BELLEVUE PAIN INSTITUTE
relief repair renew

PATIENT INFORMATION

Date: _____ Sex: ☐ M ☐ F

Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Birth Date: _____ Age: _____

Patient SS#: _____

How did you hear about us? : _____

PHONE NUMBERS

Home: _____ Work: _____

Cell: _____

☐ AT&T ☐ Verz ☐ T-Mob ☐ Nextel ☐ Virgin ☐ Sprint

Email: _____

Best time to reach you: _____

EMERGENCY CONTACT: _____

Relationship: _____

Phone #: _____

Spouse's Name: _____ DOB: _____

EMPLOYMENT

Past / Current Occupation: _____

Employer: _____

Employed: ☐ Full-Time ☐Part-Time ☐ Retired

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: _____

PHYSICIAN INFO.

Primary or Referring MD: _____

Clinic Name & Phn: _____

Other Physicians involved in care: _____

_____

Clinic Name & Phn: _____

_____

INSURANCE

Insured's Name: _____

Relationship to Patient: _____

Insurance Co.: _____

ID #: _____

Additional Insurance: _____

Subscriber's Name: _____

Birth Date: _____ SS#: _____

Relationship to Patient: _____

ACCIDENT INFORMATION

Is this condition due to an accident: ☐ YES ☐ NO
If known, what was the date of the injury: (____/____/____)

- ☐ Worker's Compensation
- ☐ Personal Injury/ Liability
- ☐ Other

To whom have you made a report of this accident:

- ☐ Auto Insurance
- ☐ Employer
- ☐ Workers Compensation
- ☐ Other

Attorney Name & Phone Number (if applicable):

_____

_____

Date: _____ Name: _____ DOB: _____

What is your single most important complaint / problem for which you are seeking treatment? Describe how it feels. (Additional complaints can be listed on the next page)

_____

_____

_____

ONSET: When/How did your complaint start? (check appropriate boxes)

When did it first start? _____years _____months _____week _____days

☐ Suddenly ☐ Gradually ☐ Bending ☐ Pulling ☐ Lifting ☐ Fall ☐ Injured at work

☐ Injured during sports ☐ Injured in auto accident ☐ Unknown ☐ Other _____

What is the severity of this complaint 0-10 (0=best, 10=crippling/bedrest required) _____

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

☐ Mild ☐ Moderate ☐ Moderate - Severe ☐ Severe

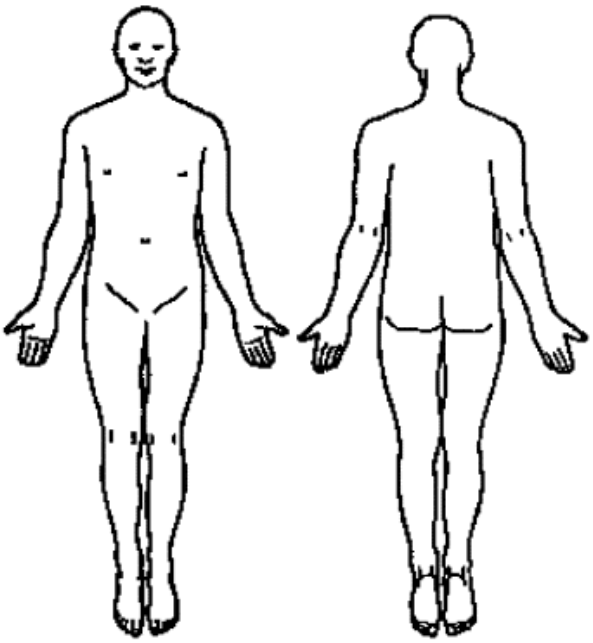
TIMING OF PAIN: How often do you have your complaint? ☐ Constant ☐ Intermittent ☐ Occasional

Is your sleep disturbed by your complaint? ☐ Yes - How many times do you wake/night _____ ☐ No

Is the complaint getting worse? ☐ Yes – describe:_____ ☐ No

How are the following affected by your complaint (please check one for each item)?

	Aggravates	Not Affected	Alleviates
Lying Down			
Standing			
Walking			
Sitting			
Sit & Pushup on hands			
Sit with Support			
Bending Slightly			
Bending Fully			
Coughing/Sneezing			
Raising Arm Overhead			
Driving			
Hygiene / Bathing			
House Cleaning			
Work			



Have you taken any recent falls? ___ Yes _____ No
How many blocks can you walk? #_____Blocks
To assist walking, I use a: ___Cane _____Walker ___Wheelchair
___No Assistance Device
Have you unintentionally dropped objects recently: ___ Yes ___ No

PAIN LOCATION: Please mark the location(s) of your **primary** complaint symptoms on the diagrams using: **X=Pain B=Burning C=Cramping N=Numbness S=Soreness ST= Stiffness T=Tingling W=Weakness R=Radiating**

MOTIVATION / COMMITMENT:

