

# CONFIDENTIAL PATIENT DATA

## PAIN MANAGEMENT OF BERKS COUNTY

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST **(PLEASE PRINT)**

Today's date:						
<b>PATIENT INFORMATION</b>						
Patient's last name:		First:	Middle Initial:	Nickname:	Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Work Phone:	Home Phone:	Preferred Phone: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	
Address Line 2:			Cell Phone:	Cell Service Provider:		
City:		State:	Zip Code:	Email:		
Employer:			Occupation:			
Would you like to receive appointment reminders? Choose ONE: <input type="checkbox"/> Email <input type="checkbox"/> Text Message <input type="checkbox"/> Phone <input type="checkbox"/> None				Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed <input type="checkbox"/> Other		
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> German <input type="checkbox"/> French <input type="checkbox"/> Italian <input type="checkbox"/> Russian <input type="checkbox"/> Portuguese <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Other _____						
Please check ALL races that apply: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Decline to Answer						
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic nor Latino <input type="checkbox"/> Declined to Answer						
Preferred Communication: <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> In Person						
Smoking Status: <input type="checkbox"/> Current everyday <input type="checkbox"/> Current some days <input type="checkbox"/> Former <input type="checkbox"/> Never Start Year _____ Quit Date _____						
Current Medications:						
1. Drug Name: _____		Strength (eg. 10MG) _____		Dose (e.g. 1 tab) _____		
Frequency (e.g. once daily) _____		Date Started: _____				
2. Drug Name: _____		Strength (eg. 10MG) _____		Dose (e.g. 1 tab) _____		
Frequency (e.g. once daily) _____		Date Started: _____				
3. Drug Name: _____		Strength (eg. 10MG) _____		Dose (e.g. 1 tab) _____		
Frequency (e.g. once daily) _____		Date Started: _____				
4. Drug Name: _____		Strength (eg. 10MG) _____		Dose (e.g. 1 tab) _____		
Frequency (e.g. once daily) _____		Date Started: _____				
5. Drug Name: _____		Strength (eg. 10MG) _____		Dose (e.g. 1 tab) _____		
Frequency (e.g. once daily) _____		Date Started: _____				
Drug Allergies:						
1. Drug Name _____		Reaction (e.g. hives) _____		Date Started: _____		
2. Drug Name _____		Reaction (e.g. hives) _____		Date Started: _____		
3. Drug Name _____		Reaction (e.g. hives) _____		Date Started: _____		
Other Allergies: _____						
Referred by:			Referring Physician?:			
Alcohol Use: <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy		Drug Use: <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy		Exercise: <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy		
<b>INSURANCE INFORMATION</b>						
Primary Insurance:				Insured ID:		
Insured Name:			Group Number:			
Patient is the <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Self <input type="checkbox"/> _____ to the insured.				Ins. Date of Birth:		
Secondary Insurance:				Insured ID:		

I certify that I, and/ or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to **Pain Management of Berks County** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. **I also understand that any illicit or sexually suggestive remarks made by me will result in immediate termination of the any session, and I will be liable for payment of the scheduled appointment.**

X \_\_\_\_\_  
 Signature of Patient/ Guardian Date Please print Patient/ Guardian

**FAMILY HISTORY**

Please indicate which conditions exist or have existed by marking the boxes below.

	Self	Mother	Father	Sister	Brother	Son	Daughter
Bone Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Esophageal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastric Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deep Vein Thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Embolism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unknown Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia/Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gestational Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impaired Fasting Glucose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin Resistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maturity onset Diabetes (MODY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pre-Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type 1 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type 2 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Familial adenomatous polyposis (FAP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lynch Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unknown Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Kidney Disease (assoc. Diabetes Type 2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Nephrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nephritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nephrotic Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unknown Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Lower Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Self	Mother	Father	Sister	Brother	Son	Daughter
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OCD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PTSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Phobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Septicemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/Brain Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PATIENT HISTORY**

Please describe your past accidents:

1. Accident: \_\_\_\_\_  Job  Auto  Other Date: \_\_\_\_\_  
 2. Accident: \_\_\_\_\_  Job  Auto  Other Date: \_\_\_\_\_  
 3. Accident: \_\_\_\_\_  Job  Auto  Other Date: \_\_\_\_\_

Please describe your past surgeries:

1. Surgery: \_\_\_\_\_ Date: \_\_\_\_\_  
 2. Surgery: \_\_\_\_\_ Date: \_\_\_\_\_  
 3. Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

Do you have any implants?  Yes  No If yes, please describe \_\_\_\_\_

Are you currently pregnant?  Yes  No If yes, please list your due date: \_\_\_\_\_

**\*\*Vitals to be completed by Staff Member\*\***

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_ Temp: \_\_\_\_\_

Please indicate which conditions **YOU** (the patient) have experienced by marking the boxes below.

AIDS	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Bladder Trouble	<input type="checkbox"/>	Bone Fracture	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	Constipation	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Dislocated Joints	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	German Measles	<input type="checkbox"/>	Headache	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Herniated Disk	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	Kidney Disorder	<input type="checkbox"/>	Loss of Bowel Control	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	Numbness	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>	Pinched Nerve	<input type="checkbox"/>	Polio	<input type="checkbox"/>
Poor circulation	<input type="checkbox"/>	Reproductive disorder	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	Serious Injury	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Tumors or Growths	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	_____	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

**Primary Doctor:** \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_

**Emergency Contact Phone:** \_\_\_\_\_

Office Use Only:

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

What is the main reason for your visit today?

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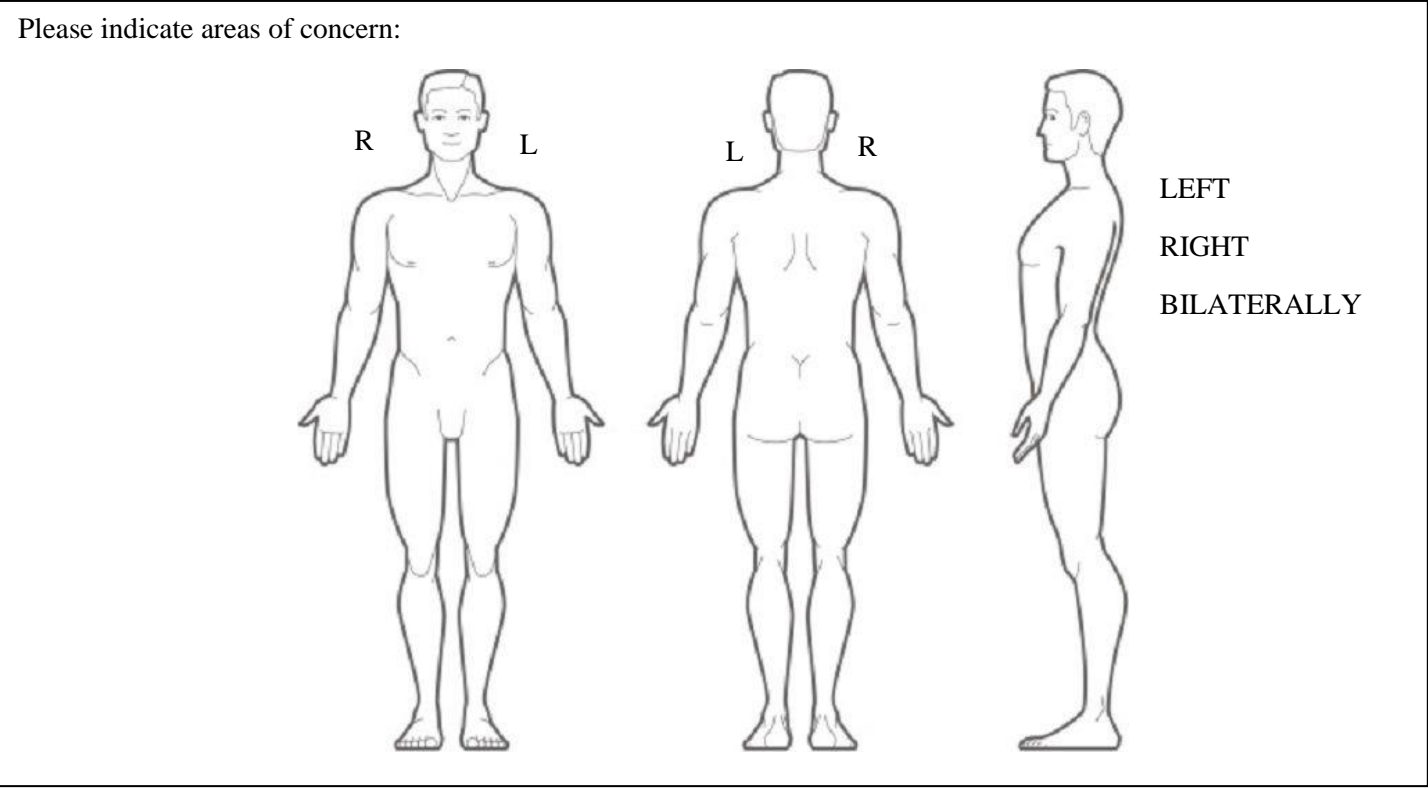
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Is your condition work related?                      Are you currently having discomfort or pain?

Yes     No     Yes     No

**Pain Cause:**

A Fall    Work Injury    Auto Accident    Illness    Lifting Injury    Unknown    Gradual Onset  
 Other: \_\_\_\_\_

**Pain aggravated by:**

Bending    Coughing    Driving    Exercising    Getting up/down    House Work    Increased Activity    Lifting  
 Looking down    Lying down    Overhead activities    Preparing food    Reaching    Resting    Sitting    Sneezing  
 Standing    Twisting    Typing    Walking    Other \_\_\_\_\_

**Pain relieved by:**

Exercise    Heat    Ibuprofen    Ice    Knees Bent Up    Lifting    Lying Down    Medication    No Movement    Reaching  
 Resting    Sitting    Standing    Stretching    Support    Turning Head    Walking

**Pain Quality:**

Aching    Burning    Cramping    Deep    Diffuse    Dull    Numbness    Radiating    Sharp    Shooting    Stiffness    Tight    Tingling

**What has been done before to treat this symptom?**

Acupuncture    Prescription medicine    Massage    Surgery    OTC Medicines    Chiropractic    Physical Therapy

Office Use Only:

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

How long have you had this condition?

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How does it impact your quality of life?

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What aggravates this condition?

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What improves this condition?

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Do you have any allergies (medicines, cosmetics, environment, foods)?

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Do you have any difficulty lying on your front, back or side? If yes, please explain.

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Do you sit for long hours at a workstation, computer, or driving? If yes, please describe.

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Do you perform any repetitive movement in your work, sports, or hobby? If yes, please describe.

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Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? If yes, please identify.

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Office Use Only:

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Where do you hold your stress in your body?

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What do you do when you want to release stress and/or just relax?

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How many hours do you usually sleep per night? \_\_\_\_\_

Do you wake feeling refreshed? \_\_\_\_\_

Office Use Only:

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**CANCELLATION POLICY:** 24 hours' notice is necessary for cancelled appointments. We reserve the right to bill for missed appointments. \_\_\_\_\_ Initials \_\_\_\_\_ Date

**INSURANCE:** *Pain Management of Berks County* will help you with your insurance billing. This is a service we provide for you, yet is a clinic expense. Please understand that we have a primary relationship with you, and not your insurance company. If you are planning on using your insurance coverage to pay for your services at TSWC you must provide us with the INSURANCE PAPER WORK. We expect that you will arrive at the office with ALL your insurance information including your insurance card. If you have been unable to complete the INSURANCE PAPER WORK, we will kindly require you to pay for our services at your appointment. We accept Visa, MC, Care Credit, cash and check. For your convenience, we will provide a statement for you to turn in for reimbursement. If you have questions regarding your insurance, please make sure to discuss all questions to our insurance and billing department.

\_\_\_\_\_ Initials \_\_\_\_\_ Date

**PATIENT CONSENT FORM (HIPAA)** I understand that, under the Health Insurance portability & Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to: ~Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. ~Obtain payment from third party payers ~Conduct normal healthcare operations such as quality assessments and physician certifications. I have been informed by *Pain Management of Berks County* of our Notice to Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing of this consent. I understand that this organization has the right to change its Notice to Privacy Practices from time to time and that I may contact The Spine and Wellness Center to obtain a current copy of this notice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand The Spine and Wellness Center is not required to agree to my requested restrictions, but if *Pain Management of Berks County* does agree then they are bound to abide by such restrictions. I understand that if I correspond by email or texting with *Pain Management of Berks County* that email and texting source is not HIPAA secure and my medical information shared via email or text could be compromised. I understand that I may revoke this consent in writing at any time, except to the extent that *Pain Management of Berks County* has taken action relying on the consent. You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you, to carry out treatment, payment or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or Intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law. We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name. We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence. You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you

\_\_\_\_\_ Initials \_\_\_\_\_ Date

I also acknowledge that from time to time, *Pain Management of Berks County* and/or the Department may take photographs of me participating in programs or activities offered by the Department for use and publication in various publications or media, including but not limited to *Pain Management of Berks County* website, department program brochures or materials, and *Pain Management of Berks County* or Department informational, promotional or marketing materials, and I hereby expressly grant to *Pain Management of Berks County* and the Department the right to use and publish such photographs as contemplated herein, all without compensation or payment for such use and publication .

\_\_\_\_\_ Initials \_\_\_\_\_ Date

**CONSENT TO TREAT** I hereby request and consent to the performance to any treatment for any medical conditions relating to my visit from this day forward while under Dr. Harold J. Einsig at *Pain Management of Berks County* 3933 Perkiomen Avenue, Reading PA 19606 and any surgical/outpatient facilities that procedures and/or therapies would be scheduled for my care. Imaging-pain management procedures-other related care to my condition.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

\_\_\_\_\_ Initials \_\_\_\_\_ Date

Office Use Only:	
Patient Name: _____	Date: _____

**RECORDS RELEASE AUTHORITY**

TO: \_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_ HEREBY REQUEST THAT YOU RELEASE

(Patients's name or guardian)

\_\_\_\_\_ RECORDS TO:

**PAIN MANAGEMENT OF BERKS COUNTY**

**H.J. EINSIG, MD, ATC**

3933 PERKIOMEN AVENUE SUITE 101

READING, PA 19606

PHONE: 610-779-9292

FAX: 610-779-3937

A report of my diagnosis, treatment, prognosis, and recommendations, as well as other data pertinent to your treatment of me from \_\_\_\_\_ to **PRESENT**.

All records  X-rays  MRI Films  Bloodwork  Other \_\_\_\_\_

I hereby authorize disclosure of the health information for the above named patient. This authorization is **valid for 1 year** from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

**I DO UNDERSTAND THAT THE RELEASING OFFICE/FACILTY MAY CHARGE A FEE FOR THESE RECORDS. THIS FEE IS NOT IN ASSCIATION WITH *Pain Management of Berks County***

\_\_\_\_\_  
Patient's OR Guardian's Signature

\_\_\_\_\_  
Patient's Name **PLEASE PRINT**

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

Patients  
DOB: \_\_\_\_\_

Please:

**Fax Report**

Patients  
SSN: \_\_\_\_\_

**Mail Films/CD**