

PATIENT DEMOGRAPHIC INFORMATION

PAIN & ORTHOPEDIC

Appointment Date, Time:	
Referring Physician:	Phone:
	Fax:
Primary Care Physician:	Phone:
	Fax:
MRI: Yes No Date/Location:	

All Information Must Be Obtained

Last Name:	First Name:	Middle Initial:
Address:		
City:	State:	Zip code:
(H) Phone:	(w) Phone:	(C) Phone:
Email:		
Social Security Number:	Preferred Language:	
Date of Birth:	Sex:	F M
Employer:		
Emergency Contact:	Phone:	
Primary Insurance Name:		
Policy Holder:	S.S.N:	DOB:
Insurance ID #:	Insurance Group #:	
Insurance Phone #:		
Secondary Insurance Name:		
Policy Holder:	S.S.N.	DOB:
Insurance ID #:	Insurance Group #:	
Insurance Phone #:		
Workers Comp / PIP:	DOI:	Claim #:
Ins Carrier:	Claim Address:	
Adjuster Name:	Phone:	

HIPAA NOTICE OF PRIVACY NOTICE OF PRIVACY PRACTICES

Name: _____ **DOB:** _____ **Date:** _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ORTHOPEDIC & WELLNESS including pain management physicians and orthopedic physicians, are required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

General Authorization of Release of Medical Records that you sign authorizes your Medical Care Provider to disclose the information in your medical records to the extent needed for the following purposes:

1. For the purpose of providing treatment to you. This would include, for example, sharing information with employees and contractors of Provider, or with other Health Care Providers who are treating you or consulting in your care.
2. For the purpose of arranging payment for your care. This may include, for example, your insurer or other third-party who is responsible for paying all or part of the cost of your care.
3. For the purpose of Provider's "Health Care Operations." This would include such things as internal quality assessment activities, contacting other Health Care Providers regarding treatment alternatives, evaluating provider performance, training Providers of care, legal and medical review of care provided, business planning and management, customer service, resolution of internal grievance and the provision of legal and auditing services.
4. For the purpose of other Health Care Provider's "Health Care Operations", to the extent that they have a treatment relationship with you.

Specific Authorization for Release of Medical Records that you may sign authorizes the Provider to make a specific disclosure that is not covered under the section above. A Specific Authorization will name the party to whom you are authorizing disclosure, and will contain any limitations on the authority to disclose your records.

1. You may revoke any authorization provided to Provider by giving Provider a written notice of revocation. Provider may refuse to treat you if you revoke the General Authorization.
2. Provider may be required by law, in some cases, to make disclosures of your records that you have not authorized. Examples are subpoenas in criminal or civil litigation, or requests/surveys by license agencies or the U.S. Department of Health and Human Services.
3. Provider may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
4. You have the following rights with respect to your medical records/information:

[continued]

- a.** You have the right to request restrictions on the use and disclosure of your medical records/information; however, Provider is not required to agree to restrictions not guaranteed by law. You will be informed if Provider will not agree to a requested restriction.
- b.** You have the right to receive confidential communications of your health information and to direct the place and manner of communication.
- c.** You have the right to inspect and copy your medical records (Provider is entitled to charge you a reasonable fee related to the cost of copying your records).
- d.** You have the right to seek to amend your medical records, and if Provider does not agree with your request, to note your objection in the medical record.
- e.** You have the right to receive an accounting (list) of disclosures of your medical records/information made by Provider (Except for those disclosures that are made to you or with your specific authorization that fall within the scope of Provider's "Health Care Operations," or disclosures made for payment or treatment purposes).
- f.** You have the right to receive a paper copy of this notice.

In the event that **ORTHOPEDIC & WELLNESS** is sold or merged with another organization, your health information/records will become the property of the new owner.

Provider is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices, as well as changes to those practices. Patients will be provided with revised notices, as appropriate. If a patient believes that his or her privacy rights have been violated, the patient may complain to the Provider, or to the Secretary of the U.S. Department of Health and Human Services. To complain to the Provider, please write or call us with the details. Provider will not retaliate in any way against a patient for making a complaint.

If you, as a patient or guardian, believe that your privacy rights have been violated, and wish to notify our practice, please call our office and ask to speak with our designated Privacy Complaints Contacts at 240.629.3998 or submit your complaint to: **ORTHOPEDIC & WELLNESS**, P.O. Box 2348, Germantown MD 20875.

If you are not satisfied with the manner in which our office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Avenue, SW, Room 509F HHH Building, Washington, DC 20201. Or call 410.402.8000. www.medicare.gov/Ombudsman

Acknowledgement of Receipt of Notice

I wish to restrict my Private Healthcare information: I have filed a Request of Restriction Form.

Patient Name: _____ **Patient Signature:** _____ **Date:** _____

PATIENT BILL OF RIGHTS

As a patient being treated in our office you have a right to:

- To have consideration of your privacy concerning your own medical care.
- To know the name of all physicians and/or staff directly assisting in your care.
- To have medical records pertaining to your medical care treated as confidential (except as required by law or third party contracted agreement).
- To know what rules and regulations in our practice apply to your conduct as a patient.
- To expect emergency procedures to be implemented without delay; if there is a need to transfer you to another facility the responsible person and facility will be notified of your condition prior to your arrival.
- To have good quality care and high professional standards that are continually maintained and reviewed.
- To have full information in layman's terms concerning diagnosis, treatment, prognosis and possible complications.
- To give an informed consent to the physician prior to the procedure.
- To be advised of participation in a medical care research program or donor program (You will be asked to give your informed consent prior to participation in such a program and you may refuse to continue in a program that you may have previously given informed consent to participate in).
- To refuse drugs or procedures and have a physician explain the medical consequences of your refusal.
- To be given medical and nursing services without discrimination based upon age, race, color, religion, national origin, handicap, disability or source of payment.
- To have access to an interpreter whenever possible.
- To have access to all information contained in your medical record unless access is prohibited by law.
- To expect good management techniques to be implemented that consider effective use of your time and avoid unnecessary discomfort.
- To be able to examine and receive a detailed evaluation of your bill.
- To be informed at your request of your provider's credentials.
- Of an individual to exercise their rights without discrimination or reprisal.
- To voice grievances.
- Of an incompetent individual and their Power of Attorney.
- To receive care in a safe setting.
- To be free from abuse/harassment.

We recognize that you have a choice for healthcare services, and we are grateful that you have chosen us as your provider.

For more information or to report a problem, please contact Corporate Management at 240.629.3998, or State of Maryland DHMH, Office Healthcare Quality (www.dhmf.maryland.gov/ohcq) Spring Grove Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, MD 21228, OR call 1.800.492.6005 or <http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html>

Patient Name: _____ Patient Signature: _____ Date: _____

PATIENT RESPONSIBILITY STATEMENT

The patient has the responsibility to:

- Provide the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health.
- Participate in health care decisions and for the following the treatment plan outlined by the practitioner responsible for his/her care.
 - This includes following instructions of the physicians, nurses, and other health care personnel carrying out the plan of care and enforcing rules and regulations.
- For assuring that the financial obligations of his/her healthcare are fulfilled as promptly as possible, and in the case of financial difficulty, making all reasonable efforts to meet any agreed upon financial payment plan.
- Responsibility for his/her actions if he/she refuses treatment or is non-compliant in following a plan of treatment recommended by his/her physician.
- To know the rules and regulations of Orthopedic & Wellness affecting his care and conduct, and for following those Orthopedic & Wellness rules and regulations.
- For being considerate of the rights of other Orthopedic & Wellness patients and Orthopedic & Wellness personnel, and for assisting in the control of noise and the non-smoking policy of the Orthopedic & Wellness.
- For being respectful of the property of other persons and of Orthopedic & Wellness.
- To make known to his/her physician, attending nurse, or other health care personnel, any concerns or complaints he/she may have.
- To make sure he/she understands all information regarding the implications of his symptoms, his/her surgery or procedure (if applicable) and any risks related to having or declining such surgery or procedure, the expected outcomes of the plan of care outlined by this physician, and his responsibilities in regards to that plan of care.
- To be made aware of advanced directives, living wills and the limitations if any to comply with such request.
- To refuse any drug regimen he /she does not feel is necessary and assume the risks involved with such refusal.
- To change providers at any time or gather a second opinion from another provider.
- To provide urine sample for purposes of drug screening and adhere to the opioid agreement.
- To provide transport and a responsible caregiver after any procedure if directed to do so by the provider or physician.

We recognize that you have a choice for healthcare services, and we are grateful that you have chosen us as your provider.

For more information or to report a problem, please contact Corporate Management 240.629.3998, or State of Maryland DHMH, Office Healthcare Quality, Spring Grove Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, MD 21228, OR call 1.800.492.6005

Patient Name: _____ **Patient Signature:** _____ **Date:** _____

OFFICE POLICIES

CONSENT AND INSURANCE AUTHORIZATION FOR TREATMENT AND BILLING

Patient Name: _____ **DOB:** _____ **Date:** _____

BILLING NOTICE

I hereby authorize the Physicians at ORTHOPEDIC & WELLNESS and Advanced Anesthesiology Associates, to provide medical treatment, release information pertaining to treatment deemed necessary by my insurance companies, attorney or referring Physician, and to receive direct payments for professional treatment otherwise payable to me for service rendered. My insurance carrier or I may revoke this authorization at any time in writing. **Initial:** _____

Confession of Judgment: I hereby acknowledge and agree that I am responsible for any portion of this claim that for any reason is not covered by my insurance. In the event that my account is past due more than sixty (60) days, I understand that ORTHOPEDIC & WELLNESS will exercise its rights and remedies under the law to enforce such payment, including, but not limited to, institution of legal proceedings against me to recover the above amount. I irrevocably authorize any attorney to appear in any court of competent jurisdiction and confess a judgment without process in favor of the creditor for such amount as may then appear unpaid hereon, and consent to immediate execution upon such judgment. I understand and agree that I will be responsible for all costs incurred by ORTHOPEDIC & WELLNESS to enforce such payment, including attorneys' fees. **Initial:** _____

For Worker's Compensation Cases: It is your responsibility to make sure that your accident insurance company has authorized your procedure. If your insurance company does not pay for the visit, you will be held accountable for the entire charge. **Initial:** _____

Waiver: If I am a member of a HMO insurance and the Physicians at ORTHOPEDIC & WELLNESS, are not participating members or I choose to be treated without a referral or authorization, I acknowledge that I am fully responsible for any and all charges incurred as a result of my decision to be treated by ORTHOPEDIC & WELLNESS. I understand and agree that I am financially responsible to ORTHOPEDIC & WELLNESS for co-pays, deductibles and non-covered items as outlined in my insurance policy contract. I hereby certify that the information above is correct. **Initial:** _____

For Health Insurance Cases: It is your responsibility to adhere to all of the regulations and requirements of your health plan, in or out of network. If your health insurance plan requires you to obtain a written referral and/or authorization number from your Primary Care Physician for your office visit or procedure, you must supply us with the referral/auth number. If you do not, you will be responsible for the entire charge for that date of service. This is a rule of the Health Plan that you selected. **Initial:** _____

Statements that you are expected to receive: Be advised that ORTHOPEDIC & WELLNESS, Advanced Anesthesiology Associates, and our associated ambulatory surgery centers function under different Tax ID numbers and therefore insurance participation may vary. Depending on the location of your choice, surgeries, procedures, and injections may take place under APSC, ASSC, FMH (Frederick Memorial Hospital), Adventist Hospitals and you should expect a separate statement from that facility. **Initial:** _____

OWNERSHIP NOTICE

ORTHOPEDIC & WELLNESS and Advanced Anesthesiology Associates are health care facilities owned by Dr. Malik. Pursuant to federal and state regulations, the above Physician hereby notifies you that he maintains ownership and financial interest in ORTHOPEDIC & WELLNESS and Advanced Anesthesiology Associates. You have the option to seek treatment at a health care service provider of your own choice. **Initial:** _____

ACKNOWLEDGEMENT OF OWNERSHIP

I acknowledge that I am aware of the ownership and financial interest held by Dr. Malik in ORTHOPEDIC & WELLNESS, and further, I am aware that I may request that my treatments be performed elsewhere. It is my choice to be treated at ORTHOPEDIC & WELLNESS. **Initial:** _____

CRISP NOTICE

We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may “opt-out” and disable all access to your health information available through CRISP by calling 1.877.952.7477 or completing and submitting on Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. **Initial:** _____

MISSED/LATE ARRIVAL APPOINTMENT POLICY

All patients are required to give a **24 hour notice if unable to keep a scheduled appointment**. A **\$35.00 fee** will be collected for any non-compliance with our policy. Repeated late cancellations and/or missed appointments will result in the discontinuation of your treatment with ORTHOPEDIC & WELLNESS. At ORTHOPEDIC & WELLNESS, we value your time and in turn, we strive to maintain a time-conscious schedule. Our Physicians and Staff work together to keep the schedule on time. We ask that our patients help us by arriving at least 30 minutes early for each appointment in order to be ready to be seen at their scheduled appointment time. Our Physicians are rotationally “on call” which can sometimes impinge the promptness of an appointment; we apologize for any inconvenience but ask for your support and understanding. If a patient arrives after their scheduled appointment time, ORTHOPEDIC & WELLNESS has the right to ask that patient to reschedule their appointment if there is no available time for the patient to be seen. **Initial:** _____

INSURANCE, BILLING AND PRIVACY NOTICE ACKNOWLEDGEMENT

I have received and read the above information in this packet, which includes the company’s referral policy, the billing information, and the Notice of Privacy Practices. I have read and acknowledge the policies of ORTHOPEDIC & WELLNESS, as stated above. I understand failure to comply with these policies may result in the discontinuation of my treatment with the said facilities.

Patient Signature: _____ **Date:** _____

Guardian/Power of Attorney: _____ **Date:** _____

ADVANCE DIRECTIVES NOTICE

At your request, we can make available an Advance Medical Directives formulary for you to read, fill out, and sign at your discretion. Maryland law recognizes as valid “living wills” and advance medical directives allowing you to decide under certain circumstances, in advance, that in the event of an unexpected medical crisis such as cardiac or respiratory arrest, no attempt should be made to resuscitate you, and all life sustaining procedures should be withheld from you. Also, in the event that you are incapacitated and unable to make such a decision on your own behalf, medical decisions, including the decision to withhold or withdraw life support, may, under the same circumstances, be made for you by a “health care agent” previously designated by you, or by a “surrogate” decision maker, such as your adult child, parent or spouse. Because of the nature of our facilities, and recognizing that surgical services provided in these facilities are elective, we are unable to honor “do not resuscitate” orders or similar advance medical directives. In the event of a sudden life-threatening medical situation, we will immediately begin the administration of life-sustaining procedures, and transfer you to the nearest hospital as soon as possible.

- I am aware of Advance Directives and do not require one now. **Initial:** _____
- I am aware that Advance Directives will be available for me to fill out whenever I request them. **Initial:** _____

Patient Name: _____ **Patient Signature:** _____ **Date:** _____

Guardian/Power of Attorney: _____ **Date:** _____

AUTHORIZATION TO DISCUSS INFORMATION WITH DESIGNATED PERSON

It is often difficult to reach a patient to discuss appointments, medications and other information pertinent to our patient's care. In this event with your signed authorization, we would discuss such information to a person you designate. Please complete the section below:

I, hereby, authorize ORTHOPEDIC & WELLNESS to discuss any information required in the course of my examination or treatment (when I cannot be reached by phone) to the following designated person(s):

Name of Designee (1): _____

Relationship to Patient: _____

Name of Designee (2): _____

Relationship to Patient: _____

No Designee

When a designee is not on file, family members, spouses or friends are not permitted to make or change a patient's appointment time.

I agree to all of the above.

Patient Name (PRINT)

Patient or Legal Guardian Signature

Date

This form shall expire one year from date of signature.

PATIENT OPIOID AGREEMENT

Patient Name: _____ Date: _____

PLEASE INITIAL ALL STATEMENTS - Failure to comply with these guidelines will result in termination of treatment and your prescriptions will be revoked.

- _____ You agree not to ask or to receive pain medication from any other Physician. Refusal to comply with this will result in discharge from ORTHOPEDIC & WELLNESS. Only your pain doctor will prescribe opioid medications for you.
- _____ You agree to keep all scheduled appointments, not just with your Physician, but also with recommended therapists and psychological counselors.
- _____ All patients receiving controlled substances must have a Primary Care Physician to attend to other medical needs that will arise. The Physicians at ORTHOPEDIC & WELLNESS will not assume the role of PCP.
- _____ You agree to random urine screening. Any patient who refuses testing will not receive treatment and be discharged. Positive tests for any illegal substances, or opioids not prescribed by your pain doctor, will result in your discontinuing opioids and referral elsewhere for substance abuse evaluation and management.
- _____ All prescriptions are written for a 30 day supply. No prescriptions will be refilled early. You will follow up every 30 days for evaluation by your Pain Physician while being prescribed opioids. Prescriptions will not be written greater than 7 days in advance.
- _____ Prescriptions for controlled substances are issued only during appointments. They will not be mailed or left for patients to pick up or called in to your pharmacy.
- _____ Refills for non-narcotic medications are allowed, but can only be done or authorized during office hours with approval of your Pain Physician.
- _____ You will only use one pharmacy for refilling opioids. Should the need arise to change pharmacies, our office must be notified.
- _____ No prescriptions will be refilled if you lose, destroy, or have any of your medication stolen. You agree to keep all opioid medications locked up and in a safe place. A written explanation is required for all thefts and lost medications, plus a police report for all thefts.
- _____ No medication adjustments are permitted without prior approval from your Pain Physician. Development of another painful condition does not justify increased use of your medication without permission from ORTHOPEDIC & WELLNESS. Controlled substances will NOT be refilled early due to misuse.
- _____ You agree not to share or sell your medications. You acknowledge that we will contact Drug Enforcement Agency and/or the Police if you violate the Federal Law regarding opioid medications.
- _____ You agree to comply fully with all aspects of your treatment program including behavioral medicine (psychology/psychiatry) and physical therapy, if recommended. Failure to do so may lead to discontinuation of your medication and referral to another provider or treatment center.
- _____ Successful pain management entails employing multiple interventions, including active participation in regular physical exercise, appropriate procedures, other treatment options and the use of psychological coping strategies. A pattern of passive reliance on medications, resistance to more active physical treatments, and repeated failure to demonstrate the implementation of psychologically based coping strategies that have been taught to you may lead to discontinuation of medications and/or referral to another provider or treatment center.
- _____ Disruptive, threatening or violent behavior, and persistent noncompliance with the prescribed pain treatment plan will lead to patient dismissal from our practice.

We understand that emergencies can occur and under some circumstances, exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.

ACKNOWLEDGEMENT OF OPIOID WARNINGS AND SIDE EFFECTS

Opioids may cause drowsiness that can be worsened with alcohol, benzodiazepines, and other sedating medications. We absolutely do not recommend driving an automobile or operating machinery while taking any opioid medication because they may alter judgment resulting in serious injury or death to you or anyone involved in an accident with you. Furthermore, an overdose caused by opioids can cause severe side effects, such as respirator depression and even death. Opioids can alter hormonal levels leading to impotence, changes in personality and behavior, lowering of bone strength and increase tooth decay. Other common, usually temporary, side effects include nausea, itching, and sweating. Psychological depression and lowered testosterone levels may also occur. Sleep apnea, if present, may be worsened by opioids. Constipation commonly occurs, and often does not improve with time. It is impossible to predict opioid side effects in any individual patient. Having side effects on one opioid does not necessarily mean there will be side effects on another opioid.

You must take opioids only as directed. Federal law prohibits giving this medication to anyone else. Physical dependence will develop with regular use, but does not by itself indicate addiction; this means that a withdrawal syndrome will develop if you stop your medication abruptly. Tolerance may develop to the pain relieving effects of opioids; this means that the pain relief may decrease over time, but in chronic pain states this usually occurs slowly, if at all. Not all pain conditions respond to opioids. Some pain may only be partially responsive to opioid therapy. Total elimination of pain is an unrealistic goal. Escalating dosages may indicate that opioids are not effective or that there is an underlying problem with addiction or psychological dependence. Discontinuation of opioid medications may need to be done under these circumstances: not enough pain relief, persistent side effects, not achieving goals of opioid treatment (such as improvement in function), problematic dose escalation, or inability to comply with the treatment agreement.

I, the undersigned, agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. I give permission to my pain doctor to contact any of my other healthcare providers, for the purposes of sharing information concerning my situation, as is deemed necessary for coordinated, high quality care. If I do not follow these guidelines fully, my doctor may taper and stop opioid treatment and refer me elsewhere for care.

A copy of this document has been given to me.

Patient Name: _____ **Patient Signature:** _____ **Date:** _____

Physician Name: _____ **Physician Signature:** _____ **Date:** _____

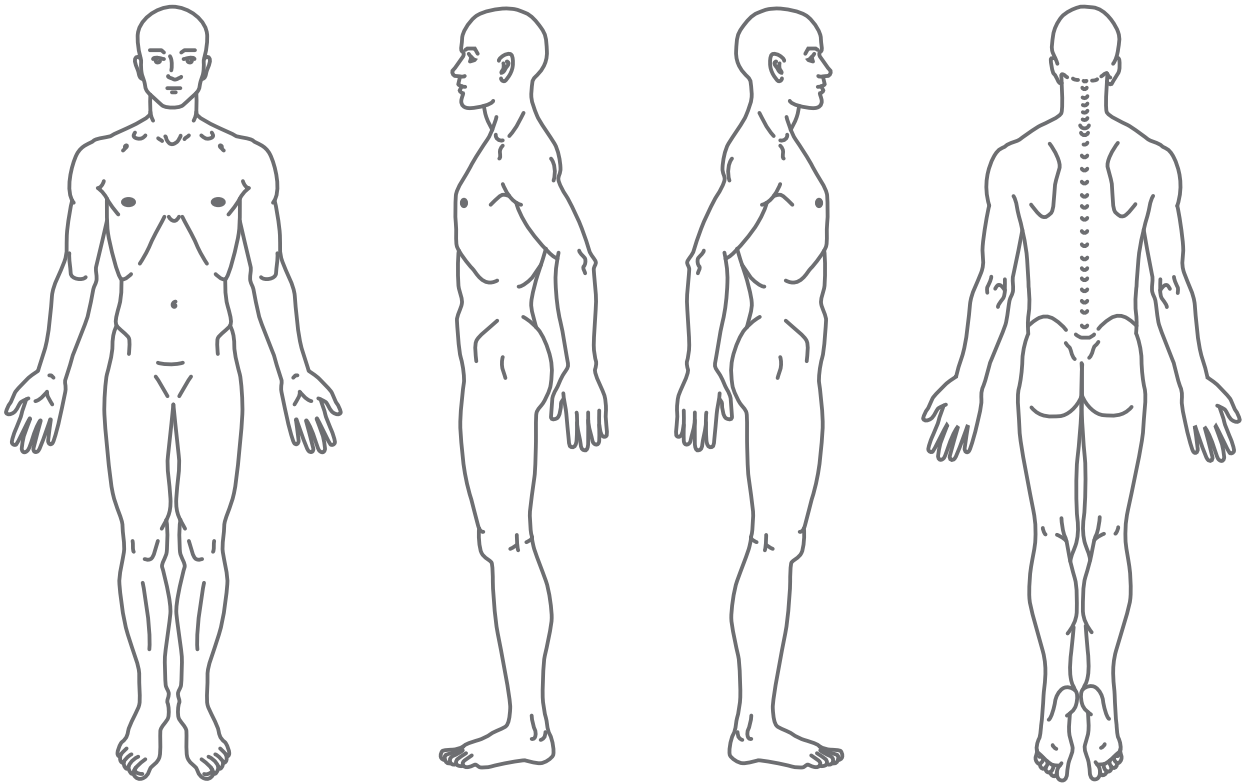
PHARMACY AND PCP INFORMATION MUST BE COMPLETED.

_____ NAME OF PHARMACY	_____ NAME OF PRIMARY CARE PHYSICIAN
_____ ADDRESS	_____ ADDRESS
_____ PHONE NUMBER	_____ PHONE NUMBER

HISTORY AND PHYSICAL

Patient Name: _____ **DOB:** _____ **Date:** _____

Please mark the area(s) in which your pain is located:



About Your Pain

Pain Location #1 (Refer to one pain location in this section, use page 2 if you have another pain issue):

Location of pain: _____ When did your pain begin? _____

What was the injury or the cause of the pain? _____

How often do you experience this pain? (Circle one) **Constantly** **Frequently** **Occasionally** **Rarely**

Check off your current pain intensity with "1" representing no pain and "10" representing the most severe pain.

What is your pain score right now? 1 2 3 4 5 6 7 8 9 10

What is your usual pain score? 1 2 3 4 5 6 7 8 9 10

What is your pain score during a flare-up? 1 2 3 4 5 6 7 8 9 10

FOR STAFF ONLY

Wt: _____ **Ht:** _____ **Temp(F):** _____ **BP:** _____ / _____ **Pulse:** _____ **RR:** _____ **SatO2:** _____ %

Patient Name: _____ **DOB:** _____

Please check the one(s) that apply to Pain #1:

Location of Pain	Radiation of Pain	Quality	Aggravated by	Relieved by
<input type="checkbox"/> Upper Back <input type="checkbox"/> Mid Back <input type="checkbox"/> Lower Back <input type="checkbox"/> Gluteal Area <input type="checkbox"/> Left Flank <input type="checkbox"/> Right Flank <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Neck <input type="checkbox"/> Thighs	<input type="checkbox"/> Back <input type="checkbox"/> None <input type="checkbox"/> Left Ankle <input type="checkbox"/> Right Ankle <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Calf <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Thigh	<input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Deep <input type="checkbox"/> Diffuse <input type="checkbox"/> Discomforting <input type="checkbox"/> Dull <input type="checkbox"/> Localized <input type="checkbox"/> Numbness <input type="checkbox"/> Piercing <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting <input type="checkbox"/> Stabbing <input type="checkbox"/> Superficial <input type="checkbox"/> Throbbing <input type="checkbox"/> Other: _____	<input type="checkbox"/> Nothing <input type="checkbox"/> Ascending Stairs <input type="checkbox"/> Bending <input type="checkbox"/> Changing Positions <input type="checkbox"/> Coughing <input type="checkbox"/> Daily Activities <input type="checkbox"/> Descending Stairs <input type="checkbox"/> Extension <input type="checkbox"/> Flexion <input type="checkbox"/> Jumping <input type="checkbox"/> Lifting <input type="checkbox"/> Lying/Rest <input type="checkbox"/> Rolling over in bed <input type="checkbox"/> Pushing <input type="checkbox"/> Running <input type="checkbox"/> Sitting <input type="checkbox"/> Sneezing <input type="checkbox"/> Standing <input type="checkbox"/> Twisting <input type="checkbox"/> Walking	<input type="checkbox"/> Nothing <input type="checkbox"/> Exercise <input type="checkbox"/> Heat <input type="checkbox"/> Ice <input type="checkbox"/> Lying Down <input type="checkbox"/> Injections <input type="checkbox"/> Massage <input type="checkbox"/> Movement <input type="checkbox"/> OTC Medication <input type="checkbox"/> Pain Medication <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Spontaneously <input type="checkbox"/> Stretching <input type="checkbox"/> Rest <input type="checkbox"/> Sitting

Pain Location #2 (If Not Applicable, then skip to next page):

Location of pain: _____ When did your pain begin? _____

What was the injury or the cause of the pain? _____

How often do you experience this pain? (Circle one) **Constantly** **Frequently** **Occasionally** **Rarely**

Check off your current pain intensity with "1" representing no pain and "10" representing the most severe pain

What is your pain score right now? 1 2 3 4 5 6 7 8 9 10

What is your usual pain score? 1 2 3 4 5 6 7 8 9 10

What is your pain score during a flare-up? 1 2 3 4 5 6 7 8 9 10

Please check the one(s) that apply to Pain #2:

Location of Pain	Radiation of Pain	Quality	Aggravated by	Relieved by
<input type="checkbox"/> Upper Back <input type="checkbox"/> Mid Back <input type="checkbox"/> Lower Back <input type="checkbox"/> Gluteal Area <input type="checkbox"/> Left Flank <input type="checkbox"/> Right Flank <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Neck <input type="checkbox"/> Thighs	<input type="checkbox"/> Back <input type="checkbox"/> None <input type="checkbox"/> Left Ankle <input type="checkbox"/> Right Ankle <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Calf <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Thigh	<input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Deep <input type="checkbox"/> Diffuse <input type="checkbox"/> Discomforting <input type="checkbox"/> Dull <input type="checkbox"/> Localized <input type="checkbox"/> Numbness <input type="checkbox"/> Piercing <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting <input type="checkbox"/> Stabbing <input type="checkbox"/> Superficial <input type="checkbox"/> Throbbing <input type="checkbox"/> Other: _____	<input type="checkbox"/> Nothing <input type="checkbox"/> Ascending Stairs <input type="checkbox"/> Bending <input type="checkbox"/> Changing Positions <input type="checkbox"/> Coughing <input type="checkbox"/> Daily Activities <input type="checkbox"/> Descending Stairs <input type="checkbox"/> Extension <input type="checkbox"/> Flexion <input type="checkbox"/> Jumping <input type="checkbox"/> Lifting <input type="checkbox"/> Lying/rest <input type="checkbox"/> Rolling over in bed <input type="checkbox"/> Pushing <input type="checkbox"/> Running <input type="checkbox"/> Sitting <input type="checkbox"/> Sneezing <input type="checkbox"/> Standing <input type="checkbox"/> Twisting <input type="checkbox"/> Walking	<input type="checkbox"/> Nothing <input type="checkbox"/> Exercise <input type="checkbox"/> Heat <input type="checkbox"/> Ice <input type="checkbox"/> Lying Down <input type="checkbox"/> Injections <input type="checkbox"/> Massage <input type="checkbox"/> Movement <input type="checkbox"/> OTC Medication <input type="checkbox"/> Pain Medication <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Spontaneously <input type="checkbox"/> Stretching <input type="checkbox"/> Rest <input type="checkbox"/> Sitting

Patient Name: _____ DOB: _____

REVIEW OF SYSTEMS only check the one(s) that apply

CONSTITUTIONAL	YES	NO	GASTROINTESTINAL	YES	NO	METABOLIC/ENDOCRINE	YES	NO
Change in Appetite			Abdominal Mass			Abnormal Habitus		
Chills/Rigors			Abdominal Pain			Abnormal Hair		
Decreased Activity			Bloating			Distribution		
Decreased Appetite			Blood in Stool			Chronically Overweight		
Fatigue			Constipation			Chronically Underweight		
Fever			Decreased Appetite			Goiter		
Increased Appetite			Diarrhea			Gynecomastia		
Insomnia			Dysphagia			Heat intolerance		
Irritability			Fecal Incontinence			Hyperpigmentation		
Lethargy			Flatulence			Hypoglycemia		
Malaise			Heartburn			Infertility		
Night Sweats			Hemorrhoids			Insulin Reactions		
Pallor			Melana			Jaundice		
Weakness			Nausea			Polyphagia		
Weight Gain			Vomiting			Polyuria		
Weight Loss			Rectal Bleeding			Tremors		
CONSTITUTIONAL	YES	NO	Reflux			GENITOURINARY	YES	NO
Aphasia			Stomach Ulcer			Change In Urine Color		
Dizziness			DERMATOLOGIC	YES	NO	Cloudy Urine		
Dysarthria			Acne			Decreased Stream		
Focal Weakness			Contact Allergy			Decreased Urine Output		
Gait Disturbance			Excessive Diaphoresis			Dysuria		
Headache			Excessive Skin Infections			Flank Pain		
Incontinence			Frequent Skin Infections			Foul Urine Odor		
Incoordination			Hair Loss			Frequent Urination		
Loss of Consciousness			Hirsutism			Groin Mass		
Memory Impairment			Nail Changes			Hematuria		
Near Syncope			Photosensitivity			Hesitancy		
Paresthesias			Pigment Change			Nocturia		
Seizures			Pruritus			Passage Stone		
Speech Changes			Rash			Polyuria		
Tremors			Change in Mole			Suprapubic		
Vertigo			Skin Lesion			Urgency		
Visual Changes			Shingles			Urinary Incontinence		
CARDIOVASCULAR	YES	NO	RESPIRATORY	YES	NO	HEMATOLOGIC	YES	NO
Chest Pain			Accelerated Respirations			Cytopenias		
Dyspnea			Cough			Easy Bleeding		
Edema			Cyanosis			Easy Bruising		
Nocturia			Dyspnea			Lymphadenopathy		
Nocturnal Dyspnea			Hemoptysis			Petechiae		
Orthopnea			Painful Respiration			Thromboembolic Events		
Irregular Heartbeat			Snoring			Bleeding Diathesis Work Up Performed		
Syncope			Sputum			Hypercoagulability Work Up Performed		
IMMUNOLOGICAL	YES	NO	Stridor			MUSCULOSKELETAL	YES	NO
Hay Fever			Wheezing			Back Pain		
Urticaria/Hives			Frequent Upper			Bone /Joint Symptoms		
Angioneurotic Edema			Respiratory			Myalgias		
Animals at Home			Infection			Muscle Weakness		
Animals in Work Place			Known TB Exposure			Neck Stiffness		
Asthma			PSYCHIATRIC	YES	NO	Rheumatologic Manifestations		
"Bee" sting allergies			Difficulty Concentrating					
Chemicals at Home			Psychiatric Emotional					
Chemicals in Work Place								
Contact Dermatitis								
Food Allergies								

