VIP Valor Interventional Pain

NEW PATIENT INFORMATION FORM

Last Name: _____ **First Name**: _____ MI: _____

Date of Birth: _____ SSN: _____ Gender: Male ☐ Female ☐ Other ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Race: _____

Address: _____ Cell Phone: _____

City/State: _____ Zip Code: _____ Home Phone: _____

Email: _____ Work Phone: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referring Physician: _____ Primary Care Physician: _____

Spouse's Name (if applicable): _____ Date of Birth: _____

Spouse's Employer: _____ Employer Phone: _____

Insurance Information

_____ _____

Primary Insurance Carrier — Subscriber Name / DOB / SSN

_____ _____

Insurance ID# — Insurance Group#

_____ _____

Secondary Insurance Carrier — Subscriber Name / DOB / SSN

_____ _____

Insurance ID# — Insurance Group#

*Note: We will bill your secondary insurance as a courtesy. If claims are not paid within 60 days, the balance will be transferred to the patient's responsibility.

Name, contact information, and/or address of **pharmacy**:

_____

_____

_____

If you have been involved in an accident and it is under an open personal injury case, please list attorney and/or law firm:

_____

- Date of injury/accident: _____

My signature below indicates that I have been given the chance to read and review the following and understand and agree to their terms:

*Financial Policy, Consent for Treatment, and Release of Medical Information Form

*Notice of Privacy Practices at my discretion (located in the front waiting room)

I agree that the information documented on this form is true and I authorize this information to be used to obtain financial reimbursement. Additionally, I authorize my attending physician to administer treatment and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to my attending physician. In the event my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. This authorization is to remain in full force unless I revoke the same in writing.

Patient's Signature: _____ Date: _____

Policy, Consent for Treatment, Release of Medical Information

Thank you for trusting us with your healthcare.

PLEASE READ CAREFULLY

You and your insurance carrier are responsible for your bill.
Knowing your insurance benefits plan is your responsibility.

If you have medical insurance, we are grateful to assist you in receiving your maximum allowable benefits. In order to achieve these goals, we need your support and understanding of our financial policy.

- Insurance information must be presented and updated at the time of making your appointment, not at the time of service. Most insurance companies have requirements for authorization of services and/or referrals from the Primary Care Physician prior to the services. If you present for your appointment and you have not provided your correct insurance to ensure verification, authorization of services, and all required referrals, you will not be seen, and your appointment will be rescheduled.

- _____ (initial) **Payment in full for non-insurance services is expected at the time of service. Co-payments for services are required at the time of registration. Please be advised that we are contractually obligated by your insurance carrier to collect your co-payment at the time of service. If you arrive without the ability to pay for your services or your co-pay you will not be seen, and your visit will be rescheduled.**

- If you have insurance, as a courtesy to you, we will file your primary and secondary insurance claim for services at no cost to you. However, we will not wait more than 45 days for the insurance to pay. After 45 days it is your responsibility to contact your insurance company and follow up on why your claim has not been paid. You must take the necessary action required to get your claim paid and communicate your actions to our office. Failure to assist our office in timely payment of your insurance claim will result in the total charges being transferred to patient liability. Any patient liability assigned to you by your insurance carrier will be billed to you. Once insurance has paid, payment in full of the patient assigned liability will be expected with the receipt of your statement. You will receive two billing statements regarding your balance. If we do not hear from you after these two statements, your account will be subject to our collection process unless prior arrangements are made with our financial office.

- _____ (initial) We are committed to providing the highest quality care for our patients and we charge what is usual and customary for our area. You are ultimately responsible for all clinic and surgery fees relating to your care. **You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates.** Your insurance policy is a contract between you and your insurance company. Any disagreement you have concerning the amount your insurance pays should be directed to your insurance company.

- _____ (initial) For services that are not covered by insurance, the practice requires payment of 100% of the total estimated charges unless prior payment arrangements have been set up with our office.

- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. Your policy may also contain plan specific limitations that apply to referrals, referral dates, and number of visits. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our

findings. However, this does not guarantee payment from your insurance carrier. The contract of coverage is between you and your insurance carrier, and it is your responsibility to understand your coverage, coverage requirements and limitations due to the variations between policies. You will be expected to pay for the patient liability assigned to you by your insurance carrier.

- **Insured individuals electing to be self-pay.** The patient has the right to elect not to file their health insurance and elect to be a self-pay patient for services provided. The patient will be financially responsible for charges incurred and payment will be due at the time of service. After services have been rendered, the patient will not be able to file their health insurance for the services due to insurance claim submission requirements. We will not file insurance for any services where the patient elected to be self-pay. The patient's election to not file the services to their insurance company does not affect or reduce any out of pocket financial responsibility for future services as determined by their insurance plan.

