

ST. JOHN-CLARK

PAIN TREATMENT CENTER

13700 58th St N Suite 205 Clearwater, FL 33760
727-347-HEAL (4325)

Welcome to the St. John - Clark Pain Treatment Center!

By coming here you have decided to take an active role in maintaining your most important asset - Your Health! Our staff includes some of the most respected and highly trained therapists in the world who are dedicated to help you attain a pain-free and healthy life. It is our pleasure to serve you.

“The doctor of the future will give no medicine, but will interest his patients in the care of the human body, in diet, and in the cause and prevention of disease.”

Thomas Edison

Initial Appointment Date _____

Last Name _____ First Name _____

Address _____

City _____ State _____ Zip _____ Country _____

Home Phone (____) _____ Work (____) _____ Cell (____) _____

E-mail (office use only) _____ Fax (____) _____

Local Contact Information (if different) _____

Occupation _____

Date of Birth _____ Height _____ Weight _____ Sex _____

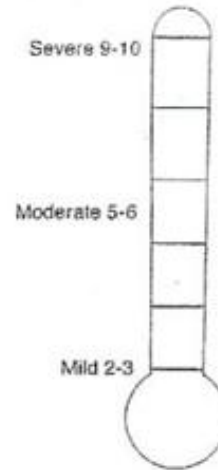
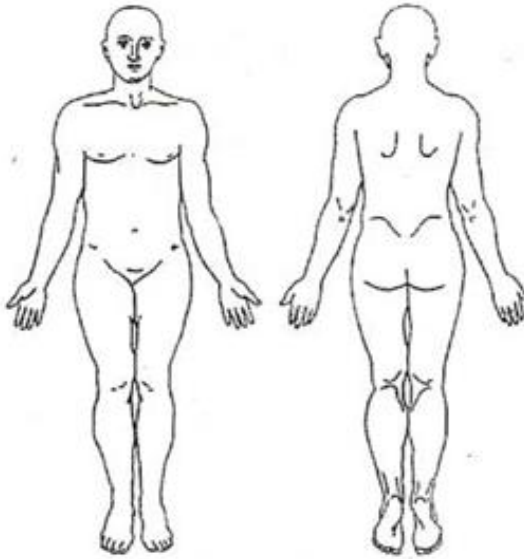
Marital Status: Single Married Divorced Separated Widow(er)

Spouse's Name (if applicable) _____

Spouse's Occupation _____

How did you find out about us? _____

Where exactly is the problem? Mark the figure below to specify.
Rate the recent level of pain by shading in the thermometer below.
Has it been getting better or worse? (Circle one)



Have you ever been treated for the same condition?

Were you admitted to the hospital?

Describe how it feels: (aching, cramping, dull, sore, deep, sharp, shooting, stabbing, stinging, tingling, burning, numbness, radiating - if so where?)

How did it start the first time and this time, if this is not the first? (Sudden or gradual onset and mechanism of injury)

How often does it bother you? (Constant all the time, everyday, __x per week __x per month)

How long does it last once it is there? (Always there, ___ minutes/hours, no pattern)

What specifically makes it worse? (Certain movements/activities, stress, time of day, no pattern)

What makes it feel better? (Certain movements/activities, heat/ice, time of day, therapies, nothing)

Do you have a diagnosis from a Doctor? If, yes list it and name of the doctor.

Other therapies/remedies tried and results:

Have you ever had any surgeries and were they beneficial at the time?

List any other health problems for which you are being treated:

Do you have any pre-existing conditions that relate to this present injury? YES NO

If yes, please explain:

Current Medications:

Activities of Daily Living

In this section, the idea is to get a sense of what type and to what *intensity* and *frequency* of activities/movements, postures/positions, and exercise you get a regular basis.

Job/Work Duties:

Household Duties:

Regular Activities/Hobbies:

Exercise:

Sleeping Position:

Other:

What do you believe caused or is causing this condition?

Do you believe it is possible to heal 100%? If not, what %?

How long do you feel it will take?

