PAUL H. CHIU, M.D.

707 S. Garfield Ave. Ste 304
Alhambra, CA 91801
(626) 281-PAIN (7246) (626) 281-9040 FAX

Name:_____
名字 Last Name 姓名 First Name 名字 M.I.

Date of Birth:_____ **Age:**_____ **Gender:Male/Female**
今天日期 生日日期

Home Address_____
家地址 Street 街道 City 城市 State /Zip Code 郵政號碼

Home Phone:(___) _____ -_____ **Cell Phone (___)**_____
家電話號碼 手機號碼

E-Mail:_____ **Social Security #:** _____ - _____ - _____ .
電郵地址 社會安全卡

Occupation: _____
職業

Emergency Contact: _____ **(____) _____ -**_____
緊急聯絡人 Name 名字 Relationship 關係 Phone Number 聯絡人電話號碼

Referral Physician_____ **Physician's Office Phone (_____) _____ .**
介紹醫師名字 介紹醫師診所電話號碼

Health Insurance Carrier _____ **Member ID**_____
健康保險公司名稱 會員編號

Medical Group _____
醫療團體名字

Subscriber's Name _____
健康保險卡人名字

Language Preference: □ English □ Spanish □ Mandarin □ Cantonese □ Vietnamese □ Other _____

How Did you hear about our office?
如何得知本公司? □ Newspaper 報紙 □ Ad 廣告 □ Yellowpages 黃頁 □ Other 其它 _____

☐ ***I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my insurance benefits are denied.***
☐ ***I clearly understand that the initial consultation is only for pain assessment and does not imply any agreement of dispense of pain medications or injection therapies.***
☐ ***I understand that I will be charge for picking up prescriptions due to early refill, if approved by the doctor.***

Patient's Signature 簽字 _____ **Date 日期:** _____

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Patient Name:
D.O.B:
Age:
Date:

HIPPA Acknowledgement

I understand that I have the right to review **Paul H. Chiu, M.D., Inc**. Notice of Privacy prior to signing this consent. I understand **Paul H. Chiu, M.D., Inc** reserves the right to change their notice and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations, and the organization is not required to agree to re restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I understand that I am authorizing the release of all or any part of my medical record for the purposes of treatment, payment, or practice operations. This release may include records containing information regarding the diagnosis and/ or treatment of HIV/ AIDS, mental illness, and/ or drug and/ or alcohol addiction or abuse to any person or corporation which is or may be liable under a contract for all or part of the medical charges, including but not limited to: Medicare, MediCal, or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer. The record may be needed in order to process a claim for medical services. I authorize **Paul H. Chiu, M.D., Inc** to release information needed for billing purposes to entities that may provide services pertinent to my physician visit, such as reference laboratories.

Signature of Patient or Legal Representative _____ Date _____

Printed Name of Patient _____ Witness _____

Release of Medical Information to Family Members
During the course of your treatment it may become necessary to discuss your condition with a family member or family friend. Below, please indicate to whom may we discuss your condition and/ or treatment with:

Spouse Name:

Family Member Name (s):

Friend(s) Name(s)

Restrictions
Please do not my treatment with:

Documentation of Failure to Obtain Signed Acknowledgement. I presented this acknowledgement to the patient. The patient refused to provide a signature when requested

Staff Member Signature _____ Date _____

707 S. Garfield Ave. #304
Alhambra, CA 91801
(626) 281-PAIN (7246)
(626) 656-1296 (Fax)

Paul H. Chiu, M.D., Inc.

Vanguard IPS 介入性疼痛治療中心

PATIENT – FACILITY
ARBITRATION AGREEMENT

1. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

2. I voluntarily agree to submit to arbitration any and all claims involving persons bound by this agreement (as set forth in Article 3) whether those claims are brought in court, contract or otherwise. This includes but is not limited to, suits for personal injury, actions to collect debts, or any kind of civil action.

3. I understand and agree that this Patient-Facility Arbitration Agreement binds me, my heirs, assigns or personal representative and the undersigned facility, the professional corporation or partnership, if any, its employees, partners, heirs, assigns or personal representative and any consenting substitute physician. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this agreement.

4. I agree to accept medical services from the undersigned facility and to pay for those services in full the priced determined by the facility. I UNDERSTAND THAT IF I DO SIGN THE AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY REVOKE THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED FACILITY WITHIN THAT TIME STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT. After those 30 days, this agreement may be changed or revoked only by a written revocation signed by both parties.

5. I have read and understood this Agreement, and this writing makes up the entire arbitration agreement between the undersigned facility and me.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ _____
(Patient or parents if patient is a minor) Date Time

_____ _____
Witness Date Time

PAUL H. CHIU, M.D.

707 S. Garfield Ave. Ste 304
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Phone: (626) 281-7246
Fax: (626) 281-9040

Patient Name:
D.O.B:
Age:

Paul H. Chiu, M.D.
OPIOID THERAPY INFORMED CONSENT

Patient Name: _____ Date: _____

Opioid treatment for chronic pain can be used extremely effectively and successfully to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to perform daily activities. This may include exercise, use of non-opioid analgesics, physical therapy, psychological counseling and/or other therapies or treatment.

I, _____, understand that compliance with the following guidelines is important in continuing pain treatment with

Dr. **Chiu.**

1) I understand that I have the following responsibilities:
   a) I will take medications only at the dose and frequency prescribed.
   b) I will not increase or change medications without the approval of this doctor or the designated clinician within this doctor's practice.
   c) I will actively participate in this doctor's efforts and programs designed to improve functionality (including social, physical, psychological and daily or work activities).
   d) I will not request opioids or any other pain medicine from physicians other than from this doctor. This doctor will be informed of, approve or prescribe all other mind and mood altering drugs.
   e) I will inform this doctor of all other medications that I am taking.
   f) I will obtain all medications from one pharmacy, with full consent for this clinical practice to talk with the pharmacist or other appropriated pharmacy personnel, given by signing this informed consent.
   g) I will protect my prescriptions and medications. No controlled substance prescriptions will be replaced by this office for any reason. I will keep all medications from children.
   h) I agree to participate in psychiatric or psychological assessments as deemed necessary by my medical provider.

   i) If I have an addiction problem, I will not use illegal or street drugs or alcohol. This doctor may ask me to follow through with a program to address this issue. Such programs may include, but are not limited to the following:
      i) 12-step program and securing a sponsor
      ii) Individual counseling
      iii) Inpatient or outpatient treatment
      iv) Other: _____

2) I am responsible for signing a consent to request record transfer to this doctor. No more than 3 days of medications may be prescribed by any emergency room or other medical provider without approval from this medical staff.

3) I understand that I will consent to random drug screens as deemed appropriate by this doctor or affiliated medical staff. A drug screen is a laboratory test in which a sample of my urine is checked to see what drugs I have been taking. I understand that my medical provider may require blood analysis specific to opioid levels and/or hormone levels, since testosterone and estrogen have been shown to significantly decrease during chronic opioid therapy.

4) I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment. I understand that this doctor may stop prescribing opioids or change the treatment plan if:
   a) I do not show any improvement in pain from opioids or my functionality has not improved or certain pre-established goals remain unmet.
   b) My behavior is inconsistent with the responsibilities outlined in #1 above.
   c) I give away, sell or misuse the opioid medications or other controlled substances.
   d) I develop rapid tolerance or loss of improvement from the treatment.
   e) I obtain opioids or other controlled substances from other than this doctor.
   f) I refuse to cooperate when asked to provide a urine or blood sample if requested.
   g) If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
   h) If I am unable to keep follow-up appointments.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date

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Patient Name:
D.O.B:
Age:
Date:

OPIOID TREATMENT INFORMED CONSENT (continued)

YOUR SAFETY RISKS WHILE UNDER THE INFLUENCE OF OPIOIDS:
You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment or a motor vehicle. Read and follow any warnings on your prescription bottles. If you have any questions, ask your doctor.

