



**Stacy John Berckes, M.D.**

Diplomate, American Board of Anesthesiology  
Board Certified in Pain Management  
Board Certified in Pain Medicine

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11 Waterman Avenue  
Mt. Dora, Florida 32757

We would like to thank you for your inquiry about the services we provide here at Florida Pain Management Center.

Enclosed you will find a medical questionnaire, registration form and authorization sheet you need to complete and return to us as soon as possible. If you have any medical records pertaining to your condition please send us copies of those records (do not send us the originals as they will not be returned). If you do not have copies please provide us with the name and phone number so we can request records from your physician or the facility where testing was done. It is important for Dr. Berckes to see the X-Ray reports, MRI reports or any other reports regarding your condition.

As soon as we receive your completed paper work Dr. Berckes will review it. Please note the completion of the forms does not guarantee an appointment if Dr. Berckes determines he can't be of any help to your condition at this moment.

We know pain can be a debilitating condition and we are here to help you. We will expedite your visit with Dr. Berckes as much as we can. Please don't hesitate to contact us if you have any questions or need additional information.

Sincerely,

Florida Pain Management Center

## ACKNOWLEDGEMENT

I, the undersigned, understand that submission of this information to Florida Pain Management Center and Dr. Berckes in no way guarantees that I will be given an appointment for evaluation and/or treatment.

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

THE FLORIDA PAIN MANAGEMENT CENTER - STACY JOHN BERCKES, M.D.  
PATIENT REGISTRATION FORM

Date \_\_\_\_\_ SS# \_\_\_\_\_ Drivers License # and State \_\_\_\_\_  
First Name \_\_\_\_\_ Last Name: \_\_\_\_\_ Sex F  M   
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
DOB \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Marital Status: M  S  D  W  Spouse's name: \_\_\_\_\_  
Email: \_\_\_\_\_ May we contact you via email? Yes  No   
OTHER HOME ADDRESS IF NOT FULL TIME FLORIDA RESIDENT AND DIFFERENT FROM ABOVE:  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
NEAREST RELATIVE NOT LIVING WITH YOU : Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
PRIMARY /FAMILY PHYSICIAN: Name: \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
REFERRING PHYSICIAN : Physician's Name \_\_\_\_\_  
Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

EMPLOYER'S INFORMATION: Retired Yes  No  If no, Employer's Name: \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

**If this injury regarding Auto Accident, Personal Injury or Worker's Compensation, please complete additional information on back of this page.**

PRIMARY INSURANCE INFORMATION: Insurance Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Sex F  M  DOB \_\_\_\_\_ Insured's relation to patient: \_\_\_\_\_  
Policy # \_\_\_\_\_ Group Name/# \_\_\_\_\_ Group ID# \_\_\_\_\_

SECONDARY INSURANCE INFORMATION: Insurance Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Sex F  M  DOB \_\_\_\_\_ Insured's relation to patient: \_\_\_\_\_  
Policy # \_\_\_\_\_ Group Name/# \_\_\_\_\_ Group ID# \_\_\_\_\_  
Medigap  or Employer Supplemental

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

**Please complete and return to The Florida Pain Management Center**

Only complete this section if your injury is due to Auto, Personal Injury or Worker's Compensation accident:

**WORKER'S COMPENSATION:**

Claim/ID# \_\_\_\_\_ Date of Injury \_\_\_\_\_

Name of Employer through which this claim was filed \_\_\_\_\_

Insurance Company:

Name: \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_

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

Dr. of Record \_\_\_\_\_ Tel (\_\_\_\_\_) \_\_\_\_\_

Case Worker's Name \_\_\_\_\_ Tel (\_\_\_\_\_) \_\_\_\_\_

**AUTO ACCIDENT / PERSONAL INJURY**

Date of Injury \_\_\_\_\_ State where accident occurred \_\_\_\_\_ Adjustor's name: \_\_\_\_\_

Insurance Co \_\_\_\_\_ Tel (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Insured's Name \_\_\_\_\_ Policy/ID# \_\_\_\_\_

