BAY AREA PAIN & SPINE INSTITUTE

PATIENT INFORMATION SECTION

TITLE | LAST NAME | FIRST NAME | MAIDEN NAME | BIRTHDATE / / | AGE:

STREET ADDRESS | ☐ MALE ☐ FEMALE

CITY | STATE | ZIP CODE | SOCIAL SECURITY NUMBER / /

( ) HOME PHONE | ( ) WORK PHONE | ( ) CELL PHONE | ☐ No If yes: EMAIL ADDRESS

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU BEEN TREATED BY ANY DOCTOR IN THIS OFFICE BEFORE? ☐ NO ☐ YES IF YES WHEN?

NAME AND ADDRESS OF FAMILY DOCTOR | **NAME AND ADDRESS OF PHARMACY**

EMPLOYEE NAME | OCCUPATION

EMPLOYER'S ADDRESS | CITY | STATE | ZIP CODE

SPOUSE OR PARENT'S NAME | SOCIAL SECURITY NUMBER | RELATIONSHIP TO PATIENT ☐ PARENT ☐ SPOUSE ☐ OTHER

EMERGENCY CONTACT

NAME | RELATIONSHIP | HOME PHONE NO. ( ) | WORK PHONE NO. ( )

INSURANCE INFORMATION - PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST

PRIMARY INSURANCE COMPANY | **SECONDARY** INSURANCE COMPANY

MAILING ADDRESS | CITY | STATE | ZIPCODE | MAILING ADDRESS | CITY | STATE | ZIP CODE

SUBSCRIBER | RELATIONSHIP/D.O.B. | SUBSCRIBER | RELATIONSHIP/ D. O B.

I.D. NUMBER: | GROUP NUMBER: | I.D. NUMBER: | GROUP NUMBER:

HISTORY OF PROBLEM

PLEASE EXPLAIN BRIEFLY WHY YOU ARE SEEING THE DOCTOR, SPECIFY LEFT OR RIGHT

FIRST SYMPTOM OR DATE OF INJURY

HOW DID INJURY OCCUR & WHEN?

WAS AN AUTOMOBILE INVOLVED? ☐ YES ☐ NO | DATE OF ACCIDENT | NAME OF ATTORNEY | PHONE NO.

WERE YOU INJURED ON THE JOB? ☐ YES ☐ NO *IF YES, COMPLETE WORK RELATED INJURIES SECTION*

WORK RELATED INJURIES

NAME OF COMPENSATION INSURANCE CARRIER | ADJUSTER'S NAME & PHONE NUMBER

INSURANCE CARRIER ADDRESS: | CITY | STATE | ZIPCODE

NAME OF EMPLOYER (AT TIME OF INJURY) | NAME OF ATTORNEY:

ADDRESS: | ATTORNEY PHONE NUMBER: ( )

NURSE CASE MANAGER: | NCM PHONE NUMBER: | ATTORNEY FAX NUMBER: ( )

INDUSTRIAL CLAIM & CASE NUMBER: | **DATE OF INJURY**

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE **BAY AREA PAIN & SPINE INSTITUTE** TO RELEASE INFORMATION REGARDING MY TREATMENT OR EXAMINATION RENDERED TO ME FOR MEDICAL SURGICAL CARE TO INSURANCE COMPANY(S) OR ITS REPRESENTATIVES. I ALSO AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO **BAY AREA PAIN & SPINE INSTITUTE** IN THE AMOUNT DUE FOR ALL MEDICAL AND/OR SURGICAL CHARGES FOR MYSELF OR MY ELIGIBLE DEPENDENTS I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED OR PAID BY MY INSURANCE COMPANY(S)

SIGNATURE: ______________________________ DATE: ____________

OVER-PLEASE COMPLETE BACK OF FORM

MEDICARE PATIENTS ONLY

LIFETIME BENEFICIARY AUTHORIZATION

_______________________________ (NAME OF BENEFICIARY)

_______________________________ (HIC NUMBER)

I REQUEST PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO **BAY AREA PAIN & SPINE INSTITUTE** FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN/SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE TO RELATED SERVICES.