Patient Name: _____ **DOB:** _____

Past Medical History

Do you have any of the following conditions?

	YES	NO		YES	NO		YES	NO
Anemia			COPD			Migraine Headaches		
Angina			Coronary Artery Disease			Multiple Sclerosis		
Arrhythmia			Diabetes			Parkinson's Disorder		
Asthma			Fibromyalgia			Peripheral Nerve Disorder		
Atrial Fibrillation			Hepatitis C			Renal Disease		
Blood Clots			HIV/AIDS			Rheumatoid Arthritis		
Brain Tumor			Hyperlipidemia			Seizure Disorder		
Cerebrovascular Accident			Hypertension			Spinal Cord Tumor		
Cirrhosis			Kidney Failure			Thyroid Disease		
Colon Cancer			Liver Disease			Tremor		
Congestive Heart Failure			Lung Cancer			Stomach Ulcers		

Past Surgical History

SURGERY	YEAR

Family History

Diagnosis	Mother	Father	Other	Diagnosis	Mother	Father	Other
ADD/ADHD				Hearing Deficiency			
Alcoholism				Hyperlipidemia			
Allergies				Hypertension			
Alzheimer's Disease				Irritable Bowel Syndrome			
Asthma				Learning Disability			
Blood Disease				Mental Illness			
CAD				Migraines			
CAD - Premature				Obesity			
Cancer				Osteoporosis			
CVA (Stroke)				PVD			
Depression				Renal Disease			
Developmental Delay				Seizure Disorder			
Diabetes				Other: _____			
Eczema				Other: _____			

Patient Name: _____ **DOB:** _____

Social History

EMPLOYER NAME				
Phone				
Occupation				
Employment Status (Circle One)	FULL-TIME	PART-TIME	RETIRED	DISABLED
Last Day Of Work				

Marital Status (Circle one): Single Married Divorced Widowed Legally Separated

Hand Dominance (Circle one): Right Left Ambidextrous

Activity Level (Circle one): Sedentary Moderate Vigorous

Have you ever filed any legal claims related to your pain problem? No Yes (please explain): _____

Have you ever had psychiatric, psychological, or social work evaluations or treatment for any problem, including your current pain? No Yes (please explain): _____

Are you suffering from or do you have a history of alcoholism? No Yes

Do you or did you ever smoke cigarettes or use tobacco? No Yes

Have you had any change in sleep patterns? No Yes (please explain): _____

Current Medications

List all your medications, dosages, how often you take them every day, and name of prescribing Physician.

	NAME	DOSAGE	DIRECTION	PRESCRIBING PHYSICIAN
1				
2				
3				
4				
5				
6				
7				
8				

Are you taking any blood thinners? No Yes

Drug Allergies

	MEDICATION NAME	REACTION
1		
2		
3		

Patient Name: _____ **DOB:** _____

Do you have any symptom such as red itchy eyes, general itching, shortness of breath, wheezing, fast heartbeat, feeling faint, nausea, or vomiting when exposed to the following?

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Dye | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Rubber (band-aids, tape, spandex, balloons) |
| <input type="checkbox"/> Shellfish | <input type="checkbox"/> Strawberries, Kiwis, Chestnuts. |
| <input type="checkbox"/> Foods: _____ | <input type="checkbox"/> No Known Allergies |

Please list any previously taken pain medications that you stopped taking and the reason for stopping:
