

### TELL ME ABOUT YOUR PAIN

Patient Name: _____		Date: _____
Chief Complaint _____	Date of injury _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Where did the injury occur? <input type="checkbox"/> At Work <input type="checkbox"/> Auto Accident <input type="checkbox"/> Sports <input type="checkbox"/> Gym <input type="checkbox"/> Other _____		

History of condition \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_

- Standing  Sitting  Bending  Lifting  Twisting  Sleeping

What makes your pain feel better? \_\_\_\_\_

- Rest  Ice  Heat  Exercise  Stretching  Nothing

Describe your Pain \_\_\_\_\_

- Burning  Numbness  Sharp  Dull  Stabbing  Tingling  Aching

How often does your pain occur? \_\_\_\_\_

- Constant  Intermittent  Minutes  Daily  Hours

Does it travel? \_\_\_\_\_

- Down Arms  Down Legs  To the Chest  Down Back

Timing \_\_\_\_\_

- Night  After Exercise  Morning

Has the pain come on **Suddenly** (within 72 hours) or **Gradually**? (Circle one)

Have you experienced unexplained weight loss of 5 lbs or more a week?  Y  N

Do you experience nausea or vomiting?  Y  N

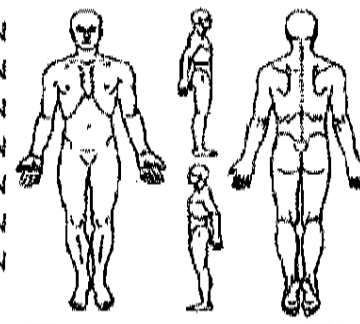
Does this condition wake you up at night?  Y  N

Do you experience fever or night sweats?  Y  N

Have you noticed a decrease in strength?  Y  N

Have you seen any other doctor for this injury prior to today?  Y  N

Are you currently taking any supplementation i.e. vitamins?  Y  N



Site - Please circle on the chart the area of your pain/discomfort

Severity - Please circle the number indicating the severity of your pain

No Symptoms ☺ 1—2—3—4—5—6—7—8—9—10 ☹ Extreme Pain

Date of last x-rays or MRI and the area studied: \_\_\_\_\_

Date of recent Blood work and/or Urinalysis: \_\_\_\_\_

Medications you are taking: \_\_\_\_\_

List any surgeries you have had: \_\_\_\_\_

Anything else the doctor should know about present complaint? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**For Office Use Only:**

Vitals: Lt. BP \_\_\_\_\_ Rt. BP \_\_\_\_\_ Pulse: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

\_\_\_\_\_  
 Healthcare Professional Signature

Case # \_\_\_\_\_

# PATIENT INFORMATION

Please allow our staff to photocopy your driver's license and all available insurance cards.

WELCOME! PLEASE PRINT.

Full Name \_\_\_\_\_ Gender: M F Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status (Circle One): S M W D Sep No. Children \_\_\_\_\_

SS# \_\_\_\_\_ Driver's License # \_\_\_\_\_

Your Employer \_\_\_\_\_ Your Occupation \_\_\_\_\_ Years on Job \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Do you have health insurance where you work?  Yes  No Plan/Group # \_\_\_\_\_

Insurance Company \_\_\_\_\_

Name of Spouse, Parent or Guardian \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_ Years on Job \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone \_\_\_\_\_

Does your spouse have health insurance at work?  Yes  No Plan/Group # \_\_\_\_\_

Insurance Company \_\_\_\_\_

How did you find out about our office? \_\_\_\_\_

Describe the major complaints that bring you to our office: \_\_\_\_\_

Is your condition due to an accident?  Yes  No Date of your accident: \_\_\_\_\_

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all copayments and non-covered services. I also understand and agree to pay all copays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

We file your primary insurance at no charge to you. Filings for policies in addition to your primary coverage are completed for a fee and as time permits.