On a scale of 0-10, how much effort are you willing to put in to achieve maximum healing? 1 2 3 4 5 6 7 8 9 10

Circle the level of stress you are experiencing on a regular basis on a scale of 1 to 10

(1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Medical History

- Arthritis
- Allergies/hayfever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune Disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal Tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental Problems
- Depression
- Diabetes
- Diverticular Disease
- Drug addiction
- Eating Disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic Disease
- Glaucoma
- Gout
- Heart Disease
- Infection, chronic
- Inflammatory Bowel Disease
- Irritable Bowel Syndrome
- Kidney or Bladder Disease
- Learning Disabilities
- Liver or gallbladder disease (stones)
- Mental Illness
- Migraine Headaches
- Neurological problems (paralysis, Parkinson's)
- Sinus Problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually Transmitted Disease
- Seasonal Affective Disorder
- Skin Problems
- Tuberculosis
- Ulcer
- Urinary Tract Infection
- Varicose Veins
- Other ____

Medical (Men)

- BPH
- Prostate Cancer
- Decreased sex drive
- Infertility
- STD
- Other ____

Medical (Women)

- Menstrual Irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- PMS
- Breast Cancer
- Pelvic Inflammatory Disease
- Vaginal Infections
- Decreased Sex Drive
- STD
- Other ____
- Age of first period: __
- Date of last gynecological exam
- Mammogram + -
- PAP + -
- Form of Birth Control __
- # of Children .
- # of Pregnancies _
- C-Section
- Surgical Menopause
- Menopause
- Date of last menstrual cycle __
- Length of Cycle: _____Days
- Interval of time between cycles: _____Days
- Any recent changes in normal menstrual flow (e.g. heavier, large clots) __

Family Health History (Parents and Siblings)

- Arthritis, rheumatoid
- Asthma
- Alcoholism
- Alzheimer's Disease
- Cancer
- Depression
- Diabetes
- Drug Addiction
- Eating Disorder
- Genetic Disorder
- Glaucoma
- Heart Disease
- Infertility
- Learning Disabilities
- Mental Illness
- Mental Retardation
- Migraine Headaches
- Neurological Disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide

Other: ____

Health Habits

- Tobacco
- Cigarettes # / day _
- Cigars #/day .
- Alcohol
- Wine: # glasses/ d or wk __
- Beer: # glasses/ d or wk __
- Liquor: # ounces/ d or wk __
- Caffeine
- Coffee: # 6 oz cups/ d _
- Tea: # 6 oz cups/ d __
- Soda w. Caffeine: # cans/ d _
- Other Sources ____
- Water: # glasses/ d .
- Exercise**
- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per work out
- 30-45 minutes duration per workout
- Less than 30 min
- Walk
- Run, Jog, Jump Rope
- Weight Lift
- Swim
- Box
- Yoga

Nutrition and Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt Restriction
- Fat Restriction
- Starch/Carbohydrate Restriction
- The Zone Diet
- Total Calorie Restriction
- Specific Food Restrictions
- Dairy Wheat
- Eggs Soy
- Corn Oil Gluten
- Other: __

Food Frequency

- Servings per day:
- Fruits (citrus, melons etc.) __
- Dark green or deep yellow/orange vegetables .
- Grains (unprocessed) __
- Beans, Peas, Legumes _
- Dairy/ Eggs .
- Meat, Poultry, Fish ____

Eating Habits

- Skip Breakfast
- Two meals/day
- One meal/day
- Graze (small freq. meals)
- Food Rotation
- Eat constantly whether hungry or not
- Generally eat on the run
- Add salt to food

Current Supplements

- Multivitamins
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/ GIA
- Calcium, source ____
- Magnesium
- Zinc
- Minerals, describe __
- Friendly Flora (acidophilus)
- Digestive Enzymes
- Amino Acids
- CoQ10
- Antioxidants (e.g. lutein, resveratrol, etc.)
- Herbs (teas)
- Herbs-extracts
- Chinese Herbs
- Ayurvedic herbs
- Homeopathy
- Bach Flowers
- Protein Shakes
- Superfoods (e.g. bee pollen, phylonutrient blends)
- Liquid Meals (e.g. Ensure)
- Other: ____

Would you like to:

- Have more energy
- Be stronger
- Have more endurance
- Increase your sex drive
- Be thinner
- Be more muscular
- Improve you complexion
- Have stronger nails
- Have healthier nails
- Be less moody
- Be less depressed
- Be less indecisive
- Feel more motivated
- Be more organized
- Think more clearly and be more focused
- Improve memory
- Do better on tests in school
- Not be dependent on over-the-counter medications like aspirin, Tylenol Benadryl, Sleeping Aids
- Stop using laxatives or stool softeners
- Be free of pain
- Sleep better
- Have agreeable breath
- Have agreeable body odor
- Have stronger teeth
- Get less colds/ flus
- Get rid of your allergies
- Reduce your risk of inherited disease tendencies (e.g cancer, heart disease, diabetes, etc.)

Release and Indemnification

I hereby authorize the St. John-Clark Pain Treatment Center to provide any and all information, copies or records to any clinic, physician, lawyer, insurance company, or workman's compensation fund as deemed necessary. A copy of this authorization shall be considered as valid as the original.

I hereby authorize any physician to release any and all information, copies of all records to St. John-Clark Pain Treatment Center as deemed necessary for treatment. A copy of this authorization shall be considered as valid as the original.

I give permission that photographs and video footage may be taken of me or my X-rays, CAT, or MRI scans during the course of treatment at the St. John-Clark Pain Treatment Center. These photographs are strictly to be used for education for other healthcare practitioners and will not be displayed anywhere else without my written permission.

Printed Name _____ Date _____

Signature _____

(Guardian if under 18) _____

24 Hour Cancellation Policy

I, _____, understand there is a 24 hour cancellation policy for appointments scheduled for less than 2 hours. When an appointment is scheduled for 2 hours or longer on the same day, a 48 hour cancellation policy is in effect. Cancellation of a scheduled appointment must be made by calling or e-mailing the St. John ó Clark Pain Treatment Center.

Failure to cancel without the minimum notice will result in the full charge for the cancelled/missed appointment. Cancellation for Mondays and the day after holidays must be made on the prior business day during normal business hours.

Payment for the entire amount of the scheduled appointment will be expected regardless of the patients' arrival time.

Insurance patients who fail to comply with this policy understand that since insurance companies will not honor claims of this nature, it is the patient's responsibility to pay for canceled/missed appointments.

Signature

Print Name

Date

St. John-Clark Pain Treatment Center

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Clearwater, FL 33760
727-347-4325



From Northern County: Clearwater, Palm Harbor

US Highway 19 South to Ulmerton Rd

Turn left at Ulmerton Rd. Take Ulmerton to 58th St and take a left on to 58th St.

Take 58th St. and take a left onto Commerce Court. Building 2 is the first parking lot on the left, and the clinic is suite 205 on the south side of the building.

Or:

McMullen Booth Road to Bayside Bridge. Continue south on 49th Street to Ulmerton Rd

Turn right onto Ulmerton Rd, turn right at 58th St and make a left on Commerce Court and take a left. Building 2 is the first parking lot on the left, the clinic is suite 205 on south side of the building.

From Tampa/Tampa International Airport:

I 275 S to Ulmerton Rd exit. Take Ulmerton Rd West to 58th St N. Turn right at 58th St then make a left on Commerce Court and take a left. Building 2 is the first parking lot on the left, the clinic is suite 205 on south side of the building.

Gandy Bridge: Continue west on Gandy Blvd, becomes Park Blvd in Pinellas County. Continue west on Park Blvd to 49th St. Turn right onto 49th St and head north to Ulmerton Road. Turn left onto Ulmerton Road. Continue to 58th St and turn right. Make a left on Commerce Court and take a left. Building 2 is the first parking lot on the left, the clinic is suite 205 on the south side of the building.

From South County and Points South:

I 75 N to I 275 N (over Sunshine Skyway Bridge)

Continue north on I 275 to Roosevelt Blvd. Take Roosevelt West to Ulmerton Rd.

Take Ulmerton Rd West to 58th St N. Turn right at 58th St then make a left on Commerce Court and take a left. Building 2 is the first parking lot on the left, the clinic is suite 205 on the south side of the building.