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New Patient Questionnaire:

Patient Name: _____ Date of Birth: _____ Age: _____

Home Phone: _____ Cell Phone: _____ Wk Phone: _____

Occupation: _____ Employer: _____

Education Level: _____ Retired: Yes / No If yes, date:_____

Marital Status: _____ Children: Son(s) ____ Daughter(s) ____

Referring Physician: _____ Phone #: _____

Other Treating Physicians: _____

Emergency Contact: _____ Rel: _____ Phone: _____

***Optional - Do not have to answer**

*Race:_____ *Ethnicity:_____ *Preferred Language:_____

If your pain is the result of Accident/Fall/Injury, please fill out the following 3 questions:

1) How and when did you hurt yourself?

_____
_____

2) Who first treated you and where?

_____
_____

3) Who has treated you and what has been done since the injury occurred?

_____
_____

Are you currently working? Yes / No (circle one) If no, last date worked? _____
Job Duties:

_____
_____

Social History:

Tobacco Use: Yes / No (circle one)
Type: _____ per day:_____
Years smoked: _____ Year quit:_____

Alcohol Use: Yes / No (circle one)
How many drinks: _____ Type:_____
How often: _____

Illicit Drug Use: Yes / No (circle one)
Type of drugs: _____
How often: _____

Exercise Level: Yes / No (circle one)
What type: _____
How often: _____

Past Medical History: (circle all that apply)

AIDS/HIV	DIABETES TYPE I	HYPERTHYROIDISM
ALCOHOLISM	DIABETES TYPE II	HYPOTHYROIDISM
ALZHEIMERS	DIVERTICULITIS	IRREG. MENSES
ANEMIA	DIZZY/FAINTING	KIDNEY DISEASE
ARTHRITIS	DRUG ABUSE	KIDNEY STONES
ASTHMA	ERECTILE DYSF.	LEUKEMIA
BLEEDING PROBLEMS	FIBROMYALGIA	LUNG CANCER
BLOOD CLOTS	GLAUCOMA	LUNG PROBLEMS
BREAST CANCER	GOUT	OSTEOARTHRITIS
CANCER: _____	HEART ATTACK	PNEUMONIA VACCINE (65 and older)
CERVICAL CANCER	HEART DISEASE	PREGNANCY
COLON CANCER	HEPATITIS __A__B__C	PROSTATE PROBLEMS
CONSTIPATION	HIGH BLOOD PRES.	SEIZURE
COPD	HYPOGLYCEMIA	TUBERCULOSIS
DEPRESSION	HYPERGLYCEMIA	ULCERS

MAMMOGRAM (40 and older) ___ Yes ____ No Date:_____
PNEUMOCOCCAL VACCINE DATE:_____ OTHER: _____

Review of Systems: Do you have any of the following? (circle all that apply)

CHEST PAIN EASY BRUISING SHORTNESS OF BREATH

ABDOMINAL PAIN ANKLE SWELLING COUGH HEADACHES

PROBLEMS WITH BOWEL MOVEMENTS PROBLEMS WITH URINATION

ANY OTHER CONCERNS:

_____

_____

Previous Pain Management: (circle all that apply)

ACCUPUNCTURE
CHIROPRACTOR
DISCOGRAM
EPIDURAL
FACET INJECTION
HEAT TREATMENT
ICE TREATMENT
IDET/NUCLEOPLASTY
MASSAGE THERAPY
OCCIPITAL NERVE BLOCK
PHYSICAL THERAPY
PUMP TRIAL
RFTC (RADIOFREQUENCY)
SCS TRIAL
SCS IMPLANT
SYMPATHETIC BLOCK
TENS UNIT
TRIGGER POINT
OTHER: _____
_____

Family History: Circle **(M)** for **M**other and **(F)** for **F**ather

Mother: Living / Deceased Age: ____ Father: Living / Deceased Age: ____

M / F - AIDS/HIV
M / F - ALCOHOLISM
M / F - ALZHEIMERS
M / F - ANEMIA
M / F - ARTHRITIS
M / F - ASTHMA
M / F - CA BREAST
M / F - CA BONE
M / F - CA CERVICAL
M / F - CA COLON
M / F - CA LIVER
M / F - CA LUNG
M / F - CA OVARIAN
M / F - CA PROSTATE
M / F - CA UTERINE
M / F - COLITIS
M / F - DEPRESSION
M / F – DIABETES (**Please Circle: TYPE I / TYPE II**)
M / F - DRUG ABUSE
M / F - GOUT
M / F - HEART DISEASE
M / F - HODGKIN'S DISEASE
M / F - HYPERTENSION
M / F - KIDNEY DISEASE
M / F - LIVER DISEASE
M / F - MIGRAINES
M / F - MUSCLE DISEASE
M / F - OBESITY
M / F - OSTEOPOROSIS
M / F - OSTEOARTHRITIS
M / F - PARKINSON'S
M / F - SEIZURES
M / F - ULCERS

Surgical History: (MUST include date, Surgeons full name, R or L side, Facility where performed)

_____

_____

_____

_____

Are you allergic to any medications? (What reaction did you experience?)

