HI PAIN
HAWAII INSTITUTE FOR PAIN

NEW PATIENT PACKET

Aloha and welcome to the Hawaii Institute for Pain (a.k.a. HI Pain)!

Dr. Jerald Garcia, M.D. founded HI Pain with one mission: To give chronic pain sufferers the best possible outcome while providing them with the best possible experience.

To achieve this goal, it is important that we have a thorough grasp of you as a patient including your medical history. Please take the time to complete this packet. Note that **every** page in this packet must be filled out and all pages that require a signature must be signed and dated before you can be seen by our staff and providers.

Mahalo,
Jerald Garcia, M.D.
Josianna Henson, M.D.
Calvin Chen, D.O.
& the HI Pain Ohana

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PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Initial: _____
Male___ Female___ Date of Birth: _____ Social Security Number:_____/_____/_____
Race: _____ White / Hispanic / Non-Hispanic (please circle) Language: _____

Street Address:_____
City:_____ State:_____ Zip Code:_____
Phone Number: _____ Cell/ Home (please circle)
Alternate Phone Number: _____Email Address: _____

Primary Care Provider: _____ Referring Physician (if different): _____
Emergency Contact Name: _____ Phone:_____
Current Pharmacy:_____ Phone:_____

Insurance and Guarantor Information
Please select one of the following and provide proof of coverage when submitting this form

<u>Private Insurance</u> (This MUST be filled out even if you have an active case for work comp/no fault)
Insurance Carrier: _____ Subscriber Number: _____
Secondary Insurance: _____ Subscriber Number: _____

<u>Worker's Compensation</u>
Employer Name:_____ W/C Insurance Carrier: _____
Date of Injury: _____ Claim #: _____
Case Manager Name (if applicable): _____ Phone: _____
Attorney (if applicable): _____

<u>No Fault Injury/Motor Vehicle Insurance</u>
Primary Ins. Carrier: _____ Secondary Ins. Carrier: _____
Claim #: _____ Estimated Available Benefit:_____
Adjuster Name: _____ Phone: _____
Attorney (if applicable): _____

Please sign below to state that you have read and understand the policies that were included in your New Patient Packet including the Notice of Privacy Policy, Office Policy on Cancellation & No-Show Appointments, Patient Financial Responsibility Agreement, Patient Courtesy Policy, and the Prescription Medication Policy.

_____ _____
Signature Date

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Name:_____ **Date:** _____

1. Height: _____ Weight: _____
2. Medication Allergies: _____
_____
_____
_____

Referring Physician: _____

Women only:
Last Menstrual Period: ____/____/____
Pregnant? **YES NO** Due Date?_____
Trying to get pregnant? **YES NO**
Breastfeeding? **YES NO**

3. Please List ALL Medications you are currently taking, including over the counter: N/A SEE LIST (please attach)

Pain Medication	Dosage & Frequency	Last Dose	Helpful?
			Y N
			Y N
			Y N
			Y N
Non-Pain Medication			

4. **Are you currently under an Opioid Agreement or Contract with another physician/provider? YES NO (please circle)**

5. **Are You On Blood Thinners? YES NO (please circle) If yes; please list name: _____**

6. **Please check below and indicate any pre-existing medical conditions that you are being treated for, or have been treated for in the past (please circle):**

N/A (If NO pre-existing medical conditions, please circle N/A and go the next section)

- 0 **Cardiac Disease**: MI/Heart Attack, Coronary Artery Disease, Congestive Heart Failure
- 0 **Irregular Heart Rate/Rhythm**: Atrial Fibrillation, Atrial Flutter, Bradycardia, Tachycardia, MVP
- 0 **Lung Disease**: Asthma, Emphysema, COPD, Chronic Bronchitis, Tuberculosis, Pneumonia
- 0 **Gastrointestinal Disease**: Chron's Disease, Ulcers, GERD, Ulcerative Colitis
- 0 **Auto Immune Disease**: HIV/AIDS, Lupus, Rheumatoid Arthritis, Fibromyalgia
- 0 **Hypertension**: Controlled, Uncontrolled
- 0 **Thyroid:** High Low
- 0 **Diabetes:** Type I, Type II
- 0 **Neurological:** Seizures, Headaches, Difficulty with Balance
- 0 **Cancer: Yes NO Type:_____ Currently in Radiation/Chemo? YES NO**
- 0 **Stroke / CVA / TIA**
- 0 **Hepatitis: Type_____ Active? YES NO**
- 0 **Liver:** Liver Failure, Cirrhosis
- 0 **Kidneys:** Chronic Kidney Failure, Polycystic Kidney Disease, Kidney Stones, Dialysis
- 0 **Psychiatric:** Depression, Anxiety, Bipolar disorder, Schizophrenia
- 0 **Vascular Disease:** DVT, Peripheral Artery Disease, Peripheral Neuropathy, Vericose veins, Diabetic ulcers

Name:_____

7. **Please list all surgeries you have had:**

_____
_____
_____

8. **If known, please list medical conditions of blood relatives: N/A (please circle if not known)**

_____
_____

9. **Occupation: _____**

Full Time Part Time Not Working Student Retired Disabled

10. **Marital Status: Single Married Domestic Partner Divorced Widowed Separated**

11. **Do you have any children? Yes No If yes, how many: Boys:_____ Girls: _____**

12. **Do you use Tobacco? Yes No E-cig RARELY FREQUENTLY DAILY**

13. **Do you use Alcohol? Yes No RARELY FREQUENTLY DAILY**

14. **Do you use Marijuana? Yes No Card RARELY FREQUENTLY DAILY**

15. **Do you use illicit drugs? Yes No RARELY FREQUENTLY DAILY**

If yes to number 16, what illicit drugs do you use? _____

_____

Do you now, or have you ever, had issues with alcohol or drug abuse? YES NO

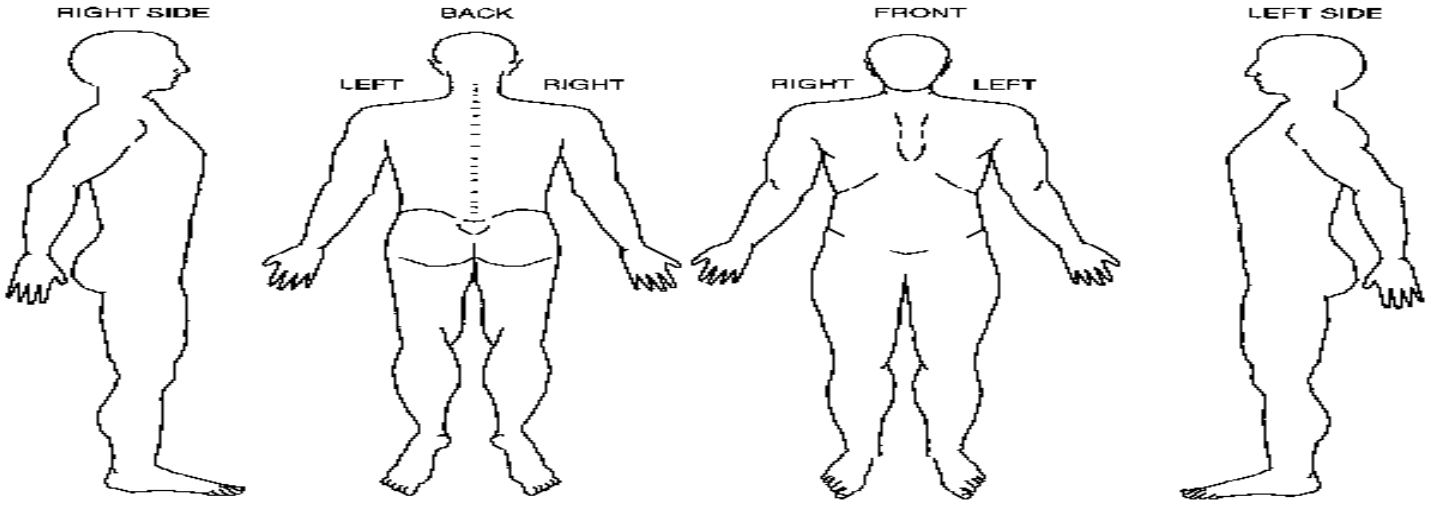
If yes, please list recovery date (approx.): _____

Name:_____

Please fill out picture below once printed.

CHIEF COMPLAINT

1. **On the Diagram below, please mark the area(s) where you experience pain:**
   severe (SSS) moderate (xxx) mild (mmm) slight(lll)



How long have you had this pain?_____ (Estimated date: Month/Day/Year)

1. **Where is your most intense/severe pain: (PLEASE CHOOSE ONE LOCATION) _____**
2. **The onset of pain was: _____ No known inciting event or injury _____ After a work related injury**
   _____ After a motor vehicular accident _____ I've had back or neck surgery
   Other: _____

3. **Please describe your pain:**
   _____ aching/dull _____ cramping _____ throbbing _____ sharp _____ stabbing _____ burning

4. **Using the scale below, please indicate the percentage of time you experience pain:**

Occasional		Comes & Goes		Frequent			Constant		
10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

5. **Using the scale below, please circle the Severity of your pain TODAY:**

None		Slight		Mild		Moderate		Severe	
1	2	3	4	5	6	7	8	9	10

6. **Using the scale below, please circle the box that represents your WORSE possible pain at any time:**

None		Slight		Mild		Moderate		Severe	
1	2	3	4	5	6	7	8	9	10

Name:_____

My No Fault Injury/Work Comp Case is currently: Open Closed

7. **What brings about or increases your pain intensity?**
   a. Sitting
   b. Standing
   c. Walking
   d. Lifting
   e. Laying Flat
   f. Other: _____

8. **What diminishes or relieves your pain and discomfort?**
   a. Sitting
   b. Standing
   c. Stretching
   d. Walking
   e. Resting
   f. Nothing
   g. Other: _____

9. **When in the grocery, do you lean on the shopping cart to relieve your back pain?**
   Yes___ No_____

10. **In addition to your pain, do you experience any of the following?**
    a. Shooting pain going down an extremity (not tingling or numbness - **PAIN**!).
       If YES, specify location: _____
       _____
    b. Numbness/tingling – specify location: _____
    c. Weakness – specify location: _____
    d. Spasms – specify location: _____
    e. Loss of bladder control due to pain **YES** **NO**
       If yes, do you have to wear a diaper at all times? **YES** **NO**
    f. Loss of bowel control due to pain **YES** **NO**
       If yes; do you have to wear a diaper at all times? **YES** **NO**
    g. Fever/Chills **YES** **NO**
       If yes; what was your most recent temperature _____**F** When taken? **DATE:** _____
       TIME: _____

Name:_____

11. In regards to your pain and/or discomfort, please indicate ALL medications previously tried by encircling them. Also, please let us know if these medications helped control your pain by encircling the appropriate outcome:

0	**Over-the-Counter Agents including OTC NSAIDS (Tylenol, Motrin/Ibuprofen, Aleve, Advil, Aspirin, Salon Pas, Icy-Hot)**	**HELPED**	**DID NOT HELP**
0	**Prescription Non-Steroidal Anti-Inflammatories or NSAIDS (Celebrex, naproxen, ibuprofen, meloxicam/Mobic, Duexis, diclofenac)**	**HELPED**	**DID NOT HELP**
0	**Muscle Relaxants (Flexeril, Soma, Zanaflex/tizanidine, Robaxin, Skelaxin, baclofen)**	**HELPED**	**DID NOT HELP**
0	**Prescription Nerve Medication or Membrane Stabilizers (Neurontin/gabapentin, Topamax, Lyrica/pregabalin)**	**HELPED**	**DID NOT HELP**
0	**Prescription Topical Analgesics (Voltaren gel, Lidoderm Patch, Flector Patch, Medrox Patch)**	**HELPED**	**DID NOT HELP**
0	**Opioid Analgesics or Prescription Pain Medications (Norco, Percocet, Oxycodone, Dilaudid, Morphine, Oxycontin, Fentanyl, Tramadol, Suboxone)**	**HELPED**	**DID NOT HELP**
0	**Anti-Depressants for Nerve Pain (Cymbalta, Effexor, mmitriptyline, nortriptyline)**	**HELPED**	**DID NOT HELP**
0	**Others (Specify):_____**	**HELPED**	**DID NOT HELP**

12. Please indicate any of the following treatment therapies that you have undergone for your current condition. Also, please let us know if these helped with your pain by encircling the appropriate outcome.

0	**Physical Therapy (Last done on:_____ for approximately_____ sessions)**	**HELPED**	**DID NOT HELP**
0	**Aquatherapy / Water Therapy**	**HELPED**	**DID NOT HELP**
0	**Massage Therapy**	**HELPED**	**DID NOT HELP**
0	**TENS Unit**	**HELPED**	**DID NOT HELP**
0	**Acupuncture**	**HELPED**	**DID NOT HELP**
0	**Bracing**	**HELPED**	**DID NOT HELP**
0	**Home Exercise Regimen**	**HELPED**	**DID NOT HELP**
0	**Activity Modification**	**HELPED**	**DID NOT HELP**
0	**Chiropractic Treatment**	**HELPED**	**DID NOT HELP**
0	**Cortisone Injections: Site:_____**	**HELPED**	**DID NOT HELP**
0	**Surgery: Site:_____**	**HELPED**	**DID NOT HELP**