

Patient Registration

Date: _____

Patient Name: _____ Date of Birth: _____ Sex: M F
Home Address: _____ Social Security # _____
City, State, Zip: _____ Marital Status: M S D W
Home Phone: _____ Referring Physician: _____
Cell Phone: _____ Referring phone/fax: _____
Email Address _____

***Please mark the appropriate box if you are involved in a litigated case: Yes No**

Private Insurance:

Primary Insurance: _____ Name of Insured: _____
Claims address: _____ Insured D.O.B : _____
_____ Policy # _____

Secondary Insurance:

Secondary Insurance: _____ Name of Insured: _____
Claims address: _____ Insured D.O.B : _____
_____ Policy # _____

Workers Compensation:

Insurance Carrier: _____ Employer: _____
Claims address: _____ Claim# _____
_____ Date of Injury: _____
Name of Adjuster: _____ Phone: _____
Nurse Case Manager: _____ Phone: _____

CALIFORNIA PAIN MEDICINE CENTERS

New Patient History and Intake Form

Date: _____ Name: _____ Age: _____ Sex: _____ Occupation: _____

1. Who referred you?

PCP: _____

Referring Specialist: _____

2. What is your primary complaint?

How long have you had this pain/symptom?

(ie: years/months/weeks)

If you do not have a pain component then please go directly to the Allergy Section (Question 12)

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

Aching

^^^

Numbness

===

Pins & Needles

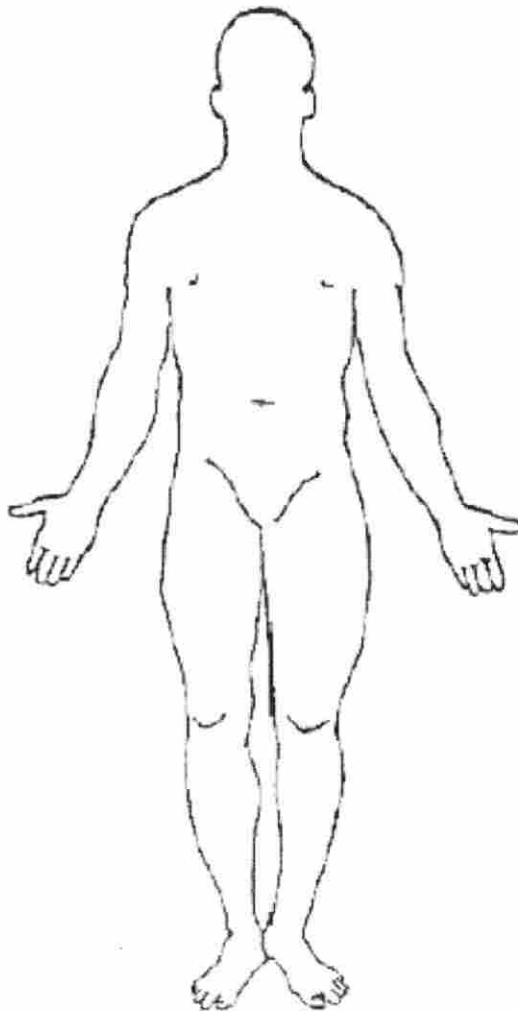
ooo

Burning

xxx

Stabbing

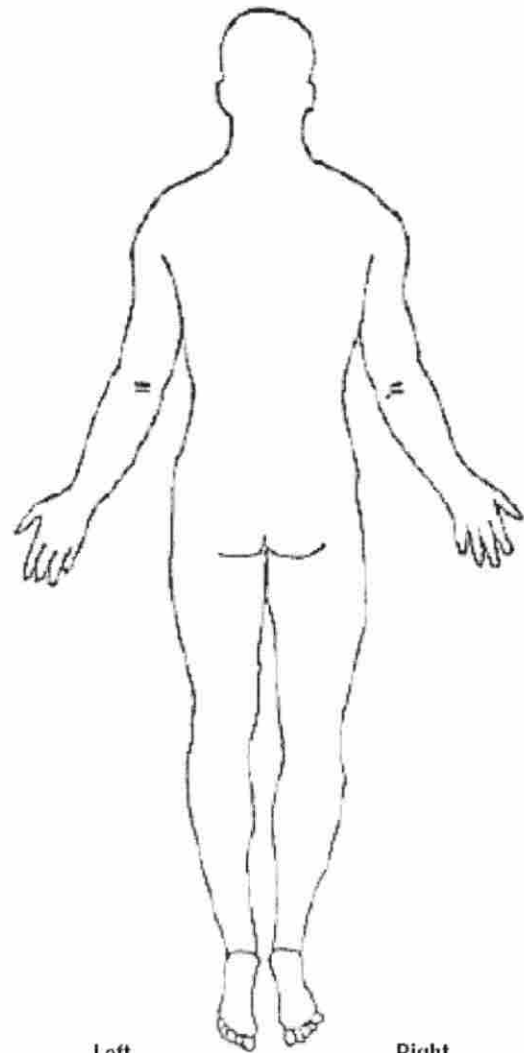
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Right

