Reset Form

ADVANCED PAIN CONSULTANTS

KRAFT CENTER FOR PAIN CONTROL, LLC

Raimundo F. Leon, M.D.

Date: _____

Dear: _____

We would like to confirm your appointment with Dr. Leon or Dr. Prater. Enclosed is the information packet, as you can see it is very extensive. Please complete this questionnaire and packet as fully as possible, as this will greatly assist the Doctor in your diagnosis and/or treatment. If you have any questions regarding any of the items in the enclosed packet, we will happily answer them for you in person on the day scheduled below.

Kindly bring the following items to your appointment to avoid delays or having to reschedule your appointment.

1. *This entire packet (completed)*
2. *Your insurance card (s)*
3. *Your current Driver's License (photo Identification)*
4. *MRI, CT and X-Ray reports*

Your appointment date is scheduled for:

DATE:_____ **TIME:**_____

For your convenience, we have included a map of our different locations. We look forward to seeing you and thank you in advanced for your cooperation.

Main Office (West)
2650 Crimson Canyon Drive
Las Vegas, NV 89128

Office in Henderson
1701 Green Valley Parkway
Building 2, Suite B
Henderson, NV 89074

Flamingo Office (East)
2121 E. Flamingo Road
Suite 212
Las Vegas, NV 89119

Telephone: **702-731-2642**
Fax: **702-791-2070**

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ADVANCED PAIN CONSULTANTS

KRAFT CENTER FOR PAIN CONTROL, LLC
2650 Crimson Canyon Drive
Las Vegas NV 89128
(Office) *702-731-2642* - (Fax) *702-791-2070*

Raimundo F. Leon, M.D.

Disclosure of Worker's Compensation Claims

The purpose of this form is to determine whether or not the condition for which the physician will treat you is in any way related to a claim that could be considered under Worker's Compensation Laws. By providing us with this information, we can properly coordinate the billing of your account. **If this does not apply to you, please mark "NO" and sign at the bottom of the page.**

1. Is the condition for which you are seeing the physician today related to an injury that occurred while on the job?

   Yes ☐ No ☐

2. Have you EVER filed a Worker's Compensation claim?

   Yes ☐ No ☐

3. If you answered **Yes** above, what body part(s) were related? _____

   What were your injuries? What body part(s) were related?

   _____
   _____
   _____

4. What is the current status of your Worker's Compensation claim?

   Open Case ☐ Closed Case ☐ Trying to re-open ☐

PATIENT'S SIGNATURE:_____ DATE:_____

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MEDICAL INFORMATION

PATIENT NAME:_____ **DATE:**_____

Please list all health care providers, including (Emergency Room Visits, Physical Therapists, Chiropractors, Physicians, Etc.,) that you have seen for this problem:

1. _____ 2. _____
3. _____ 4. _____

Have you ever had any of the following?

Yes	No		Yes	No	
○	○	Allergies (Medications) _____	○	○	High Blood Pressure
			○	○	Excessive Thirst or Urination
○	○	Diabetes (High Blood Sugar)	○	○	Neurologic Condition
○	○	Stomach Ulcers	○	○	Stroke
○	○	Bleeding (Gums, Rectal, Nose, _____)	○	○	Seizures
○	○	Heart Condition/Chest Pain			

Have you ever sought medical treatment for neck, mid-back, low-back or extremity pain?

Yes ☐ **No** ☐

Have you ever had a work related injury?

Yes ☐ **No** ☐

Have you ever been involved in a motor vehicle accident?

Yes ☐ **No** ☐

Surgical History

Type of Surgery	Date
Low Back (Lumbar)	_____
Neck (Cervical)	_____
Mid-Back (Thoracic)	_____

Other Surgeries:

_____	_____
_____	_____
_____	_____

Please list all medications you are currently taking and the reason for taking them:

Medication	Medical Condition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List all X-Rays, MRI's, CT Scans, EMG, EEG, Ultrasounds, Myleogram, or other tests:

Test:_____ Date:_____ Location:_____
Test:_____ Date:_____ Location:_____
Test:_____ Date:_____ Location:_____

List all medications you have taken for pain and circle the ones that have most helped you.

☐ _____	☐ _____	☐ _____	☐ _____
☐ _____	☐ _____	☐ _____	☐ _____
☐ _____	☐ _____	☐ _____	☐ _____

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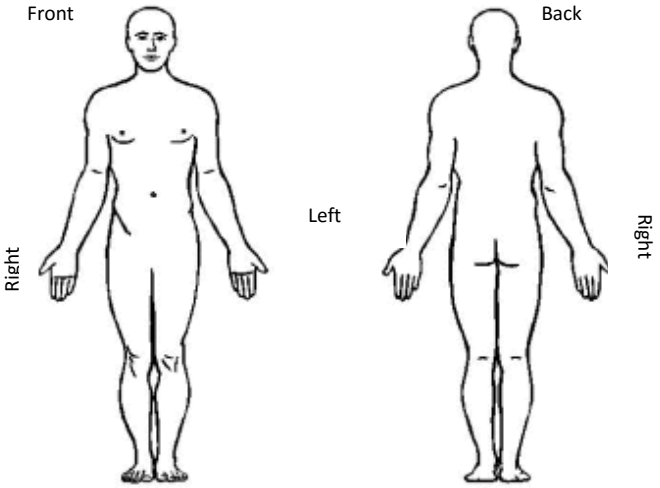
PAIN QUESTIONNAIRE

PATIENT NAME:_____ **DATE:**_____

Using the diagram, draw the areas which are affected by your pain.



Pain scale: Please rate your pain

1 2 3 4 5 6 7 8 9 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Describe your pain:

☐ Burning ☐ Aching ☐ Throbbing ☐ Constant
☐ Intermittent ☐ Unpredictable ☐ Sharp ☐ Dull
☐ Electric Shock ☐ Stays in one place ☐ Moves Around
☐ Shoots someplace

Height: _____(feet) _____(inches)
Weight:_____(lb) Your Age: _____

When did your pain begin? _____(Date) Was there an accident? ☐ **Yes** ☐ **No** _____ (Date)

Describe what happened: _____

_____

_____

¿Do you have an attorney? ☐ **Yes** ☐ **No** Attorney's Name: _____

Of the following, which have you tried to help alleviate your current pain?

☐ Medication ☐ Chiropractor ☐ Physical Therapy ☐ TENS Unit ☐ Hypnosis

☐ BioFeedback ☐ Surgery ☐ Nerve Blocks ☐ Psychology ☐ Pain Treatments

Which of the following above have helped you the most and how? _____

_____

List all medications and/or dyes you are ALLERGIC to: _____

_____

_____

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ADVANCED PAIN CONSULTANTS

Patient Demographic

Name:_____ Date of Birth: _____ Age:_____ Sex: ☐ F ☐ M

Address: _____City:_____ State: _____ Zip Code: _____

Home Phone:_____ Cell Phone:_____Work Phone:_____

Employer: _____ Social Security Number: _____

Occupation: _____

Emergency Contact:

Name: _____ Telephone: _____ Relationship:_____

What body part is related to this claim? _____

Place an ***(X***) in the space provided to indicate the coverage for this injury (Check only One)

1._____ **Workmen's Comp** 2. _____ **Health Insurance** **5.**_____**Cash**

3._____**Attorney Lien** 4. _____ **Auto Med-Pay**

Next complete the appropriate numbered section that corresponds to your selection above.

1. **Workmen's Comp**

Company Name: _____ Telephone: _____

Contact: _____Claim #: _____ Date of Injury: _____

2. **Health Insurance**

Primary Company:_____

Address: _____

City:_____ State: _____ Zip Code:_____

Insured: _____ DOB:_____

Insured SSN:_____

Employer:_____

Policy #:_____

Group #: _____

Secondary Company:_____

Address:_____

City:_____State: _____ Zip Code:_____

Insured: _____ DOB:_____

Insured SSN:_____

Employer:_____

Policy #:_____

Group #: _____

3. **Attorney Lien**

Attorney Name: _____

Law Firm:_____

Telephone: _____Contact:_____

Date of Injury: _____

Address: _____

City: _____State:_____Zip Code: _____

4. **Auto Med-Pay**

Insurance Company: _____

Telephone:_____ Contact:_____

Date of Injury:_____

Name of Insured: _____

Claim/Policy #: _____

Were YOU the: ☐ DRIVER ☐ PASSENGER ☐ OTHER

PATIENT SIGNATURE:_____ **DATE**:_____

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ADVANCED PAIN CONSULTANTS
REVIEW OF SYMPTOMS

	Yes	No
Constitutional		
Have you had recent weight gain or loss?		
Do you have regular fevers or chills?		
Do you have night time sweats?		
Neurologic		
Have you ever had a stroke?		
Do you have frequent headaches?		
Have you ever passed out?		
Have you experienced changes in your vision, hearing, smell or taste?		
Pulmonary		
Do you have chronic cough?		
Have you ever coughed up blood?		
Do you awaken at night short of breath?		
Cardiovascular		
Have you ever had a heart attack?		
Do you have chest pain?		
Do you have heart failure?		
Do you have heart valve problems?		
Genitourinary		
Have you ever had blood in your urine?		
Do you have frequent urinary tract infections?		
Do you have a history of kidney disease?		
Gastrointestinal		
Do you have a history of ulcers?		
Do you have nausea and vomiting currently?		
Have you ever vomited blood?		
Have you had liver problems?		
Muscolusketal		
Do you have swelling, redness or pain in your joints		
Do you have skin rashes?		
Do your muscles cramp easily?		
Psychiatric		
Have you had a psychiatric illness?		
Do you have a history of depression?		
Have you been treated by a psychiatrist/psychologist?		
Hematologic		
Have you had a history of anemia?		
Do you bleed / bruise easily?		