Dr. Navin Mallavaram

New Patient Intake Paperwork

5924 Stoneridge Dr. Suite 206 Pleasanton CA 94588 P: 925-469-9120 F: 925-469-9121

Your completed intake paperwork helps our providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call 925-469-9120 if you have any questions or are unsure how to complete any section of this form.

Today's Date _____

Patient Information

Your Name: _____ Social Security Number: _____

Street Address: _____ Date of Birth: _____ Age: _____

City/State/Zip: _____ Height:_____ Weight:_____

Gender: ❑ Male ❑ Female Driver's License State / #: _____

Physical Address Same as Mailing? ❑ Yes ❑ No If not: _____

Preferred Phone: _____ ❑ Home ❑ Mobile ❑ Work

Secondary Phone: _____ ❑ Home ❑ Mobile ❑ Work

Email: _____

Preferred Contact Method for appointment confirmation: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other _____

Race: ❑ Refuse to Report ❑ American Indian or Alaskan Native ❑ Asian or Pacific Islander ❑ Black ❑ White

Ethnicity: ❑ Refuse to Report ❑ Hispanic ❑ Non-Hispanic Primary Language: ❑ English ❑ Spanish ❑ Other

Referral

How were you referred to our clinic? ❑ Doctor ❑ Website ❑ Insurance Company ❑ Family ❑ Friend ❑ Other _____

Referring Physician: _____ Primary Care Physician: _____

Phone: _____ City: _____ Phone: _____ City: _____

Primary Insurance Plan

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

If you are not the policy holder, please complete this section:

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

Complete this box if you are *not* the policy holder for your secondary insurance

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim.

Workers Comp Company: _____ Adjuster Name: _____

Phone number: _____ Fax number: _____

Claim Number: _____ Date of initial injury: _____

Attorney Name: _____ Phone number: _____

Fax number: _____

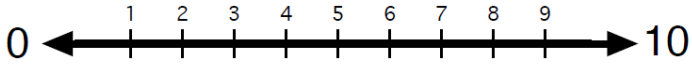
Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City/State/Zip: _____

Use this pain scale to rate your pain for the questions below:

0 – Pain-free
1 – Very minor annoyance, occasional minor twinges
2 – Minor annoyance, occasional strong twinges
3 – Annoying enough to be distracting
4 – Can be ignored if you are really involved in your work/task, but still distracting
5 – Cannot be ignored for more than 30 minutes
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9 – Unable to speak, crying out or moaning uncontrollably, near delirium
10 – Unconscious, pain makes you pass out



_____ What number on the pain scale (0-10) best describes your pain **right now**?

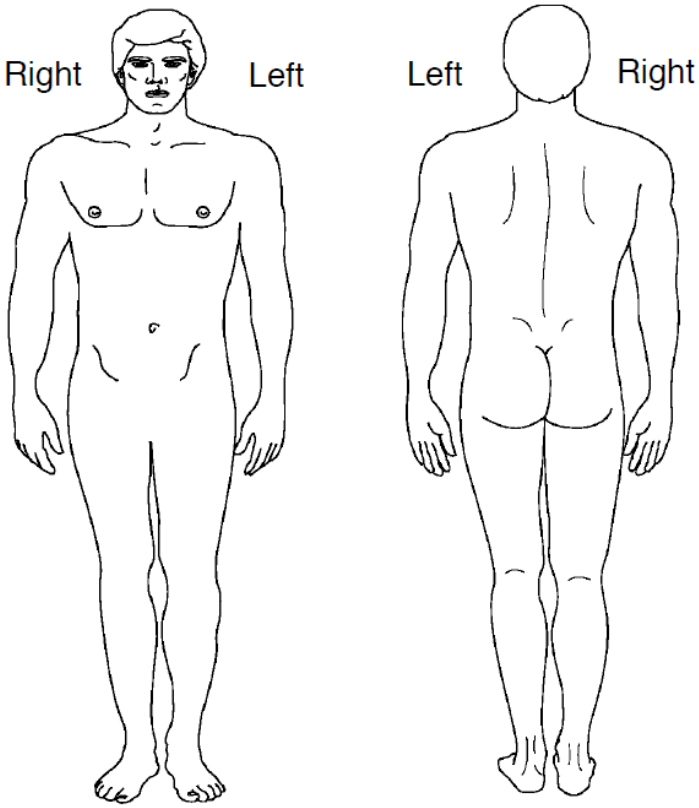
_____ What number on the pain scale (0-10) best describes your **worst pain**?

_____ What number on the pain scale (0-10) best describes your **least pain**?

_____ What number on the pain scale (0-10) best describes your **average pain over the last month**?

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

"N" = numbness
"S" = stabbing
"B" = burning
"P" = pins and needles
"A" = aching



Where is your worst area of pain located? _____

Does this pain radiate? If so, where? _____

Please list any additional areas of pain: _____

Initials_____

Onset and Mechanism of Injury

Approximately when did this pain begin? _____

Briefly describe what caused your current pain complaints? _____

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

Since your pain began, how has it changed? ❑ Decreased ❑ Increased ❑ Stayed the same

Pain Description

Check all of the following that describe of your pain:

❑ Aching	❑ Band-like	❑ Burning / Hot
❑ Cramping	❑ Dull	❑ Numb
❑ Pressure	❑ Shooting	❑ Stabbing / Sharp
❑ Shock-like	❑ Spasming	❑ Throbbing
❑ Tiring / Exhausting	❑ Tingling / Pins and Needles	

What makes your pain worse? ❑ Sitting ❑ Standing ❑ Walking ❑ Lying down ❑ Work ❑ other _____

What makes your pain better? _____

Pain Interference

Check all of the following activities that your pain interferes with:

❑ **Nothing**	❑ Driving	❑ Leisure Activities
❑ Personal Grooming	❑ Relationships	❑ Sleep
❑ Walking	❑ Work duties	❑ Other: _____

Prior Pain Treatments

Mark all of the following treatments you have had prior to today's visit for your current pain complaints:

❑ Acupuncture ❑ Chiropractic ❑ Pain Medications ❑ Physical Therapy ❑ Psychological Therapy

❑ Epidural Steroid Injection(s) ❑ Trigger Point Injections ❑ Joint Injection(s) ❑ Nerve Blocks

❑ Radiofrequency Ablation ❑ Spinal Cord Stimulator – (circle one) Trial Only / Permanent Implant

❑ Spine Surgery – What type? _____ When? _____

❑ Other: _____

❑ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS.

Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

❑ MRI of the _____ Date: _____ Facility: _____

❑ X-ray of the _____ Date: _____ Facility: _____

❑ CT scan of the _____ Date: _____ Facility: _____

❑ EMG/NCV study of the _____ Date: _____ Facility: _____

❑ Other diagnostic testing: _____

❑ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

Past Medical History

Mark the following conditions/diseases that you are being or have been treated for:

❑ Anemia	❑ Anxiety	❑ Arthritis	❑ Asthma
❑ Back Problem	❑ BPH	❑ CAD	❑ Colon
❑ Cancer	❑ CHF	❑ High Cholesterol	❑ COPD
❑ Dementia	❑ Depression	❑ Dermatitis	❑ Diabetes
❑ Epilepsy	❑ GERD	❑ Glaucoma	❑ Gout
❑ Headache	❑ Hepatitis	❑ HIV	❑ Hypertension
❑ MI	❑ Migraine	❑ Pneumonia	❑ Kidney Stone
❑ Stroke	❑ TB	❑ Thyroid Disease	❑ Ulcer (GI)

❑ Other_____

_____

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Abdominal Surgery

_____

Neurologic Surgeries

_____

Heart Surgery

_____

Joint Surgery

_____

Neck / Back Surgery

❑ Discectomy (levels)_____

❑ Laminectomy (levels)_____

❑ Spinal fusion (levels) _____

Other Surgeries

_____

_____

_____

❑ I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE

Initials_____

Current Medications

Please indicate which (if any) of the following blood-thinners you are taking:
❑Aggrenox ❑ Coumadin / Warfarin ❑ Effient ❑Lovenox ❑ Plavix ❑ Pletal ❑ Pradaxa ❑ Prasugrel
❑ Ticlid ❑ Other _____

Please list *all* medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Allergies

Do you have any known drug allergies? ❑Yes ❑No

If so, please list all medications you are allergic to.

