



# PAIN CONSULTANTS, PLLC

9800 Levin Road NW, Suite 201 P: 360-692-2330  
Silverdale, WA 98383 F: 360-692-2329

www.painconsultantspllc.com

**Christopher Merifield, MD**  
Fellowship: Interventional Pain Medicine  
Diplomate of the American Board of Anesthesiology  
Board Certified Interventional Pain Medicine

**John Hache, MD**  
Fellowship: Interventional Pain Medicine  
Board Eligible in Anesthesiology and Pain Medicine

**Erin Henderson, ARNP**

## PATIENT INFORMATION

Last Name		First Name		MI	Alias or Maiden Name	
Date Of Birth	Sex	Social Security Number		Marital Status		
Mailing Address			City	State	Zip	
Home Phone		Cell Phone		Work Phone		
Employer			Employed Full time or Part time?			
Preferred Language		Race	<input type="checkbox"/> Refuse to report	Ethnicity	<input type="checkbox"/> Refuse to report	
Email address				<input type="checkbox"/> No Email/Elect not to disclose		
Referring Provider			Primary Care Provider			
Pharmacy Name and Location						
Emergency Contact Name and Relationship				Emergency Contact Phone #		

## RESPONSIBLE PARTY INFORMATION *(if different from patient information)*

Last Name		First Name		MI	Alias or Maiden Name	
Date Of Birth	Sex	Social Security Number		Employer Name		
Street Address			City	State	Zip	

**INSURANCE INFORMATION – Must be completed in order to bill your insurance.**

PRIMARY Insurance Company	ID Number	Group Number
Subscriber Name	Subscribers DOB	Relationship to the patient
SECONDARY Insurance Company	ID Number	Group number
Subscribers Name	Subscribers DOB	Relationship to patient
<b>PRESCRIPTION COVERAGE</b>		
If you have prescription benefits, please list your insurance carrier		ID Number

<b>WORK RELATED INJURY OR MOTOR VEHICLE ACCIDENT</b>		Is this an open claim? YES or NO
Insurance Company	Claim Number	Date of Injury
Insurance Address		Phone Number

**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. In the event that legal action should become necessary to collect any unpaid balance due for medical services rendered to me, I agree to pay reasonable attorney fees or other such costs as the court determines proper. I agree that the venue for any legal action shall be in Kitsap County.

**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.

**Attendance Agreement:** My signature acknowledges that I understand that Pain Consultants 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.

SIGNATURE: \_\_\_\_\_

Printed Name: \_\_\_\_\_ DATE: \_\_\_\_\_



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## NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

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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:

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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. Please let us know if you would like a copy of this notice.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

This form will be retained in your medical record



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## NEW PATIENT HEALTH INFORMATION

