

Name:

DOB:



Date:

Neil B. Kirschen, M.D.
Robert Iadevaio, M.D.
Jacob Rauchwerger, M.D.

Patricia Kirschen, L.Ac.
Haydee Pimentel-Tejada, FNP

PATIENT DEMOGRAPHIC

Mark One:

New Change Change New Insurance
Patient Name Address Effective: _____

Is this related to: **Motor Vehicle Accident?** YES NO

Work Related Accident? YES NO

If YES, ask for additional forms

Patient Last Name		First Name		MI	Date of Birth		Age	Sex
Patient Address			City	State	Zip Code		Social Security #	
Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D W		Primary Language <input type="checkbox"/> ENGLISH <input type="checkbox"/> _____		Race <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Unknown <input type="checkbox"/> White <input type="checkbox"/> Decline Info			Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Type Unknown	
Patient Telephone#		Patient Cell Phone #		Patient Work#		Email:		
Emergency Contact		Relationship		Telephone #		Family Doctor Name & Phone:		
Primary Reason for Visit			Referred to us by:			Pharmacy Name and Address:		
1st Insurance		Policy #		Group #		Policy Holder Date of Birth		
Policy Holder Name		Relationship to Pt.		Insurance Billing Address				
2nd Insurance		Policy #		Group #		Policy Holder Date of Birth		
Policy Holder Name		Relationship to Pt.		Insurance Billing Address				
3rd Insurance		Policy #		Group #		Policy Holder Date of Birth		
Policy Holder Name		Relationship to Pt.		Insurance Billing Address				

PLEASE HAVE PHOTO I.D. AND ALL INSURANCE CARDS AVAILABLE

☆ We can share you health information with your:

Spouse _____ **Significant Other** _____ **Parent** _____ **Children** _____ **PCP** _____ **Attorney** _____

Other: _____

☆ I understand that copayments are due at time of service

☆ I understand that referrals are my responsibility

☆ I have received a copy of my HIPAA Privacy Policy

Patient Signature

Name:
DOB:
Chart:
Age:
Date:

Neil B. Kirschen, M.D.
Robert Iadevaio, M.D.
Jacob J. Rauchwerger, M.D.



Patricia Kirschen, L.Ac.
Haydee Pimentel-Tejada FNP

Comprehensive Pain Evaluation and History

Date (Fecha): _____ Height: _____ Weight: _____ lbs Blood Pressure: _____ / _____

ALLERGIES: No Known Drug Allergies

Allergic to:	Severity
_____	<input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> anaphylactic
_____	<input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> anaphylactic
_____	<input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> anaphylactic
_____	<input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> anaphylactic
_____	<input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> anaphylactic

Please list all previous **surgeries** and dates: _____

Is there a family history of addiction or chronic pain? (specify) _____

LIFESTYLE (Current Smoking Status:)

<input type="checkbox"/> Never Smoker	<input type="checkbox"/> Former smoker Year started smoking _____ #Packs per day _____
<input type="checkbox"/> Smoker, Current status unknown	<input type="checkbox"/> Current Every Day Smoker..... Year started smoking _____ #Packs per day _____
<input type="checkbox"/> Unknown if ever smoked	<input type="checkbox"/> Current Some Day Smoker.... Year started smoking _____ #Packs per day _____
	<input type="checkbox"/> Tobacco smoker __Heavy __ Light...Year started smoking ____ # Packs / Day ____

☑ MEDICAL HISTORY: Do you or have you had: (check all that apply)

<input checked="" type="checkbox"/>	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Heart attack (MI)	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Cancer: _____
<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/> Urinary retention	<input type="checkbox"/> Liver diseases	
<input type="checkbox"/>	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Low energy	<input type="checkbox"/> Thyroid disease	Mother's Medical History <input type="checkbox"/> No relevant history
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Arrhythmia (irregular heart beat)	_____
<input type="checkbox"/>	<input type="checkbox"/> Migraines	<input type="checkbox"/> Constipation	<input type="checkbox"/> Easy bruising/ Bleeding	Father's Medical History <input type="checkbox"/> No relevant history
<input type="checkbox"/>	<input type="checkbox"/> Seizures	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Excessive thirst	_____
<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Difficulty sleeping	

☑ Please list all other **medical conditions** you have, or other medical conditions you have, or are under treatment for?

(Liste todas sus condiciones medicas)

☑ What is the complaint which you are seeking help for? (Cual es su dolor?)

☑ Is the pain related to an injury, accident, cancer, surgery, or other disease? (Es relacionado a un tipo de accidente, cancer, cirugia o enfermedad?)

☑ When did the pain begin? How long has it been present? (Cuando empezo su dolor y cuanto tiempo lo tiene?)

Name:
DOB:
Chart:
Age:
Date:

☉ Since it began how has the quality changed? e.g. Increased, decreased, unchanged. (Como ha cambiado su dolor? Tiene mas, menos, sin cambios desde el inicio del dolor)

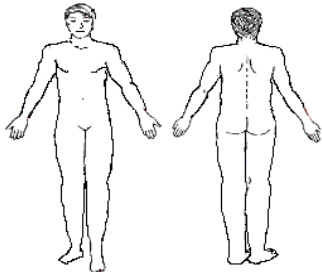
☉ How often does the pain occur? **Circle ONE** (Con que frecuencia le ocurre su dolor? Marque Uno)
Nonstop-continuous, Several times a day, Once a day several times a week (Seguido y constante,
Several times a month, Other _____ Varias veces por mes o por semana)

☉ **For the following please use 0-10** (Del # 0 al 10, con diez siendo el dolor mas grave anote como le afecta su dolor?)
0 = no pain disruption, 10 worst pain imaginable extremely disruptive

Pain at its worse ever? Maximo Dolor _____ Pain currently worst? Dolor Ahora _____
Pain at its best ever? Minimo Dolor _____ Pain currently best? _____

Pain currently most of the time? _____

☉ Please shade in the affected areas (Marque las areas de su dolor)



☉ Which characteristics describe your pain? **Check all that apply.** (Marque las descripciones de su dolor)
Denote how often? (Always, Often, Rarely for each checked)

- | | | | |
|-------------------------------------------------|---------------------------------------------|------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Throbbing (Palpitante) | <input type="checkbox"/> Gnawing | <input type="checkbox"/> Tight (Apretado) | <input type="checkbox"/> Punishing/cruel (Castigado/Cruel) |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Hot-burning (Arde) | <input type="checkbox"/> Squeezing | <input type="checkbox"/> Pins/needles (Sentir como agujas) |
| <input type="checkbox"/> Stabbing (Apuñalado) | <input type="checkbox"/> Aching (Agotado) | <input type="checkbox"/> Splitting | <input type="checkbox"/> Numb (Entumecido) |
| <input type="checkbox"/> Sharp (Agudo) | <input type="checkbox"/> Heavy (Pesado) | <input type="checkbox"/> Tiring/Exhausting (Cansado) | <input type="checkbox"/> Fearful (Miedoso) |
| <input type="checkbox"/> Cramping (Calambres) | <input type="checkbox"/> Tender (Tierno) | <input type="checkbox"/> Sickening (Enfermiso) | |

☉ What makes the pain better? (Que le alivia su dolor?)

☉ What makes the pain worse? (Que le empeora su dolor?)

☉ What specialist have you seen for the pain? Chiropractor, Neurologist, Orthopedist, Physical Therapist, Surgeon ?
Que especialistas ha consultado para su dolor? Quiropractico, Neurologo, Ortopedista, Terapia Fisica, Cirujano ?

Date seen Physical therapist (Fechas que tuvo terapia fisica?) _____

Date seen Chiropractor (Fechas que tuvo tratamientos quiropracticos) _____

Date seen Other (Fechas de otros especialistas?) _____

Name:
DOB:
Chart:
Age:
Date:

☉ What therapies have you tried for the pain? Circle & write in others. Surgery , nerve blocks, brace, physical therapy, biofeedback, relaxation, TENS and Heat, injections, acupuncture, chiropractic, massage, hypnosis, ultrasound, etc.
(Que terapias le han hecho para su dolor? Marque todas y escriba si no estan listadas: Cirugia, inyecciones, terapia fisica, relajacion, maquina TENS, acupuntura, quiropractico, masajes, ultrasonido)

☉ What medicine do you currently take for your pain? Specify next to each who prescribes them to you and whether: Helps, No-help or Not sure. Include over the counter, herbal and alternative preparations. (Que medicina esta tomando para su dolor? Especifique a lado de cada una si le ayuda. Incluya todas medicinas farmaceuticas y naturales)

☉ What other medication have you taken for pain? Why were they stopped? (Que otras medicinas ha tomado para su dolor? Porque las deajo de tomar?)

☉ Please list **all other medications** you are currently taking. Including over the counter herbal and alternative supplements.
(Liste todo tipo de medicamentos que esta tomando incluyendo vitaminas y hiebras naturales)

☉ Do you or have you used illicit or un-prescribed drugs? If so, which ones. (Usted usa drogas ilegales? Cuales)

☉ Do you share **drugs**? (Comparte o usa usted drogas?)

☉ How much **alcohol** do you consume in a week? (Cuantas bebidas alcolicas toma semanal?)

☉ What is your **current employment status**? What type of work do/did you do? (Esta trabajando? Que tipo de trabajo hace?)

☉ Are you involved in any lawsuits ? (Tiene un caso legal ahorra contra alguien?)

☉ How much relief do you expect to obtain? _____ % Reduction in my pain. (Que porcentaje de alivio espera? _____ %)

Physician Signature

Date