Neurological Associates

of West Los Angeles*

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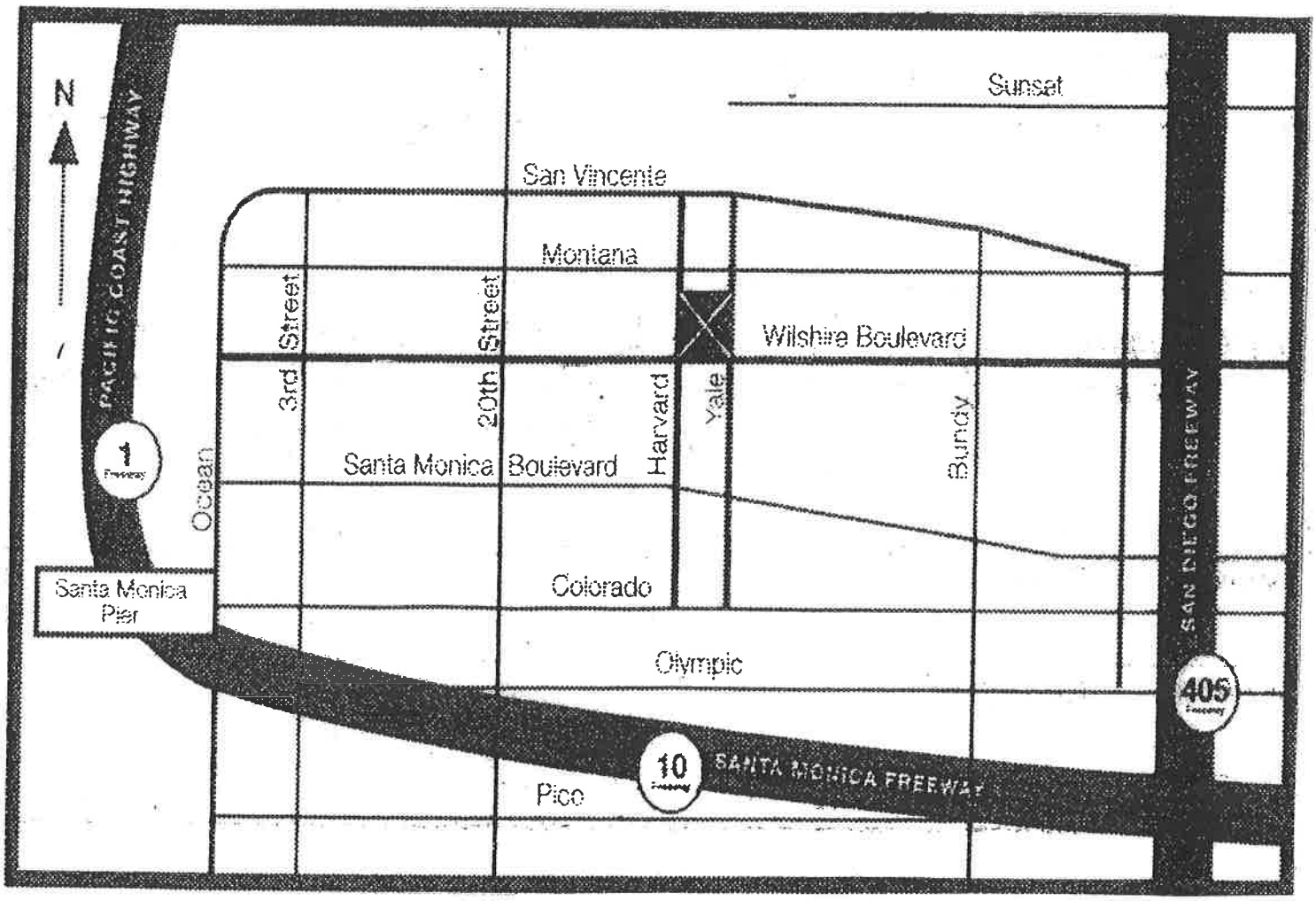
2811 Wilshire Blvd Suite 790 Santa Monica, CA 90403 Phone 310 829 5968 Fax 310 453 3685

Please complete the enclosed forms and bring them with you the day of your appointment, as well as a list of all your medications. We also require copies of your insurance cards and some form of photo identification. Please present the enclosed forms and the necessary cards when you sign in for your appointment.

