P: 702-879-2005 F: 702-805-0019
851 South Rampart Blvd. Suite 100 Las Vegas, NV 89145
100 N. Green Valley Pkwy. Ste 225 Henderson, NV 89074
3603 N. Las Vegas Blvd. Ste 111 Las Vegas, NV 89115

Patient Information					
First Name	Last Name	Middle	Birth Date		Gender ☐ Male ☐ Female
Address		City	State	Zip Code	
Preferred Phone	Email		Social Security Number		
Employer		Occupation	Employer Phone		
Preferred Method of Contact ☐ Email ☐ Call ☐ Text - LVIPC has your consent to text your preferred phone number in regards to your appointment information					
Emergency Contact Name		Relationship to patient	Emergency Contact Phone Number		
Attorney Information					
Attorney Name/Attorney Phone number			Date of Injury:		

Please check the details that apply to you in the categories below

MVA

- ☐ Driver
- ☐ Passenger
- ☐ Wearing seatbelt
- ☐ Not wearing seatbelt
- ☐ Airbags deployed
- ☐ Airbags did not deploy
- ☐ Rear ended
- ☐ T-boned
- ☐ Sideswiped
- ☐ Lost consciousness
- ☐ Ambulance arrived on scene
- ☐ Police arrived on scene
- ☐ Evaluated at the hospital/Urgent care

Slip and Fall

- ☐ Tripped
- ☐ Slipped
- ☐ Lost consciousness
- ☐ Ambulance arrived on scene
- ☐ Evaluated at the hospital/Urgent care

Other

- ☐ Motor vehicle vs pedestrian
- ☐ Assault
- ☐ Ambulance arrived on scene
- ☐ Evaluated at the hospital/Urgent care

LAS VEGAS INJURY PAIN CENTER

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Present Complaint

Where is your pain located?

What makes your symptoms feel better?	What makes your symptoms feel worse?

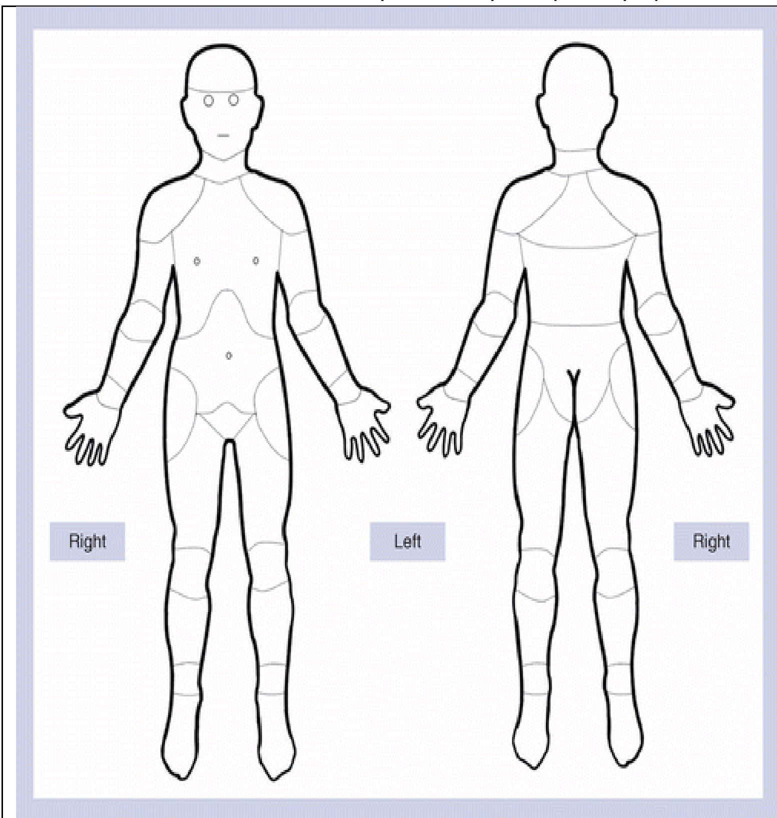
Circle words that describe your pain:

Aching	Continuous	Gnawing	Occasional	Sharp	Tender
Burning	Cramping	Deep	Dull	Miserable	Numb/Tingling
Penetrating	Sore	Shooting	Stabbing	Throbbing	Unbearable

Which other providers have you seen for this problem?