_____

_____

All Medications: **Dosage (mg):** **Directions:**

_____

_____

_____

_____

_____

_____

_____

_____

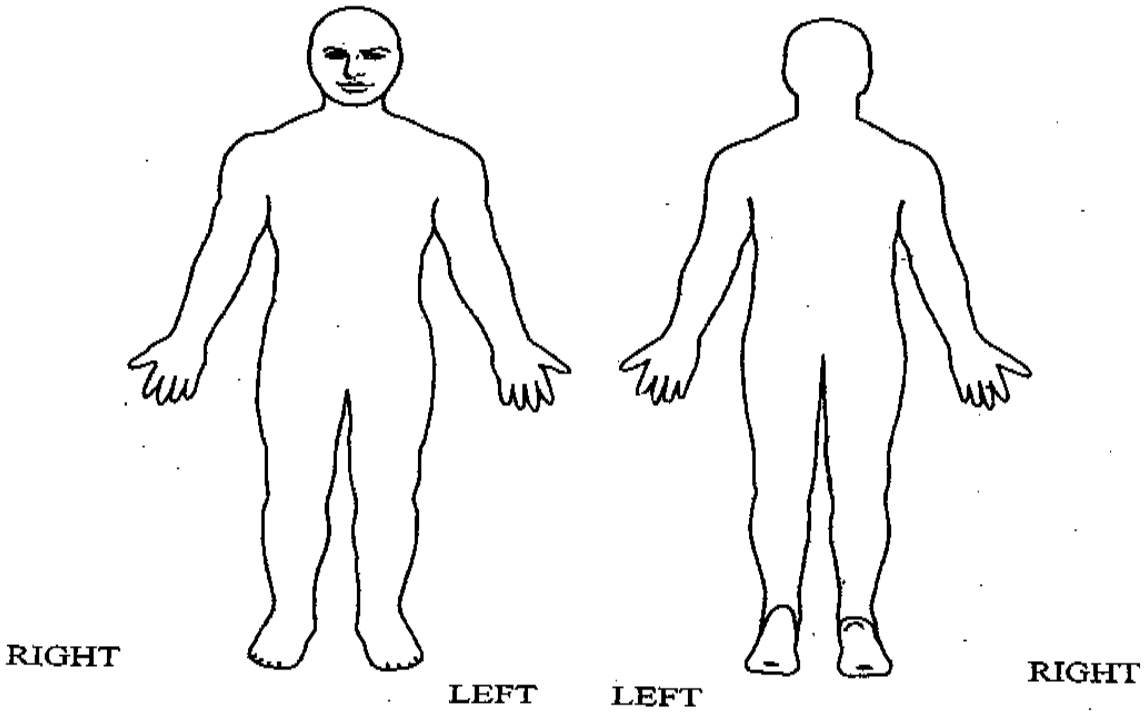
_____

Name of Pharmacy: _____ **Phone:** _____

Pharmacy Address: _____

Pain History:

Where is your pain located? (indicate on illustration)
Which area gives you the most pain? _____
Which side is worse? _____



Pain Location: (If you have **1** pain location, use section 1. If you have **3** pain locations use sections 1-3).

1. Site of Pain: _____ Increased / Decreased / Unchanged (circle one)

Pain Level Today: (least) 0 1 2 3 4 5 6 7 8 9 10 (worst)

How would you describe your pain: (circle all that apply)

Aching	Dizziness	Numb	Spasm	Throbbing
Burning	Dull	Sharp	Tightness	Weakness
Coldness	Hot	Shooting	Tingling	

2. Site of Pain: _____ Increased / Decreased / Unchanged (circle one)

Pain Level Today: (least) 0 1 2 3 4 5 6 7 8 9 10 (worst)

How would you describe your pain: (circle all that apply)

Aching	Dizziness	Numb	Spasm	Throbbing
Burning	Dull	Sharp	Tightness	Weakness
Coldness	Hot	Shooting	Tingling	

