

Johnson Creek Office 9300 SE 91st Ave, Suite 400 Portland, OR 97086 Hillsboro Office 1849 NW 188th Ave, Suite 201 Hillsboro, OR 97006 Providence Office 5050 NE Hoyt, Suite 204 Portland, OR 97213 Wilsonville Office 8995 Miley Rd, Suite 202 Wilsonville, OR 97070

Phone: 503-775-6500 Fax: 503-775-2275

PATIENT REGISTRATION FORM Primary Care Provider: Referred By: Date:						
Is treatment related to a work comp injury? Yf		nding Physician:	:			
	PATIENT IN	FORMATION				
Legal Name: (Last, First, Middle)		Preferred Name:		Marital Status: □ Single □ Married □ Divorced □ Widowed		
Email Address:		Age:	Date of Bi	rth:	Gender: □ Male □ Female	
Street Address:		City/State/Zip	Code:			
		200 6 1				
Social Security #:	Cell Phone:	*				
Home Phone:	Work Phone:		Employer	:		
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Legal Name: (Last, First, Middle) □ (Check if Sam	e as Patient)	Date of Birth:	·	Gender: □ Male □ Female	Relationship to Patient:	
Street Address:		City/State/Zip	Code:			
Social Security #:	Cell Phone:		Email Add	Iress:		
Home Phone:	Work Phone:		Employer	:		
	INSURANCI	COVERAGE				
Primary Insurance:		Phone:				
Billing Address:		City/State/Zip Code:				
Subscriber Legal Name: (Last, First, Middle) □ (Check if Sam	ne as Patient)	Date of Birth:		Gender: □ Male □ Female	Relationship to Patient:	
ID & Group #:	Employer:	Work Phone:				
Secondary Insurance:		Phone:				
Billing Address:		City/State/Zip Code:				
Subscriber Legal Name: (Last, First, Middle) 🛘 (Check if Sam	ne as Patient)	Date of Birth:		Gender: □ Male □ Female	Relationship to Patient:	
ID & Group #:	Employer:			Work Phone:		
Accident Insurance: Auto Worker's Compensation Other		Name of Accident Insurance Company:				
Billing Address:		City/State/Zip Code:				
Claim #:	Date of Injury:	Phone:		Adjuster/Case Manager:		
	EMERGENCY CONT	ACT INFORMAT	ION			
Name of Local friend/relative:				Phone:		
PERSON	NAL HEALTH INFORMATION	RELEASE & CON	TACT INFO	RMATION		
Portland Pain Care <u>can</u> share or discuss my health information with the following people:						
The above information is true to the best of my knowledge. I understand I am financially responsible for any balance not covered by my insurance carrier. MEDICARE – I request that the payment of authorized medical benefits be made on my behalf to Joseph P Stapleton MD PC, for any services related to me. I hereby authorize Joseph P Stapleton MD PC to release to the health care administrator and its agents any medical information needed to determine these benefits payable for related services under Title XVIII of Social Security Act.						
COMMERCIAL – I hereby authorize the release of inform Stapleton MD PC.	nation necessary to file a claim w	vith my insurance o	company and	assign benefits otherwise	payable to me to Joseph P	
Patient/Guardian Signature:	Patient/Guardian Signature: Date:					



HIPAA Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to undergo training so that they may understand and comply with government rules and regulations regarding Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164.

As our patient we want you to know what we respect the privacy of your personal medical records and will do all that we can to secure and protect your privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain personal consent.

Other Uses or Disclosures: We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

To avoid a serious threat to your health or safety or the health or safety of others.

As required by state or federal law such as reporting abuse, neglect or certain other events.

- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any questions regarding this form, please ask to speak to our HIPAA Compliance Officer. We will be happy to provide you with a copy of this form upon your request.

Patient Name (Print)	Date
Dationt Name (Signature)	With and Office Shoff March or
Patient Name (Signature)	Witness (Office Staff Member)

Please fill this form out before your appointment and bring it with you.

New Patient Intake Form

Patient Information	h				
Name:			Date:		
Referring Physician:			Primary Care Provider:		
Height:			Weight:		
Current Medication	is/Allergies:				
Have you had a flu shot the	his season? 🛮 Yes 🗆 No	Have you	ever had a pneumo	onia immunizat	tion? 🗆 Yes 🗆 No
Medication	Dose How often	M	edication	Dose	How often
Do you currently take any l	plood thinning medication	☐ Yes	f yes, when was you	ır last dose?	
(Aspirin, Coumadin, Warfa	rin, Plavix, Lovonox)?	□ No	, , , , , , , , , , , , , , , , , , , ,		
811 ·					
Allergies:			l have No Known Dr	ug Allergies	
		-			
Pain History					
Chief Complaint: (Reason fo	or your visit today)				
Use d	liagram to indicate the	area of your	oain. Mark locati	ion(s) with a	n 'X'
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Right	Right Left Left	Right	Right 2/	Left	W L
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Circle +	he number that best desc	rihes vour nain	(A heing no nain 1	O heing worst	70.5700YC 90.00 - 1840.
Average Pain 0 1 2			th Activity 0 1	. 2 3 4	5 6 7 8 9 10
Worse Pain 0 1 2			th Meds 0 1		5 6 7 8 9 10
Current Pain 0 1 2			thout Meds 0 1		5 6 7 8 9 10

Pai	Pain History Continued							
Activities that make pain worse:		<u>Acti</u>	Activities that make pain better:			lities of your pain:		
	NONE		NONE			NONE		
	Bending forward		Bending forward			Aching		
	Exertion/Exercise		Injections			Burning		
	Getting out of chair		Lying down			Dull		
	Lifting		Medications			Sharp		
	Lying down		Moving			Shooting		
	Moderate physical activity		Position change			Stabbing		
	Nonspecific activity		Physical activity			Throbbing		
	Position change		Procedures			Pressure		
	Reaching		Rest			Crushing		
	Significant physical activity		Sitting			Cramping		
	Sitting		Standing			Spasmodic		
	Standing					Pulling		
	Turning the head					Tender		
	Twisting					Tight		
	Walking					Knife like		
						Hot		
						Sore		
Dur	ration of your pain *Please o	hook only	, and					
	☐ No pain ☐ Constant pain ☐ Intermittent pain							
			•					
	tory –Check the box if y		•	gnosed with t	he fo	ollowing:		
His	·	ou <u>have</u>	ever been dia					
His	tory –Check the box if y	ou <u>have</u>	ever been dia	gnosed with to INFECTION Hepatitis		ollowing: <u>CANCER</u> Bladder cancer		
His	tory —Check the box if y AD/EARS/EYES/NOSE/THROAT leadaches	ou <u>have</u> GAST	ever been dia	INFECTIO		CANCER		
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Hi	story - Prior Procedures	(Example	e: Epidural	Steroid	Injections, Trigger Poir	nt Injecti	ions)
List	all past procedures for pain & ap	proximate d	ates				
Hi	story - Surgery						
	all past surgeries & approximate	dates					
LIST	t all past surgenes & approximate	dates.					
112	otom. White Dries Treets	wanta Ha	Va Had	2			
	story -What Prior Treatr			· ·			
Tre	atment	<u>Helpful</u>	Not Helpful	<u>Trea</u>	tment	<u>Helpful</u>	Not Helpful
	Acupuncture				Massage		
	Biofeedback relaxation therapy				Minimally invasive procedures		
	Botox injections				Occupational therapy		
	Chiropractic				Physical therapy		
	Heat				Surgery		
	Home exercise				TENS		
	lce						
ΙĪΙ	story –What Prior Medi	cations F	lave You Ta	aken?			
<u>Me</u>	dication	<u>Helpful</u>	Not Helpful	<u>Me</u>	<u>dication</u>	<u>Helpful</u>	Not Helpfu
	NSAIDS				Percocet Oxycodone		
	Celebrex Celecoxib				Duragesic		
	Diclofenac				Methadone		
	Flector Patch				Morphine		
	Motrin Ibuprofen				Oxycontin		
	Mobic Meloxicam				Oxymorphone Opana		
	Relafen Nabumetone				Cymbalta Duloxetine		
	Naproxen				Lyrica Pregablin		
	Voltaren Gel				Neurontin Gabapentin		
	Flexeril Cyclobenzaprine Skelaxin Metaxalone				Savella		
	Skelaxin Metaxalone Soma				Topamax Trileptal		
	Zanaflex Tizanidine		П	П	Lidoderm Patch		
	Actiq	П	П	П	Tramadol Ultracet	П	П
	Hydrocodone Vicodin				Tylenol Acetaminophen		
	Hydromorphone Dilaudid	П			- ,		

