CHOICE
PAIN & REHABILITATION CENTER, LLC

Patient Registration

Welcome to our office. We are committed to providing the most comprehensive rehabilitation to decrease pain while improving your mobility and overall quality of life. Please assist us by providing the following information to the best of your ability. All information is confidential and is released only with your consent. Please feel free to ask us any questions you may have.

First Name:	Middle Initial:	Last Name:	
Date of Birth:	Age:	Sex:	Social Security #:
Height:	Weight:	Marital Status:	Occupation Status:
Address:	City:	State:	Zip Code:
Home #:	Cell #:	Work #:	
Email Address:			
Emergency Contact Name:	Relation:	Phone #:	
Race (check): ☐Other/ Refused to report ☐American Indian/Alaska Native ☐Native Hawaiian/Other Pacific ☐White ☐Asian ☐Black/African American ☐Hispanic		Ethnicity (Check): ☐Other/ Refused to report ☐Not Hispanic/Latino ☐Hispanic/Latino	
Referring Physician Name:			
Address:	Phone #:	Fax #:	
Primary Care Physician Name:			
Address:	Phone #:	Fax #:	
Pharmacy Name:			
Address:	Phone #:	Fax #:	
Previous Pain Physician Name:			
Address:	Phone #:	Fax #:	
Please circle the correct type of insurance below.			
Health Insurance---Workers Compensation---Automobile Injury			
Primary Insurance Company:			
Address:	Phone #:	Fax #:	
Policy Holder Name (if not the patient):			
Member #:	Group #:		
Secondary Insurance Company:			
Address:	Phone #:	Fax #:	
Policy Holder Name (if not the patient):			
Member #:	Group #:		

Choice Pain & Rehabilitation

◊Lanham ◊Gaithersburg ◊Hyattsville ◊Dundalk
(P)240-786-1001 (F)240-786-1002

Office Policy

Welcome to our office. We're committed to providing you with the best possible care. In order to achieve that goal, your understanding of our office policy is essential. Please read this carefully and sign at the bottom of the page.

1. **Copayment-** Co-pays must be paid before you see the doctor. If you arrive without your co-pay, you may be asked to reschedule.
2. **Referrals-** Our office requires a referral for all patients regardless of insurance. If your insurance does requires that you have a current referral to see us, you must obtain one prior to your visit. Otherwise, you will be responsible for the full cost of your visit.
3. **Patient Balance-** Balances must be paid before or at the time of your next appointment unless otherwise arranged in advance by our billing or front desk staff.
4. **Checks-** Checks are not accepted as form of payment. All co-pays and/or balances must be paid with either a credit/debit card or in cash.
5. **Missed Appointments-** If you are unable to keep your appointment, we required 24 hours' notice. Providers are not able to make exceptions to this policy. There is a $25 fee for office visits and in office injections. There is a $100 fee for missed EMG/NCS appointments. All fees for missed procedures scheduled at a surgery center will be charged at the discretion of that surgery center.
6. **Tardiness-** If you arrive more than 10 minutes late, the doctor will see you at his/ her discretion. You may be asked to reschedule.
7. **Insurance Coverage-** Your insurance is a contract between you and your insurance company. We are not a party to that contract. You must familiarize yourself with the details of your coverage as we cannot research your policy at your visit.
8. **Non-covered Services-** Not all services, such as cosmetic procedures, are covered benefits in all contracts. In such cases, you will be asked to pay in full at the time of your visit. We can provide you with claim information by request.

I have read this information in its entirety and agree to abide by the policies of this practice. I understand that violation of this contract may lead to my discharge from the practice at my provider's discretion.

_____ _____
(Patient/ Legal Guardian) (Date)

Patient Agreement

HIPPA Notice of Privacy Practices:
I, _____, do affirm that I received and reviewed a copy of the Choice Pain & Rehabilitation Center LLC HIPPA Notice of Privacy Practices prior to being rendered any services by the above names practice and its associates.

Authorization to Pay Benefits to Physician/ Choice Pain & Rehabilitation:
I (undersigned) authorize payment of medical benefits to Choice Pain & Rehabilitation Center LLC, for any services furnished to me. I understand I am financially responsible for any amount not covered by my insurance.

Financial Agreement:
I understand that Choice Pain & Rehabilitation charges 12% interest on all accounts past 30 days. Should I default in payments due, I agree to pay all costs of collections, including collection fees, court cost, and any reasonable attorney fees up to 35% of the outstanding balance. I authorize Choice Pain & Rehabilitation Center to apply for benefits on my behalf for services rendered. I request that payment from my insurance be made directly to Choice Pain and Rehabilitation Center. I understand that regardless of insurance, payment remains patient/ guarantor responsibility.

Medical Record Release:
I authorize you to release information concerning health care, advice, treatment, or supplies provided to me to my insurance company and/or consulting physicians by mail/ fax. This information will only be used within HIPPA guidelines for treatment and/or payment.

Consent to confidential medical information: (Optional)
I hereby authorize Choice Pain & Rehabilitation to share any and all of my medical / billing information with the following people:

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

I have read and understand the above paragraphs in their entirety.

