone #: _____

Previous Medication Tried:

Anti-Seizures ( ) _____ Anti-Inflammatories ( ) _____ Narcotics ( ) _____
Gabapentin ( ) Tramadol ( ) Muscle Relaxation ( ) _____ Gel/Patches ( ) _____
Anti-Depressants ( ) _____Other ( ) _____

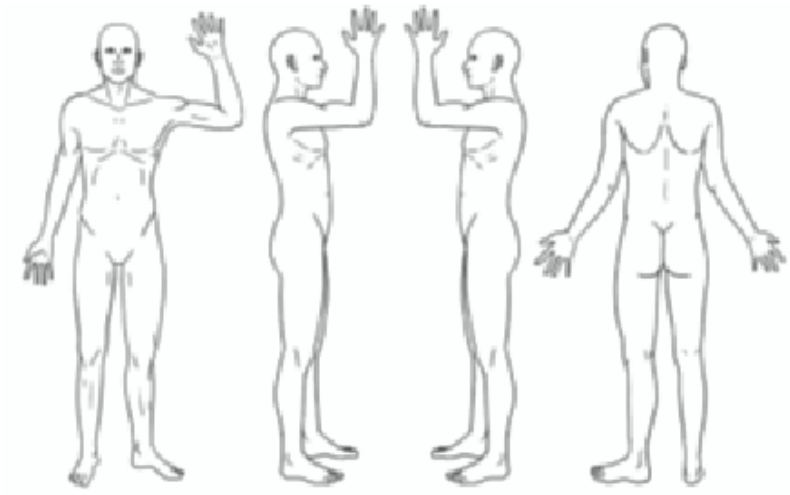
Test Rendered:

X-Rays	Date: _____	Where: _____
Labs/Blood/Urine	Date: _____	Where: _____
CT Scans	Date: _____	Where: _____
MRI	Date: _____	Where: _____
EMG	Date: _____	Where: _____

Previous Treatment and Degree of Relief of Pain

TENS Unit	☐ Excellent	☐ Moderate	☐ No Relief	When _____
Physical Therapy	☐ Excellent	☐ Moderate	☐ No Relief	When _____
NSAIDs	☐ Excellent	☐ Moderate	☐ No Relief	When _____
Muscle Relaxants	☐ Excellent	☐ Moderate	☐ No Relief	When _____
Surgery	☐ Excellent	☐ Moderate	☐ No Relief	When _____
Chiropractic	☐ Excellent	☐ Moderate	☐ No Relief	When _____
Epidural Injection	☐ Excellent	☐ Moderate	☐ No Relief	When _____
Facet Injection	☐ Excellent	☐ Moderate	☐ No Relief	When _____
Radiofrequency Lesioning	☐ Excellent	☐ Moderate	☐ No Relief	When _____
Other_____	☐ Excellent	☐ Moderate	☐ No Relief	When _____

Color the Area of Your Pain:



Professional Use Only:

Name: _____ Date: _____

Past Medical History

- Fibromyalgia
- Kidney Disorder
- HTN/High Blood Pressure
- Shortness of Breath
- Myocardial Infarction
- Hepatitis
- Diabetes
- Arthritis
- Neurological Disorders
- Sexual Dysfunction
- COPD/Emphysema
- Esophageal Reflux
- Sleep Apnea
- Asthma
- Anxiety
- Taking Blood Thinners
- HIV/AIDS
- Stroke
- Cancer
- Pulmonary Disease
- History of Addiction
- Glaucoma
- Liver Disorders
- Fatigue/Anemia
- Heart Disease
- Thyroid Disease
- Bipolar Disorder
- Depression
- Headache Syndromes
- Seizures Disorder
- Chest Pain
- Other _____

Have you had any bowel changes: Yes ( ) No ( )
Have you had any bladder changes: Yes ( ) No ( )
Have you noticed any changes in your painful area:
Increased Nail Growth: Yes ( ) No ( )
Tempature Change: Yes ( ) No ( )
Skin Change: Yes ( ) No ( )
Sweating: Yes ( ) No ( )
Swelling: Yes ( ) No ( )

Past Surgical History

- Spine Surgery
- Cardiac Surgery
- Blood Vessel Surgery
- Orthopedic Surgery
- Cancer Surgery
- Appendectomy
- Gallbladder
- Hernia Repair
- Upper GI/Colonoscopy
- Neurological Surgery
- Lung Surgery
- Gastrointestinal Surgery
- Other _____
- Other _____

Social

Tobacco Use

- Current Smoker
- Previous Smoker
- Never Smoked

Work

- Disable
- Retired
- Unemployed
- Work Full Time
- Work Part Time

Martial History

- Currently Married
- Single
- Divorced
- Widowed

Is there any chance you may be pregnant? Yes ( ) No ( )

Social Activity

- Caffeine Use
- Recreational Drug Use
- Exercise Regularly
- Alcohol Use-current
- On Disability

Educational History

- GED
- High School Diploma
- Master Degree
- College
- Technical/Trade Scho

Physchological History

- Currently in Treatment
- Previous Treatment
- On Medication

Diagnosis:_____

Family History

- Suicide
- Mental Illness
- Alcoholism
- Medication/Drug Abuse
- Cancer
- Heart Disease
- Hypertension
- Depression
- Diabetes
- Other _____

Additional Medical/Surgery History:

_____

_____

_____

Clinical Notes: _____

_____

_____

Date _____

Patient Name _____

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
TOTAL		**[ ]**		

Total Score Risk Category Low Risk 0 – 3 Moderate Risk 4 – 7 High Risk $\geq$ 8