California Headache and Pain Center

Patient's Name________________________ Date:________________
(Please Print)

Age:________________

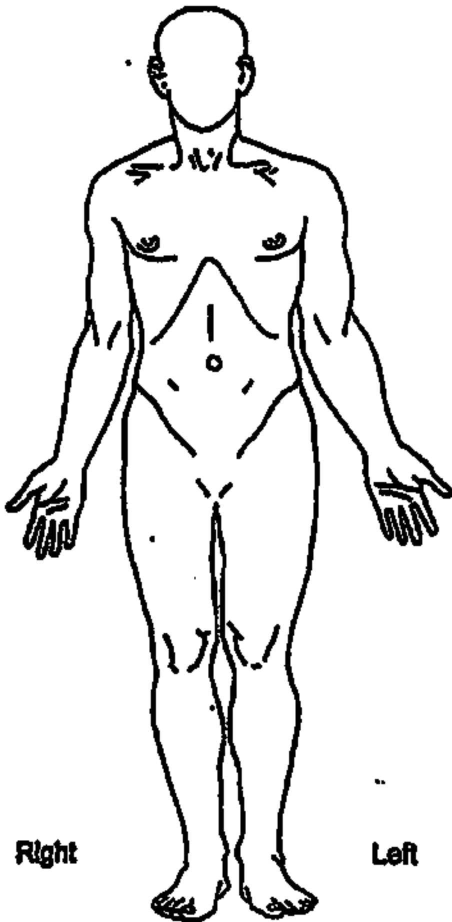
Where is your Pain NOW?

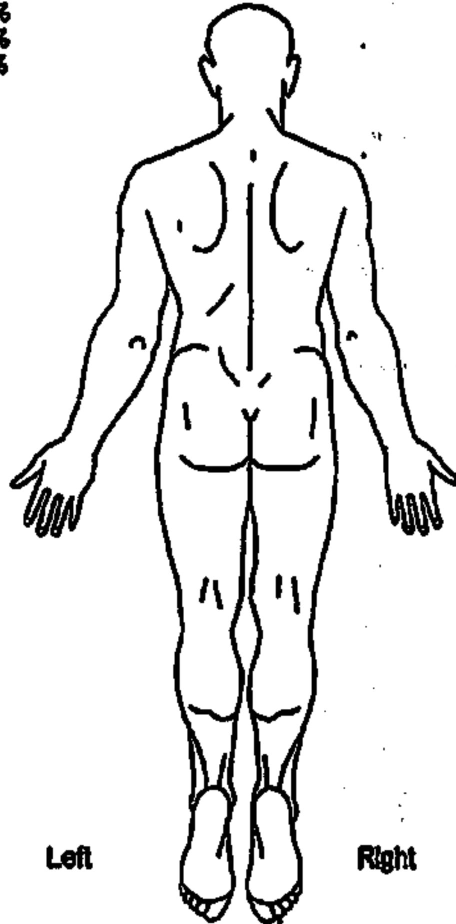
Mark the areas on your body where you feel the described sensations. Use the apporpriate symbol. Mark the area of radiation. Include all affected areas. Just to complete the Picture draw in your face..

ACHE	NUMBNESS	PINS AND NEEDLES	BURNING	RADIATING PAIN
∧ ∧ ∧	O O O	■ ■ ■	X X X	/ / /
∧ ∧ ∧	O O O	■ ■ ■	X X X	/ / /
∧ ∧ ∧	O O O	■ ■ ■	X X X	/ / /

Neck Pain________%
Arm Pain________%
Back Pain________%
Leg Pain________%

TOTAL = 100%





PLEASE MARK ON THE LINE:

How bad is your Pain now?