I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF ITEM 9 OF THE HCFA-1500 CLAIM FORM IS COMPLETED, MY SIGNATURE AUTHORIZES RELEASING OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. IN MEDICARE ASSIGNED CASES, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE, AND NONCOVERED SERVICES. COINSURANCE AND THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER.

_______________________________ BENEFICIARY SIGNATURE

_______________________________ DATE

13690 EAST 14TH STREET #230
SAN LEANDRO, CA 94578
TEL: (510) 614-9200 FAX: (510) 614-9203
H. DARIEN BEHRAVAN, D.O.

ACKNOWLEDMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices. I further acknowledge that a copy of the current Notice will be provided by the front desk staff.

You may request a copy of the Notice to keep for your records. If you have questions regarding the Notice, please do not hesitate to contact Marcella Avery at (510) 614-9200.

________________________________ _______________
Patient name (please print) Date

____
Signature

________________________________ _______________
Parent or Authorized Representative (if applicable) Indicate relationship

Detailed messages (i.e. prescription refills, test results, surgery scheduling) may be left on Answering machine: ______Yes ______ No Phone Number: ___________________

Medical information can be discussed with:

______ Patient only (if checked, STOP HERE)

______ Family Member or Friend (If checked, fill in name(s) below):

Name: ____________________________ Relationship: __________________
Restrictions*: ____

Name: ____________________________ Relationship: __________________
Restrictions: ____

Name: ____________________________ Relationship: __________________

* Restriction examples: Appointment Date/Time only, No prescription information, etc

Bay Area Pain and Spine Institute

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510-614-9200 510-614-9203

FINANCIAL RESPONSIBILITY WAIVER

Patients with Insurance: Although we will bill your Insurance Company/Medical Group for services rendered, you are financially responsible for all services rendered. If payment has not been received with sixty (60) days of billing, your Health Plan/Medical group, we will contact you for assistance. Should your Health Plan/Medical group deny coverage for any reason, you will be responsible for payment in full within thirty (30) days of your billing statement.

Dual Coverage: **Bay Area Pain and Spine Institute** abides by the Califoronia State Insurance Laws, which govern coordination of benefits. Therefore, you are responsible for providing us with all billing information from primary, secondary, and tertiary health plans.

Co-Pay Policy: Your Health Plan requires that you make your co-payment at the time of visit. However, in an emergency situation, when you are unable to make your co-payment, you will be granted a 10-day grace period in which to make a payment without penalty.

Authorization and Assignment of Benefits: I authorize the release of any medical information which may have a bearing on the determination and/or payment of my claim. I request that payment be made directly to **Bay Area Pain and Spine Institute**, and acknowledge that I am responsible for payment if this assignment is not honored.

____

____

I have read and understand the above policies and I agree to comply with them. I attest that all information given is true and accurate to the best of my knowledge.

Patient Signature ________________________________ **Date** _________________

I/we wish to accept financial responsibility for medical expenses incurred by the above-named patient.

Guarantor (Print) ________________________________ Date ________________

Gaurantor Signature ________________________________ Date ________________

BAY AREA PAIN & SPINE INSTITUTE

INITIAL COMPREHENSIVE PAIN QUESTIONAIRE

Please complete this form before your first appointment at the Institute for Pain Management. Your careful answers will help us to understand your pain problem and design the best treatment program for you. You may feel concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential. No outsider is permitted to see your case record without your written permission unless we are required to do so by law (e.g. Workmen's Compensation Claims).

Date: ____________________

Name: ____
Last **First** **Middle Initial**

Address: ____
Street Address

____
City **State** **Zip**

Home Phone: ______________________________ **Work Phone:** __________________________

Referring MD: ____

Other Physicians currently involved in my care: ____

____

Sex: □ **M** □ **F**

Age: ________ **Race:** □ **Asian-American** □ **African-American** □ **White** □ **Hispanic** □ **Other**

CHARACTERISTICS OF PAIN:

What is the main problem for which you are seeking treatment?

