CHEE GAP KIM, M.D.

Board Certified *Physical Medicine & Rehabilitation*
Electrodiagnosis
Pain Medicine

475 Grand Ave., 2nd floor, Englewood, NJ 07631
(201) 541-1111 / Fax: (201) 541-0777

Date ______________________

Patient's Name ____

Date of Birth ______________ Sex: M ________ F ________

Addresss ____

Cell Phone ______________ Emergency Contact ______________________

Email Address ____

Social Security No. ______________________ Occupation ______________________

Name of Insurance Company ______________________________________

Date of Accident ______________________ Claim No. ______________________

Name of Adjuster ______________________ Phone No. ______________________

I hereby authorize direct payment of medical benefit to Dr. Chee Gap Kim, and also permit a copy of this authorization to be used in place of the original. I hereby authorize Dr. Chee G Kim to release any information required in the course of my examination and treatment. I hereby authorize any physician, hospital or medical facility to provide at the information on my medical history to Dr. Chee G Kim. I also understand that Iam financially responsible for all the charges whether or not paid by insurance.

Date ______________ Patient's Signature ______________________________

Patient History Questionnaire

Patient Name: ______________________ Date: ______________________

Medical History: Please mark the appropriate choices

☐ Hypertension
☐ Coronary artery disease
☐ Cancer ( )
☐ Glaucoma
☐ Kidney dysfunction
☐ Surgery had before ( )
☐ Diabetes mellitus for ___ years
☐ Motor vehicle accident
☐ Gastritis
☐ Asthma
☐ Osteoporosis, arthritis
☐ Hypercholesterolemia
☐ Thyroid disease
☐ Peptic ulcer disease
☐ Liver disease

Have you ever had a motor vehicle accident? ☐ No ☐ Yes (when ______________)

Social History: Please mark the appropriate choices

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Alcohol Consumption: ☐ No ☐ Yes (how often:)

Smoking Status: ☐ No ☐ Yes (how many per day ______________)
☐ Quit (when ______________)

Drug Use: ☐ No ☐ Yes (type of drug:)

Pregnant: ☐ No ☐ Yes

Physical Disability: ☐ No ☐ Yes

Occupation: ______________

Do you exercise regularly? ☐ No ☐ Yes (how often:)

Type of housing

☐ Ground level building ☐ Multi-floor building (how many stairs:)

☐ Apartment (What floor:) Elevator available (☐ Yes ☐ No)

Family History: Please mark the appropriate choices

☐ Diabetes mellitus for _____ years
☐ Hypertension
☐ Hypercholesterolemia
☐ Coronary artery disease
☐ Thyroid disease
☐ Cancer
☐ Liver disease
☐ Asthma
☐ Anemia
☐ Osteoporosis
☐ Arthritis
☐ Glaucoma
☐ Stoke
☐ Migraine
☐ Mental Disorder
☐ Alcoholism
☐ Epilepsy
☐ Other

Reviewed by: ______________________ Date: ______________________

CHEE GAP KIM, M.D.

Board Certified *Physical Medicine & Rehabilitation*
Electrodiagnosis
Pain Medicine

475 Grand Ave., 2nd floor, Englewood, NJ 07631
(201) 541-1111 / Fax: (201) 541-0777

Patient's History Questionnaire

Review of Systems (ROS)

Please mark the appropriate choices

Name:______________________________ Date:______________________________

Constitutional

	Yes	No
Recent weight change	( )	( )
Night sweat	( )	( )
Fatigue	( )	( )

Ear/Nose/Mouth/Throat

	Yes	No
Hearing Loss	( )	( )
Nose bleed	( )	( )
Hoarseness	( )	( )

Eyes

	Yes	No
Glasses	( )	( )
Double vision	( )	( )
Glaucoma	( )	( )
Cataract	( )	( )

Cardiovascular

	Yes	No
Chest pain	( )	( )
Palpitation	( )	( )
Heart disease	( )	( )
Swelling of hands or feet	( )	( )

Respiratory

	Yes	No
Shortness of breath	( )	( )
Cough	( )	( )
Asthma	( )	( )
Blood in sputum	( )	( )

Gastrointestinal

	Yes	No
Stomach ache	( )	( )
Peptic ulcer	( )	( )
Nausea	( )	( )
Blood in stool	( )	( )

Endocrine

	Yes	No
Thirsty	( )	( )
Thyroid disease	( )	( )
Hormone abnormality	( )	( )

Neurological

	Yes	No
Frequent headache	( )	( )
Paralysis	( )	( )
Epilepsy	( )	( )
Tingling of hands/feet	( )	( )

Allergy

	Yes	No
Food	( )	( )
Aspirin	( )	( )
Antibiotics	( )	( )

Genitourinary

	Yes	No
Blood in urine	( )	( )
Kidney stone	( )	( )
Sexual dysfunction	( )	( )
Menstrual abnormality	( )	( )

Hematologic/Lymphatic

	Yes	No
Bruise easily	( )	( )

Psychiatric

	Yes	No
Insomnia	( )	( )
Memory Loss	( )	( )
Depression	( )	( )
Anxiety	( )	( )

Reviewed by ______________________________ Date ______________________________

CHEE GAP KIM, M.D.
Board Certified *Physical Medicine & Rehabilitation*
Electrodiagnosis
Pain Medicine

475 Grand Ave., 2nd floor, Englewood, NJ 07631
(201) 541-1111 / Fax: (201) 541-0777

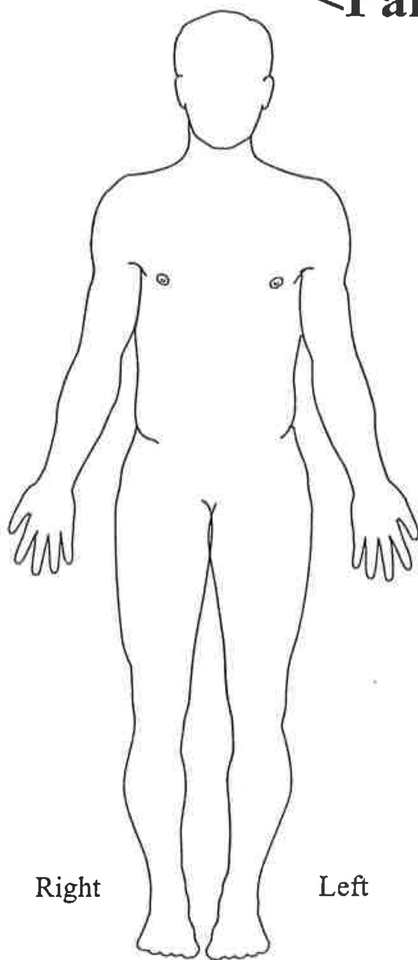
Name________________________________ Date ________________________________

Pain Diagram

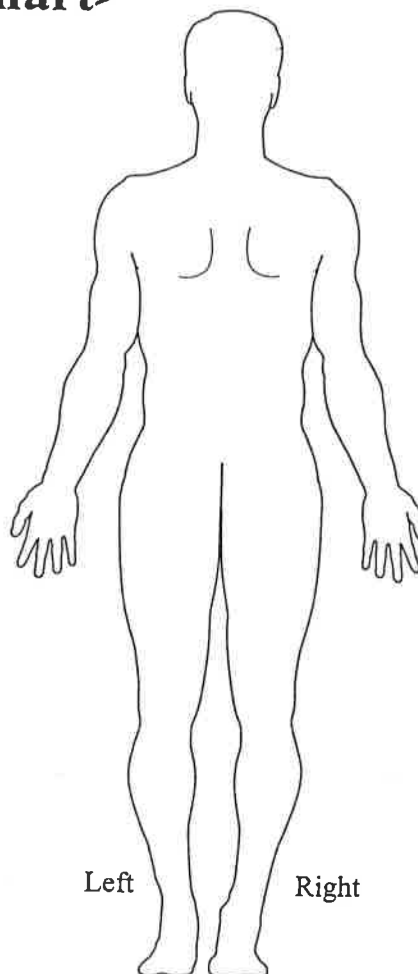
Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols.
Mark areas of radiation.
Include all affected areas.

Numbness	Pins &Needles	Burning	Aching	Stabbing
●●●●●●●●●	000000000	XXXXXXX	△△△△	////////////
●●●●●●●●●	000000000	XXXXXXX	△△△△	////////////
●●●●●●●●●	000000000	XXXXXXX	△△△△	////////////
●●●●●●●●●	000000000	XXXXXXX	△△△△	////////////

<Pain Chart>



Front



Back

CHEE GAP KIM, M.D.
Board Certified — *Physical Medicine & Rehabilitation*, *Electrodiagnosis*, *Pain Medicine*

475 Grand Ave., 2nd floor, Englewood, NJ 07631
(201) 541-1111 / Fax: (201) 541-0777

Pain Questionnaire

Name ______________________________ Date ______________________

	None	Mild	Moderate	Severe
Throbbing	0)______	1)______	2)______	3)______
Shooting	0)______	1)______	2)______	3)______
Stabbing	0)______	1)______	2)______	3)______
Sharp	0)______	1)______	2)______	3)______
Cramping	0)______	1)______	2)______	3)______
Gnawing	0)______	1)______	2)______	3)______
Hot-Burning	0)______	1)______	2)______	3)______
Aching	0)______	1)______	2)______	3)______
Heavy	0)______	1)______	2)______	3)______
Tender	0)______	1)______	2)______	3)______
Splitting	0)______	1)______	2)______	3)______
Tiring- exhausting	0)______	1)______	2)______	3)______
Sickening	0)______	1)______	2)______	3)______
Fearful	0)______	1)______	2)______	3)______
Punishing-cruel	0)______	1)______	2)______	3)______

Pain Intensity