Attorney: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_

Complete address: \_\_\_\_\_

**AUTHORIZATION TO OBTAIN / RELEASE OR USE INFORMATION FOR TREATMENT,  
PAYMENT, OR HEALTH CARE OPERATIONS**

I hereby authorize the release or use of my individually identifiable health information (“protected health information”) and medical record information by Florida Pain Management Center in order to carry out treatment, payment, or healthcare operations. **I also hereby authorize FPMC to request all medical “Protected Health Information” in order to carry out medical treatment.** I have been informed of the “Notice of Privacy Practices” for a more complete description of the potential release and use of such information. I have also been informed I have the right to review such Notice prior to signing this Consent Form.

FPMC reserves the right to change the terms of its Notice of Privacy Practices at any time. If changes to the terms of its Notice of Privacy Practices are made, I may obtain a copy of the revised Notice. I retain the right to request FPMC to further restrict how my protected health information is released or used to carry out treatment, payment or health care operations. FPMC is not required to agree to such requested restrictions; however, if they do agree to my requested restrictions(s), such restrictions are then binding on FPMC. **I acknowledge and agree that the FPMC may disclose my protected health information and medical record information to the following individuals who are my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:**

Name of individuals authorized to received my health protected information:  <hr/>
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I agree that Florida Pain Management Center may also disclose the following types of information contained in my medical record (please initial the appropriate categories listed below):

- |  |  |
|--|--|
| <input type="checkbox"/> HIV/AIDS Information        | <input type="checkbox"/> Sexually Transmitted Disease Information                            |
| <input type="checkbox"/> Mental Health Information   | <input type="checkbox"/> If Patient is under the age of eighteen (18), Pregnancy Information |
| <input type="checkbox"/> Substance Abuse Information |  |

Florida Pain Management Center may refuse to treat if I (or any authorized representative) do not sign this Consent Form. If I (or authorized representative) sign this Consent and then revoke it, FPMC has the right to refuse to provide further treatment to me as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

**I have read and understand the information in this consent. I have received a copy of this consent, (if requested) and I am the patient (or the authorized party to act on the behalf of the patient to sign this document) verifying consent to the above terms.**

_____ Signature of Patient or authorized representative	_____ Please Print Name
Date: _____	DOB: ____/____/____ SS# _____

\*Please explain Representative's relationship to the Patient and include a description of Representative's authority to act on behalf of the patient:

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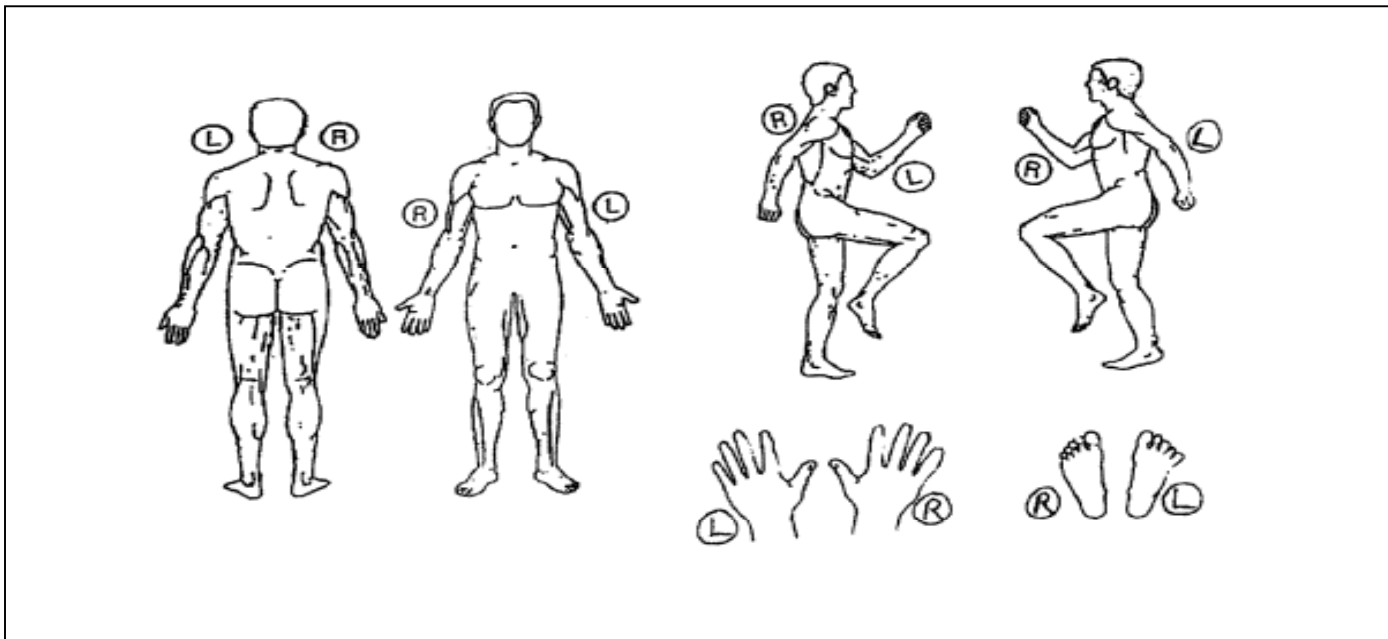
**Please complete, sign and return to The Florida Pain Management Center**