Thank you!



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NEUROLOGICAL ASSOCIATES OF WEST LOS ANGELES*
PATIENT REGISTRATION FORM

Office Use Only-DO NOT COMPLETE Date _____ Provider J O S C Acct#_____ Financial Class_____

PATIENT INFORMATION:

Last Name _____ First _____ MI ___ Age ____ Sex____

Address _____ Apt /Unit _____ City _____

State ____ Zip _____ Home Phone ( ) _____ Cell Phone ( ) _____

Mailing Address_____ Apt____City_____State____ Zip_____

DOB __ / __ /____Marital Status: S M D Sep. W Driver Lic _____ SS# ___ - __-_____

Email Address:_____ Occupation _____

Employer _____ Work Phone ( ) _____ Ext _____

Name of Spouse _____ SS# _____ - _____-_____ DOB _____ / _____ /_____

Employer _____ Work Phone ( ) _____ Ext _____

FINANCIAL RESPONSIBILITY: Self _____ Spouse _____ Other _____

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

PRIMARY INSURANCE CARRIER:

Relationship to Subscriber: Self _____ Spouse _____ Child _____ Other _____

Last Name _____ First _____ MI ___DOB __ / __ /_____

Ins. Co. Name _____ Co Pay Amount _____

Subscriber or ID# _____ Grp# _____

SECONDARY INSURANCE CARRIER:

Relationship to Subscriber: Self _____ Spouse _____ Child _____ Other _____

Last Name _____ First _____ MI ___DOB __ / __ /_____

Ins. Co. Name _____ Co Pay Amount _____

Subscriber or ID# _____ Grp# _____

REFERRED BY:

Doctor _____ Attorney _____ Insurance Co. _____ Workers Comp. _____ Self/Friend _____

Name of Referral _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

REASON FOR VISIT:

Personal Illness _____ Job Injury _____ Accident _____ Workers Comp. _____ Med/Legal _____

Onset of Illness _____ Date of Injury _____ Date of Accident _____

PRIMARY DOCTOR:

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

IN CASE OF AN EMERGENCY:

Contact _____ Phone ( ) _____

ALLERGIES:

List _____

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS:

I hereby authorize Dr. _____ to furnish the above insurance company(s) all information which said insurance company(s) may request. I hereby assign Dr. _____ all money to which I am entitled to, for medical expenses related to the service rendered by him. I understand that total payment for medical services is my responsibility and not that of the insurance company

_____ _____ _____

Patient Signature Insured or Guardian Signature Date

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MEDICAL HISTORY

Neurological Associates of West Los Angeles

Name : _____ Age: _____ Birth: _____ / _____ / _____

Right-Handed _____ Left-Handed _____ Height _____ Weight _____

1. What are the problems you are seeing the doctor for today? (Brief answer)

2. When did it start? (Approximate date) _____ / _____ / _____

3. What has happened since it began? (List events in chronological order up to the present, including dates when other physician(s) were seen, test(s) and the result(s))

4. Are you on disability? Yes ❑ No ❑

5. Any allergies to medicine? If Yes, list drug(s) and type(s) of reaction. Yes ❑ No ❑

6. Have you had any surgery? List date(s) and description(s). Yes ❑ No ❑

7. Any loss of consciousness? (seizures, fainting, or dizziness) Yes ❑ No ❑

8. Any head, neck, back injuries, or other injuries? If Yes, list date(s), description(s) Yes ❑ No ❑

9. Any serious illness in the past? Describe. Yes ❑ No ❑

10. Do you smoke or drink alcohol? If Yes, How much? How long? Yes ❑ No ❑

11. Any emotional or psychiatric problems requiring treatment? Describe. Yes ❑ No ❑

12. Was there anything unusual about your birth or early development? (premature, breech birth, delayed walking or talking) Describe. Yes ❑ No ❑

13. Are you currently taking any medicine or vitamins? List type, how long? Yes ❑ No ❑

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14. Have you ever been exposed to toxic chemicals in unusual amount? Describe. Yes ☐ No ☐

(lead, arsenic, mercury, insecticides, herbicides, etc.) Yes ☐ No ☐

15. Any illness during foreign travel? When? Where? Describe. Yes ☐ No ☐

16. Check the appropriate boxes below if you have had any of the following. Yes ☐ No ☐
Describe symptoms.

☐ Tuberculosis, Polio, HIV _____

☐ Diabetes _____

☐ Meningitis, Encephalitis _____

☐ Diseases of eyes, nose, ears, mouth, throat _____

☐ Diseases of thyroid, or other hormone problem _____

☐ Disease of heart, lung _____

☐ Blood pressure problems _____

☐ Fever, weight loss, venereal disease _____

☐ Disease of stomach, liver, intestines _____

☐ Problems of bowel or bladder control _____

☐ Bleeding disorder, bruise easily _____

☐ Problems with skin _____

☐ Any changes in mood, sleepiness _____

☐ Headaches _____

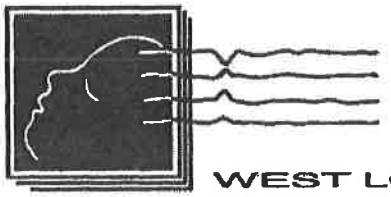
☐ Tumors _____

☐ Muscle pains _____

17. List your immediate family member(s), their ages, health or cause of death (parents, siblings, spouse and children).

18. Are there any diseases, which have occurred in more than one family member?
(heart problems, diabetes, high blood pressure, cancer, nervous system problems)

SIGN:_____ DATE:_____



Neurological Associates

WEST LOS ANGELES*

PATIENT CONTACT INFORMATION/ RESTRICTION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual□s office instead of their home. I wish to be contacted in the following manner (check all that apply):

___ **Home Telephone** _____

____ O.K. to leave message with detailed information.

____ Leave message with call back number only.

___ **Cell Telephone** _____

____ O.K. to leave message with detailed information.

____ Leave message with call back number only.

___ **Work Telephone** _____

____ O.K. to leave message with detailed information.

____ Leave message with call back number only.

___ **Written communication**

____ O.K. to mail to my home address.

____ O.K. to fax to _____

___ **Other** _____

APPOINTMENT CONFIRMATIONS WILL BE MADE TO THE HOME NUMBER

I Hereby consent to the release of Protected Health Information to the following individuals. I understand this authorization will be effective until which time it is revoked.

NAME	RELATIONSHIP
_____	_____
_____	_____

_____ _____

Patient Signature Date

_____ _____

Print Name Birthdate

2811 Wilshire Boulevard Suite 790 Santa Monica, California, 90403
Telephone: 310 829-5968 Facsimile: 310 453-3685

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SUMMARY NOTICE OF PRIVACY PRACTICES

We are required by federal law to provide you with a Notice of Privacy Practices that describes how medical information that we maintain about you may be used or disclosed. The Notice describes how, when, and why we use and disclose medical information about you, and provides a description of your rights and our obligations under federal and state privacy laws.

Uses and Disclosures
We are permitted to use and disclose your health information under a variety of circumstances. Sometimes we must obtain your authorization before we use or disclose that information, but in other circumstances we may use your information without your authorization and without informing you of the use or disclosure. Some of the reasons that we may use or disclose your information include:

- To provide information about your health condition to other health care providers who may treat you;
- To provide information about the treatment that we provided in order to obtain payment from your health plan;
- To report a communicable disease, or other legal reporting requirements; or
- To comply with a court order requiring the disclosure of your medical record.

These examples are merely illustrative. For a full description of the uses and disclosures that we are permitted to make, please consult the Notice of Privacy Practices.

Your Rights
While the records that we maintain about you belong to us, under the federal privacy law you have a variety of rights with respect to the information maintained in those records. For instance, you have the right to access and receive a copy of the medical information we maintain about you and to request that we amend any of the information that you believe, is incomplete or incorrect. Also, you may request that we provide you with a list of disclosures that we have made of your medical information. All of these rights are subject to some exceptions that are described in full in the Notice.

Acknowledgement
You will be asked to sign an acknowledgement of your receipt of this Notice of Privacy Practices. However, your receipt of care and treatment is not conditioned upon your signing the acknowledgement form.

Our Obligations
We are required to provide you with our Notice of Privacy Practices and to abide by its terms. We may change the Notice from time to time. All amendments apply retroactively. Our full Notice of Privacy Practices is attached. Please read it carefully. If you would like a copy please let us know. If you have any questions or require additional information, please contact the office manager at 310-829-5968 x246.

Neurological Associates of West Los Angeles
2811 Wilshire Blvd. #790, Santa Monica, CA 90403-4803

Acknowledgement of Receipt of Notice of Privacy Practices

Neurological Associates of West Los Angeles
2811 Wilshire Blvd., Suite 790
Santa Monica, CA 90403-4803

Office Manager 310/829-5968 x246

I hereby acknowledge that I have been offered/received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

☐ Patient declined copy.

Neurological Associates Review of Systems

Name: _____ Date: _____

System	Circle if problem is present	Check if OK
constitutional	fever, weight loss, weight gain, fatigue, chills, sleepiness, insomnia	☐
musculoskeletal	muscle pain, atrophy, weakness, joint pain, stiffness, posture change	☐
neurological	memory loss, language problem, seizures, headache, incoordination, gait	☐
cardiovascular	dizziness, faint, palpitations, angina, murmur, sleep upright, heart attack	☐
chest/breasts	pain, swelling, lung, discharge	☐
ears, nose, throat	hearing loss, ringing, vertigo, swallowing problem, speech difficulty	☐
eyes	blurring, spots, double vision, redness, pain	☐
genitourinary	urine frequency, urgency, hesitancy, incomplete empty, incontinence	☐
gastrointestinal	heartburn, nausea, vomiting, diarrhea, constipation, bowel incontinence	☐
hematological	lymph nodes, bleeding, clotting, bruising	☐
psychiatric	mood, thoughts, anxiety, enjoyment, motivation, control, focus; suicidal	☐
respiratory	shortness of breath, wheezing, cough sputum, blood, hoarseness, pain	☐
skin	itch, rash, discoloration, sweating, wounds, burns	☐
allergy/immunology	sneezing, wheezing, itching, rash, lip swelling	☐

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2811 Wilshire Blvd Suite 790 Santa Monica, CA. 90403 Phone 310 829 5968 Fax 310 453 3685

CBSQ Questionnaire form AA

NAME _____ DATE _____

READ INSTRUCTIONS FIRST. This form is important for measuring the outcome of treatment. Based on your experiences in the PAST WEEK, answer the following questions regarding how often symptoms would be likely to increase if you were to engage in certain activities.
Circle the number corresponding to how likely it would be for symptoms to increase during an activity so much that you would have to stop or modify the activity. DO NOT LEAVE ANY BLANKS.
If a CONSTANT ongoing symptom would not be more noticeable during the activity, mark the answer "0."
If a symptom would increase during half of the instances of the activity, mark the answer "5."
Only mark "10" if your symptoms would increase during EVERY instance of the activity.

1. **Pain is caused by experiences that ordinarily are not painful. Examples include a light stimulation of the skin, joints or muscles, such as a light draft, the rub and tug of clothing, or the touch of something moderately hot or cold.**

0 1 2 3 4 5 6 7 8 9 10
It would **NEVER** happen this past week — This past week, it would happen **ALWAYS**

2. **Disabling pain that can last into the next day is caused by activities that ordinarily produce only mild discomfort. Examples include a light exercise session, a physical therapy treatment or a physical examination.**

0 1 2 3 4 5 6 7 8 9 10
It would **NEVER** happen this past week — This past week, it would happen **ALWAYS**

3. **Hand or arm aches or fatigues with arm exercise, particularly with overhead or outstretched positioning.**

0 1 2 3 4 5 6 7 8 9 10
It would **NEVER** happen this past week — This past week, it would happen **ALWAYS**

4. **Hand or arm swells after arm exercise, including after any activities that require repetitive arm movements.**

0 1 2 3 4 5 6 7 8 9 10
It would **NEVER** happen this past week — This past week, it would happen **ALWAYS**

5. **Sensations of tingling or numbness in the hand or arm increase when reaching overhead or outwards. Examples include brushing hair or blow-drying hair, reaching for an overhead shelf, or working with arms overhead as in painting a ceiling or screwing in light bulbs.**

0 1 2 3 4 5 6 7 8 9 10
It would **NEVER** happen this past week — This past week, it would happen **ALWAYS**

6. **Sensations of tingling or numbness increase in the hand or arm when awakening from sleep.**

0 1 2 3 4 5 6 7 8 9 10
It would NEVER happen this past week This past week, it would happen ALWAYS

7. **Sensations of tingling or numbness increase in the hand or arm with repetitive finger movements as in writing, typing, sewing, playing musical instruments or assembling objects.**

0 1 2 3 4 5 6 7 8 9 10
It would NEVER happen this past week This past week, it would happen ALWAYS

8. **Sensations of tingling or numbness increase with prolonged or forceful grasping as in holding a steering wheel to drive, using tools, handling office instruments or controlling industrial equipment.**

0 1 2 3 4 5 6 7 8 9 10
It would NEVER happen this past week This past week, it would happen ALWAYS

9. **Sensations of tingling or numbness increase while bending elbow or leaning on elbow, for example, while holding telephone receiver or leaning on a desk.**

0 1 2 3 4 5 6 7 8 9 10
It would NEVER happen this past week This past week, it would happen ALWAYS

10. **Hand is clumsy or weak while trying to hold onto objects or while attempting to open jars, use keys to open a lock, pull zippers or button clothing.**

0 1 2 3 4 5 6 7 8 9 10
It would NEVER happen this past week This past week, it would happen ALWAYS

11. **Pain going down the arm increases with neck movement, as in turning, flexing or extending the neck.**

0 1 2 3 4 5 6 7 8 9 10
It would NEVER happen this past week This past week, it would happen ALWAYS

12. **Pain in the arm or shoulder increases instantly with brief shoulder movement as in throwing something or in reaching behind the body.**

0 1 2 3 4 5 6 7 8 9 10
It would NEVER happen this past week This past week, it would happen ALWAYS

13. **Symptoms have occurred with the above activities in the past.**

yes no (circle your answer) If the answer is "yes", please list by number and explain on back.

