Community Pain Medicine
140-21 32nd Avenue, Suite C1
Flushing, NY 11354

REGISTRATION FORM

PATIENT INFORMATION

Date:_____

Name:_____ Gender: ☐Male ☐Female

Date of Birth:_____ Age:_____ Race *(Optional)*:_____

Social Security Number (SSN):_____ E-Mail:_____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Street Address: _____ Apt #: _____

City:_____ State:_____ ZIP:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Contact Preference: ☐Home Phone ☐Cell Phone ☐Work Phone

Would you like to receive automated text alerts/confirmations? ☐Yes ☐No

IN CASE OF EMERGENCY			
Name of Local Friend or Relative	Relationship to patient	Home/Cell Phone #	Work Phone #

PRIMARY CARE PHYSICIAN INFORMATION

Family Doctor or PCP:_____

Phone #: ( )_____ Fax #: ( )_____

REFERRAL INFORMATION: How did you hear about us?

☐Family Doctor or PCP Name of Doctor or Hospital:_____

☐Other Health Care Provider Address: _____

☐Hospital Phone #:_____ Fax#:_____

☐Friend - Name of Friend:_____

Is this friend a patient at this clinic? ☐Yes ☐No Address:_____

Phone #:_____

☐Radio/Television Station – Name of Radio/Television Station:_____

☐Newspaper – Name of Newspaper:_____

☐Church Bulletin – Name of Church:_____

☐Internet Search/Website – Name of Search Engine/Website:_____

☐Insurance Company – Name of Insurance:_____

☐Other – Please Specify:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Community Pain Medicine** or insurance company to release any information required to process my claims.

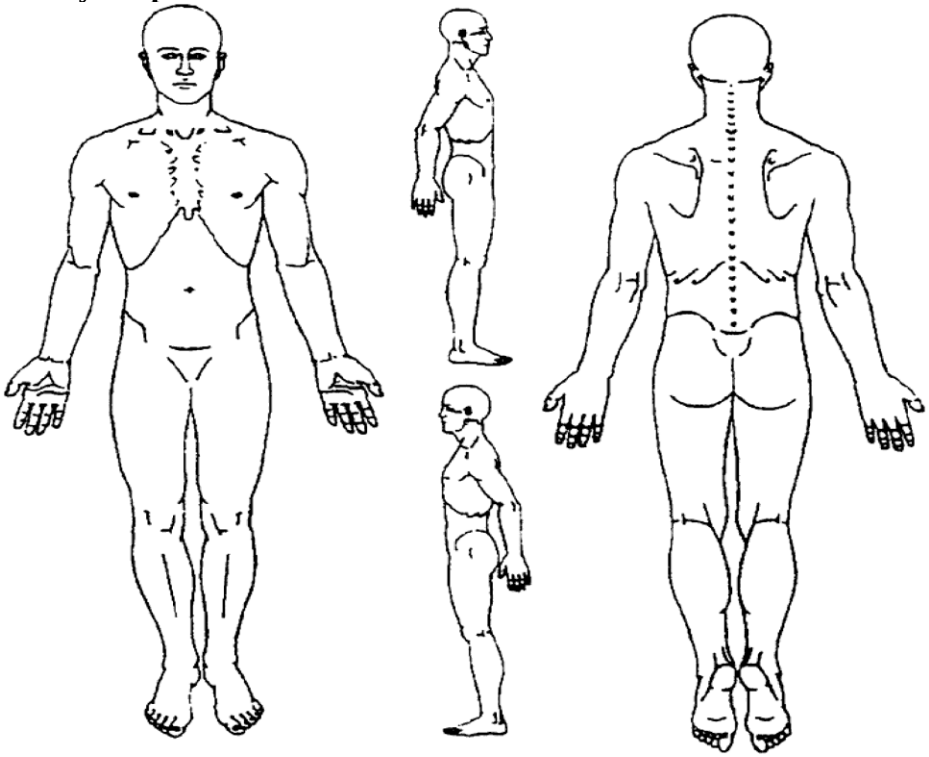
PATIENT/GUARDIAN SIGNATURE:	**DATE:**

Community Pain Medicine
140-21 32nd Ave., Flushing, NY 11354

NAME: _____ **DATE:**_____

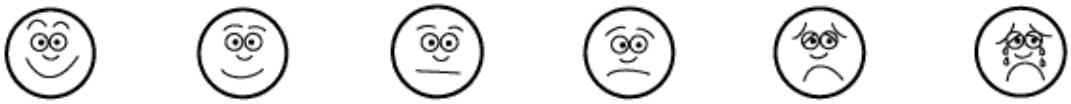
BIRTHDATE: _____/_____/_____ **Age:** _____ **Sex:** □ Male □ Female

1. Please indicate where your pain is.



(For Office Use)	
BP:	
P:	
T:	
H:	
W:	

1. My pain/discomfort is… (circle number):



0 1 2 3 4 5 6 7 8 9 10

No pain Mild Moderate Severe Excruciating

2. How long has the pain (or your problem) been present? Days _____ Months _____ Years _____

3. Has your problem worsened recently? □ No □ Yes – How recently? _____

4. What started the pain (or problem)?

□ work-related injury □ car accident □ Other_____

5. What best describes your pain?

□ achy □ dull □ sharp □ shooting □ stabbing □ hot/burning
□ heavy □ cramping □ throbbing □ tingling □ pins & needles
□ other: _____

6. When do you experience an increase of pain?

□ sitting □ standing □ walking □ climbing stairs □ laying down
□ driving □ lifting things □ bending forward □ other: _____

7. What treatments have you received in the past? □ None

□ acupuncture □ physical therapy □ chiropractic treatment □ anti-inflammatory medications
□ narcotics □ epidural steroid injections □ cortisone injections □ other: _____

8. How long have you received these treatments? _____

9. Which of the following tests have been performed? □ None

□ X-rays □ CT Scan □ MRI □ Nerve Conduction □ Other: _____

NAME: _____ BIRTHDATE: _____/_____/_____

10. Are you currently taking narcotics, such as Percocet, Oxycontin or Vicodin?

□ No □ Yes

11. Are you here today because you need a prescription for narcotics?

□ No □ Yes

MEDICAL HISTORY

Please indicate any medical problems you have presently. (Check all that apply)

□ None

□ High blood pressure
□ High Cholesterol
□ Diabetes
□ Pacemaker
□ Thyroid Problems
□ Gallbladder Problems
□ Gastritis
□ Reflux
□ Arthritis
□ Osteoporosis
□ Rheumatoid arthritis
□ Parkinson's disease
□ Prostate Problems
□ Depression
□ Anxiety
□ HIV/AIDS
□ Hepatitis
□ Cancer - of _____
□ Addiction to _____
□ Other: _____

Surgical History: **Previous surgeries – list procedure and date.** □ None

OPERATION	DATE

Family History: (**Check all that apply**) □ No medical problems

□ Stroke □ High blood pressure □ Diabetes □ Arthritis □ Cancer
□ Alcoholism □ Other: _____

MEDICATIONS:

List all medications that you are currently taking: □ None

Medication	Dose

Pharmacy Name:_____Pharmacy Phone #: _____

Pharmacy Address: _____

NAME: _____ BIRTHDATE: _____/_____/_____

ALLERGIES: □ No known allergies

□ Penicillin □ X-Ray Dyes □ Iodine □ Sulfur □ Latex □ Shellfish

□ Pollen □ Dust □ Other: _____

What symptoms do you experience when having an allergic reaction?

□ rash □ itching □ shortness of breath □ coughing/sneezing □ other_____

SOCIAL HISTORY

1. Do you smoke?

□ Never □ Quit – When? _____

□ Yes – How often? _____

2. How often do you drink alcohol?

□ Never □ Occasionally □ Frequently (more than three days a week)

□ Alcoholic □ Recovering alcoholic

3. How many times in the past year have you had 4-5 drinks in a day?

□ Never □ Once □ Twice □ More than twice – How often? _____

4. Drug use/abuse:

□ Never □ Currently □ In the past What drug(s)? _____

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date