Front

Left



Left

Back

Right

3. How did the pain start?

- Suddenly Pulling
- Gradually Injured at work
- Lifting Injured in auto accident
- Twisting Hit from behind
- Fall Injured during sports
- Bending No apparent cause

4. What activities make the pain worse?

- Exercise (during) Bending forward
- Exercise (after) Bending backward
- Sitting Coughing
- Standing Sneezing
- Walking

5. What reduces the pain?

- Lying down Physical Therapy
- Sitting Injections
- Standing Muscle Relaxant Pills
- Walking Anti-inflammatory Pills
- Chiropractic Cognitive Therapy
- TENS unit Other:

6. Have you had any of these tests?

- | | Yes | No |
|-------------------|--------------------------|--------------------------|
| Diagnostic X-rays | <input type="checkbox"/> | <input type="checkbox"/> |
| CT scan | <input type="checkbox"/> | <input type="checkbox"/> |
| Myelogram | <input type="checkbox"/> | <input type="checkbox"/> |
| EMG | <input type="checkbox"/> | <input type="checkbox"/> |
| Discogram | <input type="checkbox"/> | <input type="checkbox"/> |
| MRI | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthrogram | <input type="checkbox"/> | <input type="checkbox"/> |
| Injections | <input type="checkbox"/> | <input type="checkbox"/> |

7. What kind of injections?

8. Was X-Ray used for those injections?

- No Yes

9. Have you ever been hospitalized or seen in the ER for this pain?

- No Yes
- Number of times _____ Most recent visit (Date) _____

10. Have you had surgery for this problem?

- No Yes

What kind of surgery: _____

Surgeon(s): _____

11. Have you had any of these symptoms?

- numbness (where: _____)
- weakness (where: _____)
- loss of bladder control
- loss of bowel control

Please rate your pain by circling the number that best describes your pain at its **WORST** in the last 24 hours

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain by circling the number that best describes your pain at its **LEAST** in the last 24 hours

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain by circling the number that best describes your pain on the **AVERAGE**

0 1 2 3 4 5 6 7 8 9 10

12. Allergies:

- Contrast dye (or Iodine)
- Antibiotics (which one(s): _____)
- Other: _____

Please list your **current**

Pain Medications:

Regular Medications:

- Plavix Coumadin Ticlid

If female, are you pregnant? Yes No

Major Illness or Medical Problems:

- Diabetes High Blood Pressure
- Heart Disease Asthma Emphysema
- Hepatitis High Cholesterol
- Heart Attack (When: _____) Seizures

Other Medical Problems: _____

Past Surgeries (please include date):

Family History (please list major health problems)

Mother's age: _____ deceased

Father's age: _____ deceased

Siblings: _____

Children: _____

Social History:

- Single Married Separated/Divorced Widowed
 Employed Unemployed Retired Employer: _____
If you had an injury, was it work related? Yes No (if Yes, which employer: _____)
Disability: Yes No
Litigation: Are you currently involved or planning on initiating a legal case? Yes No
Tobacco:
 Yes-Currently Yes-in the past No-never
 How many packs/day? _____
 How many years did you smoke for? _____
 When did you quit? _____

Alcohol:

- Yes No How many drinks/week? _____

Illicit Drug Abuse:

- Marijuana Heroin Cocaine Amphetamines Other: _____

Have you ever had a problem w/ prescription medications (ie: misuse, abuse, addiction)?

