



PATIENT REGISTRATION

PATIENT LEGAL NAME (i.e. Social Security, Driver's License)

LAST NAME		FIRST NAME		MIDDLE NAME	
AKA					

DATE OF BIRTH	MONTH	DAY	YEAR	DRIVER'S LICENSE		SOCIAL SECURITY	
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GENDER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER <input type="checkbox"/> DECLINE TO ANSWER	LANGUAGE (CHOOSE ONE)	<input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> OTHER: _____	MARITAL STATUS	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED
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HOME PHONE		CELL PHONE		EMAIL ADDRESS	
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HOME ADDRESS *NO PO BOX*

STREET ADDRESS					
CITY		STATE		ZIP CODE	

MAILING ADDRESS (IF DIFFERENT)

STREET ADDRESS					
CITY		STATE		ZIP CODE	

WORK STATUS	<input type="checkbox"/> EMPLOYED <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> RETIRED <input type="checkbox"/> DISABLED <input type="checkbox"/> SELF-EMPLOYED	EMPLOYER		WORK PHONE	
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RACE (CHOOSE ONE)	<input type="checkbox"/> AMERICAN INDIAN <input type="checkbox"/> ASIAN <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> WHITE <input type="checkbox"/> OTHER <input type="checkbox"/> DECLINE TO DISCLOSE	ETHNICITY (CHOOSE ONE)	<input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> OTHER <input type="checkbox"/> NON-HISPANIC/LATINO <input type="checkbox"/> DECLINE TO DISCLOSE
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EMERGENCY CONTACT

NAME		RELATIONSHIP		PHONE	
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REFERRING PHYSICIAN	
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ASSIGNMENT & RELEASE

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO NAVARRO PAIN CONTROL GROUP, INC. OR TO ROSA M. NAVARRO, MD. I AM FINANCIALLY RESPONSIBLE FOR ALL NON-COVERED SERVICES.

PATIENT SIGNATURE		DATE	
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DO NOT WRITE BELOW-OFFICE USE ONLY

PATIENT NAME AS IT APPEARS ON INSURANCE CARD IF DIFFERENT

LAST NAME		FIRST NAME		MIDDLE NAME	
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INSURANCE-PRIMARY

INSURANCE NAME		ID #		GROUP #	
INSURED'S NAME		DOB		RELATIONSHIP	
INSURED'S SSN		MEDICARE:		MEDICAL:	

INSURANCE-SECONDARY

INSURANCE NAME		ID #		GROUP #	
INSURED'S NAME		DOB		RELATIONSHIP	
INSURED'S SSN		MEDICARE:		MEDICAL:	

PCP		CHECKED/COMPLETED BY		DATE	
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NEW PATIENT QUESTIONNAIRE

PATIENT NAME		DATE OF BIRTH	
DATE OF SERVICE		AGE	

Please tell us why you are here (CC): _____

Which words **BEST** describe your pain, please check all that apply

<input type="checkbox"/>	THROBING	<input type="checkbox"/>	ACHING	<input type="checkbox"/>	SHARP	<input type="checkbox"/>	DULL
<input type="checkbox"/>	BURNING	<input type="checkbox"/>	NUMBNESS	<input type="checkbox"/>	STABBING	<input type="checkbox"/>	ELECTRIC
<input type="checkbox"/>	PINS & NEEDLES	<input type="checkbox"/>	SHOOTING	<input type="checkbox"/>	THIGHNESS	<input type="checkbox"/>	

YOUR PAIN IS:

<input type="checkbox"/>	CONSTANT	
<input type="checkbox"/>	ON/OFF	
<input type="checkbox"/>	DURATION	
<input type="checkbox"/>	TIMING	
<input type="checkbox"/>	LOCATION	

SELECT YES OR NO	YES	NO
Did your PAIN start sudden?		
Did your PAIN start gradually?		
Where you in an MVA?		
Where you injured at work?		
Is legal action pending?		

ARE YOU TAKING ANY OF THESE MEDICATIONS:

BLOOD THINNERS	
Aggrenox/Dipyridamole	Heporin/Heporin
Aritra/Foundaparinux	Lovenox/Enoxaparin
Bevyxxa/Betrixaban	Plavix/Clopidogrel
Brilinta/Tricagrelor	Prodaxa/Dabigatran
Cilostazol/Pletal	Savaysa/Edoxaban
Coumadin/Warfarin	Trental/Pentoxifylline
Effient/Prasugel	Ticlid/Ticlopidine
Elquis/Apixaban	Xarelto/Rivaroxaban
Fragmin/Dalteparum	None

ALLERGIES	YES	NO
Allergy to any Medication?		
Do you have any Allergies		
If YES, please list Allergies		

Please rate your pain on the following scale **ZERO** is **NO PAIN**, while **10** is the **WORST IMAGINABLE**

