California Headache and Pain Center

Patient's Name______________________ Date:______________
(Please Print)

Age:______________

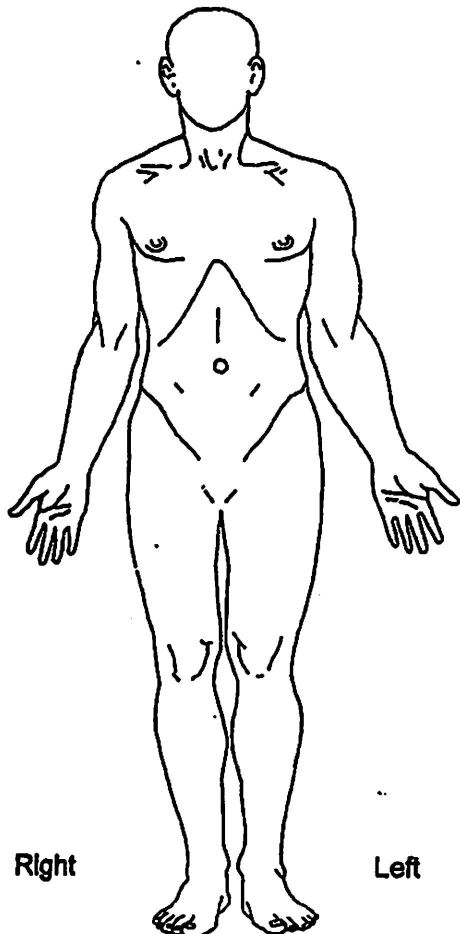
Where is your Pain NOW?

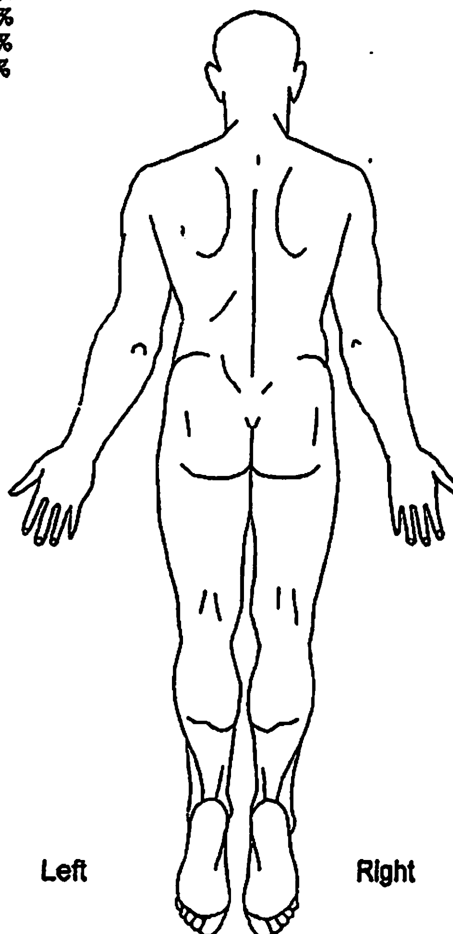
Mark the areas on your body where you feel the described sensations. Use the apporpriate symbol. Mark the area of radiation. Include all affected areas. Just to complete the Picture draw in your face..

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

Neck Pain__________%
Arm Pain__________%
Back Pain__________%
Leg Pain__________%

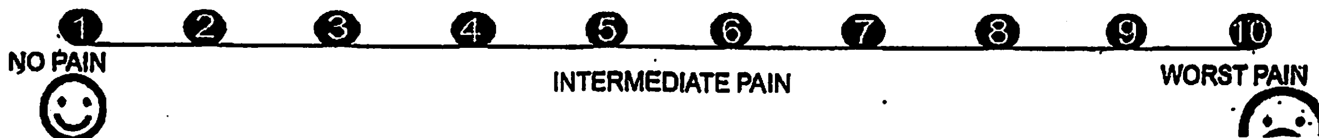
TOTAL = 100%





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 (Foricet) / 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) / Zomiltriptan (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.chpci.com

Headache 頭痛 Neck pain 頸痛 Back pain 背痛 Orofacial Pain 面頜關節痛 Sleep Medicine 睡眠醫学
Spine injection Nerve block Botulinum toxin injection Physical therapy Pain psychotherapy Biofeedback Acupuncture

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 ___________________

California Headache and Pain Ctr.
420 W. Las Tunas Drive
San Gabriel, CA 91776
Tel: (626) 457-1688

HOW TO CONTACT US BY PHONE
CÓMO CONTACTARNOS POR TELÉFONO
如何通过电话与我们联系

Dial 626-457-1688
Marque 626-457-1688
拨打 626-457-1688

Press the number 1 for **English**
Presiona el número 2 para **español**
中文请拨 3

Select an option based on the need of your call, if no answer please leave a message or try your call again later.

Seleccione una opción según la necesidad de su llamada, si nadie contesta, deje un mensaje o vuelva a intentar la llamada más tarde.

拨 3 以后，在线等待，有人会用中文回答你。如果没有人接听，您将听到英语让你留言，拨 1 后在提示音留言，或挂断电话再尝试拨打我们的电话。

PLEASE KEEP THIS SHEET AS A REFERENCE
POR FAVOR GUARDE ESTA HOJA COMO UNA REFERENCIA
请保留此表作为参考

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