

Medications

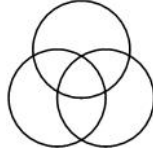
Name:

Date of 1st Visit:

Name of Medications	Strength	Directions
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____
11.	_____	_____
12.	_____	_____
13.	_____	_____
14.	_____	_____
15.	_____	_____

Allergies

Name	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



BALANCED PAIN MANAGEMENT, A Medical Group

Patient Information Sheet

Name:
Last: _____ First: _____ MI: _____

Birthdate: _____ Social Security#: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Email: _____

Home#: _____ Work#: _____ Cell#: _____

How did you hear about us? _____

Primary Care Physician: _____ Phone#: _____

Insurance
Name : _____ Subscriber: _____

If subscriber is not patient, subscriber DOB: _____ Relationship: _____

ID#: _____ Group#: _____

Insurance
Address: _____

Insurance Phone#: _____

Emergency
Contact: _____ Phone#: _____

Address: _____ Relationship: _____

To my knowledge, I believe the above information to be accurate and true.

Signature: _____ Date: _____

PAIN ASSESSMENT

PATIENTS NAME: _____ HEIGHT: _____ WEIGHT: _____

WHERE IS THE PAIN LOCATED: _____

1. Is your injury in any way related to an accident, motor vehicle or work related? _____ If yes please explain: _____

2. What is your current level of pain on a scale from 0 to 10, with 0 being no pain and 10 being severe? _____ Lowest level you experienced _____ Highest level _____
3. How long have you had the pain? _____
Is the pain constant? _____ Intermittent? _____
What relieves the pain? _____
What increases the pain? _____
4. Describe any pattern or changes

5. How does the pain affect your :
Sleep? _____
Appetite? _____
Physical Activity? _____
Concentration? _____
Social Relationships? _____
6. What treatments have you had for your pain? _____
7. Current pain medications and dosage? _____

8. List all prescription medications and "over the counter" medications(asprin, Tylenol, Vitamins) which you have taken in the last two weeks. _____
9. Have you ever had an allergy or serious reaction to any foods or medications, including shellfish? _____ If yes please describe. _____
10. Please list all operations you have had under general anesthesia (including tooth extraction and tonsillectomy). Also, please describe any problems that might have occurred with each. Include dates. _____
11. Have you ever had an illness or injury serious enough to require hospitalization? _____ if yes please describe. _____
12. Please list any other medical problems or illness. _____
13. Do you drink alcoholic beverages? If yes, how much? _____
14. Do you smoke? _____ If yes how long? _____ How much each day? _____
15. Have you ever had a mental or emotional condition that required medications? _____ If yes please describe. _____

16. Have you ever had problems with the following:

- Asthma YES NO
- Chest pain at rest YES NO
- Heart attack YES NO
- High blood pressure YES NO
- Kidney Liver YES NO
- Stroke/Seizure YES NO
- Anemia YES NO
- Stomach Ulcer YES NO

If yes, when? _____

If yes, when? _____

17. Have you ever had any respiratory problems?

- Asthma YES NO
- Difficulty breathing YES NO
- Shortness of breath YES NO
- Abnormal chest x-ray YES NO
- Chest Pain YES NO

If you answered yes to any of the above, please describe.

18. Have you ever had any of the following:

- Diabetes YES NO
- Epilepsy or seizures YES NO
- Jaundice or hepatitis YES NO
- Ulcers YES NO
- Glaucoma YES NO
- Urine retention YES NO
- Fainting YES NO

If you answered yes to any of the above, please describe.

19. Family History:

Is there anyone in your immediate family with any medical problems, such as diabetes, heart condition or cancer? _____

20. Female Patients:

- Do you think you are/may be pregnant? YES NO
- Are you taking oral contraceptives? YES NO
- Date of your menstrual cycle: _____

Patient signature _____ Date: _____

Pain Influence Scale

- | | |
|---------------------|--------------------------------|
| 1. Not at all | 10-20 Not much, but be careful |
| 2. Very seldom | 20-30 The start of trouble |
| 3. Half of the time | 30-40 Warning |
| 4. Most of the time | 40-50 Danger, too much!! |
| 5. All of the time | |

Question 1: Does the pain cause you to stay inside your house?

1 2 3 4 5

Question 2: Does your pain keep you from socializing with other people?

1 2 3 4 5

Question 3: Does your pain cause you to miss work?

1 2 3 4 5

Question 4: Does your pain cause you financial hardship?

1 2 3 4 5

Question 5: Does your pain interfere with sexual activities?

1 2 3 4 5

Question 6: Does your pain hamper or prevent leisure time activities, such as hobbies, sports, etc..?

1 2 3 4 5

Question 7: Does your pain cause you to feel like an outcast?

1 2 3 4 5

Question 8: Does your pain make you wonder whether your life is worth living?

1 2 3 4 5

Question 9: Does your pain occupy most of your thoughts?

1 2 3 4 5

Question 10: Does your pain cause you to feel angry, frustrated, or depressed?

1 2 3 4 5

BALANCED PAIN MANAGEMENT HIPPA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

114 La Casa Via #210

Walnut Creek, CA. 94598

By signing this form, I _____, authorize the use and disclosure of my health information as described below:

1. You can disclose my health information as described below:

- Leave messages on my answering machine YES NO
- Leave messages with my spouse YES NO
- Leave messages with anyone who answers phone YES NO
- Can fax information to my home YES NO
- Can fax information to my work place YES NO
- Can mail information to my home YES NO
- Can mail information to my work place YES NO

2. You can leave message confirming appointments as described below:

- Leave messages on my answering machine
- Leave messages with my spouse
- Leave messages with anyone who answers phone

Name of person/persons authorized to receive this information:

I understand that I have the right to revoke this authorization, in writing , at any time, except where uses or disclosures have already been made based upon my original permission or the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or insurance policy. I understand the uses or disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to Balanced Pain Management at 114 La Casa Via #210 Walnut Creek, CA. 94598

Signature of patient _____ Date _____

Print name of patient _____

PATIENT CONSENT AND AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatments, administration of anesthetics and performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instruction of such physician(s).

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for the charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay. It is further agreed that my credit balance resulting from payment of insurance or other sources may be applied to any other amounts owed to said physician(s) by the insured or his /her family.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to the Health Care Financing Administration and/or the patient's attorney, for all or part of the physician(s) charges, including but not limited to, patient insurance companies, worker's compensation carriers, welfare funds, or the patient's employer if a worker's compensation case.

LIFETIME AUTHORIZATION

MEDICARE AND MEDICAID PATIENT CERTIFICATION- PAYMENT CLASSIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying or payment under Title XVIII and or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare, Medicaid, or other third party claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for the physician(s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

PLEASE NOTE

Insurance contracts are made between you and the insurance company. We do not render service on the assumption that the charges will be paid by your insurance company. Payment of any and all charges are presumed to be your responsibility. All charges are due in full upon receipt of our statement. A photocopy of this form shall be valid.

DATE: _____ Patients signature or responsible party: _____