Lise Wiltse, MD
760-331-4409 | 760-724-9000

PATIENT REGISTRATION

We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Patient Name			Today's Date
Date of Birth	Age	Sex	
Parent's Name (if patient is a minor)			
Patient's Social Security Number		Marital Status	
Home Address	City	State	Zip
Mailing Address (if different than home address)	City	State	Zip
Home Phone Number	Work Phone Number	Cell Phone Number	
Occupation `	Employer's Name		
Employer's Address	City	State	Zip
Spouse's Name	Spouse's Employer		
Primary Physician's Name			

NOTIFY IN CASE OF EMERGENCY

Name	Relationship		
Address	City	State	Zip
Home Phone Number	Work Phone Number	Cell Phone Number	
Nearest Relative (not living with you)			
Home Phone Number	Work Phone Number	Cell Phone Number	

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Referring Physician
Reason for Referral
Diagnosis
When did your pain start? What was the date of your injury?
If you were injured, please describe the injury
Name of Employer (if injury is work related)
Are you involved in litigation? ❑ YES ❑ NO
If yes, attorney's name & address
If your pain is due to an accident at work A. Are you still working? ❑ YES ❑ NO B. If you are still working, are your activities or hours restricted because of pain? ❑ YES ❑ NO C. Are you receiving disability benefits? ❑ YES ❑ NO
Have you ever had nerve blocks or injections to relieve the pain? ❑ YES ❑ NO
If yes, did they relieve the pain? ❑ YES ❑ NO
If yes, how long did the pain last?
What type of injection did you have?
Have you used any of the following to relieve the pain? ❑ Acupuncture ❑ Bedrest ❑ Trigger point injections ❑ Psychotherapy ❑ Chiropractor ❑ Steroid injections ❑ TENS Unit ❑ DET, other disc procedures ❑ Biofeedback/relaxation training ❑ Physical Therapy ❑ Message ❑ Other (describe): _____
Studies

Patient Name _____

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Indicate which drugs you have used in the past for relief of your pain.

Anti-epileptics :
- ❑ Depakote
- ❑ Neurontin
- ❑ Topamax
- ❑ Tegretol
- ❑ Dilantin
- ❑ Lyrica

Muscle Relaxants:
- ❑ Flexeril
- ❑ Robaxin
- ❑ Valium
- ❑ Soma
- ❑ Baclofen

Stimulants:
- ❑ Dexedrine
- ❑ Ritalin
- ❑ Provigil

Stimulants:
- ❑ Dexedrine
- ❑ Ritalin
- ❑ Provigil

Anti-anxiety:
- ❑ Ativan (Lorazepam)
- ❑ Xanax

Opioids:
- ❑ Morphine
- ❑ MS Contin
- ❑ Roxanol
- ❑ Duragesic (Fentanyl)
- ❑ Actiq
- ❑ Levo-Dromoran
- ❑ Methadone
- ❑ Percodan
- ❑ Percocet
- ❑ Codeine
- ❑ Vicodin (Hydrocodone)
- ❑ Norco
- ❑ Dilaudid
- ❑ Oxycodone (OxyFast)
- ❑ Demerol
- ❑ Darvocet/Darvocet-N
- ❑ Darvon
- ❑ Lort

Anti-migraine:
- ❑ Inderal
- ❑ Fiorinol
- ❑ Carefgot/Ergotamines
- ❑ Imitrex

Other:
- ❑ _____
- ❑ _____

Non-Steroidal Anti-inflammatories:
- ❑ Aspirin
- ❑ Lodine
- ❑ Motrin (Ibuprofen)
- ❑ Feldene
- ❑ Vioxx
- ❑ Toradol
- ❑ Orudis
- ❑ Bextra
- ❑ Naprosyn
- ❑ Celebrex
- ❑ Relafen
- ❑ Indocin

Anti-hypertensive:
- ❑ Clonidine (Catapres)

Non-opioids:
- ❑ Tylenol

Antidepressants:
- ❑ Nortriptyline Trazadone
- ❑ Elavil (Amitriptyline)
- ❑ Cymbalta
- ❑ Zoloft Effexor
- ❑ Paxil Remeron

List all medications you are currently taking:

Medicine	Dose (amount)	Times each day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name _____

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List all ***medication*** allergies and effect

_____

_____

Are you on any blood thinners?

_____

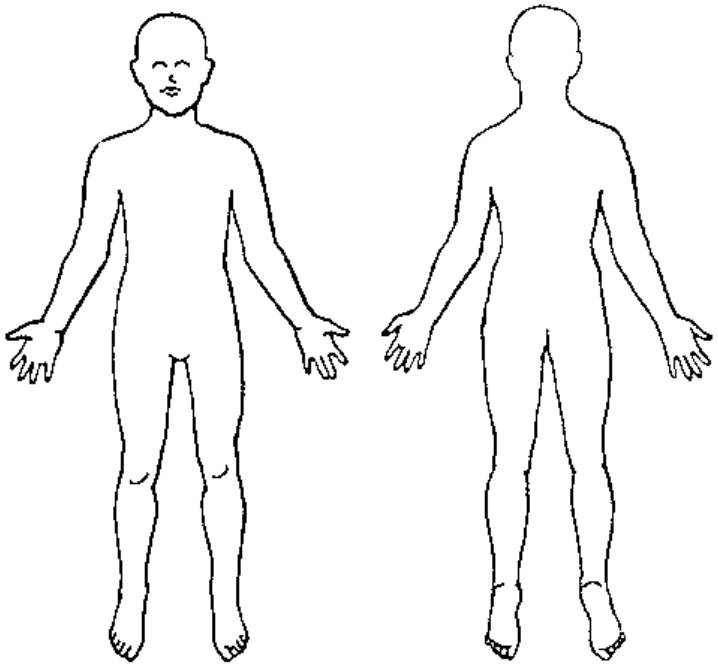
Describe the pain:
Indicate any words that best describe your pain.

❑ Pulsing	❑ Shooting	❑ Stabbing	❑ Hot
❑ Throbbing	❑ Tender	❑ Tiring	❑ Burning
❑ Pounding	❑ Taut	❑ Cold	❑ Scalding
❑ Dull	❑ Tight	❑ Sharp	❑ Tingling
❑ Sore	❑ Numb	❑ Pinching	❑ Itchy
❑ Aching	❑ Squeezing	❑ Gnawing	❑ Stinging
❑ Radiating	❑ Tearing	❑ Cramping	❑ Intense
❑ Penetrating	❑ Pricking	❑ Pulling	❑ Unbearable

❑ Other:_____

Location:

Please mark on the drawings below with a “C” the areas where you feel constant pain and with a “T” the areas you feel intermittent pain.



Patient Name _____

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This section has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please answer *every* section and mark in each section only the one box that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please mark the box which closely describes your problem.

1. Pain Intensity
   - ❍ I can tolerate the pain I have without having to use pain killers.
   - ❍ The pain is bad but I manage without having to take pain killers.
   - ❍ Pain killers give complete relief from pain.
   - ❍ Pain killers give moderate relief from pain.
   - ❍ Pain killers give very little relief from pain.
   - ❍ Pain killers have no effect on the pain and I do not use them.

2. Personal Care (Washing, Dressing, etc.)
   - ❍ I can look after myself normally without causing extra pain.
   - ❍ I can look after myself normally but it causes extra pain.
   - ❍ It is painful to look after myself and I am slow and careful.
   - ❍ I need some help but manage most of my personal care.
   - ❍ I need help every day in most aspects of self care.
   - ❍ I do not get dressed, wash with difficulty and stay in bed.

3. Lifting
   - ❍ I can lift heavy weights without extra pain
   - ❍ I can lift heavy weights but it gives extra pain.
   - ❍ Pain prevents me from lifting heavy weights of the floor, but I can manage if they are conveniently positioned, eg on a table.
   - ❍ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
   - ❍ I can lift only very light weights.
   - ❍ I cannot lift or carry anything at all.

4. Walking
   - ❍ Pain does not prevent me from walking any distance.
   - ❍ Pain prevents me from walking more than 1 mile.
   - ❍ Pain prevents me from walking more than ½ mile.
   - ❍ Pain prevents me from walking more than ¼ mile. I can only walk using a cane or crutches.
   - ❍ I am in bed most of the time and have to crawl to the toilet.

5. Sitting
   - ❍ I can sit in any chair as long as I like.
   - ❍ I can only sit in my favorite chair as long as I like.
   - ❍ Pain prevents me from sitting for more than 1 hour.

Patient Name _____

- ❍ Pain prevents me from sitting for more than ½ hour.
- ❍ Pain prevents me from sitting for more than 10 minutes.

6. Standing
   - ❍ I can stand as long as I want without extra pain.
   - ❍ I can stand as long as I want but it gives me extra pain.
   - ❍ Pain prevents me from standing for more than 1 hour.
   - ❍ Pain prevents me from standing for more than 30 min.
   - ❍ Pain prevents me from standing for more than 10 min.
   - ❍ Pain prevents me from standing at all.

7. Sleeping
   - ❍ Pain does not prevent me from sleeping well.
   - ❍ I can sleep well only by using tablets.
   - ❍ Even when I take tablets I have less than 6 hrs sleep.
   - ❍ Even when I take tablets I have less than 4 hrs sleep.
   - ❍ Even when I take tablets I have less than 2 hrs sleep.
   - ❍ Pain prevents me from sleeping at all.

8. Sex Life
   - ❍ My sex life is normal but it causes some extra pain.
   - ❍ My sex life is nearly normal but is very painful.
   - ❍ My sex life is severely restricted by pain.
   - ❍ My sex life is nearly absent because of pain.
   - ❍ Pain prevents any sex life at all.

9. Social Life
   - ❍ My social life is normal and gives me no extra pain.
   - ❍ My social life is normal but increases the degree of pain.
   - ❍ Pain has no significant effect on my social life apart from limiting my more energetic interests, eg dancing, etc.
   - ❍ Pain has restricted my social life and I do not go out as often.
   - ❍ I have no social life because of pain.

What makes the pain better? _____

What makes the pain worse? _____

Numbness or tingling?

❑ Yes ❑ No If yes, describe: _____

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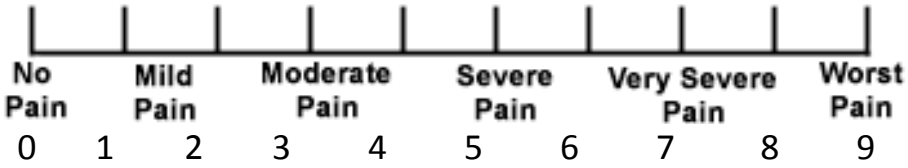
Weakness?

❑ Yes ❑ No If yes, describe: _____

Bowel or bladder problems?

❑ Yes ❑ No If yes, describe: _____

How severe is your pain?



Has the pain affected your:

Mood ❑ Yes ❑ No If yes, describe: _____

Sleep ❑ Yes ❑ No If yes, describe: _____

Appetite ❑ Yes ❑ No If yes, describe: _____

Social Life ❑ Yes ❑ No If yes, describe: _____

Work ❑ Yes ❑ No If yes, describe: _____

Have you been in a chemical dependency program? Yes no

Have you ever been to another pain doctor or pain clinic? Yes no

If yes, please state where_____

Have you ever been dismissed from a Physician office due to disagreement over meds?

Do you have an advance directive? Yes No

Have you been the victim of domestic abuse? Yes No

Please list your exercise program by activity and frequency (EX: run, 20 minutes, 4 times/week)

_____

_____

Please list any hobbies. (EX: sewing, painting, gardening, carpentry, auto repair)

_____

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Habits (circle all that apply)

	Currently Use	Previously Used	How much?	How long?	When Stopped?
Tobacco	❑ Yes ❑ No	❑ Yes ❑ No			
Caffeine	❑ Yes ❑ No	❑ Yes ❑ No			
Alcohol	❑ Yes ❑ No	❑ Yes ❑ No			
Recreational/ Street Drugs	❑ Yes ❑ No	❑ Yes ❑ No			

Enter medical condition and ages for all family members

	Current Age (or age at death)	Current Medical Condition (or cause of death)
Father		
Mother		
Brother		
Sister		
Children		
Spouse/Partner		

Patient Name _____

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REVIEW OF SYSTEMS

Required questions for insurance compliance

Please indicate below. Are you currently experiencing any of these symptoms?

General, constitutional
Good general health lately..... no yes
Recent weight change..... no yes
Fever..... no yes
Fatigue..... no yes

Eyes and vision
Eye disease or injury..... no yes
Wear glasses or contact lenses..... no yes
Blurred or double vision..... no yes
Glaucoma..... no yes

Ears, nose, throat
Hearing Loss..... no yes
Ringing in the ears..... no yes
Earaches or drainage..... no yes
Sinus problems..... no yes
Nose bleeds..... no yes
Mouth Sores..... no yes
Bad breath or bad taste..... no yes
Sore throat or voice change..... no yes
Swollen glands in neck..... no yes

Heart and cardiovascular
Heart trouble..... no yes
Chest pains..... no yes
Sudden heartbeat changes..... no yes
Swelling of feet, ankles, hands..... no yes

Respiratory
Frequent coughing..... no yes
Spitting up blood..... no yes
Shortness of breath..... no yes
Asthma or wheezing..... no yes

Gastrointestinal
Loss of appetite..... no yes
Change in bowel movements..... no yes
Nausea or vomiting..... no yes
Frequent diarrhea..... no yes
Painful bowel movements or constipation..... no yes
Blood in stool..... no yes
Stomach pain..... no yes

Psychiatric
Memory loss or confusion..... no yes
Nervousness or depression..... no yes
Sleep disturbance..... no yes

Genitourinary
Frequent urination..... no yes
Burning or painful urination..... no yes
Blood in urine..... no yes
Change in force or strain with urination..... no yes
Incontinence or dribbling..... no yes
Kidney stones..... no yes
Sexual difficulty..... no yes
Painful periods..... no yes
Irregular periods..... no yes
Vaginal discharge..... no yes

Musculoskeletal
Joint pain..... no yes
Joint stiffness or swelling..... no yes
Weakness of muscles/joints..... no yes
Muscle pain or cramps..... no yes
Back pain..... no yes
Cold extremities..... no yes
Difficulty in walking..... no yes

Skin and breasts
Rash or itching..... no yes
Change in skin color..... no yes
Change in hair or nails..... no yes
Varicose veins..... no yes
Breast pain..... no yes
Breast lump..... no yes
Breast discharge..... no yes

Neurological
Frequent or recurrent headaches..... no yes
Light headed or dizzy..... no yes
Convulsions or seizures..... no yes
Numbness or tingling sensations..... no yes
Tremors..... no yes
Paralysis..... no yes
Stroke..... no yes
Head injury..... no yes

Endocrine
Glandular or hormone problem..... no yes
Thyroid disease..... no yes
Excessive thirst or urination..... no yes

Hematologic
bruising or bleeding tendency..... no yes
anemia or transfusion..... no yes

Patient signature_____

Physician signature _____

Patient Name _____

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FORM COMPLETION FEES

Please refer to the following schedule of fees associated with completing forms on behalf of the patient. These fees cover the cost of processing and are payable in advance. Thank you.

Medical, Disability, and Insurance Forms: $50 for the first 3 pages; $5/page for each additional page

DMV Forms: $20 per form

CANCELLATION POLICY

Please review our policy on cancellation of appointments and procedures.

Appointments require a 2 business day cancelation notice, or will incur a $45 fee.

Procedures scheduled for 1-hour or less require a 2 business day cancelation notice, or will incur a $100 fee.

Procedures scheduled for more than 1-hour (discograms, stimulators, narcotic pump placements) require a 3 business day cancelation notice, or will incur a $200 fee.

Patient Name _____