

## Patient Registration Form

**Personal Information**

Today's Date

Send referral to (check one):

Justin Lo, MD

Ray Hsieh, MD

Al Cheung, MD

Patient's Name:

Home Phone

Alternate Phone

Sex M / F



Social Security Number:

Address:

(Street, City, State, Zip)



**Emergency Contact**

Relationship

Phone Number

**Employer**

Employer Address

Name of Spouse

**Workers Comp**

Claim Number

Date of Injury

Insurance Carrier

Adjuster Name

Phone Number

FAX number

Consult Authorization Date

**Primary Insurance**

Insurance Carrier

Type of insurance PPO HMO IPO Private

(circle one)

Group #

Address

Phone number

FAX number

**Secondary Insurance**

**Attorney**

Address

Phone Number

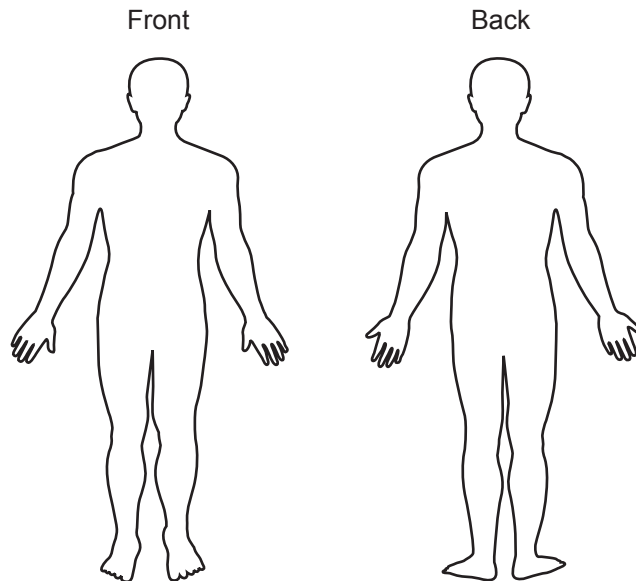
## Intake Questionnaire

Name (Last)	(First)	(M.I.)	Date of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Referred By			Month/Year your pain began
<input type="text"/>			<input type="text"/>

### 1. Where is your pain?

- Lower back
- Chest
- Abdomen
- Thigh (R, L)
- Buttock (R, L)
- Calf (R, L)
- Hand (R, L)
- Mid Back (R, L)
- Ankle (R, L)
- Head
- Arm (R, L)
- Groin
- Face
- Neck
- Upper Back
- Shoulder (R, L)
- Other: \_\_\_\_\_

### 2. Please mark the following drawing to highlight your areas of pain.



### 3. Please rate your pain level:

0=No Pain 10= worse possible pain

Maximum Pain:

Least Pain:

### 4. Is your pain related to one of the following:

Accident (Type of): \_\_\_\_\_

Illness: \_\_\_\_\_

Other: \_\_\_\_\_

### 5. Would you describe your pain as:

- Sharp
- Burning
- Aching
- Throbbing
- Shooting

### 6. Does your pain travel?

Yes

Explain \_\_\_\_\_

No

## Intake Questionnaire

**7. What time of day is your pain worse?**

7 AM   11 AM   3 PM   7 PM   11 PM   3 AM  
*(circle one)*

**8. Does the pain wake you up at night?**

Yes       No

**9. Describe (in your own words) your pain:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**10. What makes your pain worse?**

- Coughing
- Sneezing
- Standing
- Walking
- Sitting
- Bending
- Eating
- Sexual Intercourse

**11. What makes your pain better?**

- Sleeping/Resting
- Relaxation
- Away from work
- Sitting
- Standing
- Walking
- Exercise
- Alcohol
- Nothing
- Heat Application
- Cold Application
- Medicine (List): \_\_\_\_\_
- Other: \_\_\_\_\_

**12. Please list all current medications:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**13. What treatments have helped your pain in the past?**

- Medical Procedure or Surgery: (Explain)  
\_\_\_\_\_
- Medicine: (List)  
\_\_\_\_\_
- Physical Therapy
- Visual Imagery or Biofeedback
- Psychotherapy
- Other: \_\_\_\_\_

**14. What other symptoms accompany your pain?**

- Numbness
- Tingling with pins & needles
- Skin Changes
- Weakness
- Coldness
- Bowel Problems
- Bladder Problems
- Increased Sweating
- Muscle Spasms or tightness
- Other: \_\_\_\_\_

## Intake Questionnaire

**15. How does your pain affect the following:**

Sleep \_\_\_\_\_  
 Appetite \_\_\_\_\_  
 Concentration \_\_\_\_\_  
 Physical Activity \_\_\_\_\_  
 Emotions \_\_\_\_\_  
 Family \_\_\_\_\_  
 Social Relationships \_\_\_\_\_  
 Sexual Activity \_\_\_\_\_  
 Work Activity \_\_\_\_\_

**16. What do you think is causing your pain now?**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**17. Since your pain began, has it:**

- Decreased  
 Increased  
 Remained the same

**18. What is your goal in regards to your pain?**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**19. Have you been hospitalized for your pain?**

Yes

Explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

No

**20. Have you had any of the following tests to evaluate your pain?**

- X-ray                       EMG  
 MRI                          Myelogram  
 CT Scan

**21. What specific treatments/procedures have you had for the treatment of your present pain?**

Date \_\_\_\_\_  
 Procedure \_\_\_\_\_  
 Physician \_\_\_\_\_  
 How long did relief last? \_\_\_\_\_

Date \_\_\_\_\_  
 Procedure \_\_\_\_\_  
 Physician \_\_\_\_\_  
 How long did relief last? \_\_\_\_\_

Date \_\_\_\_\_  
 Procedure \_\_\_\_\_  
 Physician \_\_\_\_\_  
 How long did relief last? \_\_\_\_\_

**22. Do you smoke?**

What? \_\_\_\_\_  
 How much? \_\_\_\_\_  
 N/A

**23. Alcohol consumption**

- None  
 Social Only  
 1-2 Drinks per Day  
 3 or more

**24. Does your medication intake concern you?**

Yes                       No

**25. Do you have legal action pending related to you pain?**

Attorneys Name: \_\_\_\_\_  
 Phone number: \_\_\_\_\_

**26. Please list the name and phone number of your insurance adjuster:**

\_\_\_\_\_