- _____ (initial) **If you do not have insurance coverage for the service, are self-pay, or have insurance that we do not participate in or accept,** payment is expected at the time of service. We have established a discounted self-pay rate for our services. Prior financial arrangements must be made and approved before your visit if you cannot pay 100% at the time of service. No discount of assigned insurance patient liability (co-pay, deductibles, co-insurance) will be made to comply with federal insurance regulations and law.

- _____ (initial) **If you accept Durable Medical Equipment (DME) at your visit it is non-refundable once it leaves our facility.**

If financial arrangements have not been made and you arrive without the ability to pay for the services, you will not be seen, and your visit will be rescheduled.

- _____ (initial) Out of Network Insurance – Some insurance plans require you to pay different out-of-pocket amounts based on the provider and/or location where the service is performed. Deductibles, co-payments and co-insurance may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. It is your responsibility to inquire about any plan specific coverage limitations with your insurance company. You can choose to have the services performed as "Out of Network" or as self-pay.

- _____ (initial) Insurance information provided after the services have been provided will be billed or not billed at our discretion. Due to the Insurance contractual requirements for referrals, authorization of services and timely filing limitations insurance must be presented prior to services being provided. If we agree to bill your insurance you will be held liable for the charges if the insurance denies your claim ultimately because of late presentation of coverage or for lack of timely authorization or referrals.

- In the event your account(s) must be turned over for outside collections, you will be billed and are responsible for all fees involved in the collection process. Returned checks are subject to a handling fee of $30.00.

In the event you have an account with a credit balance, we reserve the right to transfer credits to any other outstanding account balances prior to issuing a refund.

- Patients with a history of presenting for their appointment without the ability to pay their co-pay, short notice (less than 24 hours) cancelling of appointment or not showing up for their appointments will be subject to be reviewed for dismissal from our practice.

- If approved by a provider to be competed, there is a charge of $25.00 per page to complete FMLA paperwork, forms for disability claims, accident or injury claims, attorney verification of medical condition or any other non-medical services reimbursement paperwork. Payment must be made at the time the forms are complete. Some third-party forms requests must be paid for prior to the forms being completed.

- Patients who do not show up to or attend a scheduled appointment without a 24-hour notice of cancelation will be charged a $30.00 no show fee.

- We do not tolerate aberrant or disrespectful behavior towards practice personnel. If we deem it necessary, patients, family members, and/or associated person(s) will be asked to leave the premises and discharged from the practice if they display any aberrant or disrespectful behavior towards the staff.

We realize that temporary financial problems do occur. If such problems do arise, we encourage you to contact us promptly for assistance. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us.

<u>Authorization:</u> I hereby authorize my attending physician to administer treatment, diagnostic testing and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to my attending physician. In the event my insurance makes payment directly to me for services I will immediately endorse and assign the payment to my attending physician. If my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. I give my attending physician permission to appeal any denials by my insurance for services rendered on my behalf. I will assist my attending physician with follow up of timely payment, request for information and appeals to my insurance company as necessary to ensure full and timely payment for services received.

I have read Financial Policy, Consent for Treatment, Release of Medical Information, policies and understand and agree to its terms. This authorization is to remain in full force unless I revoke the same in writing.

_____ _____

(Patient/Responsible Party) Signature (Patient/Responsible Party) Printed Name

_____ _____

(Date) Time

Bradley Keneson II, D.O.

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: Texas Administrative Code, Title22, Part 9, Chapter 170
3rd Edition: Developed by the Texas Pain Society, April 2008 (www.texaspain.org)

NAME OF PATIENT: _____ DATE: _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risk and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff and other health care providers as might be necessary or advisable to treat my condition. _____ **(initial)**

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at top of agreement) to treat my condition, which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that the medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s). _____ **(initial)**

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random and unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the test or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care. _____(initial)

I understand it can take up to 48 hours for my medications to be prescribed and sent to the pharmacy I prefer. If the pharmacy my medications are sent to does not have my medication in stock it is my responsibility to find a pharmacy of my choice that does have the medication in stock and let the physician know where I would prefer my medication prescriptions be sent to.

_____(initial)

For female patients only:
To the best of my knowledge **I am NOT pregnant**.
If I am not pregnant, I will use appropriate contraceptive/birth control during my course of treatment. I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant. **If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.**

All of the above possible side effects of medication(s) have been fully explained to me and I understand that, at present there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/fetus/baby. _____ **(initial)**

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING:
Constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension (low blood pressure), arrhythmias (irregular heartbeat), insomnia, depression, impairment of reasoning or judgement, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.
The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain. _____**(initial)**

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent. _____**(initial)**

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING: That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued**.
- I will **disclose** to my physician **all my medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician**.
- I agree not to share, sell, or otherwise permit others, including my family and friends, to have access to these medications.
- I will **not allow or assist in the misuse/diversion of my medication; nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist with a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. **If either are lost or stolen, they may NOT BE REPLACED**.
- Refill(s) **will not be ordered before the scheduled refill date.** However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my physician.
- Information that I have been receiving medication(s) prescribed by other physicians that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s).** I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- **I agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc., I also recognize that my **active participation** in the management of my pain is extremely important. I agree to **actively participate in all the aspects of the pain management program** recommended by my physician to achieve increased function and improve quality of life.
- I agree that **I shall inform any physician** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician **permission** to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician**. Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

_____**(initial)**

I certify and agree to the following:

1. I am **not currently using illegal drugs or abusing prescription medication(s)** and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgement.
2. I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, anticonvulsants, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.).
3. **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.
4. I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

_____ _____

Patient Signature Date and Time

Patient Privacy Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Valor Interventional Pain, LLC to use and disclose my protected health information to carry out:

- Treatment (including direct and/or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review a copy of your *Notice of Privacy Practices* (hanging in front waiting room/entrance), which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this is not affected.

☐ - I give permission for documents pertaining to my health to be emailed.

Today's Date and Time Signed: _____

Print Name: _____

Signature: _____

Relationship to Patient (if not signed by the patient): _____

If we need to contact you and are unable to reach you for any reason to disclose information or ask questions about your health, please list the contacts you give us permission to speak to about this information.

Name: _____ Relationship: _____ Phone: _____

Restrictions (if applicable): _____

Name: _____ Relationship: _____ Phone: _____

Restrictions (if applicable): _____

Name: _____ Relationship: _____ Phone: _____

Restrictions (if applicable): _____

VIP Valor Interventional Pain

This box is for office use only:
HT:
WT:
BP:
HR:

Patient Name: _____

Primary Care Physician: _____

PAIN DESCRIPTION

Where does it hurt the worst? _____

Does the pain radiate or move? ☐No ☐Yes: where? _____

Approximately when did this pain begin? _____

What do you think caused it? _____

What makes the pain better? _____

What makes the pain worse? _____

What word best describes the frequency of your pain? ☐Constant ☐Intermittent

When is your pain at its worst? ☐Morning ☐Day ☐Evenings ☐Middle of night

PAIN SCALE

0 ←-----1-----2-----3-----4-----5-----6-----7-----8-----9-----→ 10

0 = Pain free
1 = Very minor annoyance, occasional minor twinges
2 = Minor annoyance, occasional strong twinges
3 = Annoying enough to be distracting
4 = Can be ignored if you are really involved in your work/task, but still distracting
5 = Cannot be ignored for more than 30 minutes
6 = Cannot be ignored for any length of time, but can still go to work and participate in social activities
7 = Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 = Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain
9 = Unable to speak, crying out or moaning uncontrollably, near delirium
10 = Unconscious, pain makes you pass out

What number on the pain scale (0-10) best describes your pain right now? _____

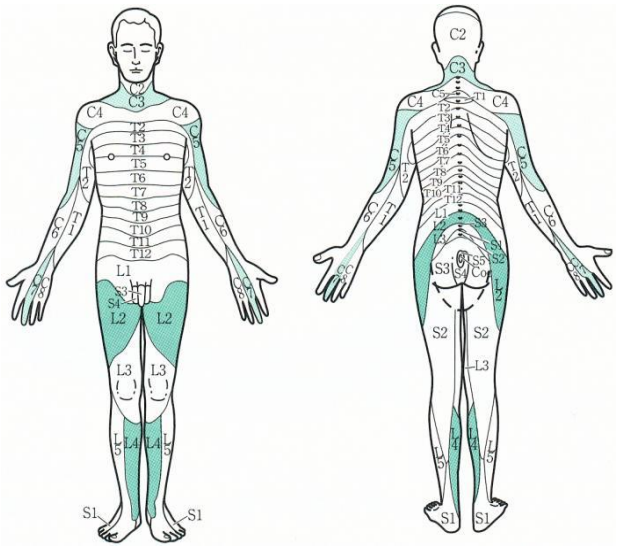
What number on the pain scale (0-10) best describes your worst pain? _____

What number on the pain scale (0-10) best describes your least pain? _____

What number on the pain scale (0-10) best describes your average pain over the last month? _____

VIP Valor Interventional Pain

Use the diagram below to indicate the location of your pain.



Check all the following that describes your pain.

☐Aching ☐Cramping ☐Dull ☐Hot/Burning ☐Numbness

☐Shock-like ☐Shooting ☐Spasm ☐Squeezing ☐Stabbing/Sharp

☐Throbbing ☐Tingling/Pins & Needles ☐Tiring/Exhausting

Mark all the following activities that are adversely/negatively affected by pain

☐Enjoyment of life ☐Normal work ☐Sleep ☐General activity ☐Recreational activity ☐Mood ☐Walking ☐Relationships with people ☐Other _____

☐My goal is to resume normal activities

In the past three months have you developed any new…

☐Balance Problems ☐Difficulty walking ☐Bladder incontinence ☐Bowel incontinence ☐Chills ☐Fevers ☐Nausea ☐Vomiting

☐Numbness/Tingling – Where? _____

☐Weakness – Where? _____

DIAGNOSTIC TEST/ IMAGING

☐MRI of the _____ Date/Location_____

☐X-Ray of the _____Date/Location_____

☐CT SCAN of the _____Date/Location_____

☐EMG/NCV of the _____Date/Location_____

☐OTHER: _____

☐ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

PAIN TREATMENT HISTORY

☐ Chiropractic If yes, how long? _____ ☐ Physical Therapy If yes, for how long? _____
☐ Epidural Steroid injections – Cervical / Thoracic / Lumbar ☐ Medial Branch Blocks / Facet injections – Cervical / Thoracic / Lumbar
☐ Joint injection – Joint(s) _____
☐ Nerve Blocks – Area/Nerve(s) _____
☐ Radiofrequency Ablation – Cervical / Thoracic / Lumbar ☐ Spinal Column Stimulator – Trial / Permanent implant
☐ Spine Surgery Level(s) _____ ☐ Vertebroplasty / Kyphoplasty – Level(s) _____

☐ Trigger Point injections – Where? _____
☐ Other Pain Procedures: _____
☐ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS

MEDICATIONS:

Please indicate which (if any) of the following **BLOOD THINNERS** you are taking?

☐Aggrenox ☐Coumadin ☐Effient ☐Eliquis ☐Lovenox ☐Plavix ☐Pletal ☐Pradaxa ☐Xarelto ☐Warfarin

Other: _____

Please list ALL the medications you are currently taking. Attach an additional sheet, if necessary.

Medication Name, Dose, Frequency

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY

Mark the following conditions/diseases you have been treated for in the past

GENERAL MEDICAL	GASTROINTESTINAL	LIVER
☐Cancer – type:	☐Bowel Incontinence	☐Hepatitis A (Active, Inactive, Unsure)
☐Diabetes – type:	☐Acid Reflux (GERD)	☐Hepatitis B (Active, Inactive, Unsure)
☐HIV / AIDS	☐Gastrointestinal bleeding	☐Hepatitis C (Active, Inactive, Unsure)

☐Glaucoma ☐Hyperthyroidism	☐Bladder infection ☐Kidney Stone
☐Headaches ☐Hypothyroidism	☐Urinary Incontinence ☐Dialysis
☐Head Injury ☐Migraines	☐Kidney infection ☐Constipation

CARDIOVASCULAR	HEMATOLOGIC
☐Anemia	☐Mitral Valve Prolapse
☐Bleeding Disorder	☐Murmur
☐Coronary Artery Disease	☐Pacemaker/Defibrillator
☐Heart Attack ☐Stroke	☐Phlebitis
☐High Blood Pressure ☐High Cholesterol	☐Poor Circulation

NEUROPSYCHOLOGICAL		
☐ Alcohol Abuse	☐ Schizophrenia	☐ Multiple Sclerosis
☐ Alzheimer Disease ☐ Seizures	☐ Epilepsy	☐ Paralysis
☐ Bipolar	☐ Depression	☐ Peripheral Neuropathy
☐ Complex Regional Pain Syndrome		☐ Prescription Drug Abuse

MUSCULOSKELETAL	
☐ Amputation ☐ Phantom Limb Pain	☐ Osteoarthritis
☐ Bursitis	☐ Osteoporosis
☐ Carpal Tunnel Syndrome	☐ Fibromyalgia
☐ Vertebral Compression Fracture	☐ Rheumatoid Arthritis / Lupus

RESPIRATORY	
☐Asthma	☐Bronchitis
☐Emphysema / COPD	☐Pneumonia
☐Tuberculosis	☐Sleep Apnea

OTHER MEDICAL CONDITIONS:

_____

_____

_____

ALLERGIES

Do you have any known drug allergies? ☐Yes ☐No

If so, please list all the medications you are allergic to: Medication Name and Allergic Reaction Type (what happens?)