What lifestyle changes have you had to make due to this complaint? _____

_____

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

Date: _____ Name: _____ DOB: _____

SECOND COMPLAINT:_____ When & how did this complaint start? _____

What makes the complaint worse? _____

What makes the complaint better? _____

What words would you use to describe this complaint? _____

Does your condition radiate anywhere? _____

What is the severity of your complaint 0-10 (0=best, 10=crippling/bedrest required) _____

What time of the day is your complaint the worst? _____

Before this complaint began, had you ever experienced this type of problem before? _____

What lifestyle changes have you had to make due to this complaint? _____

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

THIRD COMPLAINT:_____ When & how did this complaint start? _____

What makes the complaint worse? _____

What makes the complaint better? _____

What words would you use to describe this complaint? _____

Does your condition radiate anywhere? _____

What is the severity of your complaint 0-10 (0=best, 10=crippling/bedrest required) _____

What time of the day is your complaint the worst? _____

Before this complaint began, had you ever experienced this type of problem before? _____

What lifestyle changes have you had to make due to this complaint? _____

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

FOURTH COMPLAINT:_____ When & how did this complaint start? _____

What makes the complaint worse? _____

What makes the complaint better? _____

What words would you use to describe this complaint? _____

Does your condition radiate anywhere? _____

What is the severity of your complaint 0-10 (0=best, 10=crippling/bedrest required) _____

What time of the day is your complaint the worst? _____

Before this complaint began, had you ever experienced this type of problem before? _____

What lifestyle changes have you had to make due to this complaint? _____

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

Date: _____ Name: _____ DOB: _____

DIAGNOSTIC STUDIES:
Which complaint have you had diagnostic studies for? ____Primary _____Secondary _____Third _____ Fourth

X-Rays: Yes (of what)_____ No_____ **CT (Computed Tomography) Scan:** Yes (of what)_____ No_____
Discogram: Yes (of what)_____ No_____ **Electromyogram (EMG) / NCV:** Yes (of what)_____ No_____
MRI: Yes (of what)_____ No_____ **DEXA (Bone Density Testing):** Yes (of what)_____ No_____
I am allergic to contrast dye used for imaging**:** _____Yes _____ No _____ Unknown

REVIEW OF CURRENT SYSTEMS:

☐ Back problems, poor posture, arthritis. ☐ Recent or sudden weight loss, fever, chills, weakness or fatigue.

☐ Recent or sudden difficulty concentrating or memory issues. ☐ Recent headache, dizziness or syncope.

☐ Recent or sudden change in smell, vision or hearing. ☐ Recent or current enlarged lymph nodes.

☐ Recent unexplained skin rash or itching. ☐ Recent sweating, cold or heat intolerance.

☐ Recent anemia, bleeding or sudden unexplained or excessive bruising.

☐ Recent or sudden shortness of breath, coughing, chest pain/pressure/discomfort or heart palpitations.

☐ Recent food sensitivities, nausea, vomiting, diarrhea, abdominal pain or bloody stool.

☐ Recent burning on urination, change in bowel or bladder control.

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

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

My pain medications provide relief**:** ☐ None ☐ Some ☐ Most ☐ All of the time ☐ Not Applicable

***CURRENT* MEDICATIONS or SUPPLEMENTS:**

Name	**Dose / Frequency**	**Reason**

Do you take Blood thinners ie. Aspirin, Plavix or Coumadin**?** _____ Yes _____ No

Date: _____ Name: _____ DOB: _____

PAST SURGICAL HISTORY:

DATE	TYPE OF OPERATION AND OUTCOME OF THE SURGERY

PAST MEDICAL HISTORY:

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

- ☐ Angina or chest pain
- ☐ Anxiety
- ☐ Arthritis
- ☐ Bleeding/Clotting Problems
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fibromyalgia
- ☐ Heart Attacks / TIAs
- ☐ Hepatitis / Liver Problems
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ Hypertension
- ☐ Spine Trauma
- ☐ Cancer- specify type _____
- ☐ Kidney Disease
- ☐ Lyme's Disease
- ☐ Multiple Sclerosis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Weight Loss Resistance
- ☐

SOCIAL HISTORY:

Do you smoke/ chew / Vape nicotine ? ☐ Yes _____ /day ☐ No -In the Past ☐ No- Not ever

Do you use Marijuana products? ☐ Yes _____ /day Type: _____ ☐ No – Not ever

How much alcohol do you drink on a weekly basis? _____ ☐ Yes - In Past ☐ No – Never

How much caffeine do you drink daily? _____

Hand Dominance: Right _____ Left_____ Ambidextrous (Equal)_____

Your Height: _____ Your Current Weight: _____ Your Ideal Weight: _____

SUBSTANCE ABUSE:

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

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

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

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

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications, if any

Date: _____ Name: _____ DOB: _____

IMMEDIATE FAMILY HISTORY:

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your immediate blood relatives had any of the following: Disease		Relationship to you
Father						Arthritis, Rheumatoid, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes, Clotting	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	

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? _____

ALLERGIES:

Any known allergies to medications, foods or environmental? _____

_____

_____

Additional Complaints/Symptoms/Conditions/Notes:

_____

_____

_____

_____

_____

_____

_____

_____

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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