____

____

How long have you had your current pain problem?

_____ Years _____ Months

ONSET OF PAIN: How did your current pain start?

□ Injury at work
□ Injury, not at work
□ Motor vehicle accident
□ Illness, non-injury
□ Treatment caused (e.g. radiation, surgery, ect).
□ Undetermined

If there was a precipitating event not mentioned, what was it? ______________________________

SEVERITY OF PAIN: In general, over the past month, the intensity of my pain has been:

- Mild
- Moderate
- Moderate-Severe
- Severe

TIMING OF PAIN: How often do you have your pain (please check one)?

- Constantly (100% of the time)
- Nearly constantly (60-95% of the time)
- Intermittently (30-60% of the time)
- Occasionally (less then 30% of the time)

In general, during the past month, when has your pain been the worst (please check one)

- Morning
- Afternoon
- Evening
- Night
- No typical pattern

PAIN/SYMPTOM QUALITY: How would you describe your pain(please check all that apply; if there is a dominant quality to your pain, please circle the appropriate term):

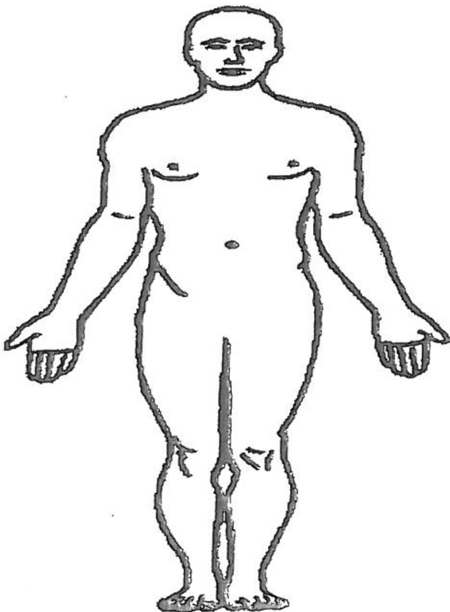
burning	sharp	cutting	throbbing
cramping	dull/aching	pressure-like	
shooting	other (describe) ______________________________		

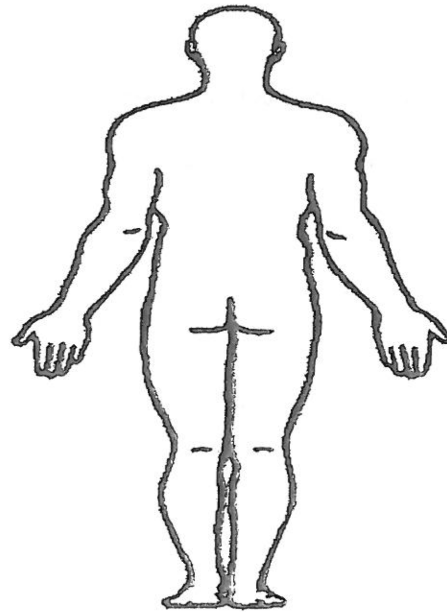
Associated with pain, I feel the following (please check all appropriate terms):

Numbness	I feel these sensations in the	Same	Different areas than the pain
Pins and needles	I feel these sensations in the	Same	Different areas than the pain

I have weakness in my:	Upper extremities	Yes	Dropping objects?	Yes
	Lower extremities	Yes	Falling?	Yes
	Other (please describe) ______________________________			

PAIN LOCATION: please mark the location(s) of your pain on the diagrams above with an "x". If whole areas are painful, please shade in these areas.





RELEIVING AND AGGRAVATING FACTORS:

How do the following affect your pain (please check one for each item).

	DECREASE	NO CHANGE	INCREASE
LYING DOWN			
STANDING			
SITTING			
WALKING			
EXERCISE			
COUGHING/SNEEZING			
BOWEL MOVEMENTS			

*I have **had** ___ or not had ___ a recent change in bowel or bladder habits.*

Please describe recent changes ____

ACTIVITIES AND YOUR PAIN:

How many blocks can you walk? ☐Less than a block ______ Blocks (how many?)

