

Welcome!

Please indicate the physician you are seeing today:

- | | |
|--|---|
| <input type="checkbox"/> Nasser Ayyad, DO | <input type="checkbox"/> Leroy Lindsay, MD |
| <input type="checkbox"/> Jaclyn Bonder, MD | <input type="checkbox"/> Michael Nicoletti, MD |
| <input type="checkbox"/> Michelle Chi, MD | <input type="checkbox"/> Ben Shin, MD |
| <input type="checkbox"/> Prabhav Deo, MD | <input type="checkbox"/> Joan Stilling, MD |
| <input type="checkbox"/> Kristen de Vries, DO | <input type="checkbox"/> Jaspal Ricky Singh, MD |
| <input type="checkbox"/> Victoria Harrison, MD | <input type="checkbox"/> Amy Skaria, MD |
| <input type="checkbox"/> Stanley Guillaume, MD | <input type="checkbox"/> Vandana Sood, MD |
| <input type="checkbox"/> Dara Jones, MD | <input type="checkbox"/> Jennifer Soo Hoo, MD |
| <input type="checkbox"/> Chi Chang David Lin, MD | <input type="checkbox"/> Katherine Yao, MD |

Please Note: All information is confidential and will become a part of your medical record. Do not leave any boxes empty, mark N/A for not applicable or None if appropriate. PLEASE PRINT CLEARLY

Patient Name:		Date of Visit:	
Date of Birth:		Social Security Number:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner		
Home Address:		Home Phone Number:	
		Other Phone Number:	
Preferred Email Address:		Emergency Contact Name and Number:	
		Relationship to Patient:	
Primary Insurance Carrier:		Insurance ID Number:	
Insurance Phone Number:		Are you the Primary Insurance Policy Holder? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If No, please list the Name and Date of Birth of the Policy Holder:			
Does Your insurance plan require referrals for specialty visits? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, do you have a referral for today's visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	



Physician and Pharmacy Information

Referring Physician

Name:

Phone:

Fax :

Were you referred for a Consultation?

Yes No

Primary Care Provider

Name:

Phone:

Fax:

Preferred Pharmacy

Name:

Phone:

Fax:

Did you sustain your injury on the job or during a motor vehicle accident?

Yes No

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all information above is true and correct. I authorize the holder of medical information about me to release to my insurance and, if I am a Medicare patient, to the Centers for Medicare and Medicaid Services and its agents, any information necessary to determine these benefits or the benefits payable for related services. I request that payment of any benefits be made on my behalf to the provider of services. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for payment in full for these services including any amounts not paid by my insurance carrier such as Copayments, Deductibles, and other non-covered services.

I understand that services deemed non-medically necessary are not covered by my insurance carrier and that I will be financially responsible for any such non-covered services.

Signature

Date

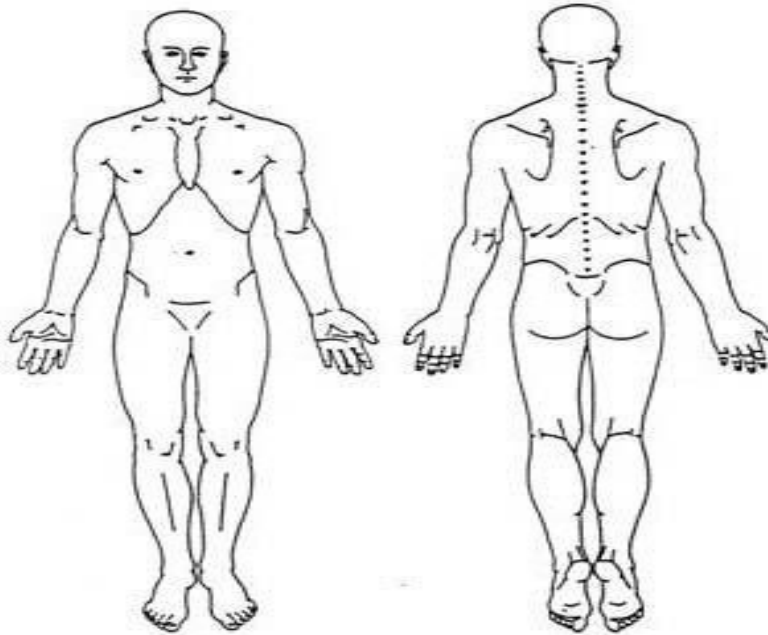


SCQ

BP	Pulse
HT	WT

Patient Name:	Patient Date of Birth:
Where is the location of the primary pain (reason you are here today)?	Referring Provider:
Did you sustain your injury on the job or during a motor vehicle accident? <input type="checkbox"/> NO <input type="checkbox"/> YES	
How long have you been experiencing the symptoms that you are seeking treatment for today?	
How did the symptoms begin?	

On the diagram below, please mark where you feel pain.



Pain Intensity

Please rate your **pain intensity**, for your **primary pain**, by marking the number that best describes your pain. 0 = no pain, 10 = most severe pain

	0	1	2	3	4	5	6	7	8	9	10
Worst pain this past week	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Least amount pain this past week	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Average pain this past week	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Current pain severity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

1. What does the pain feel like? _____
2. What makes the pain better? _____
3. What makes the pain worse? _____
4. Since the pain began is it getting better, worse, or staying the same? _____

Pain Interference

Please mark the number that describes how much, during the past week, your pain has interfered with each of the following activities. 0 = does not interfere with activity, 10 = completely interferes with activity.

	0	1	2	3	4	5	6	7	8	9	10
General activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking ability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Normal work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Relationships with other people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Enjoyment of life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you ever had pain in this area prior to this episode? If yes, when _____

Have you had any recent falls due to this pain? _____

Do you require an assistive device (such as a cane, walker, or a brace)? _____

Please indicate if you have been evaluated by any other specialists for your current issue (check all that apply):

- Pain Management Physical Medicine and Rehab Other
- Orthopedic surgery Neurosurgery
- Neurology Rheumatology

Do you have any of the following symptoms (check all that apply)?

- Easy Bleeding/Bruising Weight Change Breathing Problems Fever/Chills Heart Problems
- Stomach Problems Joint pain/ Swelling Morning Stiffness Weakness Skin Problems
- Bowel/Bladder Changes Night Pain Depression/Anxiety Numbness Tingling
- Shortness of Breath Vision Change Sleep Problems Headaches Chest Pain
- Rash Other _____

Have you had any of the following tests?

	NO	YES	Date(s)		NO	YES	Date(s)
X-Rays	<input type="checkbox"/>	<input type="checkbox"/>	_____	EMG (Nerve Test)	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____				

What treatments have you had for your current problem?

- Physical therapy Bracing Surgery Injection Acupuncture Chiropractor
- Other _____



