BELLEVUE
PAIN INSTITUTE
relief repair renew

PATIENT INFORMATION

Today's Date: _____

Name: _____

Preferred Name: _____

Birth Date: _____ Age: _____

Sex at Birth: ☐ M ☐ F Gender Identity: _____

Address: _____

City: _____ State: _____ Zip: _____

How did you hear about us?: _____

CONTACT INFORMATION

Home: _____

Cell: _____

Email: _____

Preferred Communication: ☐ Email ☐ Phone

Do we have your expressed permission to send occasional educational and promotional content to your email?

☐ Yes ☐ No

EMERGENCY CONTACT: _____

Relationship: _____

Phone #: _____

EMPLOYMENT STATUS

Past / Current Occupation: _____

Employer: _____

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

If you're unemployed, is this due to your present condition:

☐ Yes or ☐ No

If you are unemployed, indicate how long you have been off of work: _____

PHYSICIAN INFORMATION

Primary or Referring MD: _____

Clinic Name & Ph: _____

Other Physician: _____

Clinic Name & Ph: _____

Other Physician: _____

Clinic Name & Ph: _____

INSURANCE INFORMATION

☐ Commercial Health Insurance ☐ Self-Pay

Insurance Co.: _____

ID #: _____

Group: _____ SS#: _____

Subscribers Name: _____

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: _____

CHIEF COMPLAINT: 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=unbearable, hospital required) _____

What makes the complaint worse? _____

What makes the complaint better? _____

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

☐ Mild ☐ Moderate ☐ Moderate - Severe ☐ Severe ☐ Unbearable

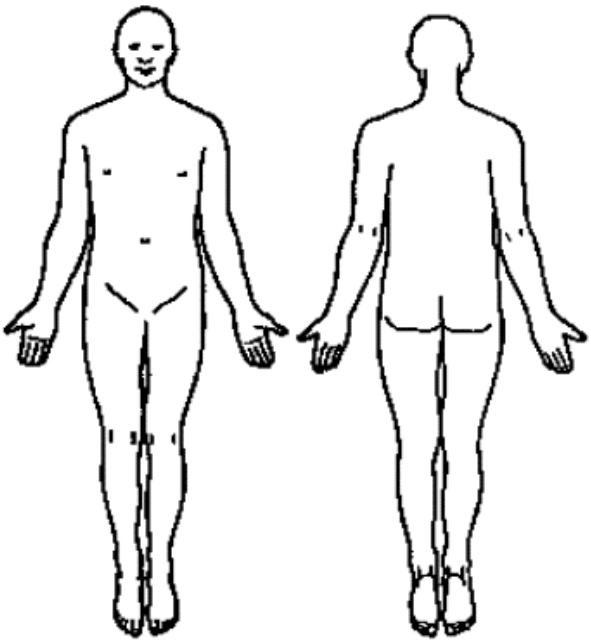
TIMING OF PAIN: How often do you have your complaint? ☐ Constant ☐ Intermittent ☐ Occasional

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 ☐ None

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 regain these aspects of your life? (1-10) _____

Pacific Coast Medical Group / Pacific Coast Integrated Medical Group , PLLC dba Bellevue Pain Institute
12360 NE 8th St. Ste. 200 Bellevue, WA 98005

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=unbearable, hospital 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=unbearable, hospital 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=unbearable, hospital 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:

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

Discogram: Yes (of what)_____ **Electromyogram (EMG) / NCV:** Yes (of what)_____

MRI: Yes (of what)_____ **DEXA (Bone Density Testing):** Yes (of what)_____

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						
MASSAGE 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

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12360 NE 8th St. Ste. 200 Bellevue, WA 98005

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
- ☐ 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 ☐ Yes -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? _____ How much water do you drink daily? _____ oz

Hand Dominance: ☐ Right ☐ Left ☐ Ambidextrous (Equal)

Your Height: _____ Current Weight: _____ Ideal Weight: _____ Recent Gain/Loss: _____

Your Current Exercise Routine: _____Frequency: _____

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

IMMEDIATE FAMILY HISTORY:

☐ I Decline to Disclose my family Health 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	

Date: _____ Name: _____ DOB: _____

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? _____

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

ALLERGIES:

Any known allergies to medications, foods or the environment? _____

_____

_____

_____

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 in the office.

Signature: _____ Date: _____

CONSENT TO RELEASE INFORMATION TO FRIENDS AND FAMILY

I give the providers and office staff of Pacific Coast Medical Group (PCMG) and Pacific Coast Integrated Medical Group (PCIMG) permission to discuss my medical condition with the following people listed below. The consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information current, as I recognize that relationships and friendships change over time.

Information to be shared:

☑ All health information

☐ Limited health information (describe here): _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Signature: _____ Date: _____

Date: _____ Name: _____ DOB: _____

ELECTRONIC COMMUNICATIONS AUTHORIZATION FORM

Pacific Coast Medical Group & Pacific Coast Integrated Medical Group dba, Bellevue Pain Institute

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health care providers take reasonable measures to safeguard your Protected Health Information (PHI) at all times. This includes securing your PHI as much as possible when it is communicated electronically via facsimile, text or email. Unfortunately, even with appropriate safeguards in place it is impossible to ensure that electronic communications are entirely safe at all times. In order to accommodate requests for electronic communications for purposes such as appointment scheduling, billing, health record transmission, and marketing, HIPAA requires that we obtain your written authorization.

We understand that you are on a path to better well-being and we would like to facilitate that process as much as possible. Electronically transmitting copies of your Electronic Health Record saves you time and money. Authorizing us to quickly communicate with you and/or others involved in the handling of you care will help us to better serve you. Please carefully read the risks listed below and ask any questions of us that you may have. You may revoke these authorizations at any time by speaking with our office staff.

Risks and Conditions of Using Electronic Communication:

- Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.
- Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
- Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the provider or patient.
- Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.
- Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
- Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.
- Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.
- The physician may forward electronic communications to staff and those involved in the delivery and administration of you care. The physician might use one or more of the services to communicate with those involved in your care. The physician will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.

☐ I understand the risks associated with secured and unsecured electronic transmissions and hereby authorize Pacific Coast Medical Group & Pacific Coast Integrated Medical, dba, Bellevue Pain Institute to communicate with me via email for the purpose of health care operations.

☐ I understand the risks associated with secured and unsecured electronic transmissions and hereby authorize Pacific Coast Medical Group & Pacific Coast Integrated Medical Group, dba. Bellevue Pain Institute to communicate with me via email for marketing purposes.

☐ I understand the risks associated with secured and unsecured electronic transmissions and hereby authorize Pacific Coast Medical Group & Pacific Coast Integrated Medical dba, Bellevue Pain Institute to communicate with my Primary Care Provider as listed in my New Patient Intake.

☐ I understand the risks associated with secured and unsecured electronic transmissions and hereby authorize Pacific Coast Medical Group & Pacific Coast Integrated Medical Group, dba, Bellevue Pain Institute to transmit my Electronic Health Record though those involved in the handling of my care with my signed authorization. I understand that I will be notified beforehand so as to ensure that my PHI is sent only to the appropriate parties as requested by me.

☑ *I understand the risks associated with secured and unsecured electronic transmissions and therefore reserve my right to opt out of any electronic communications regarding my health care.*

_____ _____ _____

Name (Printed) Signature Date

_____ _____

My email address My cell number