- Yes No Which drugs? _____

History of Alcohol Abuse: Yes No How long have you been sober? _____

History of Substance Abuse: Yes No How long have you been sober? _____

Review of Symptoms (please check the box if you have had any of these symptoms recently):

Constitutional:

- Fever Unexpected Weight loss Unexpected Weight gain Fatigue
 Sweats Chills

Head & Neck:

- Ringing in the ears Congestion Difficulty Swallowing
 Hearing Loss Glaucoma Blindness Blurry Vision

Pulmonary:

- Shortness of breath Wheeze Cough Require Oxygen

Cardiac:

- Chest Pain Palpitations Heart Attack High Blood Pressure
 Arrhythmia Valve disease

Gastro-intestinal:

- Nausea Vomiting Heartburn Constipation Diarrhea
 Hemorrhoids Blood in stool Ulcers

Genito-Urinary:

- Frequent urination Difficulty urinating Painful intercourse Menstrual problems
 Pain during urination Kidney Stones Prostate problems Blood in urine

Skin:

- Easy Bruising Itching Rash Jaundice

Musculoskeletal:

- Joint Pain Muscle Cramps Fractures Difficulty walking (requiring cane/walker)

Hematologic/Endocrine

- Thyroid Problems Diabetes Bleeding gums Bleeding disorder Hair loss

Psychological:

- Depression Anxiety Panic Attacks Suicide attempts
 Suicidal thoughts Emotional Problems Mood disorder

Neurological:

- Headaches Seizures Paralysis Dizziness Memory Loss Confusion



**CALIFORNIA PAIN MEDICINE CENTER
OPIATE USAGE CONTRACT**

Patient Name: _____

This policy is enacted to ensure the safe and proper use of any controlled substances.

Conditions and Agreement for Treatment with Opioids

Please Initial:

- _____ I do not currently have a problem with substance abuse or dependence (drug or alcohol), and I am not involved in the sale, possession, diversion or transportation of controlled or illegal substances
- _____ I agree to abstain from the use of any illicit substance while receiving opioid medications
- _____ I agree to take the pain medication only as prescribed
- _____ I agree to receive any and all pain medications only from one physician
- _____ I agree to notify the staff of any need for changes in my pain medication due to an anticipated surgical or dental procedure
- _____ I agree to consent to random urine and/or blood testing to assess the safety of my medication regimen and monitor my compliance with this treatment
- _____ I agree to bring all my pain medications to the clinic if requested by a physician
- _____ I agree to notify the physician if I am pregnant or intend to become pregnant

California Pain Medicine Center
Opiate Usage Contract

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_____ I understand that my opioid pain medication may be discontinued if
A) there are no appropriate improvements in my functioning on the medication
B) increases in my pain are not effectively managed with increases or changes in the medications
C) significant side effects or addiction develops

_____ I understand that if my opioid pain medication(s) are lost, stolen, or accidentally disposed of, I will not receive a refill of those medications without a documented police report

_____ I understand that any violation of this consent may result in my opioid pain medication being discontinued immediately and that I will be referred back to my primary care provider

_____ I understand that taking opiate and non-opiate pain medication may impair my alertness and thereby make certain activities such as driving more dangerous. I will take great care to avoid injury to myself or others while taking these medicines

I have read this document, understand it, and have had all my questions regarding risks and conditions of the treatment answered to my satisfaction. I consent to the use of opioid medication to manage my pain and I agree to all the conditions stated above in this consent. A copy of this consent will be provided to me and my primary care provider.

Patient Signature

Date

We certify the above named patient has received an explanation of the treatment being offered, including the risks and benefits to be expected. We have disclosed alternative methods of management that might be appropriate for the patient (including conservative and interventional management).

Physician Signature

Date



CALIFORNIA
PAIN
MEDICINE
CENTERS

Informed Consent
For Patients with
Worker's Compensation Insurance

I, _____
Give permission for *Sanjog Pangarkar and Associates of the California Pain Medicine Center* to provide pain medicine treatment to me for my medical condition related to an industrial injury.

I understand that the role of Dr. Pangarkar in my care will be that of a treating physician and consultant for pain related diagnoses.

I understand that Dr. Pangarkar will not assume the role of my primary treating physician.

I understand that my care may be time limited and that I may be referred back to my primary treating physician when my condition has stabilized.

I understand that Dr. Pangarkar will document the care provided to me and that these records will be made available to other professionals involved in my care.

I understand that Dr. Pangarkar will not be able to provide legal reports or opinions unless my visit has been specifically arranged with his legal department. In the event I am involved in litigation and I have not expressly advised Dr. Pangarkar or his staff of said involvement, I may be subject to additional charges for services provided to me, in accordance with Dr. Pangarkar legal fee schedule.

I have read and understand the above.

Signature

Print Name

Date: