PERSONAL INFORMATION DATA

NAME: _____ DATE OF BIRTH: _____

S.S #: _____ HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ CELL PHONE #: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____ PHONE #: _____

EMERGENCY CONTACT: _____ PHONE #: _____

RELATIONSHIP: _____

CURRENT SYMPTOMS: _____

IF YOU WERE INVOLVED IN AN ACCIDENT, PLEASE COMPLETE THE FOLLOWING:

DATE OF ACCIDENT: _____

CHECK TYPE OF ACCIDENT:

AUTO ☐ WORK ☐ PERSONAL ☐ OTHER ☐

Other than this accident you are being seen for NOW are there any other injuries/accidents in your past? _Yes__No

If yes, explain _____

BRIEFLY DESCRIBE THE INCIDENT THAT BROUGHT YOU HERE TODAY:_____

_____

WHAT BODY PART DID YOU INJURE IN THE ACCIDENT? _____

_____

PHYSICIANS/HOSPITALS & ADDRESS WHERE YOU HAVE BEEN SEEN FOR THIS INCIDENT:

_____

_____

NAME OF INSURANCE COMPANY

IF AUTOMOBILE ACCIDENT: WERE YOU THE PASSENGER OR DRIVER

NAME OF INSURANCE COMPANY: _____

ADDRESS:_____

CITY:_____ STATE: _____ ZIP: _____

NAME OF INSURED: _____ CLAIM #:_____

ADJUSTER: _____ PHONE #:_____

NAME OF YOUR HEALTH INSURANCE: _____

ADDRESS: _____

CITY:_____ STATE:_____ ZIP:_____

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INSURED: _____ DOB:_____RELATIONSHIP: _____

GROUP #: _____

MEDICARE #: (IF APPLICABLE) _____

****I DO NOT HAVE HEALTH INSURANCE:**_____

PATIENT SIGNATURE

**** PLEASE GIVE US YOUR CARD TO COPY****

DO YOU HAVE AN ATTORNEY: YES NO IF YES

ATTORNEY NAME: _____

ADDRESS:_____CITY_____

PHONE NUMBER: _____

GOVERNMENT INFORMATION REQUIRED FOR MEANINGFUL USE:

RACE: BLACK/AFRICAN AMERICAN WHITE AMERICAN/INDIAN/ALASKA NATIVE ASIAN PACIFIC ISLANDER NATIVE HAWAIIAN MORE THAN ONE RACE I DECLINE

ETHNICITY: HISPANIC/LATINO NON-HISPANIC/LATINO I DECLINE

LANGUAGE ENGLISH SPANISH GERMAN OTHER:_____

HEALTH HISTORY FORM: Please complete to the best of your ability:

Family Doctor (Name/Address/Phone):_____

Pharmacy (Name/Address/Phone):_____

Any chance of **PREGNANCY?** Yes / NO N/A

PAST MEDICAL HISTORY: Have you ever been diagnosed with any of the following conditions (past or currently)

( ) Heart Disease What Type? _____

( ) Cancer What Type? _____

( ) Blood Clots ( ) Kidney Problems ( ) Stroke ( ) Bleeding Tendency ( ) Thyroid problems ( ) Arthritis

( ) High Blood Pressure ( ) Glaucoma ( ) Hepatitis ( ) Diabetes ( ) High Cholesterol ( ) Ulcers ( ) Asthma

( ) Gum Disease ( ) Obesity ( ) Blood Transfusion ( ) Liver Disease ( ) Cataracts ( ) Vitamin Deficiency

( ) Schizophrenia ( ) Depression/Mental Disorder(s) ( ) AIDS/HIV ( ) Anemia ( ) Tumors ( )Osteoporosis

( ) Skin Disease ( ) Arrhythmia ( ) Drug Abuse ( ) Alcoholism ( ) Seizure Disorder ( ) Spinal Cord Injury

( ) Degenerative Disc Disease ( ) Neuropathy ( ) Other: *please list*

_____

PAST SURGICAL HISTORY: List all surgeries with Procedures and Dates

_____

_____

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FAMILY HISTORY

Is there any immediate family history of cancer? Please list who and type of cancer.

Please mark if you have any immediate family history of the following:

( ) Blood Clots ( ) Bleeding Disorder ( ) Vitamin Deficiency ( ) Heart Disease ( ) Arrhythmias ( ) Strokes

( ) High Cholesterol ( ) High Blood Pressure ( ) Kidney Problems ( ) Obesity ( ) Depression ( ) Mental Disorder

( ) Alcoholism ( ) Seizure Disorder ( ) Diabetes ( ) Drug Abuse ( ) Respiratory Disorder ( ) Osteoporosis

( ) Other: *please list*

CURRENT MEDICATIONS: INCLUDE BIRTH CONTROL PILLS, VITAMINS, AND SUPPLIMENTS

MEDICINE NAME	HOW TAKEN?	WHO PRESCRIBES?

ALLERGIC AND ADVERSE REACTIONS TO MEDICATIONS:

NAME OF MEDICATION	ADVERSE REACTION

Do you smoke? Yes _____ No _____

Have you ever had a problem with alcohol or illicit/street drugs? Yes _____ No _____

I have completed this form and believe everything to be true to the best of my knowledge.

Patient Signature	Print Name	Date

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REVIEW OF SYSTEM FORM (Check if Applicable):

CONSTITUTIONAL:

Weight Loss _____
Fatigue _____
Fever _____

EYES:

Glasses/Contacts _____
Eye Pain _____
Double Vision _____
Cataracts _____

EAR, NOSE, THROAT:

Difficulty Hearing _____
Ringing in Ears _____
Vertigo _____
Sinus Trouble _____
Nasal Stuffiness _____
Frequent Sore Throat ___

PSYCHIATRIC:

Anxiety/Depression _____
Mood Swings _____
Difficulty Sleeping _____

NEUROLOGICAL:

Loss of Strength _____
Numbness _____
Headaches _____
Tremors _____
Memory Loss _____

RESPIRATORY:

Cough _____
Coughing Blood _____
Wheezing _____
Chills _____

GASTROINTESTINAL:

Heartburn/Reflux _____
Nausea/Vomitting _____
Constipation _____
Change in BMs _____
Diarrhea _____
Jaundice _____
Abdominal Pain _____
Black or Bloody BM ____

GENITOURINARY:

Burning/Frequency _____
Nighttime _____
Blood in Urine _____
Erectile Dysfunction _____
Abnormal Discharge _____
Bladder Leakage _____

SKIN:

Rash/Sores _____
Lesions _____
Itching/Burning _____

HEMATOLOGY/LYMPH:

Easy Bruising _____
Gums Bleed Easily _____
Enlarged Glands _____

MUSCULOSKELETAL:

Joint Pain/Swelling _____
Stiffness _____
Muscle Pain _____
Back Pain _____

CARDIOVASCULAR:

Mumur _____
Chest Pain _____
Palpitations _____
Dizziness _____
Fainting Spells _____
Shortness of Breath _____
Difficulty lying Flat _____
Swelling Ankles _____

ENDOCRINE:

Loss of Hair _____
Heat/Cold Intolerance _____

ALLERGIC/IMMUNOLOGIC:

Hives/Eczema _____
Hay Fever _____

Any other current medical symptoms not mentioned:

_____

_____

_____

Signature/Reviewing Physician: _____

RICHARD H. KAPLAN, M.D., P.C.

RICHARD HARLAN KAPLAN, M.D., FOUNDER
RANDALL N. SMITH, M.D.
BENJAMIN E. KAPLAN, M.D.

PAIN MANAGEMENT
ELECTROMYOGRAPHY
ACUPUNCTURE
ORTHOPEDICS
PHYSICAL THERAPY
INJECTIONS
DISABILITY ASSESSMENT
INDEPENDENT MEDICAL EXAMS

REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____
(PHYSICIAN'S NAME)

_____
(ADDRESS)

_____
(CITY) (STATE) (ZIP CODE)

I HEREBY REQUEST THAT MY MEDICAL RECORDS AND/OR X-RAYS BE RELEASED TO:

RICHARD H. KAPLAN, MD, PC
9140 ACADEMY ROAD, SUITE a
PHILADELPHIA, PA 19114
215-333-9999 FAX: 215-333-9815

_____
(DATE)

_____
(PATIENT'S NAME)

_____
(PATIENT'S SIGNATURE)

_____ _____
(DATE OF BIRTH) (DATE OF ACCIDENT IF APPLICABLE)

BRIEF PAIN INVENTORY

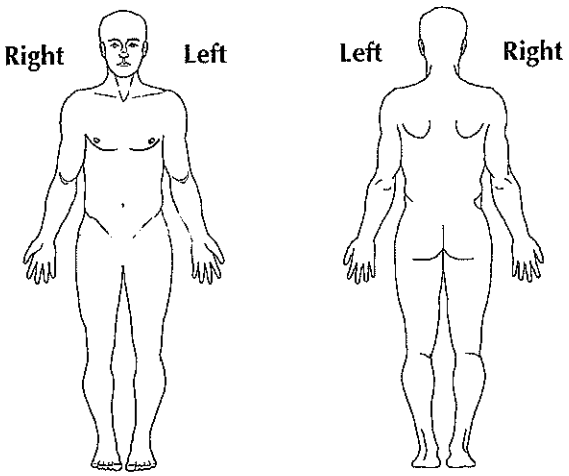
Date_____/_____/_____ Time:_____

Name:_____ _____ _____
Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

_____

_____

8) In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.

0% 10 20 30 40 50 60 70 80 90 100%

No relief — Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

D. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Brief Pain Inventory (Short Form). Source: Pain Research Group, Department of Neuro-Oncology, The University of Texas MD Anderson Cancer Center. Used with permission. Adapted to single page format.

In addition to completing the Brief Pain Inventory, to help your doctor better manage your pain, please tell us:

What does the pain feel like? Circle those words that describe your pain.

aching	throbbing	shooting
stabbing	gnawing	pricking
sharp	tender	burning
exhausting	tiring	penetrating
nagging	numb	miserable
unbearable	dull	radiating
squeezing	cramping	deep

How long have you had this pain? (Circle one)

less than a week	1 to 2 weeks
2 to 4 weeks	more than a month

What kinds of things make your pain feel better (for example, heat, medicine, rest)?

_____

_____

What kinds of things make your pain worse (for example, walking, standing, lifting)?

_____

_____

Do you have any other symptoms? Circle any that apply:

nausea	vomiting
constipation	diarrhea
lack of appetite	indigestion
difficulty sleeping	feeling drowsy
nightmares	dizziness
tiredness	itching
urinary problems	sweating
weakness	headaches

Talking About Your Pain

It's important to remember that each person's pain is different. The pain that you experience can't be compared to another person's pain. ONLY YOU know how and when you hurt, and how the pain affects your life.

It is important to describe what you are feeling to those who are trained to help you. Don't be embarrassed to talk to your doctor, nurse, or pharmacist. They need to know as much as possible about your pain in order to develop the best plan to control it. The questions on this form can help you describe your pain.

Why Is Pain Relief So Important?

Proper treatment for pain is not only a matter of comfort. Unrelieved pain can lead to nausea, loss of sleep, depression, loss of appetite, weakness, and other problems. Pain can also affect your life at home and at work. Relieving your pain means that you can continue to do the day-to-day things that are important to you.

Most Pain Can Be Controlled

It is important to know that most pain CAN be relieved. Your doctor will work with you to find the treatment that may be best for your pain.

The key to effective pain control is to take the RIGHT AMOUNT, of the RIGHT MEDICINE, at the RIGHT TIME. You should take your pain medicine on a regular schedule, as your doctor, nurse, or pharmacist tells you. Don't wait until the pain becomes severe. Pain is easier to control when it is mild than when it has reached full force.

If your pain medicine wears off too soon, is not relieving the pain, or causes problems with side effects, you should call your doctor because you may need to have your treatment plan changed.

Comments: Write down any questions or information you need to share with your doctor, nurse, or pharmacist about your pain.

_____

_____

_____

_____

_____

_____