Medication Name	Allergic Reaction Type

Topical Allergies: ❑ Iodine ❑ Latex ❑ Tape

Social History

Tobacco Use: ❑ Never ❑ Current Tobacco User, Packs Per Day _____ How many years _____
❑ Former Tobacco User

Alcohol Use: ❑ Never ❑ Socially ❑ History of Abuse

Substance Abuse: ❑ Denies Any Illegal Drug Use ❑ Currently Using Illegal Drugs (List: _____)
❑ Prescription Medications (List:_____)
❑ Formerly Used Illegal Drugs (not currently using) (Which: _____)

Have you ever abused prescription medications? ❑ Yes ❑No (Which: _____)

History of preadolescence sexual abuse: ❑ Yes ❑ No

Please list any family history that is relevant to your pain:

_____

_____

❑ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY. ❑ I AM ADOPTED (No Medical History Available).

Please check the boxes that apply

Family History of Substance Abuse: ❑ alcohol ❑ illegal drugs ❑ prescription drugs ❑ N/A

Review of Systems

PLEASE CIRCLE THE SYMPTOMS THAT APPLY TO YOU:

Constitutional: No Problems, Lack of energy, Unexplained weight gain or weight loss, Loss of appetite, Fever, Night sweats

Head, Ears, Eyes, Nose, Throat: No Problems, Difficulty hearing, Ringing in ears, Bleeding gums, Blurred vision, Difficulty swallowing

Cardiovascular: No Problems, Irregular heartbeat, Racing heart, Chest pains, Swelling of feet or legs

Respiratory: No Problems, Shortness of breath, Cough, Wheezing, Sputum production, Prior tuberculosis

GI: No Problems, Heartburn, Diarrhea, Abdominal pain, Difficulty swallowing, Nausea, Vomiting, Blood in stool, Unexplained change in bowel habits, Incontinence

Genitourinary: No Problems, Painful urination, Frequent urination, Urinary urgency, Prostate problems

Musculoskeletal: No Problems Joint pain, Muscle aches

Skin: No Problems, Persistent rash, Itching, New/worsening lesion

Neurologic: No Problems, Headaches, Weakness, Numbness, Tingling, Difficulty with walking or balance, Dizziness, Tremor, Loss of consciousness

Endocrinologic: No Problems, Cold/heat intolerance, Sweating, Flushing

Hematologic: No Problems, Easy bleeding, Easy bruising, Anemia, Swollen glands

Psychiatric: No Problems, Depressed mood, Feeling anxious, Stress problems, Suicidal thoughts, Suicidal planning, Thoughts of violence

I certify that the information I have supplied is accurate, complete and true.

I understand the doctor may have a financial interest in entities that I am referred to such as Hacienda Surgery Center, Pleasanton Surgery Center, Precision Surgicenter, Stevenson Surgery Center, Summit Surgery Center, Webster Surgery Center, Accura Imaging, Omega Anesthesia Group, laboratories, imaging facilities, and/or other medical and pharmaceutical companies.

I authorize Dr. Mallavaram and any associates, assistants, and other health care providers he may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for Dr. Mallavaram to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review the Notice of Privacy Practices, which is displayed for public inspection at the facility.This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize Dr. Mallavaram to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) or providers I may be referred to. I also authorize Dr. Mallavaram to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Dr. Mallavaram will not release my Protected Health Information to any other party (including family) without my completion of a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

I understand that if I fail to give at least 24hrs notice for an appointment or procedure cancellation with any provider, I (and not my insurance carrier) will be charged and responsible for a $30-100 late cancellation fee.

I understand that I may be prescribed opiates (pain medication such as, but not limited to, Vicodin, Percocet, and others) and that these medications have risks associated with them. These risks include, but are not limited to, physical dependence (developing withdrawal symptoms without medication), tolerance (needing more medication to achieve the same effect), increased sensitivity to pain, and alterations in hormonal and immune function. I understand that my medications may be altered or discontinued at any time as per the doctor's clinical judgment.

I understand it is my responsibility as a patient to keep all medication safeguarded at all times, including keeping medication stored in a locked safe, inaccessible to others. I am not to share my medication with anyone. I am not to engage in any potentially dangerous activity while taking any medication prescribed by the doctor. It is not the responsibility of the doctor to replace lost, misplaced, damaged, or stolen medication. In addition early refills will not be given. I will plan accordingly to make follow up appointments for medication refills, and understand that if appointments are not made in a timely manner, the doctor's schedule may be full and he may not be able to see me for some time. In addition, the doctor will not phone in medications to the pharmacy after normal business hours. I understand that I am not to obtain pain medications from other doctors or any other source. In an effort to deter the misuse of opiates and other medications, every patient who obtains a prescription will be subject to random urine toxicology testing on a regular basis.

Printed Name: _____

Signature: _____ Date: _____