

Dear: _____ Date: _____

Your appointment with Dr. Maia U. Chakerian is scheduled for:

Attached, you will find a patient questionnaire for you to **complete at home and bring with you to your appointment**. (Due to Dr. Chakerian's busy schedule, we will have to reschedule your appointment if you have not filled out these forms completely by the time of your appointment.) Any missed, rescheduled or cancelled appointment less than 24 hour notice will be charged \$100.00

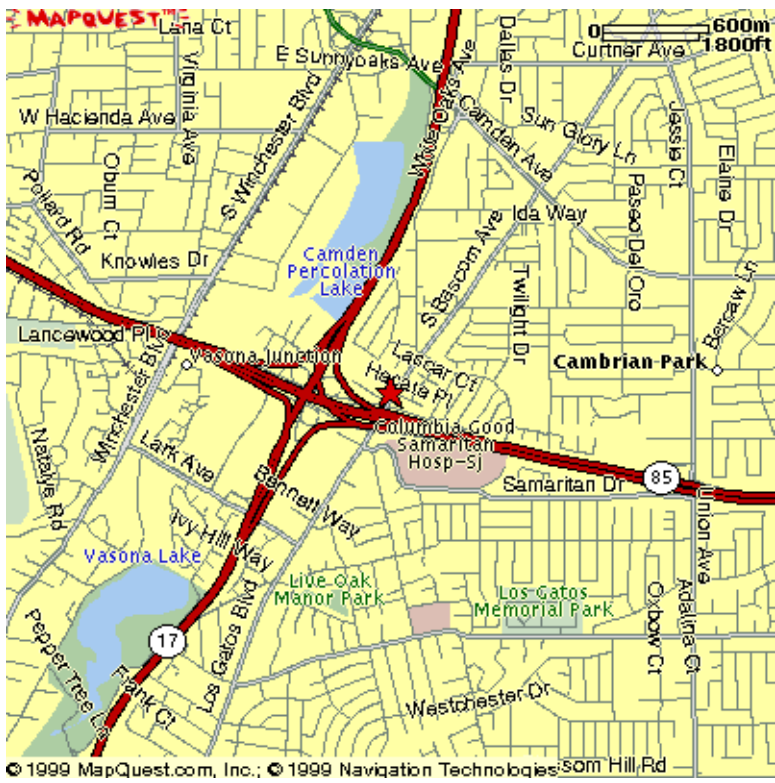
You **must** bring the following items with you to your appointment:

1. All insurance information (including worker's comp info).
2. Your authorization if you have an HMO insurance plan.
3. Any X-Ray's, MRI's, or CT Scan reports and films.
4. Latest progress notes from your referring Physician.
5. Any other information that you think relevant.

Your appointment is for a one-hour consultation with Dr. Chakerian.

Our address is: 14601 S. Bascom Ave., Ste. 240
Los Gatos, CA 95032

Our phone #: (408) 356-0503
Fax: (408) 356-4704



**If you are traveling on 17, do not take the 85 South exit. There is not an exit to Bascom Ave. from that route. Use Camden or Lark. From 85 highway (Gilroy/mountain view) Exit on Bascom ave, make a Right and quick Left into Driveway.*

Patient Information

Name: _____ M _____ F _____ Birthdate: _____ SSN#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Employer: _____ Occupation: _____

E-mail Address: _____ Marital Status: _____

Primary Insurance Information

Name of Insurance Company: _____ Address: _____

City: _____ State: _____ Zip: _____ Telephone #: _____

Subscriber's Name: _____ Birthdate: _____ Relationship: _____

ID #: _____ Group #: _____ Subscriber's SSN #: _____

Subscriber's Employer: _____ Occupation: _____

Secondary Insurance Information

Name of Insurance Company: _____ Address: _____

City: _____ State: _____ Zip: _____ Telephone #: _____

Subscriber's Name: _____ Birthdate: _____ Relationship: _____

ID #: _____ Group #: _____ Subscriber's SSN #: _____

Subscriber's Employer: _____ Occupation: _____

Worker's Comp Information

Name of Carrier: _____ Address: _____

City: _____ State: _____ Zip: _____ Telephone #: _____

Date of Injury: _____ Claim #: _____ Contact Person / Adjuster: _____

Physician Information

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Emergency Contact Information

Name: _____ Telephone #: _____ Relationship: _____

I authorize the release of any medical information necessary to process this claim to the insurance company, attorney, or other physicians. I understand that I am responsible for all charges incurred. I further authorize my insurance to make direct payment to Maia U. Chakerian, M.D. for all medical benefits.

Patient Signature: _____ Date: _____

Guarantor's Signature (If patient is a minor): _____ Date: _____

Medical Records Release Form

I, _____ give authorization to:

Maia U. Chakerian, M.D. to release medical records to:

(Name of referring physician)

Signature _____ Date _____

Medical Records Release Form

I, _____ give authorization to:

To release medical records to:

Maia U. Chakerian, M.D.
14601 S. Bascom Ave., Ste. 240
Los Gatos, CA 95032
(408) 356-0503
Fax (408) 356-4704

Signature _____ Date _____

Agreement for Controlled Substance Prescription

Maia U. Chakerian, MD

The purpose of this agreement is to prevent misunderstanding about certain medicines you will be taking for pain management. This is to help both you and your physician to comply with the law regarding controlled medications.

Controlled substance medications (i.e., opioids, tranquilizers, and barbiturates) are very useful, but have the potential for misuse and addiction and are closely controlled by the state and federal government. Because my physician is prescribing such medication for me to help manage my condition, I agree to the following conditions:

1. **I am responsible for my controlled substance medications.** If the prescription or medication is lost, or if I use it up sooner than prescribed, I understand that it **WILL NOT** be replaced. If the prescription is stolen, I must provide a police report and come in for an appointment before the medication **MAY** be replaced. If I will be out of town during my regular refill date, I will provide Dr. Chakerian with a printout of my itinerary from the airline, travel agent, hotel or other appropriate entity before an early prescription **MAY** be given.
2. If I receive a prescription for controlled medication from another doctor, I will notify Dr. Chakerian within 24 hours.
3. Refills of controlled substance medication:
 - a. **Will not be made as an emergency.** I will call at least seventy-two (72) hours ahead if I need assistance with a controlled substance medication prescription.
 - b. Will be made only during Dr. Chakerian's regular office hours. Refills will not be made at night, on weekends or holidays
 - c. Will only be made if I keep my appointments and am seen regularly to monitor the effect and the usage Of my medication.
4. I will not share, sell, or trade my medication with anyone.
5. I agree that I will submit to a urine test if requested by my physician to determine my compliance with my program of pain control medicine. I understand that illegal substance may be detected on these test, and that I may not receive further prescription for controlled substance if I am found to be utilizing illegal substance or controlled medication that has not been prescribed by Dr. Chakerian.
6. I give permission for Dr. Chakerian to obtain information about my utilization of medications from other physician, any pharmacy and the Drug Enforcement Administration.
7. I understand that State law prohibits driving and operation of dangerous equipment while taking any sedating medication, even if I do not feel sedated.

By my signature below, I acknowledge that I have read and understood this Agreement and agree to abide by its terms..

Patient Signature

Date

Copy of agreement given to pt. _____ (initial/date)

Comprehensive Pain Management Questionnaire

For office use only

Patient I.D.

Your Name: _____ Today's Date: _____

Referred by: Physician Name: _____
 Self-Referral How did you hear about us? _____
 Other Who? _____

Date of birth: _____ Age: _____ Sex: Male Female

Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Home: (____) _____ Work: (____) _____

Is your condition job related? Yes No

Who should we send reports to? _____ Phone: (____) _____

Physician: _____ Address: _____

Phone (____) _____

Physician: _____ Address: _____

Phone (____) _____

Physician: _____ Address: _____

Phone (____) _____

Attorney: _____ Address: _____

Phone (____) _____

Case Manager: _____ Address: _____

Phone (____) _____

Are you currently in litigation? Yes No

Describe the purpose of your visit and the major problems needing help:

Describe any other problems that need help: _____

HPI

How did your pain first start?

- Suddenly
- Gradually
- Lifting
- Twisting
- Fall
- Bending
- Other: _____
- Pulling
- Injured at work
- Auto accident
- Hit from behind
- Sports
- No apparent cause

When did this pain start? (Approximate date): _____

Where is your pain? _____

Describe what the pain feels like: _____

Where does it spread to? _____

Is your pain: Intermittent? Constant?

When it happens, how long does the severe pain last?

Seconds____Minutes____Hours_____

How many hours per day do you have pain? _____

In the past, did you ever have similar pain? (Approximate date): _____

How many times in the past 12 months have you been to an emergency room (ER) for treatment of your pain? _____

What makes your pain **worse**?

For office use only

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> During exercise | <input type="checkbox"/> Stress | <input type="checkbox"/> Bending forward |
| <input type="checkbox"/> After exercise | <input type="checkbox"/> Sex | <input type="checkbox"/> Bending backward |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Morning | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Night | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Touching skin |
| <input type="checkbox"/> Damp weather | <input type="checkbox"/> Cold weather | <input type="checkbox"/> Work |
| <input type="checkbox"/> Other: _____ | | |

What makes your pain **less**?

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Physical therapy |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Pain pills |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Injections |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Ice |
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Advil type pills |
| <input type="checkbox"/> Other: _____ | |

What pain treatments have you tried?

Did it help?

- | | | |
|--|------------------------------|-----------------------------|
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Trigger Point Injections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Epidural Injections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> TENS (electronic nerve stimulator) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Psychology / Counseling | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Biofeedback / Relaxation Techniques | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Group Therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Pain Management Program | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Nerve Blocks | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Pain Level:

Please mark this line with the intensity of your pain using all of the following letters:

P – present pain
W – Worst it gets

M – Most of the time
L – Least it gets

No pain |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Worst pain
0 1 2 3 4 5 6 7 8 9 10

Have you had any tests for your problem?

For office use only

X-rays	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
CAT Scan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
MRI	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
EMG / Nerve test	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
Myelogram	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
Bone Scan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
Discogram	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
Special Injections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____

Other physicians or health care providers that you have seen or are seeing:
(including chiropractors, therapists, etc.)

Name	Specialty	Address
_____	_____	_____ _____ _____ Phone (____) _____
_____	_____	_____ _____ _____ Phone (____) _____
_____	_____	_____ _____ _____ Phone (____) _____
_____	_____	_____ _____ _____ Phone (____) _____
_____	_____	_____ _____ _____ Phone (____) _____
_____	_____	_____ _____ _____ Phone (____) _____
_____	_____	_____ _____ _____ Phone (____) _____

What you can do now:

- Drive
- Walk 1 block
- Housework
- Climb Stairs
- Work at job

How many hours do you spend in bed due to pain? (excluding sleep time): _____

Describe in your own words how you spend an average day: _____

Rx

Allergies to medications: _____

Any other allergies: _____

Medicine that you take ***now***:
(including non prescription or vitamins)

Name(s)	Why taken? (pain, heart, etc.)	How much? (dose in 24 hrs)	Date started	Prescribing MD	Does it help?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Are there any side effects? _____

Do you take blood thinners (coumadin)? Yes No

Medicine(s) that you tried in the past:

Names:

Side Effects:

General Medical Problems:

- | | | | |
|-------------------------------|--------------------------|------------------------|--------------------------|
| A. Cancer History | <input type="checkbox"/> | I. Diabetes | <input type="checkbox"/> |
| B. Heart Disease | <input type="checkbox"/> | J. Epilepsy (seizures) | <input type="checkbox"/> |
| C. Lungs, asthma | <input type="checkbox"/> | K. Bowel or bladder | <input type="checkbox"/> |
| D. Liver, hepatitis | <input type="checkbox"/> | L. Arthritis | <input type="checkbox"/> |
| E. Bleeding Disorder | <input type="checkbox"/> | M. Migraines | <input type="checkbox"/> |
| F. Stomach, intestines, ulcer | <input type="checkbox"/> | N. Other: _____ | <input type="checkbox"/> |
| G. High blood pressure | <input type="checkbox"/> | O. Other: _____ | <input type="checkbox"/> |
| H. HIV Status (-) (+) (unk) | <input type="checkbox"/> | | |

Hospitalizations:

Year	Name of hospital / address	Problem and treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Important accidents or broken bones:

Year	Injury suffered	Treatments
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ROS

Respiratory	(circle one)	
Do you have any breathing problems?	Yes	No
Do you get repeated chest infections?	Yes	No
Have you coughed up blood or sputum?	Yes	No
Have you had pneumonia or pleurisy?	Yes	No
Do you suffer from any respiratory diseases?	Yes	No

Cardiovascular

For office use only

Have you had heart trouble?	Yes	No
Have you ever had high blood pressure?	Yes	No
Do you have pains in the heart or chest?	Yes	No
Do you easily become short of breath?	Yes	No
Are your ankles often swollen?	Yes	No
Do leg pains sometimes stop you from walking?	Yes	No
Have you ever had phlebitis or vein trouble?	Yes	No
Do you have a bleeding problem?	Yes	No
G.I. / G.U.		
Do you have any swallowing problems?	Yes	No
Have you had a weight loss or gain of more than 10 pounds in the past year?	Yes	No
Have you ever had a stomach ulcer?	Yes	No
Have you ever vomited blood?	Yes	No
Do you have trouble with constipation?	Yes	No
Do you use suppositories or stool softeners regularly?	Yes	No
Do you take laxatives or enemas regularly?	Yes	No
Do you have trouble with diarrhea?	Yes	No
Have you ever had black tarry stools?	Yes	No
Have you ever had a hernia (rupture)?	Yes	No
Do you dribble urine or use a catheter?	Yes	No
Have you passed blood in your urine?	Yes	No
Do you have frequent chills or fever?	Yes	No
Does it burn when you pass your urine?	Yes	No
Have you had a kidney infection?	Yes	No

G.I. / G.U. (continued)

For office use only

Have you ever had kidney or bladder stones? Yes No

Do you have problems with erections / intercourse? Yes No

Gynecologic (women only)

Give the date of your last menstrual period: _____

Do you have any problems with your menstrual period? Yes No

Are you taking birth control pills? Yes No

Give the date of your last PAP smear: _____

Endocrine

Have you ever had diabetes (high blood sugar)? Yes No

Have you had thyroid trouble? Yes No

Immune

Do you catch infections easily? Yes No

Have you ever had an HIV test? Yes No

Have you ever taken any recreational drugs? Yes No
If yes, when? _____ If yes, which drugs? _____

Do you have trouble healing? Yes No

Do you have any skin problems? Yes No

Skeletal

Do you have any joint stiffness, pain or swelling? Yes No

Do you have neck pain? Yes No

Do you have back pain? Yes No

Do you have gout? Yes No

Neurological

Do you have seizures or take medications to control seizures? Yes No

Neurological (continued)

For office use only

Do you have fainting spells or dizziness?	Yes	No
Do you have severe headaches?	Yes	No
Do you have weakness or numbness of your arms or legs?	Yes	No
Do you have any learning problems?	Yes	No
Have you ever had a stroke?	Yes	No
Did you ever have a head injury?	Yes	No

Well Being

Have you been less social lately?	Yes	No
Are you often preoccupied with your pain?	Yes	No
Are you a nervous or anxious person?	Yes	No
Have you been more irritable or temperamental lately?	Yes	No
Have you been feeling sad or depressed?	Yes	No
Do people often make you angry?	Yes	No
Have you every been treated by a psychiatrist or been in psychotherapy? If yes, when? _____	Yes	No
Are you finding fewer enjoyable things to do?	Yes	No
In the past year, have you had thoughts of suicide?	Yes	No