California Headache and Pain Center
New Patient Information

(PLEASE PRINT CLEARLY)

Patient's Name: ____
Last Name First Middle Initial

Address: ______________________________ City: ____________________

State: ______________ Zip Code: ____________ Date of Birth: _____/_____/_____

Sex: Male / Female Main Phone#: ( ) _____-______ Cell: ( ) _____-______

SSN: ____-____-_____ Driver's License #: ___________ Email: ________________

Single / Married / Divorced / Widowed Language preference: ________________

Caucasian / African American / Hispanic / Asian / Other: ________________

Employer: ______________________ Occupation: ______________________

Full / Part Time Employee Retired Full / Part Time Student Disabled

Insurance: ______________________ ID#: ______________________

Card Holders Name: ___________________________ DOB: _____/_____/_____

Customer Service Phone No.: ______________________

Pharmacy Name: ______________________ Pharmacy Phone#: ________________

Emergency Contact: ______________________ Relation: ________________

Phone#: ( ) _____-______

Your main reason for this visit: Headache / Pain / Other - please specify

____

____

____

Referred By:

Name: ______________________

Address: ______________________

____

Phone #: ( ) _____-__________

Primary Care Physician:

Name: ______________________, PCP

Address: ______________________

____

Phone #: ( ) _____-__________

Medical History

Drug Allergy

No known Drug allergy / ______________________________

Current weight: ______________ Height: ______________

Past Medical History, including current medical problems. (circle all that apply to you) : Migraine / Headache (unknown type) / Brain Tumor / Tumor in any other part of the body ____________ / Vasculitis / Cerebral Venous Sinus Thrombosis / Cerebral Aneurysm / Neck Pain / Low Back Pain / Diabetics / Stroke / Hypertension / Myocardial Infarction / Hypercholesterolemia / Fibromyalgia / Chronic Fatigue Syndrome/ Depression / General Anxiety Disorder / Panic Disorder/ Bipolar Disorder /
Other Problem (s): ______________________________

____

Past Surgical History (fill in the name and year of each <u>major</u> surgery)

____

____

____

____

Current Medications, including over-the-counter medication.

Name	Dose (mg/tab or cap)	Frequency (?/d or w)	Method (oral/pr/im)	Since (mo/yr)

Failed headache or pain medications in the past (Circle those applied to you):
Naratriptan(Amerge) / Almotriptan Malate (Axert) / Diclofenac Potassium (Cambia) / Meperidine (Demerol)/ Valproic Acid (Depakote)/ Dihydroergotamine (DHE)/ Amitriptyline (Elavil)/ Excedrin migraine/ Butalbital (Fioricet) / Frovatriptan (Frova) / Propranolol (Inderal) / Sumatriptan Succinate (Imitrex) / Amitriptyline (Elavil) / Rizatriptan (Maxalt)/ Morphine / Gabapentin (Neurontin & Gralise) / NSAIDs / Pregabalin (Lyrica) / Oxycodone / (Percocet) / Prednisone / Eletriptan Hydrobromide (Relpax) / Topiramate (Topamax) / Acetaminophen (Tylenol)/ Codeine / Tramadol (Ultram) / Verapamil / Hydrocodone (Vicodin) / Zomlitriptan (Zomig).
Other(s): ______________________________

Previously Failed Treatment (Circle those applied to you):
Physical Therapy / epidural / nerve blocks / chiropractic service
Other(s): ______________________________

Family History

Migraine: who: ______________________________

Headache with unknown type: who: ______________________________

Brain tumor: who: ______________________________

Abnormal Brain Vessel (aneurysm, arterorenous malformation, etc.):

who: ______________________________

Diabetics: who: ______________________________

Hypertension: who: ______________________________

Stroke: who: ______________________________

Other(s): ______________________________

Substances (Circle those applied to you)

Currently used:

Alcohol (Social Drinker / Habitual User or Addiction / I do not drink alcohol)

Nicotine Smoker (Occasional smoker / Habitual User or Addiction / I do not smoke cigarettes)

Amphetamine / Cocaine / Marijuana / PCP / Narcotics for Non-medical use

Other(s): ______________________________

Used in the past:

Alcohol / Nicotine Smoker / Amphetamine / Cocaine / Marijuana / PCP / Narcotics for Non-medical use / Other(s): ______________________________

Review of systems (Circle those applied to you in each category):

General: fever / chills / weight loss for 3 months / no weight change or fever

Head: bone fracture / scalp bruise / no head bone fracture or scalp bruise

Eyes: diplopia / glaucoma / eye muscle strain due to uncorrected vision / no diplopia or glaucoma

Mouth/teeth: grinding teeth / clenching jaw / temporomandibular joint pain (TMJ) / no grinding teeth or TMJ tenderness.

