Baher Yanni M.D. Tolga Kapusuz M.D.
Amanda Morris PA-C, Payal Patel PA-C, Carmen Cheng PA-C
Hye Min Kim APN

DEMOGRAPHICS FORM

Today's Date: _____

Please read these sheets carefully and answer all questions to the best of your ability. This will assist us in better treating your pain. Thank you for your time and cooperation.

Name: _____

Age: _____ Date of Birth: _____

Gender: _____ Height: _____ Weight: _____

Home #_____ Cell #_____Work #_____

Address:_____

Email Address:_____

Referring Physician(s):_____

Other Physicians seen for this problem:_____

Marital Status: □S □M □D □W □Other Ethnicity: Hispanic_____ Not Hispanic _____

SS#_____-_____-_____ Race:_____ Preferred Language_____

Spouse/Significant Other Name: _____ Phone #:_____

Your Employer: _____Phone #:_____

Primary Care Physician: _____Phone #:_____

Pharmacy: _____ Phone#:_____

Primary Insurance: _____

Subscriber ID #: _____ Group#: _____

Policyholder: _____ Phone #: _____

Relationship (if other than patient): _____ Date of Birth: ___/___/_____

Your Secondary Insurance: _____

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Subscriber ID #: _____ Group #: _____

Policy holder: _____ Phone #: _____

Relationship (if other than patient): _____ Date of Birth: ___/___/_____

Is this a Workman's Comp. Claim? □Yes □No If Yes, Complete WC Form
Is this a Car accident claim? □Yes □ No If Yes, Complete MVA Form

Authorization to release Information and Assignment of Benefits:

I hereby assign all medical and /or surgical benefits to which I am entitled, including Medicare, BCBS, HMO's and all commercial insurances to Baher Yanni M.D, Amanda Morris PA-C, Payal Patel PA-C, and their facilities. I understand that I am fully responsible for all charges whether or not they are covered by my insurance. I herby authorize assignee to release any information necessary to secure payment on my behalf. I understand I am totally responsible for all charges on my account, I understand that this office will file claims with my insurance and that I am responsible for any amount not paid. If this account has to be collected by an attorney or/ and a collection agency I understand that I will be responsible for the attorney or and the collection agency fees also. I authorize release of my medical information to my physician and insurance carrier including Medicare. I also authorize payment of benefits directly to my physician. I also give permission to take an identification photograph to be maintained in my medical records, I understand that this picture will be used in a confidential manner related only to my personal care in the above mentioned office

Patient name:_____ Patient Signature:_____
Today's Date:_____

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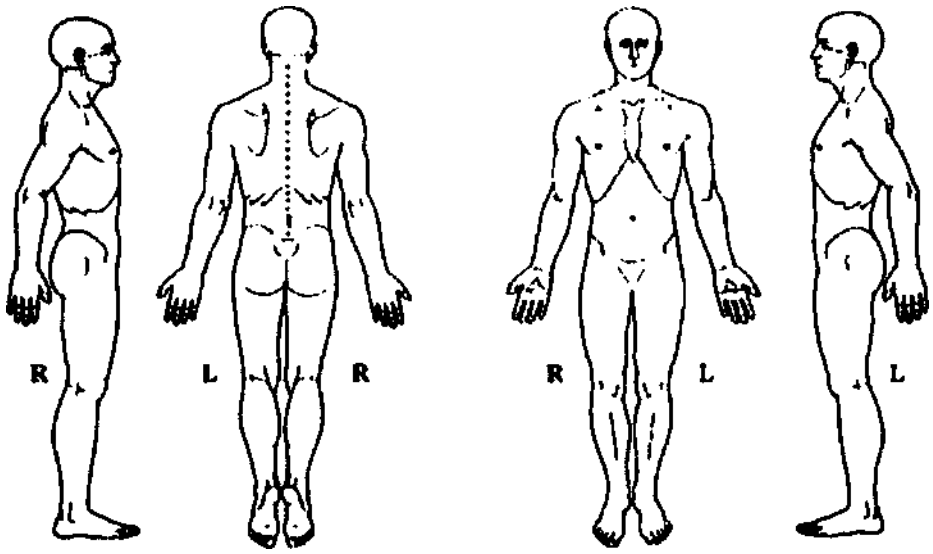
PAIN QUESTIONNAIRE

Name: _____ Today's Date:_____

Where is your pain: _____

Please mark on the diagrams where your pain is located.



- Neck Pain level : (0-10) 0 1 2 3 4 5 6 7 8 9 10
- Mid Back pain level : (0-10) 0 1 2 3 4 5 6 7 8 9 10
- Lower Back pain level: (0-10) 0 1 2 3 4 5 6 7 8 9 10
- Headache Pain level: (0-10) 0 1 2 3 4 5 6 7 8 9 10
- Other Location _____: (0-10) 0 1 2 3 4 5 6 7 8 9 10

Does your pain radiate anywhere? _____

□Shooting down the right or left arm □ shooting down right or left leg

When did the pain start?

_____

Please circle the appropriate words that best describe your pain.

ACHING	DULL	SHOOTING	NUMBING
BURNING	TIGHT	CRAMPING	TINGLING
SORENESS	STABBING	COLDNESS	SHARP

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When is the worst time of day?
□ Morning □Afternoon
□Evening □ Night □All the time

How often is your pain present?
□ Constant □ Intermittent □ Occasional

Over time has the pain been getting?
□ Better □ Staying the same □ Getting worse

What makes symptoms worse?
□ Standing □ Sitting □ Walking □ Movement □ Lying Down
□ Bending Forward □ Arching Backward □ Coughing/Sneezing
□ Using Bathroom □ Hot weather □ Cold Weather □ Lifting objects
□ Other_____

Factors that make your pain better

□Standing □ sitting □ Walking □ Movement □ Lying Down □ Bending forward
□ Arching backward □Coughing/Sneezing □ Using Bathroom □ Injections □ Medication
□ Other_____

Other Symptoms
□Numbness and tingling □Weakness □Color and temperature change □Bladder or bowel incontinence

What tests have been done and when?

MRI □ Neck _____ □ Upper Back _____ □ Lower Back _____ □ Other_____
Date Date Date Date
CT □ Neck _____ □ Upper Back _____ □ Lower Back _____ □ Other_____
Date Date Date Date
EMG □ Arm _____ □ Leg _____ □ Other _____
Date Date Date

Please check all procedures or modalities you have tried to manage or treat your pain:
□ Acupuncture □ Massage □ Chiropractor □ Physical Therapy □ Facet Block □ Tens unit
□ Biofeedback □ Meditation □ Nerve Blocks □ Epidural □ Ice/Heat
□ Medications Other_____

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Past Medical History

- **Heart** □ Coronary artery disease □Hypertension □Murmurs □High cholesterol □Valvular disease □ Aneurysm □Pacemaker □Heart failure □Other
- **Lungs** □ Asthma □ COPD □Emphysema □TB □Lung cancer □ Other
- **Gastrointestinal** □Ulcer □Reflux Gastritis □Hepatitis □Bleeding □Diverticulosis □other
- **Genitourinary** □Kidney stones □Renal Failure □Dialysis (when) _____ □ Other
- **Endocrine** □ Hypothyroidism □Hyperthyroidism □Diabetes □ Parathyroid Problem
- **Neuro** □Stroke□ Nerve injury □spinal cord injury □Dementia □Seizures □Other
- **Psychiatric** □Depression □Anxiety □Panic attacks □OCD □Bipolar □Other____

- **Musculoskeletal** □Arthritis □ Rheumatoid arthritis □ Osteoarthritis □ Gout □ Osteoporosis □Scoliosis
- **Other** _____

Past Surgery History:

_____

Allergies:

Latex □ No □ Yes Reaction _____Contrast (Dye) □ No □ Yes Reaction _____

Allergy to any medication (s)? _____

_____

Current Medications:

_____

_____

_____

Social History:

Tobacco: □ Never □ Quit in _____ □ Currently _____ pack per day
Alcohol: □ Never □ Rarely □ Moderate □ Daily
Use of drugs: □ Never □ Occasionally □ Frequently

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Significant Family History: (Cancer, Hypertension, Diabetes, Depression, back pain…)

- Father side_____
- Mother side _____

- **Review of Systems**

- **Gen** □ Weight loss □Weight gain □Fever □ fatigue □ Loss of appetite □ Nausea □ Vomiting
- **Skin** □ Skin problems □Rash □ Psoriasis □Slow healing □ Itching □ Easy bruising
- **Neuro** □ dizziness □ Fainting □ Weakness □ Stroke □ Tremor □ Seizure □Memory loss
- **Eyes** □ Vision problem □Glaucoma □Blurred Vision □ Double Vision
- **ENT** □ Ear Pain □Hearing loss □Ear noises □Nose Bleed □Sore throat □Hoarseness □ Dental Problems
- **Cardiovascular** □Chest Pain □Shortness of breath □Irregular heart beat □Murmurs
- **Respiratory** □ Coughing □ Difficulty breathing □Asthma/Wheezing □ Coughing up blood
- **Gastrointestinal** □ Constipation □Diarrhea □ Heart burn □Pain in stomach □Ulcers □Hepatitis
- **Genitourinary** □ pain urination □ Frequent urination □ Kidney stone □ Sexual difficulty □Infection
- **Endocrine** □ Hypothyroidism □Hyperthyroidism □Diabetes □ Parathyroid Problem
- **Hematology** □ Anemia □Bleeding disorder □ Easy Bleeding □Lymphoma/ Leukemia
- **Immunologic** □HIV/AIDS □Fever □Hay Fever □ Frequent sinus problems □ Allergies
- **Musculoskeletal** □ Arthritis □Rheumatoid arthritis □Osteoarthritis □Compression fracture □Head Injury □Neck injury □Low back injury □Spinal trauma □Gout □Osteoporosis □Muscular dystrophy □Muscle Pain □Scoliosis
- **Psychiatric** □Depression □Anxiety □Panic attacks □OCD □Bipolar □Homicidal □Suicidal attempts □ Suicidal ideation □psychosis □Hallucination □other

Patient Name: _____

Patient Signature:_____Today's Date:_____