Patient Registration

Date:_____

Patient Name:_____ Date f 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: _____

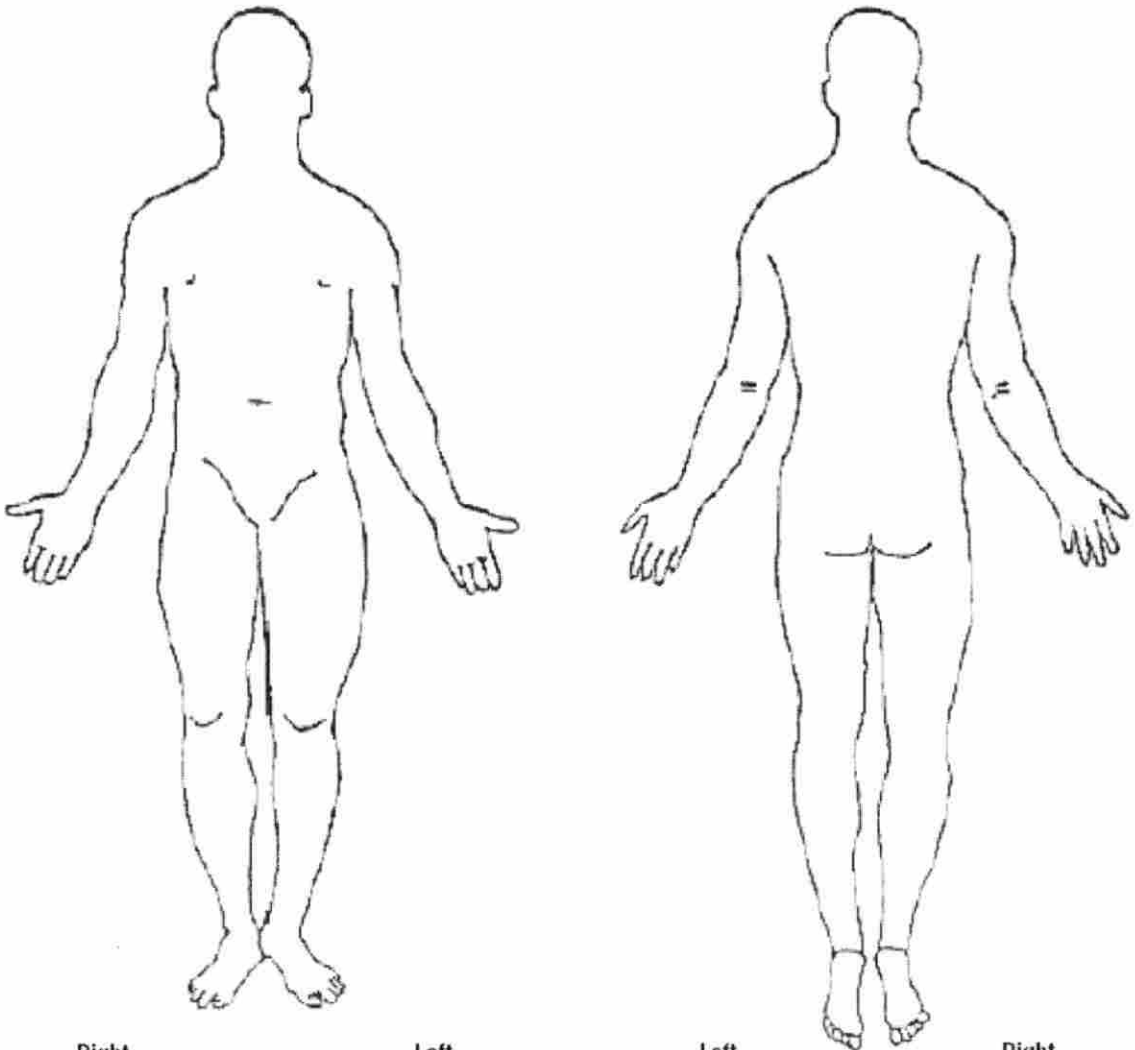
1. Who referred you?
   PCP: _____
   Referring Specialist: _____

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** 0 0 0 **Burning** X X X **Stabbing** / / /



Right Left — Front

Left Right — Back

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	☐	☐
CT scan	☐	☐
Myelogram	☐	☐
EMG	☐	☐
Discogram	☐	☐
MRI	☐	☐
Arthrogram	☐	☐
Injections	☐	☐

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

_____ 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

I, _____

Give permission for *Joshua P. Prager, M.D., M.S. and Associates of the California Pain Medicine Center* to provide pain medicine treatment to me for my medical condition.

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

I understand that Dr. Prager will not assume the role of my primary treating physician in addition he does not assume responsibilities associated with disability documents.

I understand that planning of my pain management treatment will be clarified at the time of my early visits.

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. Prager 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. Prager 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. Prager or his staff of said involvement, I may be subject to additional charges for services provided to me, in accordance with Dr. Prager's legal fee schedule. Furthermore, I accept that in the event I am involved in a litigated case for which Dr. Prager's are requested I accept the charge for this service of $3,000 and will be charged accordingly.

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

I have read and understand the above.

_____

Signature

_____

Print Name

_____

Date

Payment Policy Disclosure for Dr. Joshua Prager

This disclosure is written to inform you, "the patient", of the California Pain Medicine Center's payment policies for medical services.

Our Physicians are non contracted provider with Insurance Companies.

Payment for consultations, ketamine procedures and office visits must be paid at the time of service. An Insurance claim form will be provided for the patient to submit to their Insurance Company for reimbursement. If the Insurance Company sends the payment to our office, the patient will be directly reimbursed by the California Pain Medicine Center.

Surgeries and Medical Procedures will be billed to the patient's Insurance Company. The patient is responsible for what is not covered by their Insurance Company. For billed Surgeries and Medical Procedures, if the Insurance Company sends payment to the patient, it is the patient's responsibility to forward the payment to the California Pain Medicine Centers.

I acknowledge that I have read and understand the above payment policies of the California Pain Medicine Centers.

*I hereby authorized Dr. Joshua Prager to release any information requested by insurance company regarding treatment of the undersigned or my dependent.

*I understand and accept the insurance policies for Dr. Joshua Prager.

*Patients Name: _____ Date: _____

*Patient Signature:_____