



NEW PATIENTS' INFORMATION SHEET
www.iscoreinc.com

Please print clearly. Please complete all information so that your claim can be processed quickly and efficiently. Thank you!

PATIENT INFORMATION

Name

Date of Birth: Sex: Marital Status:

(Street) (City) (State) (ZIP)

Address:

Phone #: Social Security #:

Employer: Work #:

Employer's Address:

If Student, School Name: Full / Part Time

Primary Emergency Contact
Name: Relationship: Number:

Email:

WORKER'S COMP/ACCIDENT INFORMATION

Insurance Name:

Address: Phone #: ( ) -

Adjuster Name: Adjuster Phone #: ( ) -

Date of Injury or Accident: Claim #:

Type of Injury: [ ] Back [ ] Leg [ ] Hip [ ] Neck [ ] Shoulder [ ] Arm [ ] Head [ ] Other:

Place of work during time of accident: Phone #: ( ) -

In Litigation: [ ] Yes [ ] NO Amount of Medical Benefits: Notice of Compensation Payable: [ ] Yes [ ] NO

Attorney Information

Law Office Name: Attorney Name:
Law Office Address: City: State:
Law Office Telephone: Law Office Fax:
Law Office E-Mail: Law Office Contact Name:

**Patient Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**DOS:** \_\_\_\_\_

**PAIN SCORES (Scale 0 - 10)**

0 = No Pain ———> 10 = The most pain you have ever felt in your life

**CURRENT** pain level (today / now): \_\_\_\_\_

**HIGHEST** pain level over the last week: \_\_\_\_\_

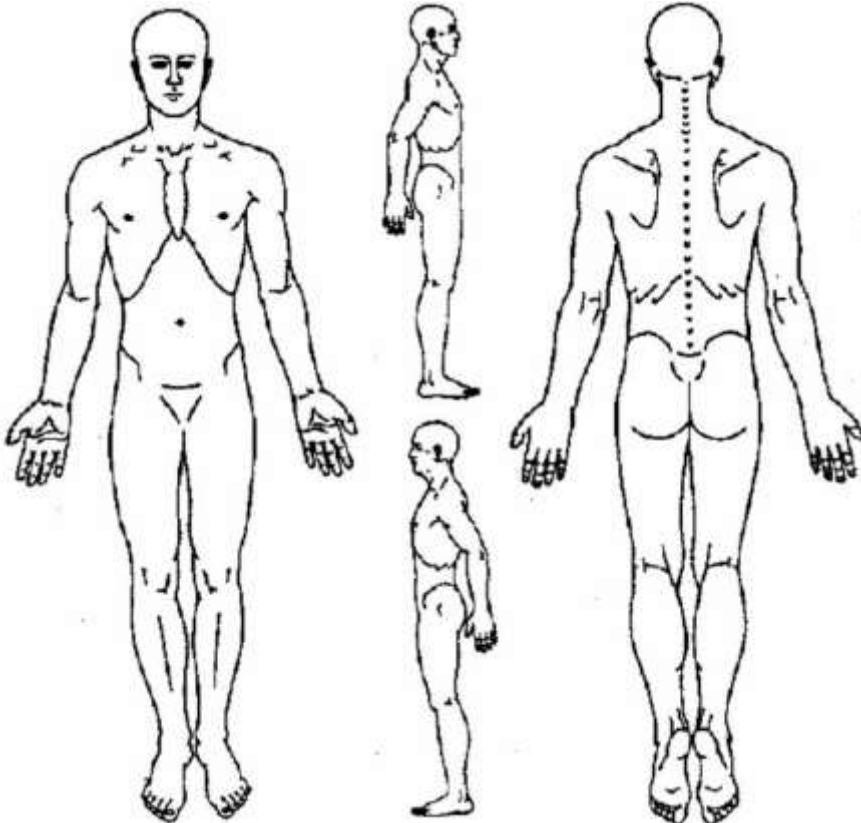
**LOWEST** pain level over the last week: \_\_\_\_\_

**PAIN DIAGRAM**

**FRONT**

**RIGHT**

**BACK**



**LEFT**

Please mark the figure with the location of your symptoms. Do not use circles.

**Pain** = x x x x

**Numbness/Tingling** = # # # #

**Characteristic(s) of pain**  
(Check all that apply)

- DULL
- ACHING
- BURNING
- SHARP
- SHOOTING
- THROBBING
- SPASMS
- OTHER: \_\_\_\_\_



Maxim Moradian, M.D., DABPMR, CAQSM, DABPM, DABRM, Q.M.E.

Revik Vartanian, D.O.

James J. Lieu, D.O.

Specializing in Physical Medicine and Rehabilitation, Pain Management, Sports Medicine, Regenerative Medicine, and Electrodiagnostic Medicine

### NEW PMR & INTERVENTIONAL PAIN MANAGEMENT INTAKE QUESTIONNAIRE

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

What is your reason for visit?: \_\_\_\_\_

How did it begin (suddenly, gradual, accident)? \_\_\_\_\_

How long has this been going on? \_\_\_\_\_

Is it constant or occasional? \_\_\_\_\_

Is it getting worse, same, or better? \_\_\_\_\_

Does the pain/discomfort go into the arms or legs? Which one? \_\_\_\_\_

If pain/discomfort goes into arms or legs, is there numbness, tingling, or weakness? \_\_\_\_\_

What makes it worse (examples - lifting, bending, sitting, walking)? \_\_\_\_\_

What makes it better (examples - resting, sitting, standing, nothing)? \_\_\_\_\_

Have you: (please circle)

Lost control of bowel or bladder because of this? \_\_YES\_\_ \_\_NO\_\_. Explain: \_\_\_\_\_

Had prior x-rays, CT, MRI, bone scans for this? \_\_YES\_\_ \_\_NO\_\_. Explain: \_\_\_\_\_

Had previous spine surgery for this problem (what type)? \_\_YES\_\_ \_\_NO\_\_. Explain: \_\_\_\_\_

Had any spinal injections for this? \_\_YES\_\_ \_\_NO\_\_. Explain: \_\_\_\_\_

When? \_\_\_\_\_ Did they help? \_\_\_\_\_

What other conservative treatments have you tried?

- Physical Therapy/Exercise     TENS/E-Stim     Opioid Medications     Cast/Boot/Walker/Cane
- Massage/Ultrasound     Traction     Anti-Inflammatories     Orthotics
- Chiropractic     Acupuncture     Muscle Relaxants     Other \_\_\_\_\_

What other medical problems do you have? (eg Asthma, Diabetes, High Blood Pressure, etc)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies to any medications? Check box if No Known Drug Allergies →

Medication:	Reaction:	Medication:	Reaction:

Family medical problems? (eg Asthma, Heart disease, Diabetes, Cancer, etc)

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Sibling: \_\_\_\_\_

Do you **smoke**?  current everyday smoker  current some days smoker  former smoker  never smoked

Use **drugs**?  never  in the past  currently  type of drug: \_\_\_\_\_

Drink **alcohol**?  never  rarely  socially  frequently (more than twice per week)  alcoholic

What medications are you currently taking? (You may attach a list)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What surgeries have you had in the past?

Approximate date of surgery:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name \_\_\_\_\_

Patient DOB \_\_\_\_\_

Patient DOS \_\_\_\_\_

**Please check off any of the following symptoms you have been recently experiencing:**

- |                          |                                           |                                                  |                                               |                                         |
|--------------------------|-------------------------------------------|--------------------------------------------------|-----------------------------------------------|-----------------------------------------|
| <b>General:</b>          | <input type="checkbox"/> Chills           | <input type="checkbox"/> Fever                   | <input type="checkbox"/> Weight Gain          | <input type="checkbox"/> Weight Loss    |
| <b>Skin:</b>             | <input type="checkbox"/> New Lesions      | <input type="checkbox"/> Rash                    | <input type="checkbox"/> Hair Loss            | <input type="checkbox"/> Itching        |
| <b>HEENT:</b>            | <input type="checkbox"/> Blurred Vision   | <input type="checkbox"/> Double Vision           | <input type="checkbox"/> Hearing Loss         | <input type="checkbox"/> Discharge      |
| <b>Respiratory:</b>      | <input type="checkbox"/> Cough            | <input type="checkbox"/> Wheezing                | <input type="checkbox"/> Shortness of Breath  | <input type="checkbox"/> Sputum         |
| <b>Cardiovascular:</b>   | <input type="checkbox"/> Chest Pain       | <input type="checkbox"/> Abnormal Blood Press.   | <input type="checkbox"/> Palpatations         | <input type="checkbox"/> Arrhythmia     |
| <b>Gastrointestinal:</b> | <input type="checkbox"/> Abdominal Pain   | <input type="checkbox"/> Constipation            | <input type="checkbox"/> Nausea               | <input type="checkbox"/> Vomiting       |
| <b>Muskuloskeletal:</b>  | <input type="checkbox"/> Neck Pain        | <input type="checkbox"/> Dec. Range of Motion    | <input type="checkbox"/> Joint Pain           | <input type="checkbox"/> Muscle Pain    |
|                          | <input type="checkbox"/> Mid-Back Pain    | <input type="checkbox"/> Swelling of Extremities | <input type="checkbox"/> Joint Stiffness      | <input type="checkbox"/> Muscle Spasms  |
|                          | <input type="checkbox"/> Low-Back Pain    | <input type="checkbox"/> Deformities             | <input type="checkbox"/> Joint Swelling       | <input type="checkbox"/> Fatigue        |
| <b>Neurological:</b>     | <input type="checkbox"/> Headaches        | <input type="checkbox"/> Fainting                | <input type="checkbox"/> Unsteadiness         | <input type="checkbox"/> Numb/Tingling  |
|                          | <input type="checkbox"/> Head Injury      | <input type="checkbox"/> Poor Coordination       | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Weakness       |
|                          |                                           | <input type="checkbox"/> Trouble Walking         |                                               | <input type="checkbox"/> Incontinence   |
| <b>Psychiatric:</b>      | <input type="checkbox"/> Anxiety          | <input type="checkbox"/> Depression              | <input type="checkbox"/> Flashbacks           | <input type="checkbox"/> PTSD           |
| <b>Endocrine:</b>        | <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> Heat Intolerance        | <input type="checkbox"/> Excessive Sweating   | <input type="checkbox"/> Diabetes       |
| <b>Hematology:</b>       | <input type="checkbox"/> Blood Clots      | <input type="checkbox"/> Abnormal Bleeding       | <input type="checkbox"/> Easy Bruising        | <input type="checkbox"/> Blood Thinners |
| <b>Genito-Urinary:</b>   | <input type="checkbox"/> Bleeding         | <input type="checkbox"/> Discharge               | <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> UTI            |

**None of The Above Apply**

---

**Your primary medical (family) doctor?** Name: \_\_\_\_\_ Tel # \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Did a doctor refer you here, and if so who?** Name: \_\_\_\_\_ Tel # \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

---

**OFFICE USE ONLY BELOW THIS LINE:**

Vital Signs:

Physical Exam: (pertinent positives)





## Consent for Treatment with Controlled Substances

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of opioid pain medication, benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of the risk of developing an addiction disorder and uncertainty regarding the extent to which they provide long-term benefit.

These drugs are monitored by the State of California and the Drug Enforcement Agency because these drugs have potential for abuse or diversion. Therefore strict accountability is required. For this reason the following policies are agreed to by you, the patient, as a condition for the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. Controlled substances must come from the physician who signs below or, during his or her absence, by the covering physician. Exceptions apply only when a controlled substance is being prescribed in a routine manner by another provider who is aware of all medications.
2. All controlled substances must be obtained at the same pharmacy, notwithstanding pharmacy-related issues made known by you to the practice.
3. You will inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take, or if you change pharmacies.
4. The prescribing physician has permission to discuss treatment details with dispensing pharmacists, or other professionals who provide you health care, to maintain accountability.
5. Unannounced urine, serum, or saliva toxicology screens may be requested and your cooperation is required.
6. You may not use any illicit substances while taking controlled substances including, but not limited to cocaine, heroin, methamphetamine, ecstasy, etc.
7. You may not share, sell, or otherwise permit others to have access to these medications.
8. You will take these medicines as prescribed or you will otherwise notify the physician.
9. **Original containers of medication will be brought to each visit for which a medication refill is being requested with the remaining corresponding medication inside.**
10. **You will maintain a journal of your medication use and bring it to each visit for which a medication refill is being requested.** An example will be provided to you. Maintain a blank original and make copies for use.
11. If your medication has been damaged, misplaced, or stolen you must complete a police report regarding the theft and provide a copy to this office.
12. Renewals are contingent on keeping scheduled appointments no less than 3 days in advance of the end of your current medication cycle. Urgent appointment requests for this purpose will not be honored and it is your responsibility to plan accordingly. Phone calls for prescriptions after hours or on weekends are not compliant with this requirement.
13. Early refills will generally not be given. You may not run out of your medications before an appointment for medication refill.
14. It is understood that any medical treatment is initially a trial and that continued prescription is contingent on evidence of benefit and safety.
15. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation). You agree to not operate heavy machinery while under the influence of these medications.
16. If the legal authorities have questions concerning your treatment all confidentially is waived and these authorities may be given full access to our records of controlled substance administration.
17. You understand that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment
18. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

**Violation of any component of this contract may be met with one warning and repeat review of this agreement. No further warnings will be given. Final violation of this agreement indicates that safe outpatient management using these medications has not been demonstrated and therefore results in immediate termination of controlled substance prescribing. A referral to a detoxification program will be provided at that time.**

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_



---

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient Telephone: \_\_\_\_\_

Patient E-Mail: \_\_\_\_\_

**PHARMACY INFORMATION**

Name of Pharmacy: \_\_\_\_\_

Address of Pharmacy: \_\_\_\_\_

\_\_\_\_\_

\* If Address unknown, please mention cross streets

Telephone of Pharmacy: \_\_\_\_\_

Fax Number of Pharmacy: \_\_\_\_\_

**ADDITIONAL PHARMACY INFORMATION (If Applicable)**

Name of Pharmacy: \_\_\_\_\_

Address of Pharmacy: \_\_\_\_\_

\_\_\_\_\_

\* If Address unknown, please mention cross streets

Telephone of Pharmacy: \_\_\_\_\_

Fax Number of Pharmacy: \_\_\_\_\_



## Consent to Receive Text Message Appointment Reminders

By signing below, I authorize iSCORE to contact me by automated SMS text message for appointment reminders. I understand that message/data rates may apply to messages sent by iSCORE under my cell phone plan. My text/mobile phone number is: \_\_\_\_\_

Initials \_\_\_\_\_

I know that I am under no obligation to authorize iSCORE to send me text messages. I may opt-out of receiving these communications at any time by calling the office at 626-460-1096 or 818-338-6860. Please allow 2-3 business days for processing. I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information. By signing below, I indicate I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages via automated technology from iSCORE.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_



**PHYSICIAN-PATIENT ARBITRATION AGREEMENT**

Article 1: **Agreement to Arbitrate:** 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.

Article 2: **All claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership and the employees, agents and estates of any of them, must be arbitrated, including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provision of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:


Effective as of the date of first medical services

\_\_\_\_\_  
Patient's or Patient's Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

**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.**

By:  \_\_\_\_\_  
Physician's or Authorized Representative's Signature      Date

**MAXIM MORADIAN, MD**  
\_\_\_\_\_  
Print or Stamp Name of Physician or Authorized Agent of Medical Group

By: \_\_\_\_\_  
Patient's or Patient Representative's Signature      Date

By: \_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.



## Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Facility Address: \_\_\_\_\_ Tel No: \_\_\_\_\_

### The information you may release subject to this signed release form is as follows:

- |                                            |                                             |                                                 |
|--------------------------------------------|---------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Complete Records  | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Progress Notes         |
| <input type="checkbox"/> Care Plan         | <input type="checkbox"/> Lab Reports        | <input type="checkbox"/> Radiology Reports      |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Treatment Record   | <input type="checkbox"/> Operative Reports      |
| <input type="checkbox"/> Hospital Reports  | <input type="checkbox"/> Medication Record  | <input type="checkbox"/> Other (please specify) |

Release my protected health information to the following entity:

**iSCORE** (Interventional Spine Care and Orthopedic Regenerative Experts)

Providers:  **Maxim Moradian, MD**  **Revik Vartanian, DO**  **James J. Lieu, DO**

Address: 317 S. Brand Blvd., Suite 103, Glendale, CA 91204

51 N. 5<sup>th</sup> Ave, Suite 301, Arcadia, CA 91006

Tel: (818) 338-6860 & (626) 460-1096; Fax: (888) 425-9079

Email: [medicalrecords@iscoreinc.com](mailto:medicalrecords@iscoreinc.com)

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient or Personal representative

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Printed Name or patient or Personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority