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? YES NO If yes, Attending Physician:

PATIENT INFORMATION

Legal Name: (Last, First, Middle)	Preferred Name:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Email Address:	Age:	Date of Birth:	Gender: ☐ Male ☐ Female
Street Address:	City/State/Zip Code:		
Social Security #:	Cell Phone:		
Home Phone:	Work Phone:	Employer:	

RESPONSIBLE PARTY

Legal Name: (Last, First, Middle) ☐ (Check if Same as Patient)	Date of Birth:	Gender: ☐ Male ☐ Female	Relationship to Patient:
Street Address:	City/State/Zip Code:		
Social Security #:	Cell Phone:	Email Address:	
Home Phone:	Work Phone:	Employer:	

INSURANCE COVERAGE

Primary Insurance:	Phone:		
Billing Address:	City/State/Zip Code:		
Subscriber Legal Name: (Last, First, Middle) ☐ (Check if Same 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 Same 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 CONTACT INFORMATION

Name of Local friend/relative:	Phone:

PERSONAL HEALTH INFORMATION RELEASE & CONTACT INFORMATION

Portland Pain Care *can* 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 information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Joseph P Stapleton MD PC.

Patient/Guardian Signature: ______________________________ Date: ______________

portland PAIN CARE | Joseph P. Stapleton, MD

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

____
Patient Name (Signature)

____
Witness (Office Staff Member)

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portland PAIN CARE | Joseph P. Stapleton, MD

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

New Patient Intake Form

Patient Information

Name:	Date:
Referring Physician:	Primary Care Provider:
Height:	Weight:

Current Medications/Allergies:

Have you had a flu shot this season? ☐ Yes ☐ No   Have you ever had a pneumonia immunization? ☐ Yes ☐ No

Medication	Dose	How often		Medication	Dose	How often

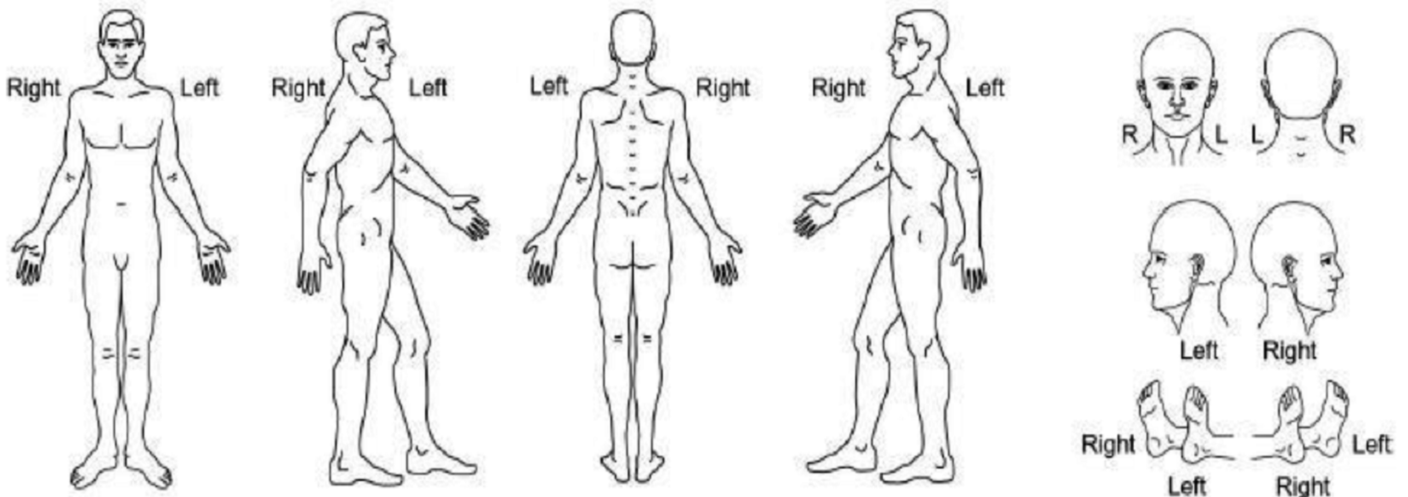
Do you currently take any blood thinning medication (Aspirin, Coumadin, Warfarin, Plavix, Lovonox)? ☐ Yes ☐ No   If yes, when was your last dose? ___________________

Allergies:	☐ I have No Known Drug Allergies

Pain History

Chief Complaint: (Reason for your visit today)

Use diagram to indicate the area of your pain. Mark location(s) with an 'X'



Circle the number that best describes your pain. (0 being no pain, 10 being worst pain)

Average Pain	0	1	2	3	4	5	6	7	8	9	10
Worse Pain	0	1	2	3	4	5	6	7	8	9	10
Current Pain	0	1	2	3	4	5	6	7	8	9	10
With Activity	0	1	2	3	4	5	6	7	8	9	10
With Meds	0	1	2	3	4	5	6	7	8	9	10
Without Meds	0	1	2	3	4	5	6	7	8	9	10

Pain History Continued...

Activities that make pain worse:

- ☐ NONE
- ☐ Bending forward
- ☐ Exertion/Exercise
- ☐ Getting out of chair
- ☐ Lifting
- ☐ Lying down
- ☐ Moderate physical activity
- ☐ Nonspecific activity
- ☐ Position change
- ☐ Reaching
- ☐ Significant physical activity
- ☐ Sitting
- ☐ Standing
- ☐ Turning the head
- ☐ Twisting
- ☐ Walking

Activities that make pain better:

- ☐ NONE
- ☐ Bending forward
- ☐ Injections
- ☐ Lying down
- ☐ Medications
- ☐ Moving
- ☐ Position change
- ☐ Physical activity
- ☐ Procedures
- ☐ Rest
- ☐ Sitting
- ☐ Standing

Qualities of your pain:

- ☐ NONE
- ☐ Aching
- ☐ Burning
- ☐ Dull
- ☐ Sharp
- ☐ Shooting
- ☐ Stabbing
- ☐ Throbbing
- ☐ Pressure
- ☐ Crushing
- ☐ Cramping
- ☐ Spasmodic
- ☐ Pulling
- ☐ Tender
- ☐ Tight
- ☐ Knife like
- ☐ Hot
- ☐ Sore

Duration of your pain *Please check only one

☐ No pain ☐ Constant pain ☐ Intermittent pain

History –Check the box if you have ever been diagnosed with the following:

HEAD/EARS/EYES/NOSE/THROAT

- ☐ Headaches
- ☐ Migraines
- ☐ Seasonal allergies
- ☐ Sinusitis

CARDIOVASCULAR

- ☐ Angina
- ☐ Arrhythmia
- ☐ Coronary artery disease
- ☐ Deep venous thrombosis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Past heart attack
- ☐ Mitral valve prolapse
- ☐ Heart murmur
- ☐ Pace maker
- ☐ Peripheral vascular disease

RESPIRATORY

- ☐ Asthma
- ☐ COPD
- ☐ Obstructive sleep apnea

GASTROINTESTINAL

- ☐ Gallstones
- ☐ GERD
- ☐ GI bleed
- ☐ Hiatal hernia
- ☐ Irritable bowel syndrome
- ☐ Pancreatitis
- ☐ Ulcers

GENITOURINARY

- ☐ Enlarged prostate
- ☐ Frequent bladder infections
- ☐ Kidney stones
- ☐ Renal failure
- ☐ Renal insufficiency

ENDOCRINE

- ☐ Diabetes
- ☐ Obesity
- ☐ Thyroid disorder

BLOOD

- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Blood transfusion

INFECTIONS

- ☐ Hepatitis
- ☐ HIV
- ☐ Shingles

NEUROLOGICAL

- ☐ Stroke
- ☐ Parkinson's disease
- ☐ Peripheral neuropathy
- ☐ Seizure disorder
- ☐ TIA

PSYCHOLOGICAL

- ☐ ADD
- ☐ Anxiety
- ☐ Bi-Polar disorder
- ☐ Dementia
- ☐ Depression
- ☐ Schizophrenia

CANCER

- ☐ Bladder cancer
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ Lung cancer
- ☐ Melanoma
- ☐ Prostate cancer

MUSCULOSKELETAL

- ☐ Back pain
- ☐ Connective tissue disorder
- ☐ Fibromyalgia
- ☐ Kyphoscoliosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Scoliosis

History - Prior Procedures (Example: Epidural Steroid Injections, Trigger Point Injections)

List all past procedures for pain & approximate dates	

History - Surgery

List all past surgeries & approximate dates.	

History -What Prior Treatments Have You Had?

	Treatment	Helpful	Not Helpful
☐	Acupuncture	☐	☐
☐	Biofeedback relaxation therapy	☐	☐
☐	Botox injections	☐	☐
☐	Chiropractic	☐	☐
☐	Heat	☐	☐
☐	Home exercise	☐	☐
☐	Ice	☐	☐

	Treatment	Helpful	Not Helpful
☐	Massage	☐	☐
☐	Minimally invasive procedures	☐	☐
☐	Occupational therapy	☐	☐
☐	Physical therapy	☐	☐
☐	Surgery	☐	☐
☐	TENS	☐	☐

History –What Prior Medications Have You Taken?

