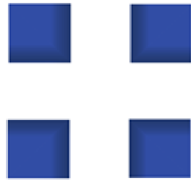


BELLEVUE
PAIN INSTITUTE
relief repair renew

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: ____________________

Email: ____________________

Do we have your expressed permission to send monthly educational and promotional content to your email?
☐ Yes ☐ No

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 the 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 range of 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

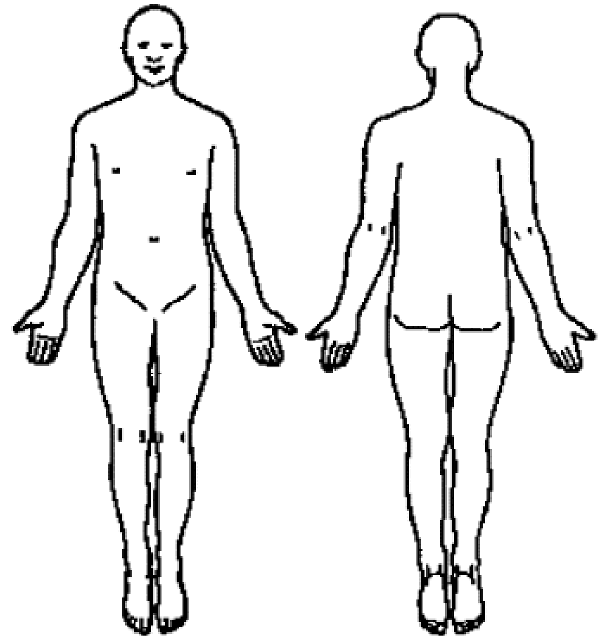
TIMING OF PAIN: How often do you have your complaint? ☐ Constant ☐ Intermittent ☐ Occasional

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)?

	Aggravated By:	Not Affected	Improves By:
Bending Fully			
Bending Slightly			
Coughing/Sneezing			
Driving			
Exercise			
House Cleaning			
Hygiene / Bathing			
Lying Down			
Raising Arm Overhead			
Sitting			
Sit & Pushup on hands			
Sit with Support			
Standing			
Walking			



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**

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

MOTIVATION / COMMITMENT:

What is the most important thing you hope to regain from successful treatment? ________________________

____

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? ____

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? ____

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? ____

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: - [please READ CAREFULLY and check appropriate boxes]

☐ 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 burning on urination, change in bowel / bladder control or recent increase in Erectile Dysfunction.

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

TREATMENT	NEVER TRIED	NO RELIEF	MILD RELIEF	MODERATE RELIEF	EXCELLENT RELIEF	DETAILS
SURGERY						
INJECTIONS/ RFA						
TRACTION						
PHYSICAL THERAPY						
ACUPUNCTURE						
CHIROPRACTIC						
ORTHOTICS						
OTHER THERAPY						

***CURRENT* MEDICATIONS or SUPPLEMENTS:**

Name	Dose/ Frequency	Reason

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

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

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/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: ___________ Current Weight: __________ Ideal Weight: ___________ Recent Gain/Loss: ______#

Your Current Exercise Routine: ____

____

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

PAST SURGICAL HISTORY:

DATE	TYPE OF OPERATION AND OUTCOME OF THE SURGERY

Hospitalizations other than Surgery listed Above

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	

☐ I Decline to Disclose my family Health History

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: ______________________________

DECLARATION

I declare under penalty of perjury (under the laws of the United States of America) that the foregoing is true and correct and that I am not attempting to investigate Bellevue Pain Institute or any of its employees as a representative of any agent or entity, or any insurance company or other organizational entity or person.

Signature: ____ Date: ______________________________

NOTES

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