



ADC Pain Institute of South Fl, Inc
A. D. Carlson, MD, P.A.

Intake History

1. Please list the previous medical professionals you have seen, including but not limited to physicians, chiropractors, and acupuncturists for the medical conditions you are experiencing today.

Physician's Name	Specialty	Last Visit	Treatments

2. Please indicate which diagnostic tests you have had to evaluate the medical conditions you are experiencing today.

Regular X-Ray	Date	C.T. Scan	Date	MRI	Date
Bone Scan	_____	Arthrogram	_____	Sleep Study	_____
Myelogram	_____	EMG/NCV/SSEP	_____	Other	_____

3. Please indicate which treatments you have had for the medical conditions you are experiencing today.

	YES	NO	Sessions	How helpful? (1 thru 10)
Physical Therapy	_____	_____	_____	_____
Electrical Stimulation	_____	_____	_____	_____
Hot/Cold Packs	_____	_____	_____	_____
Ultrasound	_____	_____	_____	_____
Massage	_____	_____	_____	_____
Manipulations	_____	_____	_____	_____
Aquatics/Whirlpool	_____	_____	_____	_____
Home Exercises	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____
Injections: Joint/Epidural	_____	_____	_____	_____
Implantable Devices	_____	_____	_____	_____
Other : _____	_____	_____	_____	_____
Other : _____	_____	_____	_____	_____

ADC Pain Institute of So. FL

A.D. Carlson, M.D., P.A.

Patient Registration

How did you hear about us? _____

Please fill out the following information to the best of your knowledge

Contact Information

Patient Name: _____ Gender: M__ F__ Date: ___/___/___

Date of Birth: ___/___/___ Social Security Number: _____ - _____ - _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Number: _____ Cell: _____

Email: _____ Fax: _____

Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Closest Relative: _____ Phone: _____

Medical Information

Current Medications: _____

Surgical History: _____

Allergies: _____

Primary Physician: _____ Phone: _____

Physician's Address: _____

Physician's Fax: _____ Date of Last Physical: ___/___/___

Pharmacy Name: _____ Phone: _____

Insurance Information

Company Name: _____ Plan Number: _____

Group Name: _____ Phone: _____

I affirm, by signing this Patient Registration Form, all information I have given above is true and correct to the best of my knowledge.

Patient's Signature: _____



Female Specific Conditions

	Yes	No	
Hysterectomy	___	___	Date: _____
Abnormal Vaginal Bleeding	___	___	
Last Menstrual Period			Date: _____
Endometriosis	___	___	
Nipple Discharge	___	___	
History of Breast Biopsy	___	___	
Last Pelvic Exam			Date: _____

Male Specific Conditions

Prostatitis	___	___	
Difficulty in Urinating	___	___	
Rectal Test	___	___	Date: _____
PSA Test	___	___	Date: _____

6. Please answer the following questions regarding your personal history.

Occupation : _____ Full ___ Part ___ Time

If retired or unemployed what was your last occupation? _____

Do you receive any disability benefits? _____

Daily physical activities : None ___ Light ___ Mild ___ Medium ___ Heavy ___

Do you use tobacco? ___ Indicate Type and Quantity (daily) : _____

Do you use alcohol? ___ Indicate Type and Quantity (daily) : _____

Have you ever been treated for substance :

Abuse _____ if so when? _____

Addiction _____ if so when? _____

Dependency _____ if so when? _____

7. Please answer the following questions regarding your family history.

Describe the current health, any major illness or cause of death of your family member:

Father : _____

Mother: _____

Siblings: _____

The preceding information has been reviewed and discussed with my patient.

 Patient's Signature

 Physician's Signature



Authorization For Release of Protected Health Information (PHI)
Under Health Insurance Portability and Accountability Act of 1996 (HIPAA) and
Drug Abuse Records, 42 CFR.

- I.** The undersigned patient, named below, hereby executes this authorization in compliance with the Federal Health Insurance Portability and Accountability Act, HIPAA, 45 CFR 164.104.
- II.** The undersigned patient, named below, hereby executes this information in compliance with the Federal regulations governing Confidentiality and Drug Abuse Records, 42 CFR, Part 2.
- III.** This authorization is directed to the following healthcare provider(s) (including its agents, employees and associates):

1.
2.
3.

- IV.** The above named healthcare provider is requested to release the protected health information (PHI) that is described below, to the patient's pain management doctor:

- V.** **ADC Pain Institute of South Fl, Inc**
A. D. Carlson, MD, P.A.

Boca Raton Professional Building 900 NW 13 Street, Ste.# 302 Boca Raton, FL 33486	Telephone: 561-362-2969 Facsimile: Fax: 561-362-2970
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- VI.** The protected health information of any nature whatsoever, from any source whatsoever, which is maintained by you in your records regarding the referenced patient and which is requested by **A. D. Carlson, MD, P.A.** If you are a physician or out-patient clinic, you are authorized to send your entire chart upon our request, including not only dictated or handwritten notes, but outside medical records or correspondence maintained in my chart. If you are a hospital or medical clinic, you are authorized to release my complete records including x-rays, MRI or related studies, office notes, face-sheets, discharge summaries, history and physical, consultation notes, intra-operative records, operative reports, pathology reports, medication administration records, therapy notes, physician orders, progress notes, laboratory notes, intake/output records, reports of all x-rays, CT scans, MRI's or PET scans, emergency room records, transfer records, operative reports, anesthesia records, admitting summary discharge summary, clinic records, pharmacy and drug records, concerning any medical treatment I have received from you, at your institution. I hereby authorize release of all records to include mental health, chemical dependency and any Federal and State protected information under Florida Statute 394.459(9) (Psychiatric Information), Florida Statutes 397.053 and 396.112 (Drug and/or Alcohol Abuse Information) and Florida Statute 381.609(2) (Human Immunodeficiency Virus, Acquired Immunodeficiency Syndrome or tests for sexually transmitted diseases.