_____ _____
(Patient/ Legal Guardian) (Date)

MEDICARE PATIENTS ONLY:

I request the payment of authorized Medicare benefits be made on my behalf to Choice Pain & Rehabilitation Center LLC for any services rendered to me by the physician(s). I authorize the release of my medical records to the Health Care Financing Administration and it agents by mail/ fax that may be needed to determine benefits payable for related services.

I have read and understand the above paragraph in its entirety.

_____ _____
(Patient/ Legal Guardian) (Date)

What doctors have you seen for treatment related to your pain? Feel out the chart to the best of your ability.
(E.g. Dr. Tristan Shockley> Pain management> Jan 2017/May 2017> Injections)

Doctor Name	Specialty	Date Seen	Treatment
1.			
2.			
3.			
4.			

What diagnostic studies have you completed since the pain began? Feel out the chart to the best of your ability?
(E.g. Community Radiology> MRI Lumbar Spine> Aug 2016> Degenerative discs)

Radiology/Other Facility	Study Completed	Date Completed	Results
1.			
2.			
3.			
4.			

What treatments/medications are you receiving or have received in the past for your pain? How much relief did it provide from 0-10; 0 being no relief and 10 being complete relief?
(E.g. Tens Units> 4> Currently receiving)

Treatment/Medication	Relief 0-10 (circle)	Check if currently receiving
1.	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10	□
2.	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10	□
3.	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10	□
4.	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10	□

Is your current pain the result of a work related accident?.....Yes/No
If "yes" please write the date of injury(s). Date of Injury(s) _____

Is your current pain the result of a non-work related accident? (E.g. Auto injury or fall)……..Yes/No
If "yes" please write the date of injury(s). Date of Injury(s) _____

Are you presently involved in a lawsuit related to your pain? .....Yes/No
If "yes" please explain on the lines below.

_____

_____

By answering the following questions, you will help you physician better understand and treat your pain.

When and how did your pain begin? Explain on the lines below. (E.g. Pain began in 2012 after falling on ice.)

_____

_____

What is your functional goal(s)? (E.g. Regain normal walking ability)

_____

Are there any other symptoms associated with your pain?

_____

Circle any symptoms that you have been experiencing in the last 6 months.

Headaches	Vision problems	Hearing problems	Dizziness	Difficulty swallowing	Fever/ Chills
Unexplained weight loss	Joint instability	Stomach pain	Nausea/ Vomiting	Erection problems	Constipation
Diarrhea	Chronic fatigue	Numbness/ Tingling	Night pain	Chest pain	Shortness of breath
Urinary incontinence	Rashes	Swollen joints	Night sweats	Weakness	Finger/feet swelling

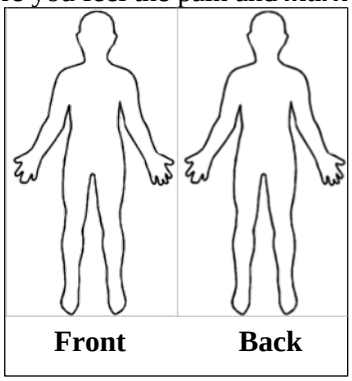
Circle the words that best describe your pain below.

Aching	Sharp	Penetrating	Throbbing	Tender	Nagging	Shooting	Burning	Numb	Stabbing
Exhausting	Miserable	Gnawing	Tiring	Unbearable	Intermittent	Continuous	Tingling	Dull	Other_____

Circle the number below that best describes how the pain has interfered with your daily functioning. 0 being the pain does not interfere at all, and 10 being the pain completely interferes.

General activity……	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10
Mood……	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10
Walking ability…….	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10
Normal work routine……	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10
Relations with other people…..	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10
Sleep…….	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10
Enjoyment of life……..	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10
Ability of concentrate…….....	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10
Appetite……	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

On the diagrams below, ***shade*** the area(s) where you feel the pain and ***mark*** with an ***"X"*** the areas that hurt the most.



What make the pain feel better? (E.g. heat, medicine, ice pack, hot bathes)

_____

_____

What makes the pain feel worse? (E.g. prolonged walking, standing, lifting, weather changes)

_____

_____

Circle the number that best describes your pain at each point during that last month. 0 being no pain at all, and 10 being the worst pain imaginable.

Worst pain level……..	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10
Least pain level……...	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10
Average pain level……..	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10
Current pain level……..	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

Current Medication List: Please include all medications you are currently taking. If none, check the box below.

□ No known medications

_____

_____

_____

Medical History: Please place a check mark "✓" under the column if you have the disease/condition. If you condition is not listed, write it in the space labeled other. If none, check the box below.

□ No known medical conditions

Diabetes	Hypertension	Heart disease	Stroke	Mental Illness	Cancer	Other

Allergies: List any allergies and their outcome (especially medications). If none, check the box below.

□ No known drug allergies

Allergen	Reaction
1.	
2.	
3.	
4.	

Surgeries: List any surgeries you have had and the date they were completed. If none, check the box below.

□ No known surgeries

Surgery	Treating physician/ Location	Date Completed
1.		
2.		
3.		
4.		