Cardiovascular: chest pain / murmur / palpitation / no chest pain or palpitation

Respiratory: cough / shortness of breath / asthma / no SOB or cough

Gastrointestinal: bowel incontinence / diarrhea / gastric acid reflux / peptic ulcer disease / no gastric acid reflux or peptic ulcer disease

Urinary: difficulty urinating / urinary incontinence / kidney stone / no urinary difficulty or kidney stone

Menstrual: dysmenorrheal / perimenopausal / postmenopausal / post-hysterectomy / no dysmenorrheal or other menstrual related problems .

Endrocrine: hypothyroidism / hyperthyroidism / no hyper- or hypothyroidism

Musculoskeletal: neck pain / back pain / knee pain / ankle pain / no neck or back pain

Neurological: seizure / syncope / head trauma / no seizure or syncope

Psychological: schizophrenia / hallucination / no schizophrenia or hallucination

Sleep Quality: snoring / sleep apnea / feeling non-refreshed in morning / daytime somnolence or drowsiness / no sleep problems.

Patient's Signature: ______________________ Date: ______________

California Headache and Pain Center
加州頭痛疼痛治療中心

Important notice regarding "being late, no show, same day last minute cancellation"

Every patient has the equal right to be seen on time and earliest possible, "being late, no show, same day last minute cancellation" seriously affecting the other patients and are absolutely not accepted.

_____I understand that I will not be seen if I am late for the appointment, repeated tardiness will result in no advanced appointment allowed.

_____I understand that repeated "no show" will result in no advanced appointment allowed.

_____I understand that repeated "same day last minute cancellation" will result in no more advanced appointment allowed.

____I understand that if I cannot follow the office rule, I will be placed on waiting list or have to call for the same day opening, no appointment is guaranteed.

Patient's name ____________________

Patient's signature __________________

Date ____________

Address: 420 W. Las Tunas Drive, San Gabriel, CA 91776. Tel: (626) 457-1688 Fax: (626) 457-1638 Web: www.chpcl.com

AUTHORIZATION TO SEND TEXT MESSAGES*(10.15.18)*

By signingthis form,I authorize California Headache and Pain Ctr. (CHPCI)to send text messages to my cell phone to notify me of upcoming appointments and other important information related to my future appointments. I understand that standard text messaging rates will apply to any messages received from CHPCI. I also understand that I or CHPCI may revoke this permission in writing at any time. I agree not to hold CHPCI liable for any electronic messaging charges or fees generated by this service. I further agree that in the event my cell phone number and or cell provider changes I will inform CHPCI promptly.

Privacy Disclaimer: This text message program is provided as a service to patients to give important information in a timely manner regarding their appointments. Their information will not be sold, distributed, or in any other way shared with entities or affiliates outside of this facility.

Patient's Name: ______________________ Date: __________________

Patient's Signature: ______________________ Cell Phone Number: ______________________

****

AUTORIZACIÓN PARA ENVIAR MENSAJES DE TEXTO

Al firmar este formulario, autorizo a California Headache and PainCtr. (CHPCI) para enviar mensajes de texto a mi teléfono celular para notificarme las próximas citas y otra información importante relacionada con mis citas futuras. Entiendo que las tarifas de mensajes de texto estándar se aplicarán a cualquier mensaje recibido de CHPCI. También entiendo que yo o CHPCI pueden revocar este permiso por escrito en cualquier momento. Estoy de acuerdo en no responsabilizar a CHPCI por cualquier cargo o tarifa de mensajería electrónica generada por este servicio. Además, acepto que, en caso de que mi número de teléfono celular y / o mi proveedor de servicios cambien, informaré a CHPCI de inmediato.

Descargo de responsabilidad de privacidad: este programa de mensajes de texto se proporciona como un servicio a los pacientes para brindar información importante.Información de manera oportuna sobre sus citas. Su información no se venderá, distribuirá ni se compartirá de ninguna otra manera con entidades o afiliadas fuera de esta instalación.

