Date ______ (PLEASE PRINT) Home Phone (____) ______

Patient Information

Name ______ Last Name ______ First Name ______ Middle Initial

SS/HIC/Patient ID # ______

Address ______ Cell Phone (____) ______

City ______ State ______ Zip ______

Sex ☐ M ☐ F Age ______ Birthdate ______ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for ______ years ☐ Minor

Patient Employer/School ______ Occupation ______

Employer/School Address ______ Employer/School Phone (____) ______

Whom may we thank for referring you? ______

In case of emergency who should be notified? ______ Phone (____) ______

Primary Insurance

Person Responsible for Account ______ Last Name ______ First Name ______ Middle Initial

Relation to Patient ______ Birthdate ______ Soc. Sec. # ______

Address (If different from patient's) ______ Phone (____) ______

City ______ State ______ Zip ______

Person Responsible Employed by ______ Occupation ______

Business Address ______ Business Phone (____) ______

Insurance Company ______

Contract # ______ Group # ______ Subscriber # ______

Names of other dependents covered under this plan ______

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______ Relation to Patient ______ Birthdate ______

Address (If different from patient's) ______ Phone (____) ______

City ______ State ______ Zip ______

Subscriber Employed by ______ Business Phone (____) ______

Insurance Company ______ Soc. Sec. # ______

Contract # ______ Group # ______ Subscriber # ______

Names of other dependents covered under this plan ______

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with ______ Name of Insurance Company(ies) and assign directly to Dr. ______ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______ Signature of Patient, Parent, Guardian or Personal Representative ______ Date

______ Please print name of Patient, Parent, Guardian or Personal Representative ______ Relationship to Patient

Registration Form

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PATIENT INFORMATION FORM

Referral Source:

Physician: ______________________________

Attorney: ______________________________

Insurance Carrier: ______________________________

Other: ______________________________

Name of Primary Care Physician: ______________________________

Address of Referral Source: ______________________________

Chief Complaint:

(1) What is your main problem?

____

____

History of Present Pain:

❖ Location: Please describe exactly where your pain is located on your body.

____

____

____

(2) How many months ago did your pain begin? ______________

(3) What event led to your present problem? (Please circle)

Cancer Disease Operation Injury Other ______________

(4) What was the date of your injury? ______________

(5) Do you have pain free intervals? Yes No

(6) Pain Scale : **MILD** **MODERATE** **SEVERE**

1	2	3	4	5	6	7	8	9	10 (max pain)

(7) What factors aggravate your PAIN?

Massage	Anxiety	Lying Down
Sitting	Walking	Coughing

Sex	Running	Cold
Heat	Straining	Standing

(8) What helps your pain?

____

____

(9) What is a comfortable position for you?

____

(10) Please describe your activities before your pain problem started.

____

____

Previous physicians. Please complete the following information regarding doctors who have evaluated your pain problem. Start with the first doctor who evaluated your pain.

Doctor #1

Doctors Name: ______________________________

Doctors Specialty: ______________________________

Year of Doctors Care: ______________________________

Doctors Diagnosis: ______________________________

List Treatments Performed by Doctor______________________________

____

*** If evaluated by more doctors for the pain problem, list their names and same information on the back of this page.**

Social History

(1) Marital Status: Single Divorced Widowed Married

(2) Highest Level of Education: ____________________

(3) Children: Yes No How Many? ________ Ages____________________

(4) Present source of financial support: (circle)

Personal earnings Workman's Comp Spouses earnings None

Disability payment Pension Insurance Other_______

(5) Do you work? (circle) Full time Part time

(6) Do you smoke? Yes No Do you drink alcohol? Yes No

(7) Is there legal action pending? ______________________________

Past medical history: (circle condition)

Asthma/breathing problems Kidney problems Liver Problems

Bleeding Problems High Blood Pressure

Diabetes Headaches Other:

Previous Treatments for pain:

Modalities	Yes	By Who?	Effectiveness
Block			
TENS			
Physiotherapy			
Biofeedback			
Counseling			
Pain Management			
Surgery			
Acupuncture Other			

Surgical History

Surgeries performed on you and the dates that they were performed:

____

____

Medications:

(1) Allergies: ____

(2) Previous medication for pain:

Drug	Effectiveness	Side Effects

(3) Current Medications:

Drugs	Dosage	Purpose	Effectiveness	Doctor

This portion of the questionnaire is extremely important. Please provide the dates and the results of the tests listed below. Also, provide a copy of these report (not films) at the time of your evaluation.

Previous Studied Laboratory Tests Performed to Evaluate Pain: (CIRCLE)

1. X-rays 2. CAT Scan 3. MRI 4. EMG 5. Nerve Conduction Studies 6. Myelogram

7. Thermogram 8. Bone Scan

L. Physical Status: Height _________ Weight _________

Your Name: ______________________________ **Drug Allergies:** ______________________________

Include: Prescriptions, Over-the-Counter Medicines, Dietary Supplements, Vitamins, Herbs, Medicine Patches, Inhalers, Medicines for Pain

Medications	Dose (mg, units, puffs, drops)	Frequency When do you take it? How many times per day? Morning and night? After meals?	Route How do you take it?	Reason Taking Why do you take it?	Comments Prescribed, How long have you been taking it, danger signs, side effects, drug-drug, drug-food interactions
Sample Drug	*25 mg*	*1X Daily*	*Oral - Pill*	*High Blood Pressure*	*Prescribed by: Cardiologist Dr. Malik*

Take your Medications as Prescribed:
Do not stop taking any medication before talking with your doctor.
Carry this list of your medications in your wallet or purse.

Use Pencil & update this list as needed:
When you see the doctor, review and update this medication list.
After hospitalization, review this medication list with your doctor.

RECORDS RELEASE AUTHORITY

To:

____

____

____

I, ________________________________ hereby request that you release to:

(Patient's Name)

PACIFIC COMPREHENSIVE PAIN MANAGEMENT
Stanley K. Chou, M.D.
10861 Cherry St., Suite 308
Los Alamitos, CA 90720
(562)799-3888/fax (562) 799-3880

A report of my diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to your treatment of me.

______________________	X______________________
Patient Date of Birth	Signature of Patient, Parent, Guardian or Personal Representative
______________________	______________________
Witness	Please **PRINT** name signed above
______________________	______________________
Date	Relationship to Patient