Payment Options (Please Indicate):  Cash  Check  MasterCard  Visa  Discover

Case # \_\_\_\_\_

# PATIENT HEALTH SURVEY

FULL NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_

## Have you ever (at any time) experienced any of the following?

Difficulty urinating	Y	N	Claustrophobia (fear of small spaces)	Y	N
Loss of bladder control	Y	N	Spinal surgery	Y	N
Loss of bowel control	Y	N	Common cold/flu	Y	N
Temporary loss of vision, one eye	Y	N	Carotid artery surgery	Y	N
Blood in urine	Y	N	Breast removal	Y	N

## Have you ever been diagnosed with or told you have one of the following?

Detached retina	Y	N	Rheumatoid Arthritis	Y	N
Stroke	Y	N	Fractured/broken vertebra	Y	N
Slipped disc	Y	N	Bleeding disorders	Y	N
Herniated disc	Y	N	High blood pressure	Y	N
Osteoporosis	Y	N	Blood in stool	Y	N
TIA's (pin or mini strokes)	Y	N	Cancer	Y	N
Drop attacks (collapsing, but not fainting)	Y	N	AIDS	Y	N
Hardening of the arteries	Y	N	Kidney disease	Y	N
Partial or complete paralysis	Y	N	Prostate disease	Y	N

## Do you currently have, or could you be, any of the following?

Pregnant	Y	N
Taking birth control pills	Y	N
Receiving hormone therapy	Y	N
<input type="checkbox"/> Male <input type="checkbox"/> Female		
Receiving chemotherapy	Y	N
Receiving radiation therapy	Y	N
Taking blood thinners	Y	N
A heavy smoker (1 or more packs.day)	Y	N
Surgical/medical implanted devices:		
Aortic clips	Y	N
Brain clips	Y	N
Artificial heart valves	Y	N
Rods, pins, screws	Y	N
IUD	Y	N
Surgical clips/wires	Y	N
Shunt	Y	N
Neurostimulator	Y	N
Dentures	Y	N
Pacemaker	Y	N
Hearing aid	Y	N
Insulin pump	Y	N
Joint replacement	Y	N
Cochlear implants (ear)	Y	N
Other implanted devices:		
Metal fragments (head, eye, skin)	Y	N
Bullets/shrapnel	Y	N
Body piercing	Y	N
Tattoos	Y	N

## In the past 14 days (2 weeks), have you experienced any of the following?

Nausea	Y	N
Vomiting	Y	N
Vertigo (spinning)	Y	N
Difficulty walking	Y	N
Incoordination	Y	N
Numbness or other sensory complaints	Y	N
Loss of consciousness	Y	N
Double vision	Y	N
Blurred vision	Y	N
Tinnitus (ringing in ears)	Y	N
Speech problems	Y	N
Clumsiness	Y	N
Memory loss	Y	N
Travel by car/truck	Y	N
Personality changes	Y	N
Fever	Y	N
Recurrent headaches	Y	N
Diarrhea	Y	N
Used a tanning bed/booth	Y	N
Skin rash/infection	Y	N
A major fall	Y	N
A minor fall	Y	N
An auto accident	Y	N
A work injury	Y	N
Loss of strength	Y	N
Pain moving bowels	Y	N
Head trauma	Y	N
Abnormal period	Y	N

## CONSENT FOR TREATMENT

I (we) authorize the health care professional of the LAS VEGAS PAIN RELIEF CENTER (LVPRC) to administer and/or order : physical examinations, x-rays, lab studies, chiropractic care, soft tissue treatment, physical therapy, massage, and/or any other clinical examinations or treatment the doctor finds necessary.

## HIPAA INFORMATION

I (we) understand and agree to allow LAS VEGAS PAIN RELIEF CENTER (LVPRC) to use my (our) Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how this information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

## MISSED APPOINTMENT POLICY

There will be a \$35 fee charged if you fail to notify us at least four (4) hours prior to your appointment time.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Date \_\_\_\_\_

Name \_\_\_\_\_

### WELCOME TO LAS VEGAS PAIN RELIEF CENTER

Please share with us how you were referred to LVPRC;  
(Please circle one)

Yellow Pages   ART Website   Doctor (Please tell us who) \_\_\_\_\_

Insurance Company (Please tell us who) \_\_\_\_\_

Friend or Family member (Please tell us who) \_\_\_\_\_

Other (Please tell us who) \_\_\_\_\_

So that we may communicate with you via email, Please  
provide us with your email address

Email Address- \_\_\_\_\_

Do you know someone who is living with pain that would  
benefit from visiting LVPRC? If so please provide us with  
their name and contact information, so that we can help.

\_\_\_\_\_

### THANK YOU FOR YOUR COOPERATION

Dr \_\_\_\_\_