The Florida Pain Management Center  
MEDICAL QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Who is your primary physician? \_\_\_\_\_ Who referred you to this office? \_\_\_\_\_

1. What is your age? \_\_\_\_\_ 2. Where is your pain located? On the diagrams below, please shade in the areas where your pain is located. Is your pain  Left  Right  both sided? \_\_\_\_\_



2. How long have you had this pain? \_\_\_\_\_

3. Do you know what caused your pain? Please explain: \_\_\_\_\_

5. What makes your pain better?  Rest  Medication  Others: \_\_\_\_\_

6. What makes your pain worse?  Activity  Weight Bearing  Others: \_\_\_\_\_

7. What time of day is your pain the worst?  Morning  Afternoon  Evening  Nighttime

8. Has your pain changed your ability to do activities of daily living, your work, or your sleep patterns?  
Please explain: \_\_\_\_\_

9. Please check any treatments you have had in the past for this pain.  
 Physical Therapy  Massage  Chiropractor  Injections \_\_\_\_\_

Others: \_\_\_\_\_

Did you receive any pain relief from the above treatment?  Yes  No

10. Rate your pain by circling the number that best describes your pain at its worst in the last month.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain you can imagine

11. Rate your pain by circling the number that best describes your pain at its least in the last month.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain you can imagine

12. Rate your pain by circling the number that best describes your pain right now.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain you can imagine

13. Please circle the appropriate words that best describe your pain.

- aching       shooting       dull       constant       annoying       sharp
- radiating       cramping       hot       heavy       brief       tight
- intense       severe       sore       stinging       tingling       excruciating
- transient       unbearable       cold       burning       numbing       stabbing

14. Please check any of the following health problems you have been diagnosed with:

- Alcoholism       Emphysema/COPD       Migraine Headaches
- Anemia       Epilepsy/Seizures       Osteoporosis
- Arthritis       Glaucoma       Pacemaker
- Asthma       Gout       Pneumonia
- Bleeding Disorder       Hepatitis       Prostate Problem
- Blood Clots       HIV/AIDS       Shingles
- Cancer of \_\_\_\_\_       High Cholesterol       Stroke
- Cataracts       Irregular Heart Beat       Suicide Attempt
- Chemical Dependency       Kidney Stones       Tuberculosis
- Depression       Gastric Reflux Disease       Thyroid Disease
- Diabetes       Hypertension       Vascular Disease
- Coronary Artery Disease       Parkinson's
- Other: \_\_\_\_\_

15. Please list all surgeries you have had, approximate dates, and surgeons name:

Surgery	Date	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

16. Please list all current medications you are taking for reasons other than pain. Include any over the counter, or herbal/natural

Medication	Reason Taking	How Often	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you take Aspirin?  No  Yes. How many? \_\_\_\_\_ strength: \_\_\_\_\_

17. Are you currently taking a "blood thinner"  Plavix  Coumadin  Ticlid,  Heparin  
 No  Yes, How much per day? \_\_\_\_\_

18. Please list all current medications you take for pain:

Medication	How Often	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

19. Please list any medications you have taken for pain in the past, and reason you stopped taking them:

Medication	How often	Reason Stopped	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

20. Do you have any drug allergies?  Yes  No If yes, please give name of drug and type of reaction you experienced.

\_\_\_\_\_

\_\_\_\_\_

21. Marital status?  Married  Divorced  Widowed  Single  separated

22. Do you live alone  Yes  No Do you have children  Yes  No Relatives near by  Yes  No

23. Do you drive?  Yes  No If yes  Automatic transmission  Manual transmission

24. Present work status:  Full time  Part time  Not working  on disability  retired

25. What is or was your usual occupation? \_\_\_\_\_

26. Do you smoke tobacco?  Yes  No If yes, how much? \_\_\_\_\_ How long? \_\_\_\_\_  
If no, have you ever smoked tobacco?  Yes  No How much? How long? \_\_\_\_\_ Year Quit: \_\_\_\_\_

27. Do you consume alcoholic beverages?  Daily  occasionally  rarely  never

28. Has any family member or relative had a chronic pain problem?  Yes  No

If yes, please specify whom and the type of pain problem: \_\_\_\_\_  
\_\_\_\_\_. Is this person living or deceased?  Living  Deceased

29. Please check any of the following that you are currently experiencing:

- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Hearing Disorder    | <input type="checkbox"/> Fatigue              |
| <input type="checkbox"/> Chest Pain/ Pressure | <input type="checkbox"/> Bruise Easily     | <input type="checkbox"/> Bleed Easily        | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> General weakness     |
| <input type="checkbox"/> Palpitations         | <input type="checkbox"/> Urinary Frequency | <input type="checkbox"/> Urinary Difficulty  | <input type="checkbox"/> Too Hot             | <input type="checkbox"/> Menstrual Difficulty |
| <input type="checkbox"/> Sexual Dysfunction   | <input type="checkbox"/> Too Cold          | <input type="checkbox"/> Loss of Appetite    | <input type="checkbox"/> Swelling            | <input type="checkbox"/> Fainting             |
| <input type="checkbox"/> Black outs           | <input type="checkbox"/> Nausea            | <input type="checkbox"/> Vomiting            | <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Constipation         |
| <input type="checkbox"/> Rash                 | <input type="checkbox"/> Always Thirsty    | <input type="checkbox"/> Joint Pain          | <input type="checkbox"/> Itching             | <input type="checkbox"/> Weight changes       |
| <input type="checkbox"/> Fever                | <input type="checkbox"/> Infection         | <input type="checkbox"/> Other: _____        |  |   |

30. Do you have any problems controlling your bladder?  Yes  No  
Do you have any problems controlling your bowel?  Yes  No If yes, please explain: \_\_\_\_\_

31. Do you have any tingling or numbness in your hands?  Yes  No In your feet?  Yes  No

32. Do you need assistance such as a wheelchair, walker, or cane to get around?  Yes  No  
If yes, which do you use? \_\_\_\_\_

33. Please indicate any diagnostic procedures (tests) you have had, and the approximate date and location where the test was performed:

- |                        |                              |             |                 |
|------------------------|------------------------------|-------------|-----------------|
| X-ray                  | <input type="checkbox"/> Yes | Date: _____ | Location: _____ |
| EMG                    | <input type="checkbox"/> Yes | Date: _____ | Location: _____ |
| C T Scan               | <input type="checkbox"/> Yes | Date: _____ | Location: _____ |
| MRI or NMR Scan        | <input type="checkbox"/> Yes | Date: _____ | Location: _____ |
| Myelogram              | <input type="checkbox"/> Yes | Date: _____ | Location: _____ |
| Nerve Conduction Study | <input type="checkbox"/> Yes | Date: _____ | Location: _____ |

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature if other than patient \_\_\_\_\_ Relationship to patient \_\_\_\_\_