

Pain Management Office of Dr. Netsere Tesfayohannes

REGISTRATION FORM

(Please Print)

Today's date:

Primary Care Physician:

PATIENT INFORMATION

Patient's last name:

First:

Middle:

Mr.
 Mrs.

Miss
 Ms.

Marital status (circle one)

Single / Mar / Div / Sep / Wid

Is this your legal name?

If not, what is your legal name?

(Former name):

Birth date:

Age:

Sex:

Yes No

/ /

M F

Street address:

Home phone no.:

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P.O. box:

City:

State:

ZIP Code:

Occupation:

Employer:

Employer phone no.:

Employer Address:

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Chose clinic because/Referred to clinic by (please check one box):

Dr.

Insurance Plan

Hospital

Family Friend

Close to home/work

Yellow Pages

Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:

Birth date:

Address (if different):

Home phone no.:

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Are you covered by Insurance:

Yes No

Primary Insurance Name:

Subscriber Name:

Group Number:

Policy Number:

Co-payment amount:

Patient's relationship to subscriber:

Self

Spouse

Child

Other

Name of secondary insurance (if applicable):

Subscriber's name:

Group no.:

Policy no.:

Patient's relationship to subscriber:

Self

Spouse

Child

Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):

Relationship to patient:

Home phone no.:

Work phone no.:

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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Please note, front desk will ask you for a copy of your ID and Insurance Card. Please have that available.

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):

M F

DOB:

Marital status: Single Partnered Married Separated Divorced Widowed

Previous or referring doctor:

Date of last physical exam:

PERSONAL HEALTH HISTORY

Childhood illness: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise) <input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf) <input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) <input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
Caffeine	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	<input type="checkbox"/> None	<input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola	
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes -- pks./day	<input type="checkbox"/> Chew - #/day <input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes <input type="checkbox"/> No