



Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Current Symptoms: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_  
5. \_\_\_\_\_ 6. \_\_\_\_\_ 7. \_\_\_\_\_ 8. \_\_\_\_\_

Date of Crash/Accident: \_\_\_\_\_ Time: \_\_\_\_\_  AM  PM

Specific Location of Crash/Accident: \_\_\_\_\_

Describe in detail, in your own words, how the crash/accident happened: \_\_\_\_\_

In general what makes your symptoms better? \_\_\_\_\_

In general what makes your symptoms worse? \_\_\_\_\_

In general how would you describe your pain? (ache, burn, dull, sharp, throbbing): \_\_\_\_\_

Are your symptoms local or do they travel to another area? (If they travel, to where?) \_\_\_\_\_

Are symptoms;  Constant >76%  Frequent 51-75%  Occasional 28-50%  Intermittent <25% of your waking hours

Were there any symptoms which you had after the crash/accident that have now resolved? (please list)

**AUTOMOBILE/MOTORCYCLE ONLY**

In the crash/accident: Were you the  Driver  Passenger  Pedestrian  Other? \_\_\_\_\_

Did your vehicle strike the other vehicle?  Yes  No Did the other vehicle strike your car?  Yes  No

Your vehicle:  Car  Pick-up Truck  Van  SUV / Other vehicle:  Car  Pick-up Truck  Van  SUV

Were you struck from?  Behind  Front  Driver Side  Passenger Side Motorcycle Only:  Left Side  Right Side

Were you rendered unconscious as result of accident?  Yes  No

Were you wearing a seatbelt?  Yes  No

Did the airbags deploy?  Yes  No

Please list any recent x-rays, MRIs, lab or other tests: Date

Facility/Doctor

Have you lost time from work?  Yes  No: If Yes, Dates: \_\_\_\_\_ to \_\_\_\_\_

Where did you go after the crash/accident?  Hospital  Urgent Care  Home  Work  Other \_\_\_\_\_

Were you taken by ambulance?  Yes  No To which hospital? \_\_\_\_\_

Have you done any of the following since the crash/accident?

Ice  Rest  Medication (name) \_\_\_\_\_  
 Heat (any kind)  Exercise  Other \_\_\_\_\_

# **PAIN MANAGEMENT CENTERS**

**To our patients and their attorneys:**

**The doctors and staff at Pain Management Centers are dedicated to serving your medical needs related to your work and personal injuries. To help us with this endeavor we are asking that you sign this form. Your signature will help ensure that your outstanding balance with our Practice will be paid and appropriate medical treatment administered.**

**In the event that you make a claim for workers' compensation benefits or make a claim against a third party for personal injury compensation, your signature below will act as a guarantee that your outstanding balance with our Practice will be satisfied. By signing this form you agree to protect the interests of Pain Management Centers. Pain Management Centers will submit all your bills to the appropriate insurance company for payment. If for any reason the insurance company does not pay it will be your responsibility to submit your bills to your attorney. Additionally, you agree and direct your attorney to submit the Practice's medical bills into evidence, pursuant to the applicable laws of any auto or workers' compensation proceeding or third party personal injury action.**

**By signing below, you also agree to pay any outstanding medical bills from any settlement or recovery you obtain in either your workers' compensation claim or your third party personal injury action. Payment will be made directly by your attorney to Pain Management Center upon distribution of the proceeds. Your signature below authorizes your attorney to distribute a payment, or direct distribution by another entity when applicable, to our Practice equal to your outstanding balance at the time of distribution.**

**I, \_\_\_\_\_, agree and affirm that I, and my attorney, will protect the interests of Pain Management Center in any auto or workers' compensation proceeding or in any third party personal injury proceeding. My signature also authorizes and directs my attorney to submit payment equal to my outstanding balance with Pain Management Center at the time of distribution of my auto or workers' compensation settlement or recovery or my third party personal injury settlement or recovery.**

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**Patient's Signature**

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**Date**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please list all medications and dosage:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