3. Site of Pain: _____ Increased / Decreased / Unchanged (circle one)

Pain Level Today: (least) 0 1 2 3 4 5 6 7 8 9 10 (worst)

How would you describe your pain: (circle all that apply)

Aching	Dizziness	Numb	Spasm	Throbbing
Burning	Dull	Sharp	Tightness	Weakness
Coldness	Hot	Shooting	Tingling	

4. Site of Pain: _____ Increased / Decreased / Unchanged (circle one)

Pain Level Today: (least) 0 1 2 3 4 5 6 7 8 9 10 (worst)

How would you describe your pain: (circle all that apply)

Aching	Dizziness	Numb	Spasm	Throbbing
Burning	Dull	Sharp	Tightness	Weakness
Coldness	Hot	Shooting	Tingling	

Does your pain radiate to different parts of your body? Yes / No (example: from low back into the leg)

If Yes, where? _____

Pain Frequency: (circle one) Constant Intermittent Occasional

Pain is aggravated by: (circle all that apply)

Bending Driving Lying Down Overhead Activity

Sitting Standing Walking Working Other: _____

Pain is alleviated by: (example: heat, ice, meds, massage, nothing)

_____

Daily Activities are limited by what percent: _____% (In increments of 10)

Do you have difficulty sleeping? Yes / No (circle one)

Are you depressed? Yes / No (circle one)

Goals: (circle all that apply)

Decrease medications Decrease pain Increase physical activities

Return to sports Return to work Return to school

Is there anything else you would like the doctor to know?

_____

_____

_____

I understand that this is a Pain Management practice and I give my permission for the providers to contact my pharmacy regarding questions they may have about my prescribed medications _____.

Initial

I have read the above Health History and have made any necessary changes to the information.

This information is correct to the best of my knowledge. _____

Signature

Today's Date: _____

TO OUR PATIENTS:

BECAUSE ALL OF OUR PAIN MANAGEMENT PROCEDURES ARE PERFORMED IN A SURGERY CENTER, YOU MAY BE REFERRED TO THE NEWPORT CENTER SURGICAL IS A CALIFORNIA CORPORATION IN WHICH YOUR DOCTOR MAY HAVE A BENEFICIAL INTEREST.

WE FEEL THAT VERY QUALIFIED AND COMPETENT MEDICAL SERVICES AND PROCEDURES ARE PROVIDED BY THIS FACILITY. HOWEVER, YOU HAVE THE ABSOLUTE RIGHT TO USE AN ALTERNATIVE FACILITY OF YOUR CHOICE. YOU ARE NOT OBLIGATED TO USE THE FACILITY, AND WE WILL BE HAPPY TO DISCUSS OTHER FACILITIES WHICH PROVIDE THE SAME MEDICAL PROCEDURES AND SERVICES.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT AND THAT ANY QUESTIONS I HAVE CONCERNING THE ABOVE MATTER HAVE BEEN ANSWERED.

DATE: _____ PATIENT SIGNATURE: _____

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL RECORDS INFORMATION:

I HEREBY IRREVOCABLY ASSIGN THE INSURANCE BENEFIT PAYMENT, BOTH BASIC AND MAJOR MEDICAL, TO WHICH I AM ENTITLED DIRECTLY TO THE DOCTOR RENDERING SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THE INSURANCE COMPANY. A PHOTOSTAT OF THIS AUTHORIZATION IS ACCEPTED WIH THE SAME AUTHORITY AS THE ORIGINAL. I HEREBY AUTHORIZE THE DOCTOR RENDERING SERVICE TO RELEASE ANY INFORMATION REQUIRED, IN THE COURSE OF MY EXAMINATION OR TREATMENT.

DATE: _____ PATIENT SIGNATURE: _____

PLEASE DO NOT WRITE BELOW THIS LINE

C-SPINE

ROM: _____
UE ROM R: _____ L: _____
SENSORY: _____
REFLEX: _____
MOTOR: _____
PULSES: _____
JAMAR: R: _____ L: _____
_

CIRCUMFERENCE

	R	L
ARM (6")	_____	_____
FOREARM (3")	_____	_____

L-SPINE

ROM: _____
(EXT 30, LAT 35)
SENSORY: _____
REFLEX: _____
MOTOR: _____
PULSES: _____
SLR: R: _____ L: _____
(SIT 90, SUPINE 60)
(BAVINSKY, HOOVER, KERNIG)
GAIT (NON-ANTALAGIC)
SQUAT / HEEL/TOE WALKING

	R	L
THIGH (9")	_____	_____
CALVES (4")	_____	_____