Who is your Primary Care Physician?	Phone Number:

Please mark/circle where you usually feel pain/symptoms.



Please place an X next to the description(s) that best describe(s) your symptoms/function due to pain on MOST days.	
	0 - No Pain
	1 - Minimal Discomfort – barely noticeable. Rarely uncomfortable. Does NOT limit function.
	2 - Mild Discomfort – Only notice pain if I focus on it. I only avoid the most rigorous activities.
	3 - Mild Pain – Pain is annoying, but I can mostly ignore it. Stops some productive activities.
	4 - Mild to Moderate – Short intervals of pain, but I can do most normal daily activities and work tasks. Sometimes interferes with daily activities, such as running errands, exercise, job performance, and house chores.
	5 - Moderate – Pain is troubling and breaks my concentration. Pain is ALWAYS on my mind, but I push through the day. I cannot perform normal tasks without increase in pain.
	6 - Moderate to Severe – Pain significantly limits my normal daily life functions. I cannot concentrate due to pain. Hard to do anything but think about pain. Almost unable to work because of pain.
	7 - Severe – Pain is impossible to tolerate for long periods. Frequent crying. I cannot perform basic tasks due to pain.
	8 - Debilitating – I no longer do ANY normal activities due to pain. I cannot focus on anything else but pain. I no longer work due to pain, or I rarely leave my bed because of pain.
	9 - Disabling – Uncontrollable screaming and crying due to pain. I can barely function or talk. I feel like I should go to the emergency room.
	10 - Worst imaginable – Call an ambulance I need immediate emergency medical attention. Paralyzing. In and out of consciousness due to pain.

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Medications & Drug Allergies

Please list any prescription or over-the-counter medicine you are taking: ☐ I am not taking any medication		**Please list any drug allergies** ☐ No known drug allergies
Medication/Dose	**Frequency Taken**	

**If you take medication(s) that thin your blood, list them here:____

Past Medical History
Do you have any medical issues? Please mark them below.

☐ I do not have any known medical problems/I am otherwise healthy

Cardiovascular (heart):
- Atrial fibrillation/arrhythmia
- Congestive heart failure
- Coronary artery disease
- Deep vein thrombosis(DVT/blood clot)
- Heart Attack, when:_______________
- Hypertension (high blood pressure)
- Peripheral vascular disease

Endocrine/Metabolic:
- Diabetes: Type I / Type II
- Diabetic Neuropathy
- High Cholesterol
- Hyperthyroid (high thyroid)
- Hypothyroid (low thyroid)
- Obesity

Musculoskeletal:
- Arthritis/osteoarthritis
- Fibromyalgia
- Gout
- Muscular Dystrophy
- Osteoporosis
- Rheumatoid Arthritis

Gastrointestinal:
- Gastric ulcer
- GERD/heartburn/acid reflex
- Inflammatory Bowel Disease

Infectious/Integument/Immunity:
- Herpes simplex (HSV 1 / 2)
- Herpes zoster (shingles)
- Hepatitis: A / B / C
- HIV/AIDS
- Impaired Immunity

Eyes:
- Glaucoma

Kidney/Urinary:
- Chronic Kidney Disease
- Kidney Stones

Respiratory:
- Asthma
- COPD/Chronic bronchitis
- Pulmonary hypertension
- Sleep apnea

Neurologic:
- Migraine
- Multiple sclerosis
- Peripheral neuropathy
- Parkinson Disease
- Seizure: last seizure_____________
- Stroke/TIA, when _______________

Psychiatric:
- Anxiety disorder
- Bipolar disorder
- Major Depressive Disorder
- Obsessive Compulsive Disorder
- Schizophrenia

Hematologic:
- Anemia
- Bleeding disorder
- Blood clotting disorder
- Cancer: Type & Treatment ____________
  ____
  ____
- Other: ____________________________
  ____
  ____
  ____
  ____

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Review of Systems
Do currently have any of the following issues? Please mark them below.

☐ I have not experienced any of the issues below.

Cardiovascular (heart): Chest pain Palpitations (racing heart) **Endocrine/Metabolic:** Unintentional weight loss/gain **Respiratory:** Difficulty breathing **Constitutional:** Fevers Chills Night sweats **Kidney/Urinary:** Blood in urine Unable to urinate Uncontrolled urination	**Gastrointestinal:** Abdominal Pain Bloody Stools Constipation Diarrhea Nausea Vomiting **Integumentary:** Skin Rash **Eyes/Ear/Nose/Throat:** Difficulty swallowing Hearing loss Nosebleed Ringing in ears Vision changes	**Neurologic:** Dizziness/Vertigo Lightheadedness Passing out/Syncope Headache **Psychiatric:** Feeling sad/Depressed/Irritable Flashback/Nightmares I am having suicidal thoughts Other: ____________________________ __________________________________ __________________________________ __________________________________ __________________________________

Past Surgical History
Have you had any surgery in the past? (please include dates)

☐ I have never had a Surgery

Appendix Removal ________________________________	Tonsillectomy________________________________
C-Section ________________________________	Tubal Ligation ________________________________
D & C ________________________________	Vasectomy________________________________
Gallbladder Removal ________________________________	Other:________________________________
Hysterectomy ________________________________	Other: ________________________________
Joint Replacement ________________________________	Other: ________________________________

Do you have any metal in your body? _________ If yes, is it MRI-compatible (titanium)?_____________

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Family and Social History	
Do any diseases run in your family? ☐Yes ☐No Unknown If so, which one(s):	
Marital Status: ☐Married ☐Divorced ☐Single ☐Widowed	Alcohol Use? ☐Yes ☐ No If so, how much? ________________________
Tobacco use: ☐Never ☐Former, Quit: ___________ Current Smoker: Packs/day: ____ # of years: ____ Chewing tobacco	Recreational drug use? If so, which ones? ________________________
Are you pregnant or nursing? ☐ Yes ☐ No	Employment Status? ☐ Full-time ☐ Part-time ☐ Disabled ☐ Unemployed ☐ Retired
Number of Children:	

Opioid Risk Tool	
This is a screening tool to be administered by each patient on an initial visit. State law requires opioid risk screening prior to prescribing opioids. It is our policy to screen all patients regardless of whether medications are prescribed.	
Mark each box that applies:	
1. Someone in my immediate family abuses:	
Alcohol	**1**
Illegal Drugs	**1**
Prescription Drugs	**1**
2. I have a history of substance abuse:	
Alcohol	**1**
Illegal Drugs	**1**
Prescription Drugs	**1**
3. I am between 16-45 years old	**1**
4. I have a history of psychological disorder: ADD, OCD, Bipolar, Schizophrenia, Depression	**1**
Total the points above:	

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Authorization Pertaining to Medical Records

Patient Information			
Name	Birth Date	Phone	
Address	City	State	Zip Code

Authorization to Request Medical Records

My signature below authorizes Las Vegas Injury Pain Center to request ALL of my medical records on my behalf INCLUDING the following:

- ☐ Mental Health
- ☐ Xray/MRI/Imaging Report
- ☐ Operative Reports
- ☐ Lab Work
- ☐ Office Notes
- ☐ Other:__________

I understand that I am entitled to a copy of this Authorization.

____ ____________________

Patient/Guardian Signature Date

Notes: ____

____

____

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Authorization to Release Medical Records

Information to be disclosed: I authorize the release of the following health information:

All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

Only the following records or types of health information____

____

I Authorize my medical records to be released to:

Name:	Relationship:
_____________________________________	_____________________________________
_____________________________________	_____________________________________
_____________________________________	_____________________________________
_____________________________________	_____________________________________

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

____ ____________________________
Patient/Guardian Signature Date