Universal Pain Management

A Comprehensive Approach to Pain and Rehabilitation

PATIENT INFORMATION

Date _____

Patient Last Name _____ First Name _____ M.I.____

Mailing Address _____ City _____ State ____ Zip _____

Home Address _____ City _____ State ____ Zip _____

Home Phone Number _____ Work/School Phone Number _____

Pager/Cell Phone Number _____ Alternative Phone Number _____

E-mail _____ Sex M / F DOB _____ Age _____

Best time and place to reach you _____

Marital Status ( ) Md ( ) Wid ( ) Sgle ( ) Minor ( ) Sep ( ) Div ( ) Partnered for _____ years

Occupation _____ Patient Employer/School _____

Employer/School Address _____

Employer/School Phone ( ) _____

Spouse's Name _____ Spouse's DOB _____

Spouse's SS# _____ Spouse's Employer _____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone ( ) _____

Work Phone ( ) _____

ACCIDENT INFORMATION

Is condition due to an accident? ( ) Yes ( ) No

Date of Accident _____

Type of Accident ( ) Auto ( ) Work ( ) Home ( ) Other

To whom have you made a report of your accident? ( ) Auto Insurance ( ) Employer
( ) Worker Comp. ( ) Other

Attorney Name (if applicable) _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ( ) Yes ( ) No ( ) Unknown

Where do you continue to have pain, numbness, or tingling? _____

_____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) 1 2 3 4 5 6 7 8 9 10

Type of pain: ( ) Sharp ( ) Dull ( ) Throbbing ( ) Numbness ( ) Aching ( ) Shooting
( ) Burning ( ) Tingling ( ) Cramps ( ) Stiffness ( ) Swelling ( ) Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ( ) Work ( ) Sleep ( ) Daily Routine ( ) Recreation

Activities or movements that are painful to perform ( ) Sitting ( ) Standing ( ) Walking
( ) Bending ( ) Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ( ) Medications ( ) Surgery ( ) Physical Therapy
( ) Chiropractic Services ( ) None ( ) Other _____

Name and address of other doctor(s) who have treated you for your condition _____

_____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Please mark to indicate if you have had any of the following:

( ) AIDS/HIV
( ) Alcoholism
( ) Allergy Shots
( ) Anemia
( ) Anorexia
( ) Appendicitis
( ) Arthritis
( ) Asthma
( ) Bleeding Disorders
( ) Breast Lump
( ) Bronchitis
( ) Bulimia
( ) Cancer
( ) Cataracts
( ) Chemical Dependency
( ) Chicken Pox
( ) Diabetes
( ) Emphysema
( ) Epilepsy
( ) Fractures
( ) Glaucoma
( ) Goiter
( ) Gonorrhea
( ) Gout
( ) Heart Disease
( ) Hepatitis
( ) Hernia
( ) Herniated Disk
( ) Herpes
( ) High Cholesterol
( ) Kidney Disease
( ) Liver Disease
( ) Measles
( ) Migraine Headaches
( ) Miscarriage
( ) Mononucleosis
( ) Multiple Sclerosis
( ) Mumps
( ) Osteoporosis
( ) Pacemaker
( ) Parkinson's Disease
( ) Pinched Nerve
( ) Pneumonia
( ) Polio
( ) Prostate Problem
( ) Prosthesis
( ) Psychiatric Care
( ) Rheumatoid Arthritis
( ) Rheumatic Fever
( ) Scarlet Fever
( ) Stroke
( ) Suicide Attempt
( ) Thyroid Problems
( ) Tonsillitis
( ) Tuberculosis
( ) Tumors, Growths
( ) Typhoid Fever
( ) Ulcers
( ) Vaginal Infections
( ) Venereal Disease
( ) Whooping Cough
( ) Other _____
_____

EXERCISE ( ) None ( ) Moderate ( ) Daily ( ) Heavy

WORK ACTIVITY ( ) Sitting ( ) Standing ( ) Light Labor ( ) Heavy Labor

HABITS

( ) Smoking Packs/Day _____
( ) Alcohol Drinks/Week _____
( ) Coffee/Caffeine Drinks Cups/Day _____
( ) High Stress Level Reason _____

Are you pregnant? Y / N Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

Pharmacy Name _____ Pharmacy Phone _____

DAILY PATIENT RECORD

Name_____ Date____/____/____ Time_____

Please use the following key to accurately mark the areas in which you feel the described sensations. Use the appropriate symbols and include all affected areas.

Dull NNN

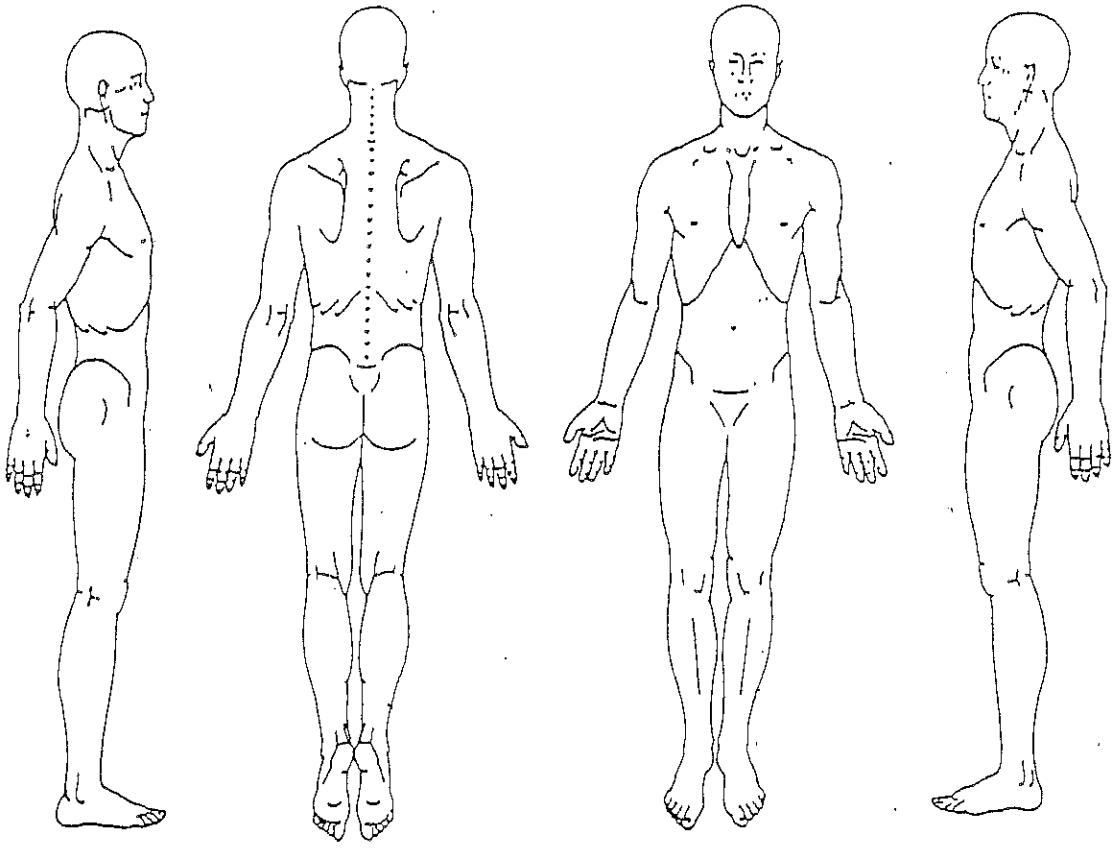
Stabbing/Cutting /// /// ///

Burning XXX

Numb = = =

Tingling (Pins & Needles) ::::::

Cramping SSS



Please place one mark on the line below to indicate your present pain level:

No pain |——————————————————————| Worst pain ever

Using the scale of 0-100, with 0 = no pain and 100 = worst possible pain, please write the number indicating your present pain level in the box at the right:

Please indicate any changes in your condition in this space:

Patient Signature_____

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A Comprehensive Approach to Pain and Rehabilitation

SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSISTANT CLINICAL PROFESSOR OF USC

FRANCIS X. RIEGLER, M.D., Q.M.E
BOARD CERTIFIED - PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSISTANT CLINICAL PROFESSOR OF USC

RAY H. d'AMOURS, M.D., Q.M.E.
BOARD CERTIFIED – PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSISTANT CLINICAL PROFESSOR OF USC

DANIEL ALVES, M.D.
BOARD CERTIFIED – PAIN MANAGEMENT AND PM&R

JAE JUNG, M.D.
BOARD CERTIFIED PAIN MANAGEMENT AND PM&R

EZEKIEL FINK, M.D.
BOARD CERTIFIED – PAIN MANAGEMENT

ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now, or in the future, render treatment to me, while employed by, working for, or associated with, or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications which may arise during a Chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the Chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that this in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Print Name(s) of Doctor Treating This Patient

Omid Mahgerefteh, D.C.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

_____ _____
Printed Name of Patient Date

_____ _____
Signature of Patient Date

Functional limitations / Activities of daily living

Patient reported that pain has the following affects of daily living.

0	=	NO interference with activity
1 – 3	=	SLIGHT interference with activity
4 – 7	=	MODERATE interference with activity
8 – 10	=	SEVERE interference with activity

SELF – CARE, PERSONAL HYGIENE

Bathing	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10
Defecating	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10
Dressing	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10
Personal Hygiene	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10
Get on/off the Toilet	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10

PHYSICAL ACTIVITY

Walking	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10
Climbing stairs	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10
Standing	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10
Squatting/Kneeling	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10
Sitting	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10
Reclining	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10
Raise from Chair	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10
Carrying of Grocery Bag	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10
Lifting/Pushing/Pulling	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10
Household Chores	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10
Getting in/out of bed	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10

TRAVEL

Getting in/out of the car	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10
Driving	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10
Being a passenger in a vehicle	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10

SEXUAL ACTIVITES	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10

SLEEP

Restful nocturnal sleep pattern	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10

SPORTS/RECREATION ACTIVITY	0	1 – 2 – 3	4 – 5 – 6 – 7	8 – 9 – 10

Name: _____ Date: _____

UNIVERSAL PAIN MANAGEMENT
PALMDALE, VALENCIA & VICTORVILLE, CA

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide *all* information requested may invalidate this Authorization.

PATIENT INFORMATION

Patient's Name: Last	First	Middle Initial	Birth Date

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of protected health information about the above patient as follows:

Authorized to USE or DISCLOSE information: (Name of person or organization you are REQUESTING information from)

Address	City	State	Zip Code

Authorized to RECEIVE information:- (Name of person or organization who will RECEIVE the information)

UNIVERSAL PAIN MANAGEMENT

☐ 819 Auto Center Drive	☐ 12830 Hesperia Road, Suite B	☐ 28212 Kelly Johnson Pkwy, #155
Palmdale, CA 93551	Victorville, CA 92395	Valencia CA 91355
(661) 267-6876 – Phone	(760) 241-0350 – Phone	(661) 367-9788 – Phone
(661) 538-9483 – Fax	(760) 243-0738 – Fax	(661) 367-9789 – Fax

DISCLOSE:

- ☐ All health information pertaining to any medical history, mental or physical condition and treatment received.
- ☐ All prescription history.
- ☐ Only the following records or types of health information: _____

Dates of Services:

☐ All ☐ Specific dates: _____

Method of use or disclosure:

☐ Mail ☐ Pick up ☐ Review/ Inspect ☐ Fax to # _____ ☐ Other _____

PURPOSE: The protected health information is being used or disclosed for the following purpose(s):

☐ Personal Use ☐ Continued Care

☐ Other: _____

EXPIRATION:

This authorization expires on (insert date or event): ☐ Date _____ ☐ Event _____

NOTICE OF RIGHTS AND OTHER INFORMATION

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the address listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization. I may refuse to sign this authorization. I have a right to receive a copy of this authorization. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

NOTE: There will be a charge for copying services.

SIGNATURE

Date:	Signature (Patient, Parent, Legal Guardian or Authorized Representative)	If other than patient, indicate relationship

Print Name:	Address:	Phone:

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Patient Name: _____ Date: _____

Universal Pain Management Medical Corporation has implemented all the HIPPA (Health Insurance Portability and Accountability) guidelines recommended by the Federal Government. For more information, please ask to see our Notice Of Privacy Practices.

We have implemented the following to protect and safeguard your health information:

- Ongoing training for all our employees on privacy policy and procedures.
- Established safeguards to protect all electronically stored data.

Universal Pain Management Medical Corporation will only use your personal information for:

- Planning your care and treatment.
- Communicating with other health care professionals who may contribute to your care.
- Communicating with your insurance care provider.

We do request your permission to have a:

- Sign-in sheet at the front desk.
- To call out your name at the time of your appointment.

We will get your written permission if we were to use your personal information for any other reasons.

You have the right:

- To revoke this consent in writing, except to the extent that Universal Pain Management Medical Corporation has already taken action in reliance thereon.
- To inspect and copy your medical information.
- Get information about the disclosures we have made on your behalf.

Please outline any other restrictions that you would like us to place in the disclosure of your health information:

_____

Please do not hesitate to contact our Privacy Officer, Lance Jackson at (661) 267-6876, Ext. 107 if you have any questions, concerns, or suggestions.

____ Accepted ____ Denied

_____ Date: _____

Signature of Patient or Legal Representative Witness

UNIVERSAL PAIN MANAGEMENT
PALMDALE, VALENCIA, VICTORVILLE, CA

PATIENT RIGHTS AND RESPONSIBILITIES
&
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received information regarding Universal Pain Management's Patient Rights and Responsibilities & Notice of Privacy Practices:

_____ _____

Patient/Parent/Legal Guardian **Date**

_____

Relationship to Patient

Documentation of Good Faith and Effort

The patient identified below was provided with information regarding UPM's Patient Rights and Responsibilities & Notice of Privacy Practices. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the above-mentioned documents; however, acknowledgement was not obtained because:

☐ Patient refused to sign.
☐ Patient was unable to sign because: _____
☐ There was a medical emergency. UPM will attempt to obtain acknowledgement as soon as practical.
☐ Other reason: _____

Employee Signature: _____ Date: _____

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In 2016, this policy will be strictly enforced.

Notice to Our Valued Patients

Missed Appointment Policy

In order for us to serve you better, it is important for you to give us at least 24 hours notice if you will not be able to make your appointment. You will be charged if cancelation does not occur within 24 hours (weekday) of your appointment. As a courtesy, you will receive a reminder call, but it is your responsibility to know your appointment date and time and cancel with notice.

Missed Appointment Fee

Office Visit -	$50.00
Procedure -	$150.00

By signing below, I understand that if I miss my appointment and run out of medication, I will not receive a refill or bridge of medications until I am seen. I further understand that I will be referred to another pain management practice for continuous violations of this policy.

_____

Print Patient's Name

_____ _____

Patient or Guardian's Signature Date