_____

Please check if you are allergic to: ☐Iodine ☐Tape ☐Latex

PAST SURGICAL HISTORY

Please indicate any surgical procedures you have done in the past, including the date, type, and any pertinent details.

_____

_____

_____

☐ I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE

FAMILY HISTORY

Mark all appropriate diagnosis as they pertain to your biological mother and father only

Mother		Father
☐	Alcohol Problems	☐
☐	Cancer	☐
☐	Diabetes	☐
☐	Drug Problems	☐
☐	Heart Disease	☐
☐	High Blood Pressure	☐
☐	Kidney Disease	☐
☐	Liver Disease	☐
☐	Rheumatoid Arthritis	☐
☐	Lupus	☐
☐	Smoking	☐
☐	Stroke	☐

☐ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY ☐ ADOPTED

SOCIAL HISTORY

Are you capable of becoming pregnant? ☐Yes ☐No If so, are you currently pregnant? ☐Yes ☐No

Highest level of education obtained: ☐Grammar School ☐High School ☐College ☐Post-Graduate

Are you currently working? ☐Yes ☐No What is your occupation? _____

ALCOHOL USE: ☐Current Alcoholism ☐History of Alcoholism ☐Social Alcohol Use

☐Never Drinks Alcohol ☐Daily Limited Alcohol Use

TOBACCO USE: ☐Current Tobacco user ☐Former Tobacco user ☐Never Used Tobacco

ILLICIT DRUG USE: ☐Denies Any Illicit Drug Use ☐Currently Using Illicit Drugs which:

Please list all illicit drugs taken:

_____

☐Currently Uses Marijuana ☐Currently using someone else's prescription medications

☐Formerly Used Illegal Drugs (not currently using), if so which ones? _____

Have you ever abused narcotic or prescription medications? ☐Yes ☐No

Are you in recovery from drugs, alcohol, or any addiction? ☐Yes ☐No ☐Other

REVIEW OF SYSTEMS

Mark the following symptoms that you **currently** suffer from.

Constitutional

☐Weakness ☐Fatigue ☐Weight Gain ☐Weight Loss ☐Fever ☐Chills ☐Night Sweats

Eyes: ☐Recent Visual Changes ☐Eyeglasses/Contact Lenses ☐Double Vision

Ear/Nose/Throat

☐Dental Problems ☐Earaches ☐Hearing Problems ☐Nose Bleeds ☐Recurrent Sore Throat ☐Ringing in Ears ☐Sinus Problems

Cardiovascular

☐Chest Pain ☐Irregular Heartbeat ☐Murmur ☐Rapid Heartbeat ☐Blood Clots ☐Fainting ☐Swollen Extremities ☐Palpitations

Respiratory

☐Cough ☐Shortness of Breath with Exertion ☐Wheezing ☐Shortness of Breath at Rest

Gastrointestinal

☐Acid Reflux ☐Abdominal Cramps ☐Constipation ☐Diarrhea ☐Vomiting ☐Coffee Ground Appearance in vomit ☐Dark and Tar like Stools

Genitourinary/Nephrology

☐Blood in Urine ☐Decreased Urine ☐Incontinence ☐Low Volume/Frequency ☐Flank Pain ☐Erectile Dysfunction ☐Painful Urination

Integumentary/Skin

☐Change in Color ☐Rashes ☐Puritis ☐Dry Skin

Musculoskeletal

☐Joint Swelling ☐Back Pain ☐Muscle Spasm ☐Joint Pain ☐Neck Pain ☐Pelvic Pain ☐Joint Stiffness

Psychiatric

☐Depressed Mood ☐Anxiety ☐Stress ☐Suicidal Thoughts

Endocrine

☐Heat Intolerance ☐Cold Intolerance ☐Hair Changes ☐Excessive Thirst

Neurological

☐Dizziness ☐Seizures ☐Headaches ☐Numbness/Tingling ☐Memory Loss ☐Difficulty with Speech ☐Coordination Problems ☐Difficulty Walking

Hematologic/Lymphatic

☐Easy Bruising ☐Easy Bleeding ☐Impaired Wound Healing ☐Lymphadenopathy

Allergic/Immunologic

☐Recurrent Infection ☐Hives ☐Swelling ☐Itching eyes/nose