Sleep Hours per night? _____

Do you have trouble falling asleep?	Yes	No
Do you have trouble staying asleep?	Yes	No
Does pain awaken you?	Yes	No
Do you have trouble with memory or concentration?	Yes	No
Is your appetite poor?	Yes	No
Are you less interested in sex?	Yes	No

Height: _____
Weight one year ago: _____

Weight: _____
My normal weight is: _____

Family and social history

For office use only

Last grade you finished in school? _____

List types of jobs in the past: _____

Do you know anyone in your family or friends who has suffered from a similar problem to yours? _____

What diseases run in your family? _____

Is there anyone disabled among your family or friends? _____

Ages and health of children: _____

How many people live in your household? _____

Who are they?

Relationship:

Do you smoke? Yes No If so, how much? _____

Were you a smoker? Yes No When did you quit? _____

Do you ever drink alcohol? Yes No How much? _____

Have you had a drink in the past 24 hours? Yes No

Ever had a problem related to alcohol? (e.g. DUI, injury, break-up, etc.) Yes No

Were you ever a heavy drinker? Yes No

Do you drink coffee? Yes No Cups per day: _____

Do you drink cola? Yes No Cups per day: _____

Some of the words below describe your **present** pain; some do not.

For office use only

- Circle a word only if it describes your pain.
- If a category does not describe your pain, please leave it blank.
- Do not circle more than one word per category.

(Note: If you have more than one pain problem, use the words below to describe your worst pain problem.)

1

Flickering
Quivering
Pulsing
Throbbing
Beating

2

Jumping
Flashing
Shooting

3

Pricking
Boring
Drilling
Stabbing
Lancinating

4

Sharp
Cutting
Lacerating

5

Pinching
Pressing
Gnawing
Cramping
Crushing

6

Tugging
Pulling
Wrenching

7

Hot
Burning
Scalding
Searing

8

Tingling
Itchy
Smarting
Stinging

9

Dull
Sore
Hurting
Aching
Heavy

10

Tender
Taut
Rasping
Splitting

11

Tiring
Exhausting

12

Sickening
Suffocating

13

Fearful
Frightful
Terrifying

14

Punishing
Grueling
Cruel
Vicious
Killing

15

Wretched
Blinding

16

Annoying
Troublesome
Miserable
Intense
Unbearable

17

Spreading
Radiating
Penetrating
Piercing

18

Tight
Numb
Drawing
Squeezing
Tearing

19

Cool
Cold
Freezing

20

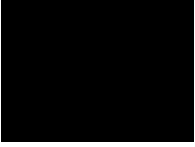
Nagging
Nauseating
Agonizing
Dreadful
Torturing

Where is your pain?

For office use only



= Severe

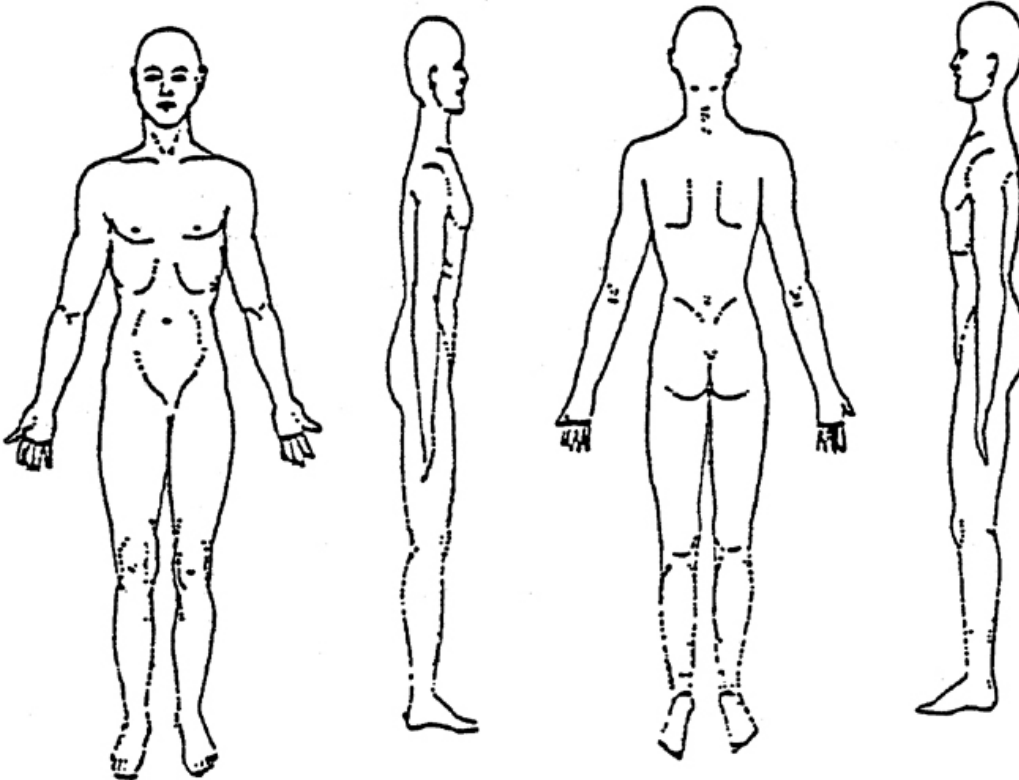


= Moderate



= Mild

Use **arrows** to show where pain radiates or travels to.



Maia U. Chakerian, M.D.

Payment Policy

Thank you for choosing to receive your pain management services from Maia U. Chakerian, M.D. Dr. Chakerian is committed to providing you with the best patient care possible. Dr. Chakerian recently revised her payment policy and is requiring that all new and existing patients provide a valid credit card number and authorization. In addition, patients will be requested to sign advanced beneficiary notices for services that may not be covered by insurance. In order to best serve you, we need your assistance and understanding of our payment policy.

Patients with Insurance Benefits: For a complete list of those insurance plans in which Dr. Chakerian participates, please ask our staff. If you are covered by a participating plan or any other health plan that will pay us directly, Dr. Chakerian will submit an insurance claim on your behalf for services rendered as follows:

In-Network Plans: If you are covered by a health plan in which Dr. Chakerian is “in-network”, you will be required to pay your copayment at the time of service, and we will file a claim with your plan for the remaining balance. We will attempt to collect the full amount allowable from your insurance plan. However, you may still be responsible for deductibles, co-insurance, or other amounts depending on your insurance policy.

Out-of-Network Plans: If you are covered by a health plan in which Dr. Chakerian does not participate or if Dr. Chakerian is considered an “out-of-network” provider, you can pay for your charges at the time of service or we will file a claim with your plan for charges that are incurred. We will attempt to collect the full amount allowable from your insurance plan. However, in the event that the insurance company denies the claim or does not pay the full amount we will charge your credit card for the balance that is owed to us.

Self-Pay Patients: If you do not have health insurance benefits or if you do not want us to file an insurance claim on your behalf, then all charges are due at the time of service.

I have read and understand this Payment Policy. I hereby agree to take full responsibility for any and all charges incurred and hereby assign any and all insurance benefits to Silicon Valley Pain Management for services received.

Patient/Guarantor Signature: _____ Date: _____

Patient/Guarantor Name: _____

Maia U. Chakerian, M.D.

CREDIT CARD BILLING AUTHORIZATION FORM

I hereby authorize Maia U. Chakerian, M.D., to charge the credit or debit card account listed below for the balance of medical charges not paid by my insurance plan(s). I understand that if my credit or debit card information changes, I must notify Dr. Chakerian of the change.

PATIENT NAME: _____

CREDIT CARD INFORMATION

VISA MASTERCARD AMERICAN EXPRESS DISCOVER

NAME ON CARD _____

BILLING ADDRESS _____

CITY, STATE, ZIP _____

DAY TIME PHONE NUMBER _____

CREDIT CARD NUMBER _____

3 Digit Code on Back of Card (CVA#) _____

EXPIRATION DATE _____

Signature _____