BELLEVUE PAIN INSTITUTE
relief repair renew

PATIENT INFORMATION	PHONE NUMBERS
Date: _____ Sex: ☐ M ☐ F	Home: _____ Work: _____
Name: _____	Cell: _____
Address: _____	☐ AT&T ☐ Verz ☐ T-Mob ☐ Nextel ☐ Virgin ☐ Sprint
_____	Email: _____
City: _____ State: _____ Zip: _____	Best time to reach you: _____
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	EMERGENCY CONTACT: _____
Birth Date: _____ Age: _____	Relationship: _____
Patient SS#: _____	Phone #: _____
How did you hear about us? : _____	Spouse's Name: _____ DOB: _____

EMPLOYMENT	PHYSICIAN INFO.
Occupation: _____	Referring MD: _____
Employer: _____	Primary Care MD: _____
Employed: ☐ Full-Time ☐Part-Time ☐ Not Working	Physicians currently involved in care: _____
If you are unemployed, is this due to your present pain condition: ☐ Yes or ☐ No	_____
If you are unemployed, indicate how long you have been off of work: _____	_____
	_____

INSURANCE	ACCIDENT INFORMATION
Insured's Name: _____	Is this condition due to an accident: ☐ YES ☐ NO
Relationship to Patient: _____	☐ Worker's Compensation
Insurance Co.: _____	☐ Personal Injury/ Liability
ID #: _____	☐ Other
Additional Insurance: _____	To whom have you made a report of this accident:
Subscriber's Name: _____	☐ Auto Insurance
Birth Date: _____ SS#: _____	☐ Employer
Relationship to Patient: _____	☐ Workers Compensation
	☐ Other
	Attorney Name & Phone Number (if applicable):
	_____
	_____

Date: _____ Name: _____DOB: _____

PAIN TREATMENTS: Please check your response to the treatments you have tried.

TREATMENT	NEVER TRIED	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
SURGERY				
TRACTION				
INJECTIONS				
PHYSICAL THERAPY				
ACUPUNCTURE				
CHIROPRACTIC				
MASSAGE THERAPY				

***CURRENT* PAIN MEDICATIONS:**

Name	Dose	Frequency

Pain medications provide me relief: ☐ Not at all ☐ Some times ☐ Most of the time ☐ All of the time

OTHER CURRENT MEDICATIONS OR SUPPLEMENTS:

ALLERGIES: _____
_____
_____

I am allergic to contrast dye used for imaging: _____Yes _____ No _____Unknown

Do you take Aspirin, Plavix or Coumadin? _____ Yes _____ No

PAST SURGICAL HISTORY:

APPROXIMATE DATE	TYPE OF OPERATION

Date: _____ Name: _____DOB: _____

PAST MEDICAL HISTORY:
Have you had any of the following health problems (please check all that apply)?

- ☐ Angina or chest pain
- ☐ Anxiety
- ☐ Arthritis
- ☐ Bleeding Problems
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fibromyalgia
- ☐ Heart Attack / TIA's
- ☐ Hepatitis / Liver Problems
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ Hypertension
- ☐ Others _____
- ☐ Cancers- specify type _____
- ☐ Kidney Disease
- ☐ Lyme's Disease
- ☐ Stroke
- ☐ Temperature Intolerance
- ☐ Thyroid Disease
- ☐ Weight Loss Resistance

SOCIAL HISTORY:
SLEEP: Recent change in sleep patterns? _____Yes _____No

Hand Dominance: Right _____ Left_____ Ambidextrous (Equal)_____

Have you ever been a smoker? ☐ Yes - Current ☐ Yes-In Past ☐ No-Never

Do you drink alcohol more than 2X/wk? ☐ Yes – Current ☐ Yes - In Past ☐ No – Never

Your Stress levels 1(min.) to 10(max.) _____ Emotional _____ Work _____ Physical _____ Family

SUBSTANCE ABUSE:

Do you have a history of alcoholism? ☐ Yes ☐ No ☐ Current Problem

Have you abused prescription pain meds? ☐ Yes ☐ No ☐ Current Problem

Cocaine or intravenous substance abuse? ☐ Yes ☐ No ☐ Current Problem

How many years has it been since you abused alcohol or drugs? _____ years Not Applicable