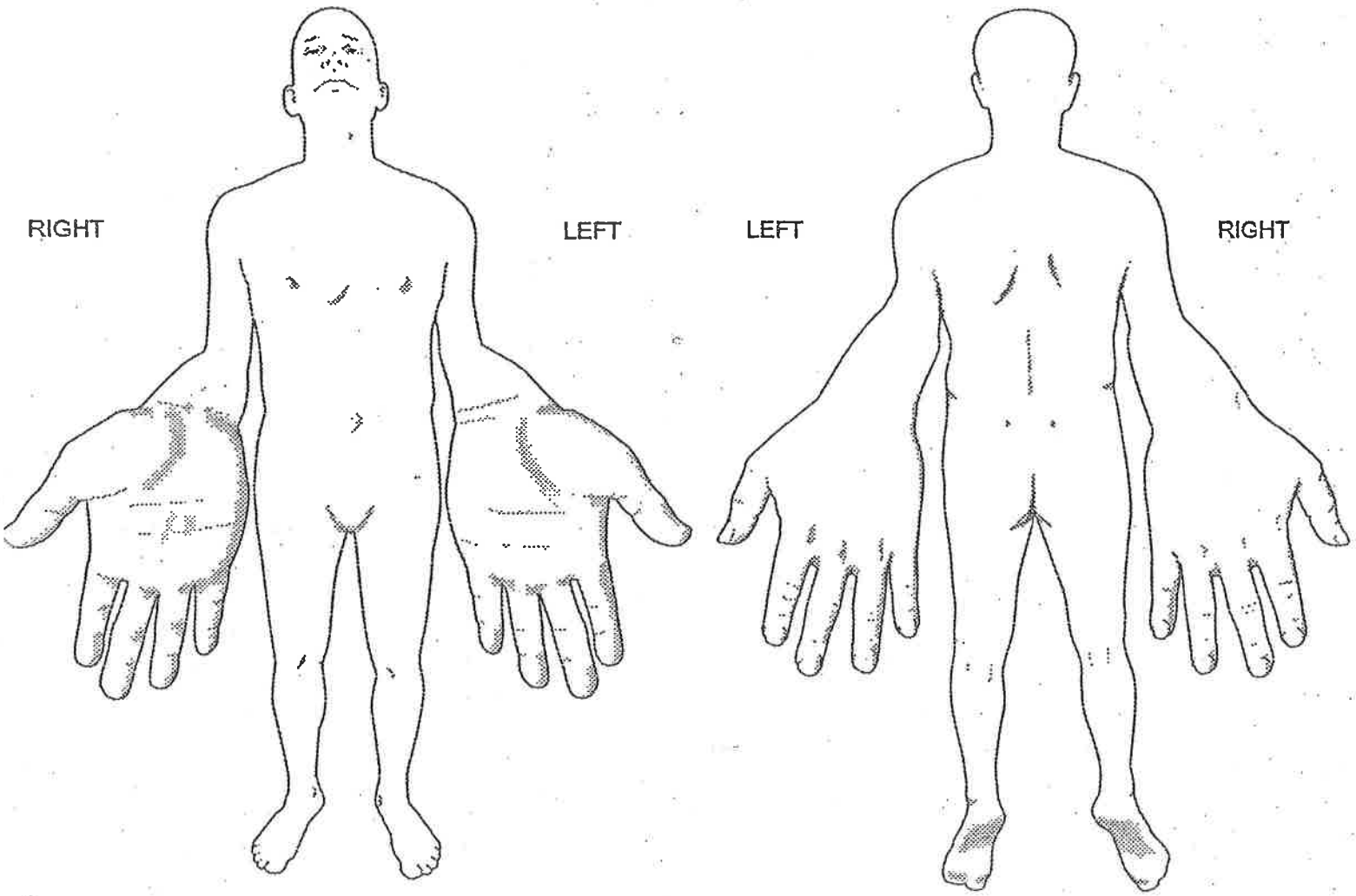
14. **Hand becomes blue, swollen, sweaty or hot.** Yes No (circle answer) If "yes" explain on back.

CERVICAL BRACHIAL SYMPTOM QUESTIONNAIRE

Mark where you feel pain with horizontal or vertical lines. Mark sensory changes with diagonal lines. If different pains or sensory changes are caused by specific items in the questionnaire, then indicate by the question number.
Use next page if necessary.

NAME_____

_____



or Mark pain

or Mark numbness or sensory disturbance including tingling

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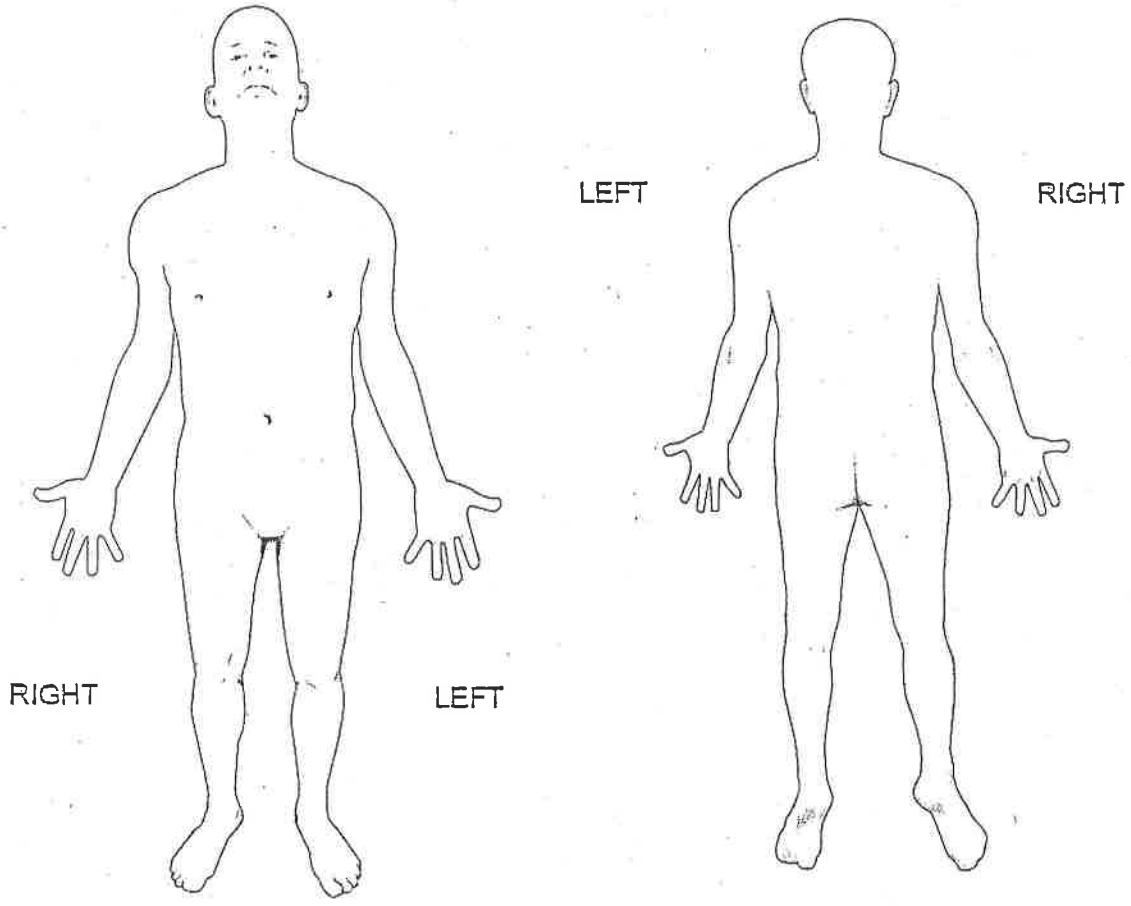
BRIEF PAIN INVENTORY

NAME_____ DATE_____

Instructions: Complete this form each time that you have an appointment. If there is no pain, then circle "no" and you are done. Note that the definition of pain includes all types of uncomfortable sensations including tingling, pins and needles, aching, shooting, burning, pressure, etc. In Item #9, "General Activity" refers to activities of daily living including grooming, dressing, eating, bathing, getting in and out of chairs, etc. "Work Activity" refers to either employment or household chores including driving, shopping, cooking, cleaning, etc.

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?
   1. yes 2. no

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE:

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW:

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain? _____

_____

_____

_____

8) In the past 24 hours, how much RELIEF have pain treatments or medications provided? Please circle the one percentage that most shows how much:

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No relief										Complete relief

9) **CIRCLE** the one number that describes how, during the past 24 hours, **PAIN HAS INTERFERED** with

A. General Activity:

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

B. Mood:

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

C. Walking Ability:

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

D. Normal work. (includes with work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

E. Relations with other people:

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

F. Sleep:

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

G. Enjoyment of life:

0	1	2	3	4	5	6	7	8	9	10
Does not										Completely

Name_____ **Date**_____

SPICE- SEH ("Spicey") Questionnaire

This questionnaire is designed to evaluate your levels of enjoyment and motivation over the past week. Circle the correct response. Do not leave blanks. If there was no opportunity to experience any of the examples, then make your best guess. Choose the response that most closely describes you.

For each question, circle one number.

1) Within the past week, you were able to enjoy social activities. Examples of activities which involve other people may include talking on the phone and visiting with family or friends.

Completely false — Somewhat true — Completely true

0 1 2 3 4 5 6 7 8 9 10

2) Within the past week, you were able to enjoy activities that ordinarily produce physical pleasure. Examples of these activities may include eating, drinking, listening to music, watching television, and reading, being sexually stimulated or engaging in recreational activities.

Completely false — Somewhat true — Completely true

0 1 2 3 4 5 6 7 8 9 10

3) Within the past week, you were able to start new projects and activities without delay. Examples of these may activities include grooming, dressing up well, bathing, shopping, and starting other tasks at home, school or work.

Completely false — Somewhat true — Completely true

0 1 2 3 4 5 6 7 8 9 10

4) Within the past week, you were able to satisfactorily complete chores and commitments on time. Examples of activities that may require timely completion include, cleaning house, settling financial matters, filling out paperwork and completing other tasks for the home, school or work.