How many minutes or hours can you sit? ____ Minutes (how many?) _____ Hours (how many?)

How often during the day do you lie down because of pain?

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐Constantly

To assist walking, I use a: ☐ Cane ☐ Walker ☐ Wheelchair ☐ No assistance device

---

Are you NOT able to perform any of the following activities of daily living? (check all that aply)

☐ Going to work ☐ Perform household chores ☐ Doing yard work or shopping

☐ Socializing with friends ☐ Participate in recreational activities ☐ Exercising

PAIN TREATMENTS: Please check your response to all the treatments you have tried.

TREATMENT	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
SURGERY			
TRACTION			
NERVE BLOCK INJECTION			
PHYSICAL THERAPY			
EXERCISE			
TENS			
HEAT TREATMENT			
ICE TREATMENT			
PSYCHOTHERAPY			
ACUPUNCTURE			
HYPNOSIS			
BIOFEEDBACK			
CHIROPRACTIC THERAPY			

PRIOR PAIN MEDICATIONS: Please check all medications you have used in the past for treatment or pain. These are listed by class of medication.

Opiods	NSAIDs/TYLENOL	Muscle Relaxants
☐ Hydrocodone (Vicodin)	☐ Tylenol	☐ Soma
☐ Propoxyphene (Darvocet)	☐ Aspirin	☐ Parafon Forte
☐ Codeine	☐ Motrin	☐ Flexeril
☐ Fentanyl (Duragesic)	☐ Naproxen	☐ Baclofen
☐ Dilaudid	☐ Daypro	☐ Zanaflex
☐ Morphine/MSContin	☐ Salsalate/Trillsate	☐ Robaxin
☐ Demerol	☐ Feldene	☐ Skelaxin
☐ Levodromoran	☐ Indocin	☐ Valium (Diazepam)
☐ Methadone	☐ Lodine	
☐ Oxycodone (Percocet)	☐ Orudis	
☐ Oxycontin	☐ Relafin	
☐ Stadol	☐ Celebrex	
☐ Talwin	☐ Vioxx	
	☐ Toradol	

ANTIDEPRESSANTS		OTHER	
☐ Elavil (amitryptiline)	☐ Paxil	☐ Neurontin	☐ Xanax
☐ Pamelor (nortriptyline)	☐ Prozac	☐ Tegretol	☐ Ativan
☐ Desipramine	☐ Serzone	☐ Dilantin	☐ Mexilitine
☐ Imipramine (tofranil)		☐ Depakote	☐ Imitrex
☐ Zoloft		☐ Klonopin	☐ Ergotamine

PAST MEDICAL HISTORY:

Have you had any of the following health problems (please check all that apply)?

☐ Hypertension	☐ Coronary Artery Disease	☐ Angina or chest pain
☐ Heart Attack	☐ Diabetes	☐ Asthma or wheezing
☐ Emphysema	☐ Kidney Disease	☐ Liver Disease
☐ Stroke	☐ Seizure or epilepsy	☐ Bleeding problem
☐ Depression	☐ Anxiety	☐ Thyroid Disease

☐ Arthritis - specify location ____________________________

☐ Cancer – specify type ____________________________

☐ Other – Specify ____________________________

PAST SURGICAL HISTORY:

DATE	TYPE OF OPERATION

CURRENT MEDICATIONS FOR PAIN:

NAME	DOSE	FREQUENCY

My pain medications provide relief:

☐ None of the time
☐ Some of the time
☐ Most of the time
☐ All of the time

Side-effects from these medications include:

☐ Nausea
☐ Vomiting
☐ Constipation
☐ Stomach Upset
☐ Sedation
☐ Other (please specify) ____________________________

CURRENT MEDICATIONS (OTHER THAN ANALGESICS)

NAME	DOSE	FREQUENCY

ALLERGIES: Please indicate the names of any medications to which you are allergic:

____

What type of reaction did you have? ____

I am allergic to contrast dye used for x-rays ____ Yes _____ No

REVIEW OF SYSTEMS: Please check all items you feel are applicable to you:

- ☐ Recent significant gain of weight: ____ pounds over ____ weeks/months/years
- ☐ Recent significant loss of weight: ____ pounds over ____ weeks/months/years
- ☐ Fever
- ☐ Dizziness
- ☐ Difficulty swallowing
- ☐ Difficulty walking
- ☐ Seizures
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty initiating urine stream
- ☐ Genital pain
- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Memory loss
- ☐ Loss of consciousness
- ☐ Double or blurry vision
- ☐ Muscle weakness
- ☐ Easy or excessive bruising
- ☐ Easy or excessive bleeding
- ☐ Rash
- ☐ Diabetes
- ☐ Adrenal disease
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Joint stiffness
- ☐ Decreased range of motion
- ☐ Pain in extremity (specify) ___________
- ☐ Swelling (specify) _________________

SOCIAL HISTORY

EDUCATION: Your highest education level achieved:

- ☐ Graduate or professional training
- ☐ College graduate
- ☐ Partial college training
- ☐ High school graduate
- ☐ GED or trade-technical school graduate
- ☐ Partial high school (10th grade through partial 12th)
- ☐ Partial junior high school (7th grade through 9th grade)
- ☐ Elementary school

EMPLOYMENT: Your current or most recent occupation:

- ☐ Semi-skilled or unskilled (eg. Waitress, assembler)
- ☐ Skilled trade or clerical (eg. Carpenter, electrician, truck driver, secretary)
- ☐ Business executive or Managerial
- ☐ Professional (eg. Lawyer, teacher, nurse, physician, psychologist)
- ☐ Homemaker
- ☐ Other: please specify ____

CURRENT EMPLOYMENT STATUS: Please check one:

- ☐ Employed full-time
- ☐ Employed part-time
- ☐ Unemployed
- ☐ Retired
- ☐ Student
- ☐ Homemaker

If you are unemployed or employed part-time is this due to your present pain condition? ☐ Yes ☐ No

If you are currently unemployed, indicate how long you have been off work:___________________

LEGAL ISSUES: Please indicate any of the following clai,s you have filed related to your pain problem:

- ☐ Worker's compensation
- ☐ Personal Injury/Liability
- ☐ Social Security Disability Insurance (SSDI)
- ☐ Other insurance

SLEEP DISTURBANCE:

Do you have difficulty falling asleep? ☐ Yes ☐ No
Do you have difficulty remaining asleep? ☐ Yes ☐ No
Are you ever awakened by pain? ☐ Yes ☐ No

If you use any sleep-aids, please specify ____________________

FAMILY LIFE: Please specify living arrangements:

☐ Living alone
☐ Living with spouse/partner
☐ Living with spouse/partner and children
☐ Living with children
☐ Living with friends
☐ Living with other

PSYCHOLOGICAL TREATMENT:

Have you ever had psychiatric, psychological, or social work evaluation or treatmenrs for any problem, Including your current pain?

☐ Yes ☐ No

For what diagnosis were you treated? ____________________

When? ____________________

Please list your current or last therapist ____________________

Have you ever considred suicide? ☐ Yes ☐ No When? __________
Have you ever planned suicide? ☐ Yes ☐ No When? __________
Have you ever attempted suicide? ☐ Yes ☐ No When? __________

SUBSTANCE ABUSE:

Have you ever been a smoker? ☐ Yes-Current ☐ Yes-In past ☐ No-Never
If you smoke, how many packs per day? __________ packs per day
For how many years did you smoke? __________ Years

Do you have a history of alcoholism? ☐ Yes ☐ No ☐ Current problem
Have you abused prescription analgesics? ☐ Yes ☐ No ☐ Current problem
Cocaine or intravenous substance abuse? ☐ Yes ☐ No ☐ Current problem