0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

NO PAIN

WORST PAIN

How severe is your pain:

MILD

MODERATE

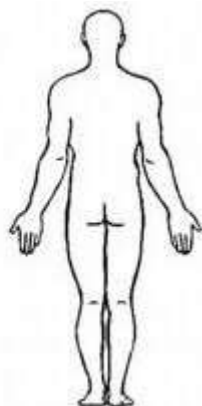
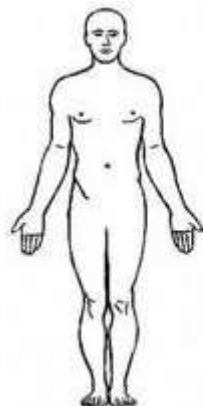
SEVERE

INTOLERABLE

PLEASE MARK EVERYWHERE YOU EXPERIENCE PAIN

FRONT

BACK



RIGHT LEFT

LEFT RIGHT

Have you had any	YES	NO	cervical	thoracic	lumbar	other
MRI'S						
X-Rays						
CT Scan						
CT Mylogram						



IN THE BOXES BELOW PLEASE TELL US IF YOUR PAIN LIMITS THE FOLLOWING ACTIVITIES

Does pain affect you appetite? YES/NO/Explain	How many hours per day you work? Type of work?
How many hours do you sleep?	How does the pain limit your activities? Type of activity:
What makes your pain worst?	**Is pain causing depression or anxiety? YES/NO Explain:
What makes your pain better?	**Do you smoke tobacco? If NO, <input type="checkbox"/> FORMER <input type="checkbox"/> NEVER If YES, <input type="checkbox"/> Since (date): <input type="checkbox"/> Frequency:
Urinary Problems? YES/NO/Explain	**Do you drink alcohol? If NO, <input type="checkbox"/> FORMER <input type="checkbox"/> NEVER If YES, <input type="checkbox"/> Since (date): <input type="checkbox"/> Frequency:
Bowel problems? YES/NO/Explain	**Do you do any recreational drugs? YES/NO (Cocaine, Heroin, or Marijuana)

PLEASE INDICATE IF YOU HAVE TRIED ANY OF THESE TREATMENTS AND IF THEY WERE EFFECTIVE

Treatment	Yes/No	Was the Treatment Effective?
Surgery		
Physical Therapy		
Chiropractor		
Acupuncture		
Massage		
Biofeedback		
TENS unit		
Steroid Injections/Nerve Blocks		

HOW IS YOUR PAIN TODAY:

<input type="checkbox"/>	Improving
<input type="checkbox"/>	Worsening
<input type="checkbox"/>	Unchanged

****PLEASE LIST ALL YOUR MEDICATIONS****

Name of Drug, and Supplements	Strength or Dosage	Number of tablets	Total number of tablets per day	Reason for taking medication

PHARMACY NAME	ADDRESS	PHONE & FAX



REVIEW OF SYSTEMS	(SELECT YES OR NO)	YES	NO	COMMENTS
CONSTITUTIONAL	Fever			
	Weight Loss			
EYES	Vision Problems			
EARS/NOSE/MOUTH	Hearing Aids?			
CARDIOVASCULAR	Chest Pain			
	Shortness of breath			
	Palpitations			
	Pedal Edema			
RESPIRATORY	Cough			
	Wheezing			
GASTROINTESTINAL	Reflux			
GENITOURINARY	Urinary Tract Infection			
MUSCULOSKELETAL	Muscle Pain			
INTEGUMENTARY	Skin			
NEUROLOGICAL	Syncope (loss of consciousness)			
	Dizziness			
PSYCHIATRIC	Depression			
ENDOCRINE	Diabetes			
HEMATOLOGY/LYMPHATIC	Bleeding tendencies			
CANCER	Prior or Current			Type: <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation

****PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS****

<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Insulin dep. diabetes	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Headaches	<input type="checkbox"/> Murmurs	<input type="checkbox"/> Muscle Disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Pace Maker	<input type="checkbox"/> High Blood Pressure/Hypertension	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Peripheral Neuropathy	<input type="checkbox"/> Shingles
<input type="checkbox"/> Radiculopathy	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Migraine	<input type="checkbox"/> Low Back Pain
<input type="checkbox"/> Pregnancy Now	<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Dialysis
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Lupus	<input type="checkbox"/> Other

****PLEASE LIST ALL SURGERIES****

Surgery	Date

SOCIAL HISTORY

FAMILY HISTORY

MARITAL STATUS	LIVING STATUS	CHILDREN	PATERNAL	YES/NO	MATERNAL	YES/NO
Married	Lives alone	YES	Alcohol Abuse		Alcohol Abuse	
Single	Lives w/spouse	NO	Drug Abuse		Drug Abuse	
Divorced	Lives w/family	How many?				
Widow	Other	Boy				
		Girl				