POSSIBLE SIDE EFFECTS OF OPIOIDS:

- Confusion or other change in thinking abilities
- Breathing too slowly – overdose can stop your breathing and lead to death
- Aggravation of depression
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Sleepiness or drowsiness
- Nausea
- Dry mouth
- Vomiting
- Constipation

THESE POTENTIAL SIDE EFFECTS MAY BE MADE WORSE IF YOU MIX OPIOIDS WITH OTHER DRUGS, INCLUDING ALCOHOL

POSSIBLE RISKS OF OPIOIDS:

- Physical dependence. This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:

Runny nose	Sweating
Difficulty sleeping for several days	'Goose bumps'
Diarrhea	Rapid heart rate
Abdominal cramping	Nervousness

- Psychological dependence/Addiction. A small percentage of patients may develop psychological dependence and addiction problems based on genetic or other factors. These conditions are characterized by compulsive opioid use despite potential or real harm.
- Tolerance. This means you may need more and more drug to get the same effect.
- Problems with pregnancy. If you are pregnant or contemplating pregnancy, discuss opioid use with your physician.

RECOMMENDATIONS TO MANAGE YOUR MEDICATIONS:

- Keep a diary of the pain medications you are taking, the medication dose, time of day you are taking them, their effectiveness and any side effects you may be having.
- Use a medication box that you can purchase at your pharmacy that is already divided in to the days of the week and times of the day so it is easier to remember when to take your medications.
- Take along only the amount of medicine you need when leaving home so there is less risk of losing all your medications at the same time. Ask your pharmacist to provide an extra, small bottle for your opioid medication(s) so that you may carry a only a small supply of medication that is properly labeled.

I have read this document, understand and have had all my questions answered satisfactorily. I consent to the use of opioids to help control my pain and I understand that my treatment with opioids will be carried out as described above.

Patient Signature Date Physician Signature Date

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Patient Name:
D.O.B:
Age:
Date

Patient Information Release Form

Patient's Name: _____ D.O.B.: _____

The above named patient has requested release of his/her personal records.

Attached are the items contained in his/her medical chart

1. Consultation note
2. Progress note
3. Operative reports
4. Laboratory reports
5. MRI/ X-ray reports
6. Procedure logs
7. Medication logs

Below you will find an authorization signed by the patient for the release of this information.

Thank you for your kind attention.

Sincerely,

Paul H. Chiu, M.D.

This is your authority to release any and all information pertaining to my medical care, including laboratory reports, imaging studies, procedure notes, medication list, etc.

Signed_____

Print Name _____

Date_____

PAUL H. CHIU, 醫學博士
先鋒介入性疼痛專家

患者姓名:
生日: 性別：男/女
日期:

Vitals	
BP	mmHg
Pulse	bpm
Weight	lbs.
Height	ft in

初步疼痛評估 (Initial Pain Evaluation)

請回答以下問題，幫助我們瞭解您的疼痛（圈出所有適用答案）

受傷日期 (Date of Injury):

_____

受傷原因 (Cause of Injury):

☐ 機動車事故 (MVA) ☐ 滑倒 (Slip & Fall)

☐ 工作傷害 (Work-related) ☐ 其他： _____

機動車事故具體細節 (Details of MVA)：

你在車裡的位置: (position)
☐ 司機 (Driver)
☐ 乘客(front passenger)
☐ 右後座 (R-Back)
☐ 左後座 (L-Back)

你有係安全帶嗎 (seatbelt)？
☐ 係安全帶 (restrained)
☐ 沒有係安全帶 (no seatbelt)

安全氣囊是否展開 (airbags deploy)?
☐ 有(Yes) ☐ 沒有(No)

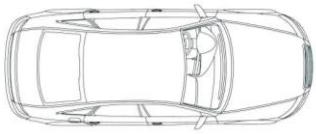
事故位置(where):
☐ 街道 (Local)
☐ 高速公路 (Freeway)
☐ 停車場 (Parking lot)

發生事故時 (Mechanism of injury):

您當時是否?
☐ 有預期 (Tensed) ☐ 毫無準備 (Unprepared)

您乘坐或駕駛的車輛是否?
☐ 移動 (Moving) ☐ 已停 (Stopped)

標記您的汽車受到影響的位置 (Mark where your car was impacted).



您的臉面向哪個方向 (head facing)？
☐ 左側 (Left) ☐ 前方 (forward)
☐ 右側 (Right) ☐ 不記得 (Unknown)

您的雙手放在方向盤上 (hand positions)**:**
☐ 右手 (Right) ☐ 左手 (Left)
☐ 雙手 (Both)

事故發生後您是否立即感到疼痛 (did you feel pain immediately)？
☐ 有(Yes) ☐ 沒有(No)

如果沒有，您何時感到疼痛(when did the pain start) _____

碰撞過程中您是否有失去意識 (did you lose consciousness)**?**
☐ 有(Yes) ☐ 沒有(No)

如果有，大概持續了多久 (how long)**?**_____

碰撞過程中您的頭部有發生撞擊嗎 (head impacted)**?**
☐ 有(Yes) ☐ 沒有(No)

您身體的其他部位是否有撞到 (other part of body hit the car)**?**
☐ 有 (yes) ☐ 沒有 (No)

如果有，請描述 (Explain)： _____

Comments:_____
_____
_____

事故發生後 (Following the accident):

圈出所有適用答案 (check all that apply):
☐ 呼叫救護車/醫務人員 (EMS)
☐ 員警抵達 (Police)
☐ 現場治療 (Treated at scene)

你去醫院了嗎(did you go to the hospital)？
☐由他人送至醫院 (Transported to hospital)
☐ 我自己就醫 (got medical attn. on own)
在哪治療(where did you go)**?**
_____
何時就醫 (when)? _____

他們在醫院做了什麼治療?
(what did they do at the hospital)
☐ 在醫院診斷 (Diagnostic tests at hospital)
☐ 開出處方藥 (Med. Prescribed)
☐ 醫院做的其他治療救護 (other tx at hospital):
_____

已接受診斷檢查:

☐ 核磁共振成像 (MRI) ☐ 電腦斷層掃描 (CT)
☐ X光檢查 (X-ray) ☐ 椎間盤造影(Discogram)
☐ 脊髓攝影術(Myelogram) ☐ 肌電圖/神經傳導 (EMG/NCV)
☐ 其他:_____

Translated by:_____
Transcribed by:_____

PAUL H. CHIU, 醫學博士

先鋒介入性疼痛專家

患者姓名:

生日: **性別：男/女**

日期:

您的疼痛部位? 請在圖表圈出您的疼痛處

疼痛等級:

0: **無痛**

1-3: 輕微的疼痛

4-5: 中度疼痛

6-7: 中度 - 劇烈疼痛

8-9: 嚴重的疼痛

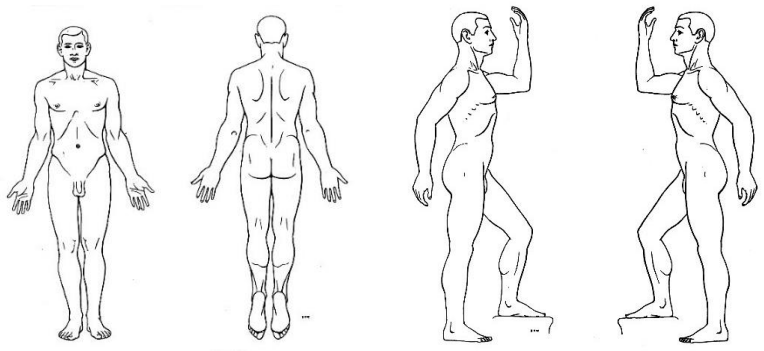
10: 最糟糕的痛苦

頻率:

持續 : 24/7

間歇: On/off

偶爾: 5-25% 時間



说明: 请使用以下的三個大框架分別回答您的疼痛部位, 选中適用于特定疼痛位置的所有答案. 如果您没有三個以上的疼痛部位, 请将其方框留空. 如果您有任何疑问，请告诉我们，谢谢.

