PAIN CONSULTANTS PLLC

Christopher Merifield, MD
Diplomate of the American Board of Anesthesiology
Fellowship: Pain Management
Subspecialty Board Certified Pain Management

Pain Consultants PLLC
9800 Levin Road NW
Suite 201
Silverdale, WA 98383

(360) 692-2330
(360) 692-2329 fax
www.painconsultantspllc.com

PATIENT REGISTRATION FORM

Patient Name: ______________________________ **Date of Birth:** _________________
(First, Middle, Last)

Mailing Address: ____
(Street, City, State, Zip Code)

Home Phone: ________________________ **Cell Phone:** ____________________

Employer: ___________________________ **Work Phone:** __________________

SSN: _______________________________ **Sex:** ☐ Male ☐ Female

Emergency Contact:

Name: ___________________________________ Phone #: ______________________

PRIMARY INSURANCE: _______________________ **ID #:** _________________________

Subscribers Name: _____________________ **Date of Birth** ______________________

SECONDARY INSURANCE: ___________________ **ID #:** _________________________

Subscribers Name: _____________________ **Date of Birth** ______________________

INJURED? ☐ At Work ☐ Auto Accident Date of Injury ___________________

Insurance Carrier: _____________________ Claim #________________________

Address: _____________________________ Phone #: _____________________

Financial Agreement: I understand that I am responsible for all co-payments, deductibles and charges for services rendered to me not covered by my insurance company. I will pay my co-payments at the time of service per contractual obligation with my insurance company and understand that Dr. Merifield will utilize my personal health information to obtain payment for said service dates.
Attendance Agreement: My signature acknowledges that I understand that Dr. Merifield's office requires 24 hours notice for appointment cancellations. Missing multiple appointments without notice, or continually giving less than 24 hours notice for cancellations, may result in termination of care.
Release of Benefits and Information: I authorize my insurance benefits be paid directly to the provider of service. I am financially responsible for any balance due. I authorize **Pain Consultants, PLLC,** to release any information required for this claim.

Signature: ______________________________ **Date:** ____________________

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NEW PATIENT HEALTH INFORMATION

NAME ______________________

When did the pain start? __________
Referring Provider ______________
Primary Doctor ________________

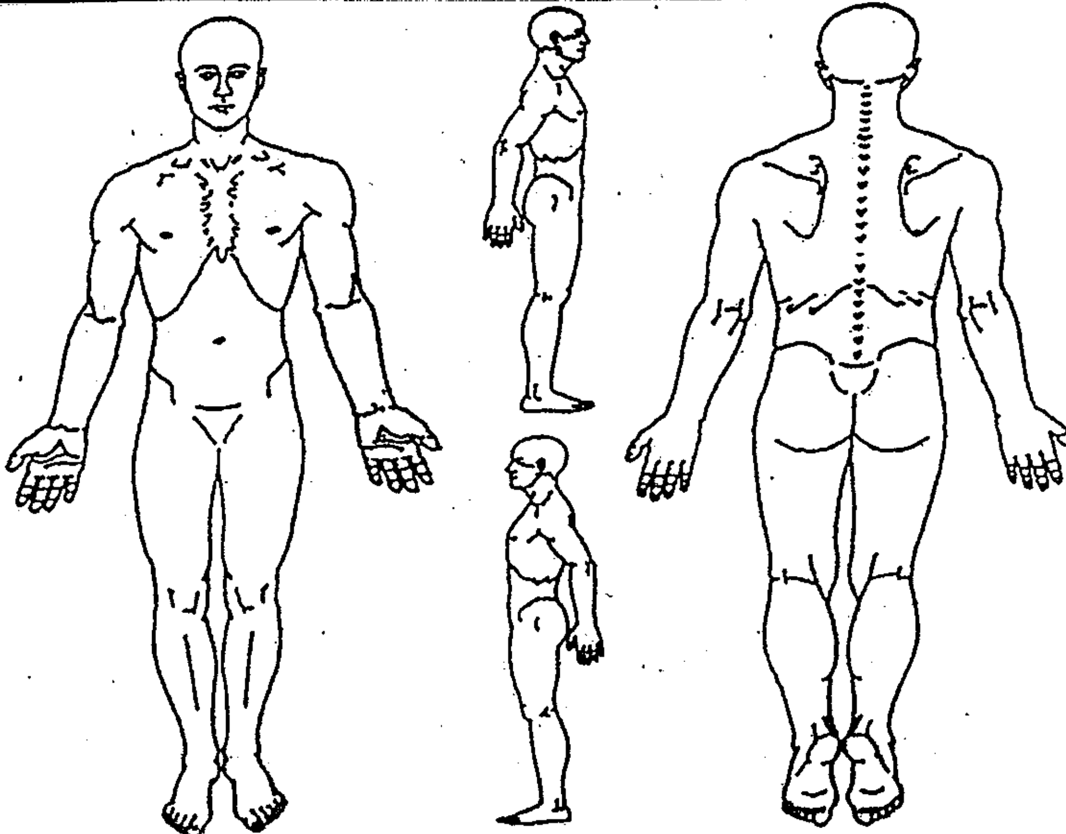
AGE _______ SEX________ WEIGHT_______ HEIGHT ________

Is your pain work related? ______________ Accident related? _________________

PLEASE BRIEFLY DESCRIBE YOUR MAIN PROBLEM/COMPLAINT.

____
____
____
____

PLEASE DRAW IN THE LOCATION OF YOUR SYMPTOMS
xxxx = pain oooo = numbness



My pain is best described as (check all that apply):

☐ Constant ☐ Intermittent
☐ Dull ☐ Aching ☐ Throbbing ☐ Burning ☐ Toothache
☐ Sharp ☐ Stabbing ☐ Shooting ☐ Electrical

Please rate your <u>highest</u> level of pain in the last 4 weeks? (Please indicate by circling a number below)

No Pain										Worst possible pain
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Please rate your <u>lowest</u> level of pain in the last 4 weeks? (Please indicate by circling a number below)

No Pain										Worst possible pain
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

PRESENT PAIN HISTORY

How do these activities affect your pain?

	Worsen	**Improve**
Standing for periods of time	______	______
Sitting for periods of time	______	______
Walking	______	______
Bending or stooping forward	______	______
Bending backwards	______	______
Lying down	______	______
Coughing or bowel movement	______	______
Getting in or out of a car	______	______
Riding in a car	______	______
Exercise	______	______
Other ______________	______	______
Other ______________	______	______

If you have pain with standing, how long can you stand without pain? ______________
If you have pain with sitting, how long can you sit without pain? ______________
Do you need a support to help you walk? ___________ If yes, what kind? ______________

How did your pain begin?

Accident at work _____ Accident at home _____
Following surgery _____ Auto accident _____
Following an illness _____ Pain just began _____
Other reason ____

Have you seen other physicians for you pain? (please list)

____________________ ______________________ ____________________
____________________ ______________________ ____________________

How many times have you been to the emergency room for your present pain? ___________

Please indicate which **diagnostic tests** you have had in evaluation of your present pain, please include dates.

MRI ______________ CT scan ______________
Myelogram ______________ Bone Scan ______________
Discogram ______________ EMG/NCS ______________
Other ____

Please indicate which **treatments** you have had for your present pain problem

	YES	NO	HELPFUL?	DATES
Physical therapy	______	______	______	______
Pool therapy	______	______	______	______
Home exercises	______	______	______	______
TENS	______	______	______	______
Manipulation	______	______	______	______
Trigger Point injection	______	______	______	______
Epidural Steroids	______	______	______	______
Acupuncture	______	______	______	______

Other procedures or injection? ______________________________

MEDICAL HISTORY

Please list any **medication allergies** ______________________________

____

Please list all **current medications,** including dosage, frequency, and duration of use

Medications	Dosage	Frequency	How long?
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______

*Please attach medication list if necessary

Please check if you have ever been treated for any of the following **medical problems**

High blood pressure	______	Heart disease	______
Lung disease	______	Diabetes mellitus	______
Kidney disease	______	Ulcers	______
Cancer	______	Seizures	______
Bowel problems	______	Stroke	______
Rheumatic disease	______	Arthritis	______
Depression	______	Headaches	______

Other Problems ______________________________

____

Please list any **past surgeries** you have had, please include dates

____

____

____

____

REVIEW OF SYSTEMS Check if positive

CONSTITUTION
______Weight loss in last 6 months
______Fatigue
______Poor Appetite
______Chills/Fever
______History of cancer

SKIN
______Itching
______Hives

EAR/NOSE/THROAT/MOUTH/EYES
______Hard of hearing/hearing loss
______Ringing in ears
______Vertigo
______Visual Changes
______Glaucoma
______Nose bleeds
______Chronic sinus problems
______Seasonal allergies
______Dry mouth
______Sore throat

HEAD
______Headaches
______History of head injury
______Facial pain

RESPIRATORY
______Recurrent cough
______Bronchitis
______COPD/Emphysema
______Shortness of breath

CARDIOVASCULAR
______Chest pain
______Passing out
______High blood pressure
______Swelling of feet
______Poor circulation

ENDOCRINE
______Thyroid
______Temperature intolerance
______Diabetes

GASTROINTESTINAL
______Nausea/Vomiting
______Constipation
______Heartburn
______Blood in stools
______Loss of bowel control
______Liver disease

GENITAL/URINARY
______Frequent urination
______Loss of control
______Blood in urine
______Burning

MUSCULOSKELETAL
______Muscles cramps
______Stiffness
______Swelling of joints
______Gout
______Osteoporosis
______Joint pain
______Muscles aches

NEUROLOGIC
______Fainting
______Memory loss
______Stroke
______Paralysis
______Weakness
______Numbness
______Seizures

HEME/LYMPHATIC
______Swollen glands
______Anemia
______Easy bruising
______Blood thinners
______Bleeding disorder

FAMILY MEDICAL HISTORY

	Relationship		Relationship
High blood pressure	___________	Asthma/COPD	___________
Heart attack	___________	Bleeding disorder	___________
Heart Disease	___________	Hepatitis	___________
Diabetes	___________	Arthritis	___________
Headaches	___________	Depression	___________
Alcoholism	___________	Drug abuse	___________
Suicide	___________		

Other ____

Any family members with chronic pain and/or psychiatric illness? _______________________

SOCIAL HISTORY

Marital status: Single _____ Married _____ Divorced _____ Widowed _____
Living arrangements: Alone _____ Friend _____ Family/relatives _____
Do you smoke? ______ How many packs per day? ______ How long? ______
Do you drink alcohol? ______ How much? ________
History of illicit or street drug use, past or present? ________________________________
Highest level of education completed _______________________

EMPLOYMENT HISTORY

What is your working status?

_____Working full time _____Working part-time
_____Unemployed _____Retired
_____Homemaker

What is the description of your job?

____

____

If you are not working, how long have you been off? ______________________
If your present pain is work related please answer the following:
What was the date of your injury? ______________________
How long have you been off work since your injury? ______________________
Do you currently have an attorney in regard to your pain condition? ______________________
If yes, please provide name and phone number: ______________________
Are you receiving financial support related to your pain? ______________________
Do you plan on filing a lawsuit because of pain? ______________________

MENTAL HEALTH HISTORY

Have you ever been treated for depression, anxiety, or stress? Yes ______ No _____
If yes, please give details of any inpatient and/or outpatient treatment that you have received:

____

____

Present treating physician or psychologist ______________________________

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NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes us to do so. You may see your records or get more information about it by contacting Amanda, our Privacy Officer.

Additionally, may we leave a message at the phone number(s) you have given us? Please initial your preference.

_______ I agree _______ I decline

Pain Consultants, PLLC also asks that you give us the names of family, friends or other providers with whom your information may be shared:

____

____

____

____

____

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

______________________________________ ____________
Patient or legally authorized individual signature Date

______________________________________ ____________
Printed name if signed on behalf of the patient Date

This form will be retained in your medical record
Last Update: ___/___/___