List any allergies to medications, foods or other: \_\_\_\_\_

**DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:**

- |   |  |  |   |
|---|--|--|---|
| Tuberculosis <input type="checkbox"/> Yes   | Lung Disease <input type="checkbox"/> Yes        | Gout <input type="checkbox"/> Yes            | Diabetes <input type="checkbox"/> Yes   |
| Kidney Disease <input type="checkbox"/> Yes | Stomach/Ulcer <input type="checkbox"/> Yes       | Heart Disease <input type="checkbox"/> Yes   | Hepatitis <input type="checkbox"/> Yes  |
| Sciatica <input type="checkbox"/> Yes       | High Blood Pressure <input type="checkbox"/> Yes | Transfusion <input type="checkbox"/> Yes     | Polio / MS <input type="checkbox"/> Yes |
| Colon Disease <input type="checkbox"/> Yes  | Stroke <input type="checkbox"/> Yes              | Cancer <input type="checkbox"/> Yes          | Bleeding <input type="checkbox"/> Yes   |
| Paralysis <input type="checkbox"/> Yes      | Seizures <input type="checkbox"/> Yes            | Arthritis <input type="checkbox"/> Yes       | Asthma <input type="checkbox"/> Yes     |
| Anemia <input type="checkbox"/> Yes         | Thyroid Disease <input type="checkbox"/> Yes     | Drug Dependence <input type="checkbox"/> Yes | AIDS <input type="checkbox"/> Yes       |
| COPD <input type="checkbox"/> Yes           | Migraine Headaches <input type="checkbox"/> Yes  | Neck Pain <input type="checkbox"/> Yes       | Back Pain <input type="checkbox"/> Yes  |

Past Surgical History: Date: \_\_\_\_\_ Procedure: \_\_\_\_\_  
 Date: \_\_\_\_\_ Procedure: \_\_\_\_\_  
 Date: \_\_\_\_\_ Procedure: \_\_\_\_\_  
 Date: \_\_\_\_\_ Procedure: \_\_\_\_\_

**Family History**

Please list any conditions your parents or siblings may have: \_\_\_\_\_

**CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED RECENTLY:**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Middle Back Pain     | <input type="checkbox"/> Lower Back Pain       | <input type="checkbox"/> Ears Ring           |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Lower Back Stiffness  | <input type="checkbox"/> Buzzing in Ears     |
| <input type="checkbox"/> Neck Stiffness    | <input type="checkbox"/> Bruised Chest        | <input type="checkbox"/> Radiating Pain        | <input type="checkbox"/> Dizziness           |
| <input type="checkbox"/> Sleep Disruption  | <input type="checkbox"/> Bruising Anywhere    | <input type="checkbox"/> Tingling in Legs      | <input type="checkbox"/> Loss of Smell       |
| <input type="checkbox"/> Depression        | <input type="checkbox"/> Blurred Vision       | <input type="checkbox"/> Tingling in Arms      | <input type="checkbox"/> Loss of Taste       |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Sensitivity to Light | <input type="checkbox"/> Jaw Pain (TMJ)        | <input type="checkbox"/> Increased Thirst    |
| <input type="checkbox"/> Fainting          | <input type="checkbox"/> Upper Arm Pain       | <input type="checkbox"/> Upper Leg Pain        | <input type="checkbox"/> Difficulty Walking  |
| <input type="checkbox"/> Muscle Spasms     | <input type="checkbox"/> Lower Arm Pain       | <input type="checkbox"/> Lower Leg Pain        | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Fatigue              | <input type="checkbox"/> Bowel/Bladder Changes | <input type="checkbox"/> Weight Change       |

Current Work Status: Retired Working Disability Other: \_\_\_\_\_

Do you smoke?  Yes  No; \_\_\_\_\_ pack(s) per day

Do you drink alcohol?  Yes  No; \_\_\_\_\_ drink(s) per day

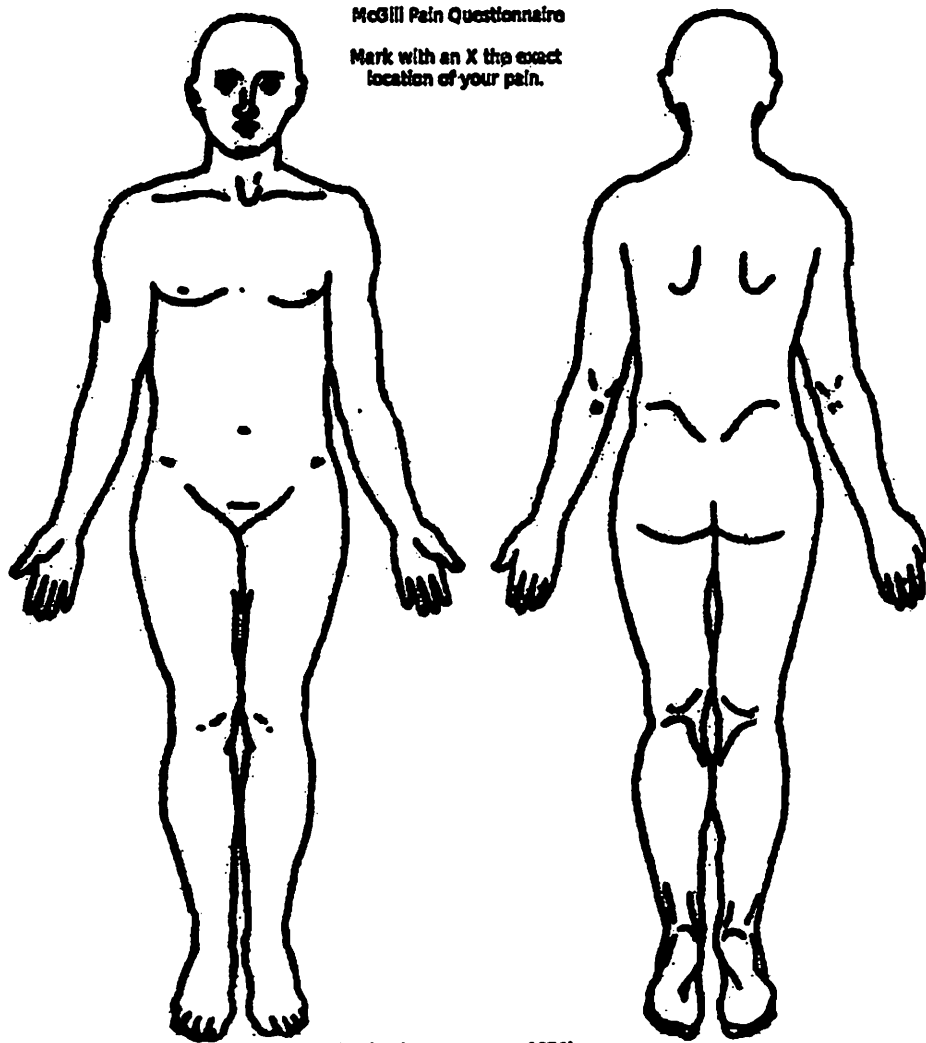
Do you live in a: House \_\_\_\_\_ Apartment \_\_\_\_\_; List other household members: \_\_\_\_\_