	Medication	Helpful	Not Helpful
☐	NSAIDS	☐	☐
☐	Celebrex | Celecoxib	☐	☐
☐	Diclofenac	☐	☐
☐	Flector Patch	☐	☐
☐	Motrin| Ibuprofen	☐	☐
☐	Mobic | Meloxicam	☐	☐
☐	Relafen| Nabumetone	☐	☐
☐	Naproxen	☐	☐
☐	Voltaren Gel	☐	☐
☐	Flexeril| Cyclobenzaprine	☐	☐
☐	Skelaxin| Metaxalone	☐	☐
☐	Soma	☐	☐
☐	Zanaflex| Tizanidine	☐	☐
☐	Actiq	☐	☐
☐	Hydrocodone| Vicodin	☐	☐
☐	Hydromorphone| Dilaudid	☐	☐

	Medication	Helpful	Not Helpful
☐	Percocet| Oxycodone	☐	☐
☐	Duragesic	☐	☐
☐	Methadone	☐	☐
☐	Morphine	☐	☐
☐	Oxycontin	☐	☐
☐	Oxymorphone| Opana	☐	☐
☐	Cymbalta| Duloxetine	☐	☐
☐	Lyrica | Pregablin	☐	☐
☐	Neurontin| Gabapentin	☐	☐
☐	Savella	☐	☐
☐	Topamax	☐	☐
☐	Trileptal	☐	☐
☐	Lidoderm Patch	☐	☐
☐	Tramadol| Ultracet	☐	☐
☐	Tylenol | Acetaminophen	☐	☐
☐			

Social History—Check the box that best answers questions about you.

☐ Single
☐ Married
☐ Domestic partner
☐ Widowed
☐ Separated
☐ Divorced

☐ Children, How Many ___________

☐ Retired
☐ Disabled
☐ Unemployed
☐ Self-employed
☐ Employed part-time
☐ Employed full-time

Current occupation ____________
Previous occupation ____________

☐ Elementary school
☐ Some high school
☐ High school
☐ GED
☐ Some college
☐ College degree
☐ Master's degree
☐ Doctorate degree

☐ Currently smoke every day
☐ Currently smoke some days
☐ Former smoker
☐ Never smoker

Cigarettes packs per day ___________
Pipe times per day _______________
Chew cans per day ________________
Total years ______________________

☐ No alcohol use
☐ Rarely use alcohol
☐ Socially use alcohol
☐ Daily use alcohol

Details: __________________________

☐ I do not use recreational drugs
☐ I use marijuana
☐ I use cocaine
☐ I use heroin
☐ I use morphine
☐ I use methamphetamines
☐ I use LSD
☐ I use mushrooms
☐ I use ecstasy
☐ I use ________________________

☐ I never exercise
☐ I exercise 1-2 times per week
☐ I exercise 3-5 times per week
☐ I exercise 6-7 times per week
☐ Aerobics
☐ Biking
☐ Running
☐ Hiking
☐ Swimming
☐ Climbing
☐ Treadmill/Elliptical
☐ Walking
☐ Weight lifting
☐ ____________________________
☐ ____________________________

Family History—Check the box that best answers questions about your family.

☐ Unknown, adopted ☐ Unknown

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	_______	_______	_______	_______	_______________
Stroke	_______	_______	_______	_______	_______________
Thyroid disease	_______	_______	_______	_______	_______________

History - Check box if you have been diagnosed with the any of the following:

☐ Depression Describe: ____

☐ Anxiety Describe: ____

☐ Psychosis Describe: ____

Check which applies

☐ I am currently not in treatment ☐ I am currently seeing a psychiatrist ☐ I am currently seeing a psychologist

Check which applies

☐ I have had thoughts of suicide ☐ I have not had thoughts of suicide

Check which applies

☐ I am coping with my chronic pain ☐ I am frustrated with my chronic pain

Review of Systems--Check the box if you *currently* are experiencing any of the following:

☐ Fever
☐ Chills
☐ Fatigue
☐ Poor appetite
☐ Poor sleep
☐ Weight gain
☐ Weight loss

☐ Hearing loss
☐ Sore throat
☐ Blurred vision
☐ Decreased vision

☐ Shortness of breath
☐ Wheezing
☐ Cough

☐ Chest pain
☐ Irregular heart beat
☐ Swelling in legs

☐ Rash
☐ Itching
☐ Lesions
☐ Bruise easily

☐ Joint pain
☐ Joint swelling
☐ Stiffness
☐ Weakness

☐ Abdominal pain
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Loss of bowel/bladder
☐ Heartburn
☐ Constipation

☐ Sexual problems
☐ Problems urinating

☐ Headache
☐ Dizziness
☐ Loss of consciousness
☐ Weakness
☐ Numbness
☐ Tingling

☐ Depression
☐ Anxiety

Functional Assessment: *Place an X in the box that best answers each question.*

During the Past Month, how much did pain interfere with the following activities?

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