主要疼痛部位（選擇一個）(primary): ☐ **頸部** (neck) ☐ **腰背部** (lower back) ☐ **R / L 肩膀** (shoulder) ☐ **R / L 膝蓋** (knee) ☐ **Other:**_____

從 1-10 疼痛程度來看, 你的疼痛程度是多少? 現在 (now)**:**_____**/10 最痛的時候** (worse)**:**_____**/10**

我的疼痛頻率是:	**疼痛感受(quality):**		**加重疼痛狀況的原因(worse)：**		**緩解疼痛的有效方法(better):**	
☐ 持續 (Constant)	☐ 板滯 (dull)	☐ 悸動(throbbing)	☐ 熱敷(heat)	☐ 躺(lying)	☐ 熱敷(heat)	☐ 按摩(massage)
☐ 間歇 (Intermittent)	☐ 酸痛 (aching)	☐ 發散 (radiating)	☐ 冷敷(cold)	☐ 咳嗽(coughing)	☐ 冷敷(cold)	☐ 休息(rest)
☐ 偶爾 (Occasional)	☐ 尖痛 (sharp)	☐ 麻木 (numb)	☐ 行走(walk)	☐ 打噴嚏(sneezing)	☐ 行走(walk)	☐ 吃藥(med.)
	☐ 炙熱 (burning)	☐ 刺痛 (tingling)	☐ 坐 (sit)	☐ 提起(lifting)	☐ 坐 (sitting)	☐ 其他:
	☐ 滲痛 (penetrating)		☐ 站立(stand)	☐ 推 (pushing)	☐ 躺 (lying)	_____
	☐ 其他: _____		☐ 拉 (pulling)	☐ 彎(bending)		
疼痛是否會擴散（疼痛、麻木、刺痛）(does the pain radiate)**?**			☐ 拉緊(strain)	☐ 靜置不動(being still)		
☐ 會(yes) ☐ 不會(no)			☐ 轉動(turning)	☐ 其他: _____		

哪個部位(where)**?**_____

第二個疼痛位置（選擇一種） (secondary): ☐ **頸部** (neck) ☐ **腰背部** (lower back) ☐ **R / L 肩膀** (shoulder) ☐ **R / L 膝蓋** (knee) ☐ **Other:**_____

從 1-10 疼痛程度來看, 你的疼痛程度是多少? 現在 (now):_____/10 **最痛的時候** (worse):_____/10

我的疼痛頻率是:	疼痛感受(quality):		加重疼痛狀況的原因(worse)：		緩解疼痛的有效方法(better):	
☐ 持續 (Constant)	☐ 板滯 (dull)	☐ 悸動(throbbing)	☐ 熱敷(heat)	☐ 躺(lying)	☐ 熱敷(heat)	☐ 按摩(massage)
☐ 間歇 (Intermittent)	☐ 酸痛 (aching)	☐ 發散 (radiating)	☐ 冷敷(cold)	☐ 咳嗽(coughing)	☐ 冷敷(cold)	☐ 休息(rest)
☐ 偶爾 (Occasional)	☐ 尖痛 (sharp)	☐ 麻木 (numb)	☐ 行走(walk)	☐ 打噴嚏(sneezing)	☐ 行走(walk)	☐ 吃藥(med.)
	☐ 炙熱 (burning)	☐ 刺痛 (tingling)	☐ 坐 (sit)	☐ 提起(lifting)	☐ 坐 (sitting)	☐ 其他:
	☐ 滲痛 (penetrating)		☐ 站立(stand)	☐ 推 (pushing)	☐ 躺 (lying)	_____
	☐ 其他: _____		☐ 拉 (pulling)	☐ 彎(bending)		
疼痛是否會擴散（疼痛、麻木、刺痛）(does the pain radiate)?			☐ 拉緊(strain)	☐ 靜置不動(being still)		
☐ 會(yes) ☐ 不會(no)			☐ 轉動(turning)	☐ 其他: _____		

哪個部位(where)?_____

PAUL H. CHIU, 醫學博士

先鋒介入性疼痛專家

患者姓名:

生日: **性別：男/女**

日期:

第三次疼痛的位置（選擇一個）：☐ **頸部** (neck) ☐ **腰背部** (lower back) ☐ **R / L 肩膀** (shoulder) ☐ **R / L 膝蓋** (knee) ☐ **Other:**_____