How many years has it been since you abused alcohol or drugs __________ years

If you have a history of alcoholism, have you ever been enrolled in Alcoholics Anonymous?
☐ Yes ☐ No When? __________

If you have a history of substance abuse, have you ever been in a detoxification program?
☐ Yes ☐ No When? __________

FAMILY HISTORY: Please specify any medical or psychiatric conditions common in your family and who suffers with these ailments:

Condition: __________ Specify family members(s): __________
Condition: __________ Specify family members(s): __________
Condition: __________ Specify family members(s): __________
Condition: __________ Specify family members(s): __________

PHYSICAL EXAMINATION

How much do you weigh? _______________ Pounds
How tall are you? _________feet ________ inches

TO BE COMPLETED BY INSTITUTE FOR PAIN MANAGEMENT STAFF

BP _______ HR _______

NOTES:

Physical examination:

HEENT: Head: □ Atraumatic □ Normocephalic □ Other: ____________________
Pupils: □ Equal, Round, Reactive and able to accommodate □ Other: ________________
Neck: □ Supple without masses □ Other: ____________________
Thyroid: □ Not enlarged □ Enlarged □ Mass detected

Heart: □ Regular Rate & Rhythm □ S1 S2 present □ Other: ___________________________
Lungs: □ Clear to auscultation bilaterally □ Wheezes □ Other: ___________________________
Abdomen: □ Soft, non-tender, non-distended with normal active bowel sounds □ Other; ____________

Neuro: Gait □ Normal □ Antalgic
Higher Intelligence: □ Intact □ CN II-XII grossly intact □ Other: _______________________
Motor □ Intact □ Other: ___________________________
Sensory □ Intact to touch and pinprick □ Other: ___________________________
Reflexes: □ Normal □ Reduced □ Hyper Specify: ___________________________

Imaging:

Differential:

Plan:

WORKMAN'S COMP INFORMATION

EMPLOYER: ____

JOB TITLE: ____

BRIEF JOB DESCRIPTION OF DAILY DUTIES: ______________________

____

WORK STATUS (ARE YOU CURRENTLY EMPLOYED, LAID OFF, FIRED, DISABILITY)__

____

LENGTH OF EMPLOYMENT: ______________________________

HISTORY OF INJURY (HOW WERE YOU INJURED ON THE JOB) ______________

____

____

____

____

____

INTERVAL HISTORY (WHAT HAVE YOU TRIED SINCE YOUR INJURY FOR PAIN RELIEF__

____

____

____

____

____

____

____

____

____

BAY AREA PAIN & SPINE INSTITUTE
PAIN MANAGEMENT AND SPINE INTERVENTION

DARIEN BEHRAVAN, D.O.

13690 EAST 14TH STREET #230 SAN LEANDRO, CA 94578
TEL: (510) 614-9200 FAX: (510) 614-9203

From South Bay I-880 N:
Take I-880 N toward Oakland. Take the Washington Ave. exit and turn right onto Washington Ave. Turn right onto San Leandro Blvd. Turn left onto East 14th Street. The building is on the right side of the street with parking in the back.

From Oakland I-880 S:
Take I-880 S toward Hayward. Take Marina Blvd exit (exit 33A). Merge onto Marina Blvd and make a slight right onto San Leandro Blvd. Turn left onto East 14th Street. The building is on the right side of the street with parking in the back.

From Oakland I-580 E:
Take I-580 E toward Hayward/Stockton. Take 150th Ave. exit and turn right onto 150th Ave. Turn right onto East 14th Street. The building is on the right side of the street with parking in the back.

From Tri Valley area (Livermore, San Ramon, Castro Valley) I-580 W:
Take I-580 W toward Oakland. Take 150th Ave/Fairmont exit and turn left at the stop sign (Foothill Blvd.). At the second signal, turn left onto 150th Ave. Turn right onto East 14th Street. The building is on the right side of the street with parking in the back.

WE ARE NEXT TO WEST COAST SPORTING GOODS