ADVANCED PAIN CARE
65 Springfield Ave, Springfield, NJ 07081
Phone: (908)242-3688 Fax: (800)615-1868

NIGNNING HE, MD
Board Certified Anesthesiologist
Fellowship Trained in Pain Medicine

AUTO PATIENT REGISTRATION

Today's Date: ____________ Referral Doctor: ____________________________Attorney:______________________

Name: ____ DOB: _________________ SSN#: ___________

Gender: □ *Male* □ *Female* Marital Status: □ *Married* □ *Single* □ *Divorced*

Street Address: ____________________________________City: _______________ State: ______ Zip Code: _______

Home phone: _________________ Mobile phone: ___________________ Alternate phone: ___________________

Email: ____

Emergency Contact: _____________________________ Relationship: __________________ Phone: _____________

Current Employment Status: □ *Full time* □ *Part time* □ *Retired* □ *Student* □ *Home maker*
□ *Unemployed* □ *Disabled* □ *Self-employed*

Most Recent Occupation: ______________________________________ Employer: ____________________________

Date of Accident: _________ Auto Insurer: ____________________ Healthcare Insurer: ______________________

Vehicle in accident: □ *Your Vehicle* □ *Commercial Vehicle* □ *Other Vehicle*

Did you lose consciousness? □ *Yes* □ *No* Were you taken to emergency room? □ *Yes* □ *No*

If Yes, which hospital? ________________________ How? □ *Ambulance* □ *Police* □ *Car*

Were you discharged on same day? □ *Yes* □ *No*

Did you go to hospital within a few days after accident? □ *Yes* □ *No*

If Yes, which hospital? _________________ When? _____________

In the accident you were: □ *Driver* □ *Passenger* □ *Walking* □ *Riding motorcycle* □ *Riding bicycle*

If you were passenger, where did you sit? □ *Front seat* □ *Back seat*

Were you wearing seatbelt? □ *Yes* □ *No* Did airbag deploy? □ *Yes* □ *No*

Where is the car hit? □ *Front* □ *Rear* □ *Side* Which side if the car is hit on side? □ *Driver side* □ *Passenger side*

Height: ___________ Weight: ___________

Do you smoke? □ *Yes* □ *No* If Yes, how much? ________________________________

Do you consume alcohol? □ *Yes* □ *No* If Yes, how often? ________________________________

Do you have any allergies? □ *Yes* □ *No* If Yes, please list _________________________________

Please list CURRENT medical conditions and medical care provider after auto accident:

____

____

____

Please list PAST medical conditions and medical care provider before auto accident:

____

____

____

Please list all SURGERIES and year:

____

____

____

____

Please list MEDICATIONS with dosage and frequency you are taking:

____

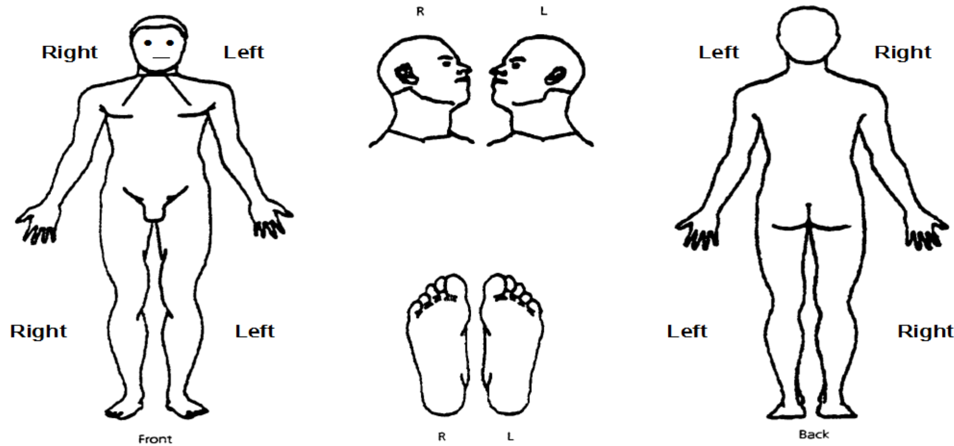
____

____

____

____

Location of Pain: Please shade in the painful areas in the diagram below. Put "x" on areas of tingling, "o" on burning areas, and "*" on areas with no feeling at all.



Least Pain level (0 being the least amount of pain): 0 1 2 3 4 5 6 7 8 9 10

Worst Pain level (0 being the least amount of pain): 0 1 2 3 4 5 6 7 8 9 10

Which of the following treatments have you had for your pain? Check all that apply.

□ *Over the counter Pain Killer (such as Motrin, Advil, Aspirin, Aleve, Tylenol)*

□ *Surgery* □ *Physical Therapy* □ *Acupuncture* □ *Chiropractic*

□ *Nerve blocks and injections (such as epidurals, facet injections, etc)*

□ *TENS* □ *Botulinum Toxin* □ *Biofeedback/Relaxation training* □ *Counseling/Psychotherapy*

□ *Other:* ____

Which of the following make your pain feel worse? Check all that apply.

□ *Sitting* □ *Standing* □ *Walking* □ *Lying down* □ *Bending forward* □ *Bending backwards* □ *Morning hours*

□ *Evening hours* □ *Coughing, Sneezing* □ *Damp weather* □ *Physical therapy* □ *Getting out of bed* □ *Stress*

□ *Other:* ____

Which of the following make your pain feel better? Check all that apply.

□ *Sitting* □ *Standing* □ *Walking* □ *Lying down* □ *Bending forward* □ *Bending backwards* □ *Morning hours*

□ *Evening hours* □ *Relaxation* □ *Physical therapy* □ *Acupuncture* □ *Heat* □ *Ice pack* □ *Alcoholic*

□ *Other:* ____

Signature______________________________ Date____________________