PSYCHOLOGICAL TREATMENT:

Have you ever had psychiatric evaluation or treatments for any problem? ☐ Yes ☐ No
For what diagnosis were you treated? _____ When?_____
Please list your current or last therapists: _____

Have you ever considered suicide? ☐ Yes ☐ No When? _____

Have you ever attempted suicide? ☐ Yes ☐ No When? _____

MOTIVATION / COMMITMENT:
What hobbies or activities are you currently missing out on due to your symptoms? _____
_____
What lifestyle changes have you had to make due to your symptoms? _____
_____

How important is it to you to do whatever it takes to re-gain these aspects of your life? (1 – 10) _____
Additional Comments _____
_____

Date: _____ Name: _____DOB: _____

PAIN DESCRIPTION: What is the main problem for which you are seeking treatment today?

_____

_____

_____

When did you first notice this problem(s)? _____years _____months _____weeks _____days

Describe your pain: [circle any} Burning, Throbbing, Ache, Stabbing-Sharp, Electric Shocks, Cold, Tingling Pins + Needles, Dead Feeling, Throbbing, Stinging, Numbness, Swelling, Tiredness, Cramping,
Other:_____

_____

ONSET: How did pain start? (check appropriate box)

☐ Suddenly ☐ Gradually ☐ Bending ☐ Pulling ☐ Lifting ☐ Fall

☐ Injured at work ☐ Injured during sports ☐ Injured in auto accident ☐ No apparent cause

SEVERITY OF PAIN: Please describe the intensity of your pain:

☐ Mild ☐ Moderate ☐ Moderate - Severe ☐ Severe

TIMING OF PAIN: How often do you have your pain?

☐ Constantly ☐ Nearly Constantly ☐ Intermittently Are symptoms getting worse? No Yes

Is your sleep disturbed due to your pain? ☐ No ☐ Yes _____

How do the following affect your pain (please check one for each item)?

	DECREASE	NO CHANGE	INCREASE
LYING DOWN			
STANDING			
SITTING			
WALKING			
EXERCISE			
COUGHING/SNEEZING			
PUSH/PULL			
BEND			

ACTIVITIES AND YOUR PAIN:

What makes your pain better? _____

What makes your pain / symptoms worse? _____

How many blocks can you walk? _____ Less than a block _____Blocks (how many?)

Is sitting tolerance limited? _____No _____Yes Is standing tolerance limited? _____No _____Yes

To assist walking, I use a: ____Cane _____Walker ____Wheelchair _____No Assistance Device

Which Activities of Daily Living are changed or limited due to pain? _____None (circle any) Bathing Dressing, Hygiene, Driving, Exercising, Sex, House Cleaning, Laundry, Working,

DIAGNOSTIC STUDIES: Have you had any of these diagnostic studies for **THIS** problem?