PATIENT NAME \_\_\_\_\_

Referring Provider \_\_\_\_\_

Primary Care Provider \_\_\_\_\_

AGE \_\_\_\_\_ SEX \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

Is your pain due to a work related injury? \_\_\_\_\_

When did your pain begin? \_\_\_\_\_

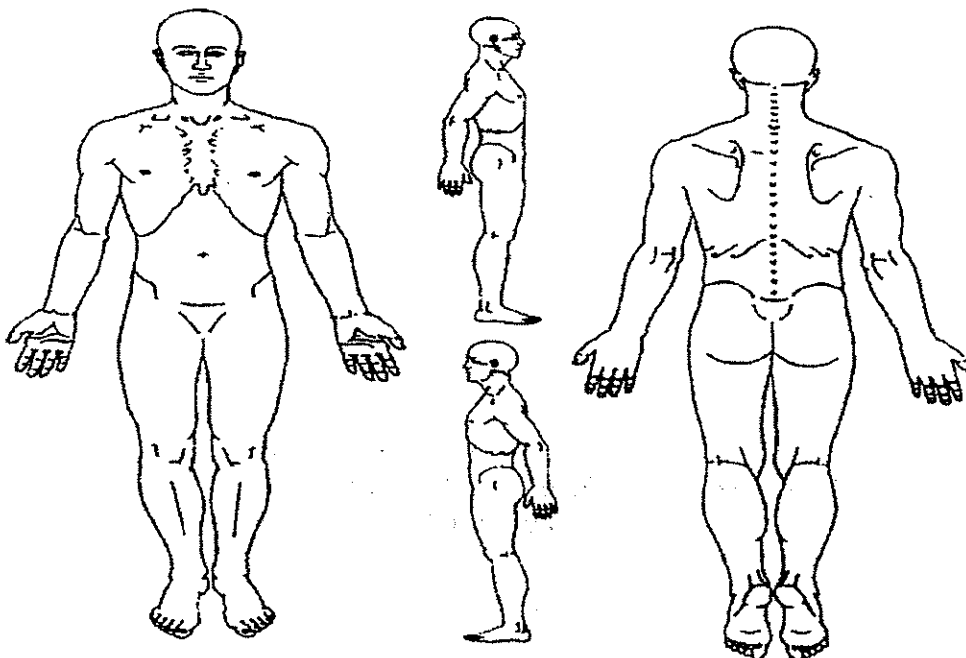
PLEASE BRIEFLY DESCRIBE YOUR MAIN PROBLEM/COMPLAINT.

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

PLEASE DRAW IN THE LOCATION OF YOUR SYMPTOMS

xxxx = pain

oooo = numbness





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

	<u>YES</u>	<u>NO</u>	<u>HELPFUL?</u>	<u>DATES</u>
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**

Arthritis	_____	High Blood Pressure	_____
Bowel Problems	_____	Kidney Disease	_____
Cancer	_____	Liver Disease	_____
Type of Cancer:	_____	Lung Disease	_____
Depression	_____	Rheumatic Disease	_____
Diabetes	_____	Reflux	_____
Headaches	_____	Seizures	_____
Heart Attack	_____	Stroke	_____
Heart Disease	_____	Ulcers	_____
Other Problems	_____		_____

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

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

**FAMILY MEDICAL HISTORY**

Alcoholism	Relationship _____	Headaches	Relationship _____
Asthma/COPD	_____	Heart Attack	_____
Arthritis	_____	Heart Disease	_____
Bleeding Disorder	_____	Hepatitis	_____
Depression	_____	High Blood Pressure	_____
Diabetes	_____	Suicide	_____
Drug Abuse	_____		
Other	_____		

Any family members with chronic pain? \_\_\_\_\_  
 Any family members with psychiatric illness? \_\_\_\_\_

**SOCIAL HISTORY**

Marital status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_  
 Living arrangements: Alone \_\_\_\_\_ With Spouse \_\_\_\_\_ Friend \_\_\_\_\_ Family/Relatives \_\_\_\_\_

Smoking Status :  
 Nonsmoker                       Current Smoker                       Former Smoker  
 How much do you smoke? \_\_\_\_\_ When did you quit Smoking? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How much? \_\_\_\_\_  
 History of illicit or street drug use, past or present? \_\_\_\_\_  
 Highest level of education completed \_\_\_\_\_

**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 \_\_\_\_\_

**EMPLOYMENT HISTORY**

What is your working status?  
 \_\_\_\_\_ Working full time                      \_\_\_\_\_ Working part-time  
 \_\_\_\_\_ Unemployed                                      \_\_\_\_\_ Retired  
 \_\_\_\_\_ Homemaker

What is the description of your current or previous 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? \_\_\_\_\_

**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

**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**

- Headaches
- History of head injury
- Facial pain
- Fainting
- Memory loss
- Stroke
- Paralysis
- Weakness
- Numbness
- Seizures

**HEME/LYMPHATIC**

- Swollen glands
- Anemia
- Easy bruising
- Blood thinners
- Bleeding disorder