Single	So	cial History—Check the	e box that b	est answers	questions al	oout	<u>you</u> .		
Married	П	Single	□ c	urrently smoke ev	erv dav	П	Ineve	er exercise	
Domestic partner	П	-		-					
Widowed	П			•				•	
Separated Cigarettes packs per day Acrobics Bikting Children, How Many Total years Running Hilking Swimming Children, How Many Total years Hilking Swimming Climbing Treadmill/Elliptical Walking Treadmill/Elliptical Unemployed Socially use alcohol Walking Weight lifting Weight liftin	_	•	_					-	
Divorced	_		_		•	_		-	
Chew cans per day	П								
Children, How Many Total years Hiking Swimming Swimming Swimming Swimming Swimming Swimming Swimming Swimming Disabled Rarely use alcohol Treadmill/Elliptical Walking Weight lifting Employed part-time Daily use alcohol Weight lifting Employed full-time Use marijuana I use marijuana I use cocaine I use heroin Some high school I use heroin Some high school I use heroin Some high school I use morphine I use	_	J.1131.334					-	•	
Retired	П	Children. How Many						-	
Retired	_	,,					•	•	
Disabled	П	Retired	□ N	o alcohol use		_		-	
Unemployed Socially use alcohol Walking Weight lifting Employed part-time Details:	П		_					o	
Self-employed Daily use alcohol Weight lifting Employed part-time Details:	П			•				· -	
Employed part-time Details:	_	• •		-				•	
Employed full-time	_			•		_	_	3	
Current occupation I do not use recreational drugs I use marijuana I use cocaine I use marijuana I use cocaine I use heroin I use heroin I use morphine I use estasy I use mushrooms I use estasy I use I us	П					_			-
Luse marijuana Luse cocaine Luse heroin Luse heroin Luse heroin Luse heroin Luse methamphetamines Luse methamphetamines Luse methamphetamines Luse methamphetamines Luse methamphetamines Luse mushrooms Luse mushrooms Luse mushrooms Luse degree Luse costasy Luse	Cur			do not use recreat	ional drugs				_
Luse cocaine Luse heroin Some high school Luse morphine High school Luse morphine High school Luse methamphetamines GED Luse LSD Luse mushrooms College degree Luse mushrooms Luse esstasy Luse mushrooms Luse mushr		· -							
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Master's degree luse Doctorate degree Docto	_	-	_						
Doctorate degree Doctorate d	_								
Family History—Check the box that best answers questions about your family. Unknown, adopted	_	=		<u> </u>					
Condition Father Mother Brother Sister Other Arthritis Asthma Bleeding disorder Coronary artery disease Cancer Congestive heart failure COPD Diabetes High blood pressure Irritable bowel syndrome Kidney disease Heart attack (MI) Peripheral artery disease	Ш	Doctorate degree							
Condition Father Mother Brother Sister Other Arthritis Asthma Bleeding disorder Coronary artery disease Cancer Congestive heart failure COPD Diabetes High blood pressure Irritable bowel syndrome Kidney disease Heart attack (MI) Peripheral artery disease	Ea	mily History Charleth	a hay that l	act answers	augstions o	hout	VOLUE	family	
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Irritable bowel syndrome Kidney disease Heart attack (MI) Peripheral artery disease	Dia	betes							_
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Kidney disease Heart attack (MI) Peripheral artery disease —————————————————————————————————	_								_
Heart attack (MI) Peripheral artery disease									_
Peripheral artery disease									_
									_
									_

Thyroid disease

Hi	story - Chec	k box if <u>you</u> h	nave b	een <u>diagn</u>	<u>osed</u> with	the any of the	followi	ng:
	Depression Anxiety Psychosis	Describe: Describe: Describe:						
Che	eck which applie						_	
	I am currently	not in treatment		I am curren	tly seeing a psy	/chiatrist	am current	ly seeing a psychologist
Che	eck which applie I have had tho	es ughts of suicide		I have not h	nad thoughts of	suicide		
Che	eck which applie	es						
☐ I am coping with my chronic pain ☐ I am frustrated with my chronic pain								
	Fever Chills		Short: Whee	ness of breath		Joint pain Joint swelling		the following: Sexual problems Problems urinating
	Fatigue		Cough	_		Stiffness		
	Poor appetite					Weakness		Headache
	Poor sleep		Chest	-				Dizziness
	Weight gain		_	lar heart beat	_	Abdominal pain		Loss of consciousness
Ш	Weight loss	Ц	Swelli	ng in legs	П	Nausea Vomiting		Weakness Numbness
П	Hearing loss	П	Rash		П	Diarrhea		Tingling
	Sore throat		Itchin	g		Loss of bowel/bla		
	Blurred vision		Lesion	=		Heartburn		Depression
	Decreased visi	on 🗆	Bruise	easily		Constipation		Anxiety
Functional Assessment: <i>Place an X in the box that best answers each question</i> . During the Past Month, how much did pain interfere with the following activities?								
	Act	ivity		None	Little	Mode	rate	A lot
Pł	ysical exercis	e						
G	sing to work							

Activity	None	Little	Moderate	A lot
Physical exercise				
Going to work				
Performing household chores				
Recreation				
Spending time with family				
Shopping				
Socializing				
Sleep				
Other				

Screening: Place an X in the box that best answers the question

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several days	More than half the days	Nearly Every Day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself — or feeling that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead of or hurting yourself in some way				

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult At All	Somewhat Difficult	Very Difficult	Extremely Difficult