X-Rays: No_____ Yes(of what)_____ **CT Scan:** No_____ Yes(of what)_____

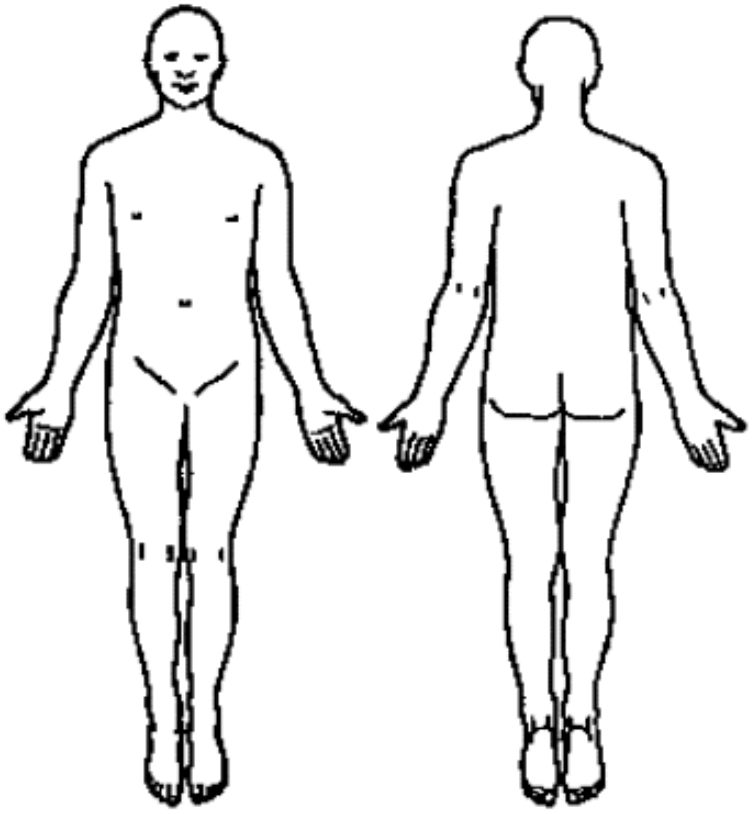
MRI: No_____ Yes(of what)_____ **EMG /NCV:** No_____Yes(of what)_____

Discogram: No_____ Yes(of what)_____ **DEXA (Bone Density Testing):** Yes_____ No_____

Date: _____ Name: _____DOB: _____

PHYSICAL EXAMINATION:
How much do you weigh? _____pounds
How tall are you? _____feet _____inches

PAIN LOCATION: Please mark the location(s) of your pain on the diagrams: **X=pain, N=numb B=burning, T=tingling, W=weakness**



I have weakness in my:

- Upper Extremities ☐ Yes
- Lower Extremities ☐ Yes
- Dropping Objects? ☐ Yes
- Falling? ☐ Yes

Current Pain Scale (1-10):

- ____ Low Back
- ____ Neck
- ____ Shoulder
- ____ Upper Back
- ____ Knee
- ____ Hip
- ____ Feet

REVIEW OF SYSTEMS: Please check all items you feel are applicable to you **NOW:**

General / Constitutional Symptoms:
☐ Recent Significant Gain of Weight
☐ Recent Significant Loss of Weight ☐ Fever ☐ Fatigue

Head / Ears / Eyes / Nose / Throat:
☐ Difficulty Swallowing(Dysphagia) ☐ Decreased Hearing ☐ Facial Pain ☐ Vertigo

Respiratory:
☐ Shortness of Breath (Dyspnea) ☐ Wheezing

Cardiovascular:
☐ Edema (Swelling of Feet) ☐ Irregular Heartbeat

Gastrointestinal:
☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation

Genitourinary:
☐ Difficulty Initiating Urine Stream ☐ Incontinence

Metabolic / Endocrine:
☐ Jaundice ☐ Insulin Reactions

Neuro / Psychiatric:
☐ Memory Loss ☐ Dizziness ☐ Seizures ☐ Coordination Problems ☐ Anxiety / Depression I

Dermatologic:
☐ Pruritis ☐ Rash

Musculoskeletal:
☐ Back Pain ☐ Muscle Pain (Myalgia)

Hematologic:
☐ Easy Bleeding/ Bruising or Excessive Bleeding

Date: _____ Name: _____DOB: _____

ASSIGNMENT OF BENEFITS

I, _____ authorize and assign payment of benefits due under terms of any insurance policy or policies that may cover the medical procedure(s) performed at the address provided on any claim form submitted to my insurance carrier(s). I hereby instruct and direct my insurance company to make payment by check made out to Pacific Coast Medical Group, PLLC dba Bellevue Pain Institute. I understand and agree that I am financially responsible for charges not covered by the assignment authorization, payment of bills and any deductibles or co-payment / co-insurance as determined by my insurance carrier's contract.

Signature: _____ Date: _____

HIPAA PRIVACY PRACTICES

I, _____ have received a copy of the HIPAA Notice of Privacy Practices. I have read and understand my rights as afforded to me under the Health Insurance Portability and Accountability Act (HIPAA). I understand that I may ask questions of the office.

Signature: _____ Date: _____

Doctor's Notes:

_____

_____

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