**Have you ever been involved in a previous Automobile or Work accidents? Please describe:**

| Date           | Injuries Sustained |
|----------------|--------------------|
| ____/____/____ | _____              |
| ____/____/____ | _____              |
| ____/____/____ | _____              |
| ____/____/____ | _____              |

**PAIN MANAGEMENT CENTERS  
Pain Chart**

Mark the diagram with an X over any area of pain.



(Melzack & Torgerson, 1971)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**CONSENT TO TREAT and ADMINISTRATIVE AUTHORIZATION**

**1. Authorization for Treatment and Diagnostic Procedures:** I voluntarily authorize, request and consent to outpatient care services, including procedures, examinations, and medical treatment as ordered by my physicians, his/her assistants, or other health care provides. I understand that, except in emergency situations, this consent does not include surgical procedures or other procedures or treatment that may require separate consent. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made as to the results of any procedures, treatments or examinations.

**2. Assignment of Insurance Benefits to Tri County Pain Management Center:** I authorize payment of health care benefits directly to Tri County Pain Management Center. In making this assignment, I understand and agree that I may be financially responsible to Pain Management Center for charges not paid under my insurance policy(ies). I permit a copy of this authorization to be used in place of the original. I authorize payment of authorized Medicare or other payor benefits to be made to me or on my behalf, to the physician or supplier for any services provided to me by the authorized physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby certify that I have read and fully understand the above consent. I have sufficient opportunity to ask whatever questions I might have, and they have been answered to my satisfaction. I voluntarily and freely consent to the above and accept its term.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**CONSENT TO TREAT A MINOR:**

**I hereby authorize the doctors of the Pain Management Centers, and/or whomever they may designate as assistants to administer treatment as deemed necessary to**

\_\_\_\_\_  
Signature of Parent or Legal Guardian: \_\_\_\_\_

Printed name: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship: \_\_\_\_\_

## HIPAA Compliance

Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please answer the following questions:

Yes / No      Leave a message regarding your appointment on your voicemail, email or with your spouse, apparent, or other member of your household (or at work, if this is the number you provide us with).

Yes / No      Leave a message regarding test results on your voicemail, email, or with your spouse, a parent, or other member of your household (or at work, if this is the number you provide us with).

Yes / No      Give test results to your spouse, a parent or to other designated family member or friend. If yes, please specify: \_\_\_\_\_.

\_\_\_ I request the above restrictions to the use or disclosure of my Protected Health Information (PHI).

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### FOR OFFICE USE ONLY

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We attempted to obtain written acknowledgement of our Notice of Privacy Practices and use of PHI, but acknowledgement could not be obtained because:

\_\_\_ Individual refused to sign

\_\_\_ Communication barriers prohibited obtaining the acknowledgement

\_\_\_ An emergency situation prevented us from obtaining acknowledgement

\_\_\_ Other (Specify: \_\_\_\_\_)



## Pain Management Centers

TriCountyPMC.com  
Phone: 215-771-1179 Fax: 877-884-6224

### AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to  
release healthcare information of the patient named above to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes  No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes  No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES 180 DAYS AFTER IT IS SIGNED.