從 1-10 疼痛程度來看, 你的疼痛程度是多少? 現在 (now)**:_____/10 最痛的時候** (worse)**:_____/10**

我的疼痛頻率是:	**疼痛感受(quality):**	**加重疼痛狀況的原因(worse)：**	**緩解疼痛的有效方法(better):**
☐ 持續 (Constant)	☐ 板滯 (dull) ☐ 悸動(throbbing)	☐ 熱敷(heat) ☐ 躺(lying)	☐ 熱敷(heat) ☐ 按摩(massage)
☐ 間歇 (Intermittent)	☐ 酸痛 (aching) ☐ 發散 (radiating)	☐ 冷敷(cold) ☐ 咳嗽(coughing)	☐ 冷敷(cold) ☐ 休息(rest)
☐ 偶爾 (Occasional)	☐ 尖痛 (sharp) ☐ 麻木 (numb)	☐ 行走(walk) ☐ 打噴嚏(sneezing)	☐ 行走(walk) ☐ 吃藥(med.)
	☐ 炙熱 (burning) ☐ 刺痛 (tingling)	☐ 坐 (sit) ☐ 提起(lifting)	☐ 坐 (sitting) ☐ 其他:
	☐ 滲痛 (penetrating)	☐ 站立(stand) ☐ 推 (pushing)	☐ 躺 (lying) _____
	☐ 其他: _____	☐ 拉 (pulling) ☐ 彎(bending)	
疼痛是否會擴散（疼痛、麻木、刺痛）(does the pain radiate)**?**		☐ 拉緊(strain) ☐ 靜置不動(being still)	
☐ 會(yes) ☐ 不會(no)		☐ 轉動(turning) ☐ 其他: _____	
哪個部位(where)**?**_____			

您有任何軟弱無力症狀嗎(do you have any weakness)**?** ☐ 有(Yes) ☐ 沒有(No) **如果有，哪個部位(where)?** _____

您有控制腸道或膀胱的問題嗎(any problem controlling your bowels/bladder)**?** ☐ 有 (Yes) ☐ 沒有(No)

該部位以往是否有遭受疼痛或受傷 (prior pain history)**?** ☐ 有 (yes) ☐ 沒有 (no)

如果有，請說明 (explain) _____

舊傷的疼痛已徹底治癒了嗎 (did the pain resolve completely)？ ☐ 有(yes) ☐ 沒有 (no)

如果沒有治癒，在這次新疼痛狀況開始前，您的疼痛等級是（0-10）(previous pain level)_____

已接受醫生提供診治（姓名）(physicians seen):

脊椎按摩師 (Chiro.): _____ ☐ 正在接受治療 (ongoing) ☐ 已完成治療 (completed)

物理治療師 (PT)：_____ ☐ 正在接受治療 ☐ 已完治療

- 是否有改善 (did it help)**?** ☐ 有 (yes) ☐ 沒有 (no)

醫師 (Physician)：_____

骨科醫生 (Orthopedist)**:** _____

神經專科醫生(Neurologist): _____

其他: _____

您是否從已接受以下治療? (treatments)：

☐ 按摩 (massage)	☐ 臥床休息 (bed rest)
☐ 物理治療 (exercises)	☐ 熱/冷敷 (Heat/Ice)
☐ 針灸 (acupuncture)	☐ 電療 (Electrical Stim.)
☐ 超聲波 (ultrasound)	☐ 局部止痛(Topical pain relievers)
☐ 打針 (injections)	☐其他:_____
☐ 藥物 (medications)	

已嘗試的止痛/非類固醇消炎藥物 (Pain med./NSAID agents tried)**:** **是否有改善?** ☐ **有** (yes) ☐ **沒有** (no)

☐ 非處方止痛藥/非類固醇消炎藥物 (OTC NSAID): _____	☐ 肌肉鬆弛劑 (muscle relaxants): _____
☐ 處方止痛藥/非類固醇消炎藥物 (Prescription):_____	☐ 皮質類固醇激素(corticosteroids): _____

PAUL H. CHIU, 醫學博士
先鋒介入性疼痛專家

患者姓名:
生日: **性別：男/女**
日期:

其他症狀 (additional concerns)**:**

☐ 頭痛 (headache) ☐ 難以集中注意力(Diff. concentrating) ☐ 喪失聽力 (hearing loss) ☐ 煩躁/憤怒 (irritability/anger)
☐ 頭暈 (dizziness) ☐ 耳鳴 (ringing in ears) ☐ 緊張 (nervousness) ☐ 悲傷 (unhappiness)
☐ 失衡 (loss of balance) ☐ 失眠 (trouble sleeping) ☐ 噁心 (nausea) ☐ 意志消沉和冷漠 (demoralization/Apathy)
☐ 視力障礙(vision dist.) ☐ 疲勞 (fatigue) ☐ 焦慮 (anxiety) ☐ 其他: _____
☐ 健忘(forgetfulness) ☐ 體重增加 (weight gain) ☐ 抑鬱 (depression) _____

無力執行的事物 - 難以履行的生活或工作職責。(Duties under Duress)

☐ 工作 (work) ☐ 駕駛 (driving)
☐ 園藝 (yardwork) ☐ 照顧兒童 (taking care of children)
☐ 洗衣 (laundry) ☐ 使用電腦 (using the computer)
☐ 清潔 (cleaning) ☐ 其他: _____
☐ 學習(studying)

日常生活活動 - 難以執行的日常活動 (Activities of Daily Living)

☐ 穿衣 (dressing) ☐ 書寫 (writing) ☐ 旅行 (traveling)
☐ 自我護理 (self-care) ☐ 家務 (household) ☐ 爬樓梯 (climbing stairs)
☐ 進食 (eating) ☐ 體育活動 (sports) ☐ 上/下床 (getting in/out bed)
☐ 性活動 (sexual activity) ☐ 社交活動 (social) ☐ 其他: _____
☐ 閱讀 (reading) ☐ 愛好 (hobbies) _____

病史

病症 (Medical Problems):

☐ 心臟病 (heart disease) ☐ 心律異常(abn. heart rhythm) ☐ 高膽固醇 (high cholesterol) ☐ 腎病 (kidney disease)
☐ 呼吸短促(shortness of breath) ☐ 肝炎 (hepatitis) ☐ 高血壓 (high blood pressure) ☐ 帶狀皰疹 (shingle)
☐ 糖尿病類型___(Diabetes) ☐ 關節炎 (arthritis) ☐ 胸痛 (chest pain) ☐其他:_____
☐ 出血性疾病 (bleeding disorder) ☐ 哮喘(asthma): ☐ 膀胱/腸道功能障礙 (bladder/bowel dysfunction)

列出以往曾接受的任何手術/日期 (previous surgeries):

_____
_____
_____
_____
_____
_____

列出所有當前使用的藥物 (current medications):

_____
_____
_____
_____
_____
_____

請列出任何過敏藥物 (allergies to med.):

☐ 青黴素 (penicillin)
☐ 磺胺類藥物 (sulfa drugs)
☐ 阿司匹林，布洛芬或其他非甾體類抗炎藥物 (NSAID agents)
☐ 其他:_____
☐ **N/A**

PAUL H. CHIU, 醫學博士

先鋒介入性疼痛專家

患者姓名:

生日: **性別：男/女**

日期:

社會史

現狀 (Status):	**職業:**	**選擇適用選項:**
☐ **已婚** (married) ☐ **離異** (divorced)	**職位(job):_____**	**你抽烟吗?** ☐ **有** (yes) ☐ **沒有** (no)
☐ **單身**(single) ☐ **喪偶** (widow)	☐ **退休**(retired) ☐ **臨時殘疾** (temp. disability)	**你喝酒吗 (多少)** (drinks alcohol)**？**
☐ **分居**(separated)	☐ **無業**(unemployed) ☐ **永久性殘疾** (perm. disability)	☐ **有** (yes) ☐ **沒有** (no)
	您的工作需要體力勞動嗎 (is your work physically demanding)？ ☐ 是 (yes) ☐ 否 (no)	**你在服用任何禁藥**吗**？** (other drugs) ☐ **有** (yes) ☐ **沒有** (no)

Notes: _____

_____

_____

證實

我保證我已如實地回答了所有問題，並且沒有故意隱瞞上述問題所涉及任何有關過去或是現在的信息詳情。

_____

請寫出您的姓名，簽名並註明日期

_____

醫生簽名(doctor's signature)

*****我們不會透過電話為患者提供**慢性連續處方箋。**所有**慢性連續處方箋**必須**要患者親自預約看醫生 已**確保您在下次預約前備有足**夠的藥物。