Family History: Please place a check mark "✓" under the column if the family member has the disease. If none, check the box below.

□ No known family medical history/ Adopted

Family member	**Alive, Deceased, Unknown**	**Diabetes**	**Hypertension**	**Heart disease**	**Stroke**	**Mental illness**	**Cancer**	**Other**	**Drug/Alcohol abuse**
Father	A, D, U								
Mother	A, D, U								
Paternal Grand Father	A, D, U								
Paternal Grand Mother	A, D, U								
Maternal Grand Father	A, D, U								
Maternal Grand Mother	A, D, U								
Paternal uncle	A, D, U								
Paternal aunt	A, D, U								
Maternal uncle	A, D, U								
Maternal aunt	A, D, U								
Siblings	A, D, U								
Children	A, D, U								
Other/ Spouse	A, D, U								

Smoking Status: Check your current status below. If status is positive, please fill out the associated questions.

□ Current smoker □ Former smoker [Quit date: _____] □ Nonsmoker

How often do you smoke cigarettes?

□Every day

□Some days, but not every day

How many cigarettes a day do you smoke?

□ 5 or less

□ 6-10

□ 11-20

□ 21-30

□ 31 or more

How soon after waking up do you smoke your first cigarette?

□ Within 5 minutes

□ 6-30 minutes

□ 31-60 minutes

□ After 60 minutes

Are you interested in quitting?

□ Ready to quit

□ Thinking about quitting

□ Not ready to quit

Alcohol Status: Have you had a drink containing alcohol in the past year? If status is positive, please fill out the associated questions.

□Yes □No longer drink alcohol [Date last consumed: _____] □No

How often did you have a drink containing alcohol in the past year?

□ Never

□ Monthly or less

□ 2-4 times a month

□ 2-3 times a week

□ 4 or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

□ 1-2 drinks

□ 3-4 drinks

□ 5-6 drinks

□ 7-9 drinks

□ 10 or more drinks

How often did you have 6 or more drinks on one occasion in the past year?

□ Never

□ Less than monthly

□ Monthly

□ Weekly

□ Daily or almost daily

Illicit Drug Status: Please answer each question by circling "yes/no". If status is positive, please check all substances that you have used.

Have you used drugs other than for medical reasons in the past 12 months?.....Yes/No

□ Marijuana	□ Cocaine	□ Heroin
□ PCP	□ Pain medications (List:_____)	□ Other (List:_____)

Have you used drugs other than for medical reasons at any point in your life? .....Yes/No

□ Marijuana	□ Cocaine	□ Heroin
□ PCP	□ Pain medications (List:_____)	□ Other (List:_____)

Have you ever had a DUI (driving under the influence)? .....Yes/No
If "yes" please list the date(s) Date of DUI(s) _____

Social Status: Please answer the following questions to the best of your ability.

What is your occupation? Describe your responsibilities. _____
□ Full-time
□ Part-time
□ Disability
□ Retired
□ Unemployed
□ Self-employed

Are you currently a student?.....Yes/No
If "yes" Part-time or Full-time

Do you drive?.....Yes/No
If "yes" how often? _____

Do you exercise regularly?.....Yes/No
If "yes" how often and what activity? _____

Who do you live with? _____

Use the lines below to write any important information you would like your provider to know about you or your condition that you feel would help direct your treatment. (Optional)

Notes:_____

_____

_____

_____

Office ORT: Please answer the following questions to the best of your ability

Total Score
_____

Are you □Male or □Female? (Please check)

Is there a family history of abuse to the following? (Please check all that apply)

F1 M3□Alcohol
F2 M3□Illegal Drugs
F4 M4□Prescription Drugs
F0 F0□Not Applicable

Have you ever abused any of the following? (Please check all that apply)

F3 M3□Abuse Alcohol
F4 M4□Illegal Drugs
F5 M5□Prescription Drugs
F0 M0□Not Applicable

Are you between the ages of 16 – 45 years old? (Please check)

F1 M1□Yes □No

Do you have any history of sexual abuse before the age of 10? (Please check)

F3 M0□Yes □No

Do you have any of the following? (Please check all that apply)

F2 M2□Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar disorder, Schizophrenia
F1 M1□Depression
F0 M0□Not Applicable

Cognitive Assessment: Have you ever experienced any of the following?
Check all that apply

□Sensation of not feeling right, being a little confused or unsteady?
□Spells you would describe as feeling faint or as if you might pass out?
□Events where you've experienced altered awareness?
□Episodes of temporary confusion or brain fog?
□Dizziness accompanied by loss of awareness or confusion?
□Difficulty finding the right words or expressing yourself?
□Lapse of time or zoning out?
□Difficulty recalling the details of conversations? (E.g. Conversations you recently had or TV shows you just watched.)
□None

Migraines/Headaches: Are you experiencing daily/weekly migraines associated with the following symptoms?
Check all that apply

□Aura or flashing/shimmering lights
□Dizziness
□Loss of awareness/consciousness
□None

Use the lines below to write any important information you would like your provider to be aware of. (Optional)

Notes:_____
_____
_____
_____
_____