Completely false — Somewhat true — Completely true

0 1 2 3 4 5 6 7 8 9 10

5) Within the past week, you were hopeful about your future.

Completely false — Somewhat true — Completely true

0 1 2 3 4 5 6 7 8 9 10

6) Within the past week, you have confidence in your ability to overcome any challenge that may come your way.

Completely false — Somewhat true — Completely true

0 1 2 3 4 5 6 7 8 9 10

Patient:_____ Date: _____

Analgesic Drug and Adjuvant Medication Scale (ADAM Scale)

Instructions: The patient may fill out items 1 through 4. The health professional should confirm average daily doses by referring to prescription records, pharmacy records or pill counts from original bottles. Patients should bring in original bottles with all remaining pills whenever possible.

1. Pain Medications taken as needed; give average daily doses in past month:

2. Pain Medications taken on a scheduled basis; give average daily doses in past month:

3. Other Medications taken as needed (these are medications that would not be considered standard pain medications but may be used to modify pain such as muscle relaxers, mood elevators, etc.); give average daily doses in past month:

4. Other Medications taken on a scheduled basis (these are medications that would not be considered standard pain medications but may be used to modify pain such as muscle relaxers, mood elevators, etc.); give average daily doses in past month:

5. Calculation of score by health professional. Circle appropriate value in right column.

None. No medication in past month	**0**
Occasional Non-opioid. Non-opioid, less than 2 doses per day in past month on the average. (such as acetaminophen, NSAID, muscle relaxants; total number of daily doses of all such medications)	**1**
Frequent Non-opioid. Non-opioid, less than 4 doses per day in past month on the average. (such as acetaminophen, NSAID, muscle relaxants; total number of daily doses of all such medications)	**2**
Constant Non-opioid. Non-opioid, 4 or more doses per day or use of a sustained/long acting preparation (such as sustained release alprazolam); average number of daily doses in the past month.	**3**
Occasional Opioid. Opioid, immediate release, less than two doses per day on the average in past month.	**4**
Frequent Opioid. Opioid, immediate release, less than four doses per day on the average in past month.	**5**
Constant Low Potency Opioid. Opioid, immediate release, predominant use of weaker analgesics (such as propoxyphene or Tramadol) = or > four doses per day or the use of a weak sustained release preparation (such as Tramadol sustained release)	**6**
Constant High Potency, Low Dose. Opioid, immediate release, predominant use of stronger analgesics (such as hydrocodone, oxycodone, morphine) = or > four doses per day or the use of a strong sustained release preparation. The total daily dose is less than 90 mg in oral morphine equivalents (oxycodone or hydrocodone less than 60 mg per day, fentanyl transdermal less than 50 mc/hr patch or methadone less than 20 mg per day).	**7**
Constant High Potency, Moderate Dose. Opioid, immediate release, predominant use of stronger analgesics (such as hydrocodone, oxycodone, morphine) = or > four doses per day or the use of a strong sustained release preparation. The total daily dose is = or > 90 mg in oral morphine equivalents (oxycodone or hydrocodone equal to or more than 60 mg per day, fentanyl transdermal equal to or more than 50 mc/hr patch or methadone = or > 20 mg per day).	**8**
Constant High Potency, High Dose. Opioid, immediate release, predominant use of stronger analgesics (such as hydrocodone, oxycodone, morphine) = or > four doses per day or the use of a strong sustained release preparation. The total daily dose is = or > 180 mg in oral morphine equivalents (oxycodone or hydrocodone equal to or more than 120 mg per day, fentanyl transdermal equal to or more than 100 mc/hr patch or methadone = or > 30 mg per day).	**9**
Constant High Potency, Very High Dose. Opioid, immediate release, predominant use of stronger analgesics (such as hydrocodone, oxycodone, morphine) = or > four doses per day or the use of a strong sustained release preparation. The total daily dose is = or > 360 mg in oral morphine equivalents (oxycodone or hydrocodone equal to or more than 240 mg per day, fentanyl transdermal equal to or more than 200 mc/hr patch or methadone = or > 40 mg per day).	**10**