Nombre del Paciente: ______________________ Fecha: __________________

Firma del Paciente: ______________________ Número de Celular: ______________________

****

授权发送短信消息

通过签署此表格，我授权 California Headache 和 PainCtr。（CHPCI）发送短信到我的手机，通知我即将到来的预约时间和其他与我有关的重要信息。我明白，标准短信费率适用于从 CHPCI 收到的任何短信。我也理解我或 CHPCI 可以随时以书面形式撤销此许可。我同意不对 CHPCI 对此服务产生的任何电子信息费或费用负责。我进一步同意，如果我的手机号码和/或手机服务提供商发生变化，我会立即通知 CHPCI。

隐私免责声明：此短信程序服务是为患者提供重要的信息。他们的信息不会以此设施以外的实体或附属机构的形式出售，分发或以任何其他方式共享。

患者姓名：______________________ 日期：__________________

患者签名：______________________ 手机号码：______________________

Assignment of Benefits and Release

I. I certified that I and/or my dependent have insurance coverage with ____________________. I authorize insurance benefits to be paid directly to California Headache and Pain Ctr, Inc. for any procedure / medical services.

II. I understand the release of my health care information to my insurance for the purpose of obtaining payment to California Headache and Pain Ctr. Inc. for services provided.

Receipt of Notice of Privacy Practices

I. I have received a copy of California Headache and Pain Center, Inc's Notice of PRIVACY PRACTICES.

II. I understand that California Headache and Pain Center Inc. apply Electronic Medical Record System, and my record may be stored inside or outside California with maximal privacy protection complying with California HIPPA law.

Print Name ____________________

Patient Signature ____________________ Date ____________________

OFFICE FOR CIVIL RIGHTS

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Most of us feel that our health information is private and should be protected. That is why there is a federal law that sets rules for health care providers and health insurance companies about who can look at and receive our health information. This law, called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gives you rights over your health information, including the right to get a copy of your information, make sure it is correct, and know who has seen it.

Get It.

You can ask to see or get a copy of your medical record and other health information. If you want a copy, you may have to put your request in writing and pay for the cost of copying and mailing. In most cases, your copies must be given to you within 30 days.

Check It.

You can ask to change any wrong information in your file or add information to your file if you think something is missing or incomplete. For example, if you and your hospital agree that your file has the wrong result for a test, the hospital must change it. Even if the hospital believes the test result is correct, you still have the right to have your disagreement noted in your file. In most cases, the file should be updated within 60 days.

Know Who Has Seen It.

By law, your health information can be used and shared for specific reasons not directly related to your care, like making sure doctors give good care, making sure nursing homes are clean and safe, reporting when the flu is in your area, or reporting as required by state or federal law. In many of these cases, you can find out who has seen your health information. You can:

- **Learn how your health information is used and shared by your doctor or health insurer.** Generally, your health information cannot be used for purposes not directly related to your care without your permission. For example, your doctor cannot give it to your employer, or share it for things like marketing and advertising, without your written authorization. You probably received a notice telling you how your health information may be used on your first visit to a new health care provider or when you got new health insurance, but you can ask for another copy anytime.
- **Let your providers or health insurance companies know if there is information you do not want to share.** You can ask that your health information not be shared with certain people, groups, or companies. If you go to a clinic, for example, you can ask the doctor not to share your medical records with other doctors or nurses at the clinic. You can ask for other kinds of restrictions, but they do not always have to agree to do what you ask, particularly if it could affect your care. Finally, you can also ask your health care provider or pharmacy not to tell your health insurance company about care you receive or drugs you take, if you pay for the care or drugs in full and the provider or pharmacy does not need to get paid by your insurance company.

- **Ask to be reached somewhere other than home.** You can make reasonable requests to be contacted at different places or in a different way. For example, you can ask to have a nurse call you at your office instead of your home or to send mail to you in an envelope instead of on a postcard.

If you think your rights are being denied or your health information is not being protected, you have the right to file a complaint with your provider, health insurer, or the U.S. Department of Health and Human Services.

To learn more, visit **www.hhs.gov/ocr/privacy/**.

For more information, visit **www.hhs.gov/ocr**.

U.S. Department of Health & Human Services
Office for Civil Rights