• • Pacific Pain Centers : Pain Management/Regenerative Medicine Registration • •

Patient name:

Sex: M F Date of birth:

Address:

City, State, Zip:

Home phone:

Social Security #:

Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Separated ◯ Divorced

Email Address:

Your occupation:

Employer:

Address:

City, State, Zip:

Work phone:

Spouse's/Life Partner's name:

Recent pregnancy (past 3 months)

Height: Weight: # Children:

Allergies:

Medications:

Regular Medical Doctor:

Regular OBGYN:

Have you had any miscarriages?

Any previous operations/surgery:

Dates & Description:

Complications of Surgery:

Any Keloids or poor wound healing?

Previous evaluation: ◯ Yes ◯ No

Previous treatments: ◯ Yes ◯ No

Where:

Describe:

Who referred you to our office, or how did you hear about us?

Symptoms (Check all that apply)

- ◯ Pain in Joint
- ◯ Swelling
- ◯ Pain in Muscle
- ◯ Hot/Cold Sensation
- ◯ Limited Joint Movement
- ◯ Pain in Ligament
- ◯ Nerve Tingling (Pins & Needles):
- ◯ Other:

Yes	No	Medical Problems
◯	◯	Bleeding abnormalities
◯	◯	Blood Clots/Embolism
◯	◯	Diabetes (self)
◯	◯	Diabetes (family)
◯	◯	Heart disease
◯	◯	Anemia
◯	◯	Hypertension
◯	◯	Arthritis
◯	◯	Seizures or neurological problems
◯	◯	Rheumatic Fever
◯	◯	Trauma (Car, Work, or Sport Injury)
◯	◯	Depression or Anxiety
◯	◯	Kidney Disease
◯	◯	Liver Disease
◯	◯	Hepatitis (date of last test):
◯	◯	HIV (date of last test):
◯	◯	Recent surgery (past 3 months)
◯	◯	Recent pregnancy (past 3 months)
◯	◯	Smoking

Other medical:

Release and Assignment

I will be responsible for any medical services rendered to me or my dependents. *Pacific Pain Centers* does not acccept health insurance